Viewpoint

NDIS and occupational therapy: Compatible in intention and purpose from the consumer perspective

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People living with disability in Australia face additional challenges compared to other people within the community. These challenges include having poorer access to health services, lower levels of engagement in meaningful education and fewer employment opportunities (Australian Bureau of Statistics, 2010a). Consequently, Australians with disabilities are 2.5 times more likely to experience poverty than the general population. To address the extra challenges, a person with a disability has a National Disability Insurance Scheme (NDIS) was proposed by the Productivity Commission (2011). The NDIS involves a federally funded support scheme that will provide lifelong support and care for people with significant disabilities. This paper aims to:

1. Highlight the unequal health status of people living with disability and how social insurance system may address this inequity.
2. Explain how the NDIS, if implemented as proposed by the Productivity Commission (2011), could provide equitable access to services to all Australians living with disability.
3. Describe potential risks and limitations to the NDIS and how these could be minimised.
4. Use a case illustration to demonstrate that compensable insurance can lead to gaining tertiary qualifications and a career in occupational therapy.
5. Describe how the occupational therapy profession and NDIS are complementary and that the values, skills and attributes of occupational therapists match those of the scheme.

I sustained a complete T1 spinal cord injury in a motor vehicle accident in 2004 but was fortunate enough to be compensable and therefore financially supported with injury-related expenses. The successful completion of my Bachelor of Occupational Therapy will be used to demonstrate what can be achieved when financial barriers are removed and individualised support provided to enable the achievement of client-centred goals. Becoming tertiary educated has provided the knowledge and skills related to health, which, when combined with my life experience, allows the provision of an informed consumer perspective to inform practice in occupational therapy.

Current Australian disability supports systems

The Productivity Commission is the Australian Government’s independent research and advisory body on a range of economic, social and environmental issues affecting the welfare of Australians (Productivity Commission, n.d.). Disability Care and Support was the Productivity Commissions Inquiry Report outlining the proposed National Disability Strategy. The current disability support system in Australia has been described as underfunded, unfair, fragmented and inefficient. According to the Productivity Commission (2011), people with disabilities are provided with limited choice, no certainty of access to appropriate supports, and little scope to participate in the community. The current disability support system in Australia has been described as underfunded, unfair, fragmented, and inefficient. It is proposed that the NDIS will provide a fairer and more accessible system by maximising community support and participation for people living with disability through individual, organisational and policy approaches (Fig. 1).

The supports and services provided have been subject to financial cycles and political influence (Department of Families, Housing, Community Services and Indigenous Affairs [FaHCSIA], 2009). This means that access to services has been subject to the availability of funding, rather than being based on a human rights
provision of services. Currently, people with chronic medical conditions are able to claim five annual allied health service visits through Medicare when managed by their general practitioner. For many people with ongoing health issues, five annual consultations are not sufficient to enable effective management and active participation in self-care, productivity and leisure tasks and roles. To address this inadequate and inequitable provision of support and services, it was proposed at the Australia 2020 Summit that the most appropriate way to satisfy the requirements of planning, efficiency and positive outcome realisation was through a social insurance type approach (FaHCSIA, 2009).

Social insurance schemes are mandatory redistributive mechanisms governments fund through taxes or premiums that are paid for by participants. Such schemes partially or fully fund injury-related expenses. No fault insurance schemes provide compulsory first party insurance for personal injuries and restrictions on the right to sue for negligence that causes or contributes to causing accidents (Cummins & Weiss, 1999). As the purpose of NDIS is to improve the health and wellbeing of people with disabilities, delivery of services will be defined under its legislation. The implementation of appropriate policies and management protocols provides guidelines and facilitates application of the legislation, while minimising liability and enabling a financially sustainable system.

Currently, disability supports are funded through state-operated organisations that prevent many people with disability from being able to engage meaningful activities, including productive and employment roles. More than 200,000 people with disabilities who are not currently in the workforce indicate they would be able to work if they were provided with appropriate support (Australian Bureau of Statistics, 2010b). The introduction of NDIS means that potentially, providing people with disabilities with assistance to gain and maintain employment could reduce the number of people reliant on welfare and increase tax revenue and that increasing the participation of people with disability in paid employment may contribute to the reduction in the fiscal gap caused by the ageing population (Long, 2012). Increased independence could reduce the reliance on family members to provide support, and this in turn will allow other family members to increase their participation in paid employment and tax contribution, further reducing the cost of NDIS.

The Productivity Commission (2011) proposes an ‘individual choice’ model, in which people with a disability (or their guardians) could choose how much control they wanted to exercise. This model, when combined with the increased access to supports and services, would provide a client-centred system that could meet the needs of people with disabilities and their families. It would allow people with disability to reduce reliance on case managers and increase self-management. Self-management involves day-to-day activities involved in managing one’s own health, including health promoting activities such as physical exercise and the management of ongoing health conditions (Lorig & Holman, 2003). The issue of self-management is especially important where only the client can be responsible for his or her day-to-day care over the length of the illness. For most of these people, self-management is a lifetime task.

Currently within Australia, the best examples of no-fault insurance schemes include the Transport Accident Commission (TAC) and Workcover Insurance systems. These schemes cover medical expenses, support services, assistive equipment, home and vehicle modifications, and loss of income protection for people involved in motor vehicle and workplace accidents. These schemes demonstrate, that if implemented and managed effectively, that the NDIS has the potential to be financially viable while meeting the needs of people with...
disabilities. However, as the NDIS involves funding individually tailored supports and services for people with disabilities, the economic impact of the scheme must be considered to determine its viability and long-term sustainability. This has to be considered because the ageing Australian population may lead to cost escalation and further vulnerability of people with disabilities.

**Benefits of NDIS**

NDIS will be the funder but not the provider of supports and services, providing financial certainty to supports and services that will improve the health and wellbeing of people who have disabilities and their families. It is proposed that NDIS will manage client accounts to provide consistency across the country and achieve better outcomes for all Australians by addressing disability reform using a three tier approach:

* Tier 1 – Everyone: All Australians will be protected against the costs involved if they or a family member acquire a significant disability.
* Tier 2 – People with or affected by disability: Information and referral services will be provided about the most effective care and support options.
* Tier 3 – People with significant care and support needs: Individualised supports and services will be available to people with significant limitations due to disability.

The proposed key benefits of NDIS include the provision of access to aids, equipment and environmental modifications, access to allied health services, and personal, community and domestic support services (see Table 1). These supports and services are in areas where occupational therapists have the skills to provide and effectively deliver services to people with disabilities.

The National Injury Insurance Scheme is a separate federated scheme that will provide fully funded care and support for all cases of people with catastrophic injury. Claims would be operated and managed by the states but funded by the federal system. It is recommended that existing institutions like the TAC and Workcover expand to include the management of other catastrophic injuries within those jurisdictions.

Boundaries and regulatory systems must be established to ensure risks and responsibilities are managed efficiently. Such systems will facilitate shared service planning and provide accountability. To enable people with disabilities and their families to have control of their lives, the NDIS is based on values of choice, security and confidence. In addition, the goal of the NDIS is to facilitate the development of a comprehensive and sustainable support sector, and an inclusive society (National Disability Services, 2013). Shared decision making between service recipients, service providers and NDIS Australia will provide flexibility and ensure the scheme is managed effectively.

**Limitations of and risks to NDIS**

Interestingly, the core features of choice and control over the supports they receive may also pose a major risk of the scheme. Enabling people with significant disabilities to have control over funds may make them vulnerable to exploitation by service providers and marketing of ineffective products with limited scientific basis. The provision of ineffective, harmful and non-evidence based interventions is often harmful to the consumer and would cause financial harm and pressures on NDIS. Enabling greater choice and control also may make NDIS vulnerable to exploitation by providers who may effectively undercut value for money service provision. The occupational therapist involved in service provision in this area has the ability to mitigate these risks through direct service provision and involvement within the NDIS Agency.

Relevant comparable examples of social insurance schemes highlight potential limitations of and risks of NDIS. The German Long Term Care (LTC) Scheme provides clear recognition of the cost burden of an ageing population. LTC has produced a financial deficit for the past 10 years in spite of failure to adjust any welfare benefits (Rothgang, 2010). Although the NDIS will not provide income support, as older people are more likely to have disabilities demand for support required is likely to increase as the population age increases (Australian Institute of Health and Welfare, 2000). This comparison highlights concerns for the financial sustainability of NDIS, with the median age of Australia’s population projected to increase from 36.7 in 2007 to

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**TABLE 1: Proposed services to be funded under NDIS and occupational therapy role**

<table>
<thead>
<tr>
<th>NDIS service</th>
<th>Direct occupational therapy service</th>
<th>Consultative occupational therapy service</th>
</tr>
</thead>
<tbody>
<tr>
<td>Allied health services</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Aids and appliances</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Home and vehicle</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>modifications</td>
<td>Personal care</td>
<td>Yes</td>
</tr>
<tr>
<td>Community access support</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Respite</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Specialist accommodation</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Domestic assistance</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Transport assistance</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Supported employment</td>
<td>Yes</td>
<td>Yes</td>
</tr>
</tbody>
</table>
between 41.9 and 45.2 years by 2056 (Australian Bureau of Statistics, 2012).

The New Zealand Accident Compensation Corporation in recent years has faced severe pressure from cost and liability escalation in their serious injury cohort. This has necessitated a review of the serious injury governance and service delivery model leading to a model which is more focussed on outcomes and evidence-based practice (FaHCSIA, 2009). Although agencies such as TAC and Workcover face these same issues, they have appropriate policies and procedures in place to effectively manage liability. For example, prescription of supports, services and medications must be recommended by qualified health professionals, including occupational therapists, physiotherapists or medical practitioners. Clinical justification must be provided and supported by scientific evidence. This ensures that only items that are of benefit to people with disabilities are funded by insurers and funding agencies. Although policies and regulations may not always appear client-centred, they are necessary to maintain an insurance model where supports can be provided to entitled claimants (Ferrera, 2000).

An insider’s perspective

As a case illustration, my experience demonstrates that when people with disabilities are given appropriate supports and services, this enables them to be productive and contributing members of the community, something that is very difficult without such assistance. Following my discharge from 19 months rehabilitation, the availability of paid attendant care support facilitated the continuation of therapy, which allowed me to improve my health and fitness, and to economically and socially participate in my community. To improve my health and fitness, to allow me to participate more fully in the community and be more independent at home, a self-managed gymnasium programme was prescribed by a community spinal physiotherapist. Regular participation in this fitness regime increased my strength and endurance which increased my independence. Funded attendant care support is necessary to set up gym equipment and to assist with completing the programme. Without this support, I would be unable to independently complete the gymnasium programme which would negatively impact my physical and mental health by reducing my community involvement and participation.

Needs-based supports involve the provision of support based on the needs of the client. Support is not limited or restricted by financial constraints, time-frames or quotas. If a physical or psychological need is caused by an individual’s impairment then services and supports are made available to address these. Needs-based supports allowed me to successfully complete tertiary studies, first starting in Health Sciences and then leading to a Bachelor of Occupational Therapy. Following rehabilitation, I did not have the ability to drive or access to public transport and as a result attendant care allowed me to access the community, which enabled me to remain active and involved in my local community. Needs-based supports enabled me to regain my driver’s license by providing specialised driving lessons in a modified vehicle and the vehicle modifications necessary to independently transport. A car was purchased using the impairment benefit received for personal injury sustained in my accident. Hand controls and an electric seat were fitted that allows me to independently get my wheelchair into and out of the car. When the NDIS is introduced all eligible clients, not just those with compensable injuries, can become empowered to become more autonomous and have greater involvement and control in their own health care and lives.

In my experience and opinion, the creation of a supportive home environment forms the foundation from which people are able to achieve beyond what society would expect. During rehabilitation, my home was extensively modified to enable wheelchair access and support my independence. This included the construction of an accessible bathroom, new entrances, a new driveway and creating a more open plan layout with greater circulation space. For many people, this is beyond them unless supported with timely and appropriate support to manage their impairment. Support as was done through TAC and could be done through NDIS. Removal of financial barriers and provision of equitable support may allow people with disability to become more actively involved in the community and increase opportunity and participation in education, employment and other productive roles.

Support for non-compensable disability

As supported by Ivanoff, Iwarsson and Sonn (2006), the provision of assistive technology and physical environmental interventions represented important strategies that promoted my occupational performance including, but is not limited to, the provision of assistive devices such as wheelchairs, commodes, vehicle modifications, and an accessible bathroom and home environment. Access to home modifications and assistive technology allows people with a disability to compensate for absent or impaired abilities and enable participation and occupational performance (Buning, 2008). With the provision of a suitable home environment, my independence was supported which enabled me to address other goals with minimal additional support and self-care issues.

My experience demonstrates that access to health professionals and individualised support facilitates effective health management of people living with disability. These client-centred supports are not currently available to more than 400,000 people that the Productivity Commission (2011) estimates who do not have compensable injury or disability. Allied health services, including
occupational therapy and physiotherapy will be fully funded under NDIS as long as they are supported by clinical evidence (Productivity Commission). Professional guidance and support will assist to address the challenges people with disabilities face in their everyday life. Individual families and people living with disability will work with a ‘planner’ to identify goals and action strategies and supports to meet client-centred goals that lead to economic or social participation. This has potential to create greater autonomy and self-management for many people with disabilities.

**NDIS and occupational therapy**

Because occupational therapy is a profession committed to improving the quality of life and economic and social participation for people with disabilities (Law, 2002), the profession is ideally placed to complement and support the NDIS. The introduction of NDIS will have a significant impact on the occupational therapy profession if it increases access to allied health services and enables access to the most effective therapies; these would strengthen and support the provision of occupational therapy services. Through the NDIS, occupational therapists may be better funded to contribute to the betterment and improved participation in the daily lives of clients.

Community-based occupational therapy practice will be facilitated and enhanced by NDIS as it will enable people with disabilities who currently are non-compensable to receive allied health services (Productivity Commission, 2011). Occupational therapists will be able to enable people to develop long-term goals, such as returning to study or gaining employment that will guide therapy and be achieved through a series of short-term goals. As shown by Doig, Fleming, Cornwell and Kuipers (2009), goals provide structure, which facilitates participation in rehabilitation despite the presence of barriers, including reduced motivation and impaired self-awareness. A therapist-facilitated, structured, goal-setting process in which the client, therapist and significant others work in partnership can enhance the process of goal setting and goal-directed rehabilitation in a community rehabilitation context. Provision of aids and appliances will facilitate therapy as financial constraints will not impede therapists’ ability to achieve the best possible outcomes for clients. Occupational therapists will have greater freedom and control over the environment as home and workplace modifications will also be funded under the NDIS (Productivity Commission, 2011).

Occupational therapists are uniquely positioned to provide services within the three tiered levels of service provision. These include increasing opportunities for people with disability by creating a more inclusive community, provision of information and referral to supports and services for people affected by disability, and by providing individualised support and services with people with significant disabilities. The profession as a whole, as well as individual practitioners, are likely to be instrumental in the implementation and continued delivery of the scheme. Occupational therapists must use client-centred practice and their knowledge of the health-care system to provide supports that enhance the lives of people living with disability. They will achieve this by creating a more inclusive and supporting community, through advocacy, and utilising clinical reasoning skills to provide fairer, more positive outcomes in the same way that has been done with compensable clients for some time. Without health-care practitioner’s involvement with the NDIS, the full benefits of the scheme are unlikely to be realised.

However, there is a possibility that opportunity for occupational therapy could result in a workforce shortage. This is likely due to increased access to allied health services by people with disability and demand for occupational therapy services, which could potentially lead to there not being enough qualified occupational therapists to cater for this increased demand for occupational therapy services. Other roles and positions created by the NDIS that occupational therapists could complete would only exacerbate this potential problem. Workforce demands are already evident through current workforce shortages of occupational therapists around Australia (Occupational Therapy Australia, 2012). The Australian Minimum Competency Standard for New Graduate Occupational Therapists (Occupational Therapy Australia, 2010) ensures therapists have diverse skills that prepare them to fulfil a range of health positions. Roles created by NDIS that occupational therapists could competently perform realistically extend beyond the planner, or direct service provider to include positions in health promotion, community development and research (Productivity Commission, 2011).

Fundamental principles that underpin occupational therapy are entrenched within the recommendations proposed by the Productivity Commission (2011). The NDIS has a holistic view of health that reflects the holistic view of health and wellness practised by occupational therapists through increased participation in meaningful occupation. This approach gives equal importance to the occupational environment, the person and their interaction, and is used to identify interventions that will promote the ability to perform occupations with greater efficiency, effectiveness and satisfaction (Schkade & Schultz, 1992). The NDIS uses a lifelong approach to provide care and support, recognising that planning must look beyond the immediate need and involve lifelong planning (Productivity Commission). This reflects an occupational perspective that views occupational engagement across the lifespan incorporating early-intervention, rehabilitative therapies and long-term goals.
NDIS and occupational therapy are both person and client centred. Client centredness is promoted within occupational therapy though individual autonomy and choice, partnership, shared responsibility, enablement, accessibility and by respecting diversity (Law, Baptiste & Mills, 1995). This is reflected in support management of the NDIS as it considers how individual client potential might be realised through personal planning, application and outcome monitoring (FaCSIA, 2009). Under the NDIS, people with disabilities will have a choice of supports and services they use, who provides them, how they are designed and provided, how resources are utilised and how their funding is managed (Commonwealth of Australia, 2013). These features are congruent with the best practice recommendations of Clark, Scott and Krupa (1993) that client involvement in intervention planning, collaboration and evaluation should form the basis for planning occupational therapy services.

Outcomes of the NDIS/moving forward with NDIS
Many inequities faced by people living with disability could be reduced by the introduction of the NDIS through equitable access to services and supports and removal of financial barriers. Australia’s ageing population leading to greater utilisation of health and support services, escalating costs and operations management systems pose potential risks and limitations for the NDIS. Many of these risks can be mitigated through regulatory systems whose effectiveness has been demonstrated in comparable insurance schemes. The NDIS will increase the demand for health services such as occupational therapy and allow improved client outcomes due to shared and complementary perspectives of health.

Occupational therapy could be strengthened, supported, enhanced and complemented by the NDIS, as the NDIS reflects occupational therapy core principles and has a lifespan view of health that may ultimately improve the health and wellbeing of people with a disability. What is certain is that the occupational therapy profession needs to be proactive in this new arena to be able to be instrumental in delivery of this scheme. My personal experience demonstrates that removing the financial burden associated with living with disability has the potential to improve the health and wellbeing of people with disabilities and enable them to be productive and contributing members of society.

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References

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Both occupational therapists and occupational therapy assistants provide essential services in the comprehensive management of feeding, eating, and swallowing problems. Occupational therapy practitioners have the education, knowledge, and skills necessary for the evaluation of and intervention with feeding, eating, and swallowing problems. Purpose. The purpose of this guideline is to clarify the role and describe the distinct perspective of occupational therapy practitioners in the delivery of occupational therapy services for people with feeding, eating, and swallowing impairments and perform Prior to 1973, occupational therapists (OTs) and physical therapists (PTs) treated children primarily in medical facilities; medically oriented residential facilities; and separate educational facilities for children with disabilities, commonly known as orthopedic schools. These facilities, while representing advancement in the provision of services to children, were separate from the educational and community environments that most children without disabilities experienced. Through the early 1970s, occupational therapy and physical therapy were deeply rooted in a medical orientation where occupational therapists can bring values to the diabetes care team by evaluating multiple levels of influence on DSM, addressing personal and environmental barriers to well-being and DSM, and supporting patients to develop of a highly complex competences and skills to satisfactorily self-manage diabetes. This article summarizes two evidence-based, well-structured occupational therapy (OT) programs that use activity-based treatments and psychosocial strategies, respectively, to improve DSM abilities and to enhance quality of life. E. Pyatak, “Participation in occupation and diabetes self-management in emerging adulthood,” American Journal of Occupational Therapy, vol. 65, no. 4, pp. 462–469, 2011. View at: Publisher Site | Google Scholar.