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Review of the NDIS Act

13 October 2015

The Victorian Healthcare Association

The VHA is the peak body representing the public healthcare sector in Victoria. Established in 1938, the VHA promotes the improvement of health outcomes for all Victorians, from the perspective of its members.

Members of the VHA include public hospitals, rural and regional health services, community health services, aged care facilities and primary care organisations. Our services provide a broad range of health, mental health, aged care and disability services.

Many members of the VHA may consider becoming NDIS service providers and all will continue to provide other health and community services to both NDIS participants and those people living with a disability who are not deemed eligible for individual NDIS support plans.

For this reason, the VHA has focused on elements of the review that relate to the interface with the aged care, health and mental health service systems.

Question 3:

How well do the access criteria enable government to further the objects and principles of the NDIS Act?

3.1 "Aged under 65 when the request is made"

The impacts of the strict 65 age split between the aged care and disability systems, must be closely monitored (particularly for those with early age related diseases such as Younger Onset Dementia), to ensure that people are able to continue to access supports that meet their needs and which support their economic and social participation.

To prevent people 'falling through the gaps', an effective interface between the disability and aged care systems will be crucial. The provision of transition support between the two is also required to ensure that people experience continuity from one system to the other.[1]

3.2 "The impairment or impairments are, or are likely to be, permanent" / "The person is likely to require support under the NDIS for the person's lifetime"

These access requirements both signify a tension between the health sector's wellness and recovery models of service provision and raise specific issues for assessing the eligibility of those living with mental illness.

[1] Alzheimer's Australia, 2013, *Response to the National Disability Insurance Scheme Bill 2012,* [6 October 2015] https://fightdementia.org.au/sites/default/files/Response_to_the_NDIS_Bill_2012.pdf

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The notions of permanency and a lifetime of care run contrary to best practice health and mental health care, which "focuses on recovery and fostering maximum independence for people with disabilities and chronic conditions"[2].

It also presents issues for health professionals in assisting their mental health clients in accessing services through the NDIS:

> *It is contrary to current evidence-based recovery practice and the episodic nature of mental illness which makes it very difficult for psychiatrists and GPs to formally state that a consumer has a permanent diagnosis/disability and functional impairment.*[3]

Additionally, the language of permanency and disability is known to "*create high levels of stigma, distress and a loss of hope"* for those living with mental illness.

Recommendation 1: Effective interface and transition arrangements between the NDIS and the Aged Care System must be in place to ensure people receive the services they need.

Recommendation 2: Rework the access criteria to reflect a best-practice recovery approach to service provision as well as the episodic nature of some disabilities (including mental illness).

Questions 6:

Question 6: How well does the legislative framework's definition of what constitutes 'reasonable and necessary supports' support the independence and social and economic participation of people with disability?

6.1 "Is most appropriately funded or provided through the NDIS, and is not more appropriately funded or provided through other service systems (such as the health system… etc)"

In order to support independence as well as social and economic participation, people with disability must have the full range of their needs (including their health needs) incorporated in their packages of supports.

One of the principles of the NDIS Act is that "*People with disability and their families and carers should have certainty that people with disability will receive the care and support they need over their lifetime*."[4]

People receiving non-health services through the NDIS will also continue to require health services. This makes the interface between the health and disability service sectors absolutely crucial. The

[2] Deeble Institute, 2014, *Implications of the National Disability Insurance Scheme for health service delivery*. Deeble Institute, Issues Brief, No.NLCG-5, Australian Healthcare and Hospitals Association, 23 June 2014, Canberra.
[3] Psychiatric Disability Services of Victoria (VICSERV), 2015, *Learn and Build in Barwon, The impact of the National Disability Scheme on the provision of Mental Health Services in the Barwon Launch site. Key Issues for Consumers, Families, and the Victorian Mental Health Service System,* VICSERV June 2015, Victoria
[4] National Disability Insurance Scheme Act 2013 (C'th)

interface must be seamless and the systems easily navigated. The interface arrangements should be developed based on the principle that people with disability must be able to easily access the full range of services they require to optimise their health, independence and social and economic participation.

Many individuals who currently receive disability services and individual support plans via State programs have health services included in their support packages. If the NDIS does not support the continued provision of required health services there will be transition issues for this cohort who cannot afford to have their health services discontinued or made to wait as part of their transition to the NDIS.

It will be crucial to monitor the scheme's interface with the health system to ensure that perverse incentives are not created that work against the wellness and recovery approach, and that service delivery for NDIS participants is outcome focused and responsive to individual goals, rather than on cost-shifting between the NDIS and state-based health systems.[5]

Recommendation 3: Monitor the interface between NDIS and the health system and ensure care planning reflects consumer needs and preferences rather than arbitrary boundaries or cost-shifting between service systems.

Further information

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[5] Deeble Institute 2014