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TRANSCRIPT OF PROCEEDINGS

PRODUCTIVITY COMMISSION

DRAFT REPORT ON DISABILITY CARE AND SUPPORT

MS P. SCOTT, Presiding Commissioner
MR J. WALSH, Commissioner

TRANSCRIPT OF PROCEEDINGS

AT HOBART ON MONDAY, 4 APRIL 2011, AT 1.08 PM

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MS SCOTT: Good afternoon. My name is Patricia Scott. I'm the presiding commissioner for this public inquiry and it is my pleasure to introduce John Walsh, who is the associate commissioner for this inquiry. John is coming to us from Sydney via Skype. He's also on the telephone so if, for some reason, you find that the picture image disappears for a minute or two, don't be worried; John can still hear you and John will be participating by asking questions and so on. Good afternoon, John.

MR WALSH: Good afternoon, everyone.

MS SCOTT: Thank you very much for making time to be here this afternoon and for any adjustments we've made to your schedule as a result of our last-minute iterations. Thank you for your interest in this inquiry and for the submissions you have made on our terms of reference. As this is a public inquiry and we want to ensure that many people can know the views of interested people, this session is being recorded for transcript purposes. The transcript will be placed on the Productivity Commission's web site, which is www.pc.gov.au. If you are interested in the other days of hearing - and this is our first day of hearing after the release of the draft report - you can follow the other days of hearings by reading the transcripts. Please visit the web site as frequently as you want.

Now, because it's a public hearing we do need to hear people and that's why we've got the microphones. It's not a town hall meeting, we won't be taking comments from the floor, but if time permits - and I hope it will, and we have been able to do this in most locations in the first round of hearings. We were able to invite short comments from the floor and I'll try and do that as close as I can to 25 past 4. It might only be for five or 10 minutes. If you're scheduled to speak, please come forward when requested, and I'm pleased to have Hudan from the team assisting me in the arrangements this afternoon.

We'd like to conduct the hearings in an informal manner, so while you might be a bit nervous about the fact that you've got the microphone in front of you and you have an audience, we do appreciate your engagement and we'll try and be considerate of your feelings about being asked sometimes difficult questions. We can appreciate that, as we're learning, you're learning about our processes as well. Participants are welcome to comment on issues raised in other submissions and from any testimony you hear this afternoon. Participants are not required to take an oath but are required under the Productivity Commission Act to be truthful in their remarks.

We have got some information about media and the arrangements for media who might be attending this afternoon. Could I have any media representatives identify themselves now, please? So no ladies or gentlemen from the media? No-one from a radio network, TV, blog or anything else? All right, thank you, that's done.

That makes that job easier. I would remind you that submissions are due by the end of April.

I'm pleased to have Dan English already at the table so, Dan, would you like to lead off with a short opening statement, please?

MR ENGLISH (RGDT): Thank you very much. My name is Dan English. I'm the chief executive officer of Royal Guide Dogs Tasmania. I'd like to welcome Patricia and - by proxy somewhat - John to Hobart, Tasmania for the opening round of these submissions to the Productivity Commission in relation to the National Disability Insurance Scheme. I have taken the liberty, John - and I apologise in your absence that you weren't able to participate as fully as I might have hoped, but I provided Patricia with a couple of small pieces to start off. So by way of what would normally be the case for somebody with a vision impairment, I'll give you a little bit of an audio description so that you get a bit of a feel for where we're at.

Just before we started I asked Patricia to place on a pair of glasses which are a set of occlusion glasses or, for want a better term, a blindfold. I also provided her with a long cane, one of which I have here. I'm not sure if you can see us, John. Are you able to?

MR WALSH: I can see you, Dan.

MR ENGLISH (RGDT): Excellent. So I have a long cane and a small device which is called a Miniguide, which I also provided to Patricia. While she was wearing the occlusion glasses I asked her how she might feel about making her way from this location to her hotel room. Funnily enough, she didn't actually strike out with any great gusto to do that. I also provided her a piece of paper, one of which has been retained for your use, that has a number of questions on it. The piece of paper - the questions are actually quite pertinent and I'll get to those a little later but it's written in a font that's almost impossible to see. So the other thing that I provided Patricia with is a small piece of equipment called a RUBY, which is a video magnifier which allowed her to actually magnify the information on that piece of paper and be able to read it much more readily than she would have been able to otherwise.

I also have a couple of other things here that I'll go through as we progress through this particular process. For example, just to confirm the time and to make sure I have enough time to continue my presentation: "It's 2 o'clock pm." Okay, so unfortunately this one hasn't been adjusted for daylight savings but I also have an audio clock here or a talking clock. It would seem strange that I would bring a variety of props to a presentation like this but I think it's incredibly important that you get a very good understanding of how our perceptions of the National Disability

Insurance Scheme as it's currently put forward in the report will impact on people who are blind or vision-impaired.

If I look at the definition particularly that related to tier 3, which is a profound core activity limitation where a person is unable to do or always needs help with a core activity task, including communication, mobility or self-care, the items that I have asked Patricia to play with today actually relate to all of those three core limitations. For example, the Miniguide and the long cane are all about mobility. If I look at something like the RUBY, or the video magnifier, it is a piece of equipment that is about communication and how blind and vision-impaired people are able to communicate.

There is reference in the report, although fleetingly, to other equipment. For example, there's a reference to a Braille machine. We actually don't have any Braille machines. We have Braille embossers, we have Perkins Braillers, we have a variety of other equipment that could be more appropriately, or I suppose generically, referred to as a Braille machine, but there is no such thing as an actual Braille machine. In many ways this is one of our concerns in relation to the report and how it actually impacts on people who are blind and vision-impaired - is that the thrust of the report seems to be focused primarily on residential care or the provision of carers for in-home support.

Any reference to people who are blind or vision-impaired seems to be very much an add-on: for example, the reference to a Braille machine with no interpretation of what that may actually be or what that may look like. For example, a Perkins Brailler may cost somewhere in the vicinity of a couple of hundred dollars. A Braille embosser and the associated technology, both hardware and software, to actually implement that would be somewhere in the vicinity of maybe tens of thousands of dollars. So a "Braille machine" as a generic descriptor isn't a particularly good descriptor for somebody who is blind or vision-impaired.

There are some points that we very strongly agree with and I say "we" both from the perspective of Royal Guide Dogs Tasmania but also from the perspective of the Australian Blindness Forum, which I am also a director of, and I attended a forum in Canberra last Thursday of all the member organisations, and a couple of other organisations of the blindness and vision impairment sector also attended that meeting. There are some things that we do agree with in the Productivity Commission report in relation to the National Disability Insurance Scheme. It's probably best that I actually do identify those before we start talking about some of our concerns.

We certainly share the belief that there should be equity of and entitlement to services regardless of age. We believe that a simplified transition between the disability service and the aged care service is incredibly important. We certainly believe that there needs to be delivery of age-appropriate services right from birth through to somebody who is in the aged care sector and may be well advanced in their years. In particular, we're very, very strong in our agreement with the concept of early intervention because, by and large, it is the component that does best encapsulate our service provision model.

One of the things that we do have some concern regarding - and whilst we recognise that the terms of reference for the Productivity Commission were set by government and that they did specifically specify that it was services for people who experience disability under the age of 65, we believe that ageing is a risk factor for vision impairment. We strongly disagree that vision impairment is a natural part of the ageing process and in may ways vision impairment has actually been either stated or inferred to be a natural part of the ageing process. This is particularly important - - -

MS SCOTT: Sorry, Dan, can I just get you to repeat that? It seems to me you're making a key point here. Could you just go back about risk factors again?

MR ENGLISH (RGDT): We believe that ageing is a risk factor for vision impairment but it is not a cause. We would strongly argue that vision impairment is not a natural part of the ageing process. Similarly, we would argue that disability is not a natural part of the ageing process. Some 50 per cent of people aged over 85, according to the National Disability Service, have a severe or profound disability. By inference, that actually says that 50 per cent don't have a severe or profound disability, which significantly undermines any argument that a disability or, by inference, a vision impairment is a natural part of the ageing process.

Having said that, this particular report - and when read in conjunction with the Caring for Older Australians report - is of significant interest to our organisation and our collective group of organisations because some 70 per cent of our client base is aged 65 or over. We believe they are at significant risk in relation to the gaps that exist within this report, and the interface between the Caring for Older Australians report and this report as well.

MS SCOTT: Dan, just on that point, what would the percentage have to be before you would be convinced that this is something related to age? You seem to think that, because it was 50 per cent, it isn't a sufficient connection. What would the percentage have to be for you to be convinced?

MR ENGLISH (RGDT): I don't necessarily think that a percentage would be something that would convince us. If we look at the various types of vision impairment, you could certainly say that the name "aged-related macular degeneration" isn't perhaps the best argument against this particular proposition. However, when you look at the range of vision impairments and the range of functional impacts of different types of vision impairments, we don't necessarily believe that vision impairment should necessarily be considered as a natural part of the ageing process because, by and large, when it is considered like that, the functional impact of those vision impairments is significantly underestimated.

There is insufficient attention provided to those functional impacts where our services could actually provide significant improvement in somebody's quality of life and their capacity to function independently; to age in place, as is one of the key recommendations of caring for older Australians. We believe that when it is considered a natural component of ageing it actually fails to recognise the significant impacts that it has.

MS SCOTT: Thank you.

MR ENGLISH (RGDT): Vision impairment: people who are blind or visually impaired have a unique set of needs and these generally require access to episodic services rather than ongoing services. Again, this is something we believe has necessarily been well catered for within the report. The relationship between functionality and engagement with services is often quite different with vision impairment.

For example, generally when you have a lower functional capacity as a result of a disability you have a higher engagement with disability service providers. However, with vision impairment generally, if you have a higher functional capacity, regardless of your clinical diagnosis you are much more likely to engage with the comprehensive services provided by the blind and vision-impaired sector, which is actually quite the inverse of most disability service models. You are also likely to continue to re-engage during your lifetime, and the more competent and functional you become the more likely you are to engage with services from the vision impairment sector.

MR WALSH: Dan, could you give some examples of that? I don't quite understand.

MR ENGLISH (RGDT): Yes, most certainly I can. For example - and I will come to this a little bit later on - one of the things that is noted in there, which is in some ways quite exciting for us, is that the National Disability Insurance Scheme has said that it will fund the provision of guide dogs and their associated training.

If we think about how somebody comes to a guide dog, a guide dog is the culmination of the continuum of care, in many ways, that's provided by organisations such as our own. For example, it is very, very rare that somebody comes into our organisation and that the first thing they receive is a guide dog. In fact it would be almost unheard of for somebody to receive a guide dog and that that somehow fixes the problems associated with their blindness or their vision impairment. It is much more likely that somebody will come in for services such as our talking clock, as a starting point, because they are in hospital and they want to know what time it is so that they can take their medication, or they have just returned home.

They may want something as simple as one of the signature guides that I have provided to you, so that they can sign the documentation that allows them to be released from hospital, or, if their vision impairment is slow-onset, their integration with our services might be quite minimal at first, particularly in relation to mobility.

If we look at mobility, which is one of our core responsibilities, it is much more likely that somebody will receive a $50 long cane and the associated training with this prior to receiving a guide dog which, conservative value, is probably closer to $40,000 to $60,000 depending on which organisation it comes from.

The training with a $50 cane is actually fundamental in learning the principles of independent travel prior to receiving a guide dog, yet there is absolutely no mention of any of those specialist services that relate to how somebody might develop their independence and their independent living skills. For example, if I want to do something as simple as make myself a cup of tea, which is going to be something that is probably much more on my mind than perhaps diving straight into a guide dog program, I'm going to need something like this.

I'm not sure if you can hear that, John. Can you hear that? It sounds like interference. It's actually a small product called a liquid level indicator. Instead of somebody trying to boil a kettle and put their finger in the top of the cup and wait until the boiling water burns their finger, this enables them to make a cup of tea safely. Negotiating your way safely around your home is going to be much more important than necessarily receiving a guide dog in the first instance. Does that answer the question?

MS SCOTT: Yes. I think that's a good example you've given. Just a clarification: the absence of a long list in the report is in some ways the fact that it was 800 pages long already. If we had to list every potential item that would be covered by the scheme, it would probably be another volume. I take your point. It's well made. I'm conscious of the time. Maybe you might want to focus on the areas where you think the final report should be different.

MR ENGLISH (RGDT): I take your point that an exhaustive list would be inappropriate. Our concern is that the very few mentions there are of sensory impairment and particularly vision impairment do seem very much like an add-on, and the guide dog is the best example of that. Many people would see a guide dog as something that a blind person would get. The lack of depth and indications of understanding of those issues that relate to vision impairment are, whilst not necessarily providing a comprehensive list of aids and equipment, probably our most key concern. Certainly we've got some issues around funding, as well. I've actually got a couple of questions for both John and yourself, Patricia, if I may.

MS SCOTT: All right.

MR ENGLISH (RGDT): What consideration, when calculating the current costs and contributors to the provision of disability services, was given to the contribution made by organisations that provide services for people who experience disability, whose income is derived primarily through public donation as opposed to government funding?

MS SCOTT: We would imagine that these organisations would continue. In some cases they may wish to change their role. It depends what service sector they are operating in and the nature of the organisation. It's hard to be definitive about all the different non-government organisations that exist. Certainly some organisations have said to me that they would like to take on the role of brokering, if the report got accepted. Others have said that they would like to be in the service field because that's where their strength is.

I don't think I can be definitive, but we have thought about the fact that organisations, obviously in the new setting, would potentially look at opportunities and decide on their own assessment where they would like to operate. That's one aspect that we have considered. Do you have a second question?

MR ENGLISH (RGDT): Sorry. Just in relation to that question, my question more revolves around how much consideration was given to the actual financial contribution. When we look at the report, there is a lot of information that seems to be derived from those organisations that are government-funded and the economic impact of that. Our concern is there doesn't seem to be an acknowledgment of the significant contribution that is made from public donation and related services and we struggled with trying to find how that was built into the costing mechanism.

MS SCOTT: What recommendations would you like to see, Dan, as a result of your reading of the draft report? I'm just conscious that your time is fast upon you. Would you like to just take that aspect about non-government funded NGOs. Is there a recommendation you'd like John and I and the team to consider?

MR ENGLISH (RGDT): We believe that the costings, based as they are at the moment, fail to recognise that and we believe that there needs to be significant investigation of the contribution made by non-government organisations that are primarily funded by public donation, as we believe otherwise the cost base for this will end up in a rationing system rather than in an entitlement system, because we believe it may well be significantly underfunded if they are taken into account. For example, the next component of our question in relation to that is what consideration is being given to the potential impact of the NDIS on the capacity for those organisations that are funded by public donation to continue to raise the necessary money to pay for the services that they currently provide, if they're not going to be provided under NDIS?

MS SCOTT: Okay, and what's your view on what you'd like to see the commission come up with as a recommendation in this area? What's your suggestion to us, given that today is mainly about us hearing from you about what you'd like to see in the report?

MR ENGLISH (RGDT): I suppose our concern again is that if the NDIS doesn't adequately cover the services for blind and vision-impaired people, there is the significant risk of philanthropic malaise amongst the donating public that would significantly impact on our capacity to fundraise to continue to provide these services. If we look at tier 2, being a referral service, the opportunity to refer to organisations that no longer can provide services because they can't actually derive the money - I don't necessarily have a recommendation that I can give in that, but certainly I think it requires significantly further investigation.

MS SCOTT: Okay, and your concern is that if funding is increased to the level that we have suggested in the draft report, in fact the Australian public may not be as interested in therefore funding your organisation. Is that the style of concern that you have?

MR ENGLISH (RGDT): Correct. Somewhere either savings have to be made or income has to be derived to pay for this particular program, as a result of which we believe that there is considerable risk to not-for-profit organisations that rely primarily on fundraising of having their income jeopardised as a result of this, unless it's very, very carefully worded. Particularly the name of the program would lead people to believe that all disabilities will be covered by this National Disability Insurance Scheme.

MS SCOTT: Have you got a suggestion about what the name should be?

MR ENGLISH (RGDT): No.

MS SCOTT: Okay.

MR ENGLISH (RGDT): I would like to think that we could come up with a recommendation but I'm sure there are many greater minds amongst the commission that could be put to that.

MS SCOTT: You're after a name that would imply better services but not all services?

MR ENGLISH (RGDT): Yes, most particularly if the services that we're talking about for our client base aren't actually going to be comprehensively covered under it.

MS SCOTT: Okay.

MR ENGLISH (RGDT): Very quickly I'd just like to talk about assessments. We have concerns that the National Disability Insurance Agency may not necessarily have or be able to readily develop the expertise to adequately assess people who are blind or vision-impaired. This has been the experience certainly here in Tasmania. If we look at the Gateway programs, we have significant concerns that by comparison the Gateway programs, which were introduced in what could be considered a similar fashion to the way the NDIA may be fashioned - and we've not received one referral in two years out of that program.

So from our perspective, what we would like to see is the potential for organisations to become, as you said, either trusted intermediaries or in some way actually able to provide specialist assessment for those people who fall into very niche areas of disability, for example particularly sensory impairment where the functional implications don't necessarily correlate with the clinical diagnosis.

One of the very brief questions I have is: is there flexibility for a person to re-access services as their needs develop without having to undergo further generic assessment? We've got concerns again that the generic assessment may not capture the needs of people who are blind or vision-impaired. Again, we couldn't interpret that from the report.

MS SCOTT: I'm not sure I understand your question. Could you try a different set of words?

MR ENGLISH (RGDT): Okay. For example, at the moment, if somebody wants to come to our service for a replacement cane after they have had a comprehensive long cane program, are they going to be expected to go back through a generic assessment and be referred on to an organisation like our own or are they going to be able to actually access services like our own for those sorts of retraining or reissues that would normally be considered, from our perspective, something of just a standard re-entry into our program? So somebody isn't reassessed for those processes within our organisation, and we would see the risk of considerable duplication of effort and misdirection of funds if somebody is going to have to be reassessed every time they enter the program.

MS SCOTT: While your question suggests that we might have to go back and have a look at some of the text, the intention is that people are in the scheme and that if it needs change they would approach the NDIA for reassessment, but if the needs are the same and just simply a replacement is required - I think that's what you're suggesting, isn't it?

MR ENGLISH (RGDT):   There are certainly elements of that, yes.

MS SCOTT: Then I guess they simply come forward and ask for a replacement. You don't need to go back to square one if someone is already in the scheme. Dan, we're conscious of time, so maybe just your last remarks?

MR ENGLISH (RGDT):   Most certainly. I suppose the best way to sum up is, as a group of organisations within the disability sector, both Royal Guide Dogs as an individual entity and the broader membership of the Australian Blindness Forum, we strongly support the need for a National Disability Insurance Scheme. However, if we look at our own specific client base, we believe there are significant gaps, that the report needs to be read in consultation, and the recommendations and any further development of it needs to be made in consultation with the Caring for Older Australians report because, whilst there are significant additional funds that have been allocated to the National Disability Insurance Scheme, if we look at the Caring for Older Australians program, that's actually been capped at the current percentage of GDP with a significant increase of ageing Australians coming into it, and those people who have a disability being transitioned across to that as well. So from our perspective, from a blindness and vision impairment group of organisations, we have significant concerns in relation to the introduction of this particular scheme if it were to move ahead as it is currently suggested.

MS SCOTT: Thank you very much. Thank you for your testimony.

MS SCOTT: I'll now ask the NDIS Taskforce, Jane Wardlaw, to come forward. Thank you. It's my pleasure to welcome you, Jane. Would you like to make an opening statement?

MS WARDLAW (NDIST):

> Disability is not something that individuals have. What individuals have are impairments ... Disability is the process that happens when one group of people create barriers by designing a world only for their way of living, taking no account of the impairments other people have.

That's a quote from Arts For All from Aotearoa, "Opening Doors to Disabled People". Disabled Australians who experience severe impairment and limited body functioning know only too well the struggle they have in order to receive support to live every day. The current disability system across Australia is fragmented, inequitable, unfair and under-resourced. The disability service system is:

> ... irretrievably broken and broke, chronically under-funded and under-resourced, crisis driven, struggling against a vast tide of unmet need.

I have taken that quote from the National People with Disability and Carer Council Shut Out report. A sense of hopelessness and fear has prevailed amongst the disabled community about their futures. For example, the disability service providers are under-resourced, which stymies contemporary service delivery, perpetrating a paternalistic, charitable welfare model of support. Individuals, for example, living with disability fear about their futures and where they or their loved ones for whom they care will end up.

Transformation or change is required. Transformation or social reform is paramount. All Australians deserve a natural entitlement to disability support and care in contemporary design. There is hope. Change is on the horizon. The Productivity Commission's draft report into disability care and support offers a solution to the broken and broke system, one whereby power relationships are equalised in a functional system which promotes freedom of choice, flexibility and a range of options for the disabled community.

This submission is presented to the Productivity Commission. As chair of the National Disability Insurance Taskforce, I am representing a number of people living with disability, and approximately 80 per cent of the funded disability service providers in the state of Tasmania. I'll endeavour to best articulate reflections concerning the report on behalf of this task force, so I hope you don't mind me reading it.

MS SCOTT: No. That's fine.

MS WARDLAW (NDIS): It is essential to note that in the quick turnaround time from the release of the report on 28 February 2011 to presenting a submission to this first hearing today, I may not have captured everything that we need to let you know. As contributors, we are also volunteers, giving our time and commitment towards undoubtedly one of the most significant social reforms our nation has witnessed. Since the report's release, our group has only had one face-to-face meeting. We do have quite a considerable transport issue here in this state. Thankfully, because of technology - and it has provided us with different avenues of communication - we also had conducted an online survey to our members, which was also widely distributed, and some of the feedback shapes this submission.

The Productivity Commission is to be congratulated and highly commended for its report. They have captured the needs, wishes, wants and desires for a workable system that will meet the needs of all people now and in the future who experience disability. As a person who is living with a degenerative muscle weakness condition - and I also have two other sisters with the same condition - this is a very personal story for us as well. We are all very, very excited. For once in our lives we have a very strong sense of hope that was given to us on 28 February with the proposal of the National Disability Insurance Scheme.

This submission will highlight the following: that Tasmania is considered the ideal trial region for the implementation in early 2014; that supports estimated to cost an additional $6.3 billion is critical - this is a critical minimal investment; support for funds to be extrapolated from consolidated revenue; governance of the National Disability Insurance agency to ensure the voice of people living with disability is equally represented around the governance table, along with funders and providers; support for individualised funding models that includes the option of self-directing and self-managing funds. We also support people living with disability to be market drivers rather than market takers, creating a diverse, contemporary service delivery model; so a case for Tasmania.

Since 2008 the Tasmanian state government committed funding towards disability reform agenda. This agenda is now in its implementation stage. A key feature has been the decentralisation of decision-making, with the creation of the regional gateway services; a one-stop shop for people living with disability whereby assessment and information and referral is provided. This model for disability services is the first implemented in Australia. We believe that this is an opportunity for the implementation and gives us the thumbs up, more or less.

Secondly, Tasmania has the highest rate of disability in Australia, above the national average, at 23.8 per cent. Tasmania has a population of 500,000 people, making it a very good sample area, residing in urban, regional and remote locations. The National Disability Taskforce Tasmania fully supports that Tasmania becomes the trial state of the NDIS. However, in our online survey feedback, many people living with disability expressed the desire for the scheme to be introduced nationally rather than rolled out in stages, in trials, regionally, for the fear is that many people living with disability - time lines are inappropriate. If you don't mind, I'd like to make a quote from one online feedback:

> We live in a remote location of Tasmania and our one and only service provider in the district has refused to take on my son with an acquired brain injury. There are many people in our community who want to work for us - they are qualified carers - but I am unable to gain confirmation from government that my family and I can self-manage our care package for my son. My wife and I are elderly, and we are providing all the care and support. We are simply at our wits' end.

An appropriately funded scheme: the report has correctly identified that the current disability support system is underfunded, unfair, fragmented and inefficient, and gives people with disability little choice and no certainty of access to appropriate supports. All Australians are under the misconception that if they experience disability through chronic illness, acquired or genetically, appropriately funded disability support and care is a natural entitlement. This is simply not the case. This report has estimated that an additional $6.3 billion is to be committed to fix the broken system. The National Disability Insurance Scheme Taskforce Tasmania fully supports this estimation as a minimal amount. We encourage that such an estimate is not to be compromised due to political pressures, nor is it to be negotiated unless there's an increase in funding, as paramount.

The disabled community needs the assurance that funding is recurrent. Already, too many families, individuals living with disability and the responding providers are fearful of what may happen to them if funding is not forthcoming. The current underfunded situation perpetrates a culture of fragmentation. Powerful relationships occur between current funders and providers, largely excluding people living with disability.

We support the report's inference that a properly funded system will enhance productivity of the sector, creating diverse and contemporary service delivery which centres upon principles of self-determination, choice, flexibility, responsibility and options. It is critical that the NDIS is funded accordingly at approximately $6.3 billion.

Government responsibility: as the disability community, we find it concerning that those who may oppose an NDIS forget the spirit of government as developing systems which ensure all citizens have a right for equal and meaningful participation in a democratic society. In our understanding of Australian democratic government, a spirit of a fair go, assisting people who are vulnerable to live meaningful lives, is part of our culture; namely, a model of citizenship. Since Australia ratified the United Nations Convention on the Rights of Persons with Disabilities, we now have a set of rights which must be adhered to. These rights are reflected in the report's proposed solution to fix the broken disability system which oppresses people living with disability.

In Tasmania we are currently facing an economic crisis of high unemployment, a review of GST income and downward income from current GST earnings. We don't believe that Tasmania is in a position to fully fund the needs and supports required to fix the broken disability system and culture of care for Tasmanians. Presently, disability services providers and the state government are working in financially constrained environments. In the meantime, disability service providers are struggling to survive and people with disability have limited choices in living a life that is equal to their non-disabled peers.

As stated in the report, given its capacity for raising efficient and sustainable taxes, the Australian government should take responsibility for meeting the entire future needs of the NDIS. The NDIS Tasmania Taskforce supports the report's recommendation that an additional $6.3 billion should be provided for from consolidated revenue.

So, good governance: successful models of disability support systems in Western societies has happened because all relevant stakeholders were meaningfully included around the negotiating and decision-making table. It makes good policy sense to meaningfully include relevant communities of interest. Generally we support the implementation of an independent national disability insurance agency. However, the NDIA must ensure that the voice of people living with disability and parent family carers are represented authentically. Further, the NDIS Taskforce Tasmania recommends that all board members and directors, particularly those individuals who are not touched by disability directly, attend credible disability awareness training. Tasmanian heads of government agencies have actually been undergoing such training and it's been so successful that they are now extending it to staff within their agencies.

Self-determination and its applicability to people living with disability: the Productivity Commission's report is to be highly commended for its inclusion of self-directing models of care for people living with disability. For too long, individualised funding models have been too controlled by government because a minimal few believe that people living with disability cannot manage their own supports. The report has correctly identified that research does not support such claims. Therefore, across Australia disability support mechanisms are over-regulated, further oppressing people living with disability who are capable of and want to manage their own support needs. Disability is not homogenous; rather, disability is heterogeneous. Therefore, the option must be available, without too much regulation, for people living with disability who have the capacity to determine their needs and/or have family supports who know best, to self-manage such supports.

I might leave that bit because it's just a bit of research that talks about what is self-determination, which is the fundamental ethos of your self-directed supports, but that can be read in the report.

MS SCOTT: Thank you.

MS WARDLAW (NDIST): The report is to be highly commended for ensuring that consumers living with disability have a system of support that promotes choice, flexibility, control and options. Just two more points. Market drivers, not market takers: the NDIS proposed will create transformational social change for the disabled and broader community by providing the tools and resources to fix the broken system and restructure the fragmented system, empowering people living with disability to have more choice, flexibility, control and exercise their self-determination. We anticipate the creation of a new service economy will emerge.

Those disability service providers who do not meet current accreditation standards yet continue to be funded because no other service exists will have no choice but to lift their game to become competitive as individuals with disability choose where best to purchase support. What will emerge is a more innovative and creative care industry which will work harmoniously with their customers, including them in policy and program development that is person-centred as opposed to agency-dominated programs. The Productivity Commission is to be congratulated for highlighting a spirit of competition and improved service models for people living with disability.

In conclusion, the Productivity Commission is to be highly commended for executing a draft report on disability support and care which reflects the dire circumstances of a volatile, unworkable, unfair, fragmented system which unconsciously oppresses the participation of all its citizens in Australian life. The larger disability community finally have hope for their futures. The fear and experience of oppression will be minimised as the independence of a properly funded system frees people with disability to emerge as valued members of society.

It is vital that government properly funds and provides the critical additional $6.3 billion to ensure the development of the NDIS. It is essential that the NDIS is implemented sooner rather than later. For some families and individuals it may well be too late. Thank you.

MS SCOTT: Thank you. John, do you have any questions for Jane?

MR WALSH: Just a quick one, Jane. You did mention the Gateway rollout in Tasmania.

MS WARDLAW (NDIST): Yes.

MR WALSH: Can you talk about what more needs to be done in Tasmania with the Gateway program.

MS WARDLAW (NDIST): Well, I'm saying that the Gateway program is a good starting point. It's very much at its early stages, but the way that I see it and read your proposal is that the Gateway could be a wonderful way for you to establish gateways across the nation which could be that first point of call and contact where assessment and referral can be actually allocated. So we believe that what has been happening here in Tasmania with their teething problems - because it's not been without teething problems - is still a very, very worthy idea to be included into one way of rolling out this nationally.

MR WALSH: If you could just quickly sum up what are the ongoing problems in Tasmania in spite of that rollout.

MS WARDLAW (NDIST): With the Gateway service itself?

MR WALSH: No, just generally with disability.

MS WARDLAW (NDIST): Completely underfunded. We're very agency-dominated here and now they are having a major struggle with trying to raise enough funds. We've had a lot of downward economic pressures here. We need to shave approximately $1.2 billion off our state budget, so we're experiencing considerable economic downward pressure.

This is now actually going to have a very big impact on what services can be delivered and our fear is that, having one of the highest disability proportions here, service providers will not be properly funded and the rollout of the new disability reform agenda will be impacted upon, which will ultimately affect people living with disability in their lives here. We actually have some of the highest rates of disadvantage, would you believe, at communities in Australia here compared to the national average.

There was one more point that I think we should also consider. In this change environment, if and when we get this up and going - and I'm positive we'll get it going - we need to ensure that there's some capacity-building for service providers and the disability community because we really do need to become more educated about how we can work together in a harmonious environment and we need to understand how we can become better at what we do.

MS SCOTT: Jane, thank you very much. Time is at its end. We welcome getting your submission. Given that you've already put that information on the record, you might want to look at the information requests at the end of the overview, where we've asked some questions about the potential scope of the scheme, to see whether your members have a view on some of those issues. I just draw that to your attention as well. Thank you very much, Jane.

MS SCOTT: Good afternoon. For the record, given that we have two presenters, could you state your name and your organisation, please.

MR HILLIARD (ALA): My name is Brian Hilliard. I'm the national president of Australian Lawyers Alliance and next to me is John Green, who's the Tasmanian president of the same organisation.

MS SCOTT: Thank you.

MR HILLIARD (ALA): Thanks for the opportunity to speak today. Just by way of introduction, I'm a personal injuries lawyer and I have been working in the area of compensation to injured people for about 20 years in Tasmania, initially working for injured people. I then spent some time giving advice to insurance companies in the area, before returning to working for injured people again about 13 years ago. John, who is next to me, also works in the area, although he has a more mixed practice. My practice is very specifically personal injuries law for plaintiffs, for injured people.

I should also say that the ALA will be presenting other submissions in relation to the draft report and we have an intention of doing so across the nation at the various hearings that you've scheduled over the next few weeks and that we also intend to provide a further, more comprehensive written submission within the time that you've limited for such.

MS SCOTT: Thank you.

MR HILLIARD (ALA): And we again thank you for that opportunity. The ALA would like to acknowledge that we take the view that the system of providing care and assistance to Australian injured and disabled people certainly requires consideration and renewal. We take the view that the proposals for the NDIS would be beneficial for many injured and disabled Australians. We think it should be pursued and we commend the commission for its report and the government for putting it to the commission for consideration.

My submission will deal, in relation to the NDIS, with the issue of what happens when decisions are made by the proposed agency in relation to the care of injured and disabled Australians when those decisions are not accepted by the injured and disabled people; that is, when adverse decisions are made. We take the view that there should be a review system implemented in relation to any agency, particularly having regard to the profound effects that decisions in relation to care can have, and I was listening with interest to the previous speaker when she acknowledged the real difficulty that families and individuals can be put into when decisions are made which are contrary to their interests. These decisions can clearly affect people's standards of life, or even their lives themselves. They are important decisions made by a government agency or a proposed government agency and there need to be rights in relation to those decisions.

We take the view that a review system akin to the review system which exists in relation to Centrelink beneficiaries, with a dedicated appeals tribunal, which is then appealable to the AAT, should be considered. AAT decisions are then referable to the Federal Court if there is a dispute. We take the view that because many injured and disabled Australians will have difficulties with such a system, there needs to be care given to the provision of advice to those appellants. We take the view that legal advice to appellants should be funded out of the scheme to help prevent injustices. At the very least, the appellants ought be entitled to costs, and costs orders should not be awarded against them if they are unsuccessful, and you may or may not be aware that this is the system which currently applies in relation to many decisions which go to the AAT. It should be contrasted to some decisions in relation to state tribunals where this is not the case.

In particular, in the Motor Accidents Compensation Tribunal or the Workers Rehabilitation and Compensation Tribunal in Tasmania it's a costs jurisdiction. The person who is seeking a review of a decision in relation to their care or medical treatment or other benefits under those no-fault systems risks costs orders against them in taking the decision to the tribunal and this is a great disincentive to seeking justice.

Decisions which may appear to be small or may only have a small financial impact can be extremely important to people with injuries. For instance, the withdrawal of some aspects of care may amount to some hundreds or thousands of dollars, may involve a potential costs order against them in excess of those amounts or well in excess of those amounts and the risk is simply too great for them to take. This is a serious access-to-justice issue and we would recommend that the commission consider it carefully when introducing the scheme or making recommendations in relation to it.

We have some further concerns in relation to the aspects of the secondary scheme which is being mooted in the draft report, which is the NIIS. In effect, many of our concerns revolve around the suggestion that there should be a removal of common law rights as a part of the introduction of such a scheme. I myself have worked in Tasmania as a personal injuries lawyer on both sides of the spectrum in situations where we have had open common law and then a restriction or a removal of those common law rights.

In Tasmania in 2001 there was basically a removal of the right for injured workers to bring actions at common law. It wasn't a removal; there was a 30 per cent whole person impairment threshold placed on it under the AMA 4 Guides. I'm not sure if you're aware of what I'm referring to - in our view, an extremely arbitrary and nonsensical threshold, but in any event it's what exists. It means that virtually no-one can seek damages at common law. It's recently been reviewed but still we haven't seen how that review is helping out yet.

So we have seen the difference between a no-fault scheme involving access to common law and the introduction of a no-fault scheme with no common law, and in fact what happens is that the power balance which used to exist, where the plaintiff or the injured person had some coercive power through the courts, is removed and it places them at the whim of claims officers in insurance companies in a privately managed scheme. When decisions are made by those claims officers which are contrary to the rights of the injured person, that can have very serious effects and they don't have the coercive power.

We didn't tend to see this when there was a common law system also in play, because it was known to the insurers that the workers had those rights through the common law courts which they could enforce with coercive powers and they could seek proper compensation. If something was taken away from them on the one hand on the no-fault side, they could continue to sue for it, so decisions tended not to be made that way because I assume the insurance companies were placing reserves on their cases, which enabled them to meet those costs. When the coercive power was taken away, the power shift balance moved to the insurance companies and unfortunately our experience is that they have abused that power in relation to the decisions made in relation to injured people.

I've noted in my written notes of my submission that we have some concerns in relation to the costing of the NIIS. We don't propose or purport to have any expertise in this area but we would recommend that the costing of the benefits that are proposed to be available under that scheme should be very seriously considered and actuarial advice should be checked carefully. So reiterating, we've got real difficulties with the general thrust of pushing towards an overall no-fault system and the consideration of a diminishing role for the common law torts based system.

Again in relation to the NIIS, any scheme needs to give careful consideration to review rights and a similar system to that which we've proposed in relation to the NDIS should be considered. The draft report makes references to the possibility of a hybrid system; a hybrid system being one with common law rights and no-fault rights. You'd be aware, of course, that there is a very good example of a hybrid system in Tasmania and we hope to be in a position, which is why John is with me, to be able to answer any questions you have about that system and to talk it through.

Basically, of course, motor vehicle accident cases in Tasmania and, up until

2001, workers compensation rights in Tasmania involved a no-fault system which immediately provides income support, medical associated expenses and care and support facilities for anyone injured in motor vehicle accidents, no matter who was at fault. But if that person is injured due to the fault of another person, generally another road user, they have completely open access to the civil courts in order to obtain compensation which is specifically addressed to them, rather than that which is covered by a scheme which by necessity has to be general in nature.

A person who gets damages in a civil court - subject to restrictions under the Civil Liability Act and other legislation, which is probably something we can talk about at another time - should be able to obtain compensation which is specifically calculated to be sufficient to meet their needs, including providing compensation for the diminishment of their life experience; that is, for pain suffering and diminution in lifestyle.

MS SCOTT: Brian, if you don't mind, just a question there. Given your recent experience - both sides - on the insurance side as well as in private practice, what proportion of your cases do you approximately estimate would actually reach a court?

MR HILLIARD (ALA): A court?

MS SCOTT: Yes. I imagine there's mainly - - -

MR HILLIARD (ALA): For motor vehicle accident cases - look, I don't have those numbers to hand, but when a client asks me that in the first interview, which many of them do, I generally say less than 1 per cent.

MS SCOTT: Then you're into the settlement.

MR HILLIARD (ALA): Yes.

MS SCOTT: In the draft report we've got a section commenting on the fact that with settlement approaches, studies that we looked at suggested that this is very much a trade-off of uncertainties; uncertainty for the insurance company and uncertainty for the individual. Would you like to comment in particular on that, how that relates to your earlier statement that one of the advantages of the common law system is the individual assessment of need and the individual's assessment of their circumstances, when in fact the draft report suggested that because so many of the cases are actually settled out of court - in your estimation 99 per cent - then you're really back to dealing with uncertainties. Could you just talk about that for a few minutes?

MR HILLIARD (ALA): In relation to the settlement of cases, of course there are uncertainties. There's primary uncertainty in relation to the issue of liability, so if a plaintiff has a case where liability is not at issue then that's taken out. I should say that in the majority of motor vehicle accident cases in Tasmania the issue of liability is not one which we need to be concerned with and it is those cases where liability is at issue that end up in court. The MAIB is a very good insurance company from the point of view of its concessions in relation to liability. It doesn't arbitrarily deny, like some insurers do.

Secondary issues in relation to liability are contributory negligence. An assessment needs to be made in relation to that. There are standards of contributory negligence which are dictated by the Civil Liability Act. For instance, the Civil Liability Act will dictate that failure to wear a seatbelt is a standard 15 per cent, I think, contributory negligence, which can be rebutted in evidence but generally that's what's accepted. Finally, there's often some doubt or there is some controversy over the adequacy of treatment, the necessity of treatment or the longevity of incapacity. Those are the matters which generally result in there being some range in a motor vehicle accident case where you're seeking to resolve it at settlement.

The right always exists for the injured person to have the matter litigated and it's that right which gives robustness to the system. Yes, most matters settle. That's because generally both sides are being advised by experienced and professional advisers who understand the system, and so if you take two lawyers who are both working in the system and who have experience and have the same evidence in front of them, one would hope that generally they can come up with an answer which is much the same.

That's probably your perfect settlement. It's where there's a serious doubt as to one of those aspects that there may be a settlement, I suppose, which may be at a lower end of the scale than you would say was acceptable. For instance, the insurance company may have serious doubts whether a person has the capacity to earn that they say they're having.

MS SCOTT: Okay. I have another two questions to follow up but I just wanted to give John a chance. John, would you like to come in here?

MR WALSH: Brian, I'm assuming from the way you spoke of it that you're actually a supporter of the MAIB in terms of the lifetime care and support of people with a catastrophic injury be provided on a no-fault basis?

MR HILLIARD (ALA): Absolutely. We've had this system in Tasmania since 1974 and it's always been my experience to work within that scheme. I haven't worked in a different situation. I believe - and I think the facts bear this out - that it appears to be affordable. The MAIB premium in Tasmania is towards the lower end of Australian premiums. It appears to be a very robust system, in that the board pays a benefit to the government; that is a dividend. Finally, it appears to provide a very good safety net for all injured Tasmanians, particularly in relation to the care and support for catastrophically injured people. It certainly is utilised almost always; that is, that almost every case that settles or goes to a judgment would have an order or a concession made under section 29A of the act.

MR WALSH: But would you support the extension of civil liability and healthcare liability to provide the lifetime care and support for the catastrophically injured people on a no-fault basis?

MR HILLIARD (ALA):   Could you just repeat the question again?

MR WALSH: Would you support the creation of an MAIB-type scheme for other injury types with respect to the future care and support of catastrophic injuries?

MR HILLIARD (ALA):   Yes. With a caveat that there's open access to common law for those people for whom it doesn't suit, we would certainly be in favour of it. Particularly, the early provision of care and support to catastrophically injured people or those with catastrophic injuries acquired not through accidents I think would be very beneficial for Australians and we'd support that - I would support that. I should say I'm speaking from my own personal view rather than as an expression of the ALA.

MS SCOTT: Sure.

MR GREEN: I agree with that as well. It's also my experience it's a very good scheme, particularly for those who are catastrophically injured.

MR HILLIARD (ALA):   I've got concerns about how you're going to pay for it.

MS SCOTT: I wouldn't mind going to payment, but just while we've got Brian, I might just go onto that. We've talked about hybrid schemes and the hybrid nature of some arrangements. Just on medical accidents, Brian, I guess you have exposure to the Tasmanian system.

MR HILLIARD (ALA):   Yes.

MS SCOTT: Or both of you, the Tasmanian system here in terms of motor accidents. A concern that has been put to us is that catastrophic medical accidents should not be in the equivalent of MAIB, they should be in the NDIS, because this would potentially affect people's access to their other common law rights. I just wanted to test that proposition on you, given your actual experience with the MAIB here.

MR HILLIARD (ALA): It's a little difficult to answer. What we, I suppose, are here to say is that the MAIB hybrid system works well. That involves total access, with no restrictions to common law rights. Any system which took that away would in our view be not a good idea. The reasoning behind it is the empowerment of the injured person that the common law provides to them.

For those people for whom statutory payments and no-fault payments over a very long period of time, where those systems do not appeal to them, do not work, and in circumstances where there is a liability and a tortfeasor to pay damages, our view is that that system ought be maintained. An extension of the payment of immediate care and support, and continued lifetime care and support, to those people who are injured in other manners, is something that I would personally support.

MR GREEN (ALA): The extension of an MAIB scheme to medical negligence wouldn't affect people's rights to sue at common law if they wanted to, and it would provide them with better care. It's very hard to fight medical negligence cases. The doctors are very organised and employ good lawyers. So that's a difficult area of practice, I think, throughout Australia, and particularly in Tasmania because it's a small state. If you want to fight a medical negligence case you've got to go interstate to find a lawyer who will say another lawyer has been negligent; within Tasmania they all know each other. I've heard a doctor say, "I think Dr Smith was negligent, but I play golf with him every weekend. I can't possibly say it publicly. It's just too embarrassing." Plus the fact they wouldn't get any referrals for that kind of thing. But that's a Tasmanian peculiarity.

The advantage of a hybrid scheme is that I've found in my experience, when common law is taken out of the workers compensation system, the amount of money injured people got was halved; they got about half, without common law. The other advantage of common law is that it tends to reduce the number of accidents. I know that insurance companies take steps to prevent the number of accidents. If they've got an employer who has a bad accident record, they will take steps to encourage that employer to improve their safety performance. If not, they won't reinsure them. So the threat of paying damages at common law is an effective deterrent, in my experience, particularly for large to medium-sized business organisations, and that would apply across the board. It would also be a deterrent to doctors and hospitals.

Another one is that the rise in the cost of medical negligence was causing hospitals to systemically look at their systems and see where their systems were failing, why people were getting the wrong drugs or double doses of drugs. They are looking at why some doctors seem to have more accidents than others. If you take away that incentive, and if there's no fault involved - I think the New Zealand experience proves this - there will be more accidents.

MR HILLIARD (ALA): Can I just talk about that aspect of things. because I know it's raised in your draft report. It caused me to think about it, because you've made some statements that, statistically, these things were not shown. I was thinking about a situation that we went through in Tasmania, where a very large employer in Hobart, which had been growing at a very fast rate during the 1990s, was having an enormous number of very serious accidents. It's a large heavy engineering company, and it was having a lot of serious accidents, with the consequence that its insurance premiums were going up astronomically for workers compensation.

It got to the point where they simply could not afford to insure in one year. They couldn't find - I can't remember how many millions - the millions that they had to pay for a premium, so they went to the government and the government, being in the mood to try and preserve this business in Tasmania because it was large, were convinced to allow them to make an application to self-insure, which is what they did. They became a self-insurer. Consequently, they were required by the regulatory authorities to put in place certain safeguards in relation to being able to meet their potential liability, and also in relation to health and safety, which they did.

I can tell you that I can't remember the last time I had a claim from that business. It's my view that there has been a dramatic increase in the safety of the business and that has been pushed because of the pressure of having to meet the cost, and that was because we had open common law.

One of the other aspects of this is - and it's not just financial - if a matter goes to trial, and the supervisor and the foreman and various other people have to turn up and provide evidence as to exactly what they did, and when and why, it's a very salutary lesson when it has been brought to their attention that they have failed. That type of experience is going to ensure that those people in those positions are far safer in the future in all other aspects.

MS SCOTT: I can see that you are drawing on the workers compensation as an analogy, but of course - - -

MR HILLIARD (ALA): Because it's changed.

MS SCOTT: - - - we are actually not, as you know, making any recommendations in that area.

MR HILLIARD (ALA): No.

MS SCOTT: I wouldn't mind going back to Brian's comment about New Zealand and doctors in New Zealand, and medical accidents there. The team and commissioners have looked at research in the area in terms of medical accidents. We didn't find it the case that suggested there had been more medical accidents, so I am just intrigued by your comment. Maybe you'd like to take it on notice, but we'd be most interested if you could find or cite any study about increased medical accidents. That hasn't been our research to date, but we have an open mind. If you are aware of any of those, any studies that - - -

MR GREEN (ALA): My understanding is that there are more accident claims in New Zealand than in Australia on a per head basis, but the - - -

MS SCOTT: I think there's a difference between claims and number of accidents. I'm interested in the number of accidents per se. If you could have a look at - - -

MR GREEN (ALA): The ALA is investigating that and hopes to be able to provide some detailed submission to you in due course as you go around the states.

MS SCOTT: All right. That will be good. We'll look forward to that. We are now fast approaching - - -

MR HILLIARD (ALA): There are a couple of other aspects I did want to - - -

MS SCOTT: We are onto our last three or four minutes.

MR HILLIARD (ALA): I would also commend that there be consideration given to provision of duty of good faith by administrators in relation to decisions made in relation to the NIIS. I'd refer you to a case that you might be aware of, CGU Workers Compensation v Garcia. It relates to workers compensation, but the issue is that decisions were made in relation to a person's entitlement to no-fault benefits. The decision was done in an environment where there was a lot of evidence pointing to continuation of benefits and one report saying no. They cut him off, and they just leave them to their own devices. There was no duty of good faith. The appeal court in New South Wales held there was no duty of good faith. We would recommend that there be a duty of care and a duty of good faith by administrators in any system to ensure that the rights and the benefits to the injured people are maintained.

MS SCOTT: Are there schemes that operate now with duty of good faith?

MR HILLIARD (ALA): Not in relation to personal injuries.

MS SCOTT: Right.

MR HILLIARD (ALA): Not in relation to insurance for personal injuries. There is a duty of good faith in general insurance, for decisions made in relation to - the problem that arises is this. In general insurance there is privity - that is that there is a contract between one person and the insurance company - and under that contract there is a duty for the insurance company to act in good faith in relation to decisions it makes. In the situation of a no-fault scheme there's no privity. That is, there's no relationship between the person who's making the claim and the person who's making the decision which imposes the duty of good faith. It can only be imposed through the legislation and so we'd commend the commission to consider that.

The final aspect that I wanted to talk about was the specific aspect of the draft report, chapter 15.4, which makes references to delay in relation to common law actions. It's the information upon which the commission is going to be making its decisions and, contrary to the common law system, we have some real concerns. There is a box 15.3 in the draft report which outlines a number of common law cases which seem to have taken an extremely long time. There are some notes in the report that sometimes there are good reasons for delay, and of course there are, and one of the major reasons for delay is waiting for maximum medical stabilisation prior to giving advice in relation to settlement or taking a matter to trial. But if the examples in 15.3 were seen as representing the current system of common law courts, then in my submission it's highly misleading.

I've been running a business which does this for over 13 years and, going through my statistics, the median for running a motor vehicle case from the day that a person contacts us until the day that the file is closed is 48 weeks. In relation to other types of cases it's similar, although sometimes a bit longer, and we would commend the Productivity Commission to consider that aspect of its report very carefully because, as I said before, the picture painted by box 15.3 is, in my submission, so misleading as to be useless.

MS SCOTT: Okay. Well, thank you very much for your comments. If there's an opportunity for you to provide some of that data you've got here about the median time - we would be also interested in the distribution around the median - that would be great.

MR HILLIARD (ALA): Yes. I was interested in that too. I was surprised to find that the shortest time was 10 weeks and the longest was in the vicinity of three years.

MS SCOTT: Right.

MR HILLIARD (ALA): But this is for one firm from one state. It makes a difference where you are. Queensland, New South Wales and other states have highly restrictive pre-litigation protocols which were probably put in with the best of ideas to try and speed up the system but in fact what it does is slows it down. In Tasmania we don't have any of those restrictions and so my statistics really only relate to my state. Also, they probably don't relate to other firms and I don't know whether they would be as willing as I am to provide the numbers, but I'm quite happy to go through and to de-identify the numbers and send them to you.

MS SCOTT: That would be good. Thank you very much. John, do you have any questions?

MR WALSH: Those statistics, Brian, if you could do it for both motor injury and medical indemnity, that would be really good.

MR HILLIARD (ALA):   Yes, I can. We do do medical work, but the numbers are smaller and so I don't know about the robustness of them. But I will do that.

MR GREEN (ALA):   You've mentioned good faith in the superannuation industry, the assessment of a person for total and permanent incapacity, by the trustee. The trustees are under a duty of good faith. That's an example of where that works.

MS SCOTT: Yes, that's a good example. Thank you. That's very good; I'll write that down. Thank you, John and thank you, Brian, for your time this afternoon. We look forward to getting your submission.

MR HILLIARD (ALA):   Thank you.

MS SCOTT: We now have Speak Out Association of Tasmania coming forth. Good afternoon. For the record, please, could you identify yourself and your organisation. I'm conscious of the time. Maybe you want to make a shorter statement and then allow John and I to ask some questions. Thank you very much.

MS MALLETT (SOATI): We'll just each say our name first to begin with. Mary Mallett. I'm the manager of Speak Out.

MS HUETT (SOATI): Judy Huett and I'm the members' president of Speak Out Association.

MS ASTELL (SOATI): My name is Rebecca Astell and I'm a board member of Speak Out.

MS BUTLER (SOATI): Julie Butler, and I'm the north-west regional advocate.

MS SCOTT: Thank you very much. Well, now, an opening statement, thank you.

MS MALLETT (SOATI): Speak Out is an independent disability advocacy service. We operate statewide in Tasmania. We're managed by a board and we're also a membership organisation for people with intellectual disability. We have a strong focus on self-advocacy and we run self-advocacy groups, facilitate self-advocacy groups, in each region, as well as an annual conference for people with intellectual disability. We are part-funded by FaHCSIA, so partly Commonwealth funded under the National Disability Advocacy Program and part-funded by DHHS in Tasmania. Do you want me to just briefly outline the points that we want to make today?

MS SCOTT: Yes, please.

MS MALLETT (SOATI): And we will be putting in a written submission before the end of the month.

MS SCOTT: Thank you.

MS MALLETT (SOATI): Our significant concern really with the report - and I just should say first we were delighted with the fact that you spent so much time and validated so much that people with disability have thought for years about how the system didn't work, so that's been fantastic, to have that validated in the report. But our significant concern, really, is about independent advocacy. There's very little in the report about advocacy, and some of the places where it is mentioned, our concern is that it's not really been understood clearly about what independent advocacy for people with disability is or ought to be, so really our primary focus is to make sure that there continues to be an appropriate level of funding for independent advocacy for people with disability; that it needs to be a national scheme and that it needs to be available to people with disability of all types of disability, but that it needs to remain independent.

I've got an example of one of the places advocacy is mentioned in volume 1 in the report, in box 4.1, which is part of the list of the specialist disability supports provided by the NDIS. It starts on the page before. But there's a part that refers to case management, local coordination and development. That's on page 4.4. It mentions at the end of that little paragraph:

> An individual could also elect to have a disability support organisation assist with case management and advocacy.

Our huge concern about that is that that wouldn't in any sense be independent advocacy for the individual. It might be advocacy in the sense of advocating for a service that the person needs, but it isn't in any way - it's not independent advocacy, which is just an essential part of the system.

MS SCOTT: Okay. I'm going to pull you up there just a little bit, if you don't mind. I just want to get a sense of what this independent advocacy is. What do you mean by "independent"? Can you define that? This is separate from the individual, because that seems to be the bit you don't like in that paragraph?

MS MALLETT (SOATI): There's a couple of bits we don't like in that paragraph. One is the concern that the commission doesn't understand what independent advocacy is and the other is the concern that the individual might have to pay for advocacy in the way that they might have to pay for other services and they might elect to pay for those out of their individualised funding.

MS SCOTT: Okay. Well, let's start from taws. Why don't you tell us what you think independent advocacy is?

MS BUTLER (SOATI): If we take as an example: there's a lot written about families supporting in terms of their individualised funding, and families do a fantastic job, but frequently we're called on by service providers, by individuals who might come to us whereby they have a conflict of interest with their family. Particularly where an individual with an intellectual disability is starting to express their own wishes and their own goals, they quite often can be in conflict with what the family is saying. In that circumstance we would be advocating for the person as opposed to for the family or for the service in that matter because quite often the service might be saying, "We think this is what the person needs," but in fact what the individual is saying is totally different.

MS SCOTT: Okay, that's fine. That doesn't, I have to say, fit with my understanding. But you also had problems with the text here because you were worried that the person would have to pay for that out of their package. Do you want to explain why that's a problem?

MS MALLETT (SOATI): Well, yes. The current way that advocacy is provided around the country is that it's free. It's at no cost to the individual who requires it and that's how we believe it should continue. There would be lots of disincentives for services to refer somebody for advocacy or for family members to refer someone for advocacy if there was a cost attached to the advocacy, which would reduce the budget available to the person for other services that they might need. It already can be problematic to have people referred to advocacy. It doesn't necessarily happen automatically. It is quite often dependent on the goodwill of individual workers who believe that a person needs an advocate.

So, yes, we have just a huge concern that advocacy could end up being just one of the spectrum of services that a person might spend their money on, and we believe that actually advocacy is needed - independent advocacy needs to be sort of a baseline. It's almost like a bit of a safety net really that underpins the operation of all of the service system for people with disabilities.

MS SCOTT: All right. Would you like to talk about how - given that you think it should be in the scheme but distinct from the individual packages -you think it should be then funded?

MS MALLETT (SOATI): We're not entirely sure yet and we are members of DANA, which is the Disability Advocacy Network of Australia, and I'm pretty sure DANA will be putting in a submission about the views of the advocacy sector nationwide and DANA certainly has a view that there should be an independent advocacy authority, which doesn't currently exist but should be funded either - separately, possibly to the side of the NDIA that would be set up, but possibly as an entirely separate authority. However, the funding is still going to come out of the quantum of funding that's available for the NDIS. And it already is. The funding for advocacy is already part of the funding that's available in the system.

So the National Disability Advocacy Program funds about 62 services nationally. In Tasmania Speak Out is one of them; Advocacy Tasmania is the other disability advocacy service and there's some citizen advocacy that happens in Launceston that are funded by FaHCSIA. Then there's also state funding that's put towards FaHCSIA, which would be funding that comes from what used to be CSTDA and it's now National Disability Agreement - I think it's called - funding. While we're talking about it - as a service that's part-funded by state and

Commonwealth - there are good and bad things about that but one of the bad things at present in a state where the budget is as tight as it is in Tasmania, Speak Out and Advocacy Tas will each lose one full-time equivalent advocacy position at the end of this financial year because the state government has withdrawn some funding that we've had for five years, due to the hole in the budget in Tasmania. I suppose our preference would be for a well-funded national system that wasn't susceptible to the vagaries of state budgets from time to time.

MS SCOTT: What about the role of the disability support organisations to provide advocacy services? That's set out in the overview. I just want your views on that.

MS MALLETT (SOATI): We would completely disagree. I don't think it's possible that those organisations - effectively what they are are brokers and they will source services for individuals and they will be paid by a commission or a percentage of the individual's budget. That would be a complete conflict of interest really for those organisations to also be doing advocacy. I think the crucial aspect of it is the independent advocacy. The services that are funded under the National Disability Advocacy Program are all independent services, so none of them are organisations that are an arm of another major service provider. They're not allowed to be.

MS SCOTT: Just on that, we didn't envisage in the draft - and this is all subject to comment - that the brokers would actually be the service providers. For example, let's say someone is after a series of learning experiences. The broker that arranges that service would not be the person actually providing the service. In that sense I am taking it that the person would be independent of the - - -

MS MALLETT (SOATI): The most likely scenario is that those brokerage organisations will be an arm of an existing disability organisation. That's where the expertise is; it's the people who have the knowledge about the system. These brokerage agencies are not just going to pop up out of the blue. They're going to have to employ people who have awareness and knowledge of the system. The most viable solution is that the current disability service providers will set up brokerage arms.

MS SCOTT: Now you're drawing two areas of divergence of the report because that's not what the report says at this stage.

MS MALLETT (SOATI): No, and that's because you don't know yet because you're setting up a system that isn't currently in existence. But even if they were to be entirely independent new organisations, we still wouldn't believe that they could also provide advocacy.

MS BUTLER (SOATI): One of the roles that advocacy plays as well is to challenge the system and to ensure that the system works in the best interests of the person. That goes largely unfunded. It can't sensibly be paid by the individual, that type of advocacy, so where we see sort of systemic issues, or issues that come to us regularly, then we work on that from a systemic basis as well. So that can't sensibly come out of an individual's budget either.

MS SCOTT: I'm sure I've interrupted the flow that you were planning to do. John, just before we go on, do you want to ask questions at this stage or are you happy to - - -

MR WALSH: I think maybe just a comment, and that is that the way you've described advocacy services is not out of line with what we had envisaged disability support organisations would do, so I think there may be a misunderstanding in the way you've read the report.

MS MALLETT (SOATI):   We'll accept that at the moment.

MS SCOTT: That's why I started searching for individual text, because I was trying to work out why you ended up with such a different interpretation to my own. I think that's because of what you said, Mary, at the end, which is you don't envisage these things being different from the service providers. Because you've got a construct where they're actually in the box, you don't see that these are independent whereas we saw them as separate from those organisation and therefore independent, but I take your point about the systemic issues. All right, we've got a little bit of time left. Do you wish to proceed with any other aspects of your presentation or are there other issues you wish to raise? I think I cut you off in your prime at one stage.

MS MALLETT (SOATI):   Yes. Judy wants to talk about self-advocacy.

MS HUETT (SOATI):   It's really important, self-advocacy. Without self-advocacy and without the support of self-advocacy I have grown much more independent and I'm more outspoken. It's enabled me to turn to learn about government policies, procedures, and have a real say - so yes.

MS SCOTT: And on self-advocacy, is there a problem with the draft as we have it written now?

MS MALLETT (SOATI):   No, it's not really there. That's the only problem. It's almost not mentioned. I suppose self-advocacy generally - the work that's done to support self-advocates and self-advocacy tends to be done by the independent advocacy sector. It's not terribly well-funded work. It's not currently recognised terribly well or funded well, but we would be lobbying, as the new scheme is set up, that there would be some specific funding directed towards self-advocacy training and support.

MS SCOTT: Thanks, Mary. Everyone is looking at you, Rebecca.

MS ASTELL (SOATI): I just wanted to explain how the self-supported would benefit my circumstance. I am married. My husband and I both have a disability. Currently, I receive nine hours a week from a service provider for support, but it doesn't currently suit our situation. With my hours, I can use them for myself. If I'm there, my husband can use them as well. But if I'm away, he can't use those hours. If he puts in for his own, it won't suit because he works and he only needs them very occasionally. So it would suit us better if we could have a program where we could join it together and share the hours so it's more flexible.

MS SCOTT: I don't think we've considered that, because the focus is on the individual. That's an interesting issue, John, about joint arrangements. Alright. Thanks, Rebecca.

MS MALLETT (SOATI): I think one of the questions you have - I don't remember which number - was about the cost of electricity.

MS SCOTT: Yes.

MS MALLETT (SOATI): A question about that.

MS ASTELL (SOATI): And because of my disability, heating is something that I need and does cost more because I constantly have to keep my house heated because of my poor circulation and because of my cerebral palsy. If I have a poorly heated house it means I have more spasms and my disability is more affected, but because of the way the cost of heating and electricity is now, it's a lot more expensive. Some of the ways that this could probably be helped is either a bigger subsidy or allowance to help with the cost of heating.

MS SCOTT: Are you aware of what you receive now in terms of a subsidy and allowance? Is it clear to you what you are getting?

MS ASTELL (SOATI): Yes, I am, because I also work in that organisation, as well.

MS SCOTT: There you go. Alright. You'd be an expert on that. Is it your experience that the allowance of existing subsidy is insufficient?

MS ASTELL (SOATI): It is. With the heating one in particular because it is income-tested. If you've got money in the bank you are not actually entitled to it.

But because things are more expensive, including equipment, or things come up, you need to be able to have savings in the bank, so it actually needs not to be income-tested. It needs to sort of go on your circumstances and your medical conditions more so than being income-tested.

MS SCOTT: I understand. Thank you, that's clear. John, any questions about that aspect?

MR WALSH: No, but it's interesting.

MS SCOTT: I've got one question, back to self-advocacy. Are you saying at the moment, Mary, that there is no specific funding for self-advocacy?

MS MALLETT (SOATI): There's very little. There are some small self-advocacy organisations around Australia that tend to be funded in a minuscule sort of way, and then most of the self-advocacy support is done by the advocacy services in the same way that we do with member organisations, or sometimes they have other ways of doing it, with regular forums. It's a particularly underfunded part of disability, though, and it's a particularly important one.

MS BUTLER (SOATI): It's extremely important in terms of building the capacity of individuals to make choices and decisions about themselves. What we see repeatedly in our organisation is, because we have focus on self-advocacy in everything we do, we try to use that model of self-advocacy, so for people who present multiple times with multiple issues, when we use a self-advocacy model we see them reducing in the amounts of times that they present to the service for assistance because they build the capacity for themselves to be able to deal with their own issues.

MS SCOTT: All right. We'd welcome material on that. I'd also welcome you drawing a diagram, Mary, if I can give you a challenge, about how you would see the advocacy arrangements working within the structure we've suggested in the draft report, because if you were going to change the functions of the disability service organisation not to include advocacy services, I'd be interested in thinking about how that's actually going to work out, because there you are, thinking this person is going to stand in the shoes of the individual with disabilities and look after their best interests, but if you actually say, "Oh well, actually there's advocacy service ABC over there," it's an interesting division of responsibilities. I'd be interested to know how you would see that working. I have to say just at the outset, I can't see my way clear through it now, so I'd welcome getting some material on that.

MS MALLETT (SOATI): Yes, we'd be happy to do that and, as I said, DANA, the national advocacy network, will certainly also be putting in some work on that.

MS SCOTT: Okay.

MS MALLETT (SOATI): The other issue that we just wanted to raise was about the move to more individualised funding.

MS SCOTT: Yes.

MS MALLETT (SOATI): We really would applaud that move. We really think that it's important that there is adequate support in that system so that people with intellectual disability are also able to take part in that, not just sort of token - you know, putting a brochure in an easy-read version but actually proper support available for people who really would like to do it, once they've had it explained to them, even if it's just part of what they do.

The other thing is about making sure that the voice of people with intellectual disability can continue to be heard as this new system rolls out, so that there are ongoing consultations and consultations that allow sufficient time. It's really good that you've had the easy-read version of the document, and I think lots of people have read that as their way of accessing the information.

MS SCOTT: I enjoyed reading it as well.

MS MALLETT (SOATI): Yes. As an example, we will be doing consultations, now, in Hobart, Launceston and Burnie, over the next couple of weeks. We will have a group of 30 or 40 people with intellectual disability at each of those consultations and we will work through that easy-read version, and of the questions that we can pick out of the enormous number of recommendations and questions, we will just focus on a few that are relevant.

It's difficult to get enough people together. It's difficult to have the time to explain the information properly. I think you will find as you go around the country and do the rest of the hearings that certainly it will be the advocacy services who are the only ones who will be doing those types of consultations specifically with people with intellectual disability. There are lots of other consultations all over the country. There are heaps of them. Every national organisation is racing around madly doing consultations, but to do them properly and sufficiently so that people understand them, it will be the advocacy services that are doing that. I think some of that is sort of hidden work that is not always obvious to the sector.

MS SCOTT: All right. Thank you very much. Thank you for your attendance today. John, we'll wrap up there.

MR WALSH: Yes. Thank you.

MS SCOTT: Thank you very much.

MS SCOTT: I now call to the table, because I am very keen to keep us on time, Donna Bain, please. Good afternoon, Donna. Would you like to state your full name and the organisation that you represent, please?

MS BAIN (SHW): Good afternoon. My name is Donna Bain. I'm the general manager of Self Help Workplace.

MS SCOTT: Would you like to make a short opening statement?

MS BAIN (SHW): Yes, I will. For those of you who may not know, Self Help Workplace is an Australian disability enterprise. We are based in the north of the state, in Launceston. We currently have 54 supported employees on our books, involved in a large range of commercial activities.

I'd like to start my story with a conversation I had with an employee this morning. At about quarter past 7, an employee came to my office who had been away for a few days having some quite comprehensive medical tests for an undiagnosed condition. She came in to see me to tell me that the results were good and that there were in fact no adverse findings and I asked her how she was feeling and she said, "I feel like such a weight has been lifted off my shoulders." I said, "That's wonderful news. I'm so pleased for you," and she said, "I'm so pleased to be back. I've missed you all," and she had only been gone for a few days. I think her story encapsulates what is very important about Australian disability enterprises: they are a place of work, they're a place of family and they're a place of community. In those few brief words to me this morning, she summarised essentially what it is about ADEs that makes them so special.

When we read through the Productivity Commission report, we were a little bit confused about whether we were in or not in. There seemed to be some ambiguity around whether specialist employment services like ADEs would be included. Self Help Workplace might be able to support the inclusion of Australian disability enterprises in the National Disability Insurance Scheme if it achieves the following outcomes: firstly, it increases the opportunities for people with disabilities to secure productive, meaningful employment; secondly, it is predicated on the continued existence of ADEs as a business and service model to provide people with disabilities with supported employment; thirdly, that inclusion of ADEs in the NDIS does not diminish the authority of ADEs to run their enterprises as they need to; finally, it improves the opportunities for people with disabilities, moving out of ADEs, to participate in the community so they can continue to enjoy independent and fulfilling lives.

We also have a couple of questions about, if ADEs were to be included, what the issues might be. I can flag these with you now or towards the end of our submission. The things that spring to mind immediately: if ADEs were to be included, who would administer the funding? How would the funding be administered? What potential employees might be referred to ADEs and how would that referral process operate? What accountability mechanisms might be in place? At present ADEs are subject to rigorous quality control systems under Disability Services Standards and are independently audited each year. That's essentially to protect our supported employees and ensure that their rights are being upheld. I'm happy to explore each of those issues in detail or answer any questions you might have about Australian disability enterprises.

MS SCOTT: I have to say that this is again a case where we thought we were being clear, but that's why we have draft reports so we can get things right for the final thing. I had anticipated that Australian disability enterprises would be part of the scheme. Mind you, there would be challenges with that model, in the sense that the individual would indicate that they wanted to be working in one of your organisations and they would nominate which one they wanted to work in and so on. Does that self-nomination pose any problems for your organisation?

MS BAIN (SHW): There are a couple of issues. As the commission is aware, we currently receive what is called CAP based funding from FaHCSIA. That limits the number of places that we can offer supported employees. One of the opportunities that the NDIS presents is that there may in fact be more funding available, so in fact there may be more opportunities for people with disabilities to secure employment if the funding comes with those individuals.

One of the challenges, though, for ADEs is that we are essentially running businesses, so whilst every decision in our enterprise is made based on a consideration about what is in the interests of our employees, we do that in a very strong commercial context. So for example - and it comes down to the nitty-gritty - we have three divisions, including our business services division at Self Help Workplace. The business services division employs two-thirds of our supported workforce, most of whom are on a part-time basis because of their age and the deterioration of their disabilities over the years. We have 22 chairs.

MS SCOTT: 22 chairs?

MS BAIN (SHW): 22 chairs in the business services section. That means that on some days, particularly today, for example, we will be rotating staff, our supported employees, through the hot-chair system because only ever at one time can 22 people have a seat. So at the end of the day ADEs need to be able to have the authority to make decisions based on the continued commercial viability of our enterprises. If we don't run strong commercial enterprises, then I can't offer even my 54 supported employees a position. So the risk that - - -

MS SCOTT: I'm sorry to interrupt, Donna. I just want to check that I've got this right. One of the messages we have heard loudly and clearly is that a number of - well, I was going to say "any number" but I can't say that. I'll just say a number of Australian disability enterprises indicated that they may - the individuals, and the organisations may - actually prefer alternative occupations; for example, retirement in some cases, but retirement where it doesn't mean just sitting at home. Retirement would be like other people find retirement. You would be actually going out and doing fun things. So on the one hand you've mentioned that your own organisation has some employees that have lower productivity because of the ageing process. Are they beyond normal retirement age?

MS BAIN (SHW): No, they're not. Our oldest employee is 63 years of age. I'll just explore the ageing issue with you at the moment.

MS SCOTT: Yes.

MS BAIN (SHW): Two-thirds of our workforce is over the age of 45 years. A significant number of those have been with us for more than 20 years, so when they start to think about retirement - and it's not a concept which they come to easily - there will be two issues for us. Those who are currently full-time may well want to go part-time because their deterioration in health will be such they can no longer work five days a week with us. At the moment, under CAP based funding I have business pressure in terms of letting them go part-time because I don't have the capacity to backfill those vacancies. Uncapping the funding and relaxing the funding would also allow us to do that, so allow our employees to move to a part-time model and backfill those vacancies. It also allows us to do some really concerted succession planning.

I rely very heavily on the fact that the 13 employees in my timber production facility have on average been there for 22 years. If they leave, if the flu goes through the timber production facility this winter and they are away for any more than seven days, production in our timber facility will fall by a third. So allowing people to employ additional work to manage those vacancies and to deal with those absences from the workforce has some benefits for our enterprise, but at the end of the day I am making decisions, our board is making decisions, in the interests of all 54 employees. So I need to have a sustainable business model.

We assume that every person who we offer a position to will be with us for life. We are a destination for employment. We are not necessarily a stepping stone to open employment, as has been alleged.

MS SCOTT: Has it never been the case that one of your employees has gone on to open employment?

MS BAIN (SHW): Yes, they have, but it is a significant minority.

MS SCOTT: Significant minority. Yes.

MS BAIN (SHW): So the majority of our employees, once they arrive, stay with us.

MS SCOTT: Yes.

MS BAIN (SHW): So I have an extraordinary long service leave bill. That loyalty is admirable but it creates some economic challenges for the organisation.

MS SCOTT: Donna, these are some of the difficult constraints you work under now. Given that the commission has been asked to work on a new arrangement, could you tell me what would need to change for you to be able to offer the type of service that you're interested in, because as you have said, the commission has at this stage suggested a doubling of total funding and quite significant change to any number of areas. So I guess what I would be suggesting to you is that you wouldn't want to necessarily think that the existing model had to stay the same, if you actually saw areas of improvement.

We would welcome your advice, your suggestions on where the improvement should be, so would you like to concentrate on three or four of those areas? For example, is it appropriate for the individual that your organisation is seen as employment for life? Is that what the individuals want?

MS BAIN (SHW): Yes, we do get calls. We get inquiries from individuals all the time about working at Self Help Workplace and if they come with a package of funding there will be an expectation that when they knock on the door there will be a position available to them, that we will become a service provider, but we are not a service provider; we are an employer and a place of business. So I would dearly love, for anybody who knocked on my door, who showed a willingness and a capacity to work, to be able to go, "Yes, that's fabulous. We would love to have you start tomorrow." The reality is I have a commercial budget which I need to meet. I have finite physical and financial resources, both in terms of chairs and people to support my employees. I can't say yes to everybody, so even if they came with a package of funding which may be of X dollars, that doesn't necessarily translate into a sustainable business model for Self Help Workplace at this time. We would need to do some serious re-engineering.

At the moment the case base funding model works for Self Help Workplace. It provides some certainty about funding based on the number of people that we've got. It gives us the capacity to plan for the business over a number of years, which certainly helps with the business model, but the case base funding model as it currently exists limits our capacity to offer even a few positions to people. It limits our capacity to deal strategically with the ageing issue. It limits our capacity to strategically manage peak flows. If we get a huge order for 1000 pallets I've got no capacity under the current CAP base funding model to employ an additional temporary workforce to manage that. We just do with what we can and have conversation with customers to keep them on board, so there are some limitations to that.

I think at the end of the day ADEs would want to be reassured that, whatever funding model is in place, their capacity to make decisions in the interests of their business isn't somehow compromised by the fact that somebody has shown up with a cheque or cash in hand, because their interests need to be balanced against the interest of the whole of the enterprise and all 54 employees under my care.

MS SCOTT: Okay, that's your central point. Your key theme is if Australian disability - John, I'm partly doing this for your benefit and for also my own, just to check that I understand your point, Donna. For Australian disability enterprises, if it is seen that they're part of our final recommendations to be in the scheme, the presentation of an individualised funding package doesn't necessarily mean an obligation for the ADE to take that individual on, because you made the point that for the commercial viability of the organisation a package per se, if it doesn't cover your total costs, is not going to be sufficient.

MS BAIN (SHW): That's right.

MS SCOTT: That's your central message. Is that all you need to get across to us today?

MS BAIN (SHW): The other thing which I thought I might mention, only because it came up in Mr English's comments early this afternoon and it touches on the role of not-for-profits in the service delivery model, is an issue about fundraising. There was a brief conversation earlier this afternoon about fundraising. We are in the fortunate position that we have a strong commercial business, so 50 per cent of our revenue this year will be drawn from the commercial sales of goods and services, 40 per cent will come from FaHCSIA through the case base funding model, and 10 per cent will be raised through fundraising. So that's through private philanthropic organisations, umpteen grant applications to umpteen state bodies.

I am very grateful that we're not reliant on fundraising as a means of keeping the door open but what it does allow us to do is a couple of things. It allows us to explore discretionary projects, so things that are perhaps linked to the welfare of our employees but not necessarily a core part of the business. Included amongst those things recently at Self Help Workplace are a book club, a kitchen garden, a life skills program. They're some of the activities that have been funded through fundraising and private donations. So it allows us to do that.

Two, it allows us to engage with the community, so it allows us to tell them the story about Self Help Workplace. We encourage them to come and visit us as a way of dismantling those barriers between people with disability and the community. The number of people who come to Self Help Workplace and go, "Gee, you're bigger than we thought. Gee, you run a really large sophisticated operation here. I didn't know that people with disabilities could do so much" - and fundraising is one of those really important conversations you have with the community about dismantling those barriers. So I think in terms of an NDIS model, we applaud the additional investment that you're proposing.

MS SCOTT: But you only want 90 per cent of it.

MS BAIN (SHW): What I'm saying is we want to make sure that there is still a place for fundraising, there is still a place for community engagement in the enterprises where people with disabilities work. We consider ourselves to be part of the Launceston community, where we are grateful for the fact that they have taken us to their hearts and their chequebooks and donate to us. I would hate to see that relationship stressed because of an assumption that perhaps we don't need that community any more. Through those conversations about fundraising there are opportunities to talk about placing our supported employees in open employment, there are opportunities to talk about new commercial business opportunities, so it's a stepping-stone for a whole range of conversations.

MS SCOTT: So the issue is how to be well funded and yet engaged with the community and you see fundraising as a key element of that.

MS BAIN (SHW): It's one of the ways we do that, yes.

MS SCOTT: Thank you very much.

MS BAIN (SHW): Can I make one last comment?

MS SCOTT: Yes. I think this is the second-last comment.

MS BAIN (SHW): The only other remark I'd like to make is about the ageing workforce issue and we've touched on it briefly already this afternoon. Self Help Workplace has been fortunate to secure two grants to do some detailed research about our ageing employees because we wanted to move to an evidence based decision-making model, not just based on what we thought our employees knew or wanted. It's revealed a couple of very interesting issues which I think have some impacts on the NDIS.

Firstly, a lot of our employees don't consider retirement to be an option. They have been with Self Help essentially for their entire adult life. Many of them have no experience of dealing with state government agencies. They are essentially, to use a glib phrase, "off the radar". So to have a conversation with them about retirement is something that they themselves haven't considered and nor have their parents. As somebody reminded me the other day, this will be the first generation of people with disabilities who are likely to outlive their parents and it's a conversation parents haven't had with their children.

I think if the NDIS is able to achieve a couple of things, one is to create a very seamless transition between people in ADEs and the community. So if they need to retire at 45, either partly or fully, then I think the scheme allows them to do that - the scheme in the commission's proposal allows them to do that, which I think is a fabulous thing, provided we've got the capacity to manage those workforce issues as and when they arise.

The second issue is that in addition to supporting our employees through that retirement process, the conversations that we've had so far - and this reveals also an issue that Speak Out has raised; that their carers and families also need support. Given the low literacy levels in Tasmania, given the socioeconomic profile of our communities in Tasmania, if their whole families are going to make informed consensual decisions about their future then we need to find a way to engage them in that conversation in a way that they can understand. All of us under the modern award found ourselves wrapped in conversations about superannuation. I don't get my own superannuation and I'm certainly not qualified to provide my employees with any advice about those, for legal and other reasons.

But it was the first time a lot of our parents had the conversation with their children about what happens when they die, and the d-word was not a conversation they had ever had or wanted to have. We found ourselves in the position at Self Help Workplace as their employers who were trying to broker information, so we had superannuation companies come in and explain it and it's still not explained satisfactorily. So if there are organisations out there like Speak Out, like Citizen Advocacy that can empower parents or carers to work alongside their adult children to make informed decisions, I think that's a really important part of any funding conversation.

Whilst I have consenting adults in my workplace and my primary responsibility is to them, I know that they don't live in isolation and that many of them will be looking to their families and carers for support, information and advice. So we endeavour, to the extent to which we can, to involve a whole group in that conversation. If there are ways to fund those organisations to empower those family and carers groups, then I think that would be really important.

MS SCOTT: Okay.

MS BAIN (SHW): Sorry, one last topic, and it will depend really on the extent to which the ADE model is wrapped up in the NDIS. At the moment there are some very hard boundaries, because of funding arrangements and public policy, between the ADE funding model and the other DESs or DENs or whatever you call them, so some very, very hard lines. For example, one of my higher-functioning supported employees last year decided that she wanted to have a go at open employment, which we applauded her for. It's a very brave thing to do. It meant that she had to leave Self Help Workplace, essentially come off our books, and put herself on the books of a DES.

I think that's entirely unsatisfactory. I think one of my employees ought to be able to stay with me - and provide all the security that employment has with us and the support that she relies on, and be able to secure the services of somebody like a DES to help her explore the opportunities, maybe even for part-time work in open employment, so come to me - come to Self Help Workplace for three days a week, open employment for two days a week, see how it goes. Over time it might reverse. But the moment we ask our supported workforce to hand in their resignation, step outside the door, keep their fingers and toes crossed in the economic environment that they're going to be able to find something which suits them, I think that's unfair.

MS SCOTT: It's the transition path. You're comfortable with the idea that people may transition but you want a more gentle path arrangement of that.

MS BAIN (SHW): One that's in their interests and recognises that they will need ongoing support, that those decisions will come more slowly and it's going to come with all the fear that comes with stepping outside of Self Help Workplace.

MS SCOTT: Okay, I got that. All right, John, unless you've got some questions - - -

MR WALSH: I've got a quick one. You've made it clear that your organisation is limited in the number of people it can take on just because you've got a business to run. Do you have any comments - I mean, Australia has a very poor record in employing people with disabilities - on the prognosis for expanding employment opportunities for people with a disability?

MS BAIN (SHW): I think we need to come up with systems that allow people with a disability to make those choices and change their mind. For some employees ADEs are the best place for them to be, and for some of them it will be a lifetime of employment, and that's all right and I think a NDIS scheme should allow them to do that. I think we should be working much more with business and government to encourage those enterprises to employ people with disabilities. Secondment, work experience, part-time work and all sorts of employment models are available to businesses, but there seems to be an assumption that it's one in, all in. I think we need to be flexible and smarter about it.

ADEs have lots of expertise and experience in employing people with disability. We have resources that we can offer other employees, based on our experience, but I think at the end of the day the decision comes down to people with disabilities and we just need to make sure, as a community, that we support their choices and their right to change their mind.

MS SCOTT: Okay. Happy, John, to move on?

MR WALSH: Yes.

MS SCOTT: All right. Thank you very much, Donna.

MS BAIN (SHW): I do have some information about ADEs which I'd be happy to leave with you.

MS SCOTT: Thank you. That's very good. I've got a question for you just at the side there. I actually am going to take the advantage of Donna finishing a little early to take a seven-minute break, so the next person will be on at exactly 3.30. Thank you.

MS SCOTT: Thank you, ladies and gentlemen. I now call to the table Baptcare. Would you like to make an opening statement on behalf of Baptcare, please.

MS D'ELIA (B): My name is Mary D'Elia, and Helen Riddell. Helen is our business manager and I'm the state operations manager for Baptcare here in Tasmania. Firstly I'd just like to thank you for the opportunity to come and speak with you today. Baptcare is very supportive of the work of the Productivity Commission and we particularly would like to commend you for the focus on consumer choice and for trying to look at developing some kind of streamlined and consistent system for all and bringing greater resources to the disability sector.

The Baptcare Gateway has a lot of similarity to some of the proposed sections of the Productivity Commission model for service delivery. In both Victoria and Tasmania, Baptcare have been providing services that have aspects of this model. In Victoria we're currently piloting a model in a local government area that looks at self-management of funds and some centralised intake. Here in Tasmania we're one of the two lead providers of the gateway for disability services, and in particular we would like to bring the commission's notice to the mapping of those functions that are in your report, particularly the National Disability Insurance Agency case management role and the role of the disability support organisations in self-management of funds that map quite closely the functions that we undertake in the Gateway.

MS SCOTT: All right. Thank you.

MS D'ELIA (B): The Gateway has been operational now for just on nine months, taking intake of disability clients. The model was developed in partnership with consumers, service providers and government. It's a fully outsourced model for the intake and assessment of people with a disability and looking at specialist service provision for those clients.

To date, the consumer experience and feedback has been overwhelmingly positive. Consumers have noted that the Gateway staff are very people-centred in their approach and they've been really very happy with the way that our staff interact and provide the feedback and follow-up that they need. We've experienced much higher demand than was modelled by government and much of what we believe anecdotally is related to that is that people are saying to us that they feel very comfortable coming to a non-government agency. They feel that, as an agency, we're very responsive to their needs.

MS SCOTT: How much, Mary, has demand exceeded the government's expectations?

MS D'ELIA (B): At the moment our demand is sitting at about four times the projected demand from government, and that's stabilising for us. In the initial time it was very, very high. It's stabilising down to somewhere between four to six times the demand that government thought would happen through that centralised intake point.

MS SCOTT: Is there a shift in costs from somewhere else? How has your funding been able to cope with demand being four to six times higher than anticipated?

MS D'ELIA (B): There's a couple of things that are helping with that demand. We have a very skilled workforce. We've integrated the Gateway into the gateway for family services and that's given us some ability to manage peaks and troughs of demand, but we're only nine months in, so we will be monitoring with government what that demand continues to look like in this place and whether or not we need something to support that demand.

MS SCOTT: So I just want to check: is this a timing factor? So you anticipated that there might be X number of customers through the first month and so on.

MS D'ELIA (B): We expect that demand will stabilise off, but we believe that it will end up being higher than what was modelled by government.

MS SCOTT: Okay. So how do you make these judgments that it's likely to stabilise? I mean, why aren't you panicky about demand continuing? Are you already seeing some easing in pressures?

MS D'ELIA (B): Certainly in the first quarter that we took over the Gateway there was an overwhelming demand, but a lot of that was about people not understanding the new system and needing to contact us and find out what that meant for them. What we've found through the October-December quarter and then into the January-March quarter is that it has stabilised back to higher-than-predicted levels but it's certainly stabilising back, so we're confident that it will begin to pattern. It looks a bit more like it will pattern through.

MS SCOTT: Okay. I just want to check, because you can tell I'm very interested in this: estimating demand and looking at behavioural responses is pretty tricky. Has the number of assessments been larger than you anticipated, as well as inquiries?

MS D'ELIA (B): The number of assessments has been larger, but they are tracking back closer to what government expected demand to be. They certainly still sit higher in each of the regions.

MS SCOTT: Can you indicate how much higher they are?

MS D'ELIA (B): On memory, for this quarter we would be sitting at about 50 per cent higher than what the model demand was.

MS SCOTT: All right. Thank you. Please proceed.

MS D'ELIA (B): So in terms of the Gateway there were just some areas of the Gateway model that I did want to speak with you about today. The Gateway is a statewide service based on an area based model. It provides a centralised intake that's accessible for all people. It's predominantly telephone-run, so it's a 1800 number that's available across the state, but it can be outreach that's built into our model. If somebody wants a face-to-face appointment they can come into our office or we can go out to them if that's more suitable.

MS SCOTT: What proportion do you do in person?

MS D'ELIA (B): The majority is done over the telephone.

MS SCOTT: The majority is done over the telephone.

MS D'ELIA (B): Yes.

MS SCOTT: 40 per cent, 30 per cent?

MS D'ELIA (B): 20 to 30 per cent would be in person or going out to people.

MS SCOTT: Why are you able to do such a large percentage over the telephone? Is that because you're using existing data?

MS D'ELIA (B): No, not completely. We're going out and speaking with people about what their needs might be, we're working with families and carers in what their needs might be in our assessment, and also talking with other providers.

MS SCOTT: Sorry, I'm a bit confused because I thought you said that 70 to 80 per cent were just done on the telephone.

MS D'ELIA (B): Yes, in terms of assessment.

MS SCOTT: Yes. So in 70 per cent of the cases you're not seeing an individual at all?

MS D'ELIA (B): We're spending quite a lot of time with individuals, talking through what their needs might be and undertaking an assessment with them, yes.

MS SCOTT: So what are you doing with them that's not - you're obviously doing something with them and then you do the assessment over the telephone, are you?

MS D'ELIA (B): I'm not sure that I understand your question.

MS SCOTT: John, you're not struggling like I am?

MR WALSH: I think if you can just talk through the process. What happens when someone gets in touch with you, first of all, and then second of all and then third of all, and how does the process run?

MS D'ELIA (B): Okay. The way that the process runs, we might get a phone call from either a service provider or someone who is in need of support. We undertake quite a detailed assessment. We begin with - there's something called the Common Assessment Tool that we utilise here in Tasmania.

So there's an initial assessment, a screening assessment that's done, that goes through some of the key needs that the person is identifying that they require. We go through that assessment process, go into a targeted assessment with the individual, and that looks at all different types of issues that someone might be looking for; so mobility issues, the type of lifestyle that they need, the different support options that they're looking for. So it's quite a comprehensive assessment of what their needs might be. We might do some of that with the individual directly. We may also be contacting other service providers that they're involved with, medical people that they're involved with, to be able to look at quite a comprehensive assessment of what that person's state of needs and requirements might be.

MR WALSH: So how much of that is done over the telephone?

MS D'ELIA (B): It depends on the individual and what they need. Quite an amount of what takes place happens over the telephone. However, we do have the option to refer someone into our casework team if more needs to be done on site and face-to-face with somebody.

MS SCOTT: All right. I'm going to show you figure 5.2. At the outset you said, Mary, that you saw many features we were proposing in the draft report that weren't dissimilar to existing operations as you currently have them. Having a look at that figure 5.2 which sets out in broad terms what we were envisaging the assessment process to be like, do you still think that the processes are fairly similar?

MS D'ELIA (B): I do believe the processes are fairly similar, yes.

MS SCOTT: Okay. So I guess the significance of this bit of the conversation, you're saying a fair bit of that is actually able to be done over the telephone?

MS D'ELIA (B): Quite an amount of this is able to be done over the telephone.

MS SCOTT: Right. Well, that has a significant bearing on the costs of things. What bits do need to be done in person?

MS D'ELIA (B): I think that to better understand somebody's circumstances and really do very clear consumer-directed work, as you're developing the plan there's certainly a need to be meeting face-to-face with someone to work that through. When I gave you the number, I think what I need to be properly more clear about is 70 to 80 per cent of our work happens across both what we would call substantive and non-substantive cases.

So non-substantive cases are up to two hours of support in the Gateway, where someone rings in, they need support. It could be someone who's self-managed in the community who needs some understanding of perhaps a Centrelink letter or some further support for how they're living in the community, versus those who are being fully assessed for some kind of package or supports that they need. Certainly more of that work is done face-to-face, so that probably skews the percentages. So I probably should be clearer: when we get into the assessment process for actual specialist disability services, then much of that is done face-to-face. Perhaps I wasn't clear at the start.

MS SCOTT: No, that's fine. I think we've established that we're on the same wavelength. That's very clear, thank you.

MS D'ELIA (B): So I guess part of the model then is that we work in partnership with the client and their carers, and those who are providing support to them, to ensure a holistic assessment of their support needs and concerns. I've talked about the use of a common assessment tool to take that through.

MS SCOTT: What tool do you use?

MS D'ELIA (B): It's a tool that was developed by the Tasmanian government, and we further developed with them in use of it in the first 10 months now of Gateway. So it's a tool that goes through a whole range of different areas that we need to assess and look at in terms of what someone's support needs and concerns might be. The other role that we have across the Gateway is the determination of eligibility under the Tasmanian act. We don't undertake the actual medical assessment, but we certainly support people in how to get those assessments and bring those back through, and our role is then to determine that the paperwork and the information they have from medical practitioners meets those requirements under the act.

MS SCOTT: Is the medical assessment done by medical doctors or by allied health professionals?

MS D'ELIA (B): We have access to doctors and also to allied health professionals, so there's a resource team in government that is an allied health professional group that's able to make some of those assessments. We also gain assessments from people's own GPs and psychs and so forth to provide that piece of information that we need.

MS SCOTT: Thank you.

MR WALSH: Are those assessment instruments publicly available?

MS D'ELIA (B): Yes, they are.

MR WALSH: Can we get a copy of those, please, Mary?

MS D'ELIA (B): Certainly. Another role of the Gateway is then making recommendations to government with regard to the funding allocations that might be suitable, so certainly in undertaking the assessment we develop into then a case plan, and for those who are looking for packages, for support for hours of support or for equipment or one-off funding or respite, we actually then make a recommendation about what that needs to look like in partnership with the client, and recommend that up. We're part of a group that meets with government around the allocation of that funding.

Once the funding allocations have been decided, based upon funds that are available we then work with clients further around where they would like to spend those dollars and how they would like to spend those dollars. Very often what we find is that in our first process of undertaking assessment it's very difficult to actually then do that further piece of planning until we know whether or not the money has been secured, and what amount has been secured, so the continuation then is to work with someone once those dollars have been allocated to make sure that they can get to a relevant provider.

MS SCOTT: What proportion do you estimate of people's assessed needs are actually met through the funding allocations?

MS D'ELIA (B): Currently? Are you talking about what wait lists we have?

MS SCOTT: Well, yes. Like that, yes.

MS D'ELIA (B): Yes - needs register?

MS SCOTT: Yes. In Queensland we've been told that someone might get assessed as needing 16 hours of attended care but get four. You're undertaking a large number of assessments. What proportion of the assessed need do people currently receive?

MS D'ELIA (B): Certainly it's quite common that someone might receive less than 30 per cent of what their assessed need might be. It's quite common that we will in a prioritised way - you know, they need 20 hours and we say, "Well, these three people will need 20, but the money will only stretch to six hours each," so it's quite common. I could provide that data to you, but I don't have it at the top of my head.

MS SCOTT: We would certainly welcome it.

MS D'ELIA (B): I'd be happy to give it to you.

MS SCOTT: Thanks.

MS D'ELIA (B): But certainly what I will say to you is this: in terms of our packaged wait list, in December last year we did an approximation of what we believed in the south-west we needed, and in the funding allocation for December there was less than 10 per cent available against what we believed was required on that needs register, so it was quite low.

MS SCOTT: Thank you. That's very useful. Just going back to the original rollout of the proposal, because I imagine when you looked at our overview and - - -

MR WALSH: Excuse me, Patricia?

MS SCOTT: Yes.

MR WALSH: Before you leave that point: Mary, does that needs register map directly from your assessment instrument you're going to show us?

MS D'ELIA (B): Yes. We assess through on need. We then undertake a prioritisation tool, because currently obviously there isn't a system whereby we can say, "This person needs 20 hours," and we can make that happen. So the needs register maps through and we have a prioritisation tool - which I can also make available to you - so that we have something to support the way that we prioritise clients through for funding or equipment.

MS SCOTT: That would be good.

MR WALSH: What I'd like to get is - you said that you only had funding for 10 per cent of the full assessed need.

MS D'ELIA (B): Yes.

MR WALSH: I'd like to know how you estimated the full assessed need.

MS D'ELIA (B): In the funding package we looked at what the approximate pricings were for the hours that we had assessed were required and we put approximate pricings against that based upon the pricings that we had from providers. So they were approximate values. Does that make sense?

MR WALSH: Yes. I'm trying to get more at how you assess the number of hours that were required.

MS D'ELIA (B): That comes from the assessment that we undertake with the client and with the medical providers around what the amount of need might be for that person.

MR WALSH: Okay, thank you, and you're going to send us those instruments?

MS D'ELIA (B): We can send that through to you.

MR WALSH: Thank you.

MS SCOTT: This is very interesting for us. Going back to what you anticipated versus your learned experience, was it the case that the Tasmania government or the department or yourself had a particular estimation profile of assessed need, if you know what I mean? How many clients in total, in the course of the first 12 months, were you originally estimated that you were going to be assessing? Can you remember that number?

MS D'ELIA (B): We had estimates given to us based upon what government had seen in each of our areas, and in the south of the state, in the south-west region, at the top of my head it was about 120 callers on inquiry per quarter, and it was about 20 to 25 of those needing to go through for eligibility assessments. In a month - a monthly figure - we're finding that we're getting still up around 120 to 150 inquiries, and in that short-term non-substantive, under two hours per month - not per quarter - is what it's stabilising back to us, and around 20 needing to go through for eligibility and support per month in the last three months. That's just in the south-west area. I can give you a breakdown for the north, but it's not at the top off my head.

MS SCOTT: That would be great. It sounds like what was unanticipated was the higher level of people needing the sort of two hours or less care. The numbers of actual full assessments sounds like it's basically as anticipated. Have I got that right?

MS D'ELIA (B): It's still sitting higher. So that 20 to 25 per quarter was the estimate from government.

MS SCOTT: Per quarter?

MS D'ELIA (B): Yes. That's in the south-west area.

MS SCOTT: Yes, and what's it running at at the moment?

MS D'ELIA (B): It's sitting at about 20 each month in the last few months.

MS SCOTT: Per month? Alright. So it's the difference between - - -

MS D'ELIA (B): So it's still sitting at, easily, 50 per cent higher.

MS SCOTT: Yes, I've got that. That's very interesting. When you undertook this work - because I imagine the department and the government thought that you would be largely dealing with existing clients - were you able to work with an existing profile of expected costs and expected clients, so for example, 5 per cent will be high-end users, 30 per cent will have this sort of cost of package and so on? Was there a profile that was developed maybe with you in anticipation of the assessments?

MS D'ELIA (B): A profile was developed. What I'll say is that there weren't strong systems in government to capture a lot of that information at the time.

MS SCOTT: Right.

MS D'ELIA (B): So certainly some of that has been a journey of working that through with government and with individuals over this past nine months - so the quality of the information and what was captured at that time - and it's certainly something that we noted in what we provided to you. A key part of the reform that we're undertaking here is about putting quality into, particularly, systems and data. It was quite difficult to get some of that profiling.

I guess the other thing is that in terms of our caseworkers and the Gateway model, we've actually rejigged and relooked at how people would be provided with service provision out there in the communities. So rather than someone who's self-managed in the community being on a caseworker's load and being seen as someone with low service needs and perhaps not being spoken to or caught up with very often, the Gateway model would have those people self-managed in the community coming through a bit differently, so our caseworkers sit with people who have high to medium needs consistently, if that makes sense.

MS SCOTT: Yes, I understand that.

MS D'ELIA (B): So it's about shifting where people interact with the system.

MS SCOTT: I've got you, yes. Because they might have been considered as low needs, and in fact, now that the service is available, they may more appropriately be envisaged as people with medium needs. I'm interested in people who might not have been in the system at all previously. One of the issues that we have to grapple with in our estimation work is that there may be people who actually do have high needs or relatively high needs but are out of the system. What's your experience with people entering into the Tasmanian disability system for the first time as a result of this initiative? Can you give me some sense of that?

MS D'ELIA (B): I don't have data against that for you. I didn't come with that data.

MS SCOTT: No, but do you have any sense of - - -

MS D'ELIA (B): But what I can say is that we've certainly, anecdotally, had a number of people come through. We could probably work on those figures for you if you would like some more information about that.

SCOTT C: We'd very much appreciate that.

MS D'ELIA (B): It's not something that I'd have at the top of my head.

MS SCOTT: No.

MS D'ELIA (B): But certainly, particularly in those early weeks of Gateway, we had a number of people who'd never been through the system, and many children or under 18s with a disability had been within community service agencies and they hadn't actually hit the system as a registered client. So that's been a key part of the work that we're doing - because obviously part of our model is about trying to think about planning in a systemised way for transition points. So having some ability to measure how many young people we have in the system, what those education transitions might look like, has been really important, and certainly that's some key work that we're undertaking at the moment to get a real handle on those numbers living in the community and needing support.

So we could probably get some information for you and give you a better understanding of that. Certainly we've had people ring through and say, "Look, I never wanted to go through government," or, "I found the government process unwieldy and therefore didn't make contact and now I'm giving the Gateways a go." So that's certainly been a common flavour of some of the calls that we've had come through, but I can get you a better sense of what that looks like at another time.

MS SCOTT: That would be good, thank you.

MS D'ELIA (B): One of the things that the Gateway model also provides - that I think is a really exciting element of this system - is something called active monitoring, and this is about trying to provide support for people who are self-managed in the community and to provide some kind of safety net for those people and for people who currently sit on our waiting lists or need registers.

The active monitoring role is about contacting people proactively to see whether or not their needs have changed. So if we think about an older carer with an adult, something that we find happens very often is that our next contact with someone in that situation might be when things have become really difficult for the carer - perhaps they're in hospital or some crisis has happened and they're unable to care for their adult child.

A key thing around this model is to say, "If you're self-managed in the community, we'd like to be in touch with you perhaps every six, nine or 12 months to see whether your needs are changing and to touch base with you and to provide a safety net around whether or not the case plan that's in place remains suitable and whether or not all options that might be supportive for you are in place at this point in time," so that we hopefully are managing those changes that take place that very often people won't ring and tell you or contact you about until things have become quite difficult or in crisis. So the active monitoring role I think is quite a good safety net and support for people living with a disability in the community.

Gateway also supports people at key transitional stages in life. So we're looking at trying to have some systems in place that plan earlier for school leaving or key life transition times, and the local area coordination team provides case management and casework support for people who live in the community who need more support.

So, from our targeted assessments and prioritisations, we're certainly able to provide a case plan if somebody or their carer feels well able to move forward with that and take those pathways, but clearly there are other people in our community who need further support and that's a key role of our case management system, to provide those supports.

MS SCOTT: I'm just conscious that we're coming up to 4 o'clock. Our next speaker is here. Look, you could tell that John and I were very keen to learn a little bit more about your data and your experiences, because that's a very important feature of what we're trying to elicit at this next stage, so we might talk out of session at some stage just to see what more you might be able to help us out with.

One of the issues that we've asked in the draft report is about the dividing line between disability services and the mental health system. I appreciate there's a lot of co-morbidity, but do you personally or does your organisation have a view about the dividing line and where it should be? We're conscious that there are specialists, specialist service providers and so on, but we do grapple, I have to say, with this problematic issue of what is a disability when it comes to mental health issues, so we ended up seeking assistance of the community and of interested parties in this inquiry to give us an answer. I don't need your answer right here now - you might want to think about it - but I'm sure it's an issue you must grapple with on a daily basis.

MS D'ELIA (B): Look, we grapple with it daily. But if I can answer it in this way: a key part of the model that Baptcare has brought to this state for Gateway has been about working in partnership and trying to knock down those silos, so in fact our Gateway is for family and disability services. In the first 10 or 11 months that we ran the family services gateway - that operated from July 2009 through till June 2010 and then we brought on the disability gateway, so it's 18 months in. But in that first 11, 12 months of operation, 20 per cent of the clients who came to our family service gateway had either a parent with a disability or a child with a disability.

One of the most exciting things about being able to operate a joint assessment process and an integrated process at the Gateway has been our ability to look at those clients holistically and really think about pathways that work best, either in family or disability services, and breaking down that barrier so that it's not so much about it being, "Is it your job or is it your job?" but, "Who is the person here who needs some support and how can we put that in place?" I think it's a key feature of the model. It's quite exciting, and what it's meant is that we're seeing some different referral pathways, both for clients with a disability and for families, because of those different pathways that you build across different systems.

So I think that it's been of benefit for us to have already had some of those connections with mental health through our family service. It's like interlinking and integrating that through. So off the top of my head, my statement is that the more that we can break down those barriers by thinking about partnerships and integrated approaches, the better we'll be able to provide what the client actually needs - a people-centred approach.

MS SCOTT: Thank you very much, both of you.

MS D'ELIA (B): Could I invite you to come to the Gateway?

MS SCOTT: Yes.

MS D'ELIA (B): I'd really like to offer that opportunity. I don't think I've done justice to explaining the way that my staff undertake their assessments. It's a really holistic assessment that's undertaken, in a very client-centred way. I'd really like to give you the opportunity to come and take a look at the Gateway at a time that's suitable to you.

MS SCOTT: I will take you up on that offer. That's excellent.

MR WALSH: Do you have any information on the software that you use?

MS D'ELIA (B): We are provided with a data system from government and that's a key thing that we're currently working on within our organisation.

MR WALSH: Okay. Thank you.

MS SCOTT: All right. Well, look, you can tell we're very interested. Thank you very much for your testimony this afternoon and we'll follow it up.

MS SCOTT: I'm conscious that we're just eating into Richard's time frame, so could I ask Richard Dyson-Holland to come forward. Welcome, Richard.

MR DYSON-HOLLAND (AOPAI): Thanks.

MS SCOTT: Thank you for coming along and I'm sorry we've eaten five minutes into your time, but let's see if we can give you a good shot.

MR DYSON-HOLLAND (AOPAI): I'll try to talk a little quicker then.

MS SCOTT: Okay. Thank you very much.

MR DYSON-HOLLAND (AOPAI): I'm presenting today as national president of the Australian Orthotic Prosthetic Association, so presenting a national perspective. My role in doing that is entirely voluntary. We're a small profession. We have about 400 clinicians Australia-wide and our professional association has two part-time staff, and the rest of the executive - we have many volunteers across the country. My paid role is as the state manager of orthotic prosthetic services Tasmania, which is the public provider of all services in Tasmania, and there's a very small private sector in Tasmania.

MS SCOTT: How small? Two or three providers?

MR DYSON-HOLLAND (AOPAI): Two part-time and one full-time. It's very small.

MS SCOTT: Yes.

MR DYSON-HOLLAND (AOPAI): AOPA - I'll just refer to it as AOPA - on the whole supports the Productivity Commission's draft report and the concept of instituting a national disability insurance scheme. We see greater opportunities for people to improve access to appropriate physical aids and devices than is presently allowable under the current disparate systems and fragmented funding schemes.

In relation to common challenges across both disciplines, orthotics and prosthetics, there are several issues which presently affect quality and access. The regulatory requirements do not protect the public, nor do they encourage access to quality orthotic and prosthetic services. The industry is currently self-regulating. Some interventions that orthotists-prosthetists can be involved in carry high risk to the client and, if delivered by incompetent clinicians, may contribute to further disabling conditions and even death, and later this month the AOPA will make a submission to be included within the National Registration and Accreditation Scheme.

MS SCOTT: Do you have evidence on the dangers? You've talked about deaths. Have you got evidence that would point to that problem?

MR DYSON-HOLLAND (AOPAI): Yes.

MS SCOTT: All right. That's good.

MR DYSON-HOLLAND (AOPAI): We can provide further detail. We didn't think it was of core concern to this inquiry.

MS SCOTT: No, no, that's fine. One of the issues is accreditation and registration and consumer standards. If you can just make passing reference to the studies that exist, that would help us.

MR DYSON-HOLLAND (AOPAI): Sure. Also of great concern are industry workforce issues. Access to adequately educated, qualified and experienced clinicians is a major issue. Significant workforce shortages exist, which means that access to services varies markedly, which has significant long-term implications for some people, particularly those living in certain states and in rural parts of Australia. By international benchmarks, orthotics and prosthetics are under-represented in the Australian health workforce. Other industrialised Western nations have an average of one orthotist-prosthetist per 40,000 people and in some parts of Australia, in some states such as New South Wales, this is as poorly off as one per 120,000.

These factors impact upon the individual by the requirement to travel great distances to access services, to wait excessive lengthy periods, to access pseudo-equivalent services by other clinicians having to practise beyond their scope, or to simply go without or not to be referred in the first place, as other disciplines may have limited knowledge or no means of referring on to an adequately qualified orthotist-prosthetist.

MS SCOTT: Would you be able to give an example of that, Richard?

MR DYSON-HOLLAND (AOPAI): For example, there will be certain places such as, say, Armidale in New South Wales where there will be very limited outreach prosthetic services, and there would have to be upskilling to a certain degree of, say, one of the physiotherapists that would be there, rather than there being an approach to try to get a part position funded, so there are many kinds of things like that across the country, where bits and pieces are sort of done, just to try to keep people in those regions going until they can make the long trip to the city.

MS SCOTT: We're very interested in the regional provision of services. If you can give us any real-life examples, that would be extremely helpful.

MR DYSON-HOLLAND (AOPAI): Okay. We can do that. So in relation to the NDIS which would require specialised assessors as existing bodies such as the Transport Accident Commission have, this places further strain on the already inadequate workforce. The AOPA recommend that a workforce planning team should be established to determine future personnel requirements, and develop a national strategy to ensure broad geographically sustainable service provision.

MS SCOTT: Richard, will your submission explain why there has been insufficient numbers of people in the sector now? Is that reflecting - a bit like you mentioned the physio - does that reflect that simply government does not provide enough places, and therefore there are not enough people coming through?

MR DYSON-HOLLAND (AOPAI): That's correct. There's one university course that's based in Melbourne, and there is also inadequate provision and structures to allow appropriately qualified internationally qualified clinicians to work within Australia, and effectively to assess the safety of their practice.

MS SCOTT: Yes, I understand, thank you.

MR DYSON-HOLLAND (AOPAI): I'd also like to address challenges specific to orthotic services for people with long-term physically disabling conditions. People with physical disabilities most often require custom-made orthoses that are designed to last for a long period of time. Usually only orthotists have the training and skills to provide such orthoses. Clients who require access to orthotic management may be affected by a range of conditions, but a majority of people accessing these services are affected by arthritis, diabetes, stroke, polio, spinal cord injury and cerebral palsy. Many of the people within these groups have no means of accessing compensation, and are reliant upon what services may be accessed within the public system.

Well-planned orthotic services greatly reduce total health budgetary costs. In many cases this is seen through a reduction in hospital bed stay, delay or elimination of the requirement for surgical intervention, the assistance in more rapidly allowing individuals to return to the community following a stay in hospital, and the potential to increase an individual's employment prospects. However, it should be noted that as this is a small and relatively new profession, there is not a depth of research or benchmarking to provide level-1 evidence for all appropriate interventions, which is potentially a risk that best practice management may not necessarily be able to attract the same levels of funding as those interventions with high levels of evidence, simply due to there being professions of greater size which have had the resources to be able to develop that degree of evidence.

MS SCOTT: Richard, so in Australia sometimes we can look at local case management and say, "Well, Tasmania or WA does it well," or in relation to a particular area of service, you might say, "Well, Queensland leads the way," or New South Wales or whatever. Within Australia is there a jurisdiction that seems to be better in this field in the provision of services than any of the others? Is there one state that's a standout?

MR DYSON-HOLLAND (AOPAI): It varies between orthotics and prosthetics, and also acute and longer-term management. I would say potentially there's somewhat more that's accessible in terms of prosthetics in South Australia and potentially in Tasmania as well.

MS SCOTT: Right.

MR DYSON-HOLLAND (AOPAI): But then it varies also in - there are particular challenges in each state, so it's not like there's a shining light.

MS SCOTT: No. Is there a shining light overseas?

MR DYSON-HOLLAND (AOPAI): Aspects of the US system there is, and probably the British and Canadian systems, given that the US system has all the other challenges with their healthcare system. However, in terms of the development in the levels of credentialing and probably the money invested into the industry, and the developments within the industry, there are advances in the US system, and that's associated with the conflicts and all of those kinds of things as well.

MS SCOTT: All right, I got it. So war creates that industry and then the government funds it. Have I got that right?

MR DYSON-HOLLAND (AOPAI): That's right, and that develops - yes, and similarly, parts of northern Europe and Germany are at the forefront as well, simply because of their history with war, I guess.

MS SCOTT: All right. This is good. I know you've probably got more things to say, and that's fine, but while I've got you here, I wanted to draw your attention to the fact that we asked a tricky question at the end of the overview about artificial limbs. Now, I know this is a little bit of a tangent, but we're having problems with all sorts of questions about what should be in and what should be out of the NDIS.

MR DYSON-HOLLAND (AOPAI): Yes.

MS SCOTT: What should be in and what should be out? In relation to the areas that you are most interested in, in relation to what reading you might have been able to do of our report, are there areas where you think the draft report is fundamentally wrong in terms of its inclusions or exclusions? Could you talk about that for a minute or two?

MR DYSON-HOLLAND (AOPAI): Sure. I mean, I was just sort of approaching comment on that.

MS SCOTT: All right, sorry.

MR DYSON-HOLLAND (AOPAI): So I guess the current equipment schemes across Australia operate completely separately, with different guidelines and funding levels, and some schemes do not even include the possibility of accessing funding for orthotic management, meaning that private sector provision is entirely at the expense of the individual or their insurer. On the whole these equipment schemes, in terms of orthotic provision, are woefully underfunded, and they only fund a portion of the required orthotic management, which often has the effect of management not being provided as the individual may not be able to afford the required contribution, and this has flow-on effects such as rehospitalisation due to ulceration or due to a fall because an orthosis hasn't been provided.

Similar barriers exist when individuals try to access services and funding for orthopaedic footwear and specialised seating in wheelchairs. This often means that those who are already disadvantaged are forced to endure poor therapeutic solutions for long periods, which may be painful, produce pressure ulcers, restrict function and severely limit quality of life.

So the association supports the concept of an NDIS for people requiring long-term orthotic service provision, including specialised footwear, which would ensure equitable access to quality services, regardless of geography or the person's means or the aetiology of their disability. The AOPA requests that clinical services associated with the delivery of an item - that being the assessment, review, follow-up - that these clinical services are also included and covered by the NDIS, not simply the item.

MS SCOTT: Can I ask a bit more about that?

MR DYSON-HOLLAND (AOPAI): Yes.

MS SCOTT: I understand that in some states which do fund orthotics, it's a very limited number - one service a year or one assessment every couple of years; no replacements within a two or three-year period, that sort of thing, so quite strict rationing arrangements. There seems to be a fear that suddenly people will go crazy and wild and want more than they need. This goes to inclusions and exclusions. In your mind, is there a model that works maybe in the UK, Canada or US about what's in and what's out and what is reasonable and what is necessary versus what is a want or an overambitious claim? Is there a model that you can point to in your area that would allow us to be able to delineate very carefully between the two - wants and needs?

MR DYSON-HOLLAND (AOPAI): Sure. The AOPA intends to put forward a more detailed plan, but I couldn't comment in detail about it.

MS SCOTT: But you hope to do that for your submission.

MR DYSON-HOLLAND (AOPAI): Yes.

MS SCOTT: Okay. That would be great.

MR DYSON-HOLLAND (AOPAI): Looking at the challenges regarding prosthetic services for amputees, there is significant disparity between states in the way early and definitive services for amputees are offered. The long-term outcomes for amputees physically, psychologically, socially and financially are not only influenced by the funding options that become available several months after the time of amputation. Pre-amputation information and access to appropriate funding and prosthetic management from the time of amputation can have significant impact upon healing rates, re-ulceration or re-amputation at higher levels.

The quality of early management may also affect length of hospital stay, patterns of walking that can later be difficult to break, psychological recovery and reintegration back into enjoying aspects of an individual's life, and also the likelihood for some amputees ever returning to work.

The provision of suboptimal prosthetic components during early management can have long-lasting negative effects. Across the country there is great disparity between funding and approaches at the pre and early post-amputation phases of rehabilitation. Preferably, there would be a system where the funding may stay with the individual throughout the course of their entire lives subsequent to their amputation occurring; so not only for long-term management but linking this early management stage as well.

Another issue is the disparity between outcomes depending upon funding source. An individual's capacity to return to being a productive member of society is significantly affected by the degree of funding that is accessible. This differs significantly between the public system, the DBA system and the different compensation and private funding systems. The public artificial limb schemes operate quite differently between states, meaning that outcomes and access differs.

Worse still is the ALS's brief to only provide essential prosthetic management. This is a severely restrictive brief and is not in keeping with current views of health and wellbeing.

The availability of only low-cost prosthetic components does not allow most amputees to adequately achieve their vocational potential or allow them to participate in most recreational activities compared with their privately compensated counterparts. For amputees who have average to high activity levels, the availability of appropriate prosthetic components is very restricted and almost always involves a significant personal contribution which is often not possible or adds financial hardship. Equitable and consistent care is required, regardless of how an individual may have lost their limb in the first place.

The AOPA recommends that a new system is designed, contributed to by local and international experts, which would deliver seamless coordinated care from pre-amputation to acute and rehabilitation management through to life-long prosthetic management.

MS SCOTT: Richard, I am just worried about time. One of the things that we were debating within the team was the fact that so many prosthetic items now are internal - you know, knee replacements. Maybe that's not how prosthetic experts think of them but, you know, knee replacements or whatever, and that forms the basis of that question at the back of the report: what should be in and what should be left for the health system to, quite reasonably, provide? Will your organisation specifically answer that question?

MR DYSON-HOLLAND (AOPAI): We can. I guess that in terms of our association, when we're referring to "prosthetics", we're referring to limb prosthetics and not internal prostheses.

MS SCOTT: Okay. That's good. I'll just explain a little bit of the difference. Cochlear ear implants people could quite reasonably expect the NDIA to provide and you think, "Oh, wait a minute. That's internal." Alright?

MR DYSON-HOLLAND (AOPAI): Yes.

MS SCOTT: On the other hand, it would seem a misallocation of resources for the scheme to provide a hip replacement, because a lot of the Australian population get hip replacements. That would not necessarily be an NDIA element.

MR DYSON-HOLLAND (AOPAI): Yes.

MS SCOTT: So the debate within the team was about what's in and out, you know;

what should be in the scheme and what should be outside the scheme. If we don't get advice from your organisation, I'm wondering who is going to be interested in this issue.

MR DYSON-HOLLAND (AOPAI): I suppose the differentiating line is that some of those things you mentioned are surgically implanted, in an operative procedure.

MS SCOTT: Yes.

MR DYSON-HOLLAND (AOPAI): We're referring to things which are provided external to the body.

MS SCOTT: Yes. But you wouldn't object to someone getting a cochlear ear in the NDIA, would you?

MR DYSON-HOLLAND (AOPAI): It's outside my area of expertise.

MS SCOTT: I'm not a medical specialist either, I'm an economist and John is an actuary, so we are never going to find that we're going to know everything about all topics.

MR DYSON-HOLLAND (AOPAI): Yes.

MS SCOTT: But I'm talking to a prosthesis expert.

MR DYSON-HOLLAND (AOPAI): Yes. I guess the commonality between the cochlear ear and, say, a limb prosthesis would be that it's a compensation for some degree of incapacity. So it's effectively a replacement of something which is missing, whereas the internal hip prostheses are a replacement of something which is worn out.

MS SCOTT: That's not bad. That's pretty good. John, can you help me here?

MR WALSH: I think this is really difficult. You could argue that a hip replacement was to fix an impairment, just the same as a below-knee amputation, I would imagine. I find the line very difficult. I had another question, Richard. I'm not trying to change the subject.

MR DYSON-HOLLAND (AOPAI): Yes. Sure.

MR WALSH: Do you have a rough ballpark of how much it would cost for someone to maintain, say, a limb prosthetic throughout the course of their life, per annum?

MR DYSON-HOLLAND (AOPAI): I'm not trying to dance around the subject. The difficulty is that there's a great deal of difference between somebody who may lose a limb at the age of 70, possibly with a life expectancy of another five years, and somebody who has lost a limb at the age of 18 or who has a congenital deformity, and it's also, more importantly, to do with their potential level of function, their potential to participate in society, in the workforce, and the cost-benefit of that, when that's looked at; not only the individual's experience of it. There's such a broad variation.

MR WALSH: Take the 18-year-old.

MR DYSON-HOLLAND (AOPAI): Yes. I guess, over that person's lifespan, you could be looking at, say, a quarter of a million dollars, potentially; up to that. On the whole, you may be looking at significantly less than that. It's a very difficult question, because you're looking at, say, 60 to 70 years of care and trying to calculate that. It's a very difficult one. For somebody who is older, they may not be anywhere near as active. There might be a broader range of components at a lower cost available to them.

MR WALSH: That cost would mean for a young person - so a replacement prosthetic every two or three years or something might cost $10,000 or something?

MR DYSON-HOLLAND (AOPAI): Yes. It would depend on their level of functioning. Just because a person is young doesn't necessarily mean that they are at the higher functioning level. Even those people who are the highest functioning level, that doesn't mean that the required components are of the absolute highest cost. I suppose that there are certain components which some funding schemes, such as the Transport Accident Commission, would fund, which are at quite a significant cost - so around the $50,000 mark - which would cover the cost of care over, say, a three to five-year period. But they are only appropriate for quite a small percentage of amputees.

MS SCOTT: Yes, I understand.

MR DYSON-HOLLAND (AOPAI): So that could be right. $10,000 over a three-year period, that may be an average, or it might even be on the high side.

MS SCOTT: Richard, if I can just implore you to chance your arm in a few of these areas, notwithstanding - I appreciate your point about level-1 evidence, and we are an evidence based organisation. You can tell that John and I are struggling with this topic because it is so specialist. We have very few people who have made submissions on this topic, so if we don't get some of the answers from your organisation, we are back on our general knowledge, which I have to say on this subject is not good enough.

MR DYSON-HOLLAND (AOPAI): Yes.

MS SCOTT: I would encourage you to see if you can answer that question for us. It's extremely important that we get your advice on this topic, because there are so few other people. On many other topics, we would have literally had two or three hundred submissions.

MR DYSON-HOLLAND (AOPAI): Yes.

MS SCOTT: On prosthetics, I think it got down to five or six. I might have that wrong, but I'm not wrong by levels of 10.

MR DYSON-HOLLAND (AOPAI): No, that's probably right.

MS SCOTT: Look, I'm happy to take your piece of paper now so I can read it on the plane.

MR DYSON-HOLLAND (AOPAI): Sure.

MS SCOTT: But we will have to now ask you to finish, and we might talk a little bit later.

MS SCOTT: I did say at the outset that I'd give people an opportunity to make a comment from the audience, to come forward and make one or two quick remarks if they wanted to, so I want to be true to my word. Is there anyone that wishes to come forward? You'll have to keep your comments very short. We really do have to pack up and leave, to be in Melbourne tomorrow, but if you would like to come forward, this is the right time. Thank you. Please come forward now.

John, this is David Gordon and he's going to make his comments in three minutes, and then we'll have to adjourn. David, please go ahead. Are you speaking on your behalf?

MR GORDON: I'm speaking on my behalf, but I'm also here as a consumer for Tasmanians with Disabilities and Physical Disability Australia. My main thing is, I'm actually what you'd classify as a walking amputee, I've had a total knee replacement and, because of the huge costs of what actually a knee replacement comes at, you find that either you've got to be privately insured to be able to get this thing done, otherwise you've got a massive waiting list of anything up to - well, I've heard of cases down here in Tasmania - eight or 10 years. That really affects somebody's life, especially if they've got chronic arthritis or, in my particular case, where my legs were actually malformed at birth. Of course, that impacted on the actual joint completely collapsing, and I'm still waiting on another one to be done.

With the cost of insurance and that going up, and being on a low fixed income, a lot of people can't afford to be in private health to cover this. Okay, yes, you could wait eight or 10 years to actually get things like this done. This is why I've shaved my head earlier on. This is the area. These sorts of prostheses need to be included in the schedule under this, because I can see that there's going to be a lot of people fall through, basically, the net. That's just one of the things.

One of the other points that I think needed to be clarified in the paper was multiple disabilities. There's no real set figure. A lot of the talk today has been on specific types of disability, but there's not been very much mention about multiple disability and the cost of the needs for multiple disabilities. I'm sitting in the position where I have got multiple disabilities; I'm legally blind, I've got chronic heart disease and, as I say, I'm a walking amputee.

MS SCOTT: Yes. Thank you very much for coming forward, David. Alright. Thank you everyone for attending today, whether you are an observer or someone presenting evidence. We very much welcome your participation in this process. I now adjourn the hearings, and we will resume tomorrow in Melbourne. Thank you.

AT 4.38 PM THE INQUIRY WAS ADJOURNED UNTIL
TUESDAY, 5 APRIL 2011