Chapter 3

Procurement and supply of AT

Factors in NDIA decision making

3.1 Submitters highlighted a number of reasons why participants may be subject to inappropriate decisions, or are experiencing misdirected funding or shortfalls in their plans. These include:

- disregard of expert advice;
- the Scheme's focus on AT products rather than services;
- varying knowledge and experience in AT of planners;
- differing abilities of participants to understand, predict, and advocate for AT; and
- the Scheme's emphasis on value for money.

Utilisation of expert reports

3.2 Reports from therapists are routinely required as part of the assessment process. Unfortunately, the committee received a plethora of feedback that there is general disregard for expert advice and recommendations on appropriate AT for participants amongst planners and staff considering applications.[1]

3.3 Can:Do Group argued that specialist recommendations are frequently ignored by delegates despite their lack of knowledge about the device or client:

> The lack of specialist knowledge of planners regarding AT needs for participants is highly concerning, as they are allocating funding and making decisions regarding appropriate devices, often without ATS assessments or in direct contravention of expert advice. This is resulting in insufficient funding to provide equipment required, or rejection of recommended equipment required by the client. There is also a lack of appreciation for specialised AT knowledge – which is evident across NDIA. Recommendations are often over ruled or over looked.[2]

3.4 The Benevolent Society raised similar concerns:

> Our staff find it very frustrating to have conducted extensive trials on equipment, to only have their recommendation following the trials declined or questioned by the NDIA who may suggest trialling less expensive but inappropriate technology. [3]

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1 For example: Develop Therapy Services, *Submission 17,* pp. 3–4; Speech Pathology Australia, *Submission 21,* p. 10; The Benevolent Society, *Submission 40,* p. 5; Can:Do Group, *Submission 36,* pp. 3 and 8; Therapy for Kids et al, *Submission 55*, pp. 3 and 4.

2 Can:Do Group, *Submission 36,* p. 3.

3 The Benevolent Society, *Submission 40,* p. 5.

3.5 The committee heard that therapists' reports are frequently misunderstood, or not read by, staff reviewing applications.[4]

3.6 Submitters argued that the Agency should recognise practitioners' AT knowledge, experience, and judgement to make appropriate recommendations, especially in cases where it has requested the advice.[5]

3.7 Ms Volkert from Occupational Therapy Australia made the point that the NDIA's administrative requirements often involve a relatively unskilled planner making decisions, sometimes in conflict with that of the therapist:

> All too often the delegate is an unskilled planner who does not have an understanding of disability, the clinical reasoning required to determine the most appropriate solution for an individual or the AT options available to address disability. We are also particularly concerned to hear of instances when a planner or an unskilled delegate has sought to change selected items within an AT application without consulting the prescribing occupational therapist, resulting in the provision of inappropriate or inoperable assistive technology.[6]

3.8 Ms Olsson from Speech Pathology Australia concurred, and provided an example of NDIA staff making recommendations about Augmentative and Alternative Communication (AAC) Assistive Technology:

> [There are] various issues related to poor planner knowledge and skills and their propensity to work outside of their scope, such as making recommendations for AAC AT themselves or suggesting alternative options to those that have been recommended by an experienced allied health practitioner, repeatedly requiring the assessor adviser to provide additional and lengthy clinical justifications for their recommendations as part of trying to make their decisions about whether the item meets the reasonable and necessary requirements, and refusing a request based on uninformed or ill-informed assumptions about what AAC AT is appropriate or represents value for money for participants.[7]

3.9 As illustrated below in the discussion about mainstream technology, the criteria used by the NDIA delegate sometimes results in perverse outcomes which do not meet the participant's needs:

> It's certainly been the experience that we have heard from our members that decisions are questioned and overturned. It is occasionally the situation that

4 Therapy for Kids et al, *Submission 55*, pp. 3 and 4.

5 For example: Can:Do Group, *Submission 36,* p. 3; Therapy for Kids et al, *Submission 55*, p. 3

6 Ms Volkert, Occupational Therapy Australia, *Proof Committee Hansard*, 22 November 2018, p. 23.

7 Ms Olsson, Speech Pathology Australia, *Proof Committee Hansard,* 22 November 2018, p. 24.

> a recommendation from an occupational therapist is overturned and something more expensive is put into place.[8]

3.10 The NDIA responded to questions from the committee that over the last two years of the Scheme operating, inconsistencies in advice from specialists has led to the Agency being circumspect about the advice provided:

> [T]he experience of the agency in the last two years is that the variation in that advice, which we didn't expect to see, has meant that in some cases we get really good advice and in other cases the advice has proved problematic. So we've had some participants with a request that we have signed off on for, say, an $18,000 wheelchair, but the actual assessment hadn't checked the person's home, so they actually couldn't get it in the front door. There was a key flaw that had occurred.[9]

3.11 When further pressed by the committee, Dr Walker from the NDIA said the Agency would 'assist' participants who are in the situation where the planner has disagreed with the advice of a specialist, to 'put strength back into that advice'.[10]

3.12 Furthermore, Dr Walker stated in response to a question on whether there should be a presumption in favour of accepting specialist advice:

> I think that would be our approach.[11]

Interaction between the NDIA and Allied Health professionals

3.13 In a related area, the committee also heard that it is very difficult for a therapist to communicate with the Agency to clarify any aspects of their advice.[12]

3.14 Submitters argued the inequity could be mitigated by requiring staff processing applications to contact the prescribing therapist if they have queries about the request, or are planning on rejecting the application, to allow for any misunderstandings to be resolved during the decision-making process.[13]

3.15 The Agency explained that NDIS delegates are unable to contact assessors if consent has not been provided by the participant.[14] However, the NDIA is working to

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8 Ms Volkert, Occupational Therapy Australia, *Proof Committee Hansard*, 22 November 2018, p. 24.

9 Dr Lloyd Walker, Special Advisor, Assistive Technology and Home Modifications, NDIA, Proof *Committee Hansard,* 22 November 2018, p. 59.

10 Dr Lloyd Walker, Special Advisor, Assistive Technology and Home Modifications, NDIA, Proof *Committee Hansard,* 22 November 2018, p. 58.

11 Dr Lloyd Walker, Special Advisor, Assistive Technology and Home Modifications, NDIA, Proof *Committee Hansard,* 22 November 2018, p. 59.

12 Noah's Ark, *Submission 25,* p. 5.

13 For example: Northcott, *Submission 30,* p. 2; Amy Martin, *Submission 31,* pp. 4–5;Therapy for Kids et al, *Submission 55*, p. 6.

14 NDIA, *answer to question on notice SQ18-000264,* received 21 November 2018.

incorporate explicit consent from participants on its improved templates to ensure that delegates can contact prescribing therapists for clarification as needed.[15]

3.16 The NDIA is also piloting a panel of specialised AT assessors in Q3 2018–19 to attempt to improve the quality of plans.[16] According to the Agency these changes are expected to help manage assessment costs, through contracted arrangements with a specialised panel of providers to inform the planning process.[17] Mr Scott McNaughton, General Manager, Government, NDIA, explained:

> …the most significant reform that we've got coming up next year is creating a specialist panel of AT assessors who'll work on arranging the functional assessment for those more complex and costly AT home modifications and vehicle modifications. The intent there is for the panel to do that assessment before a plan is approved. Then we use that information and approve the plan so the person doesn't have to wait for those assessments after the plan's approved. We think that will really expedite the process quite considerably and unblock some of those challenges we experience now. We're also creating internally a team of subject matter experts who will provide counsel and more support for our network so that we can reduce delays and help monitor and resolve more quickly any issues that keep arising.[18]

3.17 However, Vision Australia expressed deep concerns that a panel type arrangement would only provide a generic response, and would not provide the specialist knowledge that some AT decisions require for specific conditions:

> …we are concerned that the panel of assessors for AT will be a generic one, without specialist understanding or knowledge sufficient to determine the AT support needs of a participant who is blind or has low vision. Vision Impairment makes up between 2-4% of the NDIS market, and the AT support options are highly specialised, from braille devices to new technology such as Aira. Participants who are blind or have low vision, and other low incidence cohorts, will have limited confidence in a new system which does not recognise specialist need.[19]

Committee view

3.18 A fundamental aspect of how the Agency interacts with Allied Health professionals in this space is trust. Over the course of numerous inquiries the committee has heard repeated evidence of what can only be described as the development of a culture of mistrust of participants and their needs. The evidence the committee heard in this inquiry around how formal clinical reports and expert opinions of Allied Health professionals are discounted, or second guessed, in favour

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15 Dr Lloyd Walker, Special Advisor, Assistive Technology and Home Modifications, NDIA, *Proof Committee Hansard*, 22 November 2018, p. 56.

16 NDIA, *answer to question on notice SQ18-000252*, received 21 November 2018.

17 NDIA, *answer to question on notice SQ18-000259*, received 21 November 2018.

18 Mr Scott McNaughton, General Manager, Government, NDIA, *Proof Committee Hansard*, 22 November 2018, p. 54.

19 Vision Australia, *Supplementary submission 3.1*, p. 1.

of either those of the planners, or presumably in favour of other allied health professionals without specific knowledge of the case on an 'expert panel'.

3.19 The committee recognises the Agency's efforts to introduce a panel of specialised AT assessors to help improve quality of plans. However, if planners and NDIA staff placed greater trust in the advice of professionals and participants, it would not need to implement a panel of specialists.

3.20 The committee is well aware of the financial imperatives the Agency is required to work to, and that there will be circumstances where a further assessment will be appropriate. However these circumstances should be prescribed and published.

3.21 Given the evidence received, in particular from professional organisations representing highly trained and accredited Allied Health professionals, the committee is of the view that there should be a presumption in favour of accepting the advice from appropriate experts.

Recommendation 4

3.22 The committee recommends that the Agency publish criteria of the circumstances which will require the Agency to conduct further assessment beyond that provided by a registered therapist.

Focus on AT equipment rather than outcomes

3.23 The *NDIS AT Strategy* supports the provision of tablets and smartphones where they are found to be the most cost effective solution that best meets the participant's needs. It states that:

(a) AT in the NDIS includes devices used by people without disabilities (e.g. smartphones, tablets and 'apps') that are offering new ways to form connections and increase participation;[20]

(b) the Agency is committed to keeping up to date with changes to mainstream technology and how they can benefit people with disability;[21] and

(c) smartphones and tablets are offering potential solutions in some parts of the disability sector. These require further investigation and efforts to encourage take-up, given tablets and smartphones may provide similar functionality to a specialist disability device and are generally lower cost.[22]

20 NDIA, *NDIS AT Strategy*, October 2015, p. 5.

21 NDIA, *NDIS AT Strategy*, October 2015, p. 6.

22 NDIA, *NDIS AT Strategy*, October 2015, p. 13.

3.24 In many cases, a smartphone or tablet is the most appropriate and cost-effective AT solution for the participant.[23] However, the committee has repeatedly received feedback that smartphones and tablets are being rejected by the Scheme on the grounds that they are 'mainstream technology'.[24]

3.25 Ability Research Centre expressed bewilderment that the Agency would reject superior devices simply because they were 'mainstream':

> …it is clear that sometimes a generic option such as an iPad is simply the best option, offering superior outcomes and value for money. Yet these recommendations are consistently queried, or even rejected outright, by NDIA staff. Despite the inclusion of "customised commercial tablet" in the NDIA AT Code Guide, it is now notoriously difficult to get an iPad approved by the NDIA. It is baffling that the NDIA would always fund a dedicated communication device over an iPad, despite the latter being more compatible, better supported and up to ten times less expensive.[25]

3.26 The absurdity of the policy was captured in this example:

> …we had a client who had an AT system of environmental control equipment recommended for him. One element of the system was a smartphone or tablet, neither of which were owned by the client. As funding for this element of the system was denied by the NDIA, $3,000 worth of approved specialised equipment was supplied but sat idle because the client had no device to control it. The stand-off rolled on for months and then became years. Phantom approvals for a tablet appeared then disappeared. The equipment, now well out of date, was sent to the NDIA and sits in a box somewhere. The client never received their system.[26]

3.27 Ms Olsson from the Speech Pathology Australia summed up the situation succinctly:

> There's a focus on the item rather than the purpose or the outcome.[27]

3.28 Mrs Rachel Tosh, Director, Therapy Alliance Group, provided a similar example illustrating that the Agency's decision-making process does not consider what barriers are being overcome by a particular piece of equipment:

> As an example, we submitted a request for an iPad and a Proloquo2go. It was rejected. The NDIA representative suggested the alternative of an Android tablet, which doesn't support the apps that the client was already

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23 For example: Deaf Services, *Submission 11,* pp. 3–4; Ability Research Centre, *Submission 15,* p. 8; Speech Pathology Australia, *Submission 21,* p. 12; Able Australia, *Submission 29,* pp. 1 and 2; Vision Australia, *Submission 33,* p. 6; Amaze, *Submission 46,* p. 9; Yooralla, *Submission 58,* p. 9.

24 For example: Ability Research Centre, *Submission 15,* p. 8; Syndromes Without a Name, *Submission 19,* p. 1; ILC WA, *Submission 26,* p. 3; Yooralla, *Submission 58,* p. 9.

25 Ability Research Centre, *Submission 15,* p. 8.

26 Ability Research Centre, *Submission 15,* p. 8.

27 Ms Olsson, Speech Pathology Australia, *Proof Committee Hansard,* 22 November 2018, p. 32.

> using for communication. The iPad and Proloquo2go were $2000. The alternative recommended by NDIA was $7,000, hadn't been trialled with the client and was not appropriate to that client's needs, and the application for the iPad and Proloquo2Go was rejected.[28]

3.29 ILC WA pointed out that many specialist products do not allow for testing prior to purchase, limit options for local setup and repairs, and are quickly obsolete due to emerging technology.[29] It argued many devices have now crossed into mainstream markets, and not including them in plans can leave consumers with outdated and complicated equipment or none at all.[30]

3.30 The committee heard that policy ambiguity has led to some inconsistency across plans, whereby some participants have had devices funded while others in similar circumstances and with similar needs have not.[31]

3.31 In advice to the committee, the Agency confirmed that tablets, smartphones, and phone and data plans are generally considered day-to-day living costs, and are therefore not NDIS fundable. However, it is Agency policy to fund tablets when it is a stand-alone communication device required due to a person's disability.[32]

3.32 Dr Emily Steel argued there is a need to define what 'AT' covers as there is an assumption it is about products, rather than products *and* services.[33] Indeed, the Agency's definition of AT stipulates that AT is 'any device or system that allows individuals to perform tasks they could not otherwise do' which seems to imply a focus on products.

Committee view

3.33 Mainstream technology such as iPads have been transformational in the field of AT. The committee has heard countless examples of where the platform has provided for an extensive range of communication aids. The apparent ban on funding them because they are mainstream technology seems to disregard the many positive reported outcomes of the use of the technology, and the associated applications. The committee urges the Agency to make decisions based on outcomes rather than a funding ban on technology that has the potential to deliver those outcomes.

Recommendation 5

3.34 The committee recommends that the NDIA makes funding decisions based on outcomes rather on whether the item is considered mainstream, or could be used beyond its AT purpose.

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28 Mrs Rachel Tosh, Director, Therapy Alliance Group, *Proof Committee Hansard,* 22 November 2018, p. 12.

29 ILC WA, *Submission 26,* p. 2.

30 ILC WA, *Submission 26,* p. 3.

31 Syndromes Without a Name, *Submission 19,* p. 1.

32 NDIA, *answer to question on notice SQ18-000271,* received 21 November 2018.

33 Dr Emily Steel, Private capacity, *Proof Committee Hansard,* 19 October 2018, p. 30.

Knowledge of planners

3.35 Poor quality plans were linked to a lack of knowledge and experience amongst NDIS local area coordinators (LACs) and planners. Feedback suggests there is limited understanding among staff about the impact different disabilities can have on individuals and the appropriate AT solutions.[34]

3.36 The committee heard that some plans have missed key AT items:

> We are concerned that due to a lack of education and training for Planners and Local Area Coordinators, as well as staff attrition, this has also caused distress for some Participants who have experienced key items being missed on their Plan. This has been particularly the case where a Participant lacks confidence or capacity to self-advocate and/or is unsure of what AT (or other items/services) would assist them to achieve their goals and aspirations.[35]

3.37 Submitters reported some participants, despite their own limited knowledge, were having to educate planners and LACs:

> Limbs 4 Life has received numerous phone calls from educated, intelligent and positive people who, when entering the NDIS, are immediately thrown into a world they know nothing about. They need to be proactive, assertive and advocate on their own behalf to justify their needs and goals but without any tools (other than that provided by Limbs 4 Life) to do so. They have subsequently been thrown into a situation whereby they need to educate their Planners and LACs, who more often than not have a limited understanding of the unique needs of people living with limb loss, to ensure that the Planners understand what needs to be included in their Plan.[36]

3.38 Able Australia argued that some planners are not aware that some devices may not be complex on their own, but when used together they must be configured for the participant and thus require additional funding:

> Deafblind users often need a range of hardware, software and accessories that combine to provide "the device" and each of these components are from different suppliers. Bought separately they may not require an assessment but they combine to provide a holistic solution. The device should be recognised as a Category 3 complex device and receive adequate funding to customize the configure the device so that the participant can use it. There is limited expertise amongst planners to navigate this process and often breaks down.[37]

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34 For example: Ability Research Centre, *Submission 15,* p. 5; Noah's Ark, *Submission 25,* p. 4; Able Australia, *Submission 29,* p. 1; Therapy for Kids et al, *Submission 55,* p. 5; Physical Disability Council of NSW, *Submission 56,* p. 5.

35 Limbs 4 Life, *Submission 49,* p. 8.

36 Limbs 4 Life, *Submission 49,* p. 12.

37 Able Australia, *Submission 29,* p. 1.

3.39 Ability Research Centre reported that some plans include funding for the AT product but omit associated set up, customisation, and training costs:

> …NDIA staff often seem to be unaware of the essential AT services that are needed to implement and/or complement AT systems, and the additional funding therefore required. It is commonplace for planners to include a provision for "assistive technology" in a participant's plan, without additional funding for the services required to assess their needs, set up and customise their AT system, or train them in its use.[38]

3.40 The *NDIS AT Strategy* identified there is a 30 per cent abandonment rate of AT when individuals do not understand how to properly use their equipment or devices.[39]

3.41 Amaze argued that insufficient training budgets can undermine the benefits of the Scheme for participants. It expressed concern that none of the 42 respondents to its survey reported receiving funding for AT training in their plans:

> We are concerned that training is not generally being funded to support participants and their families to use complex AT. Without appropriate training, the use and cost-effectiveness of funded AT can be vastly undermined…In particular, if funding is provided for a communication app, funding must also be provided for a parent/carer and relevant others (including education providers, employers, etc.) in how to use it. This training needs to be ongoing to ensure its use is sustainable and evolves to meet the evolving needs of the user.[40]

Ability to understand and predict AT needs

3.42 The Scheme's individualised planning approach is predicated on the ability of participants to understand their disability, their requirements, the AT options available, and then advocate for their preferred AT solution. However, many participants, and their families and carers, are not well informed about disability or AT in general, and are unable to advocate strongly for their needs.

3.43 This is amplified for individuals and families with a newly acquired or complex disability and those dealing with sophisticated and ever-changing technology:

> …amongst the amputee population very little is known about accessing prosthetic trials, gaining access to a physiotherapist for further gait training and/or support from Occupational Therapists for upper limb device training. People living with limb loss are users of some of the most complex and technical AT devices required to live an ordinary life. This cohort sometimes uses advanced complex prosthetic and other AT devices; with engineering and technology advancing at a rapid pace in this particular space. In light of this the vast majority of consumers, regardless of whether

38 Ability Research Centre, *Submission 15*, p. 5.

39 NDIA, *NDIS AT Strategy*, October 2015, p. 14.

40 Amaze, *Submission 46*, p. 11.

> they have lived with limb loss for decades or only months, are not aware of the AT available to them.[41]

3.44 ILC WA argued that it takes a skilled clinician to understand and forecast appropriate AT and associated services:

> With complex AT, it takes an experienced and skilled AT clinician to see, mitigate, and plan for future issues…Under the NDIS this decision and planning is left to the responsibility of the participant who often don't hold or value this knowledge and may solely rely on suppliers or their own social networks.[42]

3.45 Limbs 4 Life pointed out that the NDIS has been a crash course for many individuals:

> For many, the process has been a crash course in education, the ability to self-advocate, an urgent need to understand their disability requirements, while simultaneously trying to understand and interpret new NDIS-related processes…With the rollout of the NDIS individuals are required to have a complete and thorough understanding of the NDIS process and structures or risk having their AT needs not met.[43]

National accreditation for AT practitioners

3.46 In response to a lack of knowledge across all stakeholders, some submitters proposed a national accreditation system for allied health professionals that recognises skills, knowledge, and experience in AT.[44] As pointed out by ARATA, a lack of accreditation makes it difficult for NDIS participants to determine who can provide appropriate and quality AT services.[45]

3.47 There are varying levels of AT knowledge held by prescribing therapists, and no minimum competencies or standardised skills across the sector. There are concerns some may be relying solely on the advice of AT suppliers which raises questions around conflict of interest.[46] Indeed, Dr Ken Baker argued that, with the future uncertain for state-funded independent living centres, independent advice and the ability to trial AT in a neutral environment is at risk of being lost.[47]

3.48 Previous work undertaken by ARATA and Assistive Technology Suppliers Australia identified the need for a credentialing and accreditation system that recognises competence and sets minimum practice standards for providers and

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41 Limbs 4 Life, *Submission 49,* p. 12.

42 ILC WA, *Submission 26,* p. 3.

43 Limbs 4 Life, *Submission 49,* p. 7.

44 NDIA, *answer to question on notice SQ18-000251,* received 21 November 2018.

45 ARATA, *Submission 35,* p. 6.

46 ILC WA, *Submission 26,* p. 3.

47 Dr Ken Baker, Principal Advisor, National Disability Services, *Proof Committee Hansard,* 19 October 2018, p. 2.

suppliers.[48] The project found that regulatory schemes such as accreditation can achieve:

- reduced abandonment of assistive products;
- greater efficiency by directing demand for higher or lower practitioner competence based on risk and complexity;
- consolidation of knowledge amongst practitioners;
- agreement on necessary AT competencies.[49]

3.49 The project reviewed national and international systems and recommended an approach to establishing an Australian national accreditation system for AT practitioners and suppliers.[50]

3.50 The committee acknowledges that some professions, such as orthotists and prosthetists, are already required to undertake core competencies in AT and should therefore not be subject to additional requirements.[51]

3.51 SWEP in Victoria provided information on their Registration and Credentialing Framework, which currently has over 8000 providers across all Allied Health and medical staff with the knowledge and skills required in the prescription of all types of AT. Key features include:

- Threshold credentials for each AT category;
- Performance expectations of prescribers at each level (green, amber and red);
- Client characteristics that may impact prescription;
- Robust, accountable and credible system that defines standards of competence;
- A matrix for categorisation of AT, client and prescriber; and
- Standards for minimum requirements for registration.[52]

3.52 According to the their submission, SWEP's 'traffic light' system works in the following way:

> SWEP credentialed prescribers are allocated a traffic light colour for each AT category which relates to their formal qualification (threshold credentials), years of experience, frequency of prescribing AT and continuing professional development (CPD). A 'white' prescriber provides

48 ARATA, *Submission 35*, p. 4.

49 ARATA and ATSA, *National Credentialing & Accreditation of AT Practitioners & Suppliers Options Paper*, May 2013, p. 8.

50 ARATA, *Submission 35*, p. 4.

51 Ms Leigh, Executive Officer, Australian Orthotic Prosthetic Association, *Proof Committee Hansard*, 22 November 2018, p. 20.

52 SWEP, *Submission 70*, p. 3.

> administrative support to registered prescribers only, they cannot prescribe. A 'green' prescriber can prescribe AT for clients that is considered non-complex. An 'amber' prescriber will have a higher level of expertise and experience, while a 'red' prescriber is recognised as an expert in their field.[53]

3.53 Speech Pathology Australia supported this model which they claim will build the capacity of the sector as a whole:

> The Association supports a model similar to one employed by the Victorian State-wide Equipment Service which can offer the scaffolded supports whereby providers can develop the knowledge, skills and expertise about AAC AT, helping to build capacity in the sector as a whole.[54]

Emphasis on value for money

3.54 Striking a balance between adequate funding for individuals whilst ensuring Scheme sustainability is no easy task. There are concerns that the NDIA is placing undue emphasis on value for money at the expense of participants' outcomes.[55]

3.55 The NDIA's operational guidance states that the Scheme will only fund the minimum necessary or standard level of support required to meet the functional specifications needed to meet the participant's goals.[56] However, submitters argued there is usually a reason why a more expensive option has been recommended.[57] Vision Australia pointed out there are many elements to a therapist's recommendation or a participant's preference:

> …things such as the design of the user interface, prior experience, the amount and availability of training and support, ergonomic considerations, reading and learning preferences, cognitive function and many more. These are often not given any consideration due to the planner's insistence on getting a cheaper product that, in their opinion, is equivalent.[58]

3.56 Therapy for Kids et al made a similar argument:

> Items can be rejected with the suggestion that a cheaper item of similar characteristics should be suitable. An understanding of how an assistive technology item removes a barrier in participation or activity for a participant assists in identifying why an item has been suggested by a therapy provider. Often a similar or cheaper product does not remove the

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53 SWEP, *Submission 70*, p. 2.

54 Speech Pathology Australia, *answer to question on notice*, received 30 November 2018, p. 2.

55 For example: Ability Research Centre, *Submission 15*, pp. 7–8; Develop Therapy Services, *Submission 17*, p. 3; Vision Australia, *Submission 33*, p. 9; Therapy for Kids et al, *Submission 55*, p. 4.

56 NDIA, *Operational Guidelines—Assistive Technology*, https://www.ndis.gov.au/Operational-Guideline/including-4 (accessed 22 October 2018).

57 Vision Australia, *Submission 33*, p. 9; Therapy for Kids et al, *Submission 55*, p. 4.

58 Vision Australia, *Submission 33*, p. 9.

> barrier being experienced by the participant and is therefore a meaningless purchase.[59]

3.57 The concerns were echoed by Develop Therapy Services:

> Planners do not always have the appropriate skills to decide to approve or not approve specific items. Approval seems to be based largely around the cost of the recommended AT when there are multiple factors to consider, as we have listed above. It is false economy to provide a cheaper alternative if it results in injury or lost opportunity to the participant.[60]

3.58 WA OTA argued that participants may choose AT suppliers based on reputation and reliability but that these preferences are being disregarded for cheaper alternatives.[61]

3.59 Vision Australia argued that a focus on cost rather than outcomes places progress in AT innovation at risk as new solutions that may be marginally more expensive are rejected.[62]

Committee view

3.60 The committee heard evidence that the focus on value for money, is more a focus on bottom line cost, rather than value. The committee fully understands the pressure the Agency is under to ensure the sustainability of the Scheme. However, a focus on monetary value alone disregards the tangible outcomes that will ensue if participants have access to the appropriate assistive technology that will assist them in being as physically, socially, and economically participative in society as possible.

3.61 The committee welcomes the continuous efforts of the agency to improve the capability of its decision makers. However, it is at a loss to understand why the Agency has not utilised the expertise and experience of state and territory systems. The credentialing model employed by SWEP in Victoria seems to offer a robust, logical, cost effective, equitable, and efficient system for ensuring the best possible outcomes for both participants and funding bodies. The committee strenuously suggests that the Agency does not re-invent the wheel yet again by attempting to design a model with all the features of the models in place before the Scheme rolled out, but with much worse outcomes for all stakeholders, including tax payers.

Recommendation 6

3.62 The committee strongly recommends that the NDIA adopt the SWEP credentialing model for prescribing Assistive Technology.

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59 Therapy for Kids et al, *Submission 55*, p. 4.

60 Develop Therapy Services, *Submission 17*, p. 3.

61 WA Occupational Therapy Association, *Submission 27,* p. 2.

62 Vision Australian, *Submission 33,* p. 9.

The supply of AT

Market conditions

3.63 Much of the success of the NDIS overall relies on providers of services coming into the Scheme to provide the choice and control that underpins the ethos of the Scheme. Competition within the AT market supply and provision is similarly essential to ensure the cost effective provision of equipment.

3.64 The NDIA provided evidence that they are exploring various options with the sector to develop initiatives to stimulate choice and competition in the market place.

3.65 Dr Lloyd Walker, Special Advisor, Assistive Technology and Home Modifications, NDIA, explained:

> …you have to recognise the agency's priority is to work within a market system. […] I was having a conversation yesterday with a provider who has a very close link to a fleet car organisation about offering fleets of very expensive power wheelchairs and vehicle modifications. The agency would fund into a participant's plan effectively a lease. We would lease off that fleet. That would cover their repairs, their maintenance. If they need to change it, they could get it changed at a moment's notice pretty much. And, potentially, they can add in a bit more money and lift the bar and go to higher product, if that is what they want as well.[63]

State and territory systems

3.66 Given the extensive delays, and supply issues around the provision of AT, the committee welcomed information on the seemingly extensive stores of AT held by states and territories, and the apparently highly efficient procurement and supply processes that were in place prior to the roll out of the NDIS.

3.67 Therapy 4 Kids described the ACT model as being a good exemplar:

> The ACT's state model was particularly quick. Sometimes I would get an answer within 24 hours, often within a week and always within a month. For items that were more expensive, it was within three months.[64]

3.68 The body responsible for AT in NSW is Enable NSW who operate the Aids and Equipment Program (AEP). Enable NSW is also a registered service provider to the NDIA and can 'provide co-ordination of equipment supports approved in NDIS Plans (for example placing orders for new equipment, ordering consumable products or contacting suppliers to arrange repairs)'.[65]

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63 Dr Lloyd Walker, NDIA, *Proof Committee Hansard*, 22 November 2018, p. 59.

64 Ms Carolyn O'Mahoney,, Director and Physiotherapist, Therapy 4 Kids, *Proof Committee Hansard*, 22 November 2018, p. 6.

65 Enable NSW, *Information for people receiving assistance from EnableNSW*, available at: http://www.enable.health.nsw.gov.au/ndis/consumers, accessed 29 November 2018.

3.69 EnableNSW also provide prosthetic and orthotic manufacturing services, specifically for people in regional and rural NSW, which is again a registered service provider to the NDIS:

> …we operate two prosthetic and orthotic manufacturing services in rural areas, which ensure people living in regional and rural New South Wales have access to a service that would be otherwise unavailable. We anticipate these services will continue to offer registered provider services to NDIS participants who choose them on an ongoing basis.

3.70 EnableNSW provided a summary of their main KPIs for both internal and external processes for Aids and Equipment and for Prosthetics:

INTERNAL – AIDS AND EQUIPMENT	
(i) Customer service and processing times	KPI
Incoming calls	Average Speed of Answer < 40 sec
Email response	< 24 hours
Repair lodged with provider	< 24 hours
Re-order lodged with provider - continence, Home Enteral Nutrition (HEN)	< 2 days
Quoted equipment request* to purchase order	<10 days
Refurbished stock request* to delivery bay	<5 days

*Assumes complete application

EXTERNAL – AIDS AND EQUIPMENT	
(ii) Equipment request (order placement to delivery)	KPI
Order delivery – continence, Home Enteral Nutrition (HEN)	< 10 days
Refurbished stock delivery bay to home	< 14 days

INTERNAL – PROSTHETIC LIMBS	
(i) Prosthetic Limb Service Metrics (request to approval/order)	KPI
Interim Limb (first limb post-amputation surgery) approval	< 24 hours
Replacement limbs and sockets	<14 days*
Minor repairs under $700	Immediate
Minor repairs ($700-$2000) – where provider telephones EnableNSW for approval	Immediate

*NB: EnableNSW guidelines are published and consistent so many providers commence work ahead of approval

EXTERNAL – PROSTHETIC LIMBS (ii) Prosthetic Service Provider Metrics (funding approval to delivery)	KPI
Interim Limbs (metro)	5 days
Interim Limbs (rural/regional)	17 days
Replacement limbs or sockets (metro)	10 days
Replacement limbs or sockets (rural/regional)	15 days[66]

3.71 Currently, in Victoria, SWEP is working 'within an informal 'business as usual arrangement' with the Agency'[67] subject to ongoing discussions. This arrangement follows SWEP being the 'in-kind' provider for the Scheme throughout the trial phase up until 2016.[68]

3.72 SWEP provided a late submission to the committee, outlining some of the key features of their program. According to the submission the model is designed to respond to funding bodies, and the needs of participants with a model that:

> …encompasses an integrated approach to provide assurance that equipment provided to AT consumers is best fit for purpose and best value for money. This approach also allows AT consumers to exercise choice and control considering parameters such as safety, functionality and durability, within the context of the funding body's requirements for dignity of personal risk for their consumers.[69]

3.73 The SWEP system has some features which appear to address precisely many of the problems the Agency is facing. Aside from the credentialing of providers discussing earlier in this chapter, the SWEP submission highlights how it operates in the following areas:

- Assessor Support;
- Infrastructure & Governance Framework;
- Repairs;

66 EnableNSW, answer to question on notice, received 30 November 2018, p. 3-4.

67 SWEP, *Submission 70,* p. 1

68 SWEP, *Submission 70,* p. 1

69 SWEP, *Submission 70,* p. 2.

- Refurbished Equipment;
- Priority of Access;
- Strategic Procurement; and
- Organisational Agility.

3.74 In terms of waiting times, witnesses and submitters supported the claims of SWEP and other state services, that their systems were significantly more efficient and timely than the NDIS model.[70] For example:

> …previously, under the State-wide Equipment Program, if something was urgent, we were able to phone the SWEP program, speak to someone, and equipment was often funded within 24 to 48 hours.[71]

3.75 SWEP's submission provided a table[72] illustrating the difference in response times for the provision of a highly customised powered wheelchair:

Process	State funded Scheme (Victoria)	NDIS
Identification of suitable item	01/10/18	06/10/17
Application received by SWEP	02/10/18	09/10/17
Quality assurance check undertaken by SWEP	05/10/18	11/10/17
Application sent to NDIA for R&N decision	N/A	11/10/17
Approval to order received from NDIA	N/A	26/02/18
Order placed	09/10/18	26/02/18
Wheelchair modifications & build commenced	10/10/18	unknown
Item delivered to participant	19/11/18	09/07/18
TOTAL TIME TAKEN	**49 days**	**277 days**

3.76 However, the committee did receive evidence from the Australian Orthotic and Prosthetic Association that, in the case of orthotics and prosthetics, it was the use of state schemes that was causing the extensive delays and called for the practice to be halted. The Association provided the following example of the system malfunctioning:

> A participant in Victoria visited an orthotist for an assessment to receive a knee-ankle-foot orthosis. An application for funding was submitted to the Victorian State Scheme (State-Wide Equipment Program) portal and was only forwarded to the NDIS after one month. After being approved by the NDIS after another month, the order has been delayed in the SWEP

70 For example: Name Withheld, *Submission 2,* p. 1; Noah's Ark, *Submission 25,* p. 4; Lifestart, *Submission 48,* p. 10; Permobil, *Submission 53,* p. 2; Therapy 4 Kids, Splash Physiotherapy and Therapy Alliance Group, *Submission 55,* p. 2.

71 Ms Suzie Green, Team Leader and Senior Physiotherapist, Noah's Ark, *Proof Committe Hansard,* 22 November 2018, p. 5.

72 SWEP, *Submission 70,* p. 8.

> administrative process for two months and the practitioner is unable to provide the service. This delay is caused by both SWEP and the NDIS.[73]

3.77 This view is supported by other groups who reported that since Scheme rollout, there have been considerable delays for AT for some participants through these state-based equipment programs:

> The transition in Victoria has caused a significant backlog for AT provision for both NDIS and Department of Education and Training (DET) funded clients. DET clients are now going on a SWEP waitlist, with the majority being told they will not receive equipment until they receive their NDIS plan (currently occurring in Bayside and Southern regions as they roll into the NDIS).[74]

3.78 However, the model under state systems was different, and often equipment provided under those systems was not fully funded, requiring the participant to either contribute or access additional funding through charities:

> Under the State-wide Equipment Program in Victoria, equipment was funded based upon risk, so urgent equipment was funded fairly quickly; less urgent equipment took longer. Some equipment, as I said before, could be funded within 24 to 48 hours. The challenge that the State-wide Equipment Program had in its funding model is that not all equipment was wholly funded. If we think back a couple of years you might have a wheelchair where part of the wheelchair was funded and then families were required to access charities, so the charity part of the funding model would take anywhere up to a year or two years to gain that funding. We appreciate, under the NDIS, that it is wholly funded, but the time frames that we're looking at at the moment are anywhere above six to 12 months for that funding to come through.[75]

3.79 Dr Walker from the NDIA also pointed out that the NDIS facilitates a much more holistic evaluation of the participant's needs, beyond simply the assistive technology:

> One of the big differences between the NDIS and state programs is the NDIS is a funding program to give participants access to a support. Most of the state programs focus on offering a fleet of equipment from which the participants receive. You've heard from Ms Hiller about EnableNSW's pool of equipment that they make available to participants. When a participant in New South Wales wants to draw off EnableNSW, they put in a request for a wheelchair, whereas, when they're approaching the NDIS, we are looking broadly at what their range of supports might mean, which is a combination of whether it's personal care support, a wheelchair, transfer equipment or modification of a house—all of those are potentially in play. That

73 Australian Orthotic and Prosthetic Association, *Supplementary Submission 57.1,* p. 11.

74 Noah's Ark, *Submission 25*, p. 3.

75 Ms Green, Noah's Ark, *Proof Committee Hansard,* 22 November 2018, p. 6.

> sometimes adds to the length of time in considering what the most appropriate option is.[76]

Committee view

3.80 The committee heard compelling evidence on the efficiency of the operation of AT equipment services in states and territories prior to the NDIS. The time periods between the necessary equipment being identified, provided and used appropriately and safely, has blown out significantly under the NDIS. According to evidence this is because of a duplication of application and assessment processes.

3.81 The committee understands that the NDIA cannot completely outsource its assessment procedures to state agencies, however the current situation is unworkable, and is producing unacceptable delays. The Agency has to decide on one process or the other. Given the experience, skills and expertise of the state schemes, the committee suggests that the Agency enter into agreements, or Memorandums of Understanding with them to process and manage applications instead of the Agency.

Recommendation 7

3.82 The committee recommends the NDIA explore entering into agreements with state schemes for the prescription, assessment, and delivery of Assistive Technology to NDIS participants.

State-based loan pools

3.83 The committee also heard suggestions that loan pools and leasing arrangements should be utilised to assist some participants to access AT temporarily in a cost effective way.[77]

3.84 Therapy for Kids et al argued that one of the reasons for delays to AT is the purchasing of new equipment. It suggested wait times for AT could be reduced by allowing NDIS funding to be used to access state-based loan pools of equipment through the State-wide Equipment Program (SWEP):

> SWEP has a reissue database. Especially for children, items are often used for 4 years due to growth. SWEP's repairs and maintenance program services the items and makes them available for reissue. Currently NDIS participants 'own' the items and are giving them away or selling them after they are no longer needed. Making use of existing state-based infrastructure to reissue AT items would make a difference to times to receive AT in some instances and would be a budget saver for the NDIA.[78]

3.85 The Australian Physiotherapy Association made a similar argument:

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76 Dr Lloyd Walker, Special Advisor, Assistive Technology and Home Modifications, NDIA, *Proof Committee Hansard,* 22 November 2018, p. 55.

77 For example: Therapy for Kids et al, *Submission 55*, pp. 5 and 7; Australian Physiotherapy Association, *Submission 62,* p. 12; Dr Ken Baker, Principal Advisor, National Disability Services, *Proof Committee Hansard,* 19 October 2018, p. 2.

78 Therapy for Kids et al, *Submission 55*, pp. 5 and 7.

> We understand that Victoria has an excellent and well established re-issue system and pool of equipment with an excellent, well maintained database for re-issue. This is easy to use and provides great solutions for people with disabilities. It is a very cost effective way for this equipment that is still in working order but not able to be used for another person.[79]

3.86 Dr Ken Baker, Principal Advisor, National Disability Services, argued that these systems are valuable for urgent and short term use:

> The second strength under some of the state systems, although it was patchy, was access to recycled equipment for people, often either children—children's needs for equipment can change quite rapidly, so it often makes sense to get equipment, use it for a short term and then for that equipment to be recycled and used by other children—or people with rapidly deteriorating neurological conditions where they don't want to wait long for equipment, they need equipment now and they won't need it for long. [80]

3.87 Speech Pathology Australia were also supportive of a loan system for AT. According to their evidence, the NDIA should support:

> …a 'library' system for AAC AT to provide participants with the ability to trial equipment, to ensure they are able to identify the best AAC AT solution for them.[81]

3.88 The NDIA explained that, for participants with degenerative conditions, planners can include a funding budget for accessing AT pools operated by specialist organisations (such as the Motor Neurone Disease Association of NSW) or state and territory AT programs.[82]

3.89 However, it pointed out that not all participants will be able to access state-based equipment loan pools. This is because delegates must consider the cost of purchasing or leasing equipment when determining whether AT supports represent value for money.[83] It also highlighted that not all government-operated state-based loan pools offer a hire service, some state programs do not provide supports to 'self-managed' NDIS participants, although, in these cases, participants can have AT supports 'agency managed' so they can hire through these programs.[84]

3.90 Ms Suzie Green, Team Leader and Senior Physiotherapist, Noah's Ark, noted that, in Victoria, NDIS participants were no longer allowed to access the SWEP loan of equipment:

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79 Australian Physiotherapy Association, *Submission 62,* p. 12.

80 Dr Ken Baker, Principal Advisor, National Disability Services, *Proof Committee Hansard,* 19 October 2018, p. 2.

81 Speech Pathology Australia, *answer to question on notice,* received 30 November 2018, p. 2.

82 NDIA, *answer to question on notice SQ18-000273,* received 21 November 2018.

83 NDIA, *answer to question on notice SQ18-000277,* received 21 November 2018.

84 NDIA, *answer to question on notice SQ18-000277,* received 21 November 2018.

> In the current system in Victoria we have the State-wide Equipment Program, which previously had a very large loan pool. Recently their rules changed in terms of: if you were NDIS funded, you were not able to access the loan pool. So, there is a very large loan pool at the State-wide Equipment Program which is available for SWEP funded clients but not for NDIS funded participants. I think they're expecting that, as more equipment is purchased by the NDIS, that pool will increase, but at this point it's very small.[85]

3.91 With the introduction of the NDIS, EnableNSW ceased its communication devices loan pool:

> We don't any longer, but we did run a communication devices loan pool, and that particularly helped with some of the issues that have been addressed this morning about the need for items to be in place and used for a good long period. We had a month where allied health professionals could get them out of the pool and work with them themselves and become familiar with them but also could leave them with a participant for a month and have them programmed for them to give them time to prove they could use them and that they were effective for them before they would go on to actually request the item… The demand for that fell away with the NDIS. As we slowly assessed that situation, we returned the remaining items to clinical services that had a need for them for people who were outside of the NDIS, particularly in the area of degenerative conditions, because it was not being accessed.[86]

3.92 While the Agency has not yet had discussions with Enable NSW regarding its plans to establish a coordinated pool of common AT across NSW community health facilities by July 2019,[87] it is considering whether to extend arrangements to assist participants to access government coordinated stock equipment and the impact this may have on the market.[88]

Recycling of equipment

3.93 The committee heard there is not currently a centralised system to recycle AT equipment that has been bought through the NDIS but is no longer required by the participant.[89] Mr Enis Jusufspahic, National Manager, Sector Development, ECIA, explained that families and business are simply running their own informal loan pools:

> There's no formal way of recycling it, so, at the moment, providers take it upon themselves, with the families that they work with, to ask them to bring

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85 Ms Suzie Green, Team Leader and Senior Physiotherapist, Noah's Ark, *Proof Committe Hansard,* 22 November 2018, p. 1.

86 Ms Jackie Hiller, Manager, EnableNSW, HealthShare NSW, *Proof Committe Hansard,* 22 November 2018, p. 49.

87 NDIA, *answer to question on notice SQ18-000278,* received 21 November 2018.

88 NDIA, *answer to question on notice SQ18-000280,* received 21 November 2018.

89 For example: Therapy for Kids et al, *Submission 55,* pp. 5 and 7; Australian Physiotherapy Association, *Submission 62,* p. 12; Dr Ken Baker, Principal Advisor, National Disability Services, *Proof Committee Hansard,* 19 October 2018, p. 2.

> in the equipment that they're not using, and then they would maintain it and repair it and loan it back out to other families. They would run their own loan pools, essentially, but there is no formal way of managing this, from a scheme perspective.[90]

3.94 The committee heard that families are selling and buying AT through platforms such as eBay, as a way to circumvent the delays of the NDIS:

> If it's an item that they've seen for sale that someone else has had, they'll say: 'I've seen that on eBay, I know that's what we want and I know we're about to go through all the trials and all the documents in the next 12 months. What if I just sell this and buy that?' If it's an item that they can readily access second-hand, they'll often choose that.[91]

3.95 EnableNSW noted that access to its equipment recycling and reissue program would save the Scheme a considerable sum of money each year:

> …at the request of the NDIA, we provide some services under working arrangements as a registered provider. These working arrangements expire on 30 June 2019. New South Wales accepted the request to provide these services in order to share our expertise in assistive technology provision, and to support access to cost-effective assistive technology through our equipment recycling and reissue program and our contract arrangements. At the time of the initial request, the NDIA found that in relation to AT access to information, some specific contracted items, and recycling and reissuing equipment that the NDIS could save $161 million per annum. This would clearly assist scheme sustainability, and those details are in the NDIS AT strategy.[92]

3.96 The program in NSW drew from more mature programs in South Australia, and from New Zealand:

> The most developed program is in South Australia. We and South Australia probably based a lot of our learnings on Enable New Zealand, which has had a very mature recycle and reissue program, but there are also programs throughout Europe and the UK.[93]

3.97 SWEP in Victoria compared the typical cost of buying new wheelchairs, with the cost of refurbishing them:[94]

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90 Mr Enis Jusufspahic, National Manager, Sector Development, ECIA, *Proof Committee Hansard,* 19 October 2018, p. 8.

91 Ms Suzie Green, Team Leader and Senior Physiotherapist, Noah's Ark, *Proof Committe Hansard,* 22 November 2018, p. 9.

92 Ms Jackie Hiller, Manager, EnableNSW, HealthShare NSW, *Proof Committee Hansard,* 22 November 2018, p. 48.

93 Ms Hiller, Enable NSW, *Proof Committee Hansard,* 22 November 2018.

94 SWEP, *Submission 70,* p. 6.

Item	Age	Current Price (New)	Reissue Cost (Second hand)	Savings
Quickie Iris manual customised wheelchair	4 years	~ $11,000	$1,256	$9,744
Quickie 2 manual customised wheelchair	2 years	~$6,500	$1,247	$5,253
QM710 customised power wheelchair & specialised backrest	2 years	~$14,000	$3,666	$10,334
Q6 Edge 2 customised power wheelchair	1 year	~$18,500	$2,935	$15,565

3.98 Speech Pathology Australia were strongly of the view that the expertise and experience of the state specialised equipment services should be retained, and accessible to NDIS participants:

> We feel it is essential that the NDIA ensures continued access to supports such as those provided by the former specialised equipment services including: - a 'one-stop' centre of support, providing access to AT Advisors who can offer independent advice as well as direct supports (i.e. assessment, training, set up and support for equipment trial, individualised set up of AT) and/or capacity building supports to participants, primary therapy providers and others.[95]

3.99 The NDIA is consulting and engaging with the AT provider sector to develop a coordinated approach to services that can acquire, refurbish, resell and when appropriate, recycle used AT. It advised that the next workshop with AT providers on this topic is scheduled for late November 2018.[96]

Committee view

3.100 Loan pools, recycling and refurbishment of assistive technology have long since been a feature of any aids and equipment programs. The NDIS model, with an emphasis on an individual bespoke solution for each participant, does not sit easily within those previous systems.

3.101 However not every AT solution is a fully customised piece of technology that can only be utilised by its intended recipient. There are thousands of standard items that the committee heard were being purchased at high cost, on an individual basis, and not being recycled or res-used afterwards. Evidence to the inquiry suggested that there were improvements and efficiencies possible across the board, on processes and procedures, as well as significant cost saving opportunities.

95 Speech Pathology Australia, *answer to question on notice*, received 30 November 2018, p. 1.

96 NDIA, *answer to question on notice SQ18-000279*, received 21 November 2018.

Recommendation 8

3.102 The committee recommends that the NDIA undertake an urgent review of all aspects of its AT delivery model, with specific focus on how it can utilise current state and territory equipment schemes, including bulk-purchasing, loan and recycling programs.

Hon Kevin Andrews MP

Chair

Senator Alex Gallacher

Deputy Chair