NDIS Costings – Review by the Australian Government Actuary

Introduction

The Australian Government Actuary (AGA) was asked by the Commonwealth Treasury to review the costings included in the Productivity Commission (PC) report on Disability Care and Support ("the report") in consultation with the States and Territories.

To this end, we held an officials workshop in early December 2011 with State and Territory officials and sought their written feedback. We have examined the spreadsheets used by the PC in developing their estimates and the evidence which the PC took into account in setting their assumptions. We have also had extensive discussions with PC staff and some of those with whom they consulted in arriving at their assumptions.

This following section provides a very brief summary of the methodology adopted by the PC. We then identify a number of areas where we considered that further investigation was warranted and the issues involved in each are discussed in the following sections.

We have then summarised our overall conclusions in relation to the PC estimates. It should be noted that our conclusions relate to the NDIS proposed by the PC; that is, a scheme focussed on meeting reasonable and necessary specialist disability support needs of people with significant and enduring disabilities through cost effective delivery of appropriate disability services. A scheme with different parameters could be expected to have quite different costs.

There are then a number of attachments to the paper.

Attachment 1 – Projection model

We have developed a simple projection model in order to build up a picture of the costs over the phase in of the scheme, noting that the PC's cost estimates did not make any allowance for future inflationary effects or population change. This attachment sets out the basis of our projection model along with the resulting estimates of cost over the PC's proposed implementation period, out to 2018-19, which take account of future inflationary effects, population change and a number of adjustments to the PC's underlying assumptions that we regard as appropriate as a result of our analysis.

Attachment 2 – Sensitivity analysis

The magnitude of the changes envisaged with the introduction of the NDIS means that the available data cannot be relied upon to provide a precise picture of the likely clients of the scheme. As a result, there is inevitably uncertainty around the cost estimates. One response to this uncertainty is to test alternative scenarios. These scenarios can help to inform decision makers about some of the key risks and also highlight areas where governance and operational standards may need to be carefully monitored. We asked the States and Territories for their views on possible scenarios to be tested and Victoria made a number of suggestions. We have included a section reporting on the sensitivity of the cost estimates to these scenarios and some of our own scenarios.

Attachment 3 - Risks

We have then included a very brief discussion of risks more generally. While this paper is not intended to deal with implementation or operational issues, the interaction between these issues and the cost estimates needs to be recognised.

Brief Summary of the PC Methodology

The PC conceptually divides the population into three nested groups:

- the entire Australian population who would benefit from effective insurance against disability;
- those with a disability or caring for someone with a disability, who would be able to access information and referral services; and
- those with significant and enduring disability support needs who would be eligible for individualised support.

The PC costings are primarily concerned with estimating the costs associated with the third group, referred to as Tier 3[1].

The PC looked at the costs of four types of services which could be provided to the Tier 3 population: individualised care and support services; aids and appliances; home modifications; and transport services. The individualised care and support services represent over 90 per cent of the gross support costs and our review has therefore focussed on this element of the costing.

Gross costs for care and support are calculated as:

$$\sum_i No\ of\ people\ in\ severity\ category\ i \times Annual\ cost\ of\ care\ for\ individual\ in\ severity\ category\ i$$

With the exception of those suffering from psychiatric disability, the number of people in each severity category has been estimated from the Survey of Disability, Ageing and Carers 2009 (SDAC) by selecting those suffering from specified disabling conditions who also have a need for functional support to address core activity or self-management limitations or schooling/employment restrictions. For those with a daily support need, a severity measure was assigned based on the frequency of daily needs across the three core activities of self-care, mobility and communication. For those with self-management limitations or education/employment restrictions but without daily needs, severity was assigned on the basis of disability status, as defined by the ABS.

The numbers in the psychiatric disability group and the associated severity distribution were determined in consultation with experts in the field.

[1] The PC also derived estimates of the operational costs associated with implementing the NDIS in consultation with Commonwealth service delivery agencies. Western Australia has suggested that operational costs may have been underestimated. In particular, they have noted that the experience with their disability support scheme would indicate that the allowance for Local Area Co-ordinators may be too low. We have not examined the estimates of administrative costs closely, but there does seem to be some basis for arguing that the salaries implicit in the costings for this group are too low.

The annual cost of support has been derived from a variety of sources, including existing expenditure levels for people getting different levels of care under accident compensation and state disability systems.

In summary, the PC assumes that the number of people receiving services under the NDIS will be around 25% higher than the number of current recipients of NDA and/or HACC services aged under 65, while the average cost of individualised support services will be around 40% higher than is the case for current users of disability support giving a total cost for this element of the scheme of between $11.1 billion and $14.1 billion. In addition, the costing allows for administrative costs and support for those not eligible for Tier 3 supports to arrive at a gross cost of between $12.1 billion and $15.1 billion.

The PC has calculated the net cost of the scheme by deducting from this figure an estimate of existing program costs that would be subsumed by the NDIS, primarily funding under the National Disability Agreement (NDA) and the Home and Community Care (HACC) program but also including some other programs. Total offsets identified by the PC amount to $7.1 billion giving a net cost between $5 billion and $8 billion in today's dollars.

Issues

As the above description makes clear, the estimate of gross costs for Tier 3 relies on the population assumed to be eligible, the distribution of that population between different levels of need (the severity distribution) and the average cost of services at each severity level.

At the December workshop, the States and Territories identified a number of issues of concern, particularly in relation to the first and third of these assumptions. The concerns around the population assumptions appear to be part of a broader apprehension regarding exactly how the eligibility criteria for acceptance into the scheme will work. Western Australia pointed to the larger populations that could potentially be considered as the client group – for example, those in receipt of disability pension. On the other hand, Victoria raised the possibility that the majority of those currently receiving services under the Home and Community Care program might not qualify for NDIS Tier 3 supports. Were this to be the case, there would be implications for the offsets that might be available.

The NDIS is intended to operate on a fundamentally different premise from current State based disability arrangements; that is, meeting reasonable and necessary needs as opposed to the current rationed arrangements. In these circumstances, there is an understandable concern about whether the PC's assumptions around average cost are reasonable. One particular assumption which was questioned by the States was the relativities between costs of formal care for children and adults suffering from a disability of similar severity.

All States and Territories were worried about the likely impact of the Fair Work Australia case in relation to Social and Community Sector workers (the SACS case) on the average cost assumptions. While the PC did not build up their average cost assumptions by multiplying a number of hours of care by a wage rate in most cases, the importance of one on one support services in the disability sector means that wages are a major driver of costs.

Finally, the modelling of population and costs for the psychiatric disability group was handled quite differently in the report from the other costs and a number of States were anxious to understand how the estimates had been derived.

In summary then, there were five issues which we saw as warranting further investigation:

- the population assumed to be eligible for Tier 3 supports, particularly whether there are any gaps in coverage relative to those currently receiving support;
- the reasonableness of the average cost estimates, including whether the assumption that costs for children would be 30 per cent of the costs for an adult with a comparable need for disability supports is reasonable;
- whether the estimates of offsets were reasonable, given the need for the States to provide residual services;
- the impact of the Fair Work Australia case on the cost estimates, noting that this has the potential to affect both the gross cost estimates and the offsets; and
- the basis of the cost estimates for the psychiatric disability component.

We sought input from the States and Territories on additional information that might be available to allow further refinement of the costings. Three States (Tasmania, South Australia and Victoria) responded. Where relevant, the information provided by the States has been referred to in the discussion of the issues below.

Subsequently, we have briefly considered the issue of operational costs.

Finally, the PC estimates did not make any adjustments for future inflationary effects or population change. Accordingly, we have also sought to obtain more contemporary estimates of relevant current expenditure. We have then brought all of this together in the development of a projection model, and presented the results in Attachment 1.

The following sections deal with each of the identified issues in turn.

Population

As noted above, the view has been put that the PC assumptions on the NDIS eligible population are both too low and too high. It is therefore worth reviewing in some detail, how they arrived at their estimates.

PC Methodology

Within the overall population which is assumed be eligible for Tier 3 supports by reason of significant and enduring disability support needs, the PC identified four distinct groups:

- those with daily needs for care/assistance with a core activity;
- those without daily care needs but with self-management limitations;
- those who would benefit from early intervention support; and
- those with psychiatric disability.

Importantly, these groups are mutually exclusive and an individual can only be counted once.

The PC found that the number of people shown as having a primary psychiatric disability in the 2009 SDAC was around half the number estimated by experts in the context of work on mental health for the 2011 Budget. It was felt this latter estimate was more reliable. Accordingly, the population for the psychiatric disability group (56,880) was set based on the expert advice and the corresponding (but significantly smaller) group was removed from

the potentially eligible population on the SDAC. The reasonableness of this estimate is discussed separately in the section dealing with the psychiatric disability group.

The SDAC was then used to estimate the populations for the remaining three groups based on a hierarchy. The estimate of 222,310 for the first group was established by looking at those who, according to the SDAC (excluding those with psychiatric disabilities), required assistance with one or more core activities at least daily and had a main disabling condition appropriate to the disability system. The second group, estimated at 50,320, excludes those who have been picked up in the first group, but who nonetheless require assistance with self-management. In other words, a person who has daily care needs and self-management limitations will be counted in the first group, rather than the second.

The early intervention group covers those who have not been captured in any of the previous three groups but for whom there was good evidence that low level or episodic interventions would be safe, cost effective and would significantly improve outcomes. The estimated number in this group is 81,770.

For all four groups, these results were checked against Burden of Disease data and the previous SDAC for reasonableness.

Could the estimate be too low?

While the SDAC data is the best available data for measuring the level of need for support, it is by no means ideal and other measures have been put forward by the States as casting doubt on the PC's population estimate. Disability pension recipient numbers and the number of people with a severe or profound core activity limitation are both considerably higher than the estimated Tier 3 population. However, these two measures are only tangentially related to the population of concern – those with a significant and enduring need for disability supports. The growth in disability pension numbers over recent years is a strong indicator of its inadequacy as a proxy for the population of concern, since the number of people with a permanent disability requiring on-going support would be expected to change relatively slowly. Similarly, it is clear that those with a severe or profound core activity limitation are likely to form a larger group than those with an enduring need for disability supports, since many disabling conditions (for example, asthma) that give rise to an activity limitation will not have associated needs for specialist disability support services.

In aggregate terms, the number of people assumed to be eligible for Tier 3 supports is well in excess of the number currently receiving support under the NDA and HACC – 411,000 compared with around 330,000. Thus, the PC is assuming that the total number of people receiving support will be at least 80,000 more than the current recipient population. As discussed further below, it is not clear that all those currently receiving support would satisfy the Tier 3 eligibility criteria. In these circumstances, the assumed Tier 3 population of 411,000 would represent a still greater increase in the number of people receiving disability support services. Effectively, the PC is allowing for a significant level of unmet demand in the current system.

On balance, we therefore see no compelling evidence to suggest that the number is too low.

Could the estimate be too high?

Victoria has suggested that fewer than 10 per cent of current HACC recipients might qualify for Tier 3 supports under the NDIS. The two criteria for entry are that an individual has a permanent disability and that they have a significant and enduring need for support. Given the generally expressed view that there is unmet need in the current system, it seems unlikely that any material level of support is currently being allocated to those without a significant need for support[2]. Thus, it is hard to envisage that anyone with a permanent disability who is currently receiving support would not be eligible for NDIS[3]. However, we understand that in some jurisdictions there is no requirement under existing programs that the need for support be enduring and, under the PC model, there is no intention that past receipt of disability services would guarantee access to Tier 3 supports. As such, someone with a temporary but significant need could be receiving support at present, but fall outside the NDIS Tier 3 population. Similarly, those who need temporary support in future would not be eligible for Tier 3 of NDIS.

The available data offers little guidance on the number of people currently receiving services who might have only a temporary need for support; there are substantial numbers of people receiving relatively low levels of support; it is estimated that around 150,000 people received assistance under HACC amounting to less than $2,000 in 2009-10 (considerably less than $2,000 for a significant minority). Low cost does not necessarily correspond with temporary need, but it seems possible that this low usage group could include a proportion of people who might access one-off or short-term assistance. It is also possible that some of those receiving more substantial assistance might have only a temporary need for support. Indeed, the 10 per cent figure proposed by Victoria would suggest that virtually all of those HACC recipients who are not also receiving services under the National Disability Agreement (NDA) have only temporary needs, equivalent to around 165,000 people.

If this were the case, there would need to be an additional 245,000 people who are currently not currently receiving any HACC or NDA services becoming eligible under Tier 3 to reach the PC's assumed population. Victoria provided a preliminary estimate of a further 10,000 people who are not currently receiving funding but would be eligible for Tier 3 services. If similar proportions applied in the other States, the additional unmet demand might amount to something less than 50,000 people. In these circumstances, we consider there must be a possibility that the population estimate, and consequently the gross cost estimate, is too high. We have included a scenario in the section dealing with sensitivity analysis assuming that there are around 50,000 fewer people in the lowest severity category of the daily needs group.

---

[2] Note, however, that this does not imply that those currently receiving services are necessarily those with the greatest needs, since the allocation of services will depend in part upon the available capacity to meet different kinds of needs. For example, there may be no supported accommodation places available, but there may be respite places in which case the person who needs only respite care might receive services but the person needing supported accommodation might not.

[3] While we consider it unlikely that jurisdictions are allocating resources to those without a significant need for support, our view is that if this were the case, the adjustment to offsets discussed on page 11 would allow for services to continue to be provided. It would be a matter for decision by States and Territories whether or not to grandfather these clients.

What would happen to those with a temporary need for services?

The NDIS is not intended to service those with temporary needs for support. The PC has proposed that the States and Territories continue to meet this residual need. We have not been able to arrive at any credible explanation for a temporary need for support other than a disability arising in the context of a health problem, for example, temporary mobility limitations arising after an operation. Our understanding is that at present, some HACC funding is used by health departments in providing such services[4]. It would make sense for these services to continue to be provided by health departments and we would highlight the PC's recommendation in Chapter 3 of the report regarding the need to agree a Memorandum of Understanding with the health sectors in each State and Territory setting out NDIS and State health department responsibilities. This proposed arrangement also has implications for the available offsets, which are discussed further below.

Conclusions

Our overall assessment is that the PC's estimate of the eligible population is perhaps more likely to be too high than too low, particularly if there are significant numbers of people currently receiving services who would not be eligible under the NDIS. However, on balance we think it is appropriate to leave this assumption unadjusted (particularly taking into account the psychiatric disability discussion later in this paper).

Average Cost Estimates

PC methodology

The PC looked at the potential costs of care services by level of severity within each of the four population categories identified above. They relied on a range of data sources in setting assumptions as set our below.

Population Group	Data Sources
Daily needs	supported accommodation in accident compensation schemes and state disability systems attendant care packages in compensation schemes and disability systems combined packages covering day program, transition to work and respite in state disability systems respite/community support packages in state disability systems
Self-management	providing 2, 3, 4, or 5 hours of care per week

[4] Note that HACC funding forms only part of the resources available through the health system to meet support services.

Population Group	Data Sources
Early intervention	providing 2, 3, 4, or 5 hours of care per week
Psychiatric disability	group home packages
	'high' packages under NSW HASI
	'moderate' support packages offered by both NSW and Victoria to people with psychiatric disability
	'standard' home-based outreach packages in Victoria

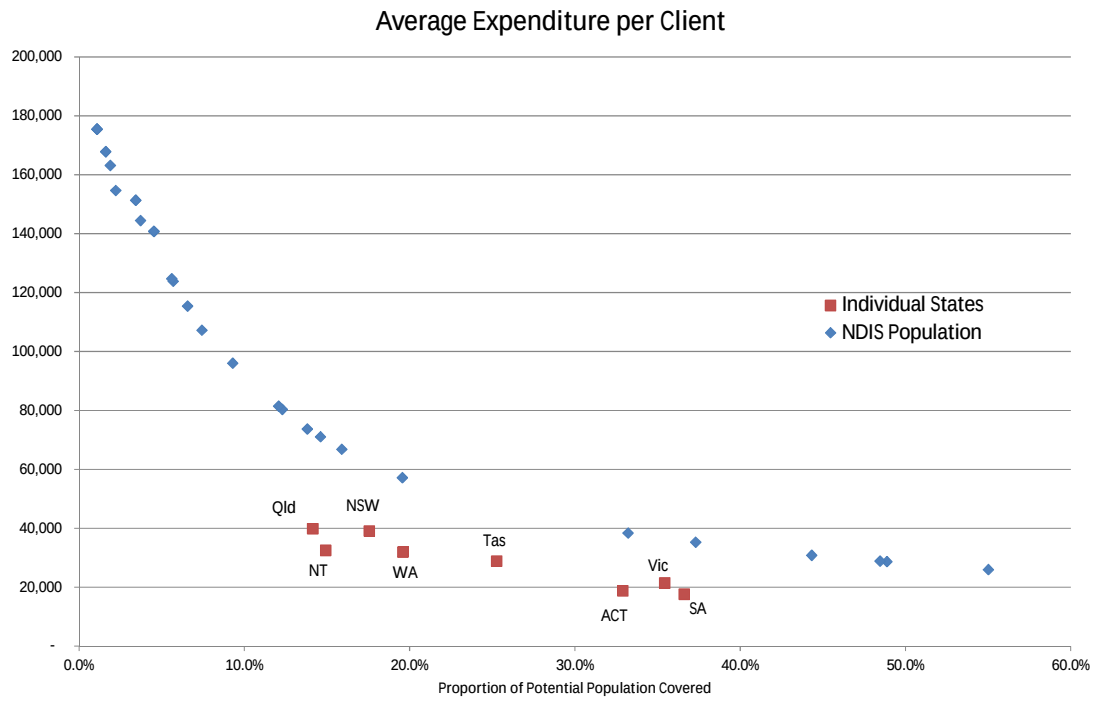
Reasonableness of average cost assumptions

The PC were able to provide us with some additional information around State disability schemes, to provide a comparison between the assumptions in their report and the resources currently being allocated to individuals at different severity levels. This suggested the assumptions did not appear unreasonable.

For example, the PC assumed that the average cost for someone aged 15 to 64 in supported accommodation would range between $150,000 and $250,000[5] depending upon the severity of needs. Information provided by the PC indicates that none of the States are averaging expenditure of more than $150,000 on individuals in supported accommodation. To allow for the possibility that the PC may have overestimated the costs for these high need clients, we have included a scenario which assumes the average cost for severity levels 22 to 24 (using the PC's ranking system) is $220,000 (excluding the cost of capital component).

A further illustration of the extent to which average costs assumed exceed the current funding levels is provided in the following chart.

[5] To allow comparison with the State expenditure figures, these numbers exclude the 12% allowance for the cost of capital made by the PC. When the cost of capital is included, the costs for these groups range between $168,000 and $280,000.



This chart shows the average expenditure per client as progressively more of the potential population are included. In this context, the potential population is the population reporting a severe or profound core activity limitation. The State figures have been derived from the Report on Government Services published by the PC and include only NDA expenditure. The NDIS figures have been calculated by starting with those with the highest severity needs and gradually including those with decreasing needs. In other words, the first data point corresponds to adults and children with the highest level of daily needs, the second data point adds in those with the next highest severity level and so on. The self-management, early intervention and psychiatric groups have been included on the basis that cost is a proxy for severity of need.

It should be noted that if non-NDA spending were included in the State figures, the data points for the States would move down and to the right. This is because the number of clients would be roughly double (in aggregate, but not necessarily for each State) the number on which these figures have been calculated, while aggregate expenditure would increase by only around one third.

A number of States have made the point that they know of individuals within their jurisdictions who incur costs higher than the cost assumed for those with the most severe needs. It needs to be understood that the PC assumptions are averages for a given severity level, not maxima. In other words, the $280,000 assumed for an adult with the highest severity needs is not a cap on spending and it would be expected that some individuals will have costs in excess of this average.

Relativity between costs for children and adults

The PC relied on evidence from accident compensation schemes and discussions with the Disability Investment Group in arriving at this assumption. They have subsequently provided some information from one such scheme which is consistent with the 30 per cent assumption.

Although the data provided by the PC does support the 30 per cent assumption, this is an area of uncertainty and it could be expected that there would be considerable variability depending upon the age of the child and the severity of needs. For example, it seems intuitively more reasonable that the percentage might increase gradually as a child ages rather than jumping suddenly at age 16, particularly for those with more intensive care needs. At the same time, at lower severity levels or at very young ages, it seems quite feasible that the percentage could be lower than 30 per cent.

Some States have expressed the view that the 30 per cent assumption is too low. We sought relevant data from another accident compensation scheme and discussed that data with the scheme. The data supported a view that attendant care and supported accommodation costs for children were not more than 30 per cent of the corresponding costs for adults. However, a material cost item for children was described by the scheme as 'integration (education) aides'. We discussed this with the scheme and were advised that integration aides are people who provide support to young claimants in a school setting. When that item was included, the cost for children appeared higher than 30 per cent of the adult cost. We discussed this with the PC who advised that this is an example of a service that was not envisaged for the NDIS, rather a service that the PC saw as the responsibility of mainstream education systems. The PC again highlighted the importance of ensuring clear lines of responsibility are established between the NDIS and other mainstream systems such as health, education, transport and so on.

Since our task has been to assess the reasonableness of the PC's cost estimates of the NDIS as described in its report, we conclude that we have not seen any empirical evidence which would clearly justify a departure from the 30 per cent assumption. Indeed, the available evidence supports to the 30 per cent assumption. Nonetheless, this is an area of uncertainty, particularly when alternative scheme design models are considered noting the potential that intensive early intervention education support for disabled children might have downstream benefits. Accordingly, we have included a scenario assuming that the ratio is 40 per cent rather than 30 per cent.

Conclusions

In summary, the PC assumptions on average cost look generous relative to current State based disability programs, both in aggregate and when looking at particular care levels. The assumption on costs for children is difficult to verify but we have not seen anything which would clearly invalidate the assumption. However, we note again that our review has been predicated on the assumption of a scheme design as envisaged by the PC. Alternative scheme design models would be expected to have different costs. By way of simple example, the PC envisages a scheme based on the concept of 'reasonable and necessary support'. A scheme based on an alternative concept such as 'reasonable and appropriate support' might be expected to have a different cost, all else being equal.

Estimates of Offsets

PC assumptions

The following table reproduces the offsets from the PC report together with some comments on their provenance.

Program	Amount ($ million)	Comments
NDA	5,210	Includes all expenditure under NDA in 2009-10, including amounts going to over 65's (and over 50's for indigenous people)
HACC	583	Based on 30% of Commonwealth and State spending under HACC in 2009-10.
Residential aged care	270	Based on 6,500 people under age 65 at an average cost of around $41,000 per person. Compares with average cost per resident aged over 70 of around $30,000 per annum in 2009-10.
Community aged care	36	Based on 2,130 people aged under 65 at an average cost of around $17,000 per person. Compares with average cost per client aged 70 and over of around $13,000 per annum in 2009-10.
Aids and appliances	65	Half of the national spend on aids and appliances as reported in the Disability Investment Group Report
Taxi subsidy schemes	36	Based on expenditure on Victorian and NSW schemes in 2009-10 assuming those aged under 65 account for 25% of costs
Autism early intervention	43	Full cost of current program for children with autism (2011-12 budgeted expenditure)
Psychiatric disability	616	A mix of actual funding for existing programs in 2007-08 and projected funding in 2015-16 for programs announced in 2011-12 Budget.
Australian Disability Enterprises	205	Full cost of current program in 2010-11

Discussion

The main area of concern in relation to offsets is the inclusion of the full amount of NDA funding. Our analysis of the available information suggests that around 5% of clients and between 5% and 10% of funding (around $250m to $500m) under the NDA may be going to those aged 65 or more (aged 50 or more in the case of indigenous Australians). Tasmania has indicated that they estimate that 4 per cent of the clients and 6.6 per cent of expenditure is going to those aged over 65. At a national level, this would equate to around $350m. Any expenditure on the over 65s will not be available as an offset.

As discussed in the section on population estimates above, it appears likely that there are some HACC clients who have temporary needs for support and hence would not be eligible for Tier 3 supports. The available data on HACC does not allow the duration of support needs to be readily determined. Some analysis by the PC suggests that around 45 per cent of those receiving some level of support under HACC might have only short term needs. This would be consistent with the large number of people receiving very low levels of assistance. If all of the 150,000 individuals receiving HACC support of less than one hour per day were assumed to be ineligible (an unrealistically high estimate), the associated HACC funding that should not be taken as an offset would amount to something less than $200 million. A more realistic estimate is probably something less than half of this amount. While the total amount of money involved for these clients is not large, there will be continuing demands upon the States to meet these needs and the funding required should not be included as an offset.

Conclusions

Overall, we estimate that the offsets may have been overstated by the order of $500 million. As noted in the discussion on population issues above, it is not intended that the NDIS would grandfather services to those who are receiving services under the current arrangements. Effectively, the reduction in the offsets covers the costs to the States of providing services to those who would not be eligible for the NDIS, including those who might be currently receiving services. It does not take account of any overstatement of offsets for the psychiatric disability group which are discussed further below. Nor does it take account of any adjustment to the value of available offsets that might be appropriate in respect of timing issues. Some jurisdictions have applied and continue to apply growth funding to their disability expenditure since the relevant date for the majority of the assumed offsets (2009-10). This is also considered later in the paper.

Fair Work Australia Case

Fair Work Australia handed down its decision on award rates for social and community sector (SaCS) workers on 1 February 2012. The decision will result in significant increases in pay rates for many of those involved in providing the care services which will form the bulk of the individual supports under the NDIS. The PC cost estimates were derived by looking at overall costs of support in accident compensation and state disability schemes rather than building up an estimate from the hours of care required multiplied by a wage rate. Implicitly, however, the PC assumed that direct wage costs for those providing the care and support (who would be expected to benefit from this decision) accounted for roughly half the costs of this element of the scheme.

All else being equal, the decision will add to the gross costs of the scheme. Since the Commonwealth and some of the States and Territories have made some allowance for the impact of the SaCS case in their projections of future spending. To the extent that they have done so, this can be recognised in higher offsets against the gross costs. As noted in the introduction, we have developed a simple projection model of gross costs and offsets over the PC's proposed implementation period and this takes account of the impact of the SaCS case on costs.

We note that there are separate issues around workforce and whether supply of carers will be sufficient to match demand. The PC has assumed a gradual start-up for the scheme which should go some way towards ameliorating any wage pressures due to labour shortages.

Psychiatric Disability Group

As noted above, the psychiatric disability group were treated quite differently, with a reliance on the advice of experts rather than direct analysis of survey and administrative data. We held a lengthy discussion with the two primary experts consulted by the PC, Bill Buckingham and Harvey Whiteford and subsequently sought some clarification on issues that remained unclear to us.

The same issues in relation to population estimates, average cost assumptions and offsets that arise for the other populations are pertinent for this group, but there are some distinctive features under each issue.

PC methodology – population

The assumed psychiatric disability population is a subset of the population of the Australian population aged 18 to 64 estimated to have a severe mental illness that was derived in the context of the 2011 Budget package on mental health. The following table shows the split of that larger population with severe mental illness between four sub-groups.

Description	Care Needs	NDIS coverage
Episodic mental illness (est. 321,000 people)	Clinical services both during episodes of illness and to maintain remission between episodes	Not included
	Disability support services may occasionally be required, particularly during a lengthy episode of illness	Not included
Severe and persistent mental illness but can manage own access to support systems (est. 103,000 people)	Clinical services	Not included
	Social inclusion programs	Not included

Description	Care Needs	NDIS coverage
Complex needs requiring co-ordinated services from multiple agencies (est. 56,000)	One on one support from a carer	Included
	Supported accommodation, where appropriate	Included
	Clinical services	Not included
	Social inclusion programs	Included[6]
Institutional care (est. 2,000)	24 hour care in the mental health sector	Not included

Discussion - population

Only those in the third subgroup (those with complex care needs) have been assumed to be eligible for supports under the NDIS. This was justified on the basis that this would be the only group with an enduring need for high level disability support services. Our reading of the PC report would not suggest that the NDIS is to be restricted to those with high level needs; rather the critical factors are the permanence and significance of the disability and the need for support. In relation to disability with an episodic manifestation, for example, page 174 of the report says:

> "Permanent refers to the irreversible nature of the disability, even though it may be of a chronic episodic nature."

Disability related to mental illness differs from many other forms of disability in that it can be difficult to determine whether the disability is permanent or not. This is especially likely to be the case for episodic illness where it may not become apparent until after a number of episodes that the illness is likely to be permanent. The advice from the mental health experts also suggested that in relation to the first group, informal support networks may be able to meet disability support needs during an episode of illness. Thus, the number of people potentially eligible from the first group might be quite small.

The second group would appear to qualify both on the grounds of a permanent and significant disability. Indeed the mental health experts agreed that the disability support services, other than one-on-one care, required by the second and third groups would be roughly similar. Thus, on the surface, it would appear inconsistent with the PC's proposed eligibility to exclude the second group. There is, however, the further complicating factor of co-morbidity; many of those with mental illness may also have some other disability and the mental illness may not be the primary cause of disability.

The PC advise that it is very difficult to untangle these relationships from the available data. In other words, we cannot identify how many of the estimated 103,000 people with severe

[6] The hourly cost of care for the psychiatric disability group is based on providing one hour of direct care and one hour of indirect care. We assume this latter component would cover the social inclusion elements of support. The PC report specifically notes that 'day programs' are intended to be covered.

mental illness who can manage their own access to support systems might have been included in the daily needs or intellectual disability groups[7]. It seems possible, however, that at least some proportion of the 103,000 might not qualify on other grounds and thus would represent an addition to the eligible population. We have included a scenario assuming that there would be an additional 50,000 people with mental illness requiring social inclusion programs.

PC methodology – average costs

The average costs for the psychiatric disability group have been estimated from three main sources: a study on care needs for a group of inmates from a Queensland psychiatric hospital, the hourly care need assumptions for the NSW Housing and Accommodation Support Initiative (HASI) and consultation with providers. An hourly cost assumption of $95[8] was based on experience with the Victorian Psychiatric Disability Rehabilitation and Support Services. As noted in the table annotation above, this figure is based on providing one hour of direct care and one hour of indirect care.

Discussion – average costs

We note that for the lowest severity category within the psychiatric disability group, assumed average costs are $3,500 greater than the costs for the lowest severity intellectual disability group, which is consistent with the estimate of costs for the non one-on-one support component. At the other end of the severity scale, the assumption of an average cost of $120,000 is consistent with advice we received from an NGO providing supported accommodation to those with mental illness and/or intellectual disability.

Offsets

The PC assumed that all current State grants to NGOs to provide support to those with mental illness would be available as offsets. Our discussions with the mental health experts made it clear that if the NDIS were to be restricted to the group with complex needs, there would be considerable demand for the services provided by this sector from the residual 100,000 individuals with severe and persistent mental illness who are able to manage their own access. Their advice was that, at present, the bulk of these services are going to those with the complex needs and that there is substantial unmet need from the larger group. They estimated a cost of $312 million to meet these needs, suggesting that none of the $262 million taken as offsets should be included. It is possible that similar issues apply to the Commonwealth-funded Support for Day to Day Living in the Community, which accounts for a further $14 million of offsets.

The issue of offsets is inextricably linked to the assumptions around population. If it is assumed that the population that can manage its own needs is entirely excluded from the NDIS, then the offsets would have been overstated by around $270 million. Our reading of the eligibility criteria combined with the characterisation of this group by the mental health

[7] The Australian Institute of Health and Welfare report on Comorbidity of Mental Disorders and Physical Conditions found very high levels of comorbidity; more than half of those with a mental disorder also had a physical condition, with 'arthritis, rheumatism and gout' being the most chronic physical condition appearing with mental disorder. These figures are not directly comparable to the NDIS target population but give some idea of the extent to which mental illness is likely to be associated with other physical conditions that could give rise to disability support needs.

[8] Victoria advise that this rate has now increased to $101.75 per hour.

experts would suggest that they should be included in the Tier 3 population. If this is the case, the offsets are available but to the extent that this group have not been encompassed in the 410,000 as a result of comorbidity, the gross costs would be understated. As noted above, we cannot be sure of the incidence of comorbidity. The maximum addition to gross costs would be around $300 million assuming none had qualified by virtue of another disability. This seems likely to be an overestimate, particularly given the earlier discussion around the Tier 3 population estimate. On balance, taking into account both materiality and the substantial uncertainty, it seems reasonable not to make any adjustment to the PC estimates in respect of this item. This judgement does not mean that we are confident that no upwards adjustment is required, rather it means that we are not confident that an upwards adjustment is required. As noted above, however, we have tested a scenario assuming there would be an additional 50,000 in the Tier 3 population.

Operational costs

The PC developed high level estimates of the operational costs that would be required to implement the NDIS. We have briefly reviewed these cost estimates for completeness. This is not our area of expertise and we have relied heavily on advice from, and discussions with, others in this regard. For this paper, we have considered those operational costs in three broad categories:

- the costs of Local Area Coordinators

- head office and regional administration costs, including the costs associated with IT and other infrastructure

- Tier 2 funding costs and costs associated with disability services sector capacity building

These cost categories are consistent with those adopted by the PC.

The PC's cost assumptions around Local Area Coordinators (LACs) assume a caseload of 60. Western Australia has indicated that their unit cost for LACs is around $130,000. The PC assumed a cost per LAC of $80,000. We discussed this with the PC and other industry operatives and have concluded that the PC assumption should be increased. Accordingly, we have adopted a unit cost assumption of $120,000, which is close to the figure reported by WA. This leads to a 50% increase in the assumed cost of LACs (or about $274m in today's dollars). For the purpose of estimating operational costs throughout the implementation period we have also assumed that the caseload will increase gradually to 60 from, initially, 35.

The PC report does not set out in any detail the source of its operational cost assumptions. In this regard, it is worth noting that the operational costs represent a relatively small proportion of the overall scheme costs and, so, even a relatively large error in the operational cost assumption will not have a material impact on the overall cost impact for a

mature scheme. Nonetheless we have conducted a very high level reasonableness check on the overall PC numbers.

We note that the PC assume operational costs in the year before the regional launch of the scheme of more than $450m. We understand that around 70% of this is intended to be allocated to the development of IT infrastructure. A sophisticated IT system will be a critical component of an NDIS. Indeed, it is at the very heart of the insurance model that the PC has proposed. Nonetheless, our discussions with industry operatives suggest that an initial outlay of around $100m (fully capitalised) with subsequent annual expenditure in the order of $70m (with around $50m being capitalised) would be realistic and reasonable. We have adopted these numbers for the purpose of our projection model.

We have assumed a cost-per-initial assessment of $600. We have assumed that the number of assessments carried out in the first launch year will be 2.5 times the number of people receiving support under Tier 3 in that year, with the ratio dropping to 1.5, then 1 then 0.8 in subsequent years. These assumptions are largely subjective but were based on discussions with industry operatives.

We have assumed that there will be around $30m per annum in base head office expenditure (apart from IT expenditure) plus 10 per cent of the combined costs of LACs, assessors, and other regional administration costs. 10 per cent is assumed to drop to 9 per cent in year 2 and 8 per cent thereafter. We have assumed that regional administration costs (apart from LACs and assessors) will be 2 per cent of the annual cost of care and support. 2 per cent is assumed to drop to 1 per cent in year 2 and then 0.8 per cent thereafter. These assumptions are largely subjective but have been supported by our discussions with industry operatives.

Finally, the PC assumed around $200m each year to cover a mix of Tier 2 funding and disability service sector capacity building. The NDIS will represent a significant challenge for parts of the disability services sector, given the requirement to transition from a block funded sector to one which operates in more of an open market. We have somewhat subjectively assumed that a reasonable method for estimating this item is based on $500 per person receiving Tier 3 services in the year plus an additional $1000 for each new Tier 3 entrant during the year until 2016-17. This approach levels out at around $200m per annum in today's dollars (Tier 2) and provides additional sector capacity building funding during the implementation period.

In summary, as noted earlier, we are not experts in this area. The basis set out above is not intended to be regarded as authoritative and should be treated with caution. Rather, it is intended only to provide a high level reasonableness check on the PC operational cost estimates, noting that the basis of those estimates is not presented in the PC's report in detail.

Conclusion

We consider the PC costing methodology to be sound. However, our analysis has identified some risks. Factors that have the potential to increase the estimated cost include the wage case for social and community sector workers, possible overstatement of offsets and the treatment of the psychiatric disability group. On the other hand, a number of States have indicated that significant numbers of those receiving support at present would not be eligible for individualised supports under the NDIS and this has the potential to reduce the estimated cost. On balance we believe that adjustments to the PC's assumptions are justified in respect of the following items:

- offsets – we conclude that a reduction in the assumed offset funding of $500m (in 2009-10 dollars) in respect of NDA and HACC funding is justified; and

- future inflationary effects (including the impact of the Fair Work Australia case) and population change – The PC did not present its cost estimates in future dollars. Accordingly, we conclude that adjustments to estimates of both the gross scheme costs and available offsets are required in order to build up a picture of the costs of the NDIS over the PC's proposed implementation period. This is dealt with in more detail in Attachment 1.

Our judgement is that it is likely that the scheme envisaged by the PC could be delivered for a net additional cost of between $6.5 and $7.0 billion in today's dollars before taking account of the SaCS case. This allows for the lower offsets on the NDA and HACC spending as well as recent growth in disability funding. It does not allow for any offset from the National Injury Insurance Scheme (NIIS) which, if implemented by 2018-19, would further reduce the estimate. After allowing for the impact of the SaCs case, we have obtained an estimate of around $7.5 billion in today's dollars, again ignoring any reduction that might flow from the NIIS[9].

We have previously circulated early drafts of this paper, the most recent in February this year. Since then, we have undertaken further analysis. We have considered operational costs at a high level, obtained more contemporary estimates of the impact of the SaCS case and obtained more contemporary estimates of current State and Commonwealth funding. We have also considered further the assumption around the relative cost for children assumed by the PC. Finally, we have developed a simple projection model to allow for future inflation and population change. Following that further work, we estimate a net cost of around $10.5 billion in 2018-19, which is around $7.5 billion in today's dollars (using a 5% deflator, consisting of 4% for wage growth and 1% for population change). This remains consistent with our earlier preliminary view that it appeared likely that the scheme could be delivered for a total net cost of $8 billion or less in today's dollars.

The cost estimates are predicated on implementation of a scheme focussed on meeting reasonable and necessary specialist disability support needs of people with significant and enduring disability through cost effective delivery of appropriate disability support services. Strong governance arrangements will be required to manage the cost pressures that might

[9] The PC estimated the NIIS offset would be of the order of $300 million. We have not reviewed this.

be expected to emerge for a range of reasons and ensure the scheme remains financially sustainable.

Australian Government Actuary
April 2012

Attachment 1 – Projection model

We have developed a basic NDIS costings model that projects the costs of the scheme out to 2018-19. It also projects out current levels of disability spending by jurisdictions and adjusts for population and price and wages movements, including the SaCS decision. Adjustments have been made to the offsets assumed by the PC in line with the discussion in this paper.

The figures also reflect the scheme's operational costs estimated by the PC with some adjustments.

Derivation of Costings

The process for estimating the projected costs involved the following steps:

(i) start with the gross costs of the scheme as calculated by the PC, which is assumed to be the spend for 2011/12

(ii) identify the source of the offsets assumed by the PC split between State and Commonwealth programs

(iii) substitute the latest available information on expenditure for these programs

(iv) make adjustments where the alternatives to the PC assumptions were considered justified

(v) project forward the resulting estimates of both gross NDIS expenditure and existing State and Commonwealth spending to 2018/19, assuming the same implementation period and structure as proposed by the PC

Each of these steps is described in more detail below.

Step (i): Gross Costs

The gross costs for the scheme based on current population estimates and average costs were identified as follows in the PC report:

Component	Amount ($m)
Care and support	11,841[10]
Additional aids, home modifications etc	778
Australian Disability Enterprises	205
Operational costs	1,064
Total	13,888

[10] This includes a loading for high needs of $1,186 million.

The PC assumed a 12 per cent cost of capital component associated with those with the highest level needs and this was assumed to account for $500 million of the estimated costs of care and support (excluding the high care loading).

Step (ii): Source of offsets

The PC included two tables disaggregating the existing program offsets of $7,064 million which were netted off against the gross costs of the scheme. Table 14.4 in the PC report showed the offsets disaggregated by the funding and spending jurisdiction, while Table 16.19 showed the offsets disaggregated by program. These tables are reproduced below.

Table 14.1 Current funding and spending on relevant disability supports [a]

Level of government	*Spending and funding amounts*
	$ million
Spending[b]	
State and territory governments	5 648
Australian Government (excluding income support and open employment)	1 416
Total	7 064
Funding	
Australian Government transfers to states under SPPs	904
Australian Government funding of own direct spending on disability supports	1 416
Total Australian Government funding	2 320
State and territory governments	4 744
Total	7 064

Table 16.2 Summary of direct offsets

Direct offsets	*$m*
National Disability Agreement	5 210
Home and Community Care	583
Residential aged care	270
Community aged care	36
Aids and appliances	65
Taxi subsidy schemes	36
Helping Children with Autism Early Intervention	43
Psychiatric disability community supports	616
Australian Disability Enterprises	205
Total direct offsets	7 064

The source for each of these offsets is shown in the following table split between Commonwealth and State responsibilities.

Program	Amount ($ million)	Comments
NDA - Commonwealth	1,052	Commonwealth expenditure under NDA in 2009/10, including $904m for the SPP which is funded by the Commonwealth but excluding open employment services
NDA - State	4,158	State expenditure under the NDA in 2009/10 less the SPP which is funded by the Commonwealth
HACC – Commonwealth	356	30% of Commonwealth spending under HACC in 2009/10.
HACC - State	227	30% of State spending under HACC in 2009/10.
Residential aged care - Commonwealth	270	Based on 6,500 people under age 65 at an average cost of around $41,000 per person.
Community aged care - Commonwealth	36	Based on 2,130 people aged under 65 at an average cost of around $17,000 per person.
Aids and appliances - State	65	Half of the national spend on aids and appliances as reported in the Disability Investment Group Report
Taxi subsidy schemes - State	36	Based on expenditure on Victorian and NSW schemes in 2009-10 assuming those aged under 65 account for 25% of costs
Autism early intervention - Commonwealth	43	2011/12 budgeted expenditure on children with autism program
Psychiatric disability - Commonwealth	353	A mix of actual funding for existing programs in 2007-08 and projected funding in 2015-16 for programs announced in 2011-12 Budget.
Psychiatric disability - State	262	State mental health expenditure in 2007/08 allocated to Non Government Organisations
Australian Disability Enterprises - Commmonwealth	205	Full cost of program in 2010/11
Total Commonwealth	2,315	
Total State	4,748	

Step (iii): Update offsets information

For Commonwealth expenditure, budget and forward estimates information have been used. Note that expenditure for Australian Disability Enterprises was not shown separately in the portfolio budget statement for the Department of Families, Housing, Community

Services and Indigenous Affairs and it has been combined with the other NDA spending. The National Partnership Agreement on Transitioning Responsibilities for Aged Care and Disability Services provides for those States who have entered into the Agreement to fund HACC services for the under 65's and the Commonwealth to meet the costs for the older age group. Victoria and Western Australia have not signed this agreement and the Commonwealth is funding HACC services to these two States on the old basis; that is, paying 60 per cent of the total program costs. For simplicity it is assumed that all HACC funding for the under 65's is now provided by the States and we have split the former Commonwealth spending in line with the potential population in each State[11].

Program	2011/12	2012/13	2013/14	2014/15
NDA - SPP	1,222	1,284	1,348	1,432
NDA – non SPP	380	395	400	358
HACC	-	-	-	-
Residential aged care[1]	336	350	365	379
Community aged care[1]	33	34	36	38
Autism	44	29	29	30
Psychiatric disability	200	312	377	442
Total	2,215	2,404	2,555	2,679

[1] These figures come from the estimates set out under the National Partnership Agreement as being the cost of providing these services to those aged under 65. Similar figures were available for Victoria and Western Australia.

These figures exclude the impact of the SaCS case but data was available on the estimated impact for these programs. The adjusted figures are shown in the following table.

Program	2011/12	2012/13	2013/14	2014/15
NDA - SPP	1,222	1,311	1,407	1,514
NDA – non SPP	380	403	418	380
HACC	-	-	-	-
Residential aged care	336	351	366	382
Community aged care	33	34	36	38
Autism	44	29	31	31
Psychiatric disability	200	320	397	473
Total	2,215	2,448	2,655	2,818

[11] Potential population refers to an estimate of the population with a profound or severs disability.

For the States and Territories, where the figures were derived from the Report on Government Services, the results from the latest report have been used. This report covers the 2010/11 year for NDA and State HACC spending and the 2009/10 year for mental health spending. The NDA spending shown for the States includes the SPP funded by the Commonwealth accounted for above, and this has been removed. As noted above, the Commonwealth component of HACC spending has been spread across the States and added to the figures included in the report.

To arrive at the psychiatric disability offset for the States, the percentages of total mental health spending going to non-Government organisations reported in the 2010 National Mental Health Report were applied to the total State spending as reported in the Report on Government Services. This percentage related to the 2007/08 financial year and had increased substantially over the preceding 15 years. If that trend has continued, the figures used in the model will be understated. However, the psychiatric offsets are a relatively small component of total State offsets.

There was no updated information in relation to aids and appliances or taxi subsidy schemes available and the numbers from the PC report have been used without adjustment. These amounts are immaterial. The following table shows the program costs assumed for 2010/11 for each State.

Program	NDA	HACC	Aids/Taxis	Psychiatric
NSW	1,438	200	36	80
Victoria	1,207	153	31	102
Queensland	702	131	19	51
Western Australia	445	66	11	30
South Australia	286	49	8	29
Tasmania	117	17	3	12
ACT	64	11	2	10
Northern Territory	46	7	1	5
Total	4,305	634	101	320

Step (iv): Adjustments to PC assumptions

We identified two main areas where we considered an adjustment to the PC assumptions was warranted. These were in relation to the NDA and HACC offsets (a reduction of $350m for NDA and a reduction of $100m for HACC have been assumed).

As well we made a number of adjustments to the operational cost assumptions, which were discussed in the main section of the paper.

The following table shows the revised estimates of State NDA and HACC expenditure after these adjustments. Note again that all relevant HACC funding is now assumed to be State and Territory money.

Program	NDA	HACC
NSW	1,321	170
Victoria	1,109	129
Queensland	645	110
Western Australia	409	55
South Australia	263	40
Tasmania	108	14
ACT	58	9
Northern Territory	42	6
Total	3,955	534

Step (v): Projecting forward expenditure

Gross NDIS expenditure was projected forward using the following assumptions:

General wage growth (excluding SaCS):	4.0%
Population growth	1.0%
Price inflation	2.5%

The assumption on the growth in program outlays for SaCS was derived from the Commonwealth program expenditure. The resulting pattern of increase is as follows:

Financial Year	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19
Increase	2.3%	2.4%	1.5%	1.5%	1.5%	1.5%	0.8%

Care and support costs and ADE expenditure were assumed to increase in line with wages, population and SaCS growth. The capital component and aids and appliances etc were assumed to grow in line with price inflation, while administrative costs grew in line with general wage growth, excluding the SaCS increase.

For Commonwealth expenditure, where projections were available out to 2018/19, these figures were used. This covered the NDA expenditure and the psychiatric component. For the residential and community aged care programs, the assumed growth rate was based on the observed growth in total Commonwealth spending for these programs adjusted for the differential population growth of the under and over 65 age groups. The resulting growth rates were 4.1 per cent for residential aged care and 3.6 per cent for community aged care.

For State expenditure, general wage growth of 4 per cent and population growth of 1 per cent was assumed for all programs apart from aids and appliances and taxis. For the latter two programs, allowance was made for population growth and price inflation. A parameter which allowed for SaCS growth at the rates assumed for the Commonwealth to be taken into account or not was also included.

It is important to note that the AGA did not have access to States' own projections of their expenditure in future years. It is virtually certain that these numbers would differ from those projected for the model, both due to different assumptions about the underlying drivers of growth and due to policy decisions which are not incorporated in the information on which the model projections were based. The results of the projection are shown in the table below.

	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19
Potential tier 3 population	0	20,606	122,597	226,629	332,723	440,916
Gross cost of care and support	$0	$729	$4,720	$9,203	$14,227	$19,717
Local Area coordinators	$0	$84	$464	$805	$1,123	$1,299
Other administration	$130	$154	$331	$435	$550	$706
Tier 2 and capacity building	$0	$35	$191	$264	$211	$290
Total Gross cost	$130	$1,002	$5,706	$10,707	$16,110	$22,012
Existing Commonwealth offsets	$0	$132	$835	$1,611	$2,465	$3,382
Existing State offsets	$0	$269	$1,704	$3,251	$4,920	$6,716
State offsets allowing for:						
Population growth	$0	$280	$1,787	$3,444	$5,261	$7,250
Population growth and SaCS	$0	$296	$1,919	$3,748	$5,807	$8,059
Total offsets	$0	$428	$2,754	$5,359	$8,272	$11,441
Net cost to Commonwealth	$130	$574	$2,953	$5,348	$7,838	$10,571

We estimate an additional cost to the Commonwealth, over and above existing Commonwealth funding and existing State and Territory funding of $10.5 billion in 2018-19. This is equivalent to $6.8 billion in today's dollars before allowing for the impact of the SaCS

case and $7.5 billion in today's dollars, after allowing for the impact of the SaCS case. We have not allowed any offset in respect of the National Injury Insurance Scheme (NIIS). The PC assumed that the NIIS would be expected to lead to a further reduction in the net cost of the NDIS to the Commonwealth in 2018-19 of around $300 million in today's dollars.

Attachment 2 – Sensitivity Analysis

As the discussion in the paper makes clear, there are uncertainties around all elements of the costing: populations, severity distributions and average costs.

We have identified some areas where we saw value in examining the impact of alternative assumptions and Victoria also asked that a number of scenarios be tested. The results are shown in the following table in today's dollars.

Scenario	Additional Cost
Doubling of Tier 2 funding	~$200m[12]
Increase all daily packages by 5%	$400m
Increase the minimum package by 20%	$55m
Increase self-management and early intervention packages by 20%	$183m
Reduce the average annual cost for severity levels 20 to 24 to $220,000	-$312m
Assume average costs for children are 40% of the costs for a comparable adult	$430m
Shift 10,000 people from severity levels 4-8 to severity levels 9-15	$390m
Assume half of those with a severity level of 1 to 3 in the daily needs population need a package of $4,000 on average	-$378m
Include a further 50,000 individuals with mental illness at an average cost of $3,000 per annum[13]	$150m
Reduce the number of people with a severity level of 1 to 3 in the daily needs population by 50% from 102,000 to 51,000	-$583m

None of these scenarios are intended to represent our view on what might be a likely outcome. Indeed, some of them could be more appropriately seen as quantifying the risks associated with inadequate governance or cost-control within an NDIS. For example, our consideration of average costs suggests that the assumptions adopted by the PC appear

[12] An allowance of $200m for both Tiers 1 and 2 has been made in the PC report, but Tier 1 costs are assumed to be small.

[13] This figure reflects the advice from Bill Buckingham and Harvey Whiteford on the costs of providing social inclusion supports to those who do not also have complex care needs.

generous if anything. Allowing for a further 5% increase in average costs, which would lift the average cost for the highest packages to almost $300,000, does not seem appropriate for a scheme meeting reasonable and necessary needs. However, such a figure could well be an underestimate if the scheme were not adequately distinguishing between needs and wants.

Other scenarios are unlikely to occur in isolation. For example, the NDIA might decide to meet the needs of the lowest severity clients through block grants to service providers rather than individualised supports. This might be seen as corresponding to an increase in Tier 2 funding and a reduction in the number of Tier 3 clients. The issues around how best to meet the needs of lower severity clients are complex and beyond the scope of this paper. We simply draw attention to the fact that there are likely to be compensating movements, with relatively small impacts on overall costs.

Attachment 3 – Risks

There are a number of risks which, while not directly related to the costing, have the potential to impact on the costs of the scheme. In brief, we see the major risks as:

- managing expectations;
  - the process of consultation and subsequent public exposure of the PC report has undoubtedly raised expectations in the disability community;
  - the PC's emphasis on reasonable and necessary services may not necessarily have registered and thus expectations may be unreasonably high;
  - educating the community about the basis on which the NDIS will operate will be an important part of the implementation of the scheme;
- developing elements of the system without regard to cost implications;
  - the NDIS needs to be seen as a coherent package with the costs depending upon robust assessment systems and efficient service provision;
  - if costs are not taken into account in development of these building blocks, there is the potential for significant cost overruns;
- starting operations without adequate information systems in place;
  - the viability of the NDIS depends critically upon the use of control systems involving frequent and detailed monitoring of experience against expectations;
  - management information systems must be able to encompass the easy storage, retrieval and analysis of data;
  - without these systems cost overruns are unlikely to be recognised quickly enough to enable appropriate corrective action to be taken;
  - moreover, without these systems in place upon commencement of the scheme, valuable learnings from the early experience might be compromised;
- transition strategy;
  - depending upon the phase-in strategy adopted, there may be a period where the current system and the NDIS are operating side by side;
  - this has the potential to lead to major inefficiencies and perverse incentives;
  - the change to individualised funding may involve substantial dislocation for current service providers and a process of information/education will be required to support them through this challenge;
- workforce supply issues;
  - the NDIS will almost double the funding going to disability services and the bulk of the increase is likely to go to pay for support services;
  - shortages in suitably skilled staff could see a situation where support service needs cannot be met;
- inadequate funding;
  - it is important that the NDIS be established with a funding base that is likely to be sufficient;
  - if funding is inadequate, the NDIA will inevitably need to return to government for supplementation and this will negatively affect public perceptions of the scheme;
  - on the other hand, if the agency has been adequately funded, the Government will be justified in demanding that the agency improve its administration and management; and

- governance
  - the evidence from similar schemes in Australia and New Zealand highlights the importance of effective governance arrangements in managing cost pressures;
  - establishing the NDIA with a suitably qualified and independent board will be essential, as will ensuring that appropriate accountabilities are embedded in the organisational arrangements.