SOUTH AUSTRALIAN GOVERNMENT SUBMISSION IN RESPONSE TO THE PRODUCTIVITY COMMISSION DISABILITY CARE AND SUPPORT INQUIRY ISSUES PAPER

The South Australian Government welcomes the opportunity to provide initial input to the Productivity Commission's Inquiry into Disability Care and Support.

Overview

It is well documented that current disability support arrangements do not adequately meet the needs of those who have a disability which requires them to be supported in their day to day activities.

The concept of a National Disability Scheme as set out in the Terms of Reference for the Inquiry would involve a fundamental change in the way that disability services are provided, managed and funded. While there are existing schemes that provide successful examples of such an approach, particularly within a catastrophic injury environment, the extension of this approach on a national scale to a broad range of disabilities would be an ambitious undertaking.

In considering such a fundamental reform of disability services in Australia it is important to first consider the objectives that are being sought from a better system.

The overarching aspiration of governments as expressed in the National Disability Agreement is that:

> "*People with disability and their carers have an enhanced quality of life and participate as valued members of the community*"

In order to support this aspiration, consideration of a new care and support scheme should be guided by the following key objectives:

- It should provide support which is flexible enough to respond to the differing needs of each individual, including changes over time.
- It should provide individuals with the capacity to influence the care and support that they receive, including, where appropriate, self-managed funding;
- It should promote self-determination, independence and community participation;
- It should encompass within one scheme a fully integrated approach to the provision of services, equipment and support that individuals require for their daily functioning, and avoid the bureaucratic run around associated with discrete program based responses;
- It should provide these supports in a timely way;
- It should recognise the need for, and the benefits of, specific supports that may arise at particular times in a person's life such as early intervention services, transitions to school and work and sudden loss of family support;

- It should support people to enable their full participation in society including the opportunity to equal access and participation in education, training and, where possible, paid work; and

- It should deliver these supports efficiently, provide better value for money than existing programs and avoid the potential for “double dipping”.

A genuinely guaranteed entitlement to care and support services for severe disability is not currently being delivered by the federal and state system or insurance products, as demand is significantly outstripping government’s ability to supply.

The State Government fully supports the need to reduce the unmet need that exists in the state, and across the nation. If a national levy was able to ensure that support services were definitively available for those with severe and profound disabilities, we would support such a scheme.

Given that all members of the community are at risk of experiencing severe and profound disability, we believe a broadly based national levy would be a fair funding model and that the community would accept such a levy and an associated entitlement to care considering they may themselves one day be in this situation[1].

The proposed National Scheme would also complement the National Disability Agreement and the United Nations Convention on the Rights of Persons with Disabilities to promote the equal and active participation of all people with disability. It would focus efforts towards achieving a society which is inclusive and enabling and would provide greater opportunities for each person to fulfil their potential.

The South Australian Government proposes, at least initially, that eligibility under the Scheme is extended only to those with severe and profound disabilities which are not the result of chronic disease processes. The Government believes that the Scheme should provide specialist disability services, with mainstream services such as health, education, housing and transport continuing to be provided by other agencies on the basis that these are fundamental rights for all people, including people with a disability.

The Productivity Commission has been asked to investigate the provision of care and support services within the framework of a social insurance model. Reform could attempt to address some of the above objectives without an insurance style funding arrangement or a levy. A better resourced and more individualised system does not *necessarily* require an insurance arrangement. The added value of an insurance arrangement is that it may be structured to support some form of guaranteed access or entitlement to a defined range of supports now and into the future. It may also be a more stable funding mechanism than one which meets costs as they arise. The success of such an arrangement would, however, be dependant on the legislative and governance framework. If a social insurance funding mechanism was not able to adequately support the long-term sustainability of a genuinely guaranteed entitlement, it may not provide a significant advantage over a reformed system that was better resourced from general Commonwealth revenues. Furthermore, any

---

[1] Ensuring that support services are definitively available for those with a severe and profound disability could be regarded as a desirable feature of a social contract that, from a position of ignorance, the community would accept considering they may themselves one day be in this situation (see John Rawls 1999 *A Theory of Justice* Revised Edition).

failure to fully guarantee entitlements could undermine community acceptance of the premium contribution.

Any premium paid for an insurance based scheme must also be acceptable to the community. Even accident based insurance schemes with actuarially determined premiums can be exposed to periodic “rationing” when premiums push the boundaries of community acceptance and legislatures are forced to re-consider benefit entitlements or modify common law damages. The public consultation process associated with the Commission’s Inquiry provides an ideal opportunity for community wide engagement, education and debate regarding the benefits of a National Disability Scheme.

State and Territory Governments do not have sufficient revenue raising options to resource comprehensive care and support services for those with severe and profound disabilities. Any additional funding or levy arrangement would need to be a Commonwealth responsibility. Furthermore if the Commission recommends a scheme with comprehensive coverage including all severe injuries the South Australian Government would be opposed to any additional costs being imposed through CTP premiums which are already relatively high in this State. Enhancements to coverage and services to victims of motor accidents should be funded through the National Scheme’s own funding mechanism(s).

An important aspect of a community wide engagement will be to place the costs of long term care and support within the context of the direct and indirect benefits that may flow from reform - not just to individuals and their families but to the community as a whole. The Productivity Commission’s report should attempt to explore the nature and magnitude of the public benefits that could accrue from better care and support arrangements for those with severe disabilities. Examples may include reduced health care costs, increased workforce participation (for both the disabled and those who currently provide informal support), improved productivity through improved education and training access and outcomes, reduced stress and family breakdown, and reduced costs of homelessness and incarceration and improved social inclusion.

Who should be eligible?

For costs to be managed effectively over time, the coverage of the scheme should be based on eligibility criteria and assessment tools that are evidence-based and as definitive as possible. The eligibility criteria should, however, also avoid arbitrary or inequitable treatments.

An entitlement to care and support services will require a significantly increased level of resourcing relative to current arrangements. Accordingly it would be important to ensure that any such entitlement is targeted to those most in need of frequent care and support which would in turn maximise the health, welfare and participation outcomes achieved.

Subject to the availability of robust and definitive assessment tools, the South Australian Government would support an arrangement that provided care and support to those with severe and profound disabilities (which are not the result of chronic disease processes) who require support for their daily functioning and activities. The general philosophy espoused in the Disability Investment Group

Report[2] – that the target group should be people who need help always or frequently as a result of their disability – seems broadly appropriate. However, a diagnostic as well as functional definition will need to be applied to exclude people with chronic health conditions from eligibility. It needs to be recognised that the current disability services system is under resourced and is not able to meet the needs of people with disabilities requiring essential support services. This needs to be the first priority for the insurance scheme. Any extension of the eligibility criteria to other groups (aged or chronic health) will make the scheme too complex and will increase the risk of the scheme failing to meet the needs of people with disabilities.

Definition of eligibility

The Productivity Commission terms of reference refer to eligible persons as those with a severe or profound disability. While it is generally accepted across Australia that specialist disability services are targeted towards people with severe and profound disability (measured in relation to the core activity areas of self-care, communication and mobility), in reality the capture of specialist disability services is somewhat broader. In South Australia the Department for Families and Communities has a greater proportion of clients classified as having a mild to moderate disability compared with other jurisdictions, as reported in the Report on Government Services. While this cohort may not be included in the Scheme, their ongoing care would need to be considered and funded along side any new system developed. The definition of eligibility needs to be specified so that it may be clearly and consistently applied by all parties interfacing with disability service provision. This will enable responsibilities for service delivery to be clearly defined, providing coverage across all requisite services while avoiding duplication.

Consideration of definitional consistency with existing accident injury compensation schemes (such as workers compensation and motor accident schemes) will also be important where there is expected to be interaction or overlap between schemes. Very clear criteria for eligibility will need to be articulated to ensure that where there is overlap with other compensation schemes or apparent demarcation, it is clear who holds the responsibility of providing support services to the person with the disability. It is important that clients who would be eligible for services provided by the proposed National Scheme are not disadvantaged and their care and support needs are met at least as well as under existing workers compensation schemes and motor vehicle accident schemes which provide agency support. A national comparison to establish which states offer the highest standards for all relevant services is recommended. In relation to workplace injuries where no fault arrangements are generally in place across Australia, the *Comparison of Workers Compensation Arrangements Australia and New Zealand 2009* published by SafeWork Australia provides a comprehensive summary of most aspects across all the workers compensation schemes (a copy will be separately provided to the Productivity Commission).

In South Australia existing coverage and identification criteria for injury compensation and program support vary as discussed below.

---

[2] The Way Forward: A New Disability Policy Framework for Australia, Report of the Disability Investment Group 2009

Motor Accident Commission

South Australia's Compulsory Third Party (CTP) motor vehicle insurance legislation does not define severe/catastrophic injuries. The CTP scheme relies on the opinions of various medical experts to support the provision of treatment, rehabilitation and care. Services that are considered reasonable and necessary are usually funded until settlement of lump sum compensation for future care. Other schemes such as Victoria's TAC, New Zealand's ACC and the NSW LTCS use the following definitions:

- Moderate or Severe Acquired Brain Injury (ABI) with Post Traumatic Amnesia > 7 days (research evidence indicates this is a stronger predictor than Glascow Coma Scale (GCS) and GCS <7);
- Spinal cord injury resulting in permanent neurological deficit;
- Multiple amputations;
- Burns (full thickness) >30% whole body; and
- Blindness.

WorkCoverSA

WorkCoverSA provides no-fault compensation to workers where their disability arises out of, or in the course of employment. Those workers who require the highest level of support and services due to the seriousness of their injuries are classified as 'serious injury' claims (see *Chapter 11A Social Rehabilitation Requirements* of the *Injury and Case Management Manual;* a copy will be separately provided to the Productivity Commission).

These are defined as those claims where the worker has sustained a physical trauma which is potentially life threatening. Serious injury includes:

- moderate to severe traumatic brain injury
- spinal cord injury
- amputation of a limb
- severe burns
- total blindness
- brachial plexus injury that results in the loss of the use of a limb
- multiple (two or more serious injury types)

where that trauma may result in:

- severe loss of functional ability
- significant permanent impairment and
- a requirement for long-term care services.

Department for Families and Communities (Disability SA)

The South Australian Department for Families and Communities (DFC) applies eligibility criteria which are more limited than the Survey of Disability, Ageing and Carers[3] (SDAC) (see Appendix 1 for the SDAC conditions deemed not to meet the DFC disability eligibility criteria). In terms of numbers, the difference is considerable –

---

[3] The SDAC defines a disabled person as a person who had one, or more than one impairment or a disability which had lasted, or was likely to last, for six months or more.

in 2007/08 on the basis of SDAC data, the number of people with severe/ profound disability aged less than 65 years is more than double the number when health conditions and other non-eligible conditions are excluded.

Assessment is a crucial component of the intake process into the specialist disability services system administered by the South Australian Department for Families and Communities. The Department, in conjunction with the University of Adelaide, has invested considerable resources into the development of the DSTART assessment tool. It is a tool that takes into account the complete environment of the client. Further information on this is being provided to the inquiry through a specific request from the Productivity Commission (see Appendix 4 for an overview).

Home and community care (HACC)

HACC services people experiencing difficulty in carrying out tasks of daily living without help and need assistance due to an ongoing moderate, severe or profound functional disability.

Submissions to the Productivity Commission may suggest that eligibility be based on functional impairment regardless of causation e.g. chronic health condition. If the eligibility under any new scheme were to include persons with a disability arising from chronic health conditions, then the eligible population for specialist disability services would increase significantly.

Age-related cut-off

While the terms of reference do not stipulate age, the issues paper discusses aged-based cut-off for entry as an option. When considering this aspect of eligibility it should be noted that ageing in place is a strategy fully supported by the South Australian Government. Currently once clients turn 65 years old they are also eligible to access aged care services, although some restrictions apply. For example, people living in disability supported accommodation are not eligible to enter residential aged care.

Consistent with this current stance, the South Australian Government believes that those who enter the scheme before age 65 should be provided with lifetime access to those care and support services that are part of the scheme. For disabilities acquired after age 65, consideration should be given to the feasibility of a defined set of non ageing related conditions that would determine eligibility, to avoid the potential inequities associated with an arbitrary age cut off (eg it would be inequitable for a person who was severely injured as a result of an accident to be denied support under the scheme purely on the basis of their age at the time of the accident).

The recent reforms in Health and Ageing may serve as a model for managing this criterion. Under this model funding and service responsibility for people over the age of 65 are assigned to the Commonwealth. Funding and services for people with disabilities under the age of 65 remain the responsibility of the State. Under this arrangement, the Commonwealth is able to purchase services from the State for people over the age of 65 whose needs can more appropriately be met through the disability services system. Similarly, the State is able to purchase aged care services (particularly residential aged care) from the Commonwealth for younger people with disabilities who require these services. This is intended to allow for a seamless service system for clients and allow clients to access those services that most appropriately meet their needs, while at the same time avoiding any cost-shifting between the ageing and disability sectors.

There are other examples of programs in aged care (eg Aged Care Assessment Team assessment of eligibility for aged care services) where there is some allowance for flexibility in clinical decision-making that enables the best choice of service response for the client within broad parameters.

Treatment of unstable or short-term episodic conditions

The South Australian Government believes that if disability arising from injury was covered by the Scheme it would need to consider eligibility based on conditions that are likely to require long term care and support over a number of years or for a lifetime. The NSW Lifetime Care and Support Scheme participants are initially assessed as eligible for entry to the scheme on an interim basis if they meet objective injury and functional criteria (for 2 years if participant is over 3 years of age). After a set period of time participants are reassessed to determine if long term support is still required and hence the need for ongoing participation in the scheme. Evidence based functional assessment instruments may be used for this determination.

Whether short-term or acute episodes of disability would trigger Scheme eligibility also needs to be determined. Specialist disability services in South Australia currently deal with chronic and ongoing impairment. The needs of clients who suffer from short-term episodic type conditions (for instance some people with mental health conditions) pose a specific challenge which needs active consideration as part of the Commission's Inquiry.

If it were decided that the Scheme should accommodate changes in condition or short-term episodes, then the interaction between other care providers would need to be resolved. For example, if an injured worker was covered under the WorkCover Scheme and their condition changed such that they would be eligible under the National Disability Scheme, would they be able to move in and out of the Scheme based on their level of need and would they 'come back' to the WorkCover Scheme if their circumstances changed?

Assessment under a new National Scheme

A single, nationally consistent, assessment tool is required that assesses both eligibility and need and recognises the requirement for flexibility to ensure any change in need is timely and proactively managed.

Consistent application of the assessment tool across the spectrum of disability service providers (eg. WorkCover, MAC, DisabilitySA) will be required.

The assessment tool should include:

- the development of consistent guidelines and protocols based on objective data, so administrative requirements are predictable, equitable and user friendly;
- coordination of disability, health, aged care, housing, education and other service provider records;
- combined disability/health/aged care/ housing/ education assessment teams;
- expansion of existing multi-disciplinary assessment teams; and
- shared resources between disability and health for assessment and care models to prevent duplication of assessment and delivery of services by both agencies.

Who makes the assessment?

Assessments should be made by health and disability care professionals who can make an objective, well-informed judgement about client needs as well as the benefits of intervention.

It can be argued that the person with a disability should determine which of their treating disability or health care professional is best suited to make these judgements. However, it should be taken into consideration that the service provider has a vested interest in the outcome of the assessment because it will increase the demand for their own services and, consequently, their income.

Means Testing

Means testing of eligibility for entitlements to publicly funded services can be an important mechanism to ensure that scarce resources are devoted to addressing the greatest needs.

In the case of a care and support scheme for people with severe and profound disabilities, however, needs are primarily defined by the nature of that disability and the limitations that it places on daily functioning and participation. From a societal perspective, ensuring that all individuals have basic opportunities for social and economic participation is arguably a desirable objective in its own right, based on notions of equal opportunity, and this can be viewed as being independent of differences in private income or assets.

Means testing can also distort behaviour and incentives and may be inimical to the pursuit of some opportunities to participate in income earning activities. It may also delay discharge from the acute and sub-acute hospital system while financial decisions and arrangements are made.

The absence of means testing of eligibility for a long term care and support scheme would not, however, preclude the possibility that in some situations voluntary co-contributions, either monetary or in-kind by family members, could supplement a package of support services, equipment or home modifications where those services are not normally covered by the Scheme.

What should the scheme provide?

The Scheme should seek to define an ‘entitlement’ or baseline of care and support. The conceptualisation of people’s *entitlement* to services will encourage decision-makers to ensure a minimum standard of service provision is available to people with disabilities at all times. Similarly to the idea of ‘universal health care’ the aim of a new disability care and support system should have universality as its goal.

The Scheme should fund services that are “reasonable and necessary”. Services need to be objectively assessed, and where appropriate, clinically justified. Only those needs arising as a direct consequence of the accident related injury or disability for those participants should be covered by the Scheme.

The desirable range of supports that would be provided under a long term care and support scheme for those with profound and severe disability would be the following:

- Care and support – includes personal care to assist clients with activities of daily living, constant supervision, therapy support and community access, home help and gardening;

- Therapy and medical treatment able to be delivered by care workers– includes physiotherapy, occupational therapy, speech therapy and other services which are clinically justified;

- Counselling and support services for the person with a disability and their direct family. Support in accessing community activities that provide social support and connection;

- Case management services – access to case management services to assist in the coordination of services and at transition periods over the course of a participant's life;

- Vehicle and home modifications;

- Equipment – rehabilitation equipment (e.g. wheelchairs) and other equipment (e.g. commodes), including replacements, repairs and maintenance, to support functional independence; and

- Accommodation support where the participant is unable to live in their home environment or a contribution to the cost of the care received when living in a supported accommodation or when temporary respite is needed.

A funding cap on some benefits such as home and vehicle modifications may need to be considered.

A case management approach should be at the core of the system. Each individual's needs should be clinically assessed but within this framework the client and/or their family should be provided with opportunities for self-determination in relation to a care plan that best suits their own individual needs. The supports should be provided on the basis that they are reasonable and necessary given the functional requirements of each client, but should be attuned to the client's own life situation and circumstances and their expressed goals. This may mean that some aspects of the care plan could be traded off or cashed out to enhance other aspects of the plan. One of the key objectives should be to maximise the independence of the client and empower them to participate in work and the community. Access to education, training and employment is a major contributor to achieving social inclusion principles, full community participation and self-determination. Employment increases self esteem and social involvement, provides individuals with the funds to participate more broadly in the community and make choices that are available to the general population. Funding access to support and assistive technology can enable community and workforce participation for some individuals with the investment far outweighing the cost[4] (see Appendix 8 for further discussion of education, training and employment linkages).

Clear service parameters for treatment, rehabilitation and care services should be instituted to achieve best possible social inclusion and participation outcomes that:

---

[4] See Mike Dockery, Elisa Birch, and Peter Kenyon (2001) *The economic and social analysis of increasing opportunities for people with a disability in VET*, Report, The Institute for Research into International Competitiveness (IRIC), Curtin Business School, Curtin University of Technology, February, http://www.dest.gov.au/sectors/training_skills/publications_resources/profiles/anta/documents/d/disabilitiesapr01_pdf.htm

- Are person centred and holistic to the participant's involvement in the management of their condition and to increase independence;

- Provides individualised funding to be considered based on individual circumstances;

- Supports choices in rehabilitation and care;

- Supports long term health outcomes and social outcomes;

- Supports the maintenance of family and other relationships; and

- Includes service provider arrangements that are designed to achieve functional independence and health outcomes.

Direct payment approaches are increasingly becoming a service option in many jurisdictions. South Australia recently commenced a first phase of self-managed funding for 50 people. Participants of this initiative have the option of receiving direct payments and managing their funding and support independently or having a carer/guardian or non-government organisation undertake all or some of these aspects of self-management on their behalf.

Direct payment models require persons with a disability and/ or their carers to have knowledge of the disability services market and the ability to make decisions about appropriate service packages based on that knowledge. It is important that there are arrangements in place to assist individuals to acquire these skills or to provide support in aspects of their self-management (eg fund-holders).

Close attention needs to be paid to the cost of support arrangements in direct payment approaches to minimise the dilution of funding due to administrative charges.

South Australia supports direct payments as a viable service option for people with disabilities. Direct payments will not suit everyone and as such should be offered as one of a set of service arrangements that may be chosen by people with disabilities.

Scheme service provision will need to consider how to define entitlement in relation to:

- Remoteness, where although there is an established entitlement the cost of providing the service would be prohibitive (eg. institutional/ high dependency accommodation or supported accommodation within the remote community);

- Complex needs, where individuals with a disability or multiple disabilities have other factors impacting on their functioning (such as high health needs, dementia, mental illness or drug and alcohol abuse). In these instances multi-agency responses may be required. It is imperative that the scheme is clear on defining disability support needs so that there is either no expectation that the scheme will cover more than disability support needs or, if the scheme is expected to cover a broader range of needs, funding from other areas (mental health, health, drug and alcohol services) is also cashed into the new arrangements; and

- Supply mechanism, where it may be more cost effective for purchasing agreements to be made by the Scheme (eg. agreed treatment fee schedules, bulk equipment purchases) rather than an individual sourcing the good/ service and then seeking reimbursement from the Scheme.

People with disabilities need a multitude of services, some of which would be the responsibility of other areas of government (housing, health and aged care, also public transport, education etc.)[5]. While a new disability care and support system is unlikely to be able to provide and finance all of these services, the system should link with other service providers to ensure that people with disability have equal access to the community. Existing disability services have tended to assume a 'whole of life' responsibility, including care and support as well as education, accommodation and employment. This has limited the capacity of the disability system to adequately meet demand. It also denies people with disabilities the same access to mainstream services as all other members of the community. There is significant room for increased mainstreaming of services as proposed in the Productivity Commission's Issues Paper.

A long term care and support scheme need not address income support requirements, which are best administered separately to avoid notions of linkages between the degree of care and support services received and eligibility for general income support. Participants will have access to income support and other compensation through existing mechanisms.

Linkage to existing and mainstream services

If a National Disability Scheme was put in place with dedicated funding mechanisms there would be substantial impacts for remaining disability, ageing and health services in South Australia.

Such a scheme is likely to leave a 'residual' population of people needing disability support that fall outside the eligibility criteria of the Scheme. Responsibility for the delivery of services to the people with moderate to mild disability needs to be considered in the design of the scheme. Early intervention is an essential service type that assists with prevention and can delay the progress of the client's impairment – the responsibility of the scheme and other providers for early intervention services needs to be considered.

Rather than creating a dual system, leaving States and Territories to provide services to the lower- level disability group who may sit outside the National Scheme, it is essential that there is an overarching national strategy which clearly delineates funding and service delivery responsibilities for all disability in order to reduce the risk of cost-shifting and to close the gaps. This would be akin to the ageing reforms, whereby the Commonwealth Government is responsible for the continuum of care in relation to aged persons. It is desirable that there be a similar arrangement in relation to specialist disability services.

The interface between the health and disability sectors is a particular concern to South Australia because of discharge delays and avoidable admissions.

There are delays in discharging people with a disability from hospital because their needs are unable to be met by existing community disability services, including not

---

[5] For example, the South Australian Dept for Transport, Energy and Infrastructure currently provide support for carers through the PlusOne Free Companion Card which provides free public transport too over 21,000 carers in South Australia.

being able to immediately access the care they had prior to hospital admission or temporary extra care. Data collected statewide consistently indicates that at any time there is a cohort of 32 to 48 patients in South Australia with a disability who are ready for discharge to a more appropriate setting. The mean length of hospital stay for these patients in acute care was 207 days in June 2010. The range of length of hospital stay for those currently awaiting placement varies from 9 days to 1298 days.

The delay in discharge for this cohort is often a result of a complex set of circumstances, including:

- complex care needs;
- the need to resolve a range of matters associated with appropriate guardianship;
- the need to determine eligibility for services provided by disability services;
- delays in the provision of home modifications and equipment (recently ten patients have been kept in metropolitan hospitals waiting for home modifications and equipment for a total of 1430 days – two people in the Repatriation General Hospital have been waiting a total of 676 days and five people in the Hampstead Rehabilitation Centre (HRC) have been waiting a total of 658 days); and
- a lengthy waiting list to access disability services.

There are two reasons for avoidable admissions:

- there are instances where admissions to hospital could have been avoided with the provision of more proactive assessment and support in the community. People with disabilities have been admitted to hospital where their needs have changed (usually increasing) and their existing support structures are unable to cope. A timely assessment and response may have helped these people to avoid an admission and the typical resultant loss in function associated with an hospital admission; and

- a lack of coordination between agencies or service providers. For example, people with a mental illness experiencing other disabilities (eg brain injury and intellectual disability) usually have high and complex support needs (eg. drug and alcohol problems, interaction with the criminal justice system or homelessness). Mental health rehabilitation and psychiatric disability support services tend to operate separately resulting in a lack of access to the appropriate services for this cohort of people. As a result these people often end up in hospital emergency departments and/or admitted to hospital and discharge is often delayed due to the lack of disability support services and accommodation. The South Australian Department of Health is attempting to address some of these issues (see Appendix 6).

Linkages to existing accident compensation schemes and litigation

In South Australia there is a statutory no fault compensation scheme for workplace injuries and a modified common law fault based statutory compensation scheme for motor vehicle accident injuries. There is no private underwriting of either scheme. As is the case elsewhere in Australia, injuries arising from medical misadventure or other accidental causes can receive compensation if fault is proven or accepted by another party who has insurance or assets to satisfy such a claim with the same limits to the level of compensation as motor vehicle injuries (*SA Civil Liability Act*). Apart from workplace injuries, lump sum compensation awarded as damages for personal injury underpins the future care requirements for those suffering catastrophic injuries in South Australia.

The South Australian WorkCover Scheme is the only no fault accidental injury compensation scheme operating in South Australia at present. For seriously injured workers it provides income maintenance, reimbursement of medical expenses, compensation for non economic loss and social rehabilitation entitlements which include, but are not limited to:

- domestic and gardening help
- housing modifications
- travel and accommodation
- child care services
- respite care
- family counselling
- provision of appliances and equipment eg, wheelchairs, crutches etc

Further detail regarding serious injury incidence, identification and entitlements within the South Australian WorkCover Scheme are provided at Appendix 2.

Those with catastrophic injuries that are covered under existing CTP scheme arrangements are not guaranteed to have sufficient or appropriate long term care and support arrangements in place. The South Australian CTP scheme has some limitations in the context of a litigious scheme in influencing early intervention best practice approaches. The claimant's long term care and support arrangements are established by a variety of parties engaged by the claimant and often in the absence of a coordinated case management approach. As a result services are adhoc and fragmented. Whilst reasonable and necessary services may be funded until settlement, scheme administrators have limited influence in improving existing models of care and support. Once settlement is finalised the claimant is left to their own devices to manage their own health, care and rehabilitation needs from their lump sum settlement funds. More broadly evidence suggests that people who claim lump sum compensation for their injuries have poorer health outcomes than those who have similar injuries but are not involved in a compensation process[6].

The South Australian CTP scheme and others interstate are continuing to experience increases in care costs, due to care utilisation and care cost inflation. In South Australia the scheme is subject to commercial attendant care rates and there is a limited opportunity to influence utilisation through improved functionality, outcomes and participation and supported accommodation. The NSW Long Term Care and Support Scheme has done some work in this area with an actuarial assumption for care inflation only of 4 per cent per annum.

The ability of an individual suffering severe injuries to receive or purchase ongoing care and support thus differs according to the context in which it occurs. Differences are also apparent between States.

In a 2005 report to Insurance Ministers[7] PriceWaterhouseCoopers (PWC) estimated that nationally there were around 772 new cases of catastrophic injuries per annum,

---

[6] Compensable Injuries and Health Outcomes, The Australasian Faculty of Occupational Medicine, The Royal Australasian College of Physicians, Health Policy Unit. 2001

[7] Long Term Care, Actuarial Analysis on Long Term Care for the Catastrophically Injured, PricewaterhouseCoopers Actuarial, March 2005.

around half of which arose from motor vehicle accidents. At that time PWC estimated that only around 48% received compensation for their future care. Since that time the introduction of the NSW Lifetime Care and Support Scheme would have increased the proportion of compensated catastrophic injuries to just over half of all such injuries nationally.

Even where damages are recovered they may not be used for their intended purpose. PWC estimated that lump sum payments provided to those with compensable catastrophic injuries last, on average, for around 7-9 years. Given that 70% of all such injuries occur to those aged under 30, such payments do not in many cases last long enough to resource lifetime care.

Taxpayer funded services are required to respond to the needs of both non compensable clients and compensable clients for whom funds turn out to be inadequate. Of those who are not eligible for compensation, PWC estimated that only around 15% were receiving long term care in the form of planned accommodation support through disability programs.

The patchwork of current compensation arrangements within and across the States and Territories poses some challenges in terms of defining the scope of a National Disability Scheme. It is unclear whether there are insurance products available which provide affordable first party cover in relation to accidental injury. The Commission may wish to investigate this further.

It is difficult to envisage that it would be viable for the States and Territories to establish arrangements that met care and support needs on a no fault coverage basis for severe disability arising from general (non workplace and motor vehicle) accidents and medical misadventure. While the medical requirements of a person with a disability as a result of medical misadventure would be covered through the public health system, the long term ongoing support requirements for general and medical injuries are not comprehensively covered under current insurance arrangements, and State and Territory Governments have limited mechanisms to fund the care requirements for those not currently compensated[8]. It would be inappropriate for premiums levied under State workplace and motor accident schemes to reflect the costs associated with injuries occurring outside those contexts.

Assuming that a national scheme would, at a minimum, need to cover uncompensated general and medical catastrophic injuries there are essentially three options for other catastrophic injuries under a national scheme. The national scheme could:

1. assume responsibility for care associated with all severe disability (existing insurance schemes would continue to manage other compensation for catastrophic injuries such as loss of earnings and pain and suffering not covered in the national scheme along with compensation for less severe injuries); or

2. fill in the gaps arising from differential access to compensation under existing insurance schemes – ie the scheme would cover those with

---

[8] The March 2005 PWC Report estimated that the delivery of long term care and support services to uncompensated general and medical catastrophic injuries could be in the order of $350 million per annum nationally.

severe/catastrophic disabilities where there was no claim to compensation under existing schemes; or

3. leave workplace and motor accident injuries out of scope but attempt to establish a framework for State and Territories to extend coverage of motor vehicle accident compensation arrangements so that no fault care and support entitlements were provided to all catastrophic disabilities arising in this context. This would have significant implications for premiums under those schemes.

If feasible the first option would offer the most equitable and consistent approach and could address some of the inefficiencies associated with current arrangements. This approach would, however, reinforce the need for access to a funding mechanism which supports some form of guaranteed entitlement to services at least for those who would otherwise have access to compensation. If the National Scheme were predominantly funded on a pay as you go basis and significantly susceptible to rationing, the second approach (filling in the gaps created by existing compensation arrangements) would appear to be a more feasible arrangement to avoid disadvantage to those with a claim under existing accident compensation schemes. On the other hand, a significant shortcoming in a scheme that left out those with rights to compensation under existing schemes would be the disadvantage that this would create for those who had their compensation entitlements significantly reduced (eg on account of some form of contributory negligence) or had a range of disabilities some of which are compensable and some of which are not.

If it were feasible to create a comprehensive national scheme, this could involve the removal of access to common law damages for future care for all injuries covered by the scheme, although this may create some problematic boundary issues and uncertainty for clients regarding whether they were eligible to receive care and support services under the national scheme or not. Interim care and support responsibilities may need to be established between the no fault scheme and relevant insurers, particularly where there are disputes as to liability. It may also mean that State Civil Liability Acts would have to be amended to be very prescriptive as to what persons can obtain by way of damages to be consistent with a National Scheme and avoid any new heads of damage emerging.

Alternatively common law access to future care damages could remain, giving those with a case in negligence a choice as to whether to pursue lump sum compensation or seek support under a national scheme. This may be advantageous to those who prefer maximum flexibility in the way that the compensation is deployed to meet their needs. Those who receive lump sum compensation could subsequently “buy in” to care and support services provided under a national scheme. The significant disadvantage of this approach is that lump sum compensation may be inadequate, compromised due to dispute over liability, or wasted and there will be cases where individuals are left to eventually rely on other disability programs, seemingly at odds with the efficiency and equity objectives of the proposed national scheme.

If income maintenance payments are excluded from the National Scheme, catastrophically injured workers would then maintain some connection to existing injury compensation insurers for the provision of these payments. To reconcile this, catastrophic injury claims would need to continue to be lodged with and managed by existing insurers. The National Scheme could then be a resource to facilitate improved rehabilitation and service provision and ‘top-up’ entitlements to ensure those people that are catastrophically injured receive nationally consistent services.

Any comprehensive coverage would also need to consider transitional issues with respect to those already in receipt of compensation in either a lump sum or ongoing entitlement arrangement. Those who have previously received lump sum compensation could elect to buy in to the scheme. Those receiving ongoing periodic entitlements to care and support services could transition to the national scheme subject to mutually satisfactory arrangements being struck with existing insurers with regard to funding and claims management arrangements. The process of inclusion may need to occur incrementally, with the National Scheme builds initially supporting those people with the greatest need, such as those who previously had limited access to disability services and support. Once the National Scheme capacity had developed, new claims that previously would have been managed by existing compensation schemes could be absorbed. Lastly, pre-existing claims under the existing compensation schemes could be transferred to the National Scheme.

Funding

Clearly funding will be critical in determining the success of the Scheme.

Disability programs have traditionally been funded through the general revenues of Commonwealth and State Governments. Support for people with disabilities also relies on substantial contributions from non-government agencies, investment income, fundraising, etc. Intergovernmental agreements have provided some certainty regarding Commonwealth funding contributions towards disability programs delivered by State Governments. Funding for disability programs competes with other government programs based on emerging needs and priorities.

A lack of funding is leading to large unmet need in South Australia – in December 2009[9] Disability SA had a total of 2,667 eligible clients waiting for services. These figures are not comprehensive as they do not record unmet need for some key areas (eg sensory disability and some children's services) and only record 'identified' need ie does not include many people who are being cared for by unpaid/informal carers who have not approached our system but who may wish to receive a payment under a national insurance scheme[10]. They also exclude people with a disability who are inappropriately accommodated in residential aged care and people waiting for services from other programs such as HACC. Disability SA does not currently deliver services to the majority of people with disabilities who are potentially eligible for services. These people currently rely on family and informal supports.

Furthermore, the inability of Disability SA to meet needs has flow on cost effects on other agencies such as SA Health (as previously described).

While the current system could be improved by better resourcing and a greater focus on individualised arrangements, the success of a National Disability Scheme will depend on the ability of the scheme to eliminate rationing by ensuring an uncapped funding source that provides a guarantee of a fully-costed base level of care for all

---

[9] http://www.sa.gov.au/upload/franchise/Community%20Support/Disability/Disability%20collection/statistics/The%20Provision%20of%20Disability%20Services%20in%20South%20Australia%20Dec%202009.pdf

[10] Modelling commissioned by the Disability Policy Research Working group (DPRWG) and undertaken by PriceWaterhouseCoopers indicates that, across Australia, some 50% of people with a severe/profound disability (all ages) do not receive support from formal support services, and that 81% of the care that is provided to the severe/profound disability population is provided by informal sources (ie family, friends or other means).

those within the scheme. This equates to the provision of an entitlement to a base level of support being met over a lifetime and paid at market rates at a level commensurate with adequate care, without assuming that families and other carers will automatically take on some of this task. This would provide financial and emotional security for people with disability and their families.

While there appears to be considerable community support for the concept of a National Disability Scheme, the over-riding issue is the ultimate cost to taxpayers of such a scheme. Given current funding levels fall well short of the type of care expected to be paid for by a social insurance scheme, the level of overall funding, and its growth over time, will need to be significantly greater than what is currently contributed by state and federal governments. This is especially the case if a national insurance scheme extended entitlement to the population currently not in receipt of formal disability services.

It is not only the Scheme funding that needs to be established. Funding of those who are not eligible (for instance, people with lower level disability or short-term incapacity resulting from illness) or services that are out scope (eg. health, housing, education) need to be estimated. The financial modelling to establish likely on-going costs will be extremely complex, and may be hampered by the lack of reliable data to undertake this task. Cashing out of existing disability funding would need to leave capacity to deal with these issues not covered by the scheme. Currently, non-government disability agencies contribute significant funding from their own sources (e.g. investment income and fundraising). The degree to which the community would be willing to continue to donate to the disability sector (funding donations and volunteer time) may change significantly under the proposed National Scheme. The sensory sector requires careful consideration when considering future funding models. Currently it generates substantial amounts of philanthropic revenue, which gets rolled into service provision. Any adjustment in funding models could put that revenue stream at risk if there was an expectation that a form of insurance should be supporting those services.

If a National Disability Scheme were to have comprehensive coverage of all severe disabilities and injuries, the funding mechanisms could involve a number of elements:

- Transferring resources from existing insurance pools into the national scheme via a levy on the relevant insurers. Insurers should only be expected to contribute funds based on future care costs incurred through existing coverage and scope – any additional costs for injuries not covered through these schemes should be met through the National Scheme's own funding mechanism. This would ensure that the premiums charged continued to reflect the future care costs of severe injury arising in those contexts, but no more so than is inherent in the existing insurance coverage arrangements which represent current community acceptance in each context and jurisdiction. There may also be transitional issues to consider – ie whether insurance schemes transfer existing as well as new claimants to the national scheme upon commencement.

- Accessing resources currently devoted to Commonwealth and State Disability programs. An assessment would need to be made of the proportion of current program spending that is devoted to the services and clients that would obtain care and support through the National Disability Scheme. This would be a once and for all initial assessment, and over time the funding stream would be adjusted in accordance with current indexation arrangements under the National Disability Agreement.[11] Legislative provisions could underpin this arrangement. The assessment would need to ensure that sufficient funding streams were available (and appropriate arrangements put in place) to deliver services and support to those not covered by the national scheme.

- The National Disability Scheme's own funding stream which would meet the (significant) residual costs not met through existing insurance or program support arrangements. This could take the form of a dedicated levy or "premium" or it could be funded through general Commonwealth Government revenues.

The cost of the services delivered to people with a long term disability under existing insurance schemes could be transferred to a National Scheme with no cost impact on existing premiums. However, determining an arrangement for transferring such funds would need careful consideration to identify the best approach. Relevant issues would include:

- undertaking an actuarial assessment of the cost of existing serious injury claims;
- consideration for the proportion of services existing insurers would still provide (such as income maintenance); and
- how often existing insurers would pay a levy to a National Scheme Authority.

Unlike injury, where premiums can be applied to directly target those engaged in activities causing injury, disability is a risk shared relatively equally throughout the population. As such any new levy or premium contribution would be most appropriately spread as broadly as possible across the resident population. From this perspective the incidence effects of a levy/premium or funding sourced from general Commonwealth revenues may not be significantly different. Indeed, with appropriate legislative arrangements in place the scheme could presumably be funded through an actuarially determined premium charge against Commonwealth Government general revenues.

The value of an insurance style premium should instead be judged in terms of whether it can offer a superior and robust support for a guaranteed entitlement. If not, the administration costs of an insurance funding mechanism could outweigh any benefits if it failed to support entitlements and avoid rationing of services. Furthermore any failure to fully guarantee entitlements could undermine community acceptance of the premium contribution.

The Disability Investment Group Report[12] suggested that a "fully funded" scheme may not be achievable. One issue is how the additional care and support costs associated with existing disability are funded – ie whether current premium payers should meet costs associated with past as well as current and future prevalence. The alternative approach would be to set the premium to meet the costs of new entrants only, with (enhanced) general Commonwealth government revenues

---

[11] Rolling five year average of year on year nominal GSP growth

[12] The Way Forward: A New Disability Policy Framework for Australia, Report of the Disability Investment Group, September 2009

meeting the costs of existing disability. To the extent that the scheme did rely at least in part on appropriations from general revenue the governance framework will need to ensure that mechanisms were in place to guarantee entitlements. A regular and public independent assessment of current and future funding requirements may be warranted to transparently highlight emerging costs and funding implications.

If there is to be a separate premium or levy, it should be:

- acceptable and affordable to the community;
- applied on the broadest base possible;
- applied in a way that minimises administration and collection costs, ideally piggybacking on an existing broad based revenue collection mechanism.; and
- structured in a manner that takes into account capacity to pay.

If an insurance arrangement were to be pursued it would not be necessary to load the premium with a profit margin or seek dividend returns to Governments. South Australia’s workers compensation and motor accident schemes do not make dividend payments to the South Australian Government. Given the long term nature of the liabilities it may not be necessary for the premium setting arrangements to be slavishly attuned to a full funding requirement in relation to the entitlements that it supports. Given inherent volatility in investment and financial markets a fixed funding ratio target can introduce significant volatility in premiums when investment returns and discount rates move erratically.

Consideration would need to be given to risks that may impact on the viability of the scheme and the premium requirement (such as injuries arising from acts of war, terrorism or airline disasters) and other coverage issues such as foreign residents injured in Australia, Australian residents injured overseas and acts of self harm.

Governance

Currently the role of the State Government in disability services is manyfold - as a service provider, purchaser and regulator. The State Government (through Disability SA) is the largest specialist disability service provider in the State, as well as the principle provider of equipment for people with disabilities through the Domiciliary Equipment Scheme, operated by Domiciliary Care SA. Under a National Disability Scheme the ‘marketplace’ for services may look very different, given people with disability will be able to purchase from whichever service provider they choose.

Changes to purchasing arrangements will have significant impacts on existing service delivery agencies that are currently grant funded, and as such have their on-going viability and continued demand assured to some extent.

The governance framework for a National Scheme needs to have regard to the funding model. If the scheme was wholly reliant on funding from general government revenues on a pay as you go basis it could conceivably be administered nationally through a government department structure.

Under an insurance premium or levy style approach to funding, the goal would be to maximise the potential to support guaranteed access to services. To feasibly meet this objective it would need some independence from annual budget processes. A national statutory authority with an independent board could be established which has a fiduciary duty to maintain a viable scheme and an ability to set relevant premium levies (at least for the entitlement aspect of the scheme). The legislative framework would set out the eligibility rules, service entitlements, funding arrangements, accountabilities and responsibilities of various bodies that may be involved including accreditation arrangements. Nationally consistent legislation and criteria would ensure equity of treatment and portability of entitlements when clients move between States.

A national scheme that delivers care and support services to all who experience severe disability does not necessarily mean, however, that local solutions to the delivery of such support could not be accommodated.

One option is to establish a framework with the following division of responsibilities:

- A National Disability Authority that acts as the fund holder and manager is responsible for the broad eligibility criteria, service definitions and assessment tools, research and data management;

- Case management responsibilities funded through State or regionally located bodies that are either part of the National Authority or other parties with relevant expertise and interest eg State and Territory government disability departments, accident schemes or other non government bodies. This model could take advantage of, and build upon, existing expertise in catastrophic injury support services where they exist in some jurisdictions; and

- A network of service providers.

The balance between available services and funding requirements will need to be continually monitored. Both clients and funders would need to be given input to decisions made regarding the ongoing structure of the scheme, particularly if there is rapid growth in prevalence or costs of services. An Advisory Board for key stakeholders would be one option to enable ongoing stakeholder engagement – representing interests of clients, service providers, taxpayers/premium payers, Federal and State governments and disability specialists.

Regulation and monitoring of quality of services at jurisdictional level should not be underestimated and any scheme developed would need to address these issues.

Research into clinical practices, particularly those that can help contain long term costs would be a desirable responsibility of the national scheme body.

Given the importance that such a Scheme would assume in the lives of clients and their families, dispute resolution mechanisms would be a desirable feature of the arrangements. These mechanisms should be as transparent and accessible as possible. They may involve independent medical expertise in relation to disputes surrounding care and support requirements and independent arbiters of disputes or complaints about case managers or service providers. It would be preferable to establish structures than can instil confidence in the independence of such parties to resolve disputes rather than rely on more formal legal processes.

For example, within the South Australian WorkCover Scheme there are two independent avenues to assist in the resolution of claims related disputes: Medical Panels and the WorkCover Ombudsman.

The introduction of medical panels in the South Australian Workcover Scheme means that disputes over medical matters are now decided by medical experts, not by non-medically trained arbitrators or members of judiciary, as previously occurred. The Medical Panel provides final and binding determinations on medical questions. This removes the possibility for disputes to be challenged and prolonged, leading to excessive legal costs and delaying rehabilitation.

The Office of the WorkCover Ombudsman provides free advice and assistance to injured workers and employers who have a complaint about the way services are delivered in the South Australian WorkCover Scheme. It is an independent Office that investigates complaints about the operation of the WorkCover Scheme and reports problems with the Scheme to the Minister for Industrial Relations. The WorkCover Ombudsman's office has the authority to independently analyse complaints and patterns and make recommendations to improve systems and processes.

Workforce issues

When considering a funding framework, the full cost of disability service provision including workforce capacity should be considered.

The number of employees currently working in the disability sector is not easy to quantify. However, available data on the number of employees in the community services and health workforce reflects an increasing trend in service demand. Disability worker categories are among the highest predicted growth occupations with predicted growth of 3.7% per annum to 2014 (DEEWR2010).

However, it is known that the disability sector in South Australia faces challenges in workforce development. The sector is characterised by fragmentation with no sector wide strategy for workforce development. The disability sector does not include funding for training paid carers. The health sector is currently providing this training without remuneration.

Disability services are a low wage sector with high demand jobs. Employers struggle to fill jobs and find it difficult to satisfy the skill needs. This, and the manner in which agencies are funded, leads to a common use of casual, short contract and part time labour.

The workforce issues associated with the proposed National Scheme are substantial and include:

- The impact of increased competition between existing and national schemes on existing workforce pool both from a service provider and administrative perspective;

- Service provider capacity and capability. Skill shortages currently exist in the attendant care industry. There would need to be some lead time to recruit and attain appropriate accreditation. Accreditation processes need to reflect the developments in aged care to streamline management, regulation, cost management and delivery of services. Provision should be made within the new system to fund nurses or health professionals who could deliver this training. The process for accreditation of overseas qualifications should be reviewed and discussed with assessment and immigration authorities. Regional access and infrastructure is also an issue;

- Eligibility and assessment process – medical professionals may require training and accreditation in the use of chosen assessment tools. Staff would need to be accredited/appointed to deal with eligibility disputes;
- Staff for any National Scheme operation based in South Australia – skill shortages in experienced claims management staff and allied health professionals who would be considered for these roles; and
- Impact on existing government administrative staff involved in current activities transferred to national scheme.

Appendix 1: Primary conditions and severity reported in SDAC CURF defined to met the eligibility threshold for disability services in SA

code	Primary condition	Limitation in core activities			
		Prof	Severe	Mod	Mild
Certain infections and parasitic diseases					
100	Certain infections and parasitic diseases	no	no	no	no
Neoplasms (tumours / cancers)					
204	Breast cancer	no	no	no	no
205	Prostate cancer	no	no	no	no
299	Other neoplasms (tumours / cancers)	no	no	no	no
Diseases of the blood and blood forming organs and certain disorders involving the immune system					
300	Diseases of the blood and blood forming organs and certain disorders involving the immune system	no	no	no	no
Endocrine, nutritional and metabolic disorders					
401	Disorders of the thyroid gland	no	no	no	no
402	Diabetes	no	no	no	no
404	High cholesterol	no	no	no	no
499	Other endocrine and metabolic disorders	no	no	no	no
Mental and Behaviour disorders					
500	Mental and behavioural disorders n.f.d.	no	no	no	no
511	Dementia	no	no	no	no
512	Schizophrenia	no	no	no	no
513	Depression / mood affective (excluding postnatal depression)	no	no	no	no
521	Phobic and anxiety disorders	no	no	no	no
522	Nervous tension / stress	no	no	no	no
530	Intellectual and developmental disorders n.e.c.	Yes	Yes	Yes	No (0-14) Yes (15-64)
531	Mental retardation / intellectual disability	Yes	Yes	Yes	No (0-14)

code	Primary condition	Limitation in core activities			
		Prof	Severe	Mod	Mild
					Yes (15-64)
532	Autism and related disorders (including Rett's syndrome and Asperger's syndrome)	Yes	Yes	Yes	no
595	Attention deficit disorder/hyperactivity	no	no	no	no
596	Speech impediment	no	no	no	no
605	Alzheimer's disease	no	no	no	no
599	Other mental and behavioural disorders				
	30% Psychiatric	no	no	no	no
	70% Intellectual	Yes	Yes	Yes	No (0-14) Yes (15-64)
Diseases of the nervous system					
604	Parkinson's disease	Yes	Yes	Yes	no
607	Multiple sclerosis	Yes	Yes	Yes	no
608	Epilepsy	Yes	Yes	no	no
609	Migraine	no	no	no	no
611	Cerebral palsy	Yes	Yes	Yes	no
612	Paralysis	Yes	Yes	no	no
613	Chronic / post viral fatigue syndrome	no	no	no	no
699	Other diseases of the nervous system	Yes	Yes	Yes	no
Diseases of the eye and adnexa					
703	Retinal disorders / defects	Yes	Yes	no	no
704	Glaucoma	Yes	Yes	no	no
707	Sight loss	Yes	Yes	no	no
799	Other diseases of the eye and adnexa	Yes	Yes	no	no
Diseases of the ear and mastoid process					
802	Diseases of the middle ear and mastoid	Yes	Yes	no	no
803	Diseases of the inner ear (except noise induced deafness)	Yes	Yes	no	no

code	Primary condition	Limitation in core activities			
		Prof	Severe	Mod	Mild
804	Tinnitus	Yes	Yes	no	no
810	Deafness / hearing loss	Yes	Yes	no	no
811	Deafness / hearing loss—noise induced	Yes	Yes	no	no
812	Deafness / hearing loss—congenital	Yes	Yes	no	no
899	Other diseases of the ear and mastoid process	Yes	Yes	no	no
Diseases of the circulatory system					
910	Heart disease	no	no	no	no
913	Angina	no	no	no	no
914	Myocardial infarction (heart attack)	no	no	no	no
919	Other heart diseases	no	no	no	no
922	Hypertension (high blood pressure)	no	no	no	no
923	Stroke	Yes	Yes	Yes	no
929	Other diseases of the circulatory system	no	no	no	no
Diseases of the respiratory system					
1002	Bronchitis / bronchiolitis	no	no	no	no
1003	Respiratory allergies (excluding allergic asthma)	no	no	no	no
1004	Emphysema	no	no	no	no
1005	Asthma	no	no	no	no
1099	Other diseases of the respiratory system	no	no	no	no
Diseases of the digestive system					
1101	Stomach / duodenal ulcer	no	no	no	no
1102	Abdominal hernia (except congenital)	no	no	no	no
1103	Enteritis and colitis	no	no	no	no
1104	Other diseases of the intestine	no	no	no	no
1199	Diseases of the digestive system	no	no	no	no
Diseases of the skin and subcutaneous tissue					

code	Primary condition	Limitation in core activities			
		Prof	Severe	Mod	Mild
1202	Skin allergies (Dermatitis and Eczema)	no	no	no	no
1299	Other diseases of the skin and subcutaneous tissue	no	no	no	no
Diseases of the musculoskeletal system and connective tissue					
1301	Arthritis and related disorders	Yes	no	no	no
1303	Back problems (dorsopathies)	Yes	no	no	no
1304	Repetitive Strain Injury / Occupational Overuse Syndrome	no	no	no	no
1306	Other soft tissue / muscle disorders (including Rheumatism)	no	no	no	no
1307	Osteoporosis	no	no	no	no
1399	Other diseases of the musculoskeletal system and connective tissue	Yes	no	no	no
Diseases of the genitourinary system					
1401	Kidney and urinary system (bladder) disorders (except incontinence)	no	no	no	no
1405	Menopause disorders	no	no	no	no
1499	Other diseases of the genitourinary system	no	no	no	no
Certain conditions originating in the perinatal period					
1500	Certain conditions originating in the perinatal period	Yes	Yes	no	no
Congenital malformations, deformations and chromosomal abnormalities					
1600	Congenital malformations, deformations and chromosomal abnormalities	Yes	Yes	Yes	no
Symptoms, signs and abnormal clinical and laboratory findings n.e.c.					
1701	Breathing difficulties / shortness of breath	no	no	no	no
1704	Pain n.f.d.	no	no	no	no
1705	Unspecified speech difficulties	no	no	no	no
1799	Other symptoms / signs and abnormal clinical and laboratory findings n.e.c.	no	no	no	no
Injury, poisoning and certain other consequences of external causes					

code	Primary condition	Limitation in core activities			
		Prof	Severe	Mod	Mild
1801	Head injury / acquired brain damage	Yes	Yes	Yes	no
1802	Arm / hand / shoulder damage from injury / accident	Yes	no	no	no
1804	Leg / knee / foot / hip damage from injury / accident	Yes	no	no	no
1808	Complications / consequences of surgery and medical care n.e.c.	no	no	no	no
1899	Other injury / poisoning and certain other consequences of external causes	Yes	no	no	no
2003 codes which have no ICD-10 equivalent					
1904	Restriction in physical activity or physical work	no	no	no	no
1907	Other 2003 codes which have no ICD–10 equivalent	no	no	no	no
Not applicable					
0000	Not applicable	no	no	no	no

Nfd – not further defined

Nec – not elsewhere classified

Appendix 2: WorkCover SA Serious Injury Claims

Currently within the WorkCover Scheme, those workers who require the highest level of support and services due to the seriousness of their injuries are categorised as ‘serious injury’ claims. The classification of these claims seems to closely align with existing catastrophic injury definitions and would most likely include people who may be eligible for the services the National Disability Scheme may offer.

WorkCover provides our claims agent with an *Injury and Case Management Manual* (ICMM) to assist them in making case management decisions. *Chapter 11A Social Rehabilitation Requirements* of the ICMM includes:

- how ‘serious injury’ claims are identified and classified
- workers entitlements to compensation – reasonable costs, reasonably incurred
- examples of social rehabilitation and ancillary entitlements.

This document is to be separately provided to the Productivity Commission.

Serious injury claims

Beginning in 2006, WorkCover undertook a body of work to identify those workers who required the highest level of support and services due to the seriousness of their injuries. The serious injury definition was developed following research and consultation with other jurisdictions and organisations within Australia and internationally.

‘Serious injury’ claims are recognised as those claims where the worker has sustained a physical trauma which is potentially life threatening. Serious injury includes:

- moderate to severe traumatic brain injury;
- spinal cord injury;
- amputation of a limb;
- severe burns;
- total blindness;
- brachial plexus injury that results in the loss of the use of a limb; and
- multiple (two or more serious injury types)

where that trauma may result in:

- severe loss of functional ability;
- significant permanent impairment; and
- a requirement for long-term care services.

In collaboration with the two major trauma hospitals in South Australia – the Royal Adelaide Hospital and Flinders Medical Centre, WorkCover has formalised an early notification process for serious injuries to provide early support and intervention for the immediate needs of workers and their family members. The early notification process supports social workers to organise interim accommodation, child care and travel and helps to alleviate concerns regarding income payments by ensuring the claim is received and determined as quickly as possible.

WorkCover's claims agent, Employers Mutual, has a dedicated 'serious injury' claims unit to focus on the different needs and goals of this claims cohort. Please find below data illustrating the incidence of serious injury claims within the Scheme.

Figure 1 - Number of serious injury claims received per financial year

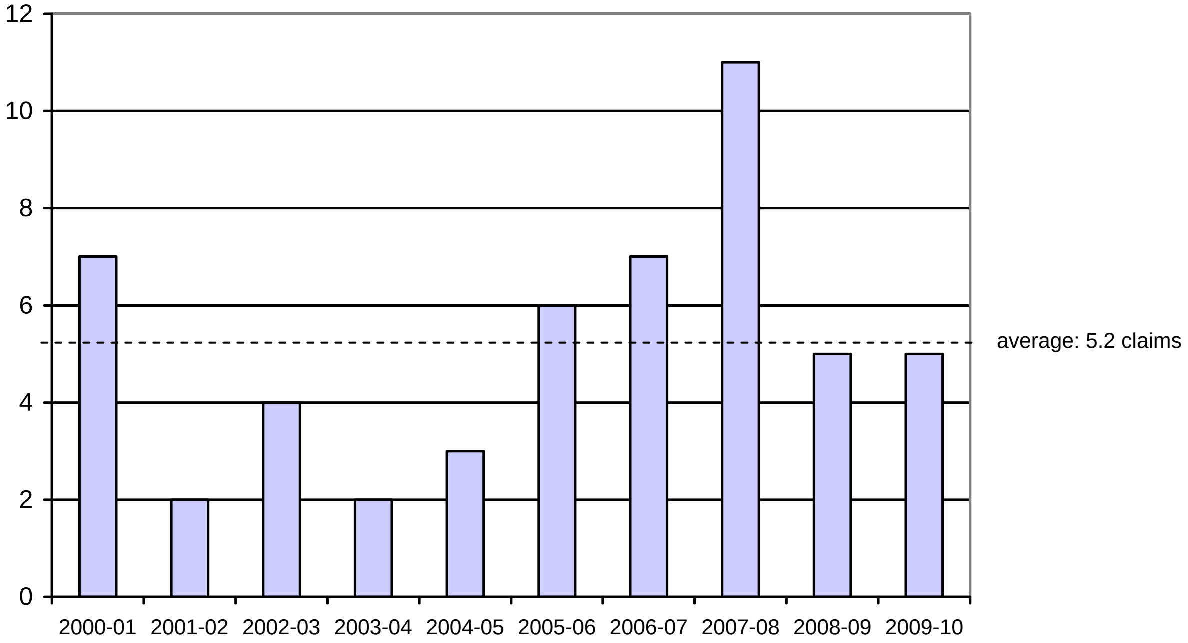


Table 1 – Number of serious injury claims by type of injury

Type of serious injury	**Claims received**	**Active claims**
moderate to severe traumatic brain injury	25	20
spinal cord injury	23	22
amputation of a limb	14	12
severe burns	4	1
total blindness	0	0
brachial plexus injury that results in the loss of the use of a limb	2	2
multiple (two or more serious injury types)	13	11
TOTAL	81	68

Compensation and services available to injured workers

Under the WorkCoverSA Scheme a range of services are available to injured workers. The conditions for their provision are outlined in the *Workers Rehabilitation and Compensation Act 1986* (the WRCA). The structuring of the provisions outlined below are all designed to aid in the workers rehabilitation and recovery and encourage timely return to work and the community were possible.

Income Maintenance

Where a worker is incapacitated for work as a result of a compensable disability they are entitled to receive weekly payments known as ‘income maintenance’. The amount paid under this entitlement (notional weekly earnings) is calculated with consideration for the workers average weekly earnings over the preceding 12 months of relevant employment.

During the first entitlement period (between 0 and 13 weeks) a worker is entitled to receive 100% of their notional weekly earnings. In the following entitlement period (weeks 14 to 26) a worker is entitled to receive 90% of their notional weekly earnings. During the third entitlement period (between weeks 27 and 130) a worker is entitled to receive 80% of their notional weekly earnings. Where a worker is able to partially return to work with reduced hours, they are entitled to receive income maintenance to top up their wages.

Once an injured worker has been in receipt of income maintenance for 130 weeks, a ‘work capacity review’ is undertaken to access their capacity to return to work or increase their working hours either on a part-time, full-time or casual basis. The review provides a check point to ensure injured workers, where possible, are returning to work in a timely manner. Following the review, the worker will have their income maintenance payments adjusted to reflect their capacity to work.

Medical expenses

Some of the services that WorkCover will reimburse the costs of include:

- medical services
- hospitalisation and associated medical, surgical and nursing services
- rehabilitation
- travel to any place for the purpose of receiving medical treatment
- accommodation, where a worker is required to be accommodated away from home for the purpose of receiving medical treatment
- therapeutic appliances
- medicines and other materials prescribed or recommended by a medical expert

Lump sum compensation for non-economic loss

An injured worker who suffers a compensable disability resulting in permanent impairment is entitled to compensation for non-economic loss by way of a lump sum payment. This payment is conditional on the following factors:

- the permanent impairment is assessed at 5% or more of whole body impairment
- the lump sum payment is not applicable to psychiatric impairment
- the degree of impairment must be assessed by a WorkCover accredited medical practitioner.

Currently, the maximum amount for a lump sum permanent impairment payment is $426,255 (indexed annually).

Other services (social rehabilitation)

Social rehabilitation is the provision of services, activities or appliances, based on assessed needs that support an injured worker's independence, activities of daily living and reintegration into the workforce. Social rehabilitation entitlements include, but are not limited to:

- domestic and gardening help
- housing modifications
- travel and accommodation
- child care services
- respite care
- family counselling
- provision of appliances and equipment eg, wheelchairs, crutches etc

Examples of commonly requested items for various injury types are outlined in the attached ICMM chapter, as a guide for case managers.

Who decides?

Section 32(1) of the WRCA entitles an injured worker to be compensated for reasonable costs that are reasonably incurred as a consequence of having suffered a compensable disability. Costs for services will be met only where the services are required as a result of a compensable disability. Reasonable costs are determined by the claims agent with regard to:

- the nature of the service
- the necessity of the service
- the relationship to the injury
- the number and frequency of services
- the benefit to the worker
- the cost of the service.

In order to determine the necessity of a service, all available information, including medical reports, should be utilised. Although the WRCA does not define the term 'reasonably incurred,' it means that the worker acted reasonably in obtaining the service and in engaging providers to deliver the service. In determining whether a cost has been reasonably incurred, the worker must be accepted as they are, and in the process consideration should be given to issues like:

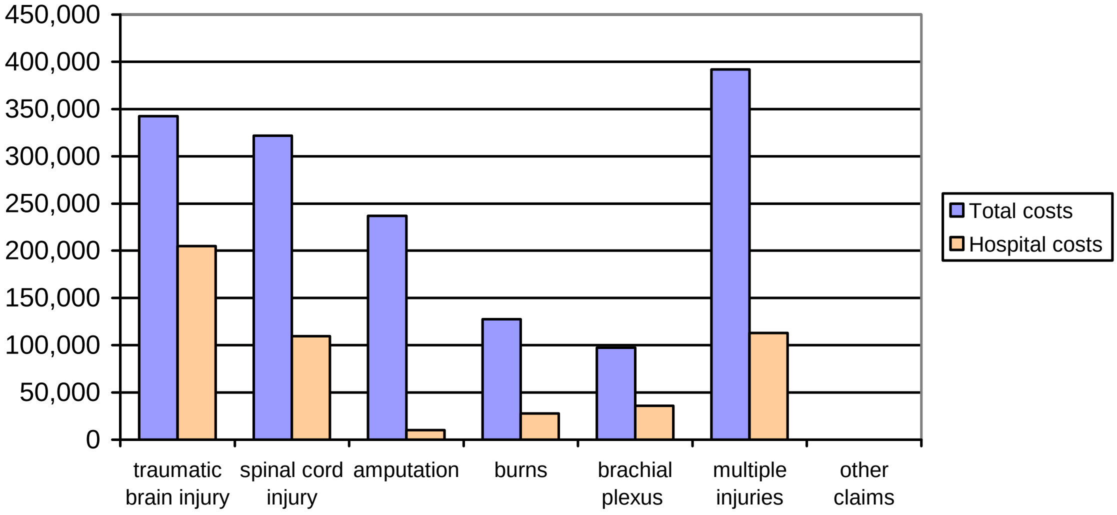
- their personal and cultural background
- their means of obtaining knowledge about the service
- any professional advice they may have been given.

A worker is not obliged to choose the cheapest or most conventional available treatment, and generally speaking, where a worker acts upon apparently reputable medical advice, the worker will be considered to be acting reasonably, even if the advice is wrong or incompetent.

However, where a worker incurs a cost for a service that the worker knew would be of little or no benefit or where the same benefit could have been obtained much less expensively, the worker may not be considered to have acted reasonably in procuring the service and undertaking to pay the cost.[13]

Below is a very broad picture of the costs associated with serious injury claims.

Figure 2 –Average total costs per active serious injury claim by type of injury



---

[13] WorkCoverSA, *Injury and Case Management Manual*, Chapter 11A: Social rehabilitation entitlements, 2009.

Appendix 3: Home and Community Care (HACC)

The Home and Community Care (HACC) program supports people of all ages with moderate, severe or profound disability and their carers. It provides basic services to maintain independence and community connections. The program recognises that providing small and basic services to help people live in the community can delay or prevent more costly intervention such as long-term residential care.

Eligibility for HACC services is based on people experiencing difficulty in carrying out tasks of daily living without help and need assistance due to an ongoing moderate, severe or profound functional disability. The HACC target population is based on the numbers of people living in the community with a moderate, severe or profound core activity restriction, as reported in the ABS Survey of Disability, Ageing and Carers.

HACC funding totalled $149.7m in 2008-09, with 38% ($56.8m) State funding and 62% ($92.9m) Commonwealth funding. In 2008-09 there were around 22,500 people receiving HACC services who were under 65 years, 24% of all HACC clients. It is estimated these people received around $56 million of total HACC funding.

HACC services include personal care, domestic assistance, delivery of meals, home maintenance and modification services, respite care, social support and transport.

It has been estimated by Access Economics in 2005 that replacement of the cost of unpaid care provided in Australia is in the order of $30.5 billion a year. This cost-saving to the community needs to be acknowledged. We also need to recognise the rights and needs of carers and not just see them as an extension of the person they care for. The South Australian Government has done this in the *Carers Recognition Act 2005*.

The HACC program provides broader carer services than is available under specialist disability services. In addition to respite care which is also available under disability services and the Commonwealth National Respite Scheme, HACC provides counselling, support, information and advocacy for carers. This helps carers with understanding and managing situations, behaviours and relationships associated with the caring role. Carer services can be conducted one-on-one or in a group setting. For example, weekend retreats are organised where carers can get together and support each other, while also receiving information useful for their caring role. A carer’s support often enables people with disability to stay at home in the community, to keep their friends and maintain social activities. This can make a significant difference to their overall well-being and capacity to recover.

The South Australian HACC Triennial Plan outlines the strategic directions, priorities and allocation of funds from 2008-09 to 2010-11. In preparing the Triennial Plan, consultations were held with all stakeholders including clients, representative bodies and service providers to seek their input into the type and quantity of services that were needed in each State Region. Growth funding each year is applied to the service types and regions identified in the Triennial Plan.

For 2008-09, total HACC funding grew by $11.1m or 8% to $149.7m. Of the $11.1m growth funding available in 2008-09:

- $8.1m was allocated to new and expanded HACC services; and
- $3m was allocated as indexation for existing recurrent HACC funded projects.

An additional $2.2m was also allocated to one-off research and development projects.

Appendix 4: D-START assessment tool

D-START (Disability Support Training and Resource Tool), which is being developed by the University of Adelaide and the Disability SA, is an assessment instrument which aims to assess support needs for service provision and transparent and equitable funding across disability services. It is designed to be used for people with different types, levels and combination of disabilities.

The assessment is comprehensive, assessing needs, capabilities and aspirations of people, including assessment domains for:

- medical and health;
- activities of daily living;
- functional skills;
- behaviour support;
- personal factors; and
- environmental factors.

The tool can be used by health professionals or the person themself or with someone who knows them well, such as a family member or carer, enabling consistency to be assessed.

The assessment generates estimates of support needs for individual and group program planning and resource allocation, captures likely future needs enabling forward resource planning, and provides a responsive and flexible approach to the management of support packages (eg. self-managed funding).

It is intended that, when fully developed, D-Start will also include a range of features such as:

- a brief assessment form (for use in screening/intake);
- individual service plans;
- group/agency reports;
- links to resources; and
- attachment of existing specific clinical tools.

Appendix 5: Women and Disability

It is of concern that very few data sets published about disability disaggregate data on the basis of gender. The Australian Institute of Health and Welfare is one example of where disaggregated data is available.

Women are less likely to access Government funded services for people with disabilities than are men, but disaggregated data related to gender is required to examine this with greater nuance.

Women with Disabilities and Poverty

Women with disabilities are amongst the poorest groups in Australian society.[14] Only 9% of women with disabilities are engaged in full-time work compared with 21% of men with disabilities. Women with disabilities are more likely to be in casual, part-time, short-term and low paid positions.[15] What this means is that women with disabilities are less likely than men to have the resources to cope with disability related expenses. Further, as women with disabilities age their disability expenses increase sharply compared with their male peers and non-disabled women.

As women with disabilities reach retirement with less superannuation and are more likely to be dependent on the Age Pension as their major source of income in old age.

Housing

Women with disabilities are particularly vulnerable in their housing tenure mostly due to their low-income status. Decreasing housing affordability and issues related to lack of suitable housing stock for persons with disabilities are also issues. Housing status has been shown to have correlations with measures of health and wellbeing.

Women as the primary carers of people with disabilities

> *“The provision of care is a highly gendered activity, which reproduces inequality between men and women. More women than men provide both paid and unpaid care”* [16]

The feminised nature of caring has very real impacts upon women’s income over the course of their lifetimes, whether because of interrupted work force participation or because of the low remuneration rates for workers in the disability services sector.

In Australia girls are only slightly more likely than boys to be a young carer, although they are significantly more likely to be a primary carer.[17] The time that young carers spend caring impacts on their education and workforce participation and can have impacts on income across the whole of their lie cycle.

---

[14] Saunders, P. (2006) The costs of Disability and the Incidence of Poverty. SPRC Discussion Paper No. 147. Social Policy Research Centre, University of NSW.

[15] Women with Disabilities Australia (WDDA) (2004) Submission to the Standing Committee on Employment and Workplace Relations Inquiry into Increasing Participation in Paid Employment. Available at: http://www.wwda.org.au/employsub.htm

[16] Adams, Valerie (forthcoming). Scoping the Australian Care Economy. A Gender Equity perspective. Canberra, Security4Women.

[17] AIHW, 2009. Disability Support Services 2007-2008: national data on services provided under the Commonwealth State/ Territory Disability Agreement.

Women with disabilities as carers of older people

Many informal women carers experience poor health and disability themselves.

"…a significant proportion (59%...) had a disability and around… (13%) had a severe or profound care activity limitation."[18]

Violence against Women with Disabilities

Compared to non-disabled women, women with disabilities[19]:

- experience violence at higher rates and more frequently;
- are at a significantly higher risk of violence;
- have considerably fewer pathways to safety;
- tend to be subjected to violence for significantly longer periods of time;
- experience violence that is more diverse in nature; and,
- experience violence at the hands of a greater number of perpetrators.

---

[18] Commonwealth of Australia, Australian Institute of health and Welfare (AIHW), 2007. Older Australians at a Glance (4th ed.). Canberra, AIHW, p. 34.

[19] Barile 2002, Abramson et al 2000, Jans & Stoddard 1999, Frantz et al 2006, Gilson et al 2001, Myers 1999, Curry et al 2002, Nosek et al 2003, Powers et al 2002, Hoog 2003, Nosek 1996, Curry 2002

Appendix 6: Department of Health' Agency Coordination Initiatives

In South Australia the Department for Health works closely with the disability sector to identify and implement strategies to enhance continuity of care for people with disabilities accessing the hospital system. For existing disability clients, disability services staff advise the hospital of an admission and this allows discharge planning to commence on admission. Early identification of client need ensures a more streamlined discharge with appropriate services and support.

Agreements are also in place between SA Health and disability services that enable carer support people who are known to the person with a disability to be funded by SA Health for the provision of support during their hospital stay.

The transition of people with a disability from hospital to appropriate ongoing services and/or accommodation requires significant coordination. Disability SA maintains a hospital priority waiting list and is in constant contact with SA Health to plan hospital discharge. This has at times had the unintended consequence of people being admitted to hospital or being maintained in hospital rather than moved to a more appropriate care setting, such as respite, for the purpose of maintaining a place on the hospital priority list for services.

Given the significant impact of delayed hospital discharge on the health system, SA Health has recently committed recurrent funding as part of the disability component of the *Every Patient – Every Service* South Australian Government election commitment. The intent of this funding is to provide short term, interim supports until required long term disability supports are available.

In coordinating the response to this initiative between SA Health and disability services, the complexities associated with increasing service demands and funding constraints for the disability sector have been noted. These constraints impose potential barriers on the flow through of patients from the acute to the community sector. A particular concern of the disability sector relates to the low level of turnover in their programs which limits their capacity to incorporate any additional activity once a transition period has been completed through the use of these new funds.

Any investment by SA Health to meet the needs of long stay hospital patients is not likely to achieve the desired outcome without investment into the long term disability support sector to reduce service blockages in the longer term.

For people with a psychiatric disability, care coordination to improve linkages and provide a seamless service between mental health rehabilitation and psychiatric disability support will help ensure these people get the services they need. This includes those people who transition through the criminal justice system.

For people with a disability in country South Australia

Small populations, remoteness and workforce availability pose particular problems for the provision of services for people in rural and remote communities in South Australia. SA Health is the major provider of health and aged care services in country South Australia. SA Health also provides a range of services to people with a disability that fall through current service gaps. This includes people who are not eligible for disability services as well as service areas that lack the resources to provide the necessary support. Most of these clients have very complex needs and are at risk if not assisted by SA Health.

The issues relating to the waiting times for disability services in country SA are similar to that in the metropolitan area. For example the lack of long term accommodation options means a number of younger people with disabilities are currently accommodated in the residential aged care sector.

Under the Multi Purpose Services (MPS) Program funding is pooled in country SA to provide a range of health and aged care services. Similar flexibility in funding arrangements for disability clients could enable innovative solutions. A client centred system would allow people to purchase services that could be contracted either from government or private providers.

Service delivery efficiencies could also be improved by having the same service provider manage care coordination, case management and service delivery aspects of disability services. This currently does not occur in country SA, with health services often filling the gaps in service provision.

Country disability service providers could be further assisted and supported through establishing clear links with metropolitan services for specialist advice and the use of technology for assessment and therapy, such as telemedicine.

Appendix 7: Disability SA’ prioritisation strategy

The limited funding available to Disability SA requires them to prioritise services. Decisions are made by Disability SA about priority are based on a range of vulnerability indicators, such as homelessness, access to services, age, health, and capacity of carer, family situation and isolation. People in the following vulnerable groups are considered to have urgent need:

- Children or young people under the Guardianship of the Minister;
- People with rapidly deteriorating neurological conditions;
- Aboriginal people with disabilities;
- People with disabilities in acute care settings awaiting discharge; and
- People under 50yrs age in danger of being placed in a nursing home.

Prioritisation in terms of service type is managed by demand. As the system is in crisis there is no great capacity, other than in specific funded targeted programs, to prioritise. All services currently provided are core essential services across the service types and is based on urgent need. Non–core services have been de-funded in South Australia e.g. advocacy services. There is no real planning other than responding to individual urgent priorities.

Appendix 8: Education and Employment Issues

There is currently no national system in the VET sector that provides the additional funding for case management support, assistive technology and support for the reasonable adjustments requirement of the Disability Discrimination Act to assist students with a disability with their study. Many students with a disability need this additional support to achieve successful outcomes in education, training and employment (additional funding support is available for people with disabilities in school education and higher education – the latter funded by the Commonwealth through DEEWR). While individual jurisdictions may provide specific programs for students with a disability, continuity of funding can impact on even successful programs, unless there is an entitlement commitment to provide the required level of support, for example that an insurance program can provide.

Eligibility to an education and/or training place is based on meeting the minimum entry TAFE course requirements. However, many students need assistance to meet the requirements for entry. Access to additional support that will lead to successful completion of training should be based on assessment of individual needs.

A process to assess an individual's capability to work is in place. Currently people are assessed through the job capacity assessment program managed by the Commonwealth through DEEWR. This program "provides comprehensive work capacity assessment, combining referral to employment and related support services with assessment of work capacity for income support purposes (such as Disability Support Pension, partial capacity to work and exemptions from activity-testing due to medical conditions lasting more than 13 weeks)"[20].

Centrelink, Job Services Australia and Disability Employment Services provide assessment and employment support services.

A number of people with disabilities are prevented from participating in post-school education because they require attendant care while studying and there is no funding to cover the training costs for the carer to attend with the student. Standards for Education and the Higher Education Act preclude such support. This will require modification to both the Standards for Education and the Higher Education Act, to allow carers to access training with the person they are supporting.

Services that should be provided in the scheme

Areas of inclusion must include:

Access to funded education and training support including support to gain employment.

- Lack of access to personal care, equipment as it relates to the person's disability, and other services beyond those provided under mainstream services which may be a barrier for people to undertake employment programs
- No nationally identified funding to support participation in training. Many people with a disability require additional supports such as access to personal care, aids, appliances, assistive technology, extra tutorial and mentoring support and additional time to complete programs.

---

[20] www.deewr.gov.au/Employment/Programs/JCA/Pages/default.aspx

Individualised support to achieve learning and employment outcomes, including adequate resources to fund assistive technology, case management support and attendant care, while undertaking education, training and employment.

Aids and appliances. An equity issue currently exists for people with disability undertaking VET in that there is no additional funding to assist VET students, whereas aids, appliances and modifications are funded under national schemes for those participating in employment and higher education.

Evidence of current system

Many people with a disability who have left school have poor literacy and numeracy skills due to their specific disability (learning disorder or intellectual disability), irregular school attendance (mental health problems or family dysfunction), lack of physical access or community attitudes, leading to lower expectations and confidence. These students may need support to address the language, literacy and numeracy abilities they require before they can access mainstream foundation skill type-programs.

Two of the most significant issues for limited disability training funds are the high cost of deaf interpreting and the increasing cost of assistive technology. The technology can be expensive to purchase and requires expert knowledge to make the best coordinated purchases and use of the technology.

The only national funding scheme is the Disabled Australian Apprentice Wage Support scheme which provides wage incentives for employers to take on an apprentice with a disability and provides additional funding to Registered Training Organisations for tutorial, interpreter and mentor services.

The ageing population will have significant impact on the workforce:

- the pool of carers available to support people with disabilities will be under pressure, and
- the ageing population will increase the numbers of people with disabilities

Mandatory requirement for Certificate IV will impact on the workforce requiring greater need for upskilling and access to Recognition of Prior Learning

An increase in the numbers of students with a disability who gain access to training and employment will have cost and workforce implications in both the training and employment sectors to improve the skill range of staff to work with their diverse needs, to adopt a social inclusion and collaborative approach to working across sectors.