29 April 2011

Disability Care and Support Inquiry
Productivity Commission,
GPO Box 1428
CANBERRA CITY ACT 2601

Dear Productivity Commissioners

SUBMISSION TO THE PRODUCTIVITY COMMISSION
DRAFT REPORT INTO DISABILITY CARE AND SUPPORT

I am writing on behalf of the Darebin Disability Advisory Committee (DDAC). DDAC acts as an advisory body to Council on issues relating to access and inclusion for people with a disability in Darebin. DDAC is chaired by a Councillor and its membership is made up of community representatives with a disability, carers, local service providers, and relevant Council staff.

We would like to commend the Productivity Commission in compiling the feedback from the initial inquiry into Long-term Disability Care and Support 2010. We feel the key issues highlighted in the first round of submissions have been captured in the draft Report and are pleased to have the opportunity to further contribute to this next phase in the proposal of a National Disability Insurance Scheme.

We are in full support of changes to the current disability system. The proposal of a National Disability Insurance Scheme has unified the sector in paving the way forward to significantly improving the lives of people with a disability and their carers. The NDIS would bring increased flexibility, choice, security, and confidence to the entire Australian population.

To set some context there are approximately 25,000 residents in Darebin with a disability, with another 4000 residents identifying as a primary carer of a person with a disability. Physical disability is the most prevalent form of disability in Darebin followed by sensory conditions and psychological and psychiatric conditions.

This submission aims to address some of the Information Requests raised by the Productivity Commission in the draft Report into Disability Care and Support February 2011.

Chapter 3

- **While the Commission has proposed a simple approach for the separate funding responsibilities of the aged care and disability sectors, the Commission seeks feedback on other possible funding approaches.**

We are concerned with the proposal that “the aged care sector would fund the care and support needs of all people over the pension age”. We believe, instead of just having a choice to stay under the NDIS, that a person with a lifelong disability ‘should’ stay under the NDIS continuing to receive care and support beyond pension age.

Currently the aged care sector is underfunded and under-resourced. The sector does not have the capacity to provide the high degree of care and specialist services, such

as therapies, to individuals who require both disability and age related specific support. There is also limited knowledge of the ageing process and support requirements of a person with a lifelong disability, which are different to the needs of a person who develops an age related disability.

The City of Darebin in conjunction with the North & West Metropolitan Region of the Department of Human Services is currently undertaking a project looking at the needs of people ageing with an intellectual disability. Consequently a literature review has been undertaken looking at, amongst other topics, the interface between the aged care and disability sectors. The academic literature indicates clearly that the two sectors do not work well together to support people ageing with an intellectual disability.

The draft submission indentifies that once people reach the age of 65 they can choose to move from the NDIS to the aged care sector. Based on our knowledge of the current disability support system compared to the aged care system, the former is better resourced than the later. Currently the two systems do not work well together. The literature highlights the lack of sharing of expertise both sectors possess. The disability system does not have a good understanding of the impact of ageing on those people it is supporting. Likewise the aged care sector lacks expertise in supporting people with long term disabilities, particularly those with an intellectual disability, that come into residential aged care.

Ideally the NDIS should facilitate the two sectors to work effectively together to support those people who are ageing with long term disabilities. The Disability Aged Care Interface Pilot, established under the Aged Care Innovative Pool Department of Health and Ageing, was an example of the two sectors sharing expertise and resources. Ideally if the NDIS was able to purchase services from the aged care sector, where appropriate that specifically meet the needs of those ageing with a long term disability, then a successful relationship between the two sectors could be developed rather than continuing the debate about cost shifting.

For some people with specific types of long term disabilities, the ageing process can begin early, for example those with down syndrome, cerebral palsy and those with the combination of more severe and profound levels of cognitive and physical disability. The provision of aged care services should therefore be based on need, not the whether the person has reached pension age.

The literature further explains the difficulties experienced by people with a disability in accessing residential aged care since the establishment of the ‘Young People in Nursing Homes’ Initiative. If the NDIS was to fund the ‘aged care support episodes’ this would enable people with a disability to receive specific age related care, including a residential aged care placement, on top of their disability related care needs through one funding stream and one point of call. This would enable increased independence, flexibility and support and most importantly targeted and appropriate services.

- **The Commission seeks feedback on where the boundaries between the mental health sector and the NDIS might lie. In particular, the Commission would appreciate feedback on which system would be best placed to meet the daily support needs (not clinical needs) of individuals with a disability arising from long lasting mental health conditions (such as schizophrenia).**

We commend the Productivity Commission for acknowledging the shortfalls in the system for people with a dual diagnosis of disability and mental health. Both the disability and mental health sectors currently struggle to take sufficient account of the needs of people with a dual diagnosis as they don't neatly fit into either category of disability or mental health, resulting in people being handballed from service to service, between the two sectors. There is a definite need for better coordination and delivery of services between the two sectors and we believe the NDIS would be better placed, of the two sectors, to meet the daily support needs of individuals with a disability arising from long lasting mental health conditions.

Similar to our suggestion on the provision of aged care to people with a disability we propose that the boundaries of care should predominantly lie with the NDIS with services being purchased from the mental health sector. We propose that individuals with a dual diagnosis should be eligible for non-acute services and supports through the NDIS, with the further option to purchase acute services from the mental health sector, allowing for both their disability and mental health needs to be met adequately.

These supports would not only benefit the individual through improved quality of life, improved health outcomes, greater independence among others but as mentioned reduce long term costs of care by reducing public expenditure in both the mental health and disability sectors.

Cost shifting between the two sectors would be avoided through assessment. If a person has a dual diagnosis then they would be entitled to access the NDIS because they have a disability and have the option to purchase appropriate mental health services from the mental health sector. If they only had a mental health diagnosis then they would solely access the mental health sector.

The general cost of the NDIS would potentially be increased to begin to cater for the support of people with a dual diagnosis however costs would be reduced in the long-term to both the disability and mental health sectors through the provision of early intervention services, which is another focus of the NDIS. Early intervention is about improving "individual outcomes beyond that which would occur in the absence of life intervention" which also then "lowers the costs and impacts associated with the disability for individuals and the wider community over the long-term". This too could be applied to supporting people with a dual diagnosis through the provision of disability and mental health supports.

Furthermore the coordination for such service arrangements would be supported through the "locally based case managers, operating at a 'grass roots' level" mentioned in Chapter 7.

Chapter 4

- **The Commission seeks feedback on the arrangements that should apply in relation to higher electricity costs that are unavoidable and arise for some people with disabilities.**

We are in support of the suggestion that "the cost of various rebates should be transferred to the NDIS" to enable equity across Australia, with many electricity providers choosing not to advertise or provide the option of a rebate to customers in the first place. Currently there are different rebate schemes across the different states where eligibility can rely on the type of disability you have, what season of the year it is and whether you are entitled to a concession card of some kind. Individuals

are then subject to different costs depending on the various pieces of equipment they require to meet their daily living needs.

There is definitely a need to have an electricity rebate that is standard across all states. However any such rebate should be related back to an individual's initial assessment and contact with the NDIS. There should be a full rebate for people whose use of electricity is for life support requirements. There should be a base rate rebate for individuals allocated into tier 2 with further eligibility requirements, as some individuals in tier 2 may not have higher electricity costs and therefore may not need a rebate.

Finally individuals who are eligible for tier 3 do so as they are seen to have higher support needs than other individuals with a disability. Therefore the electricity rebate they receive should relate to their ISP budget allocation, which is associated with meeting the assessed needs of the individual. Therefore an individual's use of electricity for daily living and aids and equipment should be factored into the final budget allocation of an ISP and be allowed to be used to pay for electricity costs.

We would now like to raise some questions regarding items that are not explicit in the report and suggest that further information be provided in future development of the NDIS.

- The draft Report explains that there will be a tiered approach when allocating the level of support people will receive through the NDIS. Noted 'specialist disability supports' that will be provided include aids & appliances, home modifications, personal care, community access among others. Are such specialist supports exclusively for individuals in tier 3?

  For instance there is currently an Aids and Equipment Program in Victoria with its own eligibility. Will this eligibility change to only support tier 3 individuals who are assessed as having a profound disability? Or will the current Aids and Equipment Program continue to operate independently of the NDIS and provide funding and services to all other individuals who do not meet tier 3 eligibility. For example a person with hearing loss or vision impairment might require assistive technology and require funding to purchase such items, but they may not fall into tier 3. Will an individual outside tier 3 still be eligible to receive specialist disability supports?

- In Chapters 7 and 8 the draft Report explores the key functions and roles of the NDIA and intermediaries and the importance of delivering quality and accountable services. However there is a lack of emphasis around decision making and advocacy supports for people with a disability and the importance of providing supports that are independent of the service system.

  The report explains that case managers would play a critical role in supporting people with a disability and negotiate in the event of a dispute or complaint. Chapter 8 further highlights that "the vulnerability of many people with a disability increases the risks of harm or poor outcomes" and a major task to be undertaken in implementing the NDIS is a public education campaign, explaining "how to seek help, people's rights as consumers and how to make complaints." However there is no reference made to 'advocacy' throughout the whole report, or any information of where a person with a disability would go for independent support regarding decision making in reference to the service system.

  The NDIS aims to help people with a disability make more informed choices, know their rights and responsibilities and what they should expect from service providers. However there will be a proportion of people with a disability who will

still require extra support to make informed decisions beyond that of a case manager. This support should also be independent of service providers to avoid conflict of interest.

Therefore we would like to propose that 'advocacy/supported decision making' be added as a function of the NDIA, which is independent of the NDIS. And as noted in Chapter 7 the NDIA could decide to contract this function out to external agencies if deemed necessary and more cost effective. However if advocacy and supported decision making continued to lie outside the scope of the NDIS, as a minimum advocacy agencies should be promoted during the implementation of the NDIS as an avenue to support people with a disability to make informed decisions.

We thank you for the opportunity to be a part of this important national discussion and are available to clarify any points made throughout our submission.

Yours sincerely

Cr Diana Asmar
MAYOR and Chair of DDAC

On behalf of
Darebin Disability Advisory Committee