RACGP

NDIS Access Changes Consultation

RACGP submission

Introduction

The Royal Australian College of General Practitioners (RACGP) welcomes the opportunity to respond to the Department of Health, Disability and Ageing's (DoHDA) consultation on National Disability Insurance Scheme (NDIS) access changes.

The RACGP is the voice of specialist general practitioners (GPs) representing more than 50,000 members in our growing cities and throughout rural and remote Australia. For more than 60 years, we have supported the backbone of Australia's health system by setting the standards for education and practice and advocating for better health and wellbeing for all Australians. Our core commitment is to support specialist GPs from across the entirety of general practice to address the primary healthcare needs of the Australian population. The College now trains more than 90% of Australia's GPs, including those in rural and remote areas and Aboriginal and Torres Strait Islander communities.

GPs are intrinsically involved with and have strong and ongoing relationships with people living with disability, their families, and carers. GPs are experts in disability care as well as being the most efficient and cost-effective part of the healthcare system. They are the only health professionals trained in whole-person, longitudinal care, often including care of the whole family, and possess unique skills central to achieving good outcomes for patients with chronic illness or impairment.

GPs play an important role in assisting their patients to access the NDIS by providing evidence of disability and functional impairment. The GP may submit this evidence by completing the relevant section of the NDIS Access Request Form, as well as providing assessments or reports outlining the applicant's functional capacity. There is often a multidisciplinary team approach to helping patients navigate the NDIS, with practice nurses and Aboriginal and Torres Strait Islander Health Workers and Practitioners involved in this process.

The RACGP recognises there are important health equity considerations pertaining to the NDIS and disability funding more broadly, and that Australians with disability experience significant disadvantages. Aboriginal and Torres Strait Islander people are 1.5 times as likely than non-Indigenous Australians to live with a disability. We recognise the importance of the NDIS First Nations Strategy and expect the commitments contained therein will be reflected in decisions around access changes.

NDIS cost blowouts have been well documented. A greater role for GPs in the NDIS will contribute to a more sustainable NDIS, ensuring people with disability get the support they need when they need it. It will also deliver better integrated health and disability services, making processes more efficient and accountable as well as reducing fragmentation.

Responses to consultation questions

1. Do the draft guiding principles provide the right foundation for a future NDIS access process?

The RACGP generally supports the guiding principles listed in the consultation paper, which reflect themes of equity, consistency, transparency and evidence-based decision-making. We broadly support the pivot to functional capacity as the key determinant of NDIS eligibility.

In addition to consultation with the disability sector, the medical sector must be included in discussions as changes to the NDIS are further refined. This includes consultation by the Technical Advisory Group for NDIS functional capacity.

Although GPs would not be performing functional capacity assessments themselves, their clinical input and expertise will bridge the gap between the health and disability sectors.

Not involving GPs in the NDIS process undermines the following principles:

- Principle 2 – failing to appreciate fully the lived experience of consumers
- Principle 3 – excluding evidence from GPs wilfully ignores information to improve the evidence base
- Principle 5 – GPs are best placed to advocate for patients with disabilities that are complex, fluctuating, episodic or not immediately visible
- Principle 7 – not including collateral evidence decreases the ability to improve the decision-making process.

We urge that the increased focus on standardisation across the NDIS does not come at the expense of individualised supports tailored to the needs of participants. The access and decision-making process must retain a degree of nuance to consider individual circumstances and the impact of their health conditions on functional capacity.

2. Should any principles be added, removed or changed?

A principle should be included to the effect that NDIS changes should be pragmatic and practical, so the new process is grounded in the real-world experiences of people with disability.

3. What do we need to consider when designing an access decision-making process that is fair, consistent, transparent, disability-informed and evidence-based?

Formally and appropriately acknowledge the GP as a medical specialist who coordinates the total healthcare of patients with disability who are also supported by the NDIS

Currently, GP involvement in the NDIS is sporadic. GPs' status as medical specialists is not formally recognised by the National Disability Insurance Agency (NDIA). Where an individual has had evidence provided by their GP, this input must be taken into consideration, which is an absent requirement. Opportunities for GPs to provide clinical input to ensure NDIS funding is appropriately allocated often depends on a patient's ability to self-advocate, and the extent to which NDIS planners understand the GP's role.

Appropriately recognising GPs in the new NDIS assessment process will ensure applicants can consult with a trusted health professional who understands their care needs and advise on tailored supports personalised to the patient. Fully delegating this task to assessors who do not know the patient would be problematic.

Ensure GP input to NDIS assessments informs decision-making

The RACGP recognises upcoming changes to functional capacity (access) and support needs assessments are designed to reduce the amount of evidence a person is required to submit when seeking NDIS funding. We have been advised there may be circumstances where components of the support needs assessment will use external health reports or quotes to ensure more complex areas of need are appropriately understood. This includes information from GPs (eg seizure management plans) to identify the need for disability-related health supports.

The RACGP is keen to avoid a scenario where personal reports/evidence, such as those prepared by a person's regular GP, have no bearing on their being admitted to the NDIS and the funding they receive in their NDIS plan. These should be considered alongside standardised tools to help better inform support needs. For many disabilities, GPs are well placed to comment on practical functional incapacities (i.e. continence management). They already perform this task across various care settings and funding schemes (eg dementia, driving, DVA claims, Gillick competence).

The principle of using a functional assessment to establish a person's needs under the NDIS is fundamentally sound. However, one-off formalised assessments can lack the nuances needed to appropriately identify what a person requires for support, particularly when conditions are fluctuating, episodic and complex. There are often psychosocial, environmental, and financial complexities around a disability, and one tool or one profession cannot comprehensively capture all these determinants on its or their own. GPs offer a unique broad perspective and can provide oversight of supports and advocate for additional assistance as needed. They can also help regulate a system that is moving away from diagnosis-based eligibility to assessments based on functional capacity, which opens the door to potential fraud without proper controls.

GPs should be able to interpret the results of the I-CAN support needs assessment and contribute their clinical expertise, particularly where patients have complex support needs.

We stress that GP input into the NDIS process is circumspect and limited to factual matters rather than opinion. GPs should not be forced into disputes between participants and the NDIA about funding decisions. This could lead to patients holding GPs personally responsible for unfavourable NDIS determinations, with the doctor–patient relationship suffering as a result. GPs can submit factual evidence about their patients' disability; however, NDIS eligibility decisions are not under the purview of the treating GP, and their role is not to mediate between patients and the NDIA.

Clarify funding arrangements for new NDIS assessments

The RACGP understands the structured support needs assessment process, used to develop NDIS plan budgets, will be rolled out from April 2027 and funded by the NDIA. Separate to this, from 1 January 2028, the assessment of substantially reduced functional capacity will be based on a standardised, evidence-based assessment of a person's functional capacity. This assessment will be used to determine someone's eligibility for the NDIS. We request further clarity on funding arrangements for these initial access assessments, given applicants routinely cite them as a barrier to NDIS entry.

Ensure NDIS staff are appropriately qualified and trained in internal processes / operational guidelines

Anecdotal evidence suggests GPs' opinions and supporting evidence are being dismissed by NDIS planners and local area coordinators.

NDIS staff and assessors must be suitably trained and qualified to understand GPs' vital role in supporting patients with disability. GPs are medical specialists and are considered treating health professionals for NDIS purposes. This is not always properly understood by NDIS staff.

All assessors engaged under the new access process must have a health background at a minimum. Ideally these roles will be performed by members of GP-led multidisciplinary care teams such as practice nurses, who work alongside GPs daily and have the skills needed to assess functional capacity.

Lack of communication from the NDIA and service providers

Members report sometimes learning only after months or years that a usual patient has been receiving NDIS funding and has been trying to work out alone what supports would best help them. The GP may only find out about their NDIS plan when funding is about to run out. Patients are often surprised to hear their GP has had no communication at all regarding their plan.

GPs will further improve the NDIS and patient outcomes if:

- every NDIS application asked for the name and contact details of the applicant's usual GP
- GPs could coordinate, review and discuss a patient's initial and ongoing NDIS plans with the patient and provide expert advice to NDIS planners for consideration prior to finalisation
- GPs automatically received a copy of a patient's NDIS plan as well as reports generated by NDIS support providers (with patient consent)
- there was a mechanism to directly engage with NDIS providers (with patient consent) to advise of issues a patient may be experiencing and the need to amend a plan
- it was mandatory for service providers (or a participant's support coordinator) to report back to their usual GP to support continuity of care and reduce siloes
- the NDIA kept GPs regularly informed of key developments via secure messaging.

While GPs are not responsible for NDIS access or eligibility decisions, having oversight of plans would allow them to advise on whether funded supports are delivering real benefits for patients in terms of improvements in function and their overall health. This could help to reduce low value care and duplication of services, ensuring the sustainability of the NDIS in the long term.

New framework planning rules

The new NDIS framework planning rules should clearly articulate the role of general practice in assessment, evidence provision, plan variation and ongoing participant support, including how any additional administrative or clinical workload on GPs will be funded and/or minimised.

Plan reassessments

Legislative reforms will tighten the criteria for unscheduled plan reassessments, with only NDIS participants, their plan nominee or guardian able to request an unscheduled reassessment. While a change in circumstances will largely be driven by changes in a participant's functional capacity (which will be evaluated using independent, standardised tools), it is critical that any input from a participant's usual GP is considered as part of these reviews.

Provide care coordination funding to support patients applying for the NDIS

Utilising GP reports and existing clinical information can reduce duplication and bureaucracy across government programs and funding streams. However, this work is not adequately funded.

It is a key principle of the Medicare Benefits Schedule (MBS) that time spent talking to carers or relatives when the patient is not present cannot be included in the consultation time. Because of this, patients applying for NDIS funding face out-of-pocket costs for GPs to provide supporting evidence detailing the functional impact of their disability. There is often no clinical reason for a patient to be present when their GP is completing forms or reports, and therefore they may be charged a private fee where no Medicare rebates are payable.

One option to address this is to fund the completion of NDIS forms (as well as paperwork for other types of government support) via MyMedicare. With proper funding GPs and practices could receive multiple targeted payments to support the delivery of additional and more comprehensive services beyond relevant fee-for-service MBS items, including care coordination activities between consultations. This would improve timeliness of care, reduce the patient's financial and access burden, and improve capacity for GPs and practices to undertake population and preventive health activities. Multidisciplinary care teams in general practice should also be leveraged to support GPs whose patients are seeking NDIS access, with tasks delegated as appropriate.

Clarify Thriving Kids arrangements

There is a growing need for clarification of when children will be able to transition from the NDIS to the new Thriving Kids program, and vice versa. The process for 'step-up' or 'step-down' supports must be as seamless as possible for families to experience trusted care.

Cultural safety must also be embedded in any programs and funding streams designed to ease pressure on the NDIS, with supports underpinned by the commitments in the NDIS First Nations Strategy. The Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability highlighted the underdiagnosis or misdiagnosis of disability amongst Aboriginal and Torres Strait Islander people, including children. With Aboriginal and Torres Strait Islander children significantly overrepresented in the criminal justice system, it is critical that Thriving Kids is designed with cultural safety and Aboriginal and Torres Strait Islander led solutions at the forefront, and that a health first approach to supporting young people who are at risk of contact with the justice system is prioritised. Appropriate linkages between the health, disability and justice sectors to enable wraparound care will also be key.

4. How could the access decision-making process, including referral pathways, be designed to reduce administrative burden and make it easier and more equitable for people with disability, their families and carers to understand what information is needed and how decisions are made? How could this support a proportionate approach to minimise the assessment burden on persons who are clearly eligible with very significant functional impairment?

Recognise the existing role of GPs in supporting patients and reduce duplication

As noted in our response to question 3, there is real scope for GPs and practices to aid in the establishment of functional capacity status, as they already perform this work for patients. One such example is the annual MBS health assessment available to patients with intellectual disability.

There is also an opportunity to utilise and adapt existing forms and templates used by GPs for NDIS purposes. GPs routinely develop chronic condition management plans for their patients under the MBS, with templates built into many software products to streamline the process.

Integrate NDIS forms with the clinical information systems (CISs) that general practices use

Technical constraints, including NDIS forms not integrating with common general practice CISs, lead to cumbersome, inefficient administrative practices requiring GPs to spend large amounts of time producing high-quality patient reports.

Improving interoperability will free up more time for GPs to provide care to patients living with disability and support their NDIS application.

The RACGP has been advised by DoHDA that any existing NDIS forms and evidence requirements will need to be updated to capture accurate information aligned with changes to legislation. The RACGP would welcome the opportunity to provide input into this process to ensure forms integrate seamlessly with general practice workflows.

Automated decision-making

The use of artificial intelligence (AI) tools to guide planning decisions and allocate funding should be avoided. Any use of AI without clear understanding, safeguards and sharing of information such as model training risks worsening transparency and trust in the assessment and decision-making processes. Retaining human oversight is essential to avoid the tragic consequences of another Robodebt scheme.

5. What should be considered to ensure the access decision-making process, as well as referral pathways, works well for all disability cohorts including people with communication, cultural, cognitive, degenerative, fluctuating, episodic or complex support needs?

Maintaining care and support through alternative funding streams

As sweeping changes to the access process will reduce the number of NDIS participants, consideration should be given to how the MBS can be leveraged to better support people with disability to access care from their trusted GP. The RACGP supports extending funding for GP-led, time-based health assessments across key life stages for priority groups to support proactive, multidisciplinary preventive care. This includes enabling access to an annual health assessment for people with disability, particularly those with moderate to severe impairment, as an expansion of the intellectual disability health assessment. We also continue to call for a 40% increase to Medicare rebates for longer consultations (Level C and D) to support patients with complex needs, a sentiment that was recently backed by the MBS Review Advisory Committee (MRAC) in its draft final report from the review of MBS time-tiered items.

Other opportunities to bolster MBS-funded care include expanding the number of allied health sessions available for patients with eligible care and management plans.

Member feedback also indicates state-based disability supports have become severely limited following the introduction of the NDIS, with many supports shutting down as people became eligible for the scheme. Foundational supports must provide adequate coverage for all cohorts of people with disability who will no longer meet NDIS eligibility criteria.

Cultural safety

Aboriginal and Torres Strait Islander people with disability face unique barriers to accessing support services, with under-utilisation of disability services a result of historical and cultural constructions of disability.

In 2022, one-quarter (25.3%) or 183,700 Aboriginal and Torres Strait Islander people had a disability and 11.6% had a profound or severe limitation. Aboriginal and Torres Strait Islander people with disability require access to culturally safe disability services, including supports available through the NDIS. Community and culture are central to the health and wellbeing of Aboriginal and Torres Strait Islander people. Aboriginal and Torres Strait Islander-led services are also important for supporting Aboriginal and Torres Strait Islander people with disability and their families.

The RACGP recognises the importance of the commitments of the NDIS First Nations Strategy, and the National Aboriginal Community Controlled Health Organisation (NACCHO) and Coalition of Peaks should be consulted and involved in any changes to the NDIS.

6. What factors and evidence should be considered when determining whether an impairment is permanent or likely permanent, including whether appropriate treatment is likely to improve the functional impact of an impairment?

The RACGP understands the NDIS legislative changes with tighten the definition of permanence used to determine eligibility. This means people with impairments that can be remedied or alleviated through treatment may no longer be eligible for the NDIS. Our members have raised concerns about future NDIS access being based on speculative improvements in a person's functional capacity. Treatment expectations should be realistic and not require patients to exhaust every conceivable option before receiving NDIS funding.

Introducing more rigid criteria to determine NDIS eligibility and the permanence of an impairment highlights a clear role for GPs to advise when other treatment options are not suitable. GPs are well placed to make this assessment and regularly do so when supporting access to total permanent disability (TPD) or life insurance. GPs have the nuance to determine if an underlying disability is permanent, even if future supports or medical treatments may improve functional impact. Members report there are patients who cannot afford supportive measures for permanent aspects of their disability (i.e. catheters, creams, dressings), and therefore end up needing more medical intervention and care than if their disability was better supported in the first instance.

While tightening the eligibility criteria is a measure to rein in NDIS spending, appropriate safeguards must be built into the process to account for fluctuations in a person's condition. For those with an impairment that is likely permanent but there is potential for future improvement, they should not be denied assistance through the NDIS if their current condition so warrants it. Furthermore, if a person is accepted onto the NDIS and their level of need changes due to temporary improvements in their functional capacity, their funding and supports should adjust accordingly. While acknowledging that some supports may not need to be lifelong, there needs to be allowance for supports that are 'maintaining' current function, not just aimed at improving it.

Other comments

Benefits of co-located services

While not directly related to the access process, the RACGP has received feedback highlighting the benefits of co-located service hubs for NDIS participants. Home visits by NDIS service providers can place considerable strain on the budget. While these will continue to be necessary where travel is impossible for participants, having community-based hubs with multidisciplinary teams, including allied health providers, onsite could support participants who require access to various services (eg children with speech delays, autism and dyslexia). Co-located services at schools and multidisciplinary teams based onsite could also reduce the number of individual providers going into schools.

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The RACGP looks forward to contributing to further discussions regarding NDIS access changes. Please contact Samantha Smorgon, Head of Funding and Health System Reform, on (03) 8699 0566 or via samantha.smorgon@racgp.org.au if you have any questions or comments regarding this submission.