Submission to:
Disability Care and Support Inquiry
Productivity Commission Issues Paper – May 2010
Part A

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Submission Summary

The provision of resources to support people with a disability in Australia has traditionally been complex. Since European settlement in 1788, a mix of both formal and informal models of funding supported ‘disability’, with support at increasing levels being provided within the institutional setting.

In the early 1970s, based on emerging international models of deinstitutionalisation such as the Independent living Movement and the Social model, policy responses to disability moved away from models of segregation and institutionalisation, towards models of support based on deinstitutionalisation and social inclusion supported community based care.

The Disability Services Act 1986 (Cwlth) was implemented as the dominant piece of legislation that would oversee the establishment of this model of community based care for people a disability. The Commonwealth State/Territory Disability Agreements (CSTDAs) were established to support the Disability Services Act in undertaking this role. The CSTDAs aimed at creating administrative efficiency and clarifying funding roles and responsibilities between State/Territory and Federal levels of governments given the large expansion in service delivery that was required in establishing a model of community based care.

As with much of the Australian health system, the split between Commonwealth and State/Territory funding parameters and jurisdictions, led to duplicity in operationalisation and administrative procedures and multiplicity in service program delivery that created fractures, lack of uniformity and lack of equality in the delivery of disability services at a national level. Determining accurate levels of need and usage of disability services and monitoring and contrasting differing levels of service delivery across Australia have until recently, been significantly hampered by the multi-level, multi-state delivery of services.

In addition, the failure to include HACC services, CRS programs, insurance-based funding of disability services (such as those received trough WorkCover and Transport Accident schemes) and disability services funded privately as a result of public liability claims within the structure of the CSTDAs have distorted the view of how disability service delivery is truly funded (or not funded) across Australia, failing to provide an adequate picture of the many inequities in funding that exist at a national level across the disability sector.

In terms of the provision health and community services programs related to disability service delivery, despite a population in Australia of only 22 million people, the AIHW has estimated that State/Territory and Commonwealth governments are responsible for more than 60 programs and services both within and outside of CSTDAs (AIHW 2003). For any one state, disability services are funded by between 4 and 8 different funding providers, inclusive of services funded under the CSTDAs, but also inclusive of Transport Accident schemes, WorkCover schemes and services received through federal funding schemes. These have evolved over many years in an ad hoc basis and in response to specific needs and demands. The framework is characterised by its siloed and jurisdictional funding approach to disability service delivery.

As with many proponents of the national health system, a move towards a nationalised funding of disability services would ensure the removal of many of the current framework’s structural problems. A nationalised disability services framework would provide a more equitable means of assessing, monitoring and delivering the wide scope of disability services required.

Most readily, a shift to a model of support provision based on individualised funding packages within a new national framework would improve equity in support provision, and increase choice and flexibility for people with impairment, and in turn meet obligations of human rights as defined by the UNCRPD.

Further, I view maintaining the role of Common Law claims within any new NDIS scheme and the support framework as crucial. I feel compensation plays an integral role in providing redress an rebalance on both an individual and social level, following the acquirement of an impairment where significant fault or negligence a been attributed to the cause of the impairment.

I feel this could most effectively be achieved if a system similar to that of the Victorian TAC system was expanded at a national level within the NDIS. The TAC system retains a Common Law claim component for serious injury where fault can be proven to be claimed through the courts, while general support services, accommodation, medical and general entitlements remain within the standard TAC division.

I feel without opportunity to claim for compensation through a Common Law claim, where income and/or livelihood was lost as a result of the acquirement of a serious impairment where there was fault, would be introducing a differing form of injustice into the arena, and that these areas would be difficult to address under a support services platform alone.

I feel a structure for Common Law claims for compensation could very easily be placed within the NDIS platform (as per that of TAC hybrid system) where Common Law claims for compensation are capped so as to not draw too great an amount of funding from the overall funding pool.

In general, I believe compensation provides scope for an individual that has acquired an injury to make significant life changes required as a result of acquiring a permanent impairment, such as income needed to repurchase a more accessible home or vehicle, continuing to meet established financial commitments from work-role provided or providing income for existing dependents.

I feel we have a great opportunity at this moment to take on significant restructuring of Australia's support frameworks for people with impairment, that would work towards supporting individuals with an impairment and families of individual's with an impairment, the means to achieve their desired goals and explore their full capabilities.

1. Chapter 4 Scheme aspirations

What other reasons are there for a new approach to a disability care and support scheme? What are the implications of these objectives for the design of the scheme?

-UNCRPD as stated in discussion paper; the need to meet reporting requirements of the new convention. New reporting requirements will need to ensure that human rights are somehow measured so that it can be shown they are being met, however how you measure and report on status of human rights, choice and flexibility in relation to support services, and in general within the community is a difficult task. This would require some sort of rights based instrument to be developed along the lines of maybe a survey with scale 1-5 response or open ended responses. Some ideas for measuring rights:
1. Is your immediate housing accessible/meeting access need?
2. Is the nearby built environment you utilise accessible?
3. Is nearby public transport accessible?
4. Are support service allocations (such as attendant care) adequate?
5. Are your medical and health requirements met (including provision of required medical supplies)?
6. Are your full equipment needs met?
7. Do you have choice in provision of services?
8. Are avenues of appeal/advocacy agents obvious?
9. Do you have ample opportunity to gain meaningful employment?
10. Do you have opportunity to engage in meaningful relationships with friends, partners and family?
11. Are your human rights met?

Also may require further education campaign by service users so that they understand the concept and operationalisation of Human Rights within a service provision context, and perhaps even more, support service providers receiving education as to their obligations in meeting Human Rights in providing support. What are their responsibilities and obligations in relation to Human Rights, how do you ensure support service providers are meeting their responsibilities and obligations in relation to Human Rights and what happens if they don't? The new Victorian Disability Services Act moves towards capacity for a support service provider being deregistered if failing to comply with their responsibilities and obligations of the Act given they are providing support on behalf of government.

Re CRPD, see French (2007, 2008) for obligations to Human Rights by states, i.e. identification of Human Right's that are immediately realizable, Human Right's obtainable through progressive realization and minimum essential levels:

- 'The CRPD is made up of different types of rights – civil and political rights (so-called "First Generation" rights), economic, social and cultural rights (so-called "Second-Generation" rights), and rights to development (so-called "Third Generation" rights) (French, 2008).
- Civil and political rights, and economic, social and cultural rights are, traditionally, subject to different standards of compliance. Civil and political rights are "immediately realisable" which means that states have an immediate obligation to respect and ensure these rights to all persons. Economic, social and cultural rights are subject to "progressive realisation." The standard of progressive realisation does not require a state to fully comply with the requirements of the right, provided it is working towards the realisation of this right as expeditiously and effectively as possible, using the maximum resources at its disposal. States do, however, have an obligation to satisfy "minimum essential levels" of the right, and to avoid deliberately regressive measures (French, 2008)
- the Optional Protocol to the CRPD permits complaints, and adjudication by the Committee on the Rights of Persons with Disabilities, in relation to all rights recognised by the CRPD. This represents an important new development in international law. Nevertheless, the traditional distinction between those rights that are immediately realisable and those that are subject to progressive realisation has important ongoing implications for assessing state compliance with the CRPD (French, 2008).
- Articles 31 to 40 of the CRPD are ***implementation and monitoring provisions.*** They contain arrangements required for implementation and monitoring of the convention at both the national and international levels. For example, at the national level this includes the establishment of focal points and coordination mechanisms to coordinate cross-sectoral implementation measures. At the international level it includes the establishment of a new treaty body to monitor implementation of the convention, and to receive complaints about violations of CRPD rights (French, 2008).

Further reasons for reform:
-to fix structural inequities in the current support service framework and develop overall, a less complex, more streamlined support framework for Australia

-increase efficiency with funding pathways – direct from funding source to consumer

-streamline/unify states transport accident and Workcover arrangements, rather than having a separate scheme in each state, given population in Australia is only 22 million and there are approximately 20 different transport accident and Workcover schemes alone in Australia

-create a single scheme (nationally) focused solely on providing the most progressive and responsive support it can for all people with impairment, based on equitable use of resources and capacity available.

-improvement of measure and reporting capabilities at a national level

-increase choice for individuals in how they wish their allocation of resources are utilisied

-move towards a new scheme that incorporates world's best practice in support, rehabilitation, childhood development and early intervention, that could only occur with a national system

What are the specific design implications of the UN Convention?

Refer to French (2007, 2008)

What weight should be given to each of the various objectives? How should the various objectives be traded-off against one another if they conflict? P13

Refer to French (2007, 2008)

2. Chapter 5 Design elements of scheme

Are there are other design aspects of a scheme that are important? How are they important and how should be incorporated into a scheme? P14

Structured review system (annually)

Structured appeals/resolution processes relating to allocations i.e. people not happy with allocation received

Structured grievance system for people not satisfied with standard of support received from a service provider. Resolution processes and accountability measures.

3. Chapter 6 Eligibility

Is need the appropriate basis for eligibility?

Yes, however certainly there is an initial task of demonstrating need. This should not be onerous, and in the case of people with fairly standard supports needs, where hours/equipment/medical supplies each week are the same, should not need to be too repetitive. i.e. if you are a C5 quadriplegic, is there persistent need for medical authorities for standard and recurrent items.

What groups have the highest needs or have been most disadvantaged by current arrangements? P16

People with high-level spinal cord injury (SCI), acquired brain injury (ABI) or worsening degenerative medical condition under state based funding that experience restricted parameters of many support and equipment programs (i.e. only 34 hours/week attendant care or only $450/year of funding for medical supplies). These people are often heavily reliant on informal support and in worst instances in past, have been forced to move into aged care facilities so that basic support needs could be met.

Children born with impairment reaching 18 and moving onto mainstream disability support structures with similar restricted parameters in service availability, added difficulties of needing extra training to gain skills for employment and difficulties in parameters of youth allowances/disability support pensions and incentives for employment

To what extent should other facets of a person’s life: their location, access to services, family circumstances and any disadvantages affect eligibility?

These varying circumstances will affect eligibility, and may need to be assessed on a case-by-case basis. Certainly levels and capacity of say informal support available is a key factor, also the varying capacity of individual’s in managing day-to-day tasks needs to be assessed, and also where support may be needed in relation to social activity and community involvement.

Further, for people having acquired an impairment, increased allocations may be required for the first few years in readjusting to change in lifestyle and supporting social/community reengagement in new and/or different physical or cognitive capacity.

Location – for people living in regional areas where attendant carers providing support are required to travel more than 50km on any one day to provide support. Possibly travel payments may be included in how allocation can be utilised and added to allocation amount. This would also act as an incentive for attendant carers in more remote regional areas to take on work.

How should carers' needs be factored into eligibility?p17

As noted above, travel allowances for attendant carers traveling more than 50km on any one day added into allocation. Provisions for meals in allocation also.

Subsidised training for carers to improve capacity to provide standard of support provision, and upskill attendant carer workforce overall.

Payments for some levels of informal care – would require assessment and monitoring by an external party to ensure utilization is reasonable, equating with actual support provided. Paid informal support would also provide an avenue for informal carers to establish a needed superannuation base in recognition of their work role.

What are the implications of adopting more or less generous eligibility criteria on fairness, adequacy of services, costs and incentives, and how could these be addressed?

More eligibility:
–some risk of dependency developing, such as individuals 2 to 3 years post trauma being unable or not wishing to move off 24/7 attendant care where there is scope for increased independence
-can the system hold-up financially? Needing to ensure there is capacity and recurrent funding for expanded levels of support at high-levels.

Less eligibility:
-risk of not meeting he Human Rights of individuals as prescribed under the CRPD. Risk of not meeting basic support needs at a daily level in terms of personal care, and not providing adequate support required for reasonable quality of life and achieving social inclusiveness for people with impairment.

Should the scheme apply to new cases of disability or to all people with existing disabilities? P21

All. People on existing schemes with ongoing income payments etc should be paid-out (e.g. those under Workcover arrangements from 1990s). All forms of income should be from only employment, DSP or a one-off lump some compensation that would provide personal income. People would then continue to be means-tested in relation to receiving any income benefits, but this would not be related to support needs. Provision of support service allocations would then sit separate from any income or compensation payments and would therefore not need to be means tested (nor should support allocations be).

To what extent should eligibility include people experiencing short-term disability (7 to 12 months) compared with people whose disability (and associated needs) is expected to last for many years?

It should include short-term impairment subject to review schedule – see below

How often should eligibility be re-assessed?

Eligibility for support allocations for short-term impairment should be reviewed initially at 3 months, 6 months and 12 months, and then at 12 months ongoing as required.
Eligibility for support allocations for people with degenerative medical conditions 12 monthly or anytime if there is significant change in life circumstances, with further availability of immediate emergency allocation if required, say where a medical episode arises, and increased allocation on a daily level is required for 3-4 weeks if say returning from hospital or to recuperating after serious medical event related to condition (e.g. pneumonia, neurological episode with MS)
Eligibility for support allocations for people with recurrent high-level need – 24 monthly or anytime if there is significant change in life circumstances, and again with availability of immediate emergency need allocation if a medical episode arises.

Should means or asset tests affect eligibility for the scheme, the amount or type of services funded by the scheme, and the size of any copayments? If tests were appropriate, what income or asset thresholds might apply?

No. Certainly receipt of support service allocations should not be means tested.

Again means testing should only be utilised to assess eligibility for income benefits such as DSP, where an individual is not employed (or not obtaining personal income from lump-sum compensation payment). I think the current means test level of approximately 250K on assets other than private residence to obtain the DSP is reasonable

What would be the impacts of means testing? P22

If support allocations were means tested it would create fractures within the support framework. Some people would sit outside the framework, and others within, and there would be the ‘grey’ area around eligibility. If people are fortunate to have a high financial base, they should not be forced to utilise these personal funds just to meet daily support needs, and deplete their income base to pay for needed support. If they are wealthy enough, then hey just don’t receive a DSP.

Provision of support services is a responsibility of the state. As a community, we have acknowledged that receipt of state funded community-based support for people with impairments is something that is just, fair and humane. We acknowledge that provision by the state of funded support services meets our responsibility as a community in achieving dignity and human rights for all members of our community.

4. Chapter 7 Who makes decisions

How can people with disability and their carers have more decision-making-power in a national disability scheme?

Decision making power for individuals with an impairment and their carers would be significantly improved by utilising a model of direct support, where all individuals would be transitioned onto Individualised Support Packages (ISPs). ISPs would see an allocation of funding provided directly from the administering body to the individual or responsible carer, whereby the individual or responsible carer would then purchase support as required from this allocation.

ISPs would give people with impairment increased choice and power in how their support needs were met, giving individuals and responsible carers the ability to prioritise their support requirements and give weight to specific support requirements they wish to purchase. The utilisation of an ISP model would mean restrictive cappings on amounts of support that can be used on a weekly or yearly basis associated with many support service programs would be avoided, and individuals and responsible carers would instead be free to purchase support requirements of their choice and up to what is required from their support allocations.

A widespread transition of all individuals with impairment onto ISPs, regardless of their current scheme structure, would work towards creating more equity across the support framework, and reduce inequity between differing funding schemes that currently exists (e.g. the significant disparity in funding allocations available between TAC and DHS claimants in Victoria). Provision of support services would then not be dictated by structures based on how an impairment was acquired, or a medical condition or if someone was born with an impairment, but instead ISPs would provide scope for all individuals to receive an allocation for funding to purchase support services based on need.

How would the success or failure of new approaches be tested?

The success of this reform could be measured utilising a human rights instrument (see section 2 above).

What should be the decision-making powers of governments and service providers?

The decision-making powers of government in relation to utilization of funding should be placed under the provision of a newly created national statutory authority. This statutory authority would operate similar to that of the TAC in Victoria, administering and monitoring ISP allocations to individual's or responsible carers. The statutory authority would assign a casemanager to each individual or responsible carer to manage queries, coordinate reviews and monitor ongoing usage on a monthly basis in reviewing allocation payment receipts.

No decision-making powers would be given to service providers. They would operate in a consumer driven environment, where individuals or responsible carers would be invoiced by service providers for services utilised, and payments would then be made from an individual's or responsible carers support allocations. As such, service providers would not need any decision-making powers in relation to support usage, as the decision-making in relation to amounts of support required would be made solely by the individual or responsible carer.

What have been the experiences overseas and in Australia with individualised funding, including their impacts on outcomes and costs? What lessons do these experiences provide for adopting this approach as an element in a national disability scheme?

My experience in utilising an ISP is that there has been an improvement in transparency of costs. In being able to review costs of service provision personally, there has been improved accountability by the service providers in how services are actually being costed, including the ability to seek further clarification in costs presented. There has also been improved transparency in hours and times being presented to service providers by attendant carers which has also led to increased transparency of costs.

In relation to this, there does appear to be some resistance by service providers around the ISP, with nervousness related to transparency and in having to detail costs.

A further experience has been a slight increase in administrative burden. This administrative burden is a result of having to personally review times and costs presented on invoices from service providers, administering payments to service providers and then providing summaries of monthly payment schedules to my funding provider TAC, each month. In total, this administrative burden has added up to approximately an hour each week in administering ISP. I also had to purchase a scanner so I could scan a copy of cheques and invoices required by my funding provider each month, which cost ~$100 from my personal income.

My experience has also been a felt improvement in my choice and control in how my support is funded and what the real costs related to my support are.

Should individualised funding include the capacity to save some of the annual payment for future purchases of services or borrow from future payments to pay for current services?

Yes and no. Certainly there should be capacity to save some annual allocation for future services (such as major equipment purchases required) if there is capacity. If the funding case-manager is made aware of why allocation is being banked, it would not appear to be a significant issue, and an individual or responsible carer should be able to work together to ensure the supports goals of the individual or responsible carer are met and review an allocation if extensive increases are needed to cover support needs. Allocations could also be higher for say the first 2 years after a traumatic event or medical diagnosis to fund needed equipment purchases, vehicle modifications and house modifications required, on top of personal care and general support service provisions that may be required

I don’t feel there should be scope to borrow from future allocations. This would create budgeting difficulties at a funder level. There is also a concern that the client would never ‘catch up’ so to speak on allocation, and if using full allocation in subsequent years after an ‘allocation loan’, would never catch up on putting allocation back into system, creating a continual and remaining allocation deficit.

I feel the framework would be strengthened by providing increased allocations for required supports and modifications in initial phases of trauma rehabilitation/medical diagnosis.

How should the national disability scheme support people’s decision-making under individualised funding, taking account of the spectrum of disability — both in terms of the nature and severity of disability?

I feel it would be good practice to have written schedules for how ISP allocations could be utilised, with clear and defined schedules on how and for what an ISP allocation can be utilised. These would need to be provided to individual or responsible carer before receiving any ISP allocation so that there was clear understanding by everyone as to how the funding allocation could be utilised and what was permitted within the scope of the allocation.

Training of individuals or responsible carers may be required to ensure there is understanding of the new funding model, to ensure obligations and responsibilities are met. This may involve increased levels of communication with case manager during initial implementation phases.

Again, some monitoring and assessment of the responsible carer will be required where they may be approving costing from the allocation for their own hours worked as an attendant carer. Possibly hours worked by a responsible carer may need to be fixed each week to ensure accountability for hours they are approving, and if a variation in hours is worked, seek some approval from case-manager regarding the specifics of the change.

A national scheme would improve capacity of individuals to move between councils and states, and even provide capacity to live overseas if there is a wish.

Should all people be able to access individualised funding, and if not, what guidelines would be appropriate?

Yes. All individuals with an impairment would receive an ISP allocation. In instances where an individual could not be deemed to manage an ISP allocation for cognitive or mental health reasons, a responsible carer could be nominated by an individual, or if in agreement to role, assigned by the case-manager.

What are the risks of individualised funding and how can they be managed? What guidelines would be appropriate? How would any accountability measures be designed so as not to be burdensome for those using and overseeing the funding?

Many of the risks and management of risks have been discussed above (i.e. approval of own wage from allocation by responsible carer – fixed hours/role of case manager, parameters of ISP spending – having schedules).

Further risk may be overspending of allocation each month. The case manager would then have a role in ensuring monthly allocation was adequate, in need of review and/or if the individual had reasonable capacity to manage the ISP allocation. Remedies could be increased training for individual or responsible carer, or buddying with case manager in making first month or two of payments. Where over-spending of ISP allocation was consistent, the case manager would need to asses capacities for managing ISP allocation and consider assigning responsibility of ISP allocation to a responsible carer.

Risks associated with direct employment of carers through ISP; this would decrease accountability and make assessment of duty of care and human rights responsibilities very difficult; the buffer when things go wrong that is provided by a formal support provider would be lost; as with loss of recruitment expertise and security checks of new staff provided by service provider; loss of advantage of having a third party involved in an issue/dispute resolution/incident involving an attendant carer (i.e. in abuse cases)

Should people be able to treat funding as ordinary income and do what they like with it?

No.

Should primary carers or other family members be able to pay themselves for providing care?

All support provided should utilise a service provider, including support provided by a family member. All family members would register themselves as an employee of a service provider. A service provider would better provide needed workcover, training and superannuation, offer an avenue of support for family member if needed, and would provide transparency of costs to some extent.

Again, some monitoring and assessment of the responsible carer will be required where a family member may have to approve costing from the ISP allocation for their own hours worked as an attendant carer. Possibly hours worked by a responsible carer, who may be a family member, may need to be fixed each week to ensure accountability for hours they are approving. If a variation in hours is worked, they may need to seek some approval from case-manager regarding the specifics of the variation required.

How would individualised funding work in rural and remote areas where service availability is poorer?

Use of ISPs in remote or rural areas would remain the same with above provisions i.e. family members that may be providing a larger portion of support in a regional/remote area receiving a fixed level of paid support each week unless a variation occurred.

As discussed, travel payment from allocation made to attendant carers as incentive for traveling a distance of more than 50km each day in providing support.

Who would be responsible for monitoring individualised funding?

The statutory authority at a national level would be responsible for monitoring ISP allocation, and specifically authority case managers.

What would be the impacts of individualised funding on service providers and do these impacts matter?

There will be some impacts on service providers. The widespread move onto ISP allocations would reduce some control and power of the service provider in prescribing how past funding could be spent. It will certainly increase transparency and reduce rorting by service providers, of which there is evidence that this has previously occurred.

Further, increased consumer choice will mean if a service provider performs badly, individuals will have a choice to change service providers if they wish, like any consumer with choice in purchasing a service. Service providers will thus need to ensure they provide quality of service, like any other service provider in the health sector industry, or risk potentially loosing business. Service provision would then be consumer-focussed (as it is in most consumer markets).

However, individuals will always require support services, and it is quite a difficult process to change attendant care agencies when the support provision is not up to standard. No doubt their will be some movement, however there is less risk than service providers are presenting of them loosing significant market share with transitions onto ISPs.

How should service providers be monitored and regulated with respect to quality, outcomes and cost effectiveness?

Service providers should be required to adhere to national accreditation for operationalisation of a service provider, met national support service standards, met national award wage conditions, met staff training, superannuation and workcover requirements and met human rights and duty of care obligations in providing support.

This may involve educating service providers of expectations and requirements in meeting standards/legislation/accreditation.

Are there ways other than individualised funding that empower people with disabilities and their families?p25

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5. Chapter 8 The Nature of Services

What are the most important services, their costs, their likely demand and who would be the predominant users?

Refer to current TAC schedules

Should all services be free or should there be scope for co-payments? To which services and/or people might a co-payment be applied? How would the size of copayments be determined?

All support services should be funded within the structure of an ISP allocation. This includes allocation for more expensive service requirements/equipment/modifications where required which are reasonable to the impairment or medical condition and are not overly excessive. Individuals should not be forced into having to copay for any services/equipment/modifications which are related to an impairment or medical condition which are deemed reasonable, as the state is recognized as having responsibility for these. An appeals structure would be established to review reasonableness if required.

If, in the unusual situation of an individual having ample wealth and wishing to purchase services/equipment/modifications privately or purchase services/equipment/modifications above reasonableness, then this would be their choice, and ISP allocation could be utlised based on assessed need and reasonableness. Possibly any single payment over 5K may need to get approval from case-manager.

To what extent, if any, should people be able to cash-out the benefits from a basic service/appliance/aid (for example, a wheelchair that met assessed need) and use it as a part payment in purchasing a premium service (a more advanced wheelchair)?

Again, all support services should be funded within the structure of an ISP allocation based on reasonableness. This includes allocation where more expensive service requirements/equipment/modifications are required which are reasonable to the impairment or medical condition and are not overly excessive. Individuals should not be forced into having to copay for any services/equipment/modifications which are related to an impairment or medical condition which are deemed reasonable, as the state is recognized as having responsibility for these. An appeals structure would be established to review reasonableness if required.

How are service needs likely to change over time and how should that be accounted for in designing a long-term care system?

Changes in individual service needs and requirement would be addressed annually within the review.

Statutory authority would be independently audited every 5 years to ensure it is adequately meeting funding allocation need and that there is not significant shortfall in adequacy of allocations being provided. Audit would ensure that premiums and government funding contributions are adequately covering funding need and that scheme remains viable long-term.

What are the challenges for delivering expanded services in remote and rural Australia, including for specific communities, such as Indigenous Australians, *whose needs may vary?*

Use of ISPs in remote or rural areas for Indigenous Australians would remain the same, with provisions for family members that may be providing a larger portion of support in a regional/remote area able to receive payment for support provided, subject to normal ISP monitoring and guidelines.

As discussed, introduce a travel payment from allocation able to be made to attendant carers as incentive for traveling a distance of more than 50km each day in providing support.

How could innovation be encouraged? P26

Establishment of larger research centres related to impairment and ‘disability’.

Should assessment gauge both eligibility and the extent of need in the one set of instruments, or should the assessments be distinct? P27

Separate

Should a nationally consistent tool be used (and what process would be used to achieve consistency quickly)?

Yes

Who should use assessment tools (GPs, specialist disability staff, specialists)? Who should employ or engage the assessors?

Qualified occupational specialists funded by national statutory authority.

Should income support and disability service provision be coordinated as part of a package, and if so, who would do that and how? What conflicts or synergies could arise between a national disability scheme and income support?

No, as discussed above, income should remain separate from support allocation. All forms of income should be from only employment, DSP or a one-off lump some compensation that would provide personal income. People would then continue to be means-tested in relation to receiving any income benefits, but this would not be related to support needs. Provision of support service allocations would then sit separate from any income or compensation payments and would therefore not need to be means tested (nor should support allocations be).

How could the capacity for people to move between services — both intra and interstate — be made easier?p30

Utilization of ISPs allocations within a national system would remove most structures currently restricting intra and interstate travel

How should disability associated with catastrophic injuries be addressed?

Individuals would receive all needed and reasonable support services through ISP allocations following an assessment of need by a national statutory authority. These would be reviewed annually, and allocated based on need, regardless of state or territory jurisdiction or how impairment was acquired.

Ability to make a common law claim for compensation in relation to fault associated with how an impairment was acquired would be available. A Common Law claim for compensation would assess loss-of-earnings and pain and suffering incurred as a result of negligent act, and would award compensation based on its findings. As with the Victorian TAC system, compensation payments would be capped at just over $1 million to avoid drawing on resources of funding pool too severely.

What are the benefits and costs of alternative approaches, including any effects on service provision for those covered by existing systems?

A hybrid scheme of ISP allocations and opportunity to claim for compensation through Common Law would be introduced to create uniformity at a national level across the support service framework.

Compensation processes would be streamlined to reduce current complexities. Five diverse pathways in relation to the receipt or non-receipt of compensation were identified. Four of these pathways were determined solely by how an individual had acquired their SCI and the funder/insurer they were subsequently assigned to, while the fifth compensation pathway identified was where individuals had chosen not to pursue any claim for compensation based on their own personal judgements.
These pathways were identified as:

- An individual pursuing a Common Law claim in seeking to receive compensation and being awarded a single lump-sum payment
- An individual receiving a single, automated pain & suffering compensatory payment and then ongoing, fortnightly loss-of-earnings payments
- An individual receiving compensation through a single, automated insurance-based payment (usually through a private insurance scheme)
- An individual choosing not to make any claim for a compensatory payment or enter the legal system in any way
- An individual having no opportunity to make a claim for compensation in any form as adequate fault could not be attributed

Compensation reform would see only 1 pathway remain in claiming compensation, that being where regardless of how an injury was acquired, an individual could pursue a single claim for compensation through

Common Law were fault/negligence could be attributed to how the impairment was acquired. This would include claims based on medical negligence, fault in relation to a transport accident, fault in relation to a workplace accident, victims of crime, military accident or any public liability claim for compensation by an individual.

*all individuals in following discussion have been de-identified
Compensation is also not viewed as provide any form of redress for their injury and is viewed as inadequate in restoring the past, however it is viewed as providing a buffer & significantly increasing financial security and comfort

In terms of individual experiences of compensation pathways, the sheer diversity of the experiences reflects the diverse pathways. Various levels of satisfaction and dissatisfaction were communicated based on amounts and adequacy of payments, opportunity for involvement in negotiations, understanding of processes, being ‘locked-in’ to payment schedules authorities, the time taken in resolving proceedings, or financial security that was felt in association with the receipt of the compensation.

Despite these extensive challenges with the Common Law legal processes related to their compensation claims however, significant advantages were noted by individuals once their Common Law claims had been settled. Jim and Lawrie noted having more freedom, flexibility and lifestyle choice once they had received their compensatory lump-sum payments. They felt satisfied with their assessments in relation to their employment income and financial benefits, and were relieved that they were no longer items of scrutiny and assessment by the insurers.

Experiences of participants receiving automated, insurance-based compensatory payments for pain & suffering and ongoing payments were varied again. Individuals noted high levels of satisfaction with the speed and efficiency with which their automated pain & suffering compensatory payments were received, however felt some resentment in not being able to actively pursue a claim for compensation through Common Law processes and be involved in negotiations in relation to their assessment. Further, these individuals expressed frustration with the lowered amounts of compensation received in comparison to people settling considerably larger compensation claims outright through Common Law processes.

These individuals noted feeling dependent and tied to their overseeing statutory authority in relation to these ongoing compensatory payments. They noted that the payments were now not going as far as they had in the past with rising costs and that the fixed levels of ongoing income payments were now not providing an adequate income to meet their lifestyle needs.

In contrast, other individuals viewed their fortnightly loss-of-earning compensatory payments as brilliant equating it to a private pension. Annie communicated being glad she had not had to fight for her compensatory payment and overall quite satisfied with the structure of the ongoing compensatory payments. In contrast to other individuals, Annie communicated being relieved that she did not have to financially administer any large compensatory payment, and seemed content with TAC (having taken over ongoing management of MAB clients) taking on the financial planning role and providing her with her set ongoing fortnightly payment. She equated these payments as her financial buffer, as aiding her economic status, as increasing flexibility in her lifestyle and as reducing levels of financial responsibility for her.

A further pathway identified was minor, automated, insurance-based compensatory payments made as a single payment and assessed by a private insurer. These individuals noted having no scope for negotiation over the assessment of their compensation payment received, and no access to legal teams or solicitors in negotiating their claim. Tom noted his experience of receiving only a minor automated compensatory payment was less than adequate and did not cover more than his first month of living expenses once he returned home from rehabilitation. Tom also queried how the amount was supposed to provide an income support for him for the rest of his life, and viewed his automated payment as insufficient in providing extra funding he required to cover his personal healthcare needs.

Distinct again was the pathway where individuals had no opportunity at all to make any form of claim for compensation. Both Matthew and Graham, because of the circumstances in how their SCIs had been acquired, had no opportunity to receive any insurance-based compensatory payments as no insurance scheme covered the specific areas of how they obtained their SCI. Further, as no fault could be attributed to any party for the occurrence of the SCI, neither of the individuals where able to make any claims for compensation through either legal or regulatory processes or a public liability claim.

The final pathway was where individuals chose not too make any claim for compensation, even though fault and negligence could reasonably be proven to exist and where a compensation payment most likely would have been awarded. These individuals cited events associated with how their impairments were acquired and feelings of moral blameworthiness associated with events as reason for not pursuing any claim for compensation.

The regulatory framework associated with the receipt of compensation within just one state thus demonstrates the significant variation in regards to claims for compensation through various insurance-based and legal means. In the cases Matthew and Graham, the inability to claim for compensation was not a result of any form of assessed justice based on how the SCI was acquired, or personal judgements made by the individual in not wanting to make a claim for compensation, but purely because neither of them fell within the parameters of any of the legal or insurance-based structures in which they could claim for compensation through. These individuals fell within what would best be described as a regulatory and legal gap in the compensation framework where because of the specific ways in which they acquired their SCIs, no opportunity to claim for any form of compensation existed. Variation in opportunity to claim for compensation thus emerged based on how an individual acquired their SCI and where each individual was positioned within the compensation regulatory framework as a result of this.

As the pathways associated with compensation discussed above demonstrate, the regulatory framework in association with the receipt of compensation in one state alone is diverse. Regulatory parameters between Common Law claims, automated payments, ongoing payments or no access to either of these structures raise significant issues of equity in relation to the awarding of compensatory payments across the state and at a national level. The extent to which this in turn impacts on lifestyle factors and the extent to which compensation can then in turn be used as a support base, and as a mechanism of rebalancing lifestyle following a SCI is diverse. Notably, having no opportunity to claim for compensation following a SCI, and where other factors such as no fixed accommodation, income from only a pension, low financial stability or shortfall in support service provision, can potentially place a person with a SCI in a vulnerable life situation.

However, it was also evident that despite the variation in pathways associated with the receipt of compensation and significant variation in sizes of compensatory payments able to be received across the compensatory framework, where an adequate form of income was available, such as from regular employment, and where an individual’s financial status was secure, and where support networks were well structured, there appeared to be a significant reduction in resentment or dissatisfaction at the inability to make a claim for compensation (or in receiving only a minor claim for compensation). Where more secure and stable financial and social positions were evident, individuals often moved entirely outside of reliance of their compensatory payment all together. It appeared evident that where individuals had became less reliant on compensation for income and financial support, and had achieved a level income security and stability from employment, that dependency and reliance on compensation was reduced. Although the awarding of a considerable compensation payment was viewed clearly as a buffer and as providing financial assistance to either purchase more provisions, equipment, provide an income if not employed and/or taking committee roles, or provide income if health was a consideration with employment, for individuals that had acquired a SCI and had returned to employment and were supported by employment income, less dependency, reliance and fixation on the ongoing and long-term status of their compensation payment was noted.

Are there lessons from existing injury insurance systems in Australia and New Zealand for a national disability scheme — regardless of whether those systems are incorporated into a national scheme?

Utilise TAC model nationally, highly progressive and reasonable and inclusive of ability to claim for compensation through Common Law. The scheme adequately covers reasonable support service needs and has been using ISPs for 2 years now.

Issues with ACC in New Zealand - refer to Duffy 2003
German insurance scheme has an individual's insurance income tied to their employer. In this way there is increased incentive by the employer to get someone that has acquired an impairment back into an employed role as any income payments being received by the individual are from the employer's insurance, so it is their direct interest to get an individual back into an employed role, rather than say just Centrelink's effort to get someone off a DSP.

What rights should remain, if any, for common law actions if no-fault arrangements were introduced?

Concerns with comment in discussion paper that compensation is a flawed system on page 23? The compensation system has its issues, however the system and concept of compensation is universal and a strong means of social rebalance and redress following the occurrence of a social wrong or breach.

Compensation is a universal social concept that emerged within social groups in ancient times. It was established in order to prevent revenge or eye-for-an eye reactions following the occurrence of a negligent or wrongful act. Where a negligent or wrongful act was said to have occurred, compensation in the form of financial reimbursement was paid to make amends or redress a wrongful act. The receipt of financial reimbursement as compensation for the act thus served to limit personal vengeance and deter further injuries (Rickett 2003; Robinson 2009). Once a breach of social duty had been identified and responsibility for the breach had been assigned, a financial reimbursement was awarded to the injured party back to restore them back to the position they were in prior to when the breach occurred (Rickett 2003; Drabsh 2005). A breach included where a known social standard or duty had not been adhered to, where a level of responsibility had not been met or where an act of negligence by one party had caused loss to another (Robinson 2009).

The compensation as a concept emerged within social groups in Western Europe as far back as the tenth century. Germanic Law understood a 'weregild' as a financial payment made as an offering to a family or a clan for a wrong, such as an injury or death. 'Were' stood for man, and 'gild' for money i.e. the money you pay for injury or death of a man (Robinson, 2009). A weregild aimed to provide a 'repair' within socially acceptable boundaries, and was awarded according to the severity of the wrong that had been made. This included settlement of feuds, disputes, theft or murders. The person receiving the wrong could be paid to abstain from retaliation by being able to compel the perpetrator to render him monetary compensation for a wrong, limiting vengeance and deterring injury (Crawford 1993; Easton 2003). A weregild thus acted as an ancient compensation system for loss of life.

Compensation schedules payable for injured parties also date back as far as Saxon England. St Augustine (having entered England in 597AD) is attributed with having encouraged local rulers to write down the law and document payments for lability that had been made to individuals as a result of injury or death that had occurred. As smaller villages within Saxon England started to merge together to form kingdoms, an ever increasing body of work related to compensation schedules and amounts liable was established, forming the basis of legal compensation precedent (Robinson 2009).

The Maori concept of *Utu* also sought to maintain social balance and involved the concept of a reciprocation or balance in response to an action (Easton 2003; New Zealand Government 2009). This includeds acts of revenge, a reward or reciprocation of kind deeds or a transfer of goods and services. Assessment of *Utu* was generally left to the receiving side's kin to assess an appropriate response. Both friendly and unfriendly actions require an appropriate response. Hence, *Utu* was thus utilised to restore balance and restablish harmony where social relations had been disturbed, covering the reciprocity of kind deeds, the seeking of revenge, and obligations between individuals and groups (Easton 2003; New Zealand Government 2009).

In 1841 Emerson, in *Compensation: An Essay,* highlighted that compensation was fundamentally associated with justice, retribution and natural life balance. He viewed compensation as having the potential to provide a level of justice or judgment often visible in nature, highlighting the particular polarity of compensation through the dual lenses of action-and-reaction and standards of good-and-ill (Emerson 1841). Emerson viewed compensation as a mechanism through which nature could rebuild its balance and re-level circumstances, something he viewed as occurring in every part of nature following a loss. He viewed compensation however as a means of evolving, as increasing from nature, and of moving away from the 'old law' and as a universal entity of physical retribution, halting commonly operating revolutions of retribution through evil acts that often developed within a social landscape. For Emerson, compensation was thus the absolute balance of give and take, allowing the use of law to achieve equal rightness and revise wrongs.

The late eighteenth century saw the first development of a formal injury related compensation schemes within westernised societies, whereby men who had been disabled in the American War of Independence received financial compensation for their injuries (Fox 1993). The period also saw the development medical Laws of Negligence in Europe between doctors and patients where negligence had occurred. On the basis of compensation for medical negligence, compensation was gradually expanded to provide financial reimbursement for injury resulting from generalised acts of negligence in the workplace (Easton 2003). Germany, under Bismarck's rule, enacted statutory protection for its workers in 1884, while the British Workers Compensation Act was passed in 1897 (Easton 2003).

Outside of Europe, New Zealand established its Workers Compensation Act in 1900, while Australia, the United States and Canada choose to introduce Workers' Compensation schemes on state-by-state bases

(South Australia Workmen's Compensation Act 1901; Queensland Workers' Compensation Act 1905; Victorian Workers' Compensation Act 1914; NSW Workers Compensation Act 1910 for dangerous occupations and expanded to all workplaces in 1926). The development of these schemes provided the first structured frameworks for the provision of compensation, allowing a worker to make a claim for financial reimbursement if an injury was acquired as a direct result of an employment-related activity (Easton, 2003; Productivity Commission: Inquiry Report No. 27, 2004)

The receipt of financial compensation following a workplace injury also provided some of the first official connections between the medical profession and the state within the western legal system (Fox 1993). The establishment of these compensation schemes involved the medical profession both in setting standards for compensatory awards and negotiating fees for treatment of compensable illness and injury (Fox 1993).

In westernised societies, the role of the courts in assessing the provision of compensation was extended as a result of these developments. The role of the courts came to include investigation into how and where the negligence had occurred, establishment of the extent of the negligence, making a finding, and nominating a mechanism for redress, and/or amount of compensation as deemed appropriate (Rickett 2003). The burden of proof was thus placed strongly on the claimant to demonstrate where and in what way a breach had occurred, and demonstrate that loss had occurred as a direct result of the injury (Rickett 2003). Once negligence was established, the courts assessed the extent of monetary reimbursement against legal standards of moral blameworthiness and contributory negligence by the claimant, and awarded the compensation payment (Goudkamp 2004; Drabsh 2005).

The Common Law of Tort

The development of modern day law associated with the provision of compensation following an injury is known as the Common Law of Tort, Tort law or Injury law. Tort law has developed primarily through the Common Law system, with the term 'tort' being the French word meaning 'wrong' or 'injury' (Cane and Trindade 1999). The Law of Tort is made up of a number of torts including trespass, defamation and negligence. It is used in assessing civil wrongs, such as some breaches of contract, protecting an individual's physical and mental health and safety and in resolving differences between interests in land, goods or property. Most commonly however, it is used in relation to personal injury (Cane 1999).

The use of Tort Law to assess personal injury through a Common Law process draws on principles of duty to ones' fellow subjects, and specifically occurrences of breaches of duty. Duty to one's fellow subjects is imposed by law, and not between the parties themselves, and thus each member of society thus takes it upon themselves to obey the law imposed and act in a manner that ensures the safety of their fellow citizens. The role of Tort Law is thus to determine the extent of negligence, on behalf of one subject, where a breach of this social duty has occurred and where another party has breached this duty and legal obligation. If this breach of duty results in an injury, and it is proven that a level of negligence has contributed to this breach and consequent loss, then it may be deemed that compensation, in most instances in the form of monetary damages, be awarded to the injured party (Cane 1999).

The use of Tort Law in assessing a breach of duty, and consequently in assessing a level of compensation to be provided to an individual for personal injury, is directed by a number of key criteria. These include evaluating the nature and extent of a claimant's loss, assessing assets in determining appropriate amounts of restitution, assessing the forms of compensatory relief available, awarding monetary damages to provide remedy, and establishing if there are any restrictions, parameters or legal technicalities associated with the scope of a remedy (Cane 1999; Luntz 2002; Rickett 2003). There are also requirements to determine the extent of compensation required to prevent the continuation of any breach of duty or injurious actions, the extent of the personal nature of any breach, the extent of causation of any breach and the extent to which a breach was foreseeable (Cane 1999; Luntz 2002; Rickett 2003). Determining real life costs (i.e. personal loss) in relation to breaches of duty and negligence when they occur, evaluating conditions attached to negligence, and assessing levels of equitable compensation, are all part of the complex tasks for the courts in assessing damages. Once damages have been assessed in association with a claim, a claimant may not re-apply for adjustments to the compensation amount awarded, even if the situation worsens at a later date (Luntz 2002).

A Tort Law claim through Common Law is initiated by the injured party, or their representative, following the acquirement of an injury. Once court proceedings are commenced, agreement is sought informally through legal negotiation outside of formalised court proceedings in an effort to determine the extent of negligence and establish a level of compensatory monetary damages that could be awarded to settle a claim (Cane 2003). If negotiations are successful, the claim is said to be settled out of court. If a claim cannot be settled through legal negotiation, the claim for compensation then proceeds to the courts. After the assessment of personal injury and extent of compensation awarded, the claimant is then said to be in '*restitutio in integrum'*, or put back in the position they would have been in had the tort not been committed (Cane and Trindade 1999). The state of *Restitutio in integrum* differs depending on circumstances of the type of loss and how assessment of the loss is applied. Factors influencing assessment include the extent of the injury on future physical and/or cognitive, the predicted potential financial earnings of the individual, estimated future need and future tax and inflation implications. The awarding of compensation following an injury is thus viewed as remedy for a breach of duty, *restitutio in integrum* and redress for the injury that occurred (Luntz 2002).

A famous English legal case associated with establishing the legal liabilities and negligence associated of compensation, and the legal liability of moral blameworthiness is that of Donoghue v Stevenson 1932

(A.C. 562). Donoghue v Stevenson 1932 established the legal concept of liability in moral blameworthiness. The prevailing outcome was an understanding that tort of negligence was based on notions of moral blameworthiness, that furnished the philosophical foundation for liability.

Advantages of Common Law of Tort

A range of views exist on the extent to which Tort Law is an adequate and equitable mechanism that provides the best remedy and redress for people entitled to a compensation. The advantages in assessing compensatory claims through Tort Law are numerous. These include established principles of protection and redress, and considered pre-requisites for liability, and of Tort Law acting as a practical mechanism in responding to a compensatory claim (Mullany 2002c).

Tort Law also allows scope for the courts to mark their disapproval at negligent misconduct by defendants engaged in reprehensible behaviour (Mullany 2002a). It allows negligent conduct to be tested in a legal setting and for the extent of individual responsibility associated with the cause of the injury to be emphasised and clearly assigned. Tort Law also allows for a decision to be appealed by both parties if the outcome is deemed not satisfactory (Mullany 2002b).

Tort Law is also viewed as advantageous in that assessment through Tort Law allows personalised assessment of individual circumstances in a judicial setting, surrounded by established principles and criteria of assessment (Mullany 2002a). The utilisation of Common Law of Tort processes and schedules within the courts, allow for a claim to be most thoroughly explored and debated within the judicial setting and for the full level of debate and evaluation in relation to be the claim to be taken-on.

A further advantage of Tort Law is the ability to test findings made by medical professionals through judicial processes. Judicial experts claim that only through the rigorous assessment allowed by the courts, are the findings made by medical professionals able to be fully tested (Mullany 2002b). This contrasts dramatically with assessments of injury and findings made by medical professionals within the setting of an insurance sector assessment panels, which are often viewed as less accountable, with no scope for testing of findings, no options or rights to appeal the injury assessment, and in the case of TAC, no scope to include the specific views of treating doctors or specialists (Drabsh 2005; Chu 2007)[1]. Despite claims of improved time efficiency in case resolution and standardisation of claims, insurance sector assessment panels and their ‘schedules –and-tables’ were generally viewed as a harsher and more impersonal means of evaluating a claim. The utilisation of medical practioners through the use of Common Law of Tort are viewed as less likely to be acting in the interests of insurance companies, and exposing the interests of claimants to the whims of insurance companies alone. Mullany (2000a) notes that

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[1] VWA medical panel context has scope for appeal and treating doctor information to be used

medical assessment through the judicial process, allows for a judge to adjudicate a claim as per his/her prescribed role, rather than a doctor or bureaucrat. As such, medical assessment through judicial process more effectively defers standards of Common Law to professional bodies ensuring basic principles of judgement are met, as opposed to claimants being exposed to insurance companies. Cane (2003) notes that despite the attraction of consistency and coherence of insurance-sector assessment panels, in reality these insurance-sector assessment panels serves to simply create a more simplistic form of assessment and justice.

The use of Common Law of Tort in assessing a claim Law is also highlighted as being a more effective form of behaviour modification (Spigelman 2002). The threat of litigation has been demonstrated as providing an effective deterrent in encouraging people to behave in a safer manner, as providing an action that forces accountability and as encouraging improved social practice (Ison 1994; Cane 2003; Drabsh 2005). The fear of the initiation of legal action has historically acted as a successful incentive for people to maintain high levels of safety and prevent the occurrence of injury, and thus works successfully in forcing individuals to be more accountable for their actions (Spigelman 2002; Mullany 2002a; Cane 2003) Drabsh, 2005 #199}.

The benefits of receipt of compensation through Common Law of Tort processes also viewed as more effectively meeting a claimants immediate right, and reducing stress, anxiety and financial burden of required changes in lifestyle and employment following an injury (Ison 1994; Productivity Commission 2004b). Conversely, the denial of compensation has been viewed as creating anxiety, depression and attributing to sustained financial stress (Ison 1994).

The use of the Common Law of Tort is also viewed as more effectively upholding a claimant's rights to receipt of full benefits and entitlements. Compensation awarded through a Common Law of Tort claim is viewed as providing a fair and thorough assessment of loss of earnings in particular (Mullany 2002a). Proponents of Tort Law actually went as far as denigrating the statutory limitations placed on compensation, such as those of partial compensation schemes like the TAC (Mullany 2002a), and viewed that only through a claim of Common Law of Tort Law can a full and thorough assessment of loss of earning on a long-term scale be awarded.

Advocates of Common Law of Tort also highlight that the model of statutory limitations on compensation awarded by the courts (or limitations from compensation awarded through statutory authorities alone), fundamentally shift the costs from the insurer (in representing the wrong doer) onto the Australian Government's social security system and community at large (Mullany 2002a; Chu 2007). Statutory limitations on compensation lead consequently to increased taxation required by community to fund income expenses no longer met by the compensation allocation received (Mullany 2002a; Chu 2007). The removal of statutory limitations on compensatory payouts would instead ensure insurance schemes took the full responsibility for costs (Mullany 2002a; Chu 2007), and provide increased scope for genuine victims of negligence (whose claim may be anticipated to be close to these thresholds) to claim entitled allocations of compensation. To quote Chu (2007):

> *claimants can be left in a position where, because of the reduction in entitlement for pain and suffering compensation, it is not economically practical for them to pursue a claim, even if at law they would be entitled to compensation for economic loss or medical expenses... few plaintiffs will be willing to proceed with litigation unless there is a real prospect for general damages or [if] economic costs are very high. It does mean that some people who are quite seriously injured are not able to sue at all.*

A further disadvantage of statutory limitations is that it more comprehensively restricts loss of earning payments for high-earners and restricts full entitlement to lost earnings from injury (Cane 2003; Chu 2007). High income earners thus bear most of the loss from the statutory limitations in relation to receipt of compensation, and instead receive only an assigned and arbitrary upper amount for loss of earnings, often in reference to a standard of predetermined schedule (Cane 2003; Chu 2007)

If governments introduced broader no-fault catastrophic injury schemes, what would be the appropriate premium income sources?

Funding for a national support framework, utilising an ISP model and inclusive of Common Law claims, could be funded through the combined revenue of all state based workcover premiums, transport accident schemes and funding from federal government. If these resources were pooled together and administered through a nationally based statutory authority, I feel they would provide sufficient resources for such a scheme to operate.

Workcover and transport accident premiums could be adjusted up or down based on resulting profit margin or increased need within the scheme. Sustainability of the scheme would be assessed by independent auditors who would monitor scheme ongoing and/or review 5 yearly.

If catastrophic injury is bundled with the national disability scheme, how would this be achieved without disrupting existing coherent systems for providing care to people experiencing catastrophic injury? P32

The sheer number of existing schemes is too high, and there needs to be a phased rollback to a single national scheme over next 2 to 5 years.

6. Chapter 10 Financing options

What would be the best way of financing a national disability scheme and why?

Funding for a national support framework, utilising an ISP model and inclusive of Common Law claims, could be funded through the combined revenue of all state based workcover premiums, transport accident schemes and funding from federal government. If these resources were pooled together and administered through a nationally based statutory authority, I feel they would provide sufficient resources for such a scheme to operate.

Workcover and transport accident premiums could be adjusted up or down based on resulting profit margin or increased need within the scheme. Sustainability of the scheme would be assessed by independent auditors who would monitor scheme ongoing and/or review 5 yearly.

To what extent would a national disability scheme draw from funds currently collected through general revenue? Would it replace some existing funding sources or consolidate them?

Funding from federal government could be consolidated with premiums/levies to fund scheme. However, ideally federal government funding for scheme could be reduced, allowing federal government to direct these funds instead towards income benefits (specifically DSP), which would remain the responsibility of federal government.

Conversely, if required, federal treasury would input funds into scheme to maintain scheme viability if required.

Should there be private funding contributions to a national disability scheme? How much? Through what means?

Not directly to the scheme, however individuals could provide contributions through building of accessible infrastructure, donating equipment privately, or providing accommodation to individuals at reduced rates (this would take strain of income benefit entitlements for individuals).

How could a national disability scheme be used to leverage greater community contributions to the care and support of people with disabilities and their families?

Utilisation of an ISP model at a national level would promote models of social inclusiveness and capabilities in providing a stable platform from which life goals could be achieved and capabilities explored. Rather than lifestyle being restricted by complexities and parameter restrictions of support programs, ISPs would provide choice and flexibility in how support was provided, and provide a more stable and efficient platform for support services provision and ensure support is a basis for achieving lifestyle goals and exploring capabilities as opposed to being all consuming and restrictive of lifestyles and personal development.

7. Chapter 11 Workforce issues

How can workers be attracted to the industry? What role should government play in this process?

Increase in wage rates, including penalty rates for weekends

Payment for extensive travel costs in getting to work

What type of skills and workers are required? What role should government play in upgrading the skills and training opportunities available to workers?

Minimum certification in health related area which not only upskills workforce, but demonstrates some commitment to working in the sector.

Compassion, understanding of issues related to disability rather than aged care, a level of basic fitness, courteousness, understanding of duty of care and responsibilities under Human Rights frameworks.

What role could volunteers and workers in mainstream services play?

Not a significant role, majority of support provision should run through an accredited service provider to ensure standards are met.

8. Chapter 12 Governance and Infrastructure

Who should do what in a national disability scheme (probity and accountability, data collection, financing, planning, gatekeeper, claims management), and how would these functions be organised?

Refer to above discussions on structure of a national scheme and utilization of TAC model at national level

should government departments or an independent statutory body administer the scheme?

Again, Refer to above discussions on establishment of national statutory authority

to what extent could one agency act as the fund holder and overall decision maker (the role performed by the Transport Accident Commission in

Victoria for people affected by catastrophic motor vehicle injury)?

Very effectively; Refer to above discussions on establishment of national statutory authority;

what is the scope for outsourcing various functions of a national disability scheme (for example, claims and risk management by private insurers)?

Outsourcing would be as limited as possible

Would the new management structure replace, either wholly or partially, the existing systems? How would the various actors in a national disability scheme engage with each other to ensure a coherent system (governments, service providers, departments)? If existing schemes remain, how will the new scheme interact and communicate with these schemes?

Refer to above discussions on establishment of national statutory authority and roles of government, service providers and individuals.

What kind of information gathering system about outcomes, costs and individual records should be developed, how would it be run, and how long would it take to develop? How would privacy concerns be managed?

Continuation of National data sets; utilization of annual reviews to obtain data; individual costs monitored by individual submitting schedule to case manager each month; privacy would be managed by deidentifying individual ISP costs in any report or publication; overall annual report of scheme would show full transparency of costs, with the report tabled by federal parliament

How would stakeholders be given a 'say' in a national disability scheme? (for example, through an advisory board and formal consultations). Who should be represented?

Establishment of a committee to provide advice and/or recommendations to scheme managers. The committee would comprise of individual's utilising the scheme, people with an interest in social welfare, health, entitlements and actuaries.

Refer to above discussions on establishment of appeal and grievance structures within a national statutory authority

What arrangements should be in place for:

making complaints (for example, a disability ombudsman; complaints devolved to service providers or a centralised complaints arrangement process)

reaching determinations in any disputes (for example, internal *departmental arrangements, independent boards, courts or tribunals, or a process involving a number of layers)?*

Certainly a national disability commissioner to be appointed as a representative; a recommendations advisory committee as discussed above; establishment of formal appeal and grievance structures related to allocation utilisation within a national statutory authority

What would be the appropriate dispute resolution processes?

A dispute resolution process would model an administrative tribunal, with scope for an individual to resolve an issue or complaint without needing a formal legal team. Where this did not resolve an issue, a complaint could proceed to a formal appeal in the courts where a legal team would be utilised

How would people find out about what they were entitled to (online, one-stop shops, service providers)?

Online on scheme website; provision for dialup information service

When and how would a national disability scheme be evaluated?

Refer to above discussions on independent audits and time schedules for scheme audits

Are there some aspects that can be implemented early (for example, some service expansion, support to a targeted group, key infrastructure)?

Movement of individuals onto ISP allocations within existing state-based structures

What are the priorities for immediate development?

Movement of individuals onto ISP allocations within existing state-based structures immediately

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