

### Victorian Disability Arrangements

The following information is provided in addition to that included in the body of the submission. It includes greater detail on current arrangements in Victoria and is organised by department/agency.

As it is supplementary information, it should be read in conjunction with the submission.

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## Victorian Department of Human Services

According to Australian Bureau of Statistics (ABS) data, the eligible population for disability services in Victoria under the National Disability Agreement is estimated to be 178,400, or just over 4 per cent of all Victorians under the age of 65 years.

The Australian Institute of Health and Welfare (AIHW) reports that in 2006-07, 85,506 Victorians received disability services, equivalent to approximately 48 per cent of the eligible population. Annually, approximately 21,000 Victorians receive employment services funded by the Commonwealth, 32,000 people access the aids and equipment program and there are 22,000 episodes of respite.

Eligibility for government funded Disability Services (DS) is defined by the Act<sup>i</sup> as:

- (a) a sensory, physical or neurological impairment or acquired brain injury or any combination thereof, which:
  - (i) is, or is likely to be, permanent; and
  - (ii) causes a substantially reduced capacity in at least one of the areas of self-care, self-management, mobility or communication; and
  - (iii) requires significant ongoing or long term episodic support; and
  - (iv) is not related to ageing; or
- (b) an intellectual disability; or
- (c) a developmental delay.

Disability supports which are not means-tested vary according to the nature of the disability. For example, support from birth takes a 'whole of life' approach with fluctuating supports based on life stages. Response to degenerative neurological conditions generally focuses on maintenance of skills and community living arrangements with increasing intensity of support. Those with acquired injuries require a rehabilitative intervention, which is more intensive in the early phases then stabilising over time with ongoing need for support to live in the community.

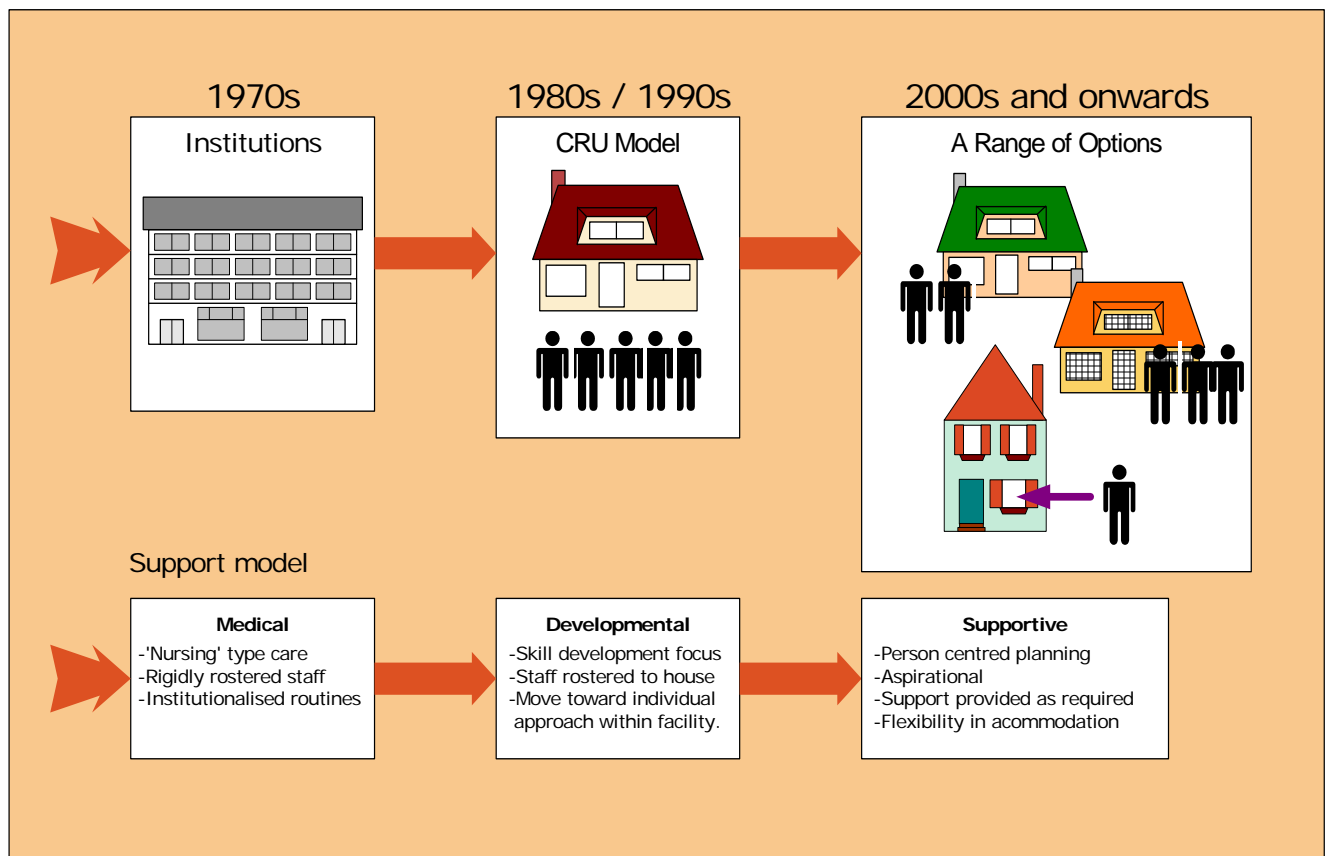
Since 2002, support development and access to services has been underpinned by a State Disability Plan which focuses on community inclusion and improving access to generic community services, recognition and fostering of informal supports and reorienting to a self-directed system of support.

### Models of support and service delivery

Prior to the 1980s, support for people with an intellectual disability was provided as part of mental health services. Seen as a health issue, support was provided through institutions or hospitals. Prior to the 1950s, education for children/adults with a disability was provided on an ad hoc basis. Education services operated from the institutions or hospitals (eg. Yooralla hospital) or provided by not for profit organisations. The 1950s saw parents establish day services for children and adults.

The 1980s saw a significant paradigm shift and reform toward 'normalisation' and inclusion of people with disability. The first deinstitutionalisation occurred alongside the establishment of the first of the community residential units<sup>ii</sup>. Services for people with intellectual disability were separated from mental health services and were governed by a separate Act<sup>iii</sup>. This decade saw a growing investment in a range of regional services. Day services for children were transferred to the then Education Department and in 1991, support for people with physical, sensory and other disabilities was transferred to the States from the Commonwealth<sup>iv</sup>. The service system was primarily focussed on people with intellectual disability.

The next paradigm shift was the development of the Victorian State Plan<sup>v</sup> and the Disability Act 2006<sup>vi</sup>. Both based on social justice and consistent with international policy and research, people with a disability are expected to have the same opportunities to participate in the life of their community. This includes equitable access to government funded services, development of disability action plans and use of community inclusion strategies. Under the Act and Plan, support has become individualised, based on individual choice and individualised planning/funding approaches, including client attached funding and self directed support approaches. Building on this approach, the trend is to individual housing and day opportunities rather than group options.<sup>vii</sup>



There are, however, still legacy/outdated models operating in Victoria, including institutions and old style congregate care.

### Assessment and resource allocation tools

While the Disability Act defines who is considered to have a disability, the Disability Support Register (DSR)<sup>viii</sup> records the current need for ongoing disability support, so that when supports become available they can be allocated in a fair, transparent and efficient way. The DSR is not a wait list and episodic support such as respite, case management and therapy can be accessed directly not via the DSR.

When a person makes an application to the DSR, the department allocates a DSR band level. There are four bands and each DSR band level has a funding range linked to it. Before a person can be funded, there must be a support plan in place – although short term, interim funding can be provided while the plan is developed. NSW has used the SNA and WA has a similar tool.

The current DS system extensively uses Individual Support Packages (ISPs), which can range from low cost, low support to high cost, high support. At the lower intensity end of the continuum, family/carer supports build on generic community services (eg. in-home support, respite) and are geared towards meeting the needs of families to continue to support their family member. At the higher intensity end there are high level ISPs and the 24 hour supported accommodation options.

### How do we treat children and young people under 18 years of age?

The Act has one principle (l) specifically addressing the needs of children and there are another four principles (h, i, j & k) addressing the needs of families.

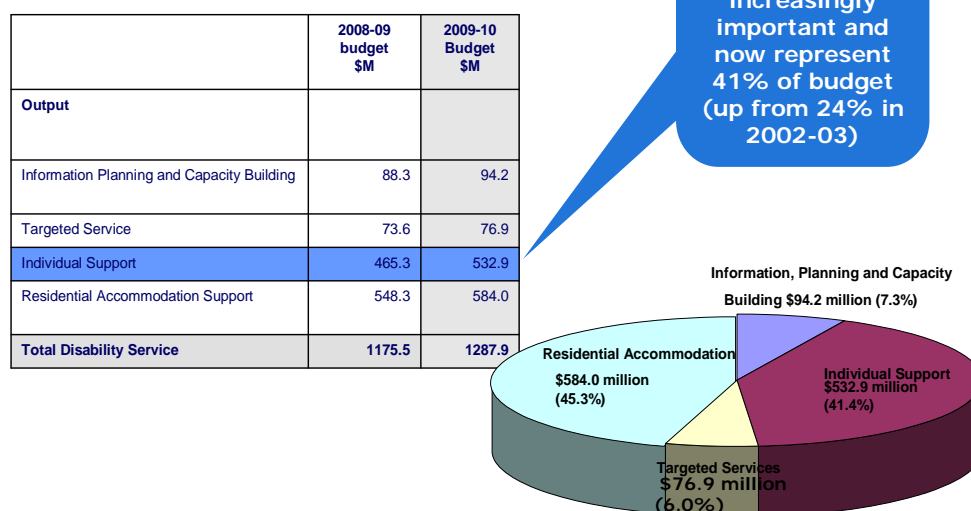
More recently, DS released a statement of principles<sup>ix</sup> for children and young persons. The purpose of the statement is to affirm the Government's commitment to protect and promote the rights of children, young people and their families. They are intended to guide the supports funded or provided by DS.

Since the mid 1990s DS has discouraged the placement of children in group homes and established a family based placement service<sup>x</sup>. Further to this, Futures For Young Adults<sup>xi</sup> aims to ensure that young people transition from schools to an appropriate post school option.

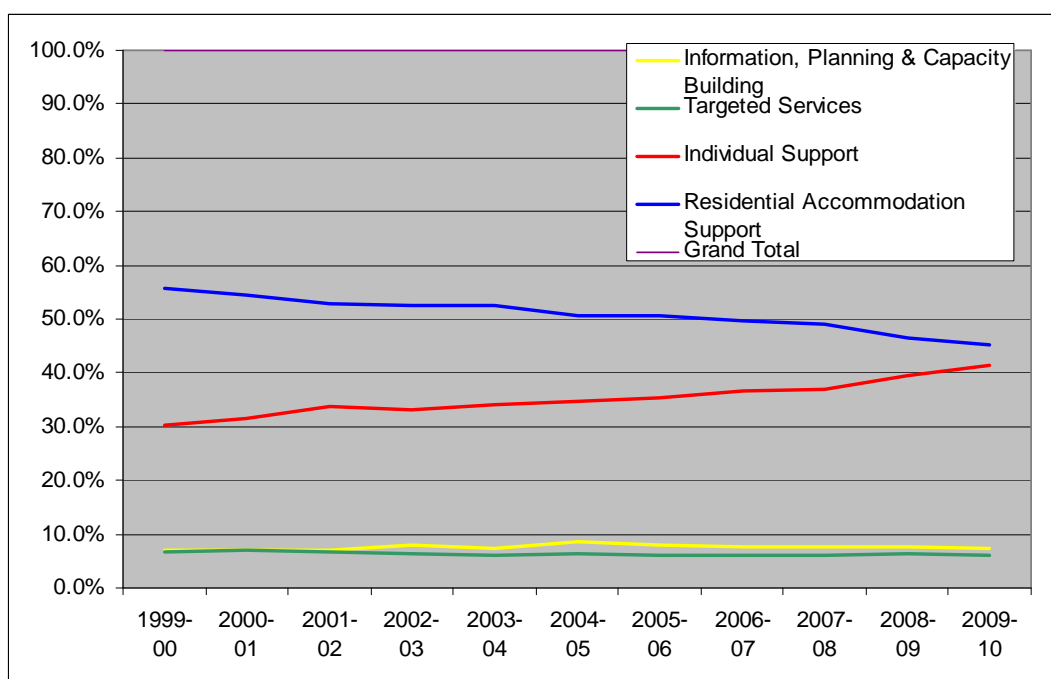
### What services are funded?

The funding of support is regulated by the Policy and Funding Plan 2009-2012<sup>xii</sup>. There are 286 organisations registered<sup>xiii</sup> to provide disability support.

## The 2009-10 budget for Disability Services is \$1,287.9 million



A significant proportion of the DS budget is provided directly to service providers to deliver support to people with a disability<sup>xiv</sup>. A small proportion of the budget is allocated to capacity building including community development, training and industry development. A growing proportion of the DS budget is allocated through Individual Support Packages<sup>xv</sup> (ISPs).



Support outputs<sup>xvi</sup> include:

- Shared Supported Accommodation
- Day services
- Respite
- Case management
- Therapy.

As at 31 December 2009, there were 2,718 people registered on the DSR<sup>xvii</sup> as having a current need for ongoing support services. This included 1,291 people requesting supported accommodation, 1,234 people requesting support to continue to live in the community, and 193 people requesting access to daytime activity services.

### Profile of providers

The majority of the 286 **registered service providers** are non-government, not-for-profit Community Services Organisations (CSOs). Local Government<sup>xviii</sup> is funded to provide some support activities, and a small proportion of funding goes to commercial/for-profit providers.

DS is a large support provider itself. DS manages a large number of the total 4983 SSA beds including the three institutions, and it operates regional client services teams undertaking information, planning and case management, and therapy, criminal justice and behaviour support activities for people with an intellectual disability.

### Children

For children with developmental delay or a disability, both Royal Children's Hospital (RCH) and Monash Medical Centre (MMC) provide significant health services. The Department of Health has funded transition clinics to enable young people too old to attend RCH and MMC children's clinics to transfer to a health service in adult sub acute services.

Health/disability interface:

- Victoria's slow stream rehabilitation program provided to people who have a non compensable Acquired Brain Injury (ABI)
- a developmental disability health service based with the Melbourne and Monash universities' schools of general practice. The role of this service is to support general practitioners with training and in their clinical practice with adults with a disability
- a demonstration project, employing nurse practitioners to provide health care support and care coordination for 300 people with a disability. This aims to improve access to community based health services, and
- a Parkinson's nurse practitioner position in a sub acute health service in the western suburbs (with Department of Health).

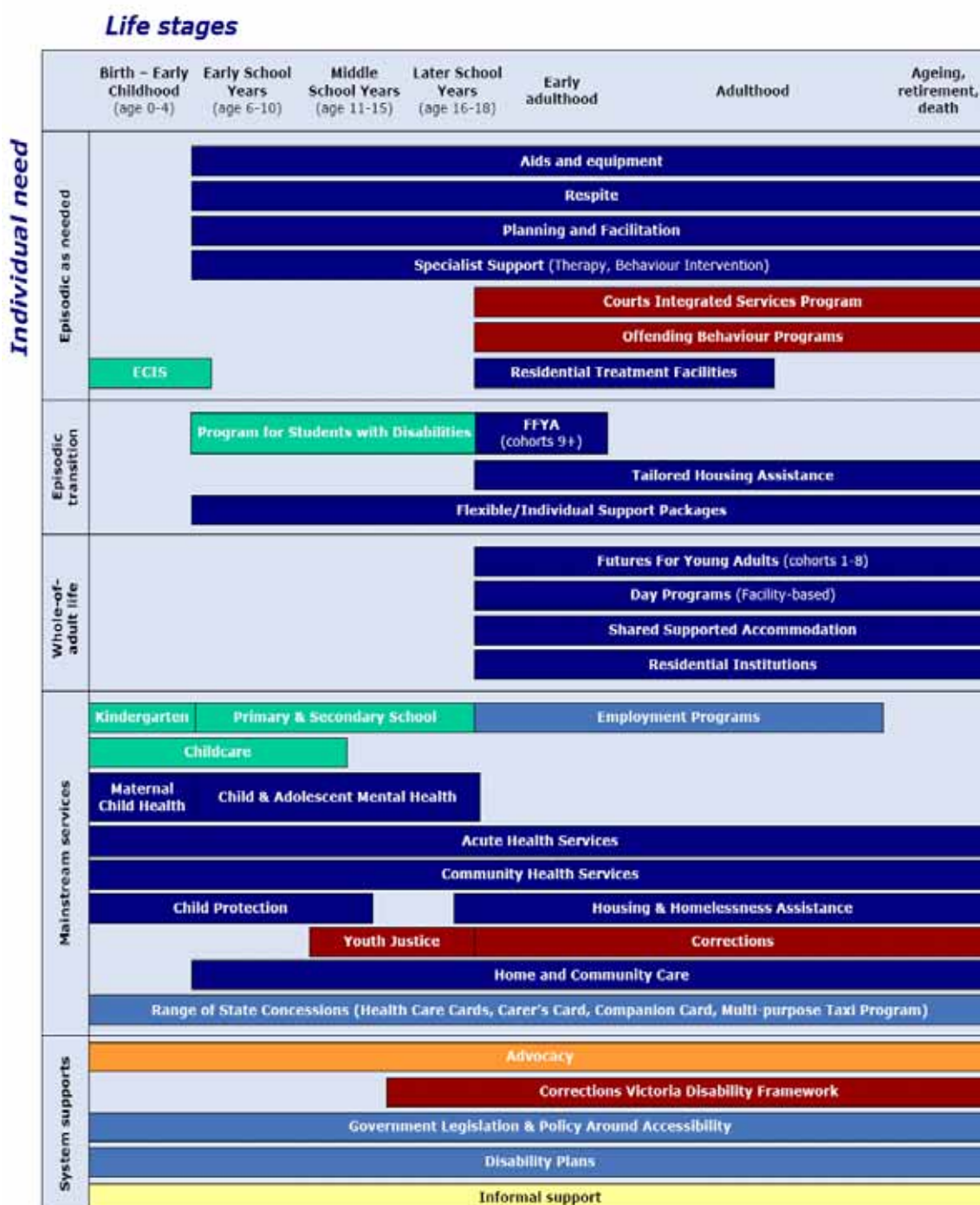


Fig: Whole of Government System of Programs and Services for People with Disabilities

## Transport Accident Commission

The *Transport Accident Act 1986* (The Act) provides for the payment of compensation to all persons injured in an incident directly caused by the driving of a motor vehicle, train or tram in Victoria, or involving a Victorian registered vehicle interstate. The scheme provides for the payment of the reasonable costs of hospital, medical, rehabilitation and disability services in addition to capped income benefits and compensation based on the assessment of impairment. All of these benefits are provided on a no fault basis.

The Act is supported by a comprehensive set of policies, developed by the TAC that deals with eligibility for particular service types.

*Disability services* are generally applicable to persons with **severe injury** and includes services such as attendant care, assistance, accommodation support, community access and household help (refer s.3 of The Act).

*Rehabilitation services* include any aid, treatment, counselling, appliance or other service (other than disability service or hospital service).

The Act provides for the reasonable cost of house and vehicle modifications.

The provision of such services, or persons delivering services is authorised by the TAC (refer s.23 of The Act).

*Severe injury*, as defined in the Act means:

- (a) a significant acquired brain injury (see criteria below), paraplegia, quadriplegia, amputation of a limb, or burns to more than 50 per cent of the body; or
- (b) any other injury specified by the regulations for the purposes of this definition.

The additional injuries prescribed include blindness and a complete brachial plexus injury as well as further clarification of eligibility in relation to full thickness burns.

There are additional benefits payable in relation to severe injuries including transportation costs to and from medical, rehabilitation or a program of disability services and some payments to family members for counselling and visiting expenses when a TAC client is hospitalised. In addition to no fault benefits, eligible TAC clients with serious injuries may also be able to sue for pecuniary loss and pain and suffering damages under part 6 of the Act up to a capped amount.

### Acquired Brain Injury Criteria

Severity in Acquired Brain Injury (ABI) can be indicated by the Glasgow Coma Score (GCS) or length of Post Traumatic Amnesia (PTA). Either of the criteria below needs to be met to allocate new claims with acquired brain injuries to the Community Support Division:

	Community Support	Benefit Delivery
GCS	3 to 8	9+
PTA	7+ days	0 to 6 days

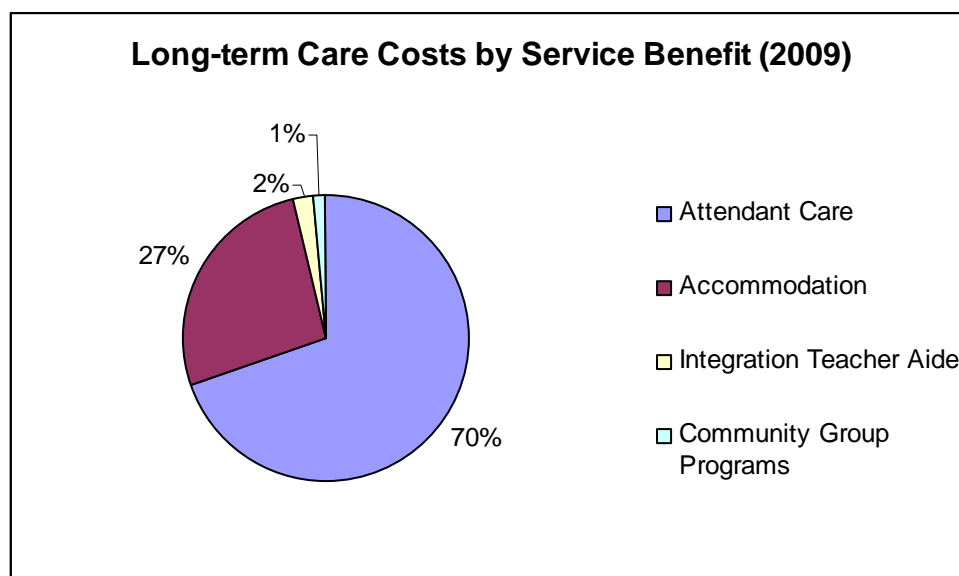


The GCS is the most widely used scoring system applied in quantifying level of consciousness following traumatic brain injury. It is used primarily because it is simple, has a relatively high degree of inter-observer reliability and because it correlates well with outcome following severe brain injury. The higher the GCS, the greater the level of consciousness and the lower the severity of injury.

PTA is the gradual process of a person coming out of coma and can last for hours, days or weeks. The length of PTA is often used as a guide to severity of brain injury with the longer the PTA the more severe the brain injury.

As of 31 March 2010, there were 30,698 active claims at the TAC. Of these active claims, 2,517 were within the Community Support division (excluding fatal claims). Of these 2,517 active claims, 1,375 are considered catastrophic (severe ABI, quadriplegia) and 1,142 are considered non-catastrophic (moderate ABI, paraplegia, blindness, severe burns, amputated limbs).

Long-term care service benefits for these clients totalled \$67.6 million in 2009 (this excludes the cost of home and vehicle modifications and equipment for activities of daily living). Attendant Care and accommodation represent the TAC's largest single liability (more than \$2.5 billion) with benefits for seriously injured clients generally being paid for life.



## Models of support and service delivery

Victoria established the Motor Accidents Board (MAB) in 1974. This was Australia's first no fault scheme. Under the scheme people injured in motor vehicle accidents could claim income benefits, medical, hospital, ambulance and other related services. Claims officers managed the claims for benefits under one claims management model regardless of the nature and severity of the injury. By the mid 1980s the number and cost of no fault claims had increased so rapidly that the MAB scheme had an unfunded liability of \$1600 million.

At fault claims for pain and suffering, permanent disability, impaired earning capacity and the need for future care were administered by the State Insurance Office (SIO). These claims took many years to resolve and persons with serious injury were often under compensated.



To address these issues and establish a scheme that was based on equity and affordability the Victorian Government passed the Transport Accident Act in 1986. This established the TAC compensation scheme that combined both no fault and common law benefits.

## **Claims Management models**

### *Past*

Initially no distinction was drawn between injuries managed, but over time a higher degree of specialisation has occurred with the management of severe injuries. The Major Injury Division was established in 1996 with a group of claims staff dedicated to managing claims from those with severe injuries such as Spinal Cord Injury (SCI) and Acquired Brain Injury (ABI).

The TAC has shifted philosophy over time and most significantly in the last decade, with the introduction of the Lifetime Support Model (LTS) in 2002. This model involves person centred individual planning, for those road accident victims that are reliant on TAC benefits for the rest of their lives. Case Managers were introduced and appointed to help clients develop individual plans to connect them with various support, home, work, leisure and social options in their local communities.

### *Present*

The Major Injuries Division has since been restructured into “Community Support” with specialised teams, including:

- Spinal Cord Injuries
- Acquired Brain Injuries
- Child and Youth.

The TAC continues to seek improved discharge planning and community based supports for clients to encourage as far as possible the maximising of independence of injured clients.

## **Assessment and resource allocation tools**

The TAC will fund income support, medical, rehabilitation and disability services under the *Transport Accident Act 1986*. To assist in determining whether a claims expense is reasonable, assessment is undertaken by medical and authorised paramedical providers. All requests for rehabilitation and disability services need to be clinically justified.

Attendant Care and shared accommodation support services are funded and reviewed regularly. The Lifetime Support (LTS) Panel was established in 2003 to evaluate, review and endorse recommendations for attendant care and shared supported accommodation. Lifetime support services are the TAC’s largest liability and the management of this liability is a key factor in maintaining viability of the scheme. LTS panel reviews have recently been strengthened by the use of comparative Functional Independence Measure (FIM) scores for persons with like injuries. This is to assist in the management of reasonable approvals and the control of future liabilities.

## **Children and young people less than 18 years of age**

Children with severe injuries are managed by a specialised team which has strong links with external providers of children’s services. Working with schools, special education

providers, young clients and their families, this team seeks to prepare for the client's transition from school to the community.

### **What services are funded?**

The TAC funds a range of services including:

- Allied health services such as physiotherapy, occupational therapy and speech therapy;
- Disability services such as attendant care, shared supported accommodation support and Community Group Programs; and
- Education services such as Integration Teacher Aides.

Recent areas of significant growth include Home Modifications (Structural Alterations) and Vehicle Modifications/Purchase. Equipment for activities of daily living (ADL) also represents a significant benefit funded by the TAC.

### **Who chooses what is funded?**

Medical and Allied Health providers recommend rehabilitation services and the other needs of TAC clients. TAC clients choose their own disability support providers.

### **Profile of providers**

The TAC funds the provision of medical, rehabilitation and disability services as a claims expense. The TAC has also funded research in the areas of ABI and SCI through the Victorian Neurotrauma Initiative (VNI) and other research funding.

Since the commencement of the TAC in 1986 the private sector medical and rehabilitation services for ABI have changed and developed to deliver high quality services to TAC clients. This is as a result of research funding and the hospital contracts that the TAC negotiates with private hospital providers.

Specialist medical and rehabilitation services for spinal cord injury are provided by the public hospitals in Victoria. Funding is provided to the Department of Health for services delivered to TAC clients. The TAC is leading and funding the Spinal Community Integration Services (SCIS) pilot in collaboration with the Department of Health and the Department of Human Services. The aim of this program is to improve the provision of services to newly injured Victorians with spinal cord injury to assist them return to home, work and the community.

Disability services are provided by a mix of for-profit and not-for-profit community agencies that are paid fee for service for each client. A high number of TAC clients with severe injury require disability support services for their lifetime. Attendant Care represents the highest liability of any service delivered to TAC clients. It is also an industry that is not regulated and faces workforce challenges such as limited availability and competency of support workers.

### **Fees**

Table 1 compares the schedule of fees for TAC, WorkSafe Victoria, DHS and Home and Community Care (HACC). The differing funding programs and models in the community care sector along with the different types of service providers make comparison of unit prices difficult. TAC and WorkSafe Victoria's indexation rate for 1 July 2010 is 1.7737%. The DHS indexation rate for 1 July 2010 is 3.14%. Table 2 compares fees for allied health services.

**Table 1: Comparison of TAC, WorkSafe Victoria, DHS and HACC Fee Schedules, 2009-10**

Service	TAC		WorkSafe	DHS	HACC
	Non-contracted	Contracted			
Attendant care (per hr)	\$31.07	\$33.85	\$30.50	\$35.06 <sup>1</sup>	\$32.51
Program establishment	\$929.77	\$941.30	\$887.30	-	-
Inactive overnight <sup>2</sup>	\$85.75	\$93.63	\$82.50	-	-
Carer training (per hr)	\$31.07	\$33.85	-	-	-
Approved travel (per km)	\$0.74 per km	\$0.74 per km	0.70 per km	-	-
<b>SSA</b>					
Daily Fee	-	Variable <sup>3</sup>	-	\$443.31	-
Additional Fee	-	Variable	-	-	-
<b>CGP</b>					
Core needs (per hr)	-	\$14.50 <sup>4</sup>	-	\$15,959 pa	\$11.60
High needs (per hr)	-	\$19.85 <sup>5</sup>	-	\$22,753 pa	\$16.30

<sup>1</sup> Personal Support (often called 1:1 support) to assist people with daily activities that they are unable to complete for themselves because of physical, intellectual or other disability.

<sup>2</sup> 8 hour shift inclusive of 1 active hour

<sup>3</sup> Service includes General Care and Support, Personal Care and Hygiene, Coordination, Participation, Liaison with professionals, families and the TAC, Maintenance of Client Documentation and Records. This will vary depending on the support needs of the TAC Client.

<sup>4</sup> Core support - staff to client ratio of 1:3 to 1:5 per hour

<sup>5</sup> High support - staff to client ratio of 1:1 to 1:2 per hour

**Table 2: Comparison of TAC and WorkSafe Victoria Fee Schedules, Allied Health Services, 2009-10**

Service	TAC	Worksafe
Occupational Therapy	Initial Assessment \$48.85	Initial consultation \$49.20
Physiotherapy	Initial Consultation \$58.85	Initial consultation \$85.30
Neuropsychology	\$133.90 per hour	\$137.65 per hour

## WorkSafe arrangements

Legislation governing eligibility and entitlements under WorkSafe is the *Accident Compensation Act 1985*. Other legislation governs other functions of the organisation, including its role as Occupational Health and Safety regulator.

An injury to a worker is compensable under the Act if it arises out of or in the course of employment. WorkSafe pays compensation for approximately 28,000 new claims each year. A range of benefits are provided to injured workers, for life if required. Benefits can include:

- weekly compensation
- ambulance transport
- hospital treatment
- medical and paramedical treatment
- attendant care and home help
- lump sum payments.

All of these benefits are paid on a “no fault” basis.

In addition, an injured worker with a serious injury (as defined under the Act) has the right to sue for damages, at common law.

### Eligibility for Care and Support

All injured workers eligible for compensation under the Scheme are entitled to reasonable costs of care and support. This includes home and vehicle modifications, where appropriate. There is no pre-defined threshold based on the nature or circumstances of the injury for these benefits.

In practice, a small number of injured workers receive the bulk of the benefits paid for care and support. The number of catastrophically injured workers in receipt of benefits is nearing 200, and typically grows by between 5 and 10 new cases per annum. The Transport Accident Commission provides specialist services to catastrophically injured workers, on behalf of WorkSafe. For these purposes a catastrophic injury is defined as follows:

- spinal injury resulting in quadriplegia or paraplegia
- acquired brain injury (ABI) rated as severe or moderately severe.

WorkSafe authorised Agents recommend injured workers for the program, however eligibility must be approved by WorkSafe.

### Models of Support and Delivery

#### Claims management models

WorkSafe has six authorised Agents who administer aspects of the Scheme:

- pay benefits to injured workers
- collect premiums
- manage compensation claims
- provide return to work and risk management advice.

WorkSafe has, for many years, used Authorised agents to undertake the day to day administration of claims and payments. This system operates through delegation of powers under the Act, and performance standards are set out in an Agency Agreement. There is a comprehensive program of engagement, review, monitoring, and audit to ensure compliance with WorkSafe standards of practice. This includes regular client satisfaction surveys of both employers and injured workers to gauge satisfaction with the performance of agents. Each employer selects an Agent from the panel to administer their WorkCover policy.

Until 2007, the care and support needs of injured workers with catastrophic injuries were managed within this same system. There are relatively small numbers of such claims within WorkSafe, and it was felt that an improved level of service and outcomes could be achieved by using specialist resources. In 2007 the TAC was engaged to provide a specialist Community Integration Program to catastrophically injured workers. Since then, this group of injured workers – which numbered around 150 at the time the agreement was established, but has since grown to around 200 - has successfully integrated into the TAC's lifetime support model, evidenced by an increase in their satisfaction with the management of their claims. The key objective of appointing the TAC was to improve the service and outcomes – in particular to improve the long-term care, quality of life and community re-integration of severely injured workers.

Under the agreement, a TAC Support Coordinator takes responsibility for managing the care and support component of the claim for the injured worker. The agent remains responsible for other aspects of the claims management, including entitlement to weekly compensation (income replacement) and assessment of any statutory lump sum entitlement.

### **Assessment and resource allocation tools**

WorkSafe will pay the reasonable cost of medical and like services approved under the Act for a work related injury or illness, where the service meets the following criteria:

- the treatment is for a work related injury or illness
- the provider is currently registered with WorkSafe to deliver the service being provided
- the service is necessary and appropriate
- the cost of the service is reasonable
- the service is specifically provided for in the Act, or approved by WorkSafe under the Act.

The injured worker's medical practitioners and healthcare professionals are primarily responsible for identifying the required medical and like services required. In deciding whether a service is necessary, the agent must consider all available information including:

- reports from treating medical practitioners or independent medical examiners
- medical certificates
- return to work plans
- treatment notification and review forms.

If there are any doubts about the necessity of a treatment, the agent may seek further information by requesting a progress report from the treating doctors(s) or an independent medical examination.

## **What services are funded?**

The injured worker can choose which medical practitioner or healthcare professional they visit.

### *Attendant Care*

Workers are eligible for reimbursement for 'personal and household services', including attendant care. Attendant care is provided to workers to assist with activities of daily living, including:

- personal care – showering, bathing, dressing, toileting, grooming, eating, drinking, preparation of specially prescribed foods, monitoring of medication, assistance with use of specialised equipment
- program implementation – implementation of goal oriented programs, conduct of physical exercise, programs designed to increase skills of daily living
- community access and recreation – providing 1:1 support for the attendance at and participation in events and activities
- respite – providing care for a worker to allow the family respite.

An attendant care service provider must have written approval of an attendant care program from the relevant agent before services are authorised to be provided to an injured worker.

Agents may seek an independent clinical review, including either an IME review and/or an ADL assessment, to independently review the clinical requirements and support needs that best meet the injured worker's health and personal care prior to authorisation of a program. Subsequent clinical reviews may be necessary to ensure that the documented program is working to plan.

Total scheme payments for attendant care are running at between \$10m and \$11m per annum, with payments made in respect of around 300 injured workers. Over 80 per cent of these payments are in respect of catastrophically injured workers, with 80 per cent to 90 per cent of catastrophically injured workers currently receiving some level of paid attendant care.

## **Provider profile**

### *Attendant Care Providers*

The legislation specifies that these services are required to be provided by a person who is approved by WorkSafe. To be approved a provider must:

- have demonstrated substantial experience in attendant care or a related field
- have the resources to provide quality service delivery at all locations in which they intend to operate. This includes access and exit procedures and reliable contact and backup to cater for injured worker attendant care needs
- have an adequate supervisory structure for service provision, case review, staff guidance and relevant policies and procedures in place
- hold appropriate public liability and professional indemnity insurance.

As a rule, paid attendant care services are not to be provided to workers by friends or members of their family. However, there may be exceptional circumstances where WorkSafe will consider the individual circumstances and merits of a particular request for friends or family members to be attendant carers. Consideration and approval will only be given after all criteria are satisfied.

Attendant carers should deliver services in such a way as to maximise the injured worker's independence and maintain functional skills and capacities. All services are required to be in accordance with the Accident Compensation Act (1985) and the Disability Services Act (1991).



## Victorian Managed Insurance Authority

With the exception of workers' compensation run-off liabilities managed by the VMIA, and specifically excluding asbestos and dust disease and CFA volunteer entitlements, the liabilities managed by the VMIA are almost exclusively claims under the *Wrongs Act*. The vast majority of these liabilities relate to medical indemnity claims, of which the VMIA receives approximately 650 each year, and also to the public and occupier liability exposures of VMIA insured departments, agencies and participating bodies.

At present, public hospitals through the State pay a premium to the VMIA to meet the expected cost of future claims arising from medical negligence. This premium does not include provision for funding for adverse outcomes within the public health system, which do not arise in consequence of negligence, but which are due to other causes. These causes might include congenital illness or severe adverse outcomes which occur in a clinical context but without practitioner fault.

The insured public and occupier liability exposures vary in size from relatively small claims to large catastrophic claims. The latter category typically includes cases involving serious injuries sustained after falls or diving from piers or into rivers, injuries caused by falling tree limbs, bicycle accidents on public pathways and the like. All claims are subject to the *Wrongs Act* thresholds for psychiatric and physical injury.

There are no access eligibility thresholds other than the requirement to establish negligence, causation and loss in relation to special damages and economic loss

### Models of Support and Service Delivery

The VMIA does not operate in a compensation scheme, so there is no defined service model. Common law damages awards are essentially on a "once and for all" basis in so far as settlements involving the catastrophically injured are concerned. For example, in cerebral palsy cases where it is alleged that negligence in the management of delivery materially contributed to the plaintiff's catastrophic condition, the plaintiff is only able to recover damages on the basis of a single award. This includes not only damages for pain and suffering but also damages which represent the compensation which an injured person would receive as "no fault benefits" if the injury or disability instead fell under the TAC or VWA schemes.

Typically, these damages include amounts for home modifications, attendant care, medical and like expenses, equipment, specialist vehicles, physiotherapy, hydrotherapy, massage etc. This has been the case for a substantial period of time.

The risks inherent in the current common law model from a major injury perspective particularly relate to affordability. In particular, medical indemnity premiums in relation to catastrophic injuries are increasingly adversely affected by changes in the frequency and cost of resolving catastrophic claims. These claims are highly elastic, with significant quantum potential.

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- <sup>i</sup> [www.dhs.vic.gov.au/\\_data/assets/pdf\\_file/0019/152605/disability\\_act\\_web\\_print\\_version.pdf](http://www.dhs.vic.gov.au/_data/assets/pdf_file/0019/152605/disability_act_web_print_version.pdf)
- <sup>ii</sup> CRUs are 4-6 bed group homes referred to as SSA.
- <sup>iii</sup> Intellectual Disabled Persons Services Act 1986
- <sup>iv</sup> Disability Services Act 1991
- <sup>v</sup> [www.dhs.vic.gov.au/disability/state\\_disability\\_plan](http://www.dhs.vic.gov.au/disability/state_disability_plan)
- <sup>vi</sup> [www.legislation.vic.gov.au/Domino/Web\\_Notes/LDMS/PubStatbook.nsf/](http://www.legislation.vic.gov.au/Domino/Web_Notes/LDMS/PubStatbook.nsf/)
- <sup>vii</sup> [www.dhs.vic.gov.au/\\_data/assets/pdf\\_file/0003/152796/future\\_directions\\_house\\_support\\_0506.pdf](http://www.dhs.vic.gov.au/_data/assets/pdf_file/0003/152796/future_directions_house_support_0506.pdf)
- <sup>viii</sup> [www.dhs.vic.gov.au/disability/supports\\_for\\_people/information\\_planning\\_and\\_advocacy/how-we-provide-services-to-people](http://www.dhs.vic.gov.au/disability/supports_for_people/information_planning_and_advocacy/how-we-provide-services-to-people)
- <sup>ix</sup> [www.dhs.vic.gov.au/disability/supports\\_for\\_people/information\\_planning\\_and\\_advocacy/how-we-provide-services-to-people](http://www.dhs.vic.gov.au/disability/supports_for_people/information_planning_and_advocacy/how-we-provide-services-to-people)
- <sup>x</sup> [www.dhs.vic.gov.au/disability/supports\\_for\\_people/families\\_and\\_carers/family\\_options](http://www.dhs.vic.gov.au/disability/supports_for_people/families_and_carers/family_options)
- <sup>xi</sup> [www.dhs.vic.gov.au/disability/supportsfor\\_people/being\\_part\\_of\\_mycommunity/futures\\_for\\_young\\_adults](http://www.dhs.vic.gov.au/disability/supportsfor_people/being_part_of_mycommunity/futures_for_young_adults)
- <sup>xii</sup> [www.dhs.vic.gov.au/disability/improving\\_supports/performance\\_reporting/policy\\_and\\_funding\\_plan](http://www.dhs.vic.gov.au/disability/improving_supports/performance_reporting/policy_and_funding_plan)
- <sup>xiii</sup> [www.dhs.vic.gov.au/disability/improving\\_supports/register\\_of\\_disability\\_service\\_providers](http://www.dhs.vic.gov.au/disability/improving_supports/register_of_disability_service_providers)
- <sup>xiv</sup> [www.dhs.vic.gov.au/\\_data/assets/word\\_doc/0003/152868/idp\\_victorianindustrydevelopstrat\\_doc\\_31100\\_6.doc\(p-2\)](http://www.dhs.vic.gov.au/_data/assets/word_doc/0003/152868/idp_victorianindustrydevelopstrat_doc_31100_6.doc(p-2))
- <sup>xv</sup> [www.dhs.vic.gov.au/disability/supports\\_for\\_people/individualsupportpackages](http://www.dhs.vic.gov.au/disability/supports_for_people/individualsupportpackages)
- <sup>xvi</sup> [www.dhs.vic.gov.au/disability/supports\\_for\\_people](http://www.dhs.vic.gov.au/disability/supports_for_people)
- <sup>xvii</sup> [www.dhs.vic.gov.au/disability/supports\\_for\\_people/information\\_planning\\_and\\_advocacy/how-we-provide-services-to-people#june2009](http://www.dhs.vic.gov.au/disability/supports_for_people/information_planning_and_advocacy/how-we-provide-services-to-people#june2009)
- <sup>xviii</sup> [www.dhs.vic.gov.au/disability/supports\\_for\\_people/being\\_part\\_of\\_my\\_community/recreation](http://www.dhs.vic.gov.au/disability/supports_for_people/being_part_of_my_community/recreation) & [www.dhs.vic.gov.au/disability/building\\_better\\_communities/ruralaccess\\_and\\_metroaccess](http://www.dhs.vic.gov.au/disability/building_better_communities/ruralaccess_and_metroaccess)