National Disability Long-term Care and Support Scheme

Submission to the Productivity Commission

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August 2010

Outline

This submission encourages and accepts the premises of a National Disability Long-term Care and Support Scheme (the National Disability Scheme):

- No fault
- Entitlement based
- Support provided in accordance with need for support
- Focused on provision of and encouragement for habilitation and rehabilitation
- Providing support for services to people with a disability, rather than income support
- Integrates people with disabilities in society
- Administratively simple and timely

The following matters will be addressed

- Criteria for the National Disability Scheme should be those set out by Woodhouse in 1973-4
- Need to set aside provisions of current compensation systems that do not meet the principles of the NDS
- Access to Medicare and other community wide health financing systems for all Australians requiring medical, hospital, medicines and other health services
- The need for improved funding for habilitation and rehabilitation services
- At the commencement of the Scheme, coverage should be limited for people first claiming after age 55
- Funding
- Education and training

Principles

The Woodhouse Committee[1] in 1974 set out five criteria, or principles, for the design of the proposed National Rehabilitation and Compensation Scheme for Australia. These general principles are still as applicable today for the design of the National Disability Scheme, and have been adopted in part or whole in many reforms over the past 35 years.

The five criteria are:

1. Community Responsibility: a social requirement and a sound economic policy
2. Comprehensive Entitlement: equal treatment for equal claims
3. Complete Rehabilitation: to maximise performance of individual activities and community participation, and to minimise the cost of disability support
4. Real Compensation: in the context of the National Disability Scheme, the level of support must be realistic in relation to need
5. Administrative efficiency: for the benefit of claimants and to minimise cost.

Current Compensation Systems: Performance and Cost

Existing compensation systems in Australia range from excellent to poor. Importantly for this Inquiry, the administrative costs of many of these systems are high, providing scope for savings which can be redirected towards funding the National Disability Scheme.

Workers compensation systems have evolved into a comprehensive set of entitlements that provide significant compensation to those eligible.

Excellent road injury systems include the Victorian Transport Accident scheme, which provides lifelong benefits to all Victorians injured in road accidents on a no fault basis, with a focus on those with the most severe needs. On the other hand, South Australia and the ACT retain fault based systems with no assistance to people “at fault”, lump sum benefits, disincentives to rehabilitation and expensive adversarial determination systems.

Many other injuries are poorly covered. Medical injury can be compensated through medical indemnity schemes, which demand that a doctor be found to be “at fault” before compensation is provided. This acts to prevent ready disclosure of errors and risks in the health system, hindering efforts to improve safety and quality. In addition, the benefit/premium ratio is low, reflecting the high cost of determining eligibility and benefits.

Public indemnity claims are likewise difficult to establish, with high expense ratios. The result has been prohibitively high premiums, deterring otherwise socially useful public activities. The negative impacts on individuals barred from participation in social and sporting activities, and on community cohesion, have been widely recognised.

As a simple illustration of the size of the cost burden that can occur, Australian Prudential Regulation Authority (APRA) statistics[2] show a net incurred claims/net premium revenue ratio of only 59% for professional indemnity claims, compared to 81% for employers' liability and 81% for CTP motor vehicle insurance.

The Woodhouse Inquiry[1] in Australia and the Pearson Inquiry[3] in the UK each found very high expense ratios in injury compensation insurance in the 1970s. **The Commission should carefully investigate the expense situation in injury compensation systems today, and the scope for savings that could be devoted to the National Disability Scheme**. In doing so, it is important to recognise that some costs, such as plaintiff's legal costs, may be met from benefits paid to a claimant, so a careful scrutiny of costs is essential.

Compensation systems that are not timely in delivering benefits are not only expensive. The delay in delivery of benefits, services and support can impose great hardship on the injured person. In addition, the adversarial system means that the benefit provider/insurer cannot actively assist the rehabilitation of the person during the claims process. As well, the injured person can act to increase payments through demonstrating maximum support needs until the benefits are determined, an active disincentive to rehabilitation.

Dollars that are now expended on system administration should be released to fund the National Disability Scheme. A clear example of this is the $115.4 million included in the 2010-11 Commonwealth Budget to subsidise the medical indemnity scheme[4]); this figure is projected to grow to $144 million in 2013-14.

Access to Medicare and other community wide health financing systems

At its establishment in 1975, Medibank included the provision of medical benefits to those accessing compulsory injury compensation systems. This coverage was removed in 1976 by the Fraser Government[5]. Hospital Medibank never included those covered by compensation schemes. These exclusions continued under Medicare.

With the maturity and broad community acceptance of Medicare, it is time that these exclusions were removed. It is inequitable that one group of people with health service needs should be excluded from the national universal health insurance scheme solely because of a separate community funding source (compulsory insurance). It is also inequitable that this group can access a broader range of services because of their separate community funding than is covered by Medicare and other community wide health systems for the general population.

People who choose private health insurance would have the part of their costs not covered by Medicare reimbursed in part or in full as for other health services.

Separate health care reimbursement also imposes substantial administrative costs on compensation and health systems, providing a further potential source of savings. Health service providers can have extended waits for payment from compensation systems, and the administrative cost of reimbursement of Medicare and hospitals when a compensation claim is accepted would no longer be necessary.

The net saving from this proposal would be a fraction of the gross transfers that would be involved. That net saving should be tapped for the National Disability Scheme. But there is further potential by recognising that the cost of the extension of Medicare and other community health coverage should be met by these systems: this corrects an unjustified but long standing exclusion from universal coverage. If that is the approach adopted, gross savings to the compensation schemes should be directed to the National Disability Scheme from existing compensation systems.

Increased Funding for Habilitation and Rehabilitation

It is vital that funding for habilitation and rehabilitation services be substantially increased as part of a National Disability Scheme. This should include health based services, education and broader services to assist people to manage their lives and participate in society.

Besides the obvious benefits to the individuals involved that would come from maximising performance of people with disabilities, maximising functioning also would act to minimise the need for assistance, with consequent savings to the National Disability Scheme.

It is ironic that the better existing compensation systems (such as the NSW Lifetime Care and Support Scheme and the Victorian no fault road injury system) now provide access to far more generous rehabilitation services than are available to others in the community not covered by these compensation systems. Service provision needs to be increased to the level provided by these best practice schemes, with provision funded by Medicare and other community wide systems.

Proactive policies need to be adopted by Commonwealth and State health funding agencies to promote the supply of habilitation and rehabilitation services, and to ensure that additional resources are not diverted to acute care for the general community.

Setting Aside Provisions of Existing Compensation Schemes

Having regard to the three sections above, major elements of existing compensation systems should be set aside as the National Disability Scheme is put in place. Disability support would be provided to all as an entitlement based on an individual's assessed need for support. Medical and hospital expenses would be covered by Medicare and other community based systems. And habilitation and rehabilitation would be available to all based on need.

The remaining element of existing compensation systems outside the ambit of the current Productivity Commission investigation is income replacement benefits and lump sums. The need for these benefits would be reduced by the broader availability of treatment, rehabilitation and support services. The Productivity Commission should urge governments to rationalise the various injury compensation systems in light of the greater benefits available to injured people from the universal entitlement to health benefits, habilitation and rehabilitation services and disability support, with the aim of freeing resources to offset the costs of these improved universal schemes.

In particular, serious consideration should be given to winding up existing medical indemnity and public liability insurance systems for injury compensation. These would have little remaining content for most people, and significant savings and incentives to improved safety and quality of health services are available by a pro-active approach to ending these outdated and inefficient systems.

Setting Priorities in the National Disability Scheme: Age 55 cutoff for most claimants

The cost of a National Disability Scheme to cover all people up the age of 65 will require a large increase in government expenditure. As well, the supply of services would be severely stretched by a comprehensive scheme, meaning that consequent price rises may well eat up part of the funding.

In addition, there are substantial difficulties in estimating the cost of the Scheme, despite the quantity of high quality data available In Australia on the demand for and supply of disability services (ABS[6] and AIHW[7,8]). These include:

- Fitting the available data to the chosen criteria for assessment of benefits under the scheme
- Likely emergence of hidden demand once a national scheme is introduced
- Increases in the cost of services in response to the increase in demand.

There is therefore a strong argument to take a progressive approach to introduction of the National Disability Scheme. It is suggested that the priority should be directed to people who have demonstrated support needs due to disability prior to age 55 and have lodged a claim on the National Disability Scheme before age 55. Many people approaching 65 will be affected by chronic health conditions that result in disability. Osteoarthritis is one example. While the needs of these people are real, they should be met by aged care services with provision being at the same level as is provided to people 65 and over.

This submission has argued for the winding down of existing injury compensation systems. A corollary to an age cutoff is that people injured after that cutoff age may need to be eligible for some or all of the benefits provided under the National Disability Scheme (older people who were injured would be covered for health services and rehabilitation under the proposals made earlier). The alternative would be retention of existing compensation systems to cover this numerically small group, threatening the potential financial and social benefits outlined above.

Given the universal nature of the National Disability Scheme, support for these injured people would best be provided under a separate national no fault scheme which could mirror many of the provisions of the National Disability Scheme. Distinct provision in this way is not a dilution of the principles of the National Disability Scheme: it is a practical response to the need to wind down existing systems but not leave injured people without support to which they are currently entitled.

Financial Issues

Pay as you go financing

The National Disability Scheme will be a community wide support system. It should be funded like other universal social welfare schemes in Australia such as income support payments and Medicare, just as current disability support schemes are funded. This means current expenditure is funded from current revenue, ie, a pay as you go system.

In contrast, a funded system would have two significant disadvantages:

- A funded scheme would start with incident cases, ie, people whose disability arose after the commencement date. Reserves would be set aside for these people. There would need to be additional funding to include people who already have a disability at the commencement date; this additional funding would gradually fall as the Scheme matured.
- Changes in asset values would need to be covered by higher or lower funding. The NZ Accident Compensation Scheme provides an informative example. The Global Financial Crisis drop in share prices in 2007 and 2008 caused a significant deficit in the fund for non-work, non-road injuries. Under the funding targets set by Government, this demanded significant additional funding from Government, to replenish financial assets, at exactly the time when the GFC response argued for direct spending in the economy.

Purchasing Services

Other funding issues need careful thought. There are strong arguments to allow people with disabilities to purchase support services where they choose. These could include professional services but also assistance that can be purchased from community members with little or no specific training (such as home maintenance, meal preparation, etc).

Increased Funding for Habilitation and Rehabilitation

Part of the funding for the scheme should be devoted to facilitation and rehabilitation services, as already discussed. Additional funding should be devoted to education and training as discussed below.

Increased Pay and Conditions in the Disability Sector

To attract workers to the disability sector, increased wages for disability support workers are essential. This should be addressed explicitly in the design of the Scheme. The alternative is likely to be prolonged campaigns for increased pay and conditions in the face of expanded demand, which

could then see the additional funding diverted in an unplanned way into covering increases won. Undue reliance on fringe benefit arrangements should be phased out of the disability support sector as pay and conditions are improved.

Education and Training

As already mentioned, injecting large sums of money into service provision will severely strain the services and people who currently provide disability support services.

It is essential that education and training be expanded to increase the supply of skilled workers. This will not be simple given the relatively unattractive pay and conditions in the sector at present. The planned improvement of pay and conditions outlined above would provide a platform to attract more people to the sector.

It may be sensible to consider tasking the new national Health Workforce Agency with the additional task of planning for expansion of the disability support labour force.

References

1. Report of the National Committee of Inquiry, Compensation and Rehabilitation in Australia, Australian Government Publishing Service, 1974

2. Australian Prudential Regulation Authority, Half Yearly Insurance Bulletin, Statistics, Table 7, June 2010

3. Pearson (Lord), Royal Commission on Civil Liability and Compensation for Personal Injury, 1978 (http://en.wikipedia.org/wiki/Pearson_Commission, accessed 16 August 2010)

4. Australian Department of Health and Ageing, Portfolio Budget Statement 2010-11, P 350

5. Scotton RB and Furber H (eds), Public expenditures and social policy in Australia, Volume II, the first Fraser years 1976-78, Longman Cheshire, 1980, P 348

6. Australian Bureau of Statistics, Survey of Disability, Ageing and Carers, various years

7. Australian Institute of Health and Welfare, Disability Support Services, various years

8. AIHW 2007c. Current and future demand for specialist disability services. Disability series. Cat. no. DIS 50. Canberra: AIHW (also earlier titles)