From: Alan Blackwood [ablackwood@mssociety.com.au]
Sent: 10 June 2003 12:38
To: workerscomp@pc.gov.au
Subject: National Comp scheme submission from the YPINH consortium

Dear Review team

I write from Multiple Sclerosis - MS Australia (Victoria) and as part of the Victorian Young People in Nursing Homes Consortium.

Young People in Nursing Homes-the issue
The YPINH issue is a real problem in itself, and is also symbolic of systemic disorganisation and failure in the way our community thinks about, and provides for disability services. The link to a national workers Compensation scheme is that we need to think broadly and intelligently about how we fund and provide support services for people with catastrophic disability from work related and other causes.

The issue of Young people in nursing homes is a complex one that needs more than simple compassion to solve. It is characterised by loss, grief and disability for individuals and families, but also about money, govt policy and responsibility.

The human side of the story can be fully told by a number of individuals and their families who can describe what life is like in a nursing home as a young person. The history of the onset of disability: through disease and disablement, and the shock of being placed in an environment that is about letting go of life, not recovery and living fully.

While aged care providers work hard and long to meet the life needs of their younger residents, the system conspires against them in that funding is short, systems are designed for frail older people, and staff are trained in the care of older people.

The problem of responsibility is something else again. The States are responsible for disability services, but their accommodation system is already overloaded. The Commonwealth is responsible for aged care, and while they house younger people they do not want to take policy responsibility. Result? the number of people under 65 in aged care has doubled over the past decade from 3000 to 6100.

Quite apart from these people who require 24 hour a day care, people who rely on government programs for equipment, home mods and attendant care are also in the group of those who rely on funded services with an interest in expanding the revenue base of community care services (such as aged care and disability services).

Upstream costs to the community
This means that 5% of aged care beds across the country are out of action for older people. With the intergenerational report highlighting the need for growth in aged care resources, we need all the aged care beds we can for aged people. To compound the problem, the older people who cannot leave hospital to go to nursing homes because of the lack of beds, block expensive hospital beds.. effectively 4-5% of capacity in public hospitals is lost for this reason.

In 2002, the Victorian Govt released figures that showed that 600 people were stuck in acute care waiting for placement at a cost of about $280,000 per day. The same goes for other states. In WA, a smaller state, 4% of their hospital system so blocked at a cost of about $90,000 per day.

All this at time when debates rage about the cost of health and who should pay. Clearly money is not the only problem, but some clever policy tricks are also required. A good place to start is to find decent homes for younger people with disabilities at a third the cost of a hospital bed.

Equity and wastage

Despite attempts to find solutions, inequity reigns. As citizens we have CTP, workers comp, private health insurance, salary and superannuation insurance as well as paying the Medicare levy.

If you acquire a non compensable injury or contract a disease such as Multiple Sclerosis you can still slip thru any disability funding into aged care..for which you may rely for life without being able to get any support from any of the personal injury schemes we pay into. These individuals who acquire non compensable disabilities and their families have dutifully paid premiums to these schemes at great cost, but are unable to derive any benefit from them. Many of these people rely on unpaid family care or end up in nursing homes to receive their care.

As a community we are insuring for the cause of injury rather than the effect. Aged care will always be the fallback where the community picks up the care for people with no other option for this group.

The level of duplication across these schemes is untenable with the cost of healthcare and the demand for community care increasing. The inequity is also of great concern.

Acquire a disability through a car accident or work injury, there is a scheme to cover you, to a greater or lesser degree. It will depend on which state you are in, who was at fault etc. There is very little consistency, and each insurance scheme has its own rules and eligibility, so trying to get a cohesive approach across 2 levels of government and multiple insurance schemes is impossible.

Consider those ’massive payouts’ to people who are injured in public or medical liability cases. These payouts do not go far when costs are deducted, Medicare and Centrelink are repaid, and care costs are met. There are many cases of people being forced back into the public system after a their ’excessive’ payout for life only lasts 10 years.

To ensure adequate 24 hour care for a person with a catastrophic disability with physical and cognitive support needs, a lump sum payout needs to set aside at least $2.5m. Add to this equipment, therapy, healthcare, home modifications, you soon realise that significant sums are needed if they are to last a lifetime.

When you consider each state has its own separate schemes for transport accidents, work accidents, and health depts, combined with private health insurance, medical indemnity schemes, Australians are grossly overinsured with 30 plus individual schemes. We cannot support this duplication with our population.

Currently the premium cost of each of these schemes do not reflect the real risk, but the pricing requirements of each scheme, based on the narrowness of their premium base. The most obvious example of this is the comparison of Medical indemnity premiums, where the professional is insured (with premiums up to $100,000 per doctor) to the TAC in Victoria, where the premium is under $500 per vehicle to cover every citizen in the state. Clearly the risk of catastrophic injury on the roads is far greater than on the operating table, however the structure of the scheme, and the capacity to pay determines the cost. We as citizens pay either way, as medical indemnity premium costs are passed on to consumers, and our taxes go to propping up clearly unviable funds.

Long Term Solutions

With a growth rate of demand for disability and aged care, we also need a funding source that is impervious to political whims like wars and border protection, and also to feuds between the Commonwealth and the States. The community’s need for care is growing, and the funding is static. Something has to give.

The Australian Institute of Health and Welfare report that 24,100 primary carers of a main recipient aged less than 65 years needed assistance but did not

receive any, and 39,200 needed more assistance than they currently received. 77,900 did not have a fall-back carer.

A National Scheme

The Consortium favours a universal no fault insurance scheme for disability that encompasses all current compensation schemes and also includes disability. The benchmark scheme in Australia is the Victorian Transport Accident Commission that operates as a monopoly. The mix of no fault and limited common law is a good one.

The cost of the scheme would be by individual contribution, by citizens. The cost to the community would be somewhat offset by the rationalisation of the current multiple schemes. Whether employers and professionals pay a separate contribution is something for wider discussion in regard to the design of such a scheme.

The cost of aged care and disability services is only going to increase as the generations age. Governments are clearly concerned with the cost side of these portfolio areas, but very little attention is going on the revenue side. This issue has been a political sleeper, however unless a viable revenue solution is found across all government jurisdictions, there will be a crisis. The funding of these services must be distinct and protected from the political budget cycle. We saw at the last Federal Budget that tax cuts were put ahead of funding community services.

To secure the $300m that is required to go towards solving the YPINH issue, just 64 cents per week from 9 million taxpayers is required. This would free up aged care beds, hospital beds etc. But instead we got a personal tax cut of $4.00 per week, and the problems are continuing.

The MS Society and the YPINH Consortium is keen to present more detailed information at a public hearing.

Thank you for the opportunity to present to the inquiry.

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