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27 August 2010

Commissioners Scott, Kalisch and Walsh
Disability Care and Support Inquiry,
Productivity Commission

Dear Commissioners,

Re: AMA Submission to the Inquiry on Disability Care and Support

Please find attached the Australian Medical Association's (AMA) submission to the Productivity Commission Inquiry into Long-term Disability Care and Support.

The AMA is the peak professional organisation representing medical practitioners in Australia. A national disability support scheme will significantly involve the medical profession at a number of levels. The attached submission seeks to bring to bear the expertise and collective experiences of the medical profession on what might contribute to the success of an optimally operating national disability support scheme from a health and medical point of view.

The AMA is happy to provide any further advice that may be of value to this Inquiry.

Should you have any questions in relation to this submission, please do not hesitate to contact Dr Maurice Rickard, Manager, AMA Public Health Policy on 02 6270 5449.

Kind regards

Dr Andrew Pesce
President

The AMA supports the establishment of a national disability insurance scheme which is ‘no fault’ and comprehensive in the care and support it provides to cover the cost of long-term care for people with serious disabilities. The AMA supports this because it recognizes the importance of appropriate support for people with serious disabilities, particularly support for health and medical needs. The importance of health and medical needs is not strongly reflected in the Terms of Reference for the Productivity Commission Inquiry, nor its associated discussion and background documents. This submission seeks to bring to bear the expertise and collective experiences of the medical profession on what might contribute to the success of an optimally operating national disability support scheme from a health and medical point of view.

PUTTING THE BEST SCHEME INTO PRACTICE – ISSUES OF IMPLEMENTATION AND TRANSITION PLANNING

Most of the recommendations made in this submission reflect what the AMA considers to be the important characteristics that an ‘optimal’ national disability scheme should have – an optimal scheme being the one that would be the most desirable to have if the circumstances allowed it. While the AMA considers its recommendations about an optimal scheme to be realistic and achievable, they are not all achievable overnight, especially given the expansive systemic reforms that a national social insurance scheme would involve.

The key to success in eventually establishing an optimal national disability scheme is appropriate transitional planning and stepped implementation.

The pace of the transition, and the features of the scheme that are implemented at each stage, might be guided by the following principles:

- prioritise achieving the greatest returns for those in greatest need, including where earlier access to assessment and intervention would decrease the final burden of disability;
- identifying areas where immediate assistance is required, eg. care assistance for ageing carers who will not be physically able to continue to care for their disabled children or other family members;
- implement at a pace that is sensitive to system capacity (accompanied by measures to build system capacity), and
- implement at a pace that is sensitive to cost sustainability.

Each of these principles will have a range of implications at the practical level.

Prioritising needs

The AMA considers that, under an *optimally operating* national disability scheme, all people who have a serious or profound disability, either congenital or acquired (through injury or disease) should be entitled to a comprehensive range of care and support. However, this will not be immediately achievable in practice, and in conformity with the first implementation principle above, the AMA considers that the initial stages of implementation should focus on the needs of:

- all children with a permanent disability diagnosed before 18 years of age requiring at least 2 hours of personal care per day, for their lifetime, and
- all adults catastrophically injured through an accident or from a serious and rare outcome arising from medical treatment requiring at least 2 hours of personal care per day, for their lifetime.

Also, in line with the same implementation principle, the initial stages of the scheme might restrict itself to categories of need (and corresponding support) that are the most critical for people with serious or profound disabilities. There will be different analyses of which categories of need have the greatest urgency, and a sound implementation plan will need to give a careful account of what these priorities might be. The AMA believes that one possible approach is to give priority to:

- enabling people to participate in the functions and activities associated with critical stages of their lives.

This may mean, for example, ensuring that children and young people with disabilities have realistic access to schooling and educational opportunities; and that people transitioning from education have appropriate opportunities to engage in the workforce. There will be other critical life stages and life functions, and needs that are central to them.

Achieving the best outcomes for those in greatest need also argues for the importance of early diagnosis and early intervention. The initial stages of implementation might therefore include a special focus on building system capacities and protocols in these areas.

Keeping pace with system capacity

One of the most significant practical factors in implementing a national disability scheme will be the extant level of disability support expertise and capacity in the system. One of the key reasons for contemplating a national disability scheme is the low capacity base currently in the system. If the pace of implementation overtakes the prevailing workforce and infrastructure capacity, this will produce potential ‘inflationary’ effects where there is very high demand and purchasing power for a low supply of services (for which inappropriately high prices may be charged). System capacity is currently low, and needs to be built in step with the staged implementation of the national disability scheme. Similarly, implementation of the scheme should not out-pace system capacity.

Another practical implication of this principle about system capacity, is the importance of making use of any appropriate administrative and organizational arrangements that may already exist in the disability or injury services sphere. This suggests that a national disability scheme might be implemented in a way that absorbs or incorporates existing state-based injury compensation schemes.

Keeping costs sustainable

Part of the justification for contemplating a social insurance approach to disability support is the fact that having a disability, congenital or acquired, is very often a matter of luck and circumstance. This fact can affect how predictable the costs of a national disability scheme will be into the future. In terms of implementation, this argues for careful consideration (in the initial phases, at least) of the type and level of entitlements that the scheme might provide to individuals – again, with priority going to support that addresses individuals' greatest needs. It also argues for the scheme having the built-in flexibility to be 'wound-back' for periods, if costs become unsustainable. Implementation planning for the scheme needs to involve careful and ongoing actuarial analysis.

As indicated, these principles for implementation, along with their practical implications, need to be at the forefront of any realistic thinking about a national disability scheme. With this said, however, the AMA believes that we need a clear conception of what such a scheme should look like in its optimal operation. The observations and recommendations to follow, seek to describe that operation, with a particular focus on its health and medical dimensions.

The following goes through each of the Terms of Reference, where appropriate, and makes comment on issues of relevance to doctors and their patients with serious disabilities, and issues relating to health care and the health system more broadly.

Eligibility criteria for the scheme, including appropriate age limits, assessment and review processes

Nature of the disabilities covered.

Recommendation 1

People who have a serious disability, either congenital or acquired (through injury or disease) should be entitled under a fully and optimally operating national disability scheme.

It may be reasonable to exclude from the scope of the scheme entitlements for individuals with significantly reduced capacities that are attributable to the natural process of ageing (eg. very restricted mobility, or deteriorated visual and auditory capacity), as long as there are appropriate levels of care and support in other areas of the health and aged-care system for these reduced capacities. However, there is a relevant difference between (significantly) reduced capacities due to the 'natural' process of ageing, and serious disabilities due to diseases whose onset is often associated with ageing (eg. Alzheimers Disease). The AMA would argue that the former should not fall under the scheme, but that the latter disease-related disability should.

Recommendation 2

A national disability support scheme should distinguish between reduced physical and mental capacities due to the process of ageing, and incapacities due to disease, including age-related disease.

Clear administrative guidelines based on medical evidence and professional understanding should be developed in the scheme for applying the distinction in individual cases. Where there is ambiguity as to how such guidelines might apply in particular cases, the professional judgement of the individual's consulting doctor(s) should be given significant weight.

Duration of the disability**.** The Commission's Discussion Paper notes the definition adopted by the Australian Institute of Health and Welfare and the ABS that a physical, intellectual or psychiatric condition that restricts everyday activities and is likely to last for at least 6 months counts as a disability. If individuals who will be debilitated for less than 6 months have appropriate and timely access to rehabilitation and allied health services, and can rely on family and other support networks for domestic care, then this 6 month period may be a plausible cut-off for eligibility under a disability support scheme. The AMA believes that the priority for a national disability scheme should be permanent disability and the provision of long term care and support, not coverage for short term injury.

With this said, there will still be identifiable groups with limited resources, and for which family and social network opportunities are not available. The AMA recognises that there will be avenues for providing this shorter term support, the most likely being state based injury and accident compensation arrangements. However, if a national scheme evolves to incorporate these state based schemes, as is considered later in this submission, it will be important for the shorter-term support that these state schemes provide not to be lost.

Recommendation 3

It is reasonable for eligibility under a national disability support scheme to be limited to conditions that will seriously or profoundly restrict a person's everyday activities for a period of at least 6 months.

It will be important to ensure that appropriate shorter-term support is still available for those whose everyday activities become restricted for a period that is likely to be less than 6 months. This is particularly so if a national disability support scheme evolves in a way that incorporates existing state-based accident compensation schemes.

The AMA recognises the importance of early intervention in improving the long-term outcomes for individuals with a serious disability.

Recommendation 4

Assessments of whether a person's level of disability makes them eligible under a national disability support scheme must be made quickly and accurately. Administration of the scheme must also be efficient so that appropriate care and support can be provided at the earliest opportunity to ensure the best outcomes.

Age limits**.** The Commission suggests an eligibility cut off age of 65 years for a national disability support scheme - the rationale being that the current aged-care system can provide support after this age. While there are disability support services in the Australian aged-care system, there are often service delivery limitations and problems of quality. It is unlikely that the quality of disability-specific support and care provided in that system would be comparable to the level that would be expected of a national disability scheme. It is also unlikely that disability support under the aged-care system would reflect the focus on independence, participation and individual decision-making that an adequate national disability scheme would reflect.

According to one estimate, nearly half (47%) of Australians who experienced a severe or profound disability in 2009 were over 65 years of age.[1] The aged care system can also expect an increasing burden as the Australian population ages over the coming decades. Where the support needs of older people with a serious or profound disability are not well met, their health and medical conditions often deteriorate. The AMA would see this as a significant failure for a national disability scheme that presumes to be based on need and equitable application. Services for (debilitating) conditions due to the natural process of ageing should be funded through the aged-care system, and services for other serious and profound disabilities (ideally at any age) should be the responsibility of a national disability scheme. It is important also that seriously disabled children are fully eligible under a scheme.

As stated earlier, the AMA recognises that there may be practical limitations in a national disability scheme providing immediate cover to all age groups (and coverage of a wide disability range, and service entitlements). The AMA would therefore support incremental implementation across eligible groups, perhaps by prioritising access initially to those most in need (which would include young people in nursing homes with a serious disability), and later extending it to assist more people, depending on financial cost and sustainability.

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[1] *National Disability Insurance Scheme*, Final Report, PriceWaterhouseCoopers, October 2009.

Recommendation 5

Services for (debilitating) conditions due to the natural process of ageing should be funded through the aged-care system, and services for other serious and profound disabilities (ideally, at any age) should be the responsibility of a national disability scheme.

Managing the funding for this will require careful actuarial analysis and planning.

In practice, the financial costs of this broad age-coverage may be considerable in the initial stages of implementation. An option would be to implement the scheme incrementally, with initial priority given to those most in need (at any age), and access extended to assist others at subsequent stages of implementation.

Assessment and review**.** Medical practitioners must play a role in the health, medical and functional assessments relevant to eligibility (and reviews of eligibility) under a national disability scheme. Given the strong evidence, the AMA would advocate a national disability scheme designed to support the benefits of early medical assessment and intervention, especially for individuals with a serious disability.

The primary role of doctors is to diagnose, treat and otherwise care for their patients' health or medical conditions. When possible and appropriate, doctors will also quantify the functional impairment imposed by those medical conditions and make prognoses for their improvement, often assisted by specifically skilled allied health professionals. To this extent, doctors should play a central and coordinative role in the processes relevant to eligibility in a national disability scheme, including the ongoing assessment of any changes in their patients' condition and functionality. Doctors can also provide advice about the changing health and medical care needs that a patient with a disability may have, and will refer or recommend them to other health professionals as required. In some situations, health and medical assessments will be straightforward and the person's primary medical practitioner will play the central role. There will also be complex assessments, and appropriately skilled medical practitioners and specialists should be involved.

Other than making these assessments, it should not be expected that doctors make decisions or recommendations about an individual's eligibility for services under a national disability scheme. This determination will presumably be a statutory matter, made by a statutory body, based on a range of criteria which includes the input of a range of health and other professionals.

Recommendation 6

Medical practitioners must play a central role in coordinating the assessment of a person's health and medical conditions, and functionality, relevant to their eligibility under a national disability scheme.

Doctors should not be expected to make decisions or recommendations about a person's eligibility for services under a scheme. The AMA regards this to be a statutory matter, properly made by a statutory body, on the basis of a range of criteria.

The AMA supports the principle of self assessment, wherever practicable, to facilitate access by people with disabilities to the most appropriate support and assistance.

Recommendation 7

The following arrangements should be in place to support doctors in making assessments and providing advice as part of the assessment process:

- minimal administrative process and red-tape in providing formal medical assessments of patients for the purposes of a disability scheme, and efficient dealing by authorities with any follow-up;

- the option of allowing individuals or their families to choose their regular doctor for the coordination of their assessment and review, rather than a mandatory state appointed doctor who will not be familiar with the patient's history or circumstances. This option contributes to the accuracy of assessments;

- remuneration for medical assessments and reviews that is appropriate and realistic to the complexities involved in diagnoses and prognoses of complex and multiple medical conditions, and their functional impacts (especially for conferencing with allied health professionals skilled in functional assessments). If medical assessments and reviews are to be remunerated under MBS arrangements, then relevant MBS items must be realistic to the number of health assessments and the level of health care planning and coordination that are appropriate in the case of patients with serious or profound disabilities;

- a health and medical review regime which is based on the health and welfare interests of individuals with a disability, and designed to identify and allow flexible action in response to changing care needs rather than to cull participants in the scheme or achieve cost cutting;

- consideration of short training options for doctors involved in assessment and review relating to the national disability scheme; and

- development of region-based online resources that doctors can access for purposes of networking with other doctors and coordinating with other health professionals involved in assessment or the provision of care to patients with serious disabilities.

It is crucial to recognise that the medical practitioners involved in assessment and review for the purposes of a national disability scheme will always have as their priority the appropriate treatment and care of their patients. Doctors will also continue to care for their patients whether or not they are receiving benefits under a national disability scheme.

Coverage and entitlements

The underlying goals of the scheme are relevant. The type and level of care and support that eligible participants should receive under the scheme will depend to some extent on the underlying goals of the scheme. The objectives sought in the National Disability Strategy are for people with a disability to achieve economic participation and social inclusion and to enjoy choice, wellbeing and the opportunity to live as independently as possible. Families and carers are also to be well supported. The AMA supports these goals for a national disability scheme, especially those which promote increased personal autonomy and self-determination. The types of service entitlements proposed under the Inquiry's Terms of Reference are consistent with these objectives – "a coordinated package of care services which could include accommodation support, aids and equipment, respite, transport and a range of community participation and day programs available for a person's lifetime.".

Recommendation 8

The AMA considers that the underlying goals of a national disability scheme should be consistent with the objectives of the National Disability Strategy, especially those objectives which reflect the importance of increased personal autonomy and self-determination.

The place of health and medical support under a national disability scheme remains unclear in the Terms of Reference, and also the associated discussion documents. The Commission gives no indication that it counts medical services, or pharmaceutical purchases as being fundable under the scheme. There is a suggestion that nursing care and allied health services may be fundable (such services are already provided under the Home and Community Care (HACC) funding program). It may also be possible that some medical services would be funded if the national scheme is modelled on existing state schemes such as the NSW Lifetime Care and Support Scheme.

Recommendation 9

It is unclear whether the Commission envisages all necessary health and medical services to be funded under a national disability scheme. If these services are not to fall within the entitlements of the scheme, but are to be provided under existing arrangements (the MBS, PBS and other aspects of the health service system), it needs to be clear how a disability scheme will interact efficiently and effectively with these existing health and medical arrangements, particularly when two government budget lines in separate portfolios are involved .

Equity and entitlement: Whatever the type of support and services a person may be entitled to under the scheme, there is an additional and central question about their *level or extent* of entitlement to these services. The National Disability Strategy goals are of limited use in setting how much eg., accommodation support, respite, aids and equipment, etc should be provided to each individual, who may be experiencing a particular type and degree of disability, in particular circumstances, with or without pre-existing means of support (eg., wealth/income, family, etc.). There are different degrees of economic participation, social inclusion, wellbeing and opportunity that can be experienced in a life. The issue of ‘how much’, or the level of support each individual person is entitled to is central, especially in estimating the overall recurrent cost of a scheme, and also for the purposes of ensuring an equitable allocation of support between people.

There will be a number of candidate criteria for setting the appropriate level of support for each individual. For example, setting support at a level that would allow individuals to lead a normal life as much as possible, or the life they may have had prior to any accident or injury. There will be strengths and weaknesses with each of these criteria, and others like them.

While the question of appropriate criteria is a difficult one, the AMA considers that the right criteria will be ones which incorporate a health and medical dimension. There is a relationship between the health and well-being of a person with a disability and the degree to which their disability care and support needs are met. If there is inadequate provision of care and support, then underlying health conditions become worse, and new ones can emerge, and this increases the need for more prolonged or intensive health care. Disability support needs to be set at a level that is at least enough to avert the deterioration of individuals’ health.

> Recommendation 10
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> Each individual should not receive a level of disability care and support that would allow their medical condition, general health or psychological wellbeing to deteriorate. Exactly what level that is will vary from case to case, and will need to be informed by medical advice.

There is a further issue concerning equity that the AMA believes is particularly important to meet in a national disability scheme. It is one thing to design such a scheme to be equitable, where all who are eligible are formally entitled to its benefits. It is another thing for the scheme to operate equitably, and for those entitlements to be realisable in practice by all. For example, Aboriginal people and Torres Strait Islanders have the same ‘formal’ entitlement to Medicare and the Pharmaceutical Benefits Scheme as any other Australian. It is well observed, however, that the degree to which Indigenous Australians actually access these social insurance and subsidy schemes is significantly lower than the rest of the Australian population. A significant (but not the sole) factor underlying this is the limited availability of culturally appropriate health and medical services (providing MBS and PBS) which Indigenous people will more readily access, and which will produce good health outcomes.

Aboriginal and Torres Strait Islanders typically experience higher rates of disability than other Australians, and they would have a significant entitlement to long term care and support under a national disability scheme. There are other identifiable groups that are also at risk of inequitable access to benefits under a national disability scheme, including those from diverse cultural backgrounds, those in rural and remote locations, those who are homeless or dislocated.

Recommendation 11

A national disability scheme must be designed and implemented to ensure that all have appropriate equitable access to its benefits.

Particular attention must be given to ensuring that Aboriginal people and Torres Strait Islanders can properly exercise their entitlements through having access to culturally appropriate long term care and support services, in accessible locations.

How will a National Disability Scheme interface with existing common law rights?

The AMA considers that a disability scheme should provide support for living and for social and economic participation, rather than compensate for pain and suffering and loss of income. The courts, however, do adjudicate in these other important dimensions, and the capacity to pursue compensation for economic loss, pain and suffering and other potential heads of damages other than care costs should be maintained.[2] This ensures a National Disability Scheme can focus on care and support for people with disabilities, and not be required to replace existing disability support pensions.

Recommendation 12

Under a national disability support scheme individuals should maintain their common law right to seek redress for pain and suffering and economic loss through the legal system from those at fault.

The interaction of a national disability scheme with the civil litigation process should ensure that both operate effectively together to enable early therapeutic interventions (where possible) and that this interaction does not create any perverse incentives, for example, any incentive not to take opportunities for early support, for fear of this impacting any judgment of the court in a civil claim for other damages.

Medical Indemnity Insurance.

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[2] Individuals whose disability is congenital, and not due to negligence or fault, will not have the same opportunity for compensation through the courts for pain and suffering. This may be relevant in considering levels of entitlement under a national disability scheme.

We have been advised by Medical Indemnity Insurers that medical indemnity premiums should, all other things being equal, reduce for some categories of medical practitioners to reflect the provision of disability care and support services through the scheme in lieu of future care costs as a head of damage. For those categories of medical practitioners, there should be less reliance than is currently the case on premium subsidies provided by the Federal Government under the Premium Support Scheme and, in turn, a reduction in the stamp duty and ROCS levies received by the Federal and State Governments. The impact of the scheme on the support provided by the High Cost Claims Scheme would also need to be carefully assessed.

These insurance support arrangements should be maintained, particularly if the right to pursue legal compensation is preserved. It is possible to argue for a redirection of Commonwealth and State monies which currently are dissipated via the transactional costs of current compensation systems toward supporting the cost of a no fault National Disability Scheme, especially if there is an overall reduction in costs for Medical Indemnity Insurance. However, the extent to which a new no fault scheme will impact on indemnity insurance premiums for classes of medical professionals is unpredictable, and it will be necessary to ensure that the affordability of medical indemnity insurance is maintained. At the very least, the Premium Support Scheme should be kept in place to ensure affordability of indemnity insurance for all doctors.

Recommendation 13

Medical Indemnity Insurance arrangements could be altered in the context of a national disability scheme if the right of individuals to pursue compensation for care costs is curtailed. If various financial support schemes are varied in order to contribute to the costs of a National Disability Insurance Scheme, it will be necessary to ensure that overall security and affordability of medical indemnity insurance is maintained for medical practitioners.

Some may argue that high premiums and claim costs acts as a discipline on practitioners to maintain high standards of treatment and care. However, the professionalism of doctors is a powerful safeguard against poor practice, and there are also a range of regulatory measures (such as the National Registration mandatory reporting regime, and the health complaints system) that act to maintain professional standards. The AMA maintains that the proper focus of a national disability scheme should be the provision of appropriate and accessible support. The proper place for peer review and quality and safety in the health system is in systems to collect, assess and respond to data via a separate quality and safety system, backed up where necessary with appropriate disciplinary processes through the Medical Board of Australia.

Choice of care providers including from the public, private and not-for-profit sectors

It is important for all individuals, regardless of their circumstances, to have choice in the disability support services, and therapeutic and health services they can access.

This is consistent with the stated aim of the Inquiry to include a focus on schemes which "assist(s) the person with disability to make decisions about their support".

> Recommendation 14
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> Consideration should be given to defining a threshold level of financial support which is made available to eligible individuals to allow them complete individual discretion in the types of disability support services and therapies they can purchase (with the exception of very expensive ones). Financial support beyond this threshold should only be available for approved or accredited services and items.

As noted earlier, the range of care and support services proposed to be funded under the scheme do not appear to include medical services, and it appears to be assumed that individuals' health care will be funded and accessed via current arrangements. There still need to be options under the scheme for people to have a choice of health care and medical services which may not be covered by Medicare and public hospital access arrangements.

> Recommendation 15
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> The AMA considers that all individuals, regardless of their circumstances, should have choice in the services they can access, including health and medical services.
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> Entitlements under a national disability scheme should include financial support or a medical allowance specifically to be used for private sector medical services, or private health insurance or medical aids and appliances that may not be adequately provided for under existing health service and funding arrangements.

Contribution of, and impact on, informal care

The current burden on family carers is very significant, and a national disability support scheme must reduce reliance on the good will and availability of family carers, and provide appropriate respite and support for carers. Of particular importance is the health and psychological well-being of family carers, who often overlook this in the process of supporting their family member with a disability. Training and skill-development options should also be available to carers, along with access to regional support networks.

The AMA considers that support for an ageing cohort of informal carers, should be a priority in the earliest stages of implementation of a national disability scheme.

Recommendation 16

The AMA considers that carers should receive sufficient respite and other support under a national disability scheme to prevent the deterioration of their health and wellbeing.

Training and skill-development options should also be available to carers, along with access to regional support networks.

Support for informal carers should be a priority in the earliest stages of implementation of a national disability scheme.

The implications for the health and aged care systems

There is an important interdependence between the health system and the disability system. If there is inadequate health provision, then the conditions underlying a person's disability can deteriorate, and prolong the disability and the consequent need for care and support. If there is inadequate provision of care and support, then underlying health conditions become worse, and new ones can emerge, and this increases the need for more prolonged or intensive health care. This speaks for the need not only to have an adequately resourced disability system, but also an appropriate level of capacity in the health care system specific to the needs of individuals with a disability.

There is a probability that improved disability care and support (along with enhanced social and economic participation) will create extra demand on the health care system, particularly for doctors. In part, the extra demand will emerge as a consequence of more individuals with disabilities having greater capacity to participate in social life and the workforce, with the independence and opportunities for decision-making this brings, including in health care. Extra demand on medical practitioners will also arise from the assessment and review process (discussed earlier). The AMA believes that part of the planning for a national disability scheme should include an audit of anticipated demand for medical services.

Recommendation 17

As part of the planning for a national disability scheme, an audit should be conducted of anticipated demand for relevant medical services.

The AMA is aware that many young people with serious and profound disabilities are currently accommodated in nursing homes. This is inappropriate for the individuals themselves, their families and the other residents of nursing homes.

Recommendation 18

A national disability scheme will need to provide for appropriate care and accommodation arrangements for seriously disabled young people.

Impacts on the aged-care system may be more difficult to identify. It may be that when elderly people with a serious disability are better supported for independence under a national disability scheme, there will be less burden on the aged-care system. However, if the national scheme results in more people living longer lives, then this may result in increased demand on the aged-care system.

The interaction with, or inclusion of, employment services and income support

As stated earlier, the income support associated with a national disability scheme should include a medical allowance component that will allow individuals to have choice in the selection of medical services and providers, as well as the possibility of purchasing private health insurance and accessing other medical-related services not currently properly funded (e.g. aids and appliances).

The interaction with national and state-based traumatic injury schemes, with particular consideration of the implications for existing compensation arrangements, and medical indemnity insurance schemes

Medical Indemnity Insurance**.** Refer to the discussion above.

Existing traumatic injury schemes**.** The early stages of implementation of a national scheme may require the harmonisation and incorporation of existing compensation and injury schemes.

GOVERNANCE AND ADMINISTRATIVE ARRANGEMENTS

Recommendation 19

The following principles should guide the governance and administration of a national disability scheme:

- transparency of decision-making for clients of the scheme as well as providers;
- appropriate review and appeal rights;
- easy access, and minimal red tape and complexity for those applying for and those providing services under the scheme;
- a focus on enhanced coordination of care and services for the individual, and
- maintenance of as much individual autonomy as possible in the choice of services and support.

Governance model for overseeing a scheme and prudential arrangements

Appropriate quality assurance arrangements will be crucial in a national disability scheme, particularly in relation to the range of therapeutic services and rehabilitation options that may emerge or expand in response to the heightened demand an established disability scheme will create.

Recommendation 20

A specific advisory group of medical professionals, including rehabilitation physicians, should be established to advise on the evidence-base for different candidate interventions and therapies related to serious disabilities, and their eligibility for coverage under a national scheme.

Recommendation 21

It is important also for a national disability scheme to have adequate local governance arrangements, so that local knowledge and services are utilised and costs and inconvenience are minimised for those seeking support services. This would mean bolstering local services and infrastructure.

Administrative arrangements, including consideration of national, state and/or regional administrative models

If proposed health system reforms (such as Local Hospital Networks and Medicare Locals) are implemented, then a national disability scheme will need to interface efficiently with these new structures.

The Costs and Financing of a Proposed Scheme

The costs of a national disability scheme will depend on its scope, in terms of who is eligible and at what level of service entitlement. It was observed above that implementation of the scheme must be sensitive to cost sustainability, and that coverage and entitlements under the scheme may contract or expand from time to time depending on anticipated demand and assessments of available finances.

<u>Determining appropriate prices for care and support services</u>**:** Government subsidies for services introduce a market distortion on prices. In the case of disability care and support services, as well as therapies, this introduces the question of what is to count as appropriate prices for services, and how this is to be determined when the market is not the sole determinant of price. There may be a risk with a government subsidy/payment regime, that prices provided for disability services are either inflated, or else set too low for the value of the service provided.

The AMA has a fees book which provides medical practitioners with a guide as to what prices are appropriate for which medical services.

Recommendation 22

Care must be taken to ensure that the government subsidies for services paid for under the disability scheme are set at an appropriate level.

The likely offsets and/or cost pressures on government expenditure in other systems as a result of a scheme including income support, health, aged care, disability support system, judicial and crisis accommodation systems

It was noted above that a national disability scheme is likely to increase the demand for health and medical services from people with a disability, as a result of their greater social and economic engagement and increased independence and decision-making. Doctors, will also be involved in the assessment and review process. If the scheme is successful in promoting independence and social participation, then there may be an increased need for supported accommodation, including attendant care, community nursing and community allied health.

Amongst the possible offsets of a national disability scheme would be costs to those groups and organisations who would otherwise face litigation and insurance charges (for example, health care professionals, hospitals, municipal councils, and community organisations.)

Models for financing including: general revenue; hypothecated levy on personal taxation, a future fund approach with investment guidelines to generate income

The AMA recognises that a national disability scheme may be financed in a number of ways. Whatever the financing arrangements, they should be fair, sustainable and sufficient to the level of care and support that will be needed into the future.

Recommendation 23

Financing arrangements for a national disability scheme should complement and not duplicate or disturb the existing financing arrangements for health care (at a system level and at an individual level).

Consideration should be given to having uncapped funding allocations for a national disability scheme, as is the case with the MBS and PBS.

Contributions of Commonwealth and State and Territory governments

The organisational and financing arrangements for a national disability scheme should be fully national to the extent that problems of jurisdictional cost and responsibility shifting are minimised. Jurisdictional cost and responsibility shifting have for a long time been entrenched in the Australian health care system, and have generated persistent inefficiencies and unmet need. The AMA would urge that these mistakes not be revisited in the financing and organisational structure of a national disability scheme.

Options for private contributions including co-payments, fees or contributions to enhance services.

It is not clear that moral hazard will be a significant potential in an insurance scheme covering people whose eligibility and ongoing needs are subject to independent expert assessment and review. This suggests that a co-payment would not be warranted as a co-insurance measure. The capacity to pay a co-payment or a fee is also relevant, and such a co-payment could act as a disincentive to people accessing the care and support they need.

Recommendation 24

Comprehensive and high quality care and support services should be available under a national scheme at no cost to the individuals with serious or profound disabilities, and their carers, who need these services.

However, a national disability scheme may not deliver everything that people may want, and there should be the opportunity for individuals to make private contributions.

The proposal was made earlier that a medical allowance be included in the entitlements under the scheme, in order to allow individuals a choice of health and medical services.

Recommendation 25

Provision for individuals to make a choice of disability care and support providers should be built into the national scheme.

Implementation of a Proposed Scheme

Changes that would be required to existing service systems; workforce capacity

A national disability scheme will only meet the high level of unmet need it aims to if there is a very significant change to current disability service systems across Australia. Significant improvements will be required in disability support service capacity, quality and consistency.

Governments must meet the major challenge of building service capacity across Australia to be commensurate with the significantly heightened demand for services expected with the establishment of a national disability scheme. It would be counter-productive to establish a scheme, with the heightened demand for services and money available to pay for them that this would generate, when there is a significant under supply of the services and health expertise that are needed. At the very least, this would undermine public confidence, and at the worst, provide a perverse incentive for the emergence of poor quality service providers and inflated service charges.

Recommendation 26

Service capacity, including infrastructure and workforce, must be strengthened ready for rolling out at the same time as a national scheme, so that service supply is at a sufficient level to meet demand, and quality services are provided when they are needed.

Staged or incremental implementation of a national disability scheme may help ensure that the service delivery sector can grow to meet potential and expanding demand over time.

Issues regarding the quality and consistency of disability services between jurisdictions may be addressed by the Review of National Standards for Disability Services that is currently underway.

Lead times, implementation phasing and transition arrangements to introduce a scheme with consideration to service and workforce issues, fiscal outlook, and state and territory transitions.

As emphasised at the beginning of this submission, given the practical issues in establishing an optimal national disability scheme, the AMA would support consideration of incremental implementation. The scheme might be implemented to give initial priority to those with the greatest support needs, and incrementally expanded over a reasonable time span to include all individuals with a serious disability who require long term care and support. There would need to be harmonisation with existing state-based compensation schemes at an appropriate early stage of implementation. A phased introduction of the scheme would also allow for training and system development.