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Inquiry into Disability Care and Support
Productivity Commission
GPO Box 1428
CANBERRA CITY ACT 2601
Email: disability-support@pc.gov.au

**INQUIRY INTO DISABILITY CARE AND SUPPORT
– AMA COMMENTS ON DRAFT REPORT 2011**

The AMA fully supports the introduction of an Australian Government (tax) funded system of comprehensive care and support for people with long-term, significant disabilities. We commend the Productivity Commission's draft report. It provides the basis for designing a world-class national disability insurance scheme.

Individuals with a disability and their families are entitled to have access to long-term essential care and support based on their level of need. Lack of access to services results in poor health outcomes, less full and effective participation and inclusion in society, and a reduction in dignity, autonomy and the ability to be independent.

The AMA supports the Productivity Commission's proposal that the Government should introduce a system of comprehensive long-term care and support (NDIS) that includes a coordinated package of services such as accommodation support, employment support, rehabilitative care, aids and appliances, and respite care, access to which should be underpinned by individual decision-making and choice.

The AMA also supports the introduction of a no-fault national injury insurance scheme (NIIS), drawing together individual state and territory schemes, to provide fully funded care and support for people requiring lifetime care and support resulting from catastrophic injury.

A priority for the Government is agreement on, and establishment of, models for sustainable financing that can reliably meet need into the future.

The AMA provides the following comments in response to the Productivity Commission's request for further information.

Mental health and disability support boundaries

It is difficult to determine whether, how clearly, or at what point in the continuum of their illness, individuals with mental health conditions would qualify for individually tailored, reasonable and necessary funded supports (including daily support needs).

The chronic nature of some individuals' mental health conditions may be such that those conditions constitute permanent disability (as required by draft recommendation 3.2). It may be that individuals with some serious depressive and psychotic conditions have 'significant difficulty with self care and/or communication'. However, in the case of difficulties with self-care, it is unclear whether those difficulties are typically due to self-neglect as opposed to an inability to care for oneself. Self-neglect, to the extent that it is a symptom, is nominally at least, clinically treatable. Difficulties of communication, particularly in psychotic and depressive conditions can be significant. However, these conditions and their symptoms are typically clinically manageable (i.e. through medication), including symptoms associated with communication.

Some may be in a group for which there was 'a reasonable potential for cost-effective early therapeutic intervention'. For example, individuals whose mental illness is acquired during their youth, and without intervention, would progress to a serious and chronic condition. Again, however, the early therapeutic interventions that would be appropriate to this group are clinical ones, which fall squarely within an appropriately resourced mental health sector.

Other daily support needs that will typically be experienced by those with serious chronic mental illnesses and relate to employment, education and housing, are excluded from support under draft recommendation 3.3.

The AMA's view is that while severe and enduring mental illnesses may be considered permanent conditions, the disabilities associated with those illnesses are symptomatic and are either clinically treatable or manageable through a fully resourced mental health system.

Medical and hospital services for people with a mental illness should already be covered by, and should remain under, the current health care funding system.

However, support will often be needed for employment, education and housing, and there is a case that these forms of support should, contrary to draft recommendation 3.3, be provided through an NDIS for all who need them. However, this is an issue regarding which information has not been requested by the NDIS.

Recommendation

The disabilities that typically arise from severe and enduring mental illness are most appropriately dealt with within the clinical context of the mental health sector.

The mental health sector, encompassing clinical interventions, monitoring and patient support through case management, should be fully resourced to allow the appropriate treatment and management of the symptoms of serious mental illness, including those that would otherwise give rise to daily support needs. Case management should include facilitation of support for educational, employment and housing needs of those with severe and enduring mental illnesses, and would appropriately be facilitated through the NDIS.

Indigenous issues

Indigenous Australians have higher rates of injury than the rest of Australia's population. These injuries result in high rates of disability and disability support service use among Indigenous Australians.

A large proportion of the burden of disability among Indigenous Australians is due to high risk behaviours which lead to injury (particularly substance use) or chronic health conditions (smoking, physical inactivity, high body mass, poor nutrition and substance use). To a certain extent this disability is preventable, including the serious forms of disability that are within the compass of an NIIS or NDIS.

The AMA considers many of the behavioural risks underlying serious acquired disability and congenital disabilities among Indigenous people to be amenable to individual health literacy education, and building community-level capacities to deal preventively with health and injury issues. Long-term commitment is needed to develop this literacy and community capacity, and the AMA considers that direct government involvement is often short-term and capricious. The best means of achieving these capacities is to fund appropriate non-government organisations to work with Indigenous communities over the long term to develop skills and capacities and sustainable change. Given the burden of disability, the long term benefits of prevention are substantial, and should be viewed as a sound investment, whether the investment is made through the NIIS, or the NDIA, or a combination of both.

It is also a sound investment, with any population, to intervene as early as possible in the development of disability through appropriately targeted service provision. There are particular challenges in doing this with Indigenous communities. Many communities are regional and remote, and Indigenous people many not readily access services that are not culturally appropriate. Funding the increased availability of culturally accessible disability support services for Indigenous Australians could be seen as a sound investment in early intervention.

Recommendation

The NIIS and/or NDIA should fund non-government organisations and community-based groups to work over the long term with Indigenous communities to develop health literacy and health-related community capacities regarding risk behaviours that lead to acquired or congenital disability.

The NIIS and/or NDIA should fund the increased availability of culturally accessible disability support services to facilitate early intervention for Indigenous Australians.

Medical accidents and inclusion in the National Injury Insurance Scheme

The AMA supports draft recommendation 16.5 to establish a no-fault injury insurance scheme to cover medical accidents. The AMA considers that the same criteria should be used for assessing a person's disability and eligibility for access to the proposed NIIS, whether the cause of the disability is a medical accident or other non-medical accident. A medical accident may be defined, for the purposes of assessing eligibility for support under the NIIS as a rare and serious outcome of medical treatment. This means that people who suffer a disability as a result of the natural expected and inevitable progression of illness or disease would not be considered 'injured'. They may be eligible to seek assistance from the NDIS.

The criterion for the scheme should be one of the following conditions:

- permanent and severe impairment; and
- have significant difficulties with mobility, self-care and/or communication.

The AMA also considers that, in the context of determining eligibility for the NIIS, there should be no attempt to determine whether a medical incident resulting in permanent disability was an ‘accident’ or was the result of ‘negligence’. This would ensure the NIIS was truly a no-fault scheme.

However, as noted in our previous submission of August 2010, individuals should still maintain their common law right to seek compensation for pain, suffering and economic loss through the legal system from those at fault, and this should still be covered by medical indemnity insurance. This will require medical practitioners to retain a high level of cover. Medical indemnity insurers will still incur high administrative and legal costs to defend negligence claims.

In respect of interim funding arrangements for funding catastrophic medical accidents covered under the NIIS, the AMA has identified the following key issues.

Assistance to people with permanent disability

There will be people who have been injured as a result of medical accidents that will require assistance under the NDIS. The Commission’s draft report tells many stories about the extent to which people who have received lump sum payments from litigation are no longer in a position to fund their care needs. The AMA recommends that these people be assessed to determine their eligibility for the scheme and that they enter the scheme on the same conditions as people who have not received any payout from litigation. This will ensure that, from the start, the scheme treats all people with a permanent disability equitably.

Funding medical accidents

People who are injured through medical accidents after the scheme commences will have their long-term care funded by the NIIS. As the scheme will be funded by state and territories via premium incomes from mandatory insurance policies and possibly other tax revenues, it follows that in financing of the costs associated with coverage for catastrophic medical accidents in the private sector, a contribution would come from the medical indemnity insurance providers.

While we would hope that medical indemnity insurer contributions to the NIIS would not increase medical indemnity premiums for medical practitioners, we believe more modelling and analysis is needed to establish if this will in fact be the case. We ask that the Commission undertake this work with the medical indemnity insurers to get a better understanding of the levy for the NIIS.

However, the medical indemnity premiums cover a range of activity and support to members, beyond insurance for litigation. The medical indemnity premiums will need to continue to cover litigation for compensation for pain, suffering and economic loss, as well as the professional support that the sector provides in respect of other complaints and investigations, such as Medical Board and Medicare Australia actions.

The AMA expects that the medical indemnity sector will need some time to carry out actuarial analysis to determine the appropriate transfer of revenue to the NIIS. It will be essential to ensure that indemnity insurance premiums remain affordable for the medical profession across all categories.

This consideration notwithstanding, the AMA supports the move towards a National Disability Insurance Scheme along the lines discussed in the Productivity Commissions draft report

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Contact

Belinda Highmore
Manager
Medical Practice and eHealth

Address:
PO Box 6090
Kingston ACT 2604