Australian Government

Department of Social Services

EXECUTIVE MINUTE

on

JOINT COMMITTEE OF PUBLIC ACCOUNTS AND AUDIT

REPORT No. 461

COMMONWEALTH RISK MANAGEMENT INQUIRY BASED ON AUDITOR-GENERAL'S REPORT 18 (2015–16)

General comments

The Department of Social Services (the department) notes the letter from the Joint Committee of Public Accounts and Audit (the Committee) dated 23 February 2018, seeking clarification of the Government's response to Report 461. The Committee directed this request to both the Department of Human Services (DHS) and the department. The response provided below addresses the requests for which the department is responsible.

The department notes that DHS will be providing a separate response addressing those requests that are relevant to its role in administering the Disability Support Pension (DSP).

Kathryn Campbell
Secretary
Department of Social Services

29 May 2018

GPO Box 9820 Canberra ACT 2601

Email • Facsimile • Telephone 1300 653 227

National Relay Service: TTY: 133 677, Speak and listen: 1300 555 727, Internet relay: www.relayservice.com.au

www.dss.gov.au

Request – A

The Executive Minute refers to a number of reviews that are planned, ongoing, or completed. The Committee therefore requests that the departments provide further information on whether/how these reviews address each of the recommendations in Report 461 (excluding Recommendation 2, which was directed to the Australian National Audit Office). For each of the reviews, the Committee would appreciate a summary of:

- *the scope;*
- *timing;*
- *objectives;*
- *overarching methodology*
- *frequency of monitoring (if ongoing); and*
- *internal reporting arrangements (regarding outcomes).*

Response A

The Government's response to Recommendation 9 included a reference to the post implementation review (PIR) of the revised Disability Support Pension (DSP) Impairment Tables introduced in 2012, for which the department was responsible. A copy of the PIR is at **Attachment A**.

The PIR was conducted within the department, in consultation with DHS representatives from the Disability Branch, the Health Professional Advisory Unit, Assessment Services Branch and FOI and Litigation Branch. Guidance and advice was also provided by the department's Policy Evaluation Branch.

The PIR was undertaken throughout 2015-16 and focussed on the period 1 January 2012 to 30 June 2015. The purpose of the PIR was to:

- analyse the implementation of the revised Tables and assess whether they are operating as intended;
- identify any issues arising with their implementation and suggest improvements in guidance and process in order to improve the rigour and consistency in applying the Tables; and
- evaluate the impact of the Tables on the characteristics of the DSP population.

More specifically, the PIR sought to assess whether the revised Tables are:

- having any particular issues with application, such as double counting of impairments or gaps in coverage;
- improving the consistency and ease of assessment;
- impacting on trends in appeals and appeal outcomes;
- having any impact on the composition of DSP grants in terms of claimants' age and medical condition; or
- preventing people with significant disability from qualifying for DSP.

The department and DHS have been working together to address the recommendations from the PIR including updating to the Guide to Social Security Law and training materials to provide additional clarification on specific issues raised in the PIR. The progress of these updates is monitored and discussed with DHS as part of the monthly programme meetings.

The Legislative Instrument containing the Impairment Tables expires on 1 April 2022. A further review of the Impairment Tables will be undertaken by the department before this time, in accordance with the recommendations made by the Advisory Committee which conducted the 2011 review of the Impairment Tables. Any variations to the Instrument that may be required in addressing recommendations will be considered as part of this review.

While not specifically referenced in the Executive Minute, the department has previously advised the Committee that a formal evaluation of the revised assessment process for DSP (introduced from 1 January 2015) was undertaken. The DSP assessment process was amended by the introduction of a Disability Medical Assessment (DMA) by a Government Contracted Doctor (GCD). In addition, the requirement for a Treating Doctor's Report (TDR) was also removed, and DSP applicants were required to provide raw medical evidence (existing medical records) which contain details of their medical condition/s as evidence of their incapacity.

The evaluation was completed by Health Outcomes International between July 2015 and March 2016, to assess how effectively the revised assessment process was undertaken, whether it achieved the policy objectives and what the related impact (if any) of the measure was on DSP applicants.

The evaluation included consultation with selected stakeholders, and analysis of claims and appeals data from the first nine months following the introduction of the revised process, contrasted where possible, with the same nine-month periods in 2013-14 and 2014-15. It also involved consultation with selected stakeholders about the impact of the revised DSP application process.

As this relates to Recommendation 5, the department has provided a copy of the *Evaluation of the revised DSP assessment process* report at **Attachment B**.

Request – B

In relation to Recommendation 3, the Committee is interested in further information on the nature of the monitoring and evaluation undertaken. As part of the departments' response, the Committee would appreciate an outline of the factors considered in assessing the cost of reviews, as per paragraph 2.11 of Report 461.

Response B

DHS and the department work closely throughout implementation and delivery of every DSP budget measure. Prior to the implementation of these measures, the departments work together to develop business requirements to enable effective monitoring and evaluation of the measures once implemented.

Following implementation, data is regularly exchanged between departments and analysed to determine the impact of the measure, to ensure it is operating as intended and how the outcomes compare to what was originally projected.

Examples of the specifics monitored for both the Under 35's and 90,000 Reviews measure include the number of reviews, outcomes of reviews, cancellation reasons and characteristics of recipients reviewed.

This analysis also informs the data that is reported publicly through senate estimates hearings and data that has been previously provided to the Committee in relation to the review measures.

The department and DHS meet regularly as part of ongoing programme management arrangements and discuss any issues or unintended consequences that may become apparent throughout the implementation. As DHS has previously advised, criteria to exclude or identify recipients for review has been strengthened as part of this monitoring process.

While the department continues to work with DHS to monitor the 90,000 Reviews measure, this process has been more protracted than originally anticipated. No formal evaluation of the reviews measures are planned at this stage. Any formal evaluation of budget measures would incur additional costs and is a decision for Government.

Request - C

In relation to the review work noted in the response to Recommendation 4, the Committee requests that DSS update the Committee on its progress in six months from the date of this letter.

Response - C

The department is currently exploring the data sharing options with the states and territories for the purposes of excluding recipients from medical reviews and will provide an update to the committee on the progress by 23 August 2018.

Request –D
Recommendation 6 focuses on the potential merits of formally extending the 21-day timeframe for clients to provide evidence. The Committee would appreciate information on whether such a possibility has been considered and if so, what decision was taken and on what rationale.

Response D

Recommendation 6 refers to DHS.

Australian Government
Department of Social Services

Disability Support Pension Revised Impairment Tables Post Implementation Review

Revised Impairment Tables – Post Implementation Review 2015-16

Table of Contents

Executive Summary

The Impairment Tables are a key feature of the policy settings for the Disability Support Pension (DSP). A review of the Impairment Tables was part of the 2009-10 *Better and Fairer Assessments* package of Budget measures. The decision to update the Impairment Tables recognised they had remained largely unchanged since the previous expert review in 1993 and required modernising to ensure that they reflected current medical and rehabilitation practice. There was also a range of important inconsistencies in the application of the Tables that needed to be addressed.

In 2010, an Advisory Committee consisting of medical, allied health and rehabilitation experts, representatives of people with disability, mental health advocates and relevant Government agencies was commissioned to oversee the review of the Impairment Tables and provide expert advice. The revised Tables are contained in a Disallowable Instrument (*Social Security (Tables for the Assessment of Work-related Impairment for Disability Support Pension) Determination 2011)* and can only be amended through the Federal Parliament. The revised Tables were introduced on 1 January 2012. Since then, the revised Tables have been applied to all DSP claims and reviews of existing recipients.

The *'Guidelines to the Tables for the Assessment of Work-related Impairment for DSP' (the Guidelines)* are contained in the *Guide to Social Security Law* (the Guide) and provide additional detailed guidance on how the revised Tables should be applied. The Guidelines are used by Job Capacity Assessors (assessors), Department of Human Services (DHS) delegates, Administrative Appeal Tribunals (AATs) and others, in applying the Impairment Tables. DHS also outlines the procedures for application of the revised Tables in its Operational Blueprint.

The revised Tables represent a significant move to a function-based approach. Greater focus is placed on functional ability to ensure that people applying for DSP are assessed according to what they can do rather than what they cannot do. The Tables are now more suited to their intended purpose of assessing the impact that impairment has on capacity for work. This has improved the targeting of the DSP to people with significant impairment which prevents them from working.

It was in the context of this major reform to the Tables that the Advisory Committee recommended the initial implementation be monitored, and an evaluation of the results undertaken, to ensure the changes were implemented and worked in practice.

Purpose of the Post Implementation Review

A Post Implementation Review is a review that addresses the question of whether an initiative was implemented in the manner envisaged, on time and within budget - and whether the relevant systems, governance and programme information and reporting are in place.

This Review is a response to the Advisory Committee's Recommendation that the implementation be monitored and the results of the reform evaluated. It focusses on the implementation of the revised Tables and considers whether the legislation and policy established by Government decision is being applied appropriately, in accordance with its intention and without unintended consequences.

The purpose of this Review was to:

1. Analyse the implementation of the revised Tables and assess whether they are operating as intended.

2. Identify any issues arising with their implementation and suggest improvements in guidance and process in order to improve the rigour and consistency in applying the Tables.
3. Evaluate the impact of the Tables on the characteristics of the DSP population.

The Review was conducted by the DSP Policy Section in the Age, Disability, and Carer Payment Policy Branch in consultation with DHS representatives from Disability Branch, the Health Professional Advisory Unit (HPAU), Assessment Services Branch (ASB), and FOI and Litigation Branch. Guidance and advice was provided by DSS' Policy Evaluation Team.

Scope and Method

The Review focussed on the period from 1 January 2012 to 30 June 2015. This enabled a range of issues captured from early implementation to be seen in the context of more accumulated experience with using the Tables.

The Review has sought to assess whether the revised Tables are:

- having any particular issues with application, such as double counting of impairments or gaps in coverage;
- improving the consistency and ease of assessment;
- impacting on trends in appeals and appeal outcomes;
- having any impact on the composition of DSP grants in terms of claimants' age and medical condition; or
- preventing people with significant disability from qualifying for DSP.

Key Findings

Review Purpose #1 - Analyse the implementation of the revised Tables and assess whether they are operating as intended.

The Impairment Tables were successfully implemented by the required date of 1 January 2012. Policy guidelines were produced prior to this date and provided through the Guide. The Guidelines were used by DHS and DSS to jointly develop training material for DHS staff prior to implementation.

The Review has confirmed the success of the revised Tables in improving the consistency and quality of assessments. Assessment processes for claims and medical reviews are being undertaken to a high standard, in keeping with legislation and policy, as confirmed by the recent findings of the performance audit conducted by the Australian National Audit Office (ANAO) entitled '*Qualifying for the Disability Support Pension* (Report 18 2015-16)'[1]. This is also demonstrated by the high level of affirmation rates for DSP appeals which have improved throughout the Review timeframe, indicating the Impairment Tables are being applied correctly on assessment.

[1] ANAO Performance Report 18 of 2015-2016 – *Qualifying for the Disability Support Pension,* released 21 January 2016

The Review has found the revised Tables are operating well on a day to day basis and have simplified the assessment of impairment. Feedback from users suggests that generally the Tables are straightforward to apply and they are able to obtain additional guidance if required.

The HPAU's provision of specialist advice and input into training material and procedures has played a strong role in supporting the quality and consistency of assessments. The HPAU monitors issues as they arise and provides advice and feedback to DSS and DHS.

Review Purpose #2 - Identify any issues arising with their implementation and suggest improvements in guidance and process in order to improve the rigour and consistency in applying the Tables.

The effectiveness of the implementation of the revised Tables is confirmed by the limited number of issues that have arisen. Residual issues are mostly minor in nature and able to be addressed through changes to process, training and guidance materials. In other cases minor changes to the wording of the Instrument would clarify the original policy intent.

The Review has identified two types of issues for resolution, those related to the:

- Complexity of conducting assessments (Appendix A); and
- Interpretation and operation of the revised Tables (Appendix B).

Review Purpose #3 - Evaluate the impact of the Tables on the characteristics of the DSP population.

The composition of DSP grants has changed by medical condition, age, and sex. Since the introduction of the revised Tables, there has been a decrease in the number of grants each year for most medical conditions. However, the proportion of total grants by medical condition has varied.

The proportion of total grants to people with intellectual and learning conditions has increased. These conditions are generally congenital with a high need for support therefore people with these types of conditions are more likely to access DSP at a younger age. This corresponds with the increase in the proportion of grants occurring under age 35.

The proportion of grants to people with mental health conditions has remained relatively stable, despite the new requirement for diagnosis to be provided by a Psychiatrist or with supporting evidence from a Clinical Psychologist (under Table 5). The proportion of grants to people with musculo-skeletal conditions has continued to decline[2]. The proportion of grants to people with cancer / tumour has increased.

[2] There were underlying trends occurring prior to the introduction of the Revised Tables. The proportion of DSP recipients with a psychological/psychiatric primary medical condition surpassed musculo-skeletal and connective tissue for the first time in2011.

These changes indicate that the revised Impairment Tables have assisted in ensuring DSP remains targeted to people with disability who are unable to support themselves to achieve financial independence, while encouraging those with some work capacity to connect to the labour force to build that capacity.

Since 2012, the annual growth of the DSP population has declined. The growth and the profile of DSP grants is now better aligned with the prevalence of profound and severe disability[3] in the underlying workforce age population as measured by the Australian Bureau of Statistics (ABS) *Survey of Disability, Ageing and Carers* (SDAC 2012).

Recommendations

1. DSS in consultation with DHS, to develop further changes to the Guidelines to clarify issues related to the interpretation and application of the Tables (Appendix C).

2. DSS in consultation with DHS, consider a limited variation to the Impairment Table Instrument involving minor word changes to clarify original policy intent (Appendix D).

3. DHS to review procedural guidelines and training for assessors and DSP decision-makers, to ensure that these reflect current legislation and policy around application of the Impairment Tables and address relevant issues identified in Appendices A and B.

4. It is recommended that the next Review of the Tables is undertaken in 2020 to align with the expiration of the current Instrument in 2022, if not amended prior.

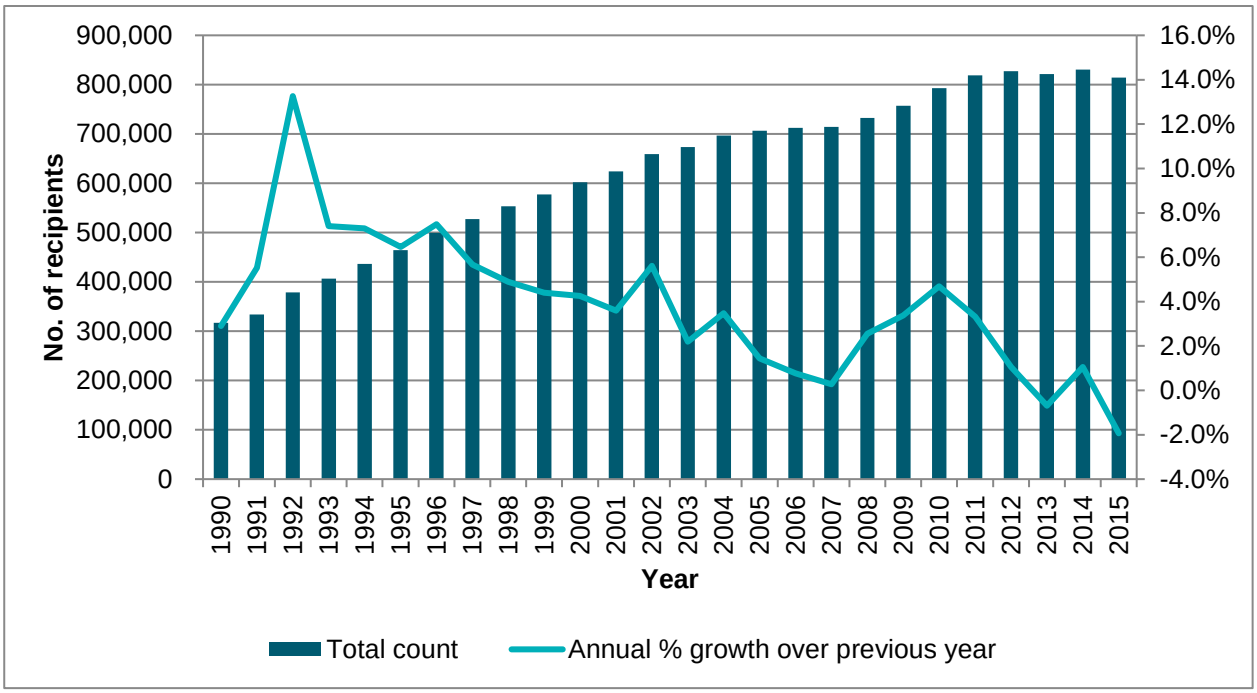
[3] See ABS SDAC Glossary of terms for definition of profound and severe core activity limitation.

Background

The purpose of DSP is to assist eligible people with disability who are unable to support themselves to achieve financial independence. DSP is designed to give people an adequate means of support if they have a permanent physical, intellectual or psychiatric impairment which attracts at least 20 points under the Impairment Tables. The person must also be assessed as being unable to work for 15 or more hours per week, for at least the next two years, because of their impairment.

As at June 2015, there were around 814,000 people in receipt of DSP, making it the largest workforce age payment, with an annual spend in 2014/15 of $16.54 billion. While DSP had the highest increase in recipient numbers of any workforce age payment over the decade to June 2011, the growth in DSP numbers has declined in recent years as both claim levels and the proportion of claims granted payment have declined. The growth in the DSP population has slowed significantly since 2012.

Figure 1: DSP Population and Growth, 1990-2015



Source: DHS administrative data

DSP is associated with long-term welfare dependence. Recipients stay on payments for long durations (average 13.8 years[4]), there are few exits from payment, and a very high proportion of recipients receive a maximum rate of payment. Most recipients remain in receipt of DSP until they pass away or move to the Age Pension. The proportion of DSP recipients participating in the workforce is under 10 per cent. An overarching policy aim is to strengthen the targeting of DSP to ensure that people with mild to moderate impairments with some work capacity are supported to maximise their capacity to join the workforce.

[4] DSS Annual Report 2014-15

Assessing qualification for DSP is complex due to the need to establish the permanency of conditions, the functional impairment they cause, and the impact of these on a person's ability to work. The application of the Impairment Tables requires professional knowledge, training, experience and judgment.

Revising the Impairment Tables

The Review of the Impairment Tables to ensure they were consistent with contemporary medical and rehabilitation practice was part of the 2009-10 *Better and Fairer Assessments* package of Budget measures. The decision to update the Tables recognised there was considerable scope to improve their operation and ease of use. Some aspects leading to inconsistencies in decision making included:

- Consideration of aids and equipment varied across Tables (e.g. hearing function was assessed without the person's hearing aid but visual function was assessed with the person wearing corrective lenses).
- Inclusion of a 'Miscellaneous' Table, was often used as a cover-all Table; and
- Some descriptors required assessors to have specific specialist knowledge, which would not be have been readily understood across the range of allied health professionals using the Tables.

The Advisory Committee overseeing the review of the Impairment Tables included medical, allied health and rehabilitation experts, representatives of disability peak bodies, mental health advocates and relevant Government stakeholders.

DSS (then FaHCSIA) consulted widely with a range of medical and allied health professionals and organisations as well as disability peak organisations representing the interests of people with disability.

Stakeholders invited to contribute to the review included but were not limited to: the National Welfare Rights Network, the National Council on Intellectual Disability, various pain stakeholder groups, the Australian Medical Association, Deafness Forum Australia, Blind Citizens Australia and the Australian Federation of AIDS Organisations.

A number of stakeholders provided feedback directly to DSS and a series of consultative workshops were also held in Canberra, Sydney, Melbourne and Brisbane. Input from all stakeholders was considered by the Advisory Committee in providing their advice on the revised Impairment Tables.

The Committee identified numerous limitations with the previous Impairment Tables:

- inconsistencies in rating levels across Tables and subjectivity of rating criteria,
- outdated terminology and unclear definition of terms and descriptors,
- insufficient guidance on the selection of Tables and the use of multiple tables,
- complexity and/or low utilisation of some of the Tables,
- use of a medical diagnosis, body system-based approach that is not effective in assessing the functional abilities required for work and/or training activities; and
- content not suited to the range of medical and allied health professionals required to use the Tables.

Change in approach

The revised Tables introduced a significant rationalisation and change in approach.

The conceptual design of the Tables was changed to focus on functional capacity rather than medical conditions and to be consistent with the *World Health Organisation International Classification of Functioning, Disability and Health*. This was a move away from quantitative assessment towards qualitative descriptors of functional capacity.

The revised Tables were streamlined and rationalised. The number of Tables was reduced from 22 to 15.

A simplified and consistent structure and layout was applied. Each Table contains descriptors for the level of functional impact and the functional abilities and limitations which must apply to achieve a rating at that level.

A more consistent generic scaling system was introduced to improve the consistency of scores applied across the 15 Tables. The descriptors are the basis for how to differentiate between extreme (30 points), severe (20 points), moderate (10 points), and mild (5 points) functional impacts. This has achieved better functional equivalence across the Tables. In the previous Tables the ratings ranged up to 40 points and the scores which could be attributed varied between individual Tables.

Under the previous Tables over 25 per cent of grants were assessed against Table 20 'Miscellaneous'. This Table was omitted in the revised Tables on the premise that impairment scores should be allocated against the specific function-related Table. Similarly Table 21 previously assessed intermittent conditions, whereas now episodic/fluctuating conditions are assessed against the relevant function they impact.

Given the complexity in accurately diagnosing mental health conditions, the revised Table for the assessment of mental health impairments requires that the diagnosis is made by a psychiatrist or by an appropriately qualified medical practitioner with diagnostic input from a clinical psychologist.

Diagnostic requirements were also strengthened for conditions resulting in:

- low Intellectual Function (Table 9) – diagnosis must be made by an appropriately qualified psychologist;
- functional impairment to Hearing and other Functions of the Ear (Table 11) – diagnosis must be made by an appropriately qualified medical practitioner with supporting evidence from an Audiologist or Ear, Nose and Throat specialist; and
- functional impairment when performing activities involving Visual Function (Table 12) - diagnosis must be made by an appropriately qualified medical practitioner with supporting evidence from an ophthalmologist.

Definitions were improved and additional guidance provided on the selection and application of Tables, use of supporting evidence and assessment where there is a complex or unclear diagnosis. Each Table contains more detailed introduction, definitions and rules for the medical evidence requirements to corroborate self-report. The revised Tables now include consistent consideration of the use of aids and equipment (e.g. prostheses, wheelchairs, oxygen, or hearing aids).

The Guidelines now contain many examples to assist users to interpret the descriptors in the Tables and inform assessment decisions.

A notable change was to move the Impairment Tables from Schedule B in the *Social Security Act 1991* into a Legislative Instrument. The Instrument will expire and need to be re-tabled in 2022 if not amended prior.

Advisory Committee Recommendations

The Advisory Committee's final report (30 June 2011[5]) included a total of twelve recommendations, the most relevant to the Review being:

Recommendation 4: DSS and DHS should monitor the initial implementation of the revised Tables and undertake a comprehensive evaluation of the results over the first 18 months following implementation. The Impairment Tables should be reviewed regularly thereafter i.e. every five years.

Recommendation 10: DSS should aim to implement Impairment Tables that are fully function-based within the next decade, i.e. a further revision so that all of the Tables reflect key functions/activities required for participation in work or training.

Recommendation 11: HPAU should monitor and report on the advice sought and utilisation of HPAU by assessors in applying the revised Table and provide feedback to DSS and DHS so that the advice sought can be covered in procedures and training.

This Review is a response to the Advisory Committee's Recommendation that the implementation is monitored and the results of the reform are evaluated. The HPAU has played a key role in the Review, providing feedback about areas for improvement.

Implementation of the revised Tables

There were advantages in conducting the review after the initial implementation. As users gained experience the nuances of applying the Tables became better understood. It also meant that information was available on how Tribunals were dealing with more complex cases and interpretation issues.

The first year of implementation involved extensive consultation, learning and improvements in consistency. There was close collaboration between DHS and DSS on the development of operational guidance for assessors and training material. If complex cases were identified requiring policy advice or clarification of wording, DHS would seek advice from DSS prior to an assessment being finalised and a claim decision being made.

Decisions involving complex assessments were often reviewed jointly by DSS and DHS to ensure a shared understanding of the policy intention. If the issue highlighted an area which required additional clarification, the Guidelines were amended and training material updated.

Since the introduction of the revised Tables, DSS and DHS have resolved many of the initial issues through further clarification in the Guidelines to the Tables.

[5] Advisory Committee Final Report, 2011 Review of the Tables for the Assessment of Work-Related Impairment for Disability Support Pension, Commonwealth of Australia

DHS facilitated implementation of the revised Tables by introducing changes to relevant systems and procedures to take effect on 1 January 2012. Prior to the introduction of the revised Tables, ASB provided training on the policy intent of the change, interpretation and definitional issues and skills in other areas to support the transition, such as the systems changes.

The ASB Quality Framework supports the development of understanding and professional practice and provides the vehicle for consistency in application of the Tables. Assessors are kept up to date with information regarding the use of the Guidelines and Tables through case studies, weekly updates, newsletters and area meetings. Continuous improvement and discussion regarding the Guidelines and application of the Tables has been important, along with ongoing training and clarification to support the development of understanding and professional practice. Assessors are supported in their roles by the HPAU and other specialist advisers such as ASB clinical psychologists. Assessments can be complex and having specialist advice readily available has improved consistency in applying the Tables.

Key aspects in the strength and quality of assessments relate not only to the tools for assessment but also who provides the assessment and how it is undertaken. All Job Capacity Assessments (JCAs) are undertaken by qualified assessors, who are health and allied health professionals employed by DHS. This also contributes to improved rigour and consistency in the application of the Tables and the Guidelines.

Regular monthly meetings are held between DSS and DHS Disability teams to discuss any issues in relation to DSP. While any issues in relation to the Tables were raised as and when required, this forum was also utilised to monitor the implementation, progress any required changes to the Guidelines and clarify the policy intent of the revised Tables. This operational framework has supported a joint understanding between DSS and DHS of particular issues where more clarity is required.

Issues for the application of the revised Tables

DSS and DHS share the view that the Tables are operating well. No major issues with the operation of the Tables were identified by the Review.

The Review drew on issues identified by DSS, DHS, the AAT and external stakeholders since the introduction of the revised Tables. This covered the context around particular issues, their priority and sensitivity and which issues arise frequently. DHS and DSS subject experts discussed general feedback on the Tables and issues specific to individual Tables. There was a focus on the types of improvements to the Guidelines which would help users. While some of the issues identified have general application, others are specific to individual Tables.

Issues for the application of the Tables can be divided into two groups related to the:

- Complexity of conducting assessments (covered in Appendix A), and
- Interpretation and operation of the Tables (covered in Appendix B).

Feedback from users indicated that certain medical conditions are by nature complex to assess, for instance those for which objective measures of symptoms are not available, where symptoms fluctuate or are intermittent, or where there is variation in the sub-components of test scores for IQ and functioning. However, no major impediments to assessment were identified.

Issues that were identified for the operation of the Tables include the interpretation of particular phrases or terminology, relativities between rating levels, and the intent of

particular descriptors. The perceived gaps in the coverage of descriptors are small and tend to be idiosyncratic (often related to rare conditions) and are able to be worked through and dealt with using existing descriptors with expert advice on specific cases from the HPAU. The Review did not identify any significant gaps in the coverage of existing descriptors.

Both sets of issues are able to be resolved through additional training, and improvements to operational processes and guidance. A small number of the issues related to Table interpretation may be best resolved via minor changes to the Instrument to better align the revised Tables with the policy intent.

Consistency and ease of assessment

The Review has found the revised Tables are operating effectively in terms of their ease of use, the consistency achieved across assessments, and the level of rigour applied to assigning impairment ratings. Feedback from users indicates that assessments are now more precise in their measurement of the severity of the impairment and the function affected. User experience in applying the revised Tables confirms their application is generally well understood. The rationalisation of the Tables with their streamlined design and consistent rating scale has greatly improved their ease of use.

The Guidelines to the Tables provide clear guidance which contributes to consistent assessment outcomes. The tight link between the structure of the Guidelines and the Tables has contributed to making assessments easier. The Guidelines are an important support tool in promoting more effective assessments. Their guidance on the steps in the assessment process and the rules for the application of the Tables have resulted in a well understood, transparent, and straight-forward decision pathway that promotes consistency in decisions.

The 2016 ANAO performance audit report, *Qualifying for the Disability Support Pension*, confirmed the revised Tables are being applied in accordance with legislation and the quality of assessments is high. The ANAO audit examined the administration of the revised Tables. It found applicants' impairment eligibility for DSP was appropriately assessed:

- Suitable Tables were used for 99.6 per cent of grants;
- Tables were applied correctly for 96.7 per cent of grants; and
- Medical evidence was available to support assessments for 97 per cent of grants.

This result was consistent with the DHS benchmark for 95 per cent of assessment reports to receive a quality rating of 'satisfactory or better'.

The additional training, guidance, and small changes to the Instrument recommended by the Review are expected to further improve the consistency and ease of assessments.

Decisions are more robust since implementation

Under Social Security law people who have their claim for DSP rejected, or whose payment is cancelled following review, have the right to have the decision reviewed.

There are four legislated appeal levels:

1. The first level is an internal review by a DHS independent Review Officer – commencing with a review by a Subject Matter Expert, who can change the decision if it is found to be incorrect.
2. The second is referral to an Authorised Review Officer (ARO).

3. If a person does not agree with the ARO decision they can appeal to the external Administrative Appeals Tribunal (AAT) Level 1 (previously the Social Security Appeals Tribunal (SSAT)).
4. If either the person or the Secretary disagrees with a decision at this level they can appeal to the AAT Level 2.

The final level of appeal is to the Federal Court; these appeals can only be made on an error of law, and are rare.

Appellants can provide additional information or medical evidence at any stage of the appeals process. This means that while a certain percentage of decisions will always be set aside or varied on appeal, this does not necessarily indicate that the original decision was incorrect, if the evidence that the new decision was based on was not provided prior to the decision.

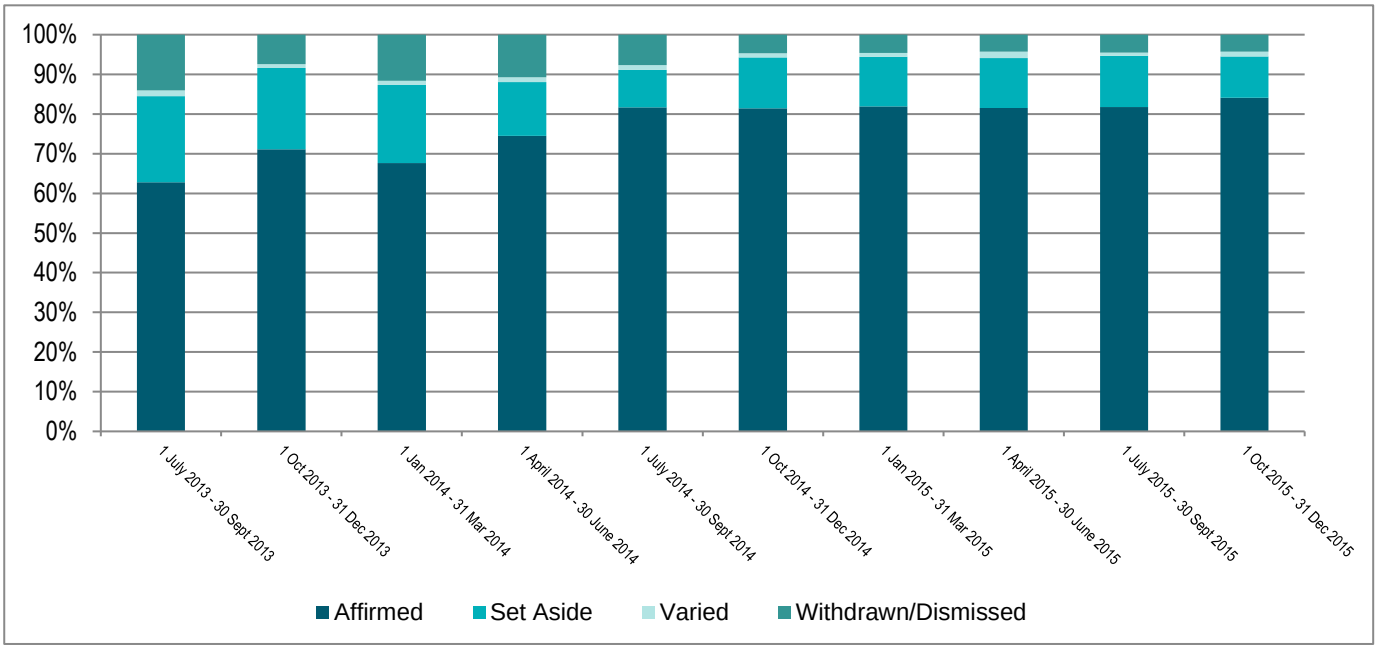
Appeals are decided by independent referees and are a good measure of how robust the assessment process is for DSP claims. The proportion of DSP appeals that are affirmed (i.e. the original decision is upheld) is well above the average level for all social security appeals.[6]

The strong affirmation rate for DSP appeals on medical grounds indicates the high quality of assessments against the revised Tables. This supports the finding that the revised Tables are working well and are operating as intended. It provides assurance that assessors are applying the Impairment Tables in line with the legislation, policy intent and guidance.

For both ARO internal reviews and external Tribunal reviews, the proportion of decisions affirmed for DSP has increased over the implementation. Since July 2014 the affirmation rate for ARO medical related appeals has been consistently above 80 per cent - this has increased from around 60 per cent in 2013 (see Figure 2). Improved affirmation rates reflect both the improved design of the revised Tables and assessors gaining more experience in applying the revised Tables as the implementation progressed.

[6] SSAT Annual Report 2014-15 (Appendix 4)

Figure 2: DSP Authorised Review Officer medical appeal outcomes 2013 – 2015



Between 2009-10 and 2014-15, there was a steady increase in the number of DSP decisions appealed to the AAT Level 1 from 2,811 to 6,139, and growing from 25 per cent to 47 per cent of all social security payment appeals (Table 1). DSP-related appeals represent the highest proportion of social security related appeals to both AAT Level 1 and Level 2.

Table 1: AAT (formerly SSAT) Level 1 applications and outcomes, 2009 – 2015

Year	Applications Received			Decision Set Aside/Varied	
	DSP	All Payments	DSP %	DSP %	All Payments %
2009-10	2811	11203	25	23.4	26.5
2010-11	2951	9846	30	22.0	26.3
2011-12	3446	9988	35	20.4	22.5
2012-13	4404	10199	43	15.7	20.7
2013-14	4437	10454	42	14.7	22.3
2014-15	6139	12989	47	15.6	22.4

Source - SSAT Annual Reports Appendix 4

Impacts on the composition of the DSP population

It is important to understand how the reform has impacted on the DSP population and whether there has been any change in:

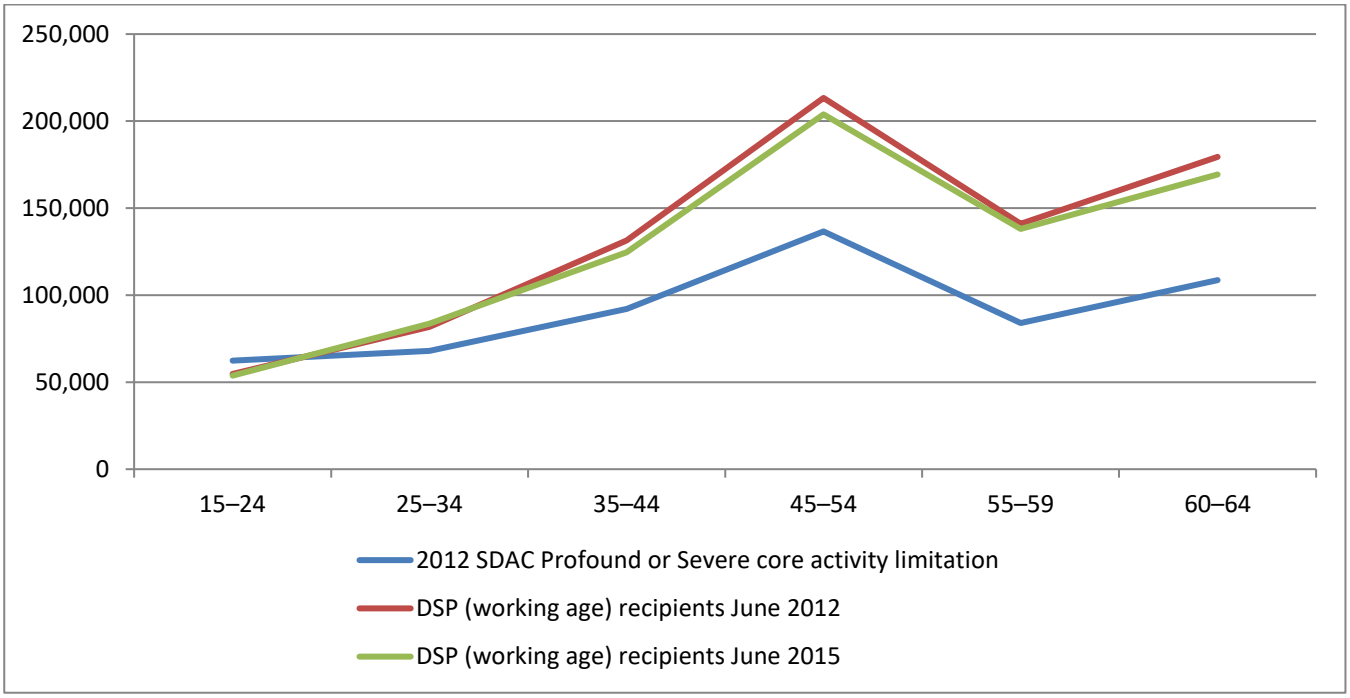
- the composition of DSP grants
- rejected claims by medical condition, or
- outcomes of medical reviews.

Since the revised Tables were introduced, DSP population growth has slowed. In December 2011 the population was 831,900 compared with around 800,000 in December 2015.

Both disability in the population and receipt of DSP are strongly age related. According to the ABS SDAC 2012, the population with a profound and severe core activity limitation has remained fairly stable over the past decade. The same cannot be said of claim levels or grant rates for DSP. The growth of the DSP population is now better aligned to the growth in the underlying population with a severe and profound disability, which may also indicate that assessments are now more precise in their measurement of the severity of the impairment and the function affected.

Figure 3 below compares the SDAC population with a profound and severe core activity limitation with the DSP (working age) population in June 2012 and June 2015, by age group. An exact correspondence is not expected, yet it is interesting to note that the age profile for the overall DSP population has moved closer to the SDAC age profile between 2012 and 2015, since the implementation of the revised Tables.

Figure 3: Comparison of SDAC population with a profound or severe core activity limitation and DSP working age population by age cohort

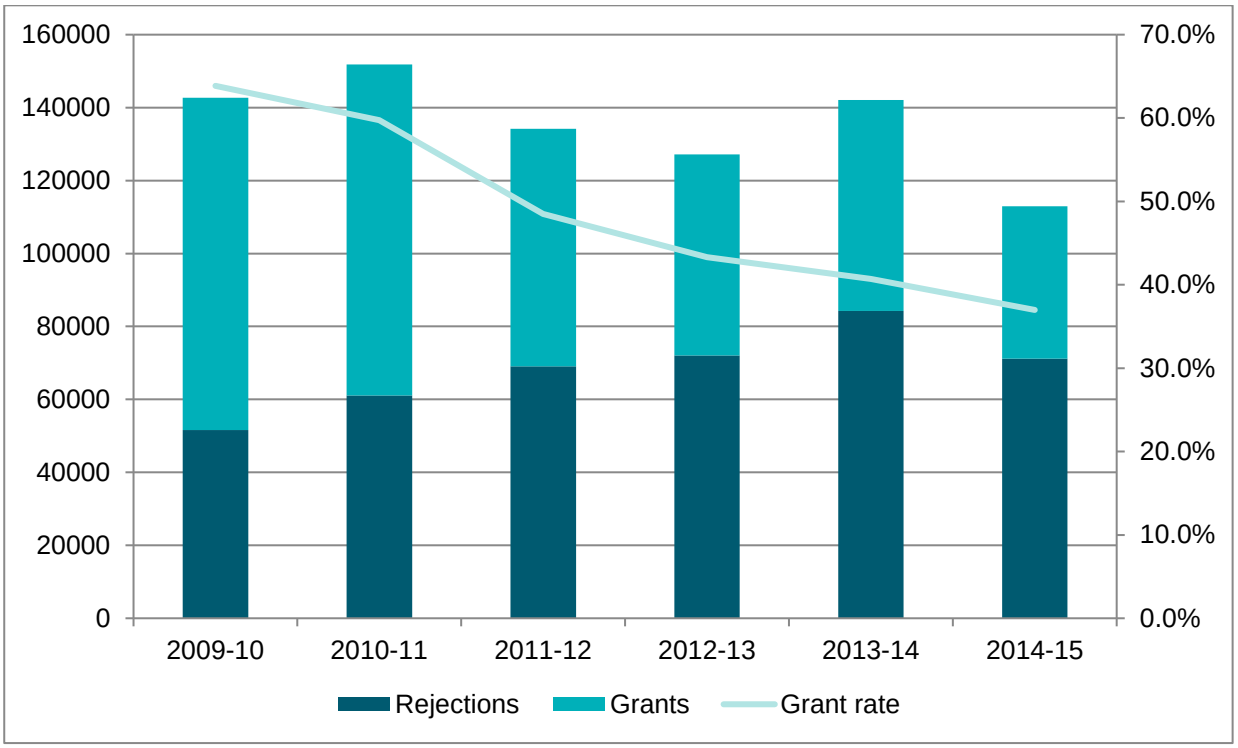


While the revised Tables have strengthened the targeting of DSP, other policy changes, in combination with wider economic changes have also influenced the growth in the DSP population. It is not possible to separately calculate the impact of one measure.

Since the revised Tables were introduced:

- The number of claims each year has declined. In 2014-15 there were 112,983 claims, down from 151,815 in 2010-11 (the highest level since DSP was introduced in 1991).
- The rejection rate (number of rejections as a proportion of number of claims) each year has increased; mainly occurring in cohorts over age 50; and
- The number and proportion of grants per year has declined.

Figure 4: DSP claims by claim outcome, 2009 – 2015



The inflow onto DSP has changed by medical condition, age and sex. The age profile for grants varies by medical condition, so the change in the composition of grants by medical condition has also changed the age profile of grants. Table 2 below illustrates that between 2010-11 and 2014-15:

- There was an increase in the proportion of total grants related to intellectual and learning conditions (from 6.7 per cent to 9.1 per cent) and 'cancer and tumour' (from 6.8 per cent to 12.7 per cent);
- A decline in the proportion of total grants related to musculo-skeletal function (from 27.8 per cent to 18.1 per cent); and
- The proportion of total grants with psychological/psychiatric conditions remained relatively stable at around 30 per cent, despite the stricter diagnostic requirements for the Mental Health Table (5).

Table 2: DSP grants by top 5 primary medical conditions, 2010-11 to 2014-15

Year	Psychological/ psychiatric		Musculo-skeletal and Connective Tissue		Intellectual and learning		Cancer/Tumour		Circulatory		Other Medical		Total Grants
	Number	%	Number	%	Number	%	Number	%	Number	%	Number	%	
2010-11	26,247	28.9	25,190	27.8	6,101	6.7	6,171	6.8	4,297	4.7	22,706	25.0	90,712
2011-12	19,568	30.1	15,251	23.4	5,834	9.0	4,867	7.5	3,535	5.4	15,994	24.6	65,049
2012-13	17,348	31.5	11,414	20.7	5,538	10.1	4,338	7.9	3,278	6.0	13,176	23.9	55,092
2013-14	18,063	31.2	11,812	20.4	5,971	10.3	4,792	8.3	3,513	6.1	13,767	23.8	57,918
2014-15	12,372	29.6	7,574	18.1	3,802	9.1	5,319	12.7	2,016	4.8	10,702	25.6	41,785

Source: DSS Analysis of DSP Events Data

People with intellectual or learning disabilities which are generally congenital usually have a high need for support, whereas claimants with musculo-skeletal conditions may have more capacity or ability to be re-trained for work.

People with a significant level of impairment are more likely to come onto DSP at a younger age. This corresponds with the increase in the proportion of grants to claimants under the age of 25 from 12 per cent to 17 per cent. Around 78 per cent of people with an intellectual or learning disability and one fifth of people with a mental health condition commence receiving DSP under age 25. Over half the people with a musculo-skeletal condition commence receiving DSP over age 55.

In combination, these changes indicate that the revised Impairment Tables have assisted in ensuring DSP remains targeted to people with disability who are unable to support themselves to achieve financial independence, while encouraging those with some work capacity to connect to the labour force to build that capacity.

The decline in the average number of grants has varied by age cohort. The overall decline was 42 per cent for males and 45 per cent for females. The largest decline occurred in the 35-39 age cohort (52 per cent), followed by the age 45-49 cohort. The lowest decline was in the age 16-19 cohort (19 per cent for males and 23 per cent for females). Again, this may indicate that the age cohorts where the biggest declines in grants are evident may be more likely to have a mild or moderate level of impairment and a higher work capacity.

The composition of new population, or stock, of DSP recipients is changing more slowly than the composition of grants. The stock reflects past grant and exit patterns. The change in the composition of grants will slowly change the composition of the overall DSP population.

When the revised Tables were introduced musculo-skeletal and mental health conditions each accounted for around 30 per cent of the primary medical conditions of DSP recipients. By June 2015 the proportion of the DSP population with musculo-skeletal conditions was 24.3 per cent and mental health conditions had become the most common primary medical condition in the population (32.5 per cent). There has been an increase in the proportion of male recipients (from 52 per cent to 54 per cent) and younger recipients.

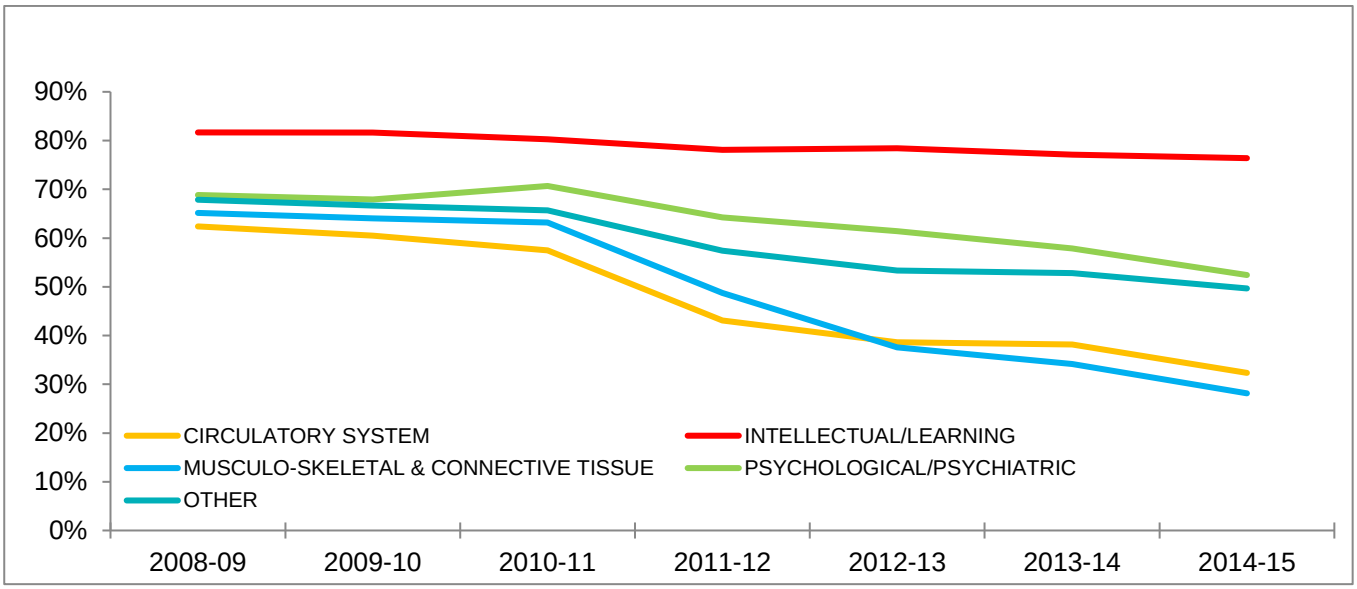
The decline in the proportion of the DSP population with musculo-skeletal conditions is expected to continue given the rapid decline in the DSP inflow (18 per cent in 2014-15), and

as people with musculo-skeletal conditions tend to be older (in 2014-15, 71.7 per cent of grants for musculo-skeletal conditions were for people aged over 50) and nearer to transferring to Age Pension. The proportion of people in the DSP population with mental health conditions continues to rise (31.9 per cent in June 2014 to 32.5 per cent in June 2015), as people with these conditions are the largest proportion of the inflow onto DSP.

People with significant impairment are able to access DSP

SDAC 2012 reports the long term health conditions with a higher proportion of profound limitation to be 'intellectual or developmental disorders' and 'psychoses or mood affective disorders'. Medical conditions with a high need for long term support include intellectual and congenital conditions. Grant and rejection rates for these conditions have not varied under the revised Tables. Figure 5 shows the DSP grant rate by primary medical condition since 2008-09.

Figure 5: Annual grant rate by medical condition, 2008-09 to 2014-15



Source: DHS administrative data

The revised Tables have impacted on the grant rate by medical condition to different degrees. The grant rate for intellectual and learning disability has remained relatively stable since the Impairment Tables were revised. The grant rate for musculo-skeletal conditions decreased the most, followed by circulatory system conditions. While the grant rate across all medical conditions was 37 per cent in 2014-15 the grant rate was 76.4 per cent for people with intellectual and learning disability and 52.4 per cent for people with mental health conditions.

Since the introduction of the revised Tables, the number of rejections for:

- Intellectual and learning disability have been the lowest among all medical conditions and have remained low (under 1,500 a year).
- Musculo-skeletal and connective tissue conditions increased the most (from around 14,000 a year to between 19,000 and 23,000 a year); and
- Mental health conditions remained fairly stable (10,000 – 13,000 per year).

However it is important to note that medical conditions are not always recorded for rejections (in 2014-15, 27 per cent of rejections did not have a primary medical condition coded), for example if a person is rejected for non-medical reasons prior to the medical assessment process.

The DSP claims dataset provides the outcomes of all DSP claims finalised using the revised Tables between 1 January 2012 and 31 December 2014. The average rejection rate over these three calendar years was 58 per cent.

Table 3 below illustrates that the most common reason a claim was rejected was because a medical condition was not fully diagnosed, treated and stabilised (42.6 per cent). The second most common reason for rejection (40.3 per cent) was due to insufficient impairment (i.e. an impairment rating of less than 20 points).

Table 3: Rejections by reason for claims finalised, 2012 - 2014.

Rejection reason	Number	Percent
Medical condition not fully diagnosed, treated, and stabilised	80,235	42.6
Insufficient impairment	75,950	40.3
Has not actively participated in a Program of Support	8,875	4.7
Disability is short term	3,946	2.1
Other (e.g. failed to reply to correspondence, compensation preclusion period, or income/assets over limit)	19,291	10.2
Total rejections	**188,297**	**100**

Source: Specialist claims data

Medical Reviews

There were 5,972 medical reviews finalised by December 2014 where the revised Tables were applied. This resulted in 294 cancellations. As at January 2015 only 27 of 294 (9.2 per cent) of people who were cancelled were current on DSP and over half (52 per cent) were not receiving any other income support. This suggests decisions to cancel DSP on review are robust in the majority of cases. The overall cancellation rate following review was 4.9 percent - it was lowest for people aged under age 35 (3.8 per cent) and highest for people aged 40-44 (6.9 per cent) and 45-49 (5.8 per cent).

Analysis of people whose DSP was cancelled following a medical review under the revised Tables may indicate the types of conditions where qualification requirements have been

strengthened or where people may have the most work capacity. The highest cancellation rates (in terms of numbers and percentage) occurred for people previously assessed against the old Tables for 'Miscellaneous' (30 per cent), 'Spinal', and 'Intermittent' conditions.

In the Review of the Impairment Tables, the Advisory Committee found that assessors were resorting to using Table 20 ' Miscellaneous' when there was insufficient medical evidence or when they were uncertain about which of the other Tables to use. Table 20 relied heavily on subjective self-reporting of pain and it included conditions that did not have any common diagnostic or functional grouping, suggesting it was relatively easy to score points on, or was inappropriately overused.

Under the previous Tables, around one quarter of grants were rated against Table 20. People rated under this Table were more likely to lose qualification when reviewed under the revised Tables. This indicates the revised Tables have a strengthened functional focus leading to better assessment of actual functional capacity than the previous Tables.

On 1 July 2014, new medical reviews commenced for DSP recipients under age 35 who were granted under the previous Impairment Tables between 2008 and 2011. As at 31 December 2015, over 22,800 reviews had been finalised with cancellation action taken on around 14 per cent of the reviews. The application of the revised Tables was responsible for 83 per cent of these cancellations.

The cancellation rate also varies by the Table used for review of medical eligibility. The highest cancellation rates and numbers occurred when assessments were against the revised Tables for 'musculo-skeletal', 'hearing' and 'consciousness' functions.

Impacts for DSP program performance indicators

The rationalisation of the Tables and their streamlined design with a consistent rating scale has improved their ease of use by assessors. It has also improved the functional equivalence between individual Tables and is contributing to better targeting of DSP. The revised Tables have impacted on the profile of entrants to DSP.

Grants for musculo-skeletal and connective tissue conditions have reduced considerably in number and as a proportion of total grants, with a significant decrease in grants since the introduction of the revised Tables in particular. Grants for psychological and psychiatric impairment have also reduced in number and as a percentage of total grants since 2012.

Musculo-skeletal conditions and mental health conditions vary greatly, and can give rise to a range of impairments, from very mild to extremely high levels. By contrast, grants due to conditions which almost always result in high levels of impairment, such as intellectual disability, have increased as a proportion of total grants. These patterns are consistent with people with mild to moderate impairment no longer being granted DSP, while people with higher levels of impairment are still able to qualify.

This shift in the characteristics of DSP recipients is expected to influence program performance indicators over time.

1. Average duration on DSP and impairment levels across the population are likely to increase.
2. A decline in the proportion of recipients with mild to moderate impairment may drive a reduction in the proportion of recipients with open employment earnings.
3. A decline in the proportion of recipients aged 55-64 may further reduce the proportion receiving a part-rate of pension due to assets.[7]
4. The higher proportion of recipients with an intellectual disability may increase the proportion of recipients in supported employment.

Recommendations

Issues with the interpretation of the Tables are generally minor in nature in terms of their scale and consequences. Most issues are able to be addressed through additional guidance. The improvements proposed in this report have been grouped according to how they can be resolved:

Appendix C: Improvements to the Guidelines to the Tables.
Appendix D: Minor changes to the Instrument in the future to clarify the current policy intention.

The recommendations aim to clarify the policy intent, enabling easier assessment of impairments and further improving consistency across assessments. Small improvements to the Guidelines and the Tables are expected to provide a stronger foundation for decision-makers.

The resolution of some issues is considered higher priority due to their consequences and frequency. These are:

1. A change to the Guidelines for Table 3 (Lower Limb function) to clarify that this Table assesses impacts of lower limb impairment on a person's ability to move around (mobility).
2. Additional guidance on the assessment of end-stage renal failure.
3. Minor word changes to Table 2-30 point descriptor, to clarify that a person must be unable to perform activities because of impairments to 'both' arms or 'both' hands.
4. Process guidance on the interpretation of test scores for IQ and adaptive functioning and consulting with health professionals, the HPAU and ASB Clinical Psychologists.

Changes to the Guidelines to the Tables for the Assessment of Work-related Impairment for DSP

Amendments to the Guidelines aim to assist users to select the appropriate Table for use in assessment, in the interpretation of descriptors, and definitional issues. Changes may require adding further definitions and examples and rephrasing of existing wording.

[7] The percentage of DSP recipients receiving part pension due to assets has always been low, however the 55-64 year age cohort is where lifetime wealth peaks and access to superannuation occurs; recipients with mild to moderate impairment are more likely to have worked in the past and accumulated retirement savings.

Appendix C outlines recommendations for changes to the Guidelines. The proposed changes should be discussed with the HPAU and DSS Legal Services prior to implementation. Related training would coincide with the Guideline changes.

Minor Changes to the Instrument

Small changes to the words in the Instrument will better align the Tables, Guidelines and the policy intention. These minor technical amendments would ensure descriptors reflect the original policy intent of the Table and would require minimal input from medical experts. They would not change the structure of the Tables or descriptors and would not require DHS system changes.

One of the changes proposed would also respond to Recommendation 20 from the House of Representatives' *Inquiry into the Harmful Use of Alcohol in Aboriginal and Torres Strait Islander communities*.[8]

Appendix D outlines recommendations for technical amendments to the Instrument. Any changes to the *Social Security (Tables for the Assessment of Work-related Impairment for Disability Support Pension) Determination 2011* are subject to parliamentary scrutiny as they would be contained in a disallowable instrument.

Changes to training and process

A review of training and messaging is recommended to ensure DHS assessors and decision-makers are supported to deal with issues related to more complex assessments that occur on a regular basis. Training on the interpretation of specific terminology and definitions and Table selection will support continuous improvements in consistency.

To support the recommended changes, DHS should review procedural guidelines and training for assessors and DSP decision-makers, to ensure that these reflect current legislation and policy around application of the Impairment Tables and address relevant issues identified in Appendices A and B.

Future review of the Tables

In 2022 the Impairment Tables Instrument will expire (if not amended prior) and need to be re-tabled. It will be important prior to that year to consider whether changes to the Instrument are required. It is recommended a full review of the Tables be scheduled for early 2020.

Any commitment to significantly change the Tables will require a Government decision. A rationale for change will need to consider the policy justification, costs, benefits, potential risks, expertise required and options on the extent of change. More limited

[8] Available at http://www.aph.gov.au/Parliamentary_Business/Committees/House/Indigenous_Affairs/Alcohol/Reporthttp://www.aph.gov.au/Parliamentary_Business/Committees/House/Indigenous_Affairs/Alcohol/Report

changes could be undertaken based on advice from HPAU and a tailored set of clinical experts and stakeholders.

While the revised Impairment Tables are predominately function-based, the Final Report of the Advisory Committee recommended a move to entirely function-based Impairment Tables within the next decade, so that all of the Tables reflect key functions/activities required for participation in work or training. For example, in such a future model, the spinal function Table and other mobility-related Tables could be replaced or combined with a Table that focusses on work-related functional abilities such as lifting and carrying, bending and reaching, pushing and pulling, moving around the workplace, etc.

This would require wide consultation and significant input from medical experts and could only be achieved through a full Review of the Tables.

In the meantime, removing 'Table 6 – Functioning related to Alcohol, Drug and Other Substance Use' would be a step towards achieving more function-based Tables. Table 6 assesses a single disorder/condition and as such is not function-based. There is also substantial overlap between the descriptors in Table 6 and other, purely function-based Tables, including Mental Health Function (Table 5), Brain/cognitive Function (Table 7) and Digestive and Reproduction Function (Table 10). The removal of this Table could be achieved in a way that does not impact on the overall Table structure, requiring minimal changes to the legislative Instrument.

Concluding Comments

The Review has confirmed that the reforms to the Impairment Tables have been successful in simplifying the assessment of impairment with a focus on ability, and improving the quality, rigour and consistency of assessments.

The effectiveness of the implementation of the revised Tables is confirmed by the limited number of issues that have arisen throughout the implementation. The issues are generally minor in nature and able to be addressed via clarifications to guidance, minor technical amendments to the Instrument, and improvements to training.

This conclusion is supported by the recent findings of the performance audit conducted by the ANAO entitled *Qualifying for the Disability Support Pension* and by the high level of affirmation rates for DSP appeals and review outcomes.

The review has not identified any unintended consequences to justify a full review of the Tables at this time. In 2022 the Instrument will expire (if not amended prior) and need to be re-tabled. It will be prudent to consider whether changes to the Instrument are required prior.

The move to a function-based approach that focuses on what people can do has improved the targeting of DSP. Since 2012 the annual growth of the DSP population has declined and the composition of the inflow has changed towards a higher proportion of people with significant impairment. The revised Tables are contributing to a better alignment between the DSP population and the prevalence of profound and severe disability in the underlying workforce age population.

Issues for Resolution
Appendix A - Complexity in Conducting Assessments

A1) Self-report of symptoms: The 'Introduction' to each Table specifies that self-report alone is insufficient evidence and that corroborating evidence is required for an impairment rating to be assigned. Some Tables accept non-medical evidence as corroborating evidence – for example Table 5 lists "interviews with the person and those providing care or support" as acceptable corroborating evidence. In cases where objective measurement of a person's condition is not available (e.g. tinnitus, hallucinations), a degree of reliance on self-reporting of symptoms is unavoidable. Appeal Tribunals have in some instances accepted non-medical evidence, for example from a person's partner. (Rec C1).

A2) Assessing the functional effects of fluctuating and intermittent conditions such as migraines, epilepsy, and some mental health conditions can be difficult given the range of circumstances related to the severity, frequency and duration of episodes. The *Guide to Social Security Law* contains advice on what should be taken into consideration when assessing the overall functional impact of the impairment/s and states that consideration should be given to the impact on the person's ability to reliably sustain work over two years without excessive leave or work absences. As this is an area where professional judgement is particularly important, assessors and decision-makers would benefit from additional guidance and examples being included training material, supplemented by the ongoing advisory role that the HPAU provides.

A3) Interpretation of test scores for intelligence and adaptive function: Table 7 and Table 9 descriptors involve decisions based on global test scores on IQ and adaptive function. Manifest eligibility is granted where a person diagnosed with Intellectual Disability has an IQ score below 70. Table 9 descriptors contain ranged scores for different tests and there are cases where the test results given as a range may cross over the ranges in descriptors.

In some situations a global score may be interpreted too simplistically. There can be variation in scores sub-indices or other factors that affect test performance (e.g. poor English or a mental health condition). There is a risk that too much weight is placed on the overall score without considering the sub components. Decision-makers need strong guidance about the interpretation of test scores. (Rec C20).

A4) End-stage renal failure: A person with end-stage renal failure may experience a range of symptoms. In the assessment of a person with renal failure assessors should apply all of the relevant Tables, taking care to avoid double counting. For example Table 10 could be used if the impact is on digestive or reproductive function or Table 1 could be used if the person experiences fatigue or shortness of breath. There will be situations where this condition may result in multiple functional impairments which can be assigned ratings from more than one Table. (Rec C5).

A5) Table Selection: There are a number of situations where Table selection can be complex. A single medical condition may result in multiple functional impairments which can be assigned ratings from more than one Table. For example, while Table 1 is the dedicated table for assessing an impact on physical exertion and stamina, functions assessed on other Tables may also incorporate an element of physical exertion and/or stamina, such as Table 2, 3 or 10. Additional guidance and training for assessors would

reinforce that care must be taken to ensure that the different Tables are being used to assess separate functional impairments and not the same functional impairment to avoid double-counting, including when to use Table 1 versus other function-based Tables. (Recs C4, C5 and C7).

Appendix B - Interpretation of the Tables

B1) Table design: While most Tables relate to a specific function there are stand-out exceptions, particularly Tables 1 (Physical Exertion and Stamina), Table 6 (Substance Use), Table 10 (Digestive and Reproductive) and Table 15 (Consciousness). In these Tables, descriptors cover specific impacts arising from conditions assessed as well as impacts on cognitive, daily living, and other functioning. As some of these functions can also be assessed by other Tables there is potentially more risk of duplication. While most of the intentional design differences across individual Tables are well understood by assessors, there may be benefit in explaining these in more detail. (Recs C4, C23 and D11).

Table 6 (Substance Use) is not related to a specific functional domain. Unlike the other fourteen Tables, it is 'condition' specific rather than focusing on domains of function. In most cases the impact of substance use could be sufficiently captured using alternative function-based Tables, depending on how the substance use impacts the person (e.g. mental health, brain or liver function). There is the potential for double counting, for example a person may have a diagnosed current drug use and mental health issues that are drug related (e.g. drug induced psychosis). This person could potentially score ratings under both Table 5 (Mental Health) and Table 6.

Table 6 is a priority for removal. Removing this Table would ensure progress towards more function-based Tables in line with the Advisory Committee recommendation for a move towards fully function-based Tables within ten years (by 2022).

B2) What it means to be 'able' or 'unable' to perform activities: There are differences between Tables in the terminology around being able or unable to perform activities and phrases such as 'some difficulty' or 'extreme difficulty' or being able to 'sustain an activity'. Different Tables apply these concepts somewhat differently. Clarification about when being unable to do an activity means unable to do it **at all** rather than unable to do it without a certain level of pain or symptoms would be beneficial.

Being 'able' to perform an activity has the meaning of being able to perform it whenever the person would normally attempt such activity. (Recs C5 and D2).

B3) The meaning of the word 'assistance' Descriptors for a number of Tables refer to the need for 'assistance' to perform an activity, yet the term is not defined in the Tables. Assistance means assistance from another person rather than any aids or equipment the person may use. This policy intention is reflected in the Guidelines.

It would be prudent to include a definition of this term in the Instrument as Tribunals have in the past interpreted it differently. (Rec D1).

B4) Application of 'examples' used in descriptors: There have been occasions where users have applied the examples in Tables 5 and 7 as if they were all criteria that must be met.(Rec C2).

B5) Use of the term ‘includes’ in descriptors. In Tables 1, 3 and 6 there are separate descriptors that say “includes people who”. These descriptors were originally intended as notes clarifying the applicability of these descriptors to certain categories of people (e.g. people using wheelchairs in Table 3) but in the drafting process they were numbered and it is not always clear whether claimants need to meet both or only one of the numbered descriptors.

Changes to both the Guidelines and Tables would specify how to interpret the ‘includes’ in Tables 1, 3 and 6 (whether the descriptor represents an ‘AND’/ ‘OR’ /or ‘SUBSET’) in relation to the previous descriptor. (Recs C7, C15, C18 and D3).

B6) Assessment of Fetal Alcohol Syndrome and Fetal Alcohol Spectrum Disorder (FAS/ FASD): The HoR Inquiry into the Harmful Use of Alcohol Report has recommended that the Commonwealth include in the appropriate Table that

“People with FAS or FASD who do not have a low IQ be assessed using Table 7 - Brain Function.

People with FASD, who do not have a low IQ are able to be assessed under Table 7 currently”.

This change would make this more explicit but would not change the operation of the Tables. (Recs C20 and D9).

Table 2 – Upper Limb Function

B7) Coverage of Descriptors: There is a perceived gap in relation to the coverage of descriptors for impairments of shoulder function. To achieve ratings of 10 or 20 points a person needs most descriptors to apply, yet most Table 2 descriptors relate to fine motor skills which shoulder injury may not impact on. There are cases where conditions of the shoulder have been rated under Table 4 Spine which does have descriptors related to the difficulty of undertaking overhead activities. (Recs C8 and C9).

B8) Interpretation of ‘both arms or both hands’: For 30 points, Tribunals have misinterpreted wording to mean that the inability to do things requiring use of both hands/arms is met if one arm/ hand is not functioning. This is not consistent with the intent of this descriptor and the incremental hierarchy of descriptors. The correct interpretation of the ratings is explained in the Guidelines. (Recs C10 and D4).

Table 3 – Lower Limb Function

B9) Table intent: Clarification is required to indicate that the intent of this Table is to assess functional impact on the lower limbs in the context of a person’s ability to move around or mobilise, rather than only the lower limb functional impacts. (Rec C11).

B10) Interpretation: More guidance is sought around the interpretation of the ability to use public transport and the treatment of motorised and non-motorised wheelchairs.
(Recs C12 and C14).

B11) Rating scale: There is concern about the scale for ratings against this Table. For example, the ability to stand unaided for over 10 minutes rates as 0 points while an inability to stand unaided for 5 minutes rates as 10 points, 10 points is also awarded to people able to walk around in a shopping centre or supermarket. (Rec C15).

Table 4 – Spinal Function

B12) A high proportion of appeal cases involve spinal injuries. There are a number of definitional and consistency concerns for Table 4. References to 'overhead activities' (10 points) are intended to measure the difficulty of looking up not reaching up. The ambiguity around this terminology is open to misinterpretation.

Assessors and decision-makers may benefit from additional guidance on the interpretation of the intention of the term, through training or the HPAU.

B13) Rating scale: There has been some confusion about the level of trunk movement required for different activities. The intention of the Descriptor (1)(b) for 20 points is an inability to either turn the head or bend the neck **at all without moving the trunk,** not even to a small degree.

A small change to the Instrument would better align it to the policy intention. (Recs C16, D6 and D7).

Table 6 – Functioning related to Alcohol, Drug and Other Substance Abuse

B14) Table 6 applies to people who have current, harmful substance use. Alcohol and drug dependence is assessed where the person's medical and other reports, history and presentation consistently indicate chronic entrenched substance use causing a functional impairment, due to behaviours associated with substance use e.g. unable to attend work or school. Former users with resulting long-term impairments should be assessed under the relevant Table(s), Table 7 (Brain Function) for permanent neurological impairment or Table 10 (Digestive Function) for liver damage.

As noted earlier there is the potential for double counting under this Table. (Rec D8).

Table 7 – Brain Function

B15) Coverage of Descriptors: There is a potential gap in that Table 7 may not strongly recognise impairments to balance due to non-visuo-spatial brain functions, although the visuo-spatial domain in this Table can be used to assess this. Balance issues can currently be assessed against a number of Tables depending on their specific characteristics; they can be visuo-spatial/neurological (Table 7), related to functions of the ear (Table 11) or lower limb impairments (Table 3). (Rec D10).

Table 9 – Intellectual Function

B16) Selecting relevant Table: Assessors are seeking more clarity about when to use Table 7 Brain Function versus Table 9 Intellectual Function.

Table 9 is to be used when the impairment originated before the person turned 18 and results in low intellectual function (IQ 70-85). Low functioning Autism and FAS/FASD are assessed under Table 9. (Recs C20 and D9).

Table 10 – Digestive and Reproductive Function

B17) End-stage renal failure: Renal failure is a relatively common condition. The Guidelines for Table 10 say 'chronic symptoms from renal disease' can be assessed using Table 10, as this is the policy intention (noting this means Table 10 can be used if the assessor thinks it is appropriate for the individual, not that it must be used). However Table 10 does not specifically mention kidneys. This may be increasing inconsistency in how end-stage renal failure is being rated by assessors.

The Guidelines should be amended to further clarify when Table 10 would be appropriate to use for renal failure. (Rec C23).

Table 14 - Functions of the Skin

B18) Rating scale: This Table can be used to score 10 points for people with limited loss of function. People who have had a Basal Cell Carcinoma removed are claiming they need to take "higher than normal precautions to avoid exposure to sunlight" and are being awarded 10 points. If the person is able to perform activities involving exposure to sunlight, there is no functional impact and 10 points should not be assigned. (Rec C24).

Improvements to the Guidelines to the Tables - Appendix C

Changes to the Guidelines are recommended to support Table selection and the interpretation of certain descriptors and terminology.

There are certain situations where people could be assessed legitimately under different Tables for the same condition because of the variety of functional impacts the condition causes. It is a requirement to avoid double counting in assessments. Additional material in the Guidelines is expected to result in more consistent Table selection and minimise the potential for double counting.

Recommendation C1: Strengthen the text around the self-report of symptoms and emphasise the rules around the self-reporting of symptoms. Include additional explanation of evidence requirements for conditions with no objective scientific measurements, e.g. vertigo, pain, tinnitus, and hallucinations. The Guidelines already address this issue but there is scope for further clarification and emphasis through the Guidelines combined with training. For relevant Tables, **bold** the rules around self-report:

'A person's self-reported symptoms must not solely be relied on'; and add

'There must be corroborating medical evidence'.

Explain the concept of primary versus secondary evidence and provide links to relevant Topics in DSS' *Guide to Social Security Law*.

Recommendation C2: Change the Guidelines wording for Tables 5 and 7 under the section 'Determining the level of functional impact' to explain more clearly that the examples contained in the descriptors in a legislative instrument are not criteria to be met. For the paragraph starting "*Each descriptor contains examples…impairment for each domain"* the following sentence will be added:

> "*These examples are not prescriptive or exhaustive. The examples are not to be treated as a further descriptor. Rather, examples are suggesting one possible impact from a set of possible impacts which indicate the level of impairment required to meet the descriptor. A person may have impairment in undertaking other activities not listed in examples, to an equivalent degree".*

This change to the Guidelines will be reinforced in training.

Ask the HPAU to provide relevant additional examples for use in training or the Guidelines.

Recommendation C3: Add further explanation about the design differences between Tables in order to promote understanding of how particular Tables are intended to be used (either in Overview or for relevant Tables). This is expected to reduce duplication and improve the consistency of practice. For example, attention and concentration related to digestive and reproductive conditions should be assessed under Table 10 for digestive and reproductive function, rather than Table 7.

Recommendation C4: Add End-stage renal failure to the 'Case Examples of Table Use for Permanent Conditions' under Section 3.6.3.07 of the Guidelines. Also add material under Section F of the Introduction "Selecting the applicable Table…." about the assessment of

end-stage renal failure. Clarify that a number of Tables can be used to assess end-stage renal failure.

Where there are gastrointestinal symptoms, Table 10 could be used, where there are problems performing activities requiring physical exertion or stamina Table 1 can be used and where there are skin symptoms, e.g. pruritus, Table 14 could be used.

Table 1

Recommendation C5: For 20 points - Clarify what is meant by unable to undertake the task described. This means there is an inability to perform one of the tasks described in the following (i)-(iv) descriptors. In these descriptors the meaning of 'unable' is not that it is unable to be performed without some pain, shortness of breath or fatigue. When a person experiences some symptoms, or pain, when performing an activity this does not mean that the person is unable to perform the task. The level of pain incurred/symptoms experienced in performing the activity is relevant to the assessment where it impacts the ability of the person to perform the activity when they would normally attempt such activity and not only once or rarely.

Recommendation C6: Provide additional guidance to ensure a rating on Table 1 would not result in double-counting i.e. if there is an impact on physical exertion and stamina and a rating has been applied on other Tables (for example Tables 2 and 3 and 10) does the rating on the other table already adequately capture the level of impairment?

Consider adding more examples of when Table 1 could be used.

Recommendation C7: Use of the term 'Includes' in Descriptors. For 30 points – Based on HPAU advice, add clarification about the descriptor related to the use of home oxygen.

For this Table it is proposed that the 'Includes' be treated as an 'OR' and a person would only need to meet descriptors 1) OR descriptor 2).

Table 2

Recommendation C8: The Guidelines to confirm that a person's limitations in relation to work tasks relate to any job available in Australia**.** Table 2 does not capture overhead activities (except for 5 points), however not all jobs in Australia commonly require performing "overhead activities" e.g. call centres, administrative duties etc.

Recommendation C9: Consider expanding and replacing the current paragraph in the Guidelines under 'Determining the level of functional impact' that says "*To avoid double-counting …restrictions on overhead tasks which result from conditions of the shoulder be rated under Table 2 only*".

Reword by adding:

"Restrictions on overhead activities under Table 2 are only relevant in applying the 5 point descriptor. If the person has more severe restrictions on overhead activities arising from shoulder injury, they should still be assessed under Table 2 in relation to what they can/cannot do in accordance with the existing descriptors. People in this category are not to be assessed under Table 4 which is to be ***solely*** *used to assess restrictions on overhead activities arising from spinal conditions."*

Recommendation C10: In relation to the interpretation of “both arms or both hands” for 20 points (1a) – Add words in the Guide to clarify that for this descriptor to apply a person must have severe difficulty using both hands or both arms or an amputation or equivalent rendering each hand or arm to be non-functional.

Table 3

Recommendation C11: Amend the Guidelines to clarify that the intention of this Table is to assess functional impairment when performing activities requiring the use of legs or feet in the context of a person’s ability to move around or mobilise.

Recommendation C12: Define public transport and confirm that an ability to use public transport is a hypothetical test and applies to any form of public transport, whether it is available or not. Likewise a ‘supermarket/community facility’ represents a hypothetical test or example. This is supported by the AAT Decision in Wilson and Secretary, DSS [2015] AATA 497. The fact that there may be no supermarket in a certain locality (e.g. in a remote community) is irrelevant to assessing a person’s ability/inability to walk certain distances, no matter what the destination might be.

Recommendation C13: Utilise HPAU to provide guidance around the interpretation of “unable to walk far”, in terms of distance and pace.

Recommendation C14: Confirm the term “wheelchair” applies equally to motorised and non-motorised wheelchairs. Explain that the content of descriptors for 10 and 20 points enables equal treatment of both types of wheelchairs, as *it is the ability to transfer in and out of a wheelchair* (motorised or non-motorised) that is critical in differentiating between a rating of 10 or 20 points.

Recommendation C15: Clarify the distinction between the various impairment levels under the descriptors and how the hierarchy of descriptors works.

Table 4

Recommendation C16: For 20 points, clarify that the intent is the person is unable to **either** turn the head without moving the trunk or bend the neck without moving the trunk rather than to be unable to **both** turn the head and bend the neck without moving the trunk. Include additional content under “Determining the level of functional impact”:

*“For 20 points there needs to be ‘either complete loss of cervical flexion or complete loss of cervical rotation’. Clarify that it is the extent of inability to turn the head or bend the neck without moving the trunk which determines the level of rating. A rating of 20 points requires no ability **at all** to either a) turn the head or b) bend the neck, without moving the trunk (not even to a small degree)”.*

Give examples in the Guide of what a ‘light’ object could be.

Recommendation C17: Consider clarifying the difference between the 10 and 20 point descriptors by providing an interpretation of “unable to sustain” through additional examples. If a person can do something only once and not when they would normally attempt such activity they are unable to sustain the activity and could be allocated 10 points.

For 20 points they need to be unable to do the activity and in this hierarchy of descriptors this means *unable to do it at all, not even once*.

Table 6

Recommendation C18 For 10 points - Change the Guidelines to clarify that "*if a person meets descriptor 2 they also need to have a moderate functional impact from harmful substance use and would also need to meet descriptor 1*" (unless Table 6 is removed).

Tables 7 and 9

Recommendation C19: Guidelines could be strengthened to say that in circumstances where there is discrepancy in the indices constituting the global score, the assessor would need to consider the context for the individual and contact relevant health professionals, or ASB psychologists to assist with interpretation.

Recommendation C20: Strengthen guidance on when to use Table 9 versus Table 7.

- Clarify that people with Autism/FAS/FASD and an IQ of 70-85 are usually assessed under Table 9 (Intellectual Function) as their condition originated before the person turned 18.

- Add FAS & FASD with IQ over 85 under heading "Conditions commonly assessed under Table 7".

- Simplify the paragraphs relating to Autism under the heading "Impairments that should not be assessed using Table 7".

- Note that Table 7 can be used to assess people whose IQ cannot be adequately assessed (for example, due to significant variation in their cognitive skills, sometimes related to learning disorders).

Table 7

Recommendation C21: The Guide could be amended to provide more examples of symptoms, under visuo-spatial (balance) and concentration (mental stamina).

Table 10

Recommendation C22: Include a note under "Determining the level of functional impact" to the effect that the design of Table 10 is different to most other Tables in the extent it specifically recognises the impact of impairments and their treatment on attention, concentration. This will clarify that the impact of digestive and reproductive functions on attention and concentration are to be rated on Table 10 and not Table 7.

The impact of digestive and reproductive function on pain and stamina can be rated on Table 10 rather than Table 1.

Double counting is to be avoided and both Tables would not be used (unless other functional impacts specific to Table 1 or Table 7 are present).

Recommendation C23: Clarify in Guidelines that there are a number of Tables relevant to assessing the wide-ranging impairments that may arise from end-stage renal disease. Where the impact is nausea or related gastro-intestinal Table 10 is relevant.

Provide examples of when it is appropriate to assess renal failure using Table 10 and Table 1.

Table 14

Recommendation C24: An addition to the Guidelines to clarify that if a person can perform the activities with sun protection then they should not receive 10 points.

Minor Changes to the Instrument to Clarify Policy Intent - Appendix D

There are a small number of technical amendments which can be undertaken via minor changes to the wording in the Instrument to better reflect the current policy intention. These changes would require minimal input from medical experts and are not expected to require DHS system changes. Changes to the Instrument will require advice from the DSS Legal Services in combination with HPAU.

Recommendation D1: Under the heading 'Interpretation' add a definition for the meaning of "Assistance". The term 'assistance' is used in descriptors for several Impairment Tables. The Guidelines have been updated to clarify that assistance means assistance from another person rather than any aids or equipment the person may use.

Recommendation D2: Rules 11 (3) "Descriptors involving performing activities" needs to be re-worded to refer to a person's inability rather than ability to do an activity, remove reference to "repetitive or habitual basis" and instead refer to when a person would normally be required to complete such an activity.

Recommendation D3: For Tables 1, 3 and 6 clarify the use of the word "includes" in descriptors:

- For Table 1 accepting the HPAU advice on the use of oxygen would mean that for 30 points *only one of the two descriptors needs apply.*
- For Table 3 for 10 and 20 points the last descriptor should be an *additional* requirement.
- For Table 6 for 10 points the intention is that a person receiving methadone should meet descriptor 1.

Table 2

Recommendation D4: A small word change in the descriptor for 30 points will clarify the agreed intent and align the Table with the Guidelines.

Change the words in Table descriptor for 30 points to say "*the person has no function in either both of their hands or both of their arms or the person has no arms or hands"*.

Table 3

Recommendation D5: Minor word change in the Descriptor for 20 points to avoid current misinterpretation that a person only needs to meet one of the points under 1(a) to achieve 20 points, when the intention is that all three points under 1(a) need to be met to achieve 20 points. i.e. remove 'any of' and add 'and' between 1(a)(i) and 1(a)(ii)

Table 4

Recommendation D6: Insert word 'either' at beginning of 1(b) to clarify that the intention of the Descriptor is an inability to either turn the head or bend the neck without turning the trunk rather than to be unable to both turn the head and bend the neck without turning the trunk.

Recommendation D7: Insert words to reinforce that 20 points applies when a person cannot bend their neck or cannot turn their head at all without moving their trunk.

Table 6

Recommendation D8: Remove this Table as a step towards a more function-based set of Tables. This may require small adjustments to the descriptors in alternative Tables (mainly Tables 5, 7, and 10).

Table 7

Recommendation D9: Add a further example after Autism Spectrum Disorder: "/FAS and FASD" to clarify that people with FAS or FASD who do not have a low IQ should be assessed using Table 7 Brain Function.

This would address Recommendation 20 of the *House of Representatives Inquiry into the Harmful Use of Alcohol* and is consistent with current assessment practice.

Recommendation D10: Change to Table descriptors to include additional symptoms re neurological balance conditions and concentration (mental stamina).

Recommendation D11: Consider whether the term 'day to day activities' should be changed to 'activities of daily living' for consistency with other Tables.

DEPARTMENT OF SOCIAL SERVICES

EVALUATION OF THE REVISED DISABILITY SUPPORT PENSION ASSESSMENT PROCESS

FINAL REPORT

6 APRIL 2017

HEALTH OUTCOMES INTERNATIONAL
5A Glynburn Road, Glynde, SA 5070 | P: 08 8363 3699 | F: 08 8365 3560
E: info@hoi.com.au | www.hoi.com.au

C

CONTENTS

TABLES

F

FIGURES

E

EXECUTIVE SUMMARY

Health Outcomes International (HOI) were engaged by the Commonwealth Department of Social Services (the Department or DSS) to complete an evaluation of the revised assessment process for the Disability Support Pension (DSP) introduced fully on 1 July 2015.

E.1 THE REVISED ASSESSMENT PROCESS

The assessment process for the DSP was amended by:

- introducing the requirement, following the Job Capacity Assessment (JCA) for a Disability Medical Assessment (DMA) by an Australian Government Contracted Doctor (GCD); and
- replacing the requirement for a medical report (also known as Treating Doctor's Report (TDR)) for new claims with the need to provide raw medical records (evidence).

The fundamental policy objective of the measure was to provide additional rigour to the DSP assessment process and improve the integrity of the welfare system.

The revised assessment process was introduced with a six-month transition period from 1 January 2015 to 30 June 2015. During the transition period the new assessment process only applied to applicants under 25 years of age and living in capital cities and was expanded to those aged under 35 years in March 2015. From 1 July 2015, all new applicants were subject to the new assessment process and the DMAs were undertaken by Doctors from a DHS Contracted Service Provider; Medibank Health Solutions.

E.2 EVALUATION AND KEY FINDINGS

The aim of the evaluation was to obtain an understanding of how effectively the revised assessment process is achieving the policy objectives and what the related impact (if any) of the measure has been on applicants. The evaluation processes included: analysis of claims and appeals data; and consultation with selected stakeholders in relation to the impact of the revised DSP application process.

The following provides the key findings from an analysis of the impact of the measure during the first nine months of operation. This is contrasted where possible with the same nine-month period in 2013/14 and 2014/15. Some caution must be taken in interpreting the results given the very short implementation lead time, the relatively short period since implementation and limited flow of DMAs to date and particularly given there already appears to be some pre-existing trends arising in DSP claims and determinations over the last two years.

Summary of Key Findings:

- Overall the revised assessment process has been implemented in a manner consistent with the policy intent and the objectives of the revised process have been met.
- The revised assessment process requiring a Disability Medical Assessment (DMA) by a Government Contracted Doctor (GCD) resulted in 77.4% of claims referred for a DMA being affirmed.
- The introduction of DMAs resulted in 2.5% of claims being rejected that would have previously been approved, reducing the overall grant rate from 23.4% to 20.9%.
- The average time taken to grant a DSP claim increased by approximately six weeks, and the time taken to reject a claim has increased by approximately 3-4 weeks. There was no significant difference for customers living in regional and remote areas.
- Manifest determinations increased as a proportion of finalised claims in 2015/16, continuing a trend that had already commenced between 2013/14 and 2014/15.
- In respect of appeals the proportion of Authorised Officer Review (ARO) decisions affirming the original decision has continued to increase over the three years examined, indicating that the revised assessment process is robust and resulting in appropriate determinations.

E.2.1 Implementation consistent with policy intent and objectives met

There were 51,868 claims lodged and assessed during the nine-month period July 2015 to March 2016. Only non-manifest claims were intended to be referred for DMA and only if the JCA did not result in rejection of the claim. Of the non-manifest claims (45,229; 87.2% of total claims) the majority (38,863, 86.0% of non-manifest claims) were rejected post-JCA. **Of the remaining claims** (6,366)**, 90.5%** (5,762 claims) **proceeded to a DMA, consistent with the policy intent.**

There were 604 claims[1] (9.5% of claims not rejected at JCA) that did not proceed to DMA, but were granted. This outcome is the result of the combined impact of:

- People originally not thought to be manifest but following JCA were found manifest and therefore not referred to GCD
- Applicants applying under an international agreement
- Appeals

It is the overall conclusion of the evaluation that the revised process has been implemented in a manner consistent with the policy intent and that the objectives of the revised process have been met.

E.2.2 Effectiveness of the revised process

As reported above, the revised assessment process was effective in introducing the requirement, following the JCA for a DMA by an Australian GCD.

[1] HOI's analysis of claims data identified 604 claims. It should be noted that DHS applies additional post-processing data cleansing rules (that were not available to HOI). DHS have reported the post data-cleansing equivalent of this figure is 72 claims. This variation does not impact on the evaluation's conclusions.

The total number of **claims finalised** in the time period July 2015 to March 2016 period (n=51,868) is substantially less than those finalised in the same time period in the previous two years. However, there had already been a fall in claims between 2013/14 and 2014/15. The evaluation has been unable to determine why this fall in applications over the last three years is occurring.

E.2.3 Impact on timeliness and outcomes of DSP claims and appeals

In the period analysed, there was an increase in the average time taken for a granted determination to be made and an increase in the time taken to reject a claim.

The proportion of all **claims granted** has also been in a steady decline from 42% (n=42,879) in 2013/14 and 37% in 2014/15 (n=33,742) to only 21% (n=10,854) in the time period July 2015 to March 2016. It should be noted that the smaller proportion granted in the latter time period could be influenced by other factors outside the scope of this evaluation.

An analysis of the claim **duration for the revised process** demonstrates that there was an increase in the average number of weeks taken for a grant determination to be made when contrasted with the same time period in 2013/14 and 2014/15 – a period of approximately six weeks (median duration also increased by approximately six weeks). A determination to reject a claim also took longer in the period analysed in 2015/16 - a period of approximately 3-4 weeks (median duration also increased by approximately 3-4 weeks).

An analysis of the duration of granted claims shows no significant difference for customer remoteness. The average claim duration increased by approximately 5 weeks between 2014/15 and 2015/16 for all city, regional and remote areas. The average duration for rejected claims increased by approximately 3 weeks for inner regional and major city areas, by 4 weeks for outer regional and remote areas and by 5 weeks for very remote areas.

Manifest determinations increased as a proportion of all finalised claims in 2015/16, however, that shift had already commenced between 2013/14 and 2014/15. Similarly, manifest grants increased as a proportion of all finalised claims and again this trend had been apparent for the previous two years, although this may also be related to a higher number of cases in 2015/16 that are yet to be determined through the DMA process. It is likely that this analysis would need to be repeated again in 12 months to determine whether this trend was maintained. In the initial year under the revised assessment process manifest granted decisions and manifestly rejected decisions were taking longer (approximately one-month longer, and 2-4 weeks longer respectively). Stakeholders have attributed this to the inconsistent quality of the raw medical evidence provided.

In respect of **appeals** (irrespective of appellant), the proportion of **Authorised Review Officer** (ARO) decisions affirming the original decision has increased over the three years examined from 78% to 92% (noting that appeals can be characterised by long time lags so not all the cases decided in the July 2015 to March 2016 period will relate to DMAs). While this appears to be a trend that had already commenced prior to the new DSP assessment process, and has continued since the implementation of the revised assessment process, the higher rates of decisions being upheld is evidence that the revised assessment process is robust and resulting in appropriate determinations. Other data with respect to appeals has identified that:

- A comparison of the outcomes of appeals decisions made by **Administration Appeals Tribunal (AAT) Level 1** shows no significant change over the last three years.
- A comparison of the outcome of appeals made by **AAT Level 2**, illustrates a downward trend in the category 'Settled/Decision by Consent' and a corresponding upward trend in 'Decision affirmed'.

E.2.4 OTHER FINDINGS

Issues around the definition of what constitutes appropriate and sufficient raw medical evidence is a concern raised by all stakeholders. Accordingly, these stakeholders sought clear guidance to provide clarity to the information providers (e.g. treating health practitioners, specialists, hospitals) and customers as to the type and extent of the evidence that is required. The view of the Department of Human Services (DHS) is that any such issues have been addressed by publication of guidelines which clearly explain the medical evidence requirements for DSP new claims.

1

INTRODUCTION

The Commonwealth Department of Social Services (the Department) engaged Health Outcomes International (HOI) to complete an evaluation of the revised assessment process for the Disability Support Pension (DSP). The DSP *provides financial support for people who have a physical, intellectual, or psychiatric condition that prevents them from working, or who are permanently blind*.[2]

1.1 THE REVISED ASSESSMENT PROCESS

The assessment process for the DSP was amended by:

- introducing the requirement for a Disability Medical Assessment (DMA) by an Australian Government Contracted Doctor (GCD); and
- replacing the requirement for Treating Doctor Report(s) for new claims with the need to furnish raw medical records.

The fundamental policy objective of the measure was to provide additional rigour to the DSP assessment process and improve the integrity of the welfare system, by ensuring that from 1 July 2015 all DSP applicants who lodge a claim and are granted DSP (excluding manifest and post-JCA rejections) have attended a DMA conducted by a GCD, based on medical evidence provided by the applicant.

The revised assessment process was introduced with a six-month transition period from 1 January 2015 to 30 June 2015. During the transition period the new assessment process only applied to applicants under 25 years of age and living in capital cities and was expanded to those aged under 35 years in March 2015. This was known as the transition period (and cohort) for the new assessment process and the DMAs were conducted by allied health professionals who are employees of DHS. Other applicants during this period were subject to the previous assessment process. From 1 July 2015, all new applicants were subject to the new assessment process and the DMAs were undertaken by Doctors from a DHS Contracted Service Provider; Medibank Health Solutions.

1.2 THE EVALUATION

The aim of the evaluation was to obtain an understanding of how effectively the revised assessment process is achieving the policy objectives and what the related impact (if any) of the measure has been on applicants. This was undertaken through addressing high level evaluation questions and associated lines of enquiry:

[2] DHS. (2015). *Disability Support Pension.* http://www.humanservices.gov.au/customer/services/centrelink/disability-support-pension.

Table 2.1: Evaluation lines of enquiry

Was the measure implemented according to the policy intent? Were the objective of the measure met?
• What processes, procedures and reporting structures were established as part of implementation of the measure? • What is the governance and oversight arrangements of the revised DSP and what are the reporting requirements for the measure? • How were guidelines and processes established for GCDs conducting DMAs to ensure consistency of DSP assessment across Australia? • What has been the value of including a transition period for the introduction of the new measure? What were the enablers and barriers to an effective transition stage? • To what extent is their national coverage in relation to DMAs being undertaken by GCDs? Is this timely and efficient? • What have been the key issues, barriers and enablers to implementation of the measure which may impact ability to achieve intended outcomes?
Are the changes to the DSP assessment process effective?
• Have the changes introduced improved the consistency and quality of the DSP assessment process and in what way? • To what extent has the measure contributed to the ability to achieve consistency and equity in DSP claims assessment across Australia? • Has the revised assessment process impacted in any way on the way manifest claims are identified, assessed and processed? • What has been the impact of the revised process on DSP claims lodged, assessment processes, referrals made, claims granted and appeals lodged? • What is the demographic and disability profile of those with unsuccessful claims and does it appear that any particular cohort is particularly affected?
Are the changes efficient and have they impacted the timeliness and outcomes of DSP claims and appeals?
• Has the introduction of the measure had sufficient impact to justify the changed process? • Are there cohorts where the impact has been sufficient to warrant continuation of the process for that group? • How has the revised assessment process impacted timeliness of claims decisions? What has contributed to the changes in claim processing timeframes?
Are there any emerging risks as a result of the implementation of the measure?
• What, if any, have been the unintended consequences or emerging risks associated with the reform?

Source: Evaluation Framework

1.2.1 Evaluation methodology

The evaluation was undertaken in two phases. The first was focussed on the transition cohort with a focus on the initial impact of the revised assessment process on manifest grants, timeliness of the process and appeals. The second phase of the evaluation included a review of the full implementation of the revised assessment process. The evaluation processes included:

1. **Analysis of claims and appeals data** in relation to the DSP application process
   a. In phase 1, analysis of claims for the transition cohort during the transition period (1 January to 30 June 2015) compared with the same cohort in the same six-month time period in 2013 and 2014.
   b. In phase 1, analysis of data for appeals on a DSP application for the period 1 January to 30 June 2015.
   c. In phase 2, analysis of claims for all new applicants for a DSP in the period 1 July 2015 to 31 March 2016 compared with all claims in the same nine-month time period in 2013 and 2014.
   d. In phase 2, analysis of data for appeals determined on a DSP application for the period 1 July 2015 to 30 April 2016 (ten months) compared with all appeals in the full twelve-month period in 2013 and 2014.
2. **Qualitative data** - feedback in relation to the impact of the revised DSP application process was sought from the various stakeholders as follows:
   a. HOI survey of DHS engaged Doctors, Psychologists and Job Capacity Assessors (n=8).
   b. Written submission made to DSS by the National Welfare Rights Network (NWRN).
   c. Documented list of issues (from GPs) compiled by the Australian Medical Association (AMA).
   d. Written submission made to DSS by the Australian Psychological Society (APS).

   A standalone summary of the qualitative findings is presented in **Appendix A** of this report.

1.3 This report

This final evaluation report provides an analysis of the applications made for DSP under the revised assessment process partially introduced in January 2015 and fully implemented on 1 July 2015. The structure of the remainder of this report is as follows:

Chapter 2	Provides an overview of the outcomes of the revised assessment process
Chapter 3	Presents an analysis of manifest determinations
Chapter 4	Presents an analysis of those applicants undergoing a DMA
Chapter 5	Presents an analysis of appeals related to DSP applications

2

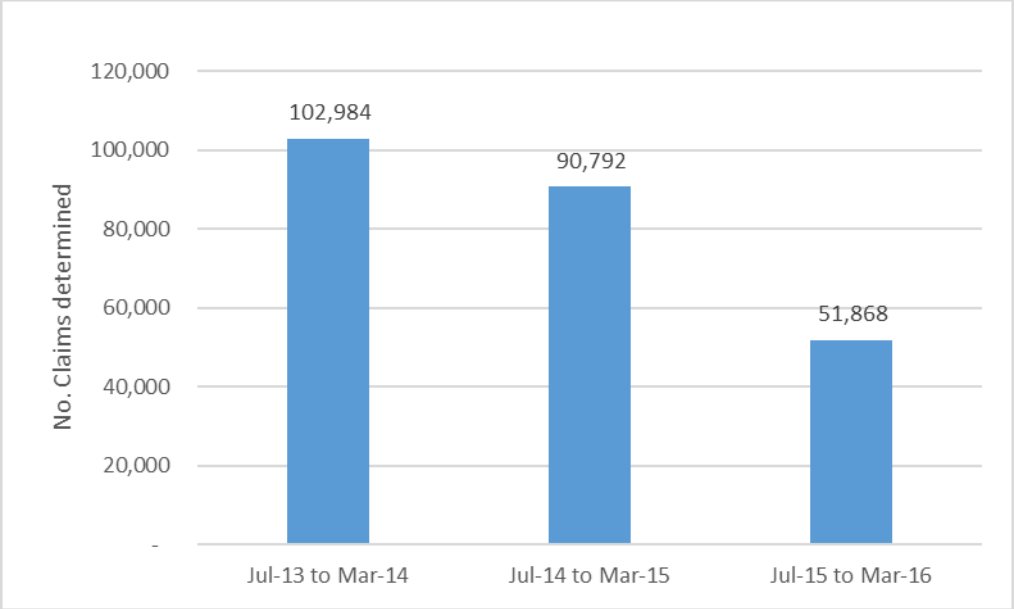
OVERVIEW

The following chapter provides an overview of all claims made for the DSP in the nine-month period from 1 July 2015 to 31 March 2016 and contrasts this against the findings for the same period in 2013/2014 and 2014/15. The chapters that follow provide more detailed analyses of manifest determinations, DMAs and appeals.

2.1 CLAIMS FINALISED

The total number of claims finalised in the time period July 2015 to March 2016 period (n=51,868) is substantially less than those finalised in the same time period in the previous two years (Figure 2.1).

Figure 2.1: Finalised Claims determined by year

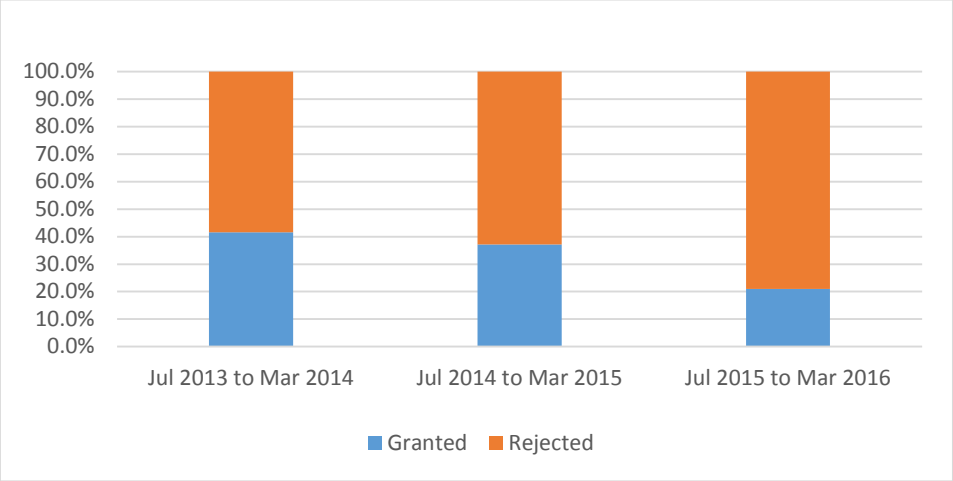


As demonstrated in Table 2.1, proportionally there were fewer claims granted in the time period July 2015 to March 2016 (21%) than the same time periods in 2014/15 (37%) and 2013/14 (42%). This is further illustrated in Figure 2.2 below which illustrates this downwards trend in claims granted.

Table 2.1: Claims granted and rejected in 2014, 2015 and 2016

All Claims	July-13 – March-14	July-14 – March-15	July-15 – March-16
DSP Grants	42,879 (42%)	33,742 (37%)	10,854 (21%)
DSP Rejections	60,105 (58%)	57,050 (63%)	41,014 (79%)
Total	**102,984 (100%)**	**90,792 (100%)**	**51,868 (100%)**

Figure 2.2: Claims granted and rejected in 2014, 2015 and 2016



The average number of claims per customer has decreased from 1.12 to 1.07 claims per customer over the study time period.

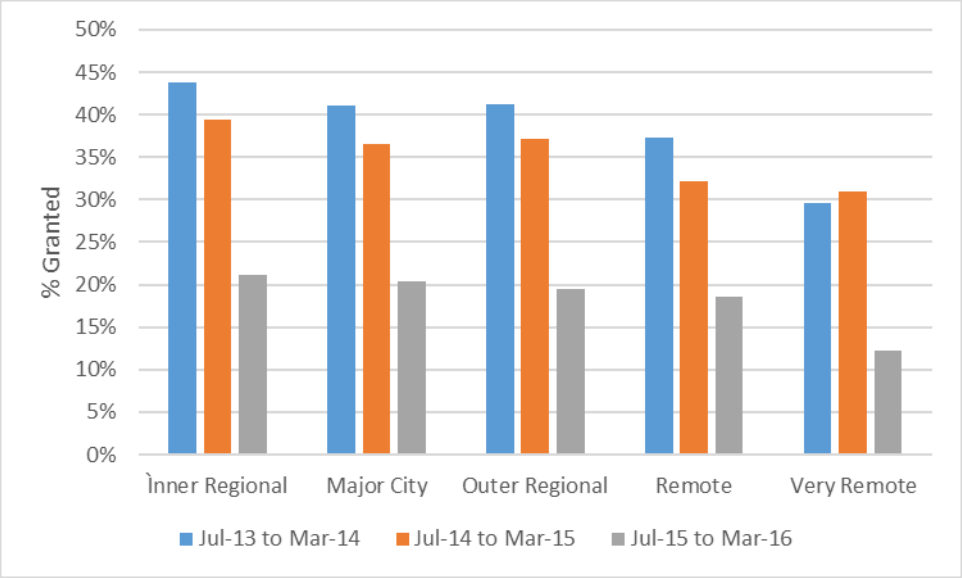
2.1.1 SPATIAL TRENDS

Table 2.2 and Figure 2.13 show that the percentage of claims granted varied little by spatial location, ranging from 21% in inner regional areas to 19% for outer regional and remote areas. However, this number declines in very remote areas with 12% of finalised claims reported as granted, caused primarily by the failure of applicants to reply to correspondence ('failure to reply' represents 46% of rejections in very remote areas, compared to an average of 20% for all locations).

Table 2.2: Finalised claims and percent granted by spatial location 2014, 2015 and 2016

All Claims	July-13 – March-14	July-14 – March-15	July-15 – March-16
Inner Regional	24,608 (44%)	21,557 (39%)	12,245 (21%)
Major City	64,388 (41%)	56,655 (37%)	32,158 (20%)
Outer Regional	11,347 (41%)	10,035 (37%)	5,892 (19%)
Remote	1,432 (37%)	1,431 (32%)	791 (19%)
Very Remote	908 (30%)	887 (31%)	586 (12%)
Unknown	301 (42%)	227 (33%)	196 (22%)
Total	**102,984 (42%)**	**90,792 (37%)**	**51,868 (21%)**

Figure 2.3: Claims granted by spatial location



2.2 Duration of process

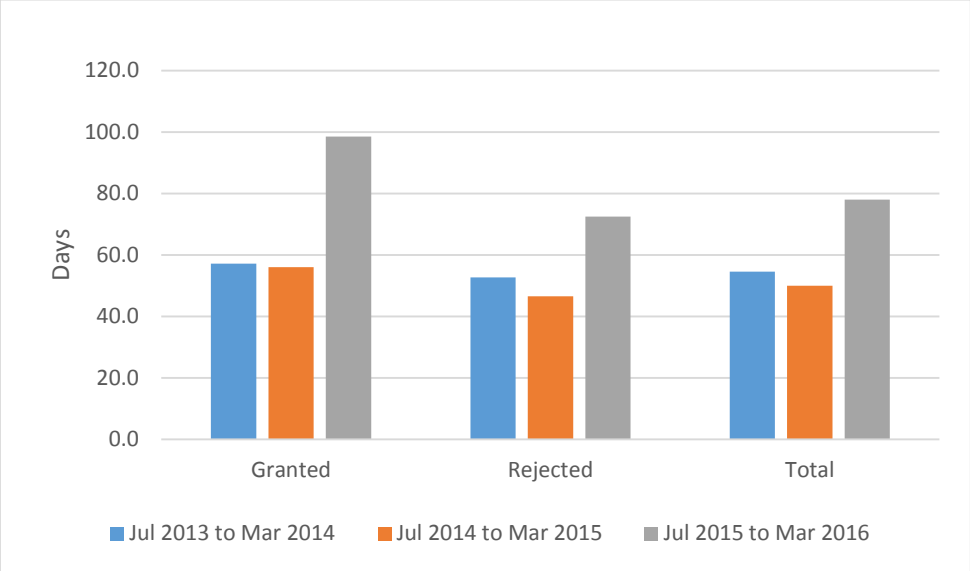
An analysis of the duration of the revised claims process demonstrates that there was an increase in the average number of weeks taken for a granted determination to be made when contrasted with 2013/14 and 2014/15; an increase of approximately six weeks (median duration also increased by approximately six weeks). A determination to reject a claim also took longer in the period analysed in 2015/16 - a period of approximately three to four weeks (median duration also increased by approximately three to four weeks). As is discussed later in the report, there were some variations for customers who required a DMA. This variation in the duration of the assessment process is further illustrated in Figure 2.4 below.

Stakeholders considered that one of the factors affecting the timeliness of claim determinations may be issues around the definition of what constitutes appropriate and sufficient raw medical evidence. Stakeholders recommended that clear guidance needs to be documented and made available to customers so that they are able to provide clarity to the information providers (e.g. treating health practitioners, specialists, hospitals) as to the type and extent of the evidence that is required and could be tailored to Doctors and Psychologists (for example). It is noted, however, that the Department of Human Services (DHS) consider that the revised SA473 Medical Evidence Requirements form available on the department's website provides appropriate and clear guidance.

Table 2.3: Duration of claims process in 2014, 2015 and 2016

Claim status	July-13 – March-14			July-14 – March-15			July-15 – March-16		
	Mean Days	Median Days	Maximum Days	Mean Days	Median Days	Maximum Days	Mean Days	Median Days	Maximum Days
Granted	57.2	43.0	456	56.0	42.0	434	99.1	83.0	274
Rejected	52.7	44.0	746	46.5	39.0	567	69.9	64.0	271
Total	**54.6**	**44.0**	**746**	**50.0**	**40.0**	**567**	**73.8**	**65.0**	**274**

Figure 2.4: Average days to determine claim by claim outcome



An analysis of the duration of granted claims shows no significant difference for customer remoteness. The claim duration increased by an average of five weeks between 2014/15 and 2015/16 for all city, regional and remote areas.

The average duration for rejected claims increased by approximately 3 weeks for inner regional and major city areas, by four weeks for outer regional and remote areas and by 5 weeks for very remote areas.

3

MANIFEST DETERMINATIONS

This chapter presents an analysis of manifest determinations associated with Disability Support Pension (DSP) claims. The analysis relates to all of the manifest claims made under the revised DSP application process during the nine-month period July 2015 to March 2016 and contrasts this with claims made for the same nine-month time periods in 2013/14 and 2014/15.

In certain circumstances a claim for DSP can be granted manifestly. This means that on the basis of medical evidence alone, the person is considered eligible for DSP without the need for a JCA or DMA, subject to meeting all other eligibility criteria. For example, a manifest grant may be made to a person with a terminal illness with a life expectancy of less than two years, a person who requires nursing home level care, or a person with an IQ of less than 70.

3.1 CHANGE IN MANIFEST DETERMINATIONS

Manifest determinations as a proportion of all claims in 2015/16 is similar to that observed in 2014/15 and 4.6 percentage points more than in 2013/14. Of the 51,868 claims finalised in the 2015/16 period; 11.2% were manifestly granted and 1.7% manifestly rejected.

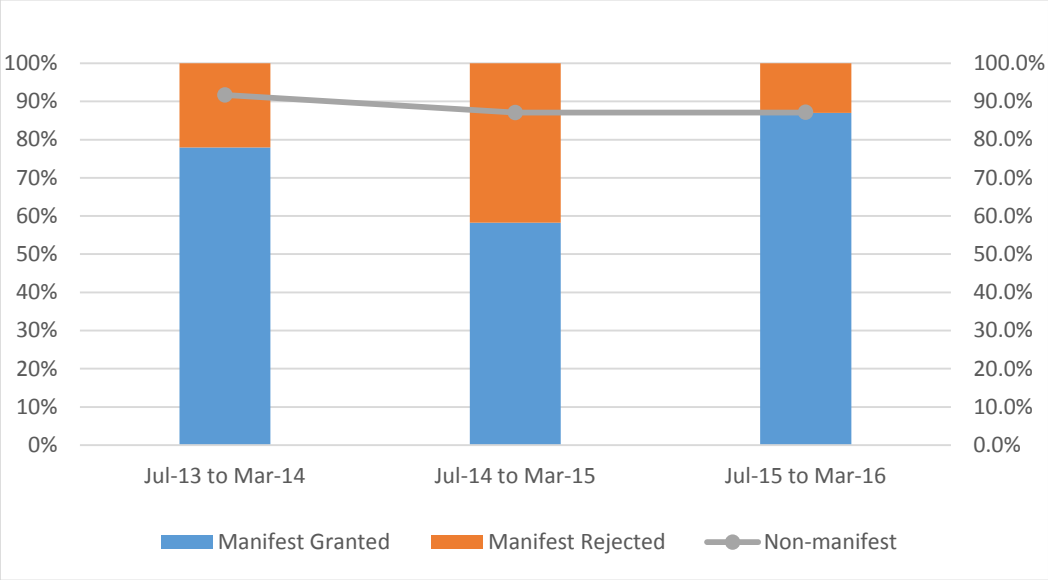
The proportions of manifestly granted claims in the nine-month period ended 31 March 2016 was greater than that in both 2013/14 and 2014/15 (6.5% and 7.5% respectively), however, the total number is lower. Joint analysis undertaken by the DHS and DSS in early 2016 indicates this is due to lower volumes of claims finalised in the timeframe, and that during this period there was no significant change in the numbers of manifest grants linked to the introduction of this measure. To confirm this the data would need to be re-analysed in another twelve months to identify whether this has become a trend or in fact whether it shifts back towards the long term average.

Manifestly rejected determinations for the 2015/16 cohort, are similar to that observed in 2013/14 but much less than was the case in 2014/15 (Table 3.1).

Table 3.1: Manifest determinations as a proportion of all DSP claims finalised

All Claims Finalised	July-13 – March-14	July-14 – March-15	July-15 – March-16
Manifest Granted	6,680 (6.5%)	6,835 (7.5%)	5,815 (11.2%)
Manifest Rejected	1,889 (1.8%)	4,895 (5.4%)	866 (1.7%)
Manifest Total	8,569 (8.3%)	11,730 (12.9%)	6,681 (12.9%)
Non manifest claims	94,415 (91.7%)	79,062 (87.1%)	45,187 (87.1%)
Total	**102,984 (100%)**	**90,792 (100%)**	**51,868 (100%)**

Figure 3.1: Change in proportion of manifest determinations



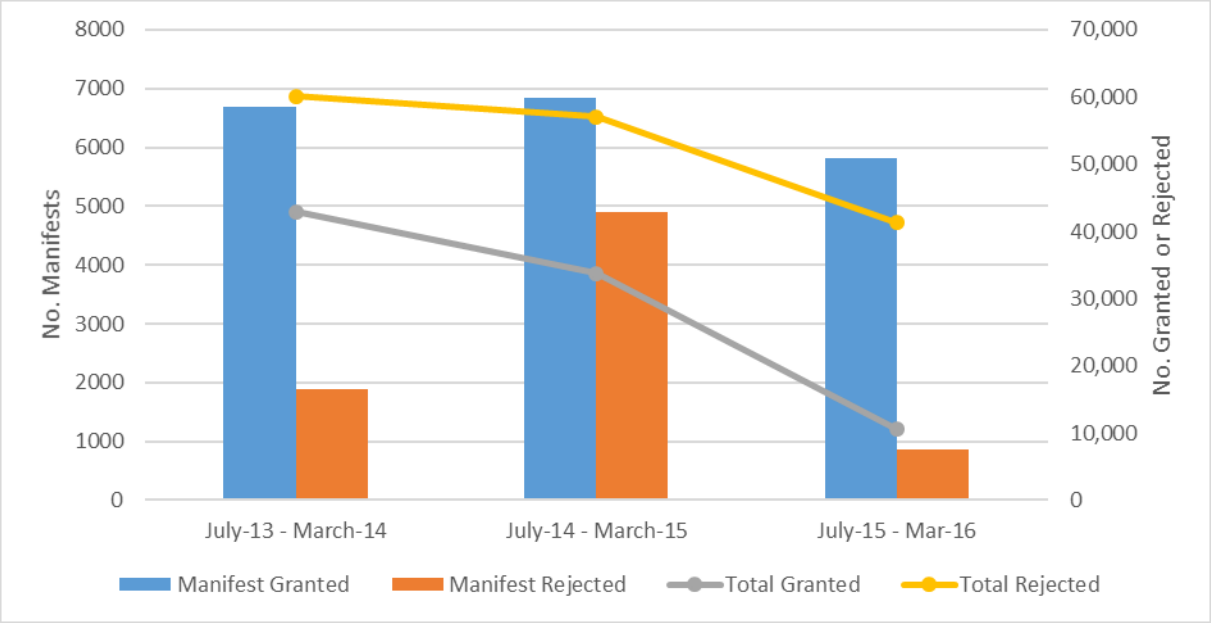
Further analysis was undertaken of the manifestly granted and manifestly rejected claims as a proportion of all claims granted or rejected respectively (Table 3.2 and Figure 3.2).

- The proportion of manifest granted as a proportion of all granted was 53.6% which is significantly greater than that observed in both 2013/14 (15.6%) and 2014/15 (20.3%). However, it is considered that this proportion was influenced by the fact that a number of claims are still going through the DMA process and are yet to be finalised.
- The proportion of manifest rejected as a proportion of all rejected in 2015/16 was significantly lower than that observed in 2014/15 (8.6%) and 1.0 percentage points less than in 2013/14.
- In analysing manifestly granted and manifestly rejected as a proportion of all claims;
  - The proportion of manifest granted as a proportion of all claims was 11.2% in 2015/16 which is higher than that observed in both 2013/14 (6.5%) and 2014/15 (7.5%).
  - The proportion of manifest rejected as a proportion of all claims was 1.7%, similar to that observed in 2013/14 (1.8%) and 3.7 percentage points less than the 5.4% recorded in 2014/15 (Table 3.2).

Table 3.2: Manifest determinations

Manifest Determinations	Manifest Granted	Total Granted	Total Claims	Manifest granted as a proportion of total granted	Manifest granted as a proportion of total claims
July-13 – March-14	6,680	42,879	102,984	15.6%	6.5%
July-14 – March-15	6,835	33,742	90,792	20.3%	7.5%
July-15 – March-16	5,815	10,854	51,868	53.6%	11.2%
Manifest Determinations	**Manifest Rejected**	**Total Rejected**	**Total Claims**	**Manifest rejected as a proportion of total rejected**	**Manifest rejected as a proportion of total claims**
July-13 – March-14	1,889	60,105	102,984	3.1%	1.8%
July-14 – March-15	4,895	57,050	90,792	8.6%	5.4%
July-15 – March-16	866	41,014	51,868	2.1%	1.7%

Figure 3.2: Manifest determinations



It is not possible to be definitive as to whether the change in the DSP assessment process has made any impact on manifest determinations. Manifest determinations increased as a proportion of all claims in 2015/16, however, that shift had already commenced between 2013/14 and 2014/15 and additionally, the limited flow of DMAs in 2015/16 could be having an influence.

Similarly, manifest granted is increasing as a proportion of all claims and again this trend had been apparent for the previous two years. It is likely that this analysis would need to be repeated again in 12 months to determine whether this trend was maintained.

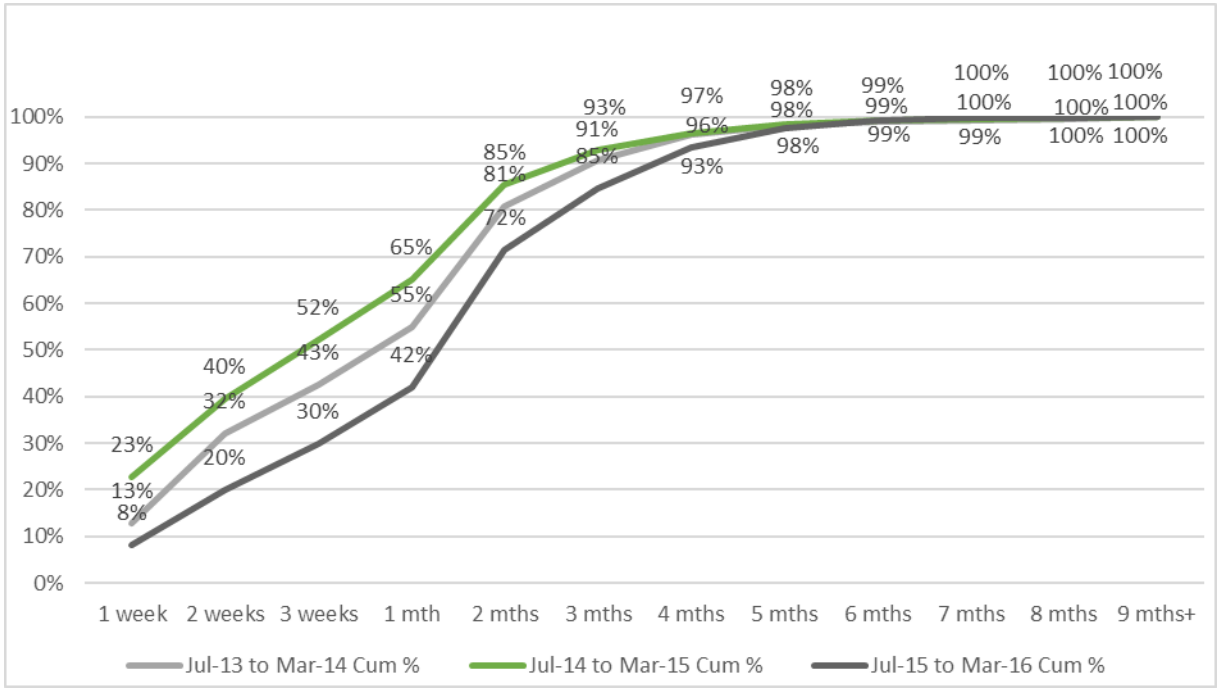
3.2 Duration of manifest determination process

Analysis was undertaken of the total time taken between a claim lodgement and a claim decision for manifest determinations granted and rejected as discussed below. We note that the majority of manifest determinations (99.4% of all manifest determinations in 2015/16) are made prior to DMA referral.

3.2.1 Manifest granted timeframe

The shortest time frame to decision for manifestly granted claims occurred in the 2014/15 year; 50% of decisions were reached within three weeks and 90% of decisions within two to three months. In comparison, 50% of decisions were reached within one month and 90% of decisions within two to three months in 2013/14. Under the revised assessment process in 2015/16, 50% of decisions were reached within one to two months and 90% of decisions within three to four months. At the end of four months, >90% of applicants have had a decision finalised in each of the three years assessed. (Figure 3.3).

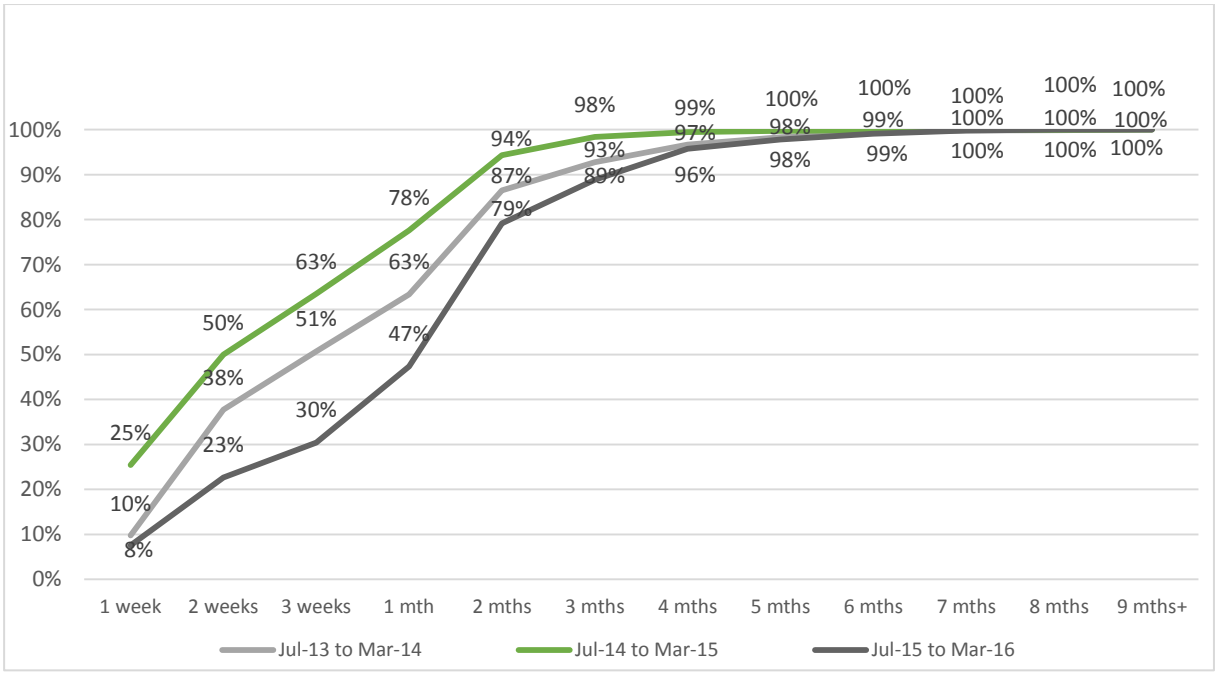
Figure 3.3: Comparison of total time taken for Manifestly Granted claims



3.2.2 MANIFEST REJECTED TIMEFRAME

The shortest time frame to decision for manifestly rejected determinations occurred in the 2014/15 year; 50% of decisions were reached within two weeks and 90% of decisions within one to two months. In comparison, 50% of decisions were reached within two to three weeks and 90% of decisions within two to three months in 2013/14. For the 2015/16 year under a revised assessment process, 50% of decisions were reached within one to two months and 90% of decisions within three to four months. The manifestly granted decisions (average approximately seven weeks) are taking longer than the manifestly rejected decisions (average approximately six weeks) in 2015/16. By the end of the third month >90% of decisions have been finalised in each time period (Figure 3.4).

Figure 3.4: Comparison of total time taken for Manifestly Rejected claims



3.3 MANIFEST ASSESSMENTS BY MANIFEST REASON

The following section provides an analysis of manifest granted and rejected determinations according to the manifest code. The analysis has been undertaken to review whether there has been any apparent change in manifest grants and rejections under the new DSP assessment process.

3.3.1 MANIFEST GRANTED

Table 3.3 provides an analysis of the number and proportion of manifest granted determinations for the three time periods being analysed. This analysis demonstrates no impact by manifest code arising from the introduction of the revised DSP assessment process. The most common manifest granted determinations were for Terminal Illness (50.4%), Intellectual/Learning (32.8%) and Nursing Home Level of Care (11.1%) and this has been consistent over all three time periods.

Table 3.3: Manifest granted by reason

Manifest reason	July-13 – March-14	July-14 – March-15	July-15 – March-16
Terminal illness	3,573 (53.5%)	3,617 (52.9%)	2,936 (50.4%)
Intellectual disability	2,041 (30.6%)	2,098 (30.7%)	1,906 (32.8%)
Nursing home level care	649 (9.7%)	719 (10.5%)	645 (11.1%)
Permanent blindness	366 (5.5%)	343 (5.0%)	274 (4.7%)
Totally & permanently incapacitated (DVA)	42 (0.6%)	57 (0.8%)	47 (0.8%)
HIV/AIDS	9 (0.1%)	1 (0.0%)	7 (0.1%)
Total	**6,680**	**6,835**	**5,815**

3.3.2 MANIFEST REJECTED

The number (and proportion, refer Table 3.2) of manifest rejected both as a proportion of all rejected and all claims have fallen in 2015/16. Comparative analysis of reason code is not possible due to the introduction (in 2014/15, not in connection with the revised assessment process) of several new manifest rejection reasons. Since that date the majority of manifest rejection reasons are: 'temporary condition'; 'can work 15 hours per week'; 'diagnosis criteria not met' and 'no continuing inability to work'.

3.4 MANIFEST GRANTED DETERMINATIONS BY GENDER AND AGE

An analysis of manifestly granted determinations as a proportion of all grants and all claims for the same gender illustrates no impact from the introduction of the revised DSP process. The key finding is (consistent with previous findings) that manifestly granted determinations represent a greater proportion of determinations made for the DSP and that this is consistent across both genders (**Appendix B**, Tables B.5 and B.6).

3.5 MANIFEST DETERMINATIONS BY AGE

The following section provides an analysis of manifest assessments by age to ascertain whether there has been any significant change for the 2015/16 cohort in comparison with previous years.

It is apparent that the change in DSP assessment process in 2015/16 has not had an impact on manifest determinations as it relates to age. Key findings of an analysis of the manifest granted determinations as a proportion of all claims for the same age group include:

- There are manifest granted determinations in each age cohort in 2015/16.
- As in the previous two years, the greatest proportion of manifest granted determinations occur in the <20 year age cohort. This cohort demonstrated a 28% increase (from 35%-45%) in the proportion of manifestly granted claims to all claims in the same age group comparative to previous years. It is noted that the majority of manifest grants for the <20 years age cohort will likely be for children turning 16 years of age who are diagnosed with a severe intellectual disability and who claim DSP). This group should remain unaffected by the new processes.
- Similarly, there were increases in all other age cohorts. However, this is to be expected given the previous finding that the proportion of manifestly granted determinations as a proportion of all claims has shown an overall increase in 2015/16.
- Significant percentage increases were demonstrated in all age groups over 45 years old (Table 3.4).

Table 3.4: Proportion of manifest granted to all claims by age group

Age	July-13 – March-14			July-14 – March-15			July-15 – March-16			% increase between 14/15 and 15/16
Years	Manifest granted	All claims	% of all claims manifest granted	Manifest granted	All claims	% of all claims manifest granted	Manifest granted	All claims	% of all claims manifest granted	
<20	1,615	4,618	**35%**	1,973	5,695	**35%**	1,762	3,934	**45%**	**28%**
20-24	547	6,332	**9%**	316	4,799	**7%**	215	2,646	**8%**	**16%**
25-34	284	10,300	**3%**	316	8,917	**4%**	242	5,035	**5%**	**20%**
35-44	456	15,430	**3%**	478	13,582	**4%**	425	8,021	**5%**	**32%**
45-54	1,016	24,078	**4%**	1,074	21,873	**5%**	979	12,807	**8%**	**53%**
55-64	2,157	33,753	**6%**	2,278	31,964	**7%**	2,054	18,789	**11%**	**56%**
65+	605	8,471	**7%**	400	3,962	**10%**	115	636	**18%**	**81%**
Total	**6,680**	**102,982**	**6%**	**6,835**	**90,792**	**8%**	**5,792**	**51,868**	**11%**	**40%**

4

DISABILITY MEDICAL ASSESSMENT

The introduction of the requirement for a Government Contracted Doctor to undertake a DMA is the key change in the revised DSP assessment process. The following chapter provides an analysis of that component of the process.

4.1 OVERVIEW

Of the 51,868 claims lodged and assessed during the period July 2015 to March 2016, 5,762 (12.7%) of all post-JCA claims made were referred for a DMA. Of those referred for DMA, 77.4% were granted and 22.6% rejected as illustrated in Figure 4.1 below.

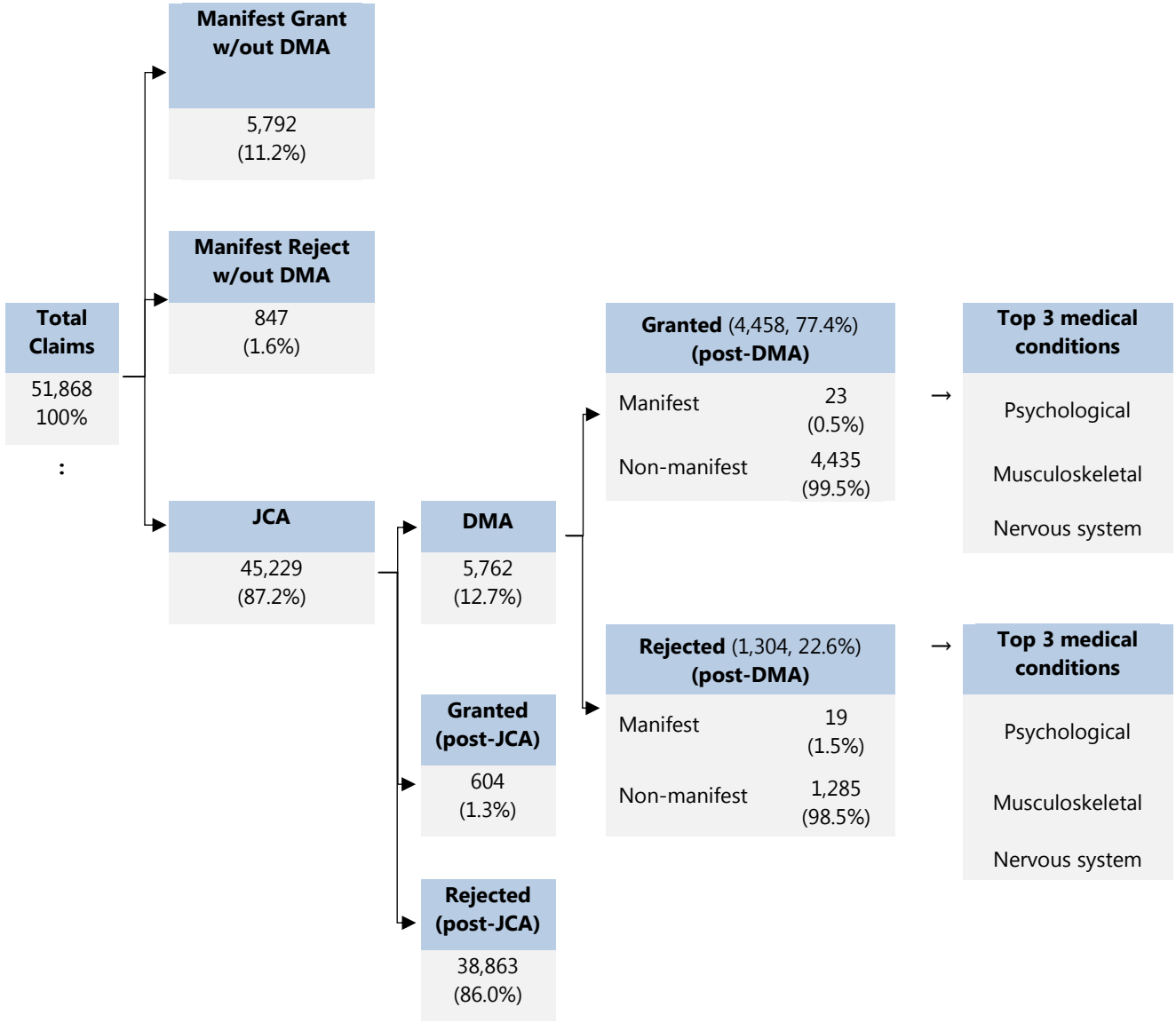
Of the non-manifest claims (45,229; 87.2% of total claims) the majority (38,863, 86.0% of non-manifest claims) were rejected post-JCA. **Of the remaining claims** (6,366)**, 90.5%** (5,762 claims) **proceeded to a DMA, consistent with the policy intent.**

There were 604[3] claims (5.8% of total granted claims in nine-month period ended 31 March 2016) that did not proceed to DMA, but were granted. This is the result of a number of factors, including:

- People originally not thought to be manifest but following JCA were found manifest and therefore not referred to GCD.
- Applicants applying under an international agreement.
- Appeals.

[3] HOI's analysis of claims data identified 604 claims. It should be noted that DHS applies additional post-processing data cleansing rules (that were not available to HOI). DHS have reported the post data-cleansing equivalent of this figure is 72 claims. This variation does not impact on the evaluation's conclusions.

Figure 4.1: Outcomes of DSP claims (1 July 2015 to 31 March 2016) [4]

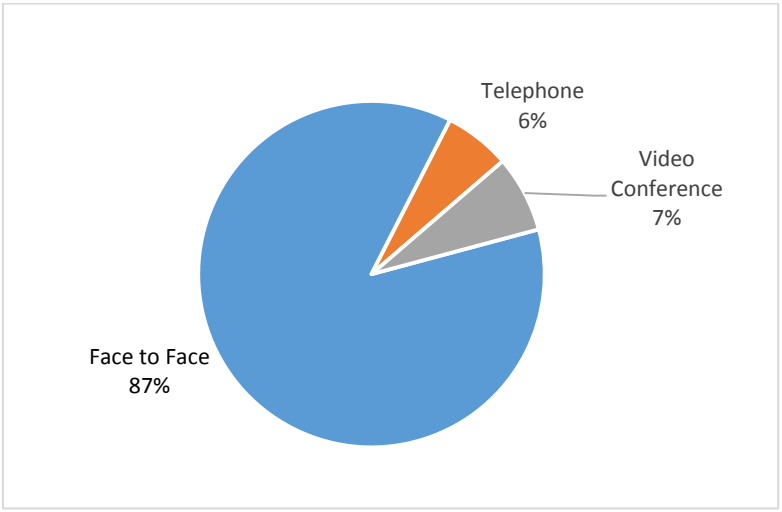


4.2 DMA REFERRAL CHANNEL

Various channels were available for the conduct of a DMA including; face-to-face, telephone and video-conference. The most common channel used was face-to-face representing 87% of all customer contacts (Figure 4.2).

[4] It should be noted that DHS applies additional post-processing data cleansing rules (that were not available to HOI) that result in some minor variations in the classifications reported. These variations are immaterial and do not impact on the evaluation's conclusions.

Figure 4.2: DMA channel type



4.3 THE CUSTOMERS ASSESSED VIA DMA

The following section provides an analysis of the 5,762 customers who were assessed via a DMA under the revised assessment process. As this is a new process no comparable data for previous years is available.

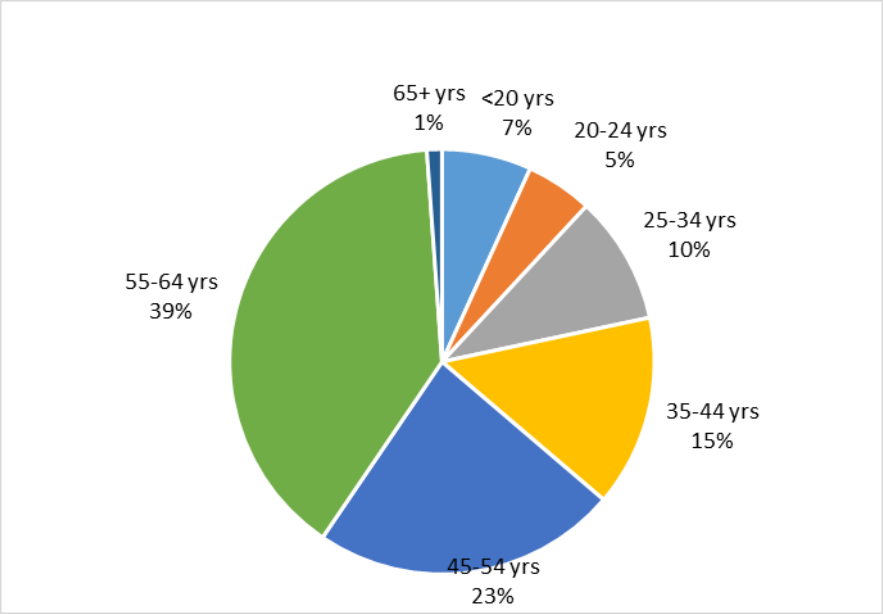
4.3.1 AGE

The highest proportion of those assessed via DMA were in the 55-64 year age group (39%) followed by those aged between 45-54 years (23%); together this cohort represented 62% of all those assessed. The proportion of applicants within each age groups assessed via DMA were very similar to that observed for total claimants suggesting that there was no impact on applications from any particular age group.

Table 4.1: Customers assessed via a DMA by Age Group

Age	Referred for DMA		All claimants	
	Number	%	Number	%
< 20 yrs.	393	7%	3,934	8%
20-24 yrs.	293	5%	2,646	5%
25-34 yrs.	562	10%	5,035	10%
35-44 yrs.	840	15%	8,021	15%
45-54 yrs.	1,341	23%	12,807	25%
55-64 yrs.	2,267	39%	18,789	36%
65+ yrs.	66	1%	636	1%
Total	**5,762**	**100.0%**	**51,868**	**100.0%**

Figure 4.3: Customers referred for DMA by Age Group



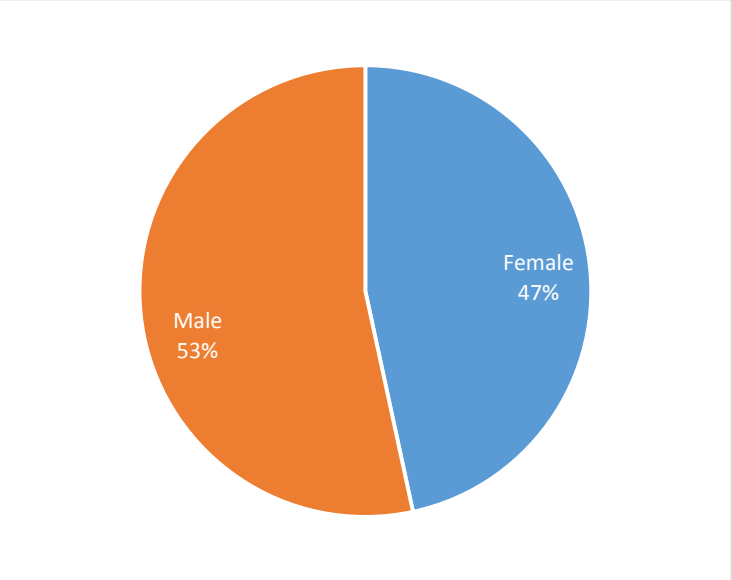
4.3.2 GENDER

The majority of customers referred for DMA were male (53%) and this was identical to the proportion of all claimants.

Table 4.2: Customers assessed via a DMA by Gender

Gender	Assessed via DMA		All claimants	
	Number	%	Number	%
Female	2,710	47.0%	28,104	46.9%
Male	3,052	53.0%	31,868	53.1%
Total	**5,762**	**100.0%**	**59,972**	**100%**

Figure 4.4: Customers assessed via DMA by Gender



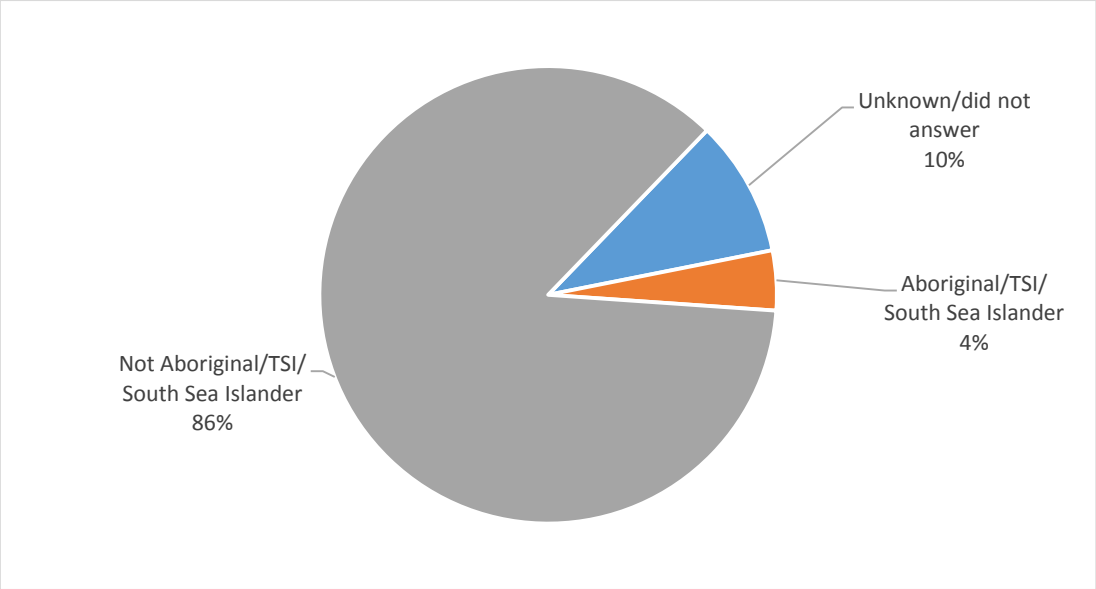
4.3.3 INDIGENOUS STATUS

Aboriginal, Torres Strait Islander and South Sea Islanders were represented in 4% of DMA assessments (Table 4.3). Given this aligns with the proportion of this cohort in the Australian population, it would appear that as a whole this revised process has not unduly impacted on Aboriginal, Torres Strait Islander and South Sea Islanders.

Table 4.3: Indigenous status of those assessed via DMA

Indigenous status	Assessed via DMA	
	Number	%
Unknown/did not answer	556	10%
Aboriginal/TSI/South Sea Islander	244	4%
Not Aboriginal/TSI/South Sea Islander	4,962	86%
Total	**5,762**	**100.0%**

Figure 4.5: Indigenous status of those assessed via DMA



4.3.4 JURISDICTION

DMAs were undertaken in every Australian jurisdiction. Understandably the larger states with more applicants correspondingly had the greatest proportion of all DMAs undertaken nationally.

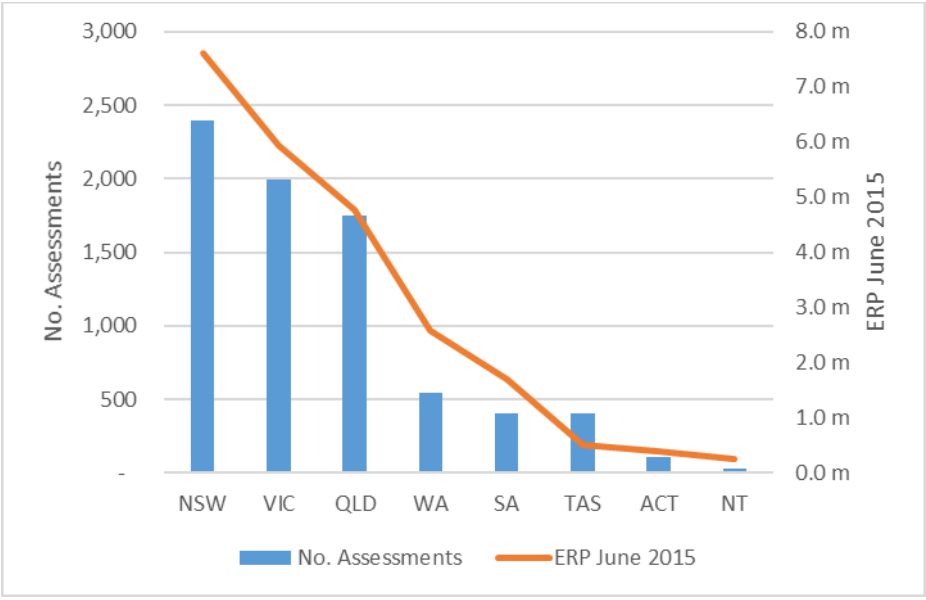
Amongst the larger states there was limited variance in the proportion of all their claimants who were assessed via DMA. The smaller states and territories showed greater variance ranging for a low of 4.2 in the Northern Territory (NT) to a high of 19.4% in Tasmania (Table 4.4). This large variance may relate to the smaller numbers of claimants. This has been further analysed below in relation to the estimated resident population of the jurisdiction.

Table 4.4: Customers assessed via DMA by Jurisdiction[5]

State	Assessed via DMA		All claimants		% of all claimants within a jurisdiction assessed via DMA
	Number	%	Number	%	%
NSW	1,807	31%	16,839	32.5%	10.7%
VIC	1,504	26%	12,575	24.2%	12.0%
QLD	1,323	23%	11,121	21.4%	11.9%
WA	409	7%	4,551	8.8%	9.0%
SA	304	5%	3,974	7.7%	7.6%
TAS	303	5%	1,562	3.0%	19.4%
ACT	81	1%	572	1.1%	14.2%
NT	23	0%	553	1.1%	4.2%
Unknown	9	0%	121	0.2%	7.4%
Total	**5,762**	**100.0%**	**51,868**	**100.0%**	11.1%

To further understand any variance at the jurisdiction level, analysis was undertaken of the proportion of the estimated resident population[6] (ERP) who are claimants and were assessed via a DMA. Figure 4.6 illustrates the number of DMA customers in contrast to the ERP and demonstrates a higher proportion of DMA customer to ERP in Queensland and particularly Tasmania.

Figure 4.6: DMA customers contrasted with the ERP



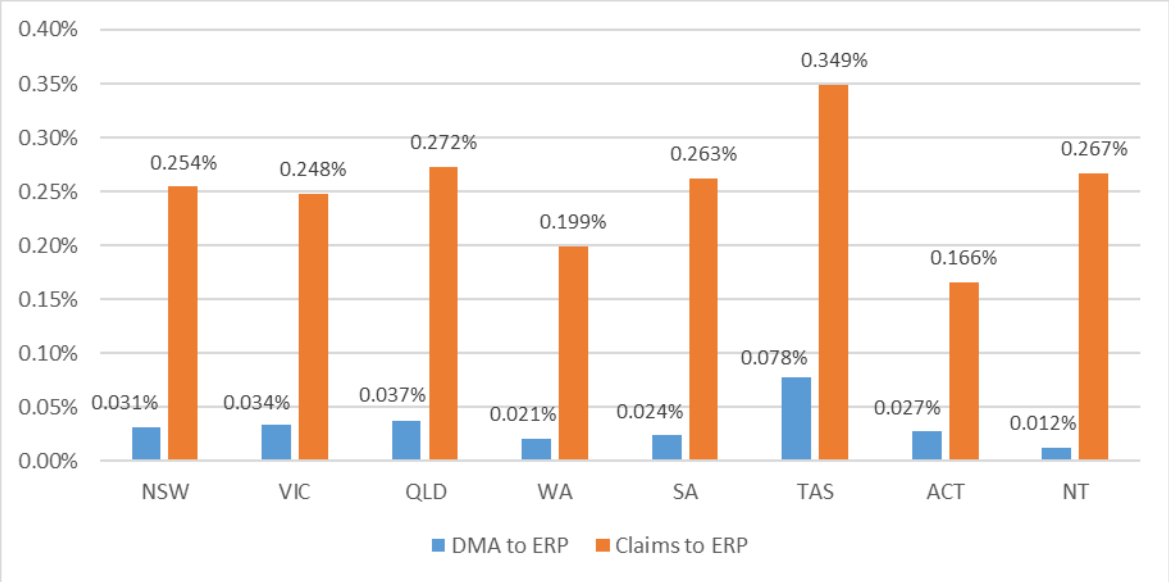
Both Table 4.5 and Figure 4.7 further demonstrate those jurisdictions that appear to be under or over represented with respect to the number of DSP claimants and correspondingly assessment via DMA as a proportion of their ERP. Tasmania has a high proportion of applicants while the NT is very low.

[5] Limited to DMAs with a claim lodged and assessed in the period July 2015 to March 2016.
[6] Australian Bureau of Statistics; 3101.0 - Australian Demographic Statistics, June 2015

Table 4.5: Claims and Assessment via DMA as a % of ERP

State	Estimated Resident Population	% of ERP referred for DMA	% of ERP are claimants
NSW	7,617,684	0.031%	0.254%
VIC	5,937,481	0.034%	0.248%
QLD	4,778,854	0.037%	0.272%
WA	2,590,259	0.021%	0.199%
SA	1,698,660	0.024%	0.263%
TAS	516,586	0.078%	0.349%
ACT	390,706	0.027%	0.166%
NT	244,500	0.012%	0.267%

Figure 4.7: Claims and assessment via DMA as a % of ERP



It is not possible to conclude whether the revised DSP assessment process has had an impact on any particular jurisdiction as the DMA is a new process and hence there is no historical data that can be utilised for comparison purposes. However, given a relatively consistent fall in the number of claimants across each jurisdiction in the 2015/16 period, it would appear that the introduction of the revised assessment process has not had an impact on any particular jurisdiction over another.

4.4 Duration of process

An analysis of the difference in time is illustrated in Table 4.6 and Figure 4.8 below, with key findings including:

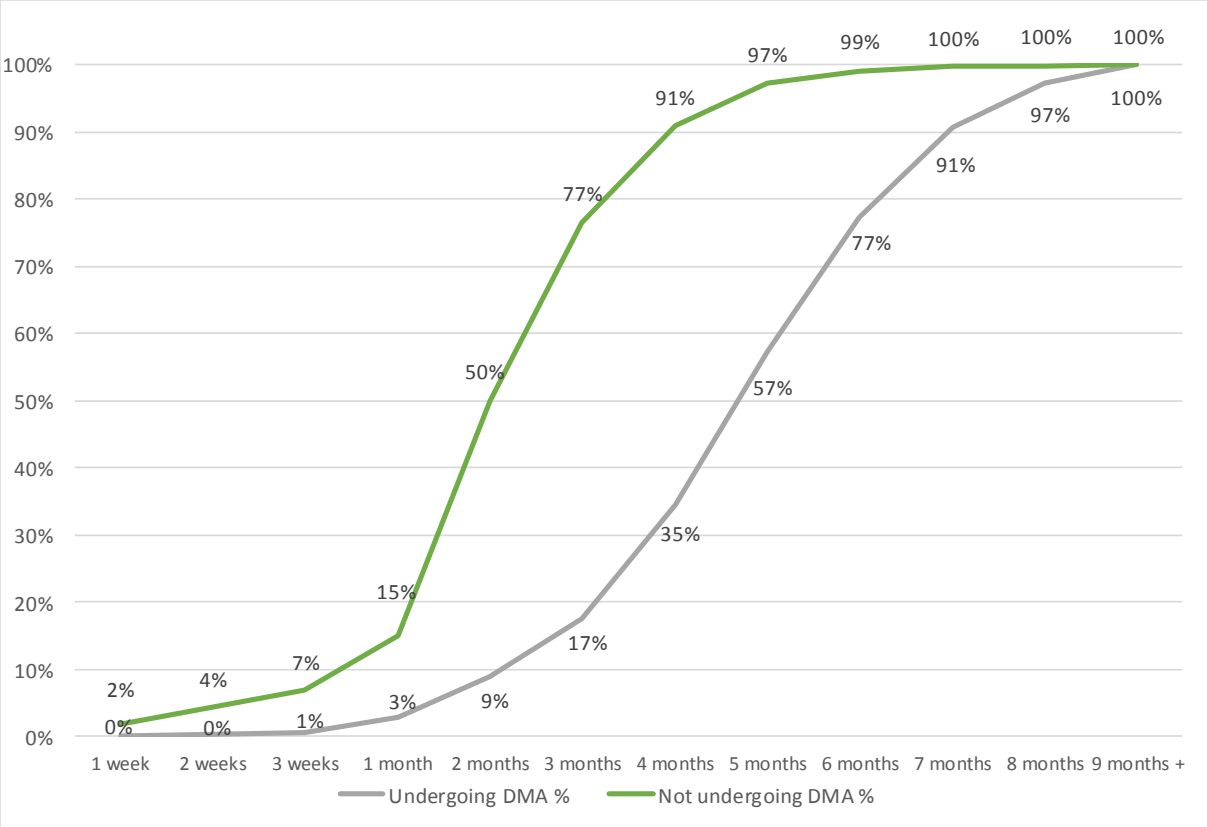
- 50% of non-DMA determinations occurred within one to two months including customers not referred for a JCA, whereas this took four to five months for those undergoing the DMA[7]. Determinations that require a DMA are expected to generally take longer than determinations that do not.
- After seven months, the time variance for determination between the two groups starts to close. After six months, 99% of those not requiring a DMA have had their claim determined, whereas this did not occur until the 8th month for those undergoing a DMA.

Table 4.6: Comparison of total time taken for determination between applicants who have undergone a DMA and those who have not (nine months ended 31 March 2016)

Days	Undergoing DMA			Not undergoing DMA			Variance in cumulative %
	No.	%	Cumulative %	No.	%	Cumulative %	
0-7 (week)	17	0%	**0%**	1,017	2%	**2%**	**-2%**
8-14 (2 wks.)	11	0%	**0%**	1,253	3%	**5%**	**-4%**
15-21 (3 wks.)	23	0%	**1%**	1,324	3%	**8%**	**-7%**
22-31 (1 Mth)	148	3%	**3%**	4,008	9%	**16%**	**-13%**
32-62 (2 mths)	435	8%	**11%**	16,306	35%	**52%**	**-41%**
63-93 (3 mths)	575	10%	**21%**	12,243	27%	**78%**	**-57%**
94-124 (4 mths)	1,121	19%	**40%**	6,590	14%	**93%**	**-52%**
125-155 (5 mths)	1,388	24%	**64%**	2,476	5%	**98%**	**-34%**
156-186 (6 mths)	1,111	19%	**84%**	631	1%	**99%**	**-16%**
187-217 (7 mths)	651	11%	**95%**	189	0%	**100%**	**-5%**
218-248 (8 mths)	241	4%	**99%**	59	0%	**100%**	**-1%**
249+ (9 mths+)	41	1%	**100%**	10	0%	**100%**	**0%**
TOTAL	**5,762**	**100%**		**46,106**	**100%**		

[7] This includes successful appeals and claims reopened after further medical evidence was provided, all of which are counted in claims data. In these cases the age of the claim is still taken from the original claim date, not the date the claim is reindexed.

Figure 4.8: Comparison of total time taken for determination between applicants who have undergone a DMA and those who have not (nine months ended 31 March 2016)



4.4.1 DURATION OF PROCESS FOR CLAIM GRANTED

Further analysis of claims granted for those who underwent a DMA and those who did not is illustrated in Table 4.7 and Figure 4.9 below. Key findings include:

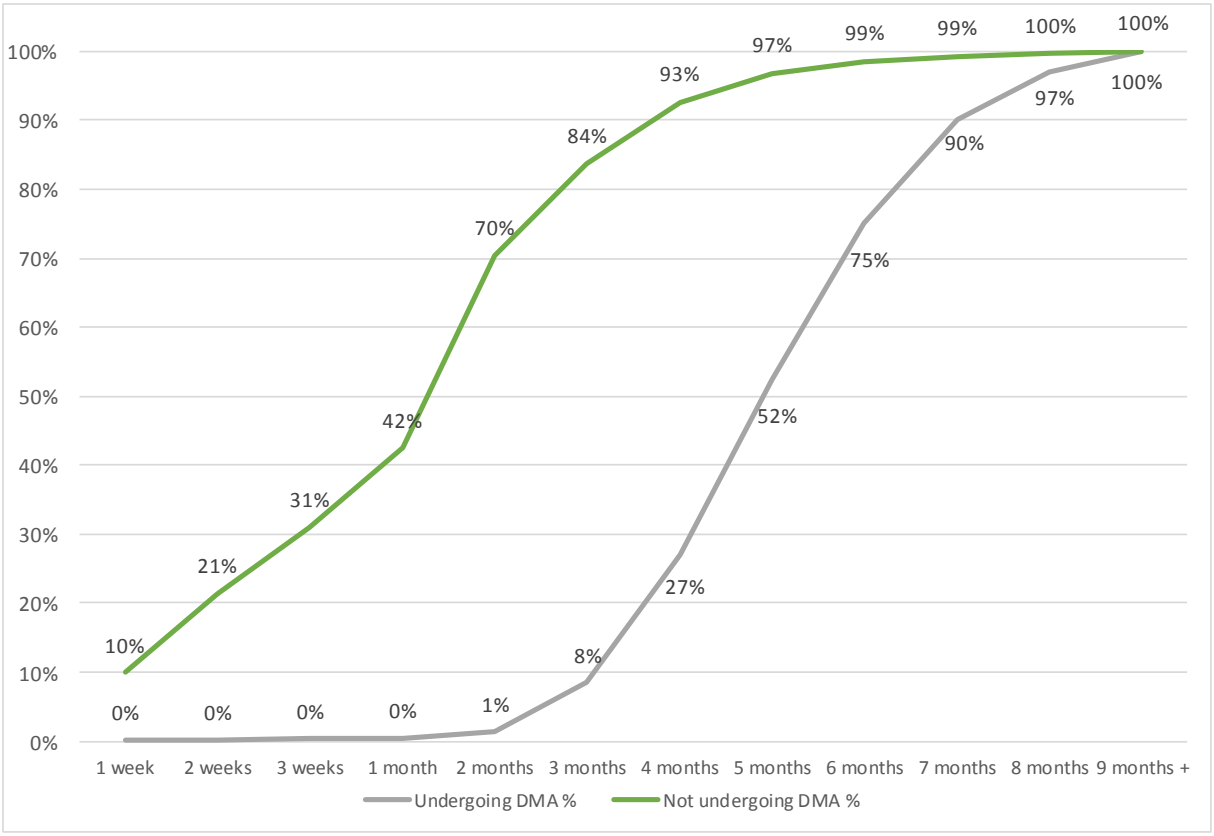
- the difference in time taken between the two groups for claims granted was much greater than that demonstrated above for all claims. This is not unexpected, as many of the non-DMA cohort would be manifest grants which were generally assessed more quickly as they did not require a JCA.
- In the first three months, determinations were just starting to occur for those undergoing a DMA (10%), whereas for non-DMA, 86% of granted determinations have occurred. That variation of approximately three months continues through to about the six-month point, when a greater number of DMA-granted determinations were starting to occur.

Table 4.7: Comparison of total time taken for claims granted between applicants who have undergone a DMA and those who have not (nine months ended 31 March 2016)

Days	Undergoing DMA			Not undergoing DMA			Variance in cumulative %
	No.	%	Cumulative %	No.	%	Cumulative %	
0-7 (week)	10	0%	**0%**	692	11%	**11%**	**-11%**
8-14 (2 wks.)	3	0%	**0%**	795	12%	**23%**	**-23%**
15-21 (3 wks.)	4	0%	**0%**	653	10%	**33%**	**-33%**

Days	Undergoing DMA			Not undergoing DMA			Variance in cumulative %
	No.	%	Cumulative %	No.	%	Cumulative %	
22-31 (1 MTh)	6	0%	**1%**	736	12%	**45%**	**-44%**
32-62 (2 mths)	48	1%	**2%**	1,792	28%	**73%**	**-71%**
63-93 (3 mths)	374	8%	**10%**	814	13%	**86%**	**-76%**
94-124 (4 mths)	967	22%	**32%**	542	8%	**94%**	**-63%**
125-155 (5 mths)	1,234	28%	**59%**	230	4%	**98%**	**-38%**
156-186 (6 mths)	1,001	22%	**82%**	92	1%	**99%**	**-17%**
187-217 (7 mths)	575	13%	**95%**	30	0%	**100%**	**-5%**
218-248 (8 mths)	197	4%	**99%**	17	0%	**100%**	**-1%**
249+ (9 mths+)	39	1%	**100%**	3	0%	**100%**	**0%**
TOTAL	**4,458**	**100%**		**6,396**	**100%**		

Figure 4.9: Comparison of total time taken for claims granted between applicants who have undergone a DMA and those who have not (nine months ended 31 March 2016)



4.4.2 DURATION OF PROCESS FOR CLAIM REJECTED

Further analysis of claims rejected for those who underwent a DMA and those who did not is illustrated in Table 4.8 and Figure 4.10 below. Key findings include:

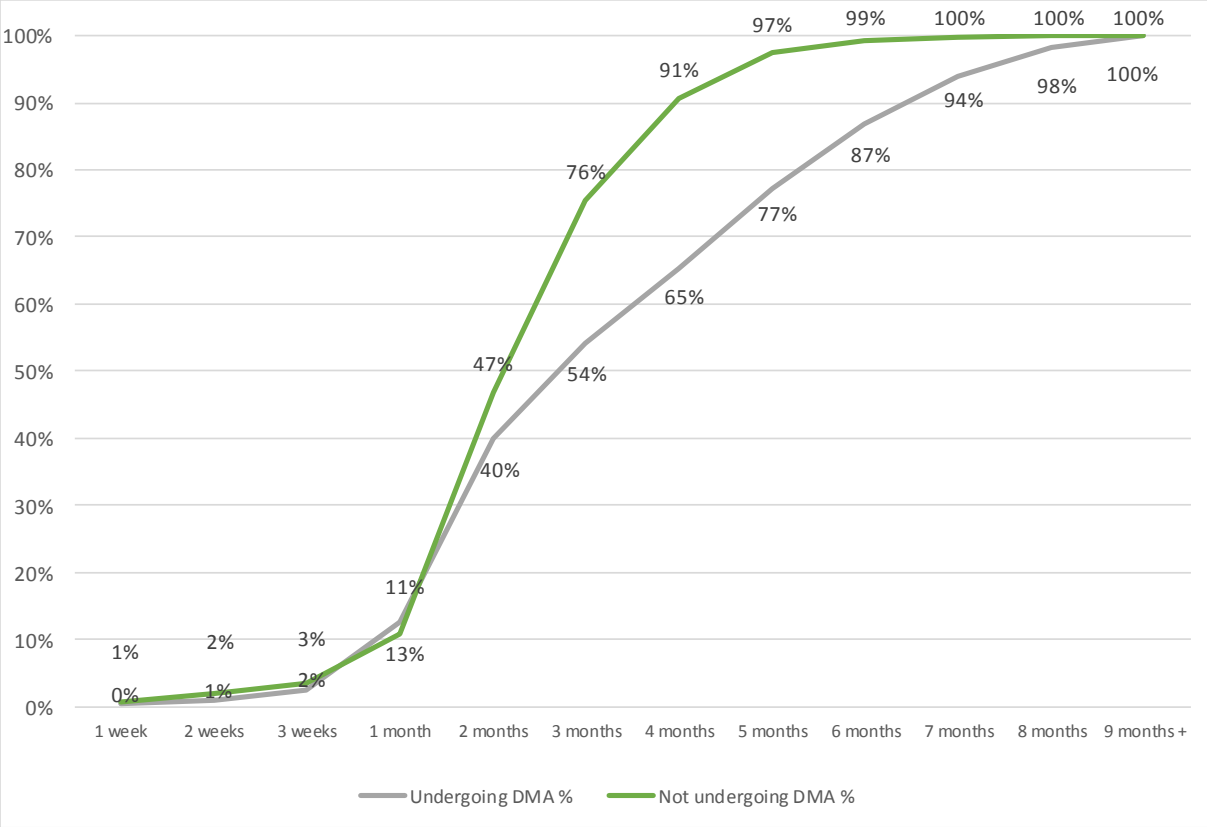
While there was a difference between the DMA and non-DMA groups this is not as great as observed for claims granted. After the one-month point, determinations for those undergoing a DMA starts to lag by one to two months and this starts to close again after four months.

In six to seven months, 90% of those undergoing a DMA have had their claim determined and 99% of those who have not required a DMA.

Table 4.8: Comparison of total time taken for claims rejected between applicants who have undergone a DMA and those who have not (nine months ended 31 March 2016)

Days	Undergoing DMA			Not undergoing DMA			Variance in cumulative %
	No.	%	Cumulative %	No.	%	Cumulative %	
0-7 (week)	7	1%	**1%**	355	1%	**1%**	**0%**
8-14 (2 wks.)	8	1%	**1%**	493	1%	**2%**	**-1%**
15-21 (3 wks.)	19	1%	**3%**	700	2%	**4%**	**-1%**
22-31 (1 mth)	142	11%	**13%**	3,305	8%	**12%**	**+1%**
32-62 (2 mths)	387	30%	**43%**	14,595	36%	**49%**	**-5%**
63-93 (3 mths)	201	15%	**59%**	11,465	29%	**77%**	**-19%**
94-124 (4 mths)	154	12%	**70%**	6,072	15%	**92%**	**-22%**
125-155 (5 mths)	154	12%	**82%**	2,256	6%	**98%**	**-16%**
156-186 (6 mths)	110	8%	**91%**	543	1%	**99%**	**-9%**
187-217 (7 mths)	76	6%	**96%**	160	0%	**100%**	**-3%**
218-248 (8 mths)	44	3%	**100%**	43	0%	**100%**	**0%**
249+ (9 mths+)	2	0%	**100%**	7	0%	**100%**	**0%**
TOTAL	**1,304**	**100%**		**39,994**	**100%**		

Figure 4.10: Comparison of total time taken for claims rejected between applicants who have undergone a DMA and those who have not (nine months ended 31 March 2016)



4.4.3 DURATION OF PROCESS BY SPATIAL LOCATION

Further analysis of the average duration for finalised claims is shown in Figure 4.11 and Figure 4.12 below. The average duration for granted claims increased to around 13 weeks for major cities and regional areas, and to 12 weeks for remote and very remote areas. This is contrary to some of the concerns raised in the consultation process that claims are taking longer to process in more remote areas (**Appendix A**).

The duration for rejected claims for most locations increased to 10 weeks on average, and for very remote areas increased to 11 weeks.

Given the concern expressed more broadly in relation to access for applicants in rural and remote areas, monitoring of timeframes under the new arrangements (specifically for those areas) should be reviewed with a full twelve months of data and probably after two full years.

Figure 4.11: Average duration for granted claims by spatial location

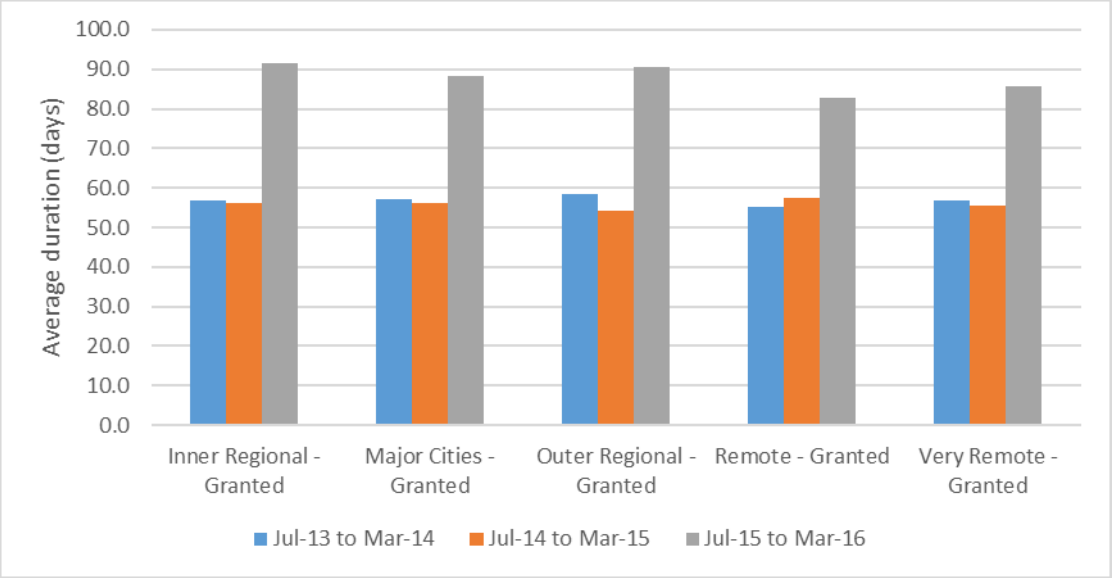
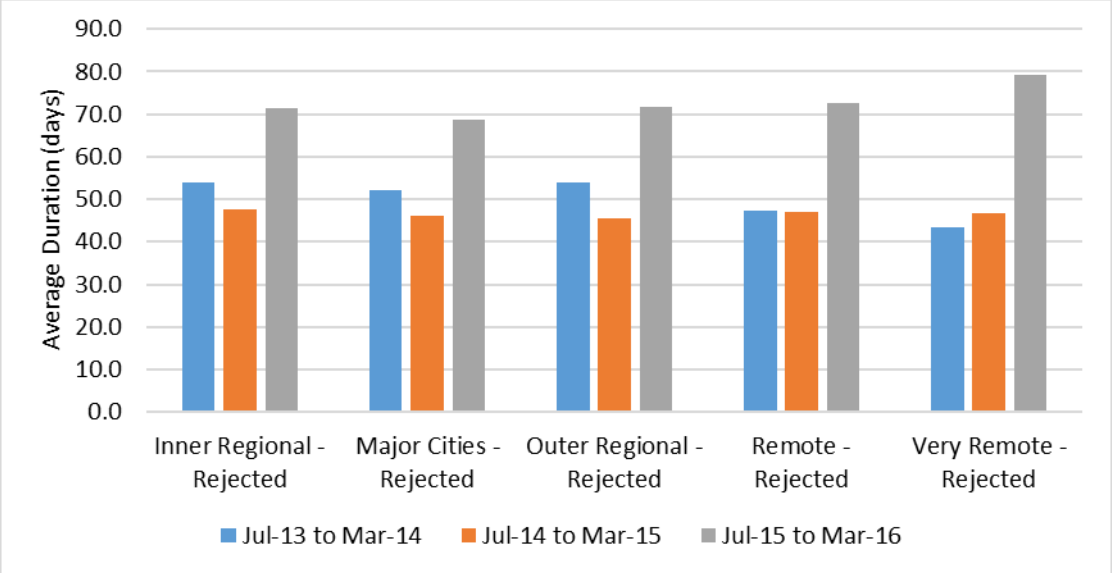


Figure 4.12: Average duration for rejected claims by spatial location



5

PROFILE OF APPEALS

The following chapter provides an analysis of appeals for rejections upon medical grounds determined in relation to the DSP in the period July 15 – March 16, contrasted against that observed in the full years 2013/14 and 2014/15.

5.1 NUMBER OF APPEALS

The proportion of all claimants appealing their determination to the Authorised Review Officer (ARO) and having a decision made in relation to their DSP application is 22% in 2015/16; a decrease over the 23% observed in 2014/15 but an increase from that observed in 2013/14 (16%) (Table 5.1).

Table 5.1: Number of appeals determined

	July 2013 to June 2014	July 2014 to June 15	July 2015 to March 2016
All Claims	102,984	90,792	51,868
# of appeals decided	16,697	21,152	11,368
% of appeals	16%	23%	22%

Based on a comparison with the previous two years, it is not clear whether the revised DSP assessment process is having an effect on overall appeal determination rates based upon data from the first nine months of 2015/16. These trends could be further analysed with a full year of data for comparison or alternatively following two full years of the new process.

Over the same period the frequency of appeals (relative to all claims) remained constant at 18% (i.e. an appeal is received for every 5.6 claims).

5.2 DEMOGRAPHIC PROFILE

The gender and age of appellants to ARO care presented in the following tables.

An analysis of appellants by gender illustrates that there has been no change related to the gender of the appellant (Table 5.2)

Table 5.2: Gender of appellants

Gender	July 2013 to June 2014		July 2014 to June 15		July 2015 to March 2016	
	No.	%	No.	%	No.	%
Female	8,185	49%	10,100	48%	5,437	48%
Male	8,512	51%	11,052	52%	5,931	52%

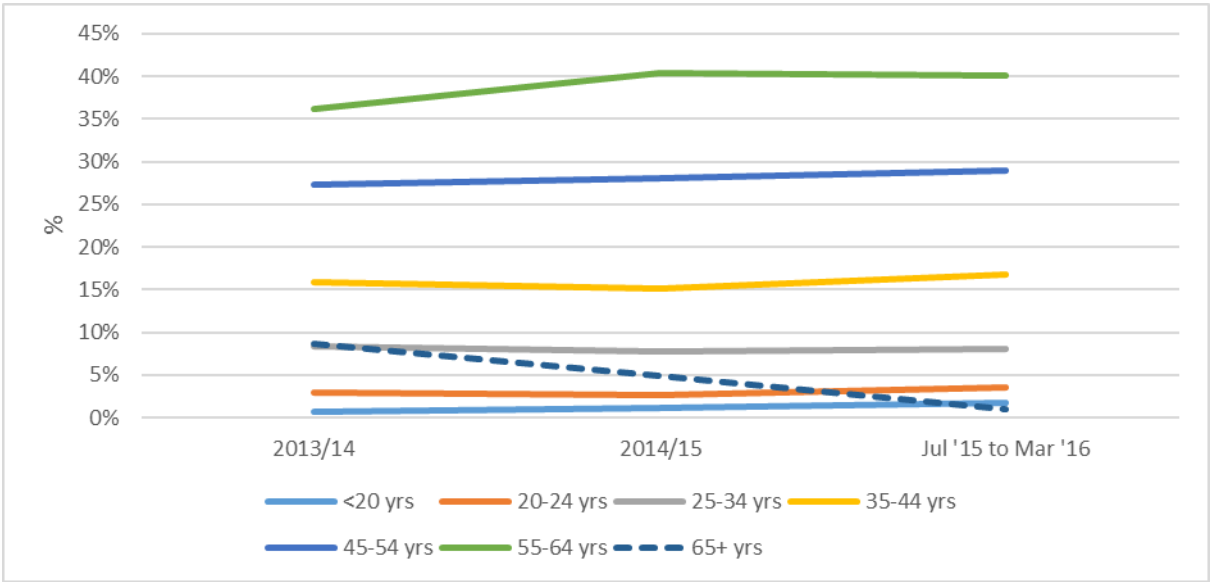
Gender	July 2013 to June 2014		July 2014 to June 15		July 2015 to March 2016	
	No.	%	No.	%	No.	%
Total	**16,697**	**100%**	**21,152**	**100%**	**11,368**	**100%**

Table 5.3 provides an analysis of appellants by age over the three time periods. This illustrates minimal changes in appeals in cohorts aged under 65 years and a decrease in those 65 years and older. However, this could relate to the emphasis on the younger cohort in January to June 2015, with appeals being determined in the nine month period ended 31 March 2016.

Table 5.3: Age of appellants[8]

Gender	July 2013 to June 2014		July 2014 to June 15		July 2015 to March 2016	
	No.	%	No.	%	No.	%
<20 yrs.	119	1%	251	1%	196	2%
20-24 yrs.	499	3%	560	3%	394	3%
25-34 yrs.	1,397	8%	1,633	8%	913	8%
35-44 yrs.	2,638	16%	3,199	15%	1,908	17%
45-54 yrs.	4,562	27%	5,942	28%	3,287	29%
55-64 yrs.	6,049	36%	8,548	40%	4,556	40%
65+ yrs.	1,433	9%	1,019	5%	114	1%
Total	**16,697**	**100%**	**21,152**	**100%**	**11,368**	**100%**

Figure 5.1: Age of appellants Jul 2013 to Mar 2016[8]



[8] Age at time of data extraction

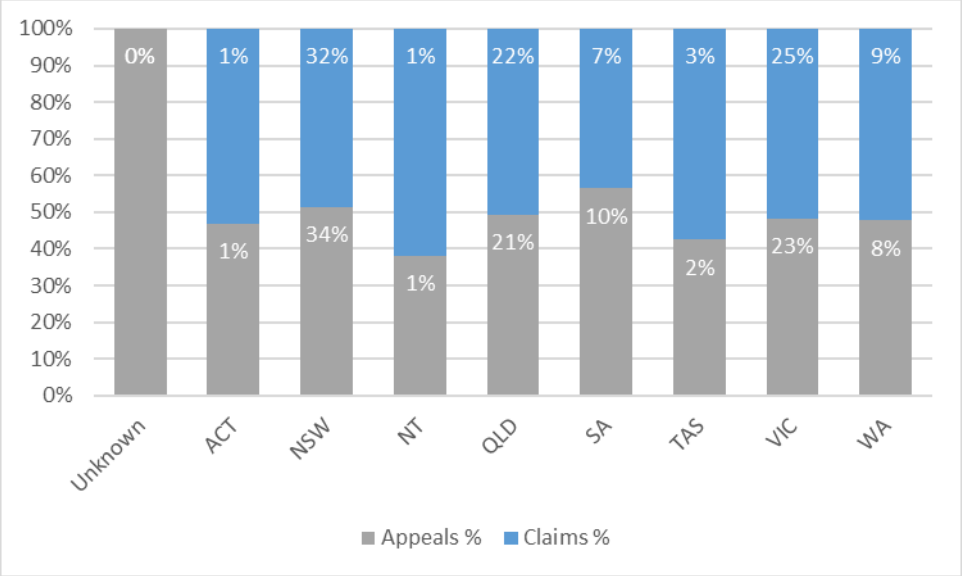
5.3 Appeals by Jurisdiction

An analysis of the percentage of appeals to the percentage of claims illustrates that there has been no significant rise (or fall) in any jurisdiction (Table 5.4 and Figure 5.2).

Table 5.4: % of appeals determined contrasted with % of finalised claims by jurisdiction

Jurisdiction	July 2015 to March 2016	
	Appeals %	Claims %
ACT	1%	1%
NSW	34%	32%
NT	1%	1%
QLD	21%	22%
SA	10%	7%
TAS	2%	3%
VIC	23%	25%
WA	8%	9%

Figure 5.2: % of appeals contrasted with % of claims by jurisdiction



5.4 Appeals Process

Figure 5.3 provides an overview of the process and outcomes for the appeals determined in the period July 2015 to March 2016.

Figure 5.3: Appeals process and outcomes

Total Appeals (Medical)
11,368

Decision of ARO	
Affirmed	9,625
Set aside	559
Varied	109
Withdrawn	147
No Jurisdiction	3
Total	**10,443**

Decision AAT Level 1	
Affirmed	2,290
Set Aside	466
Varied	2
Withdrawn	138
Dismissed/No Jurisdiction	37
All AAT1 Appeals	**2,933**

Decision AAT Level 2	
Customer:	
Affirmed	205
Dismissed/No Jurisdiction	51
Set Aside	21
Settled/Decision by consent	92
Withdrawn	270
Total Customer	**639**
Secretary:	
Affirmed	2
Set Aside	10
Settled/Decision by consent	1
Varied	1
Withdrawn	8
Total Secretary	**22**
All AAT2 Appeals	**661**

5.4.1 Reason for rejection leading to appeal

An analysis of the reason for rejection leading to appeals illustrates that 'less than 20 points impaired' (57%) and a 'medical condition not fully diagnosed/treated/stabilised' (26%) are the two most common reasons for rejection and represent 80+% of all reasons for appeal (Table 5.5). There has been an increase in the proportion of cases with an impairment less than 20 points (from 53% to 57% of all rejections), however it is not known whether this a result of the revised DSP process.

Overall the proportion of medical and non-medical rejections has remained fairly constant over the three years examined.

Table 5.5 Rejection reason leading to appeal

	July 2013 to June 2014		July 2014 to June 15		July 2015 to March 2016	
	No.	%	No.	%	No.	%
Medical Rejections						
Impairment less than 20 points	9,507	53%	12,300	55%	6,815	57%
Not Fully Diagnosed Treated & Stabilised Medical Condition	4,955	27%	5,696	26%	3,116	26%
20pts Program of Support not satisfied	1,055	6%	1,563	7%	769	6%
Short term or temporary impairment	503	3%	918	4%	300	2%
Other	677	4%	675	3%	368	3%
Total Medical Rejections	16,697	93%	21,152	95%	11,368	94%
Non-medical Rejections	1,327	7%	1,091	5%	669	6%
Total Rejections	**18,024**	**100%**	**22,243**	**100%**	**12,037**	**100%**

5.4.2 Outcome of appeals referred to ARO

In respect of reviews, the percentage of Authorised Review Officer (ARO) decisions affirming the original decision has increased over the three years examined from 78% to 92%. The other change of significance is the proportion that has been withdrawn, which has fallen from 10% in 2013/14 to 1% in 2015/16 (Table 5.6). This appears to be a trend that had already commenced and not a result of the new DSP assessment process. The DHS consider that this is consistent with steps taken to strengthen the ARO appeal process for DSP claims (that is, the ARO is required to arrange a DMA referral if they are considering overturning a JCA recommendation about DSP medical eligibility).

Table 5.6: Outcome of appeals referred to ARO

Appeal Decision	July 2013 to June 2014		July 2014 to June 15		July 2015 to March 2016	
	No.	%	No.	%	No.	%
Decision affirmed	11,571	78%	17,235	87%	9,625	92%
Set aside	1,476	10%	1,475	7%	559	5%
Varied	183	1%	243	1%	109	1%
Withdrawn	1,538	10%	875	4%	147	1%
No Jurisdiction	1	0%	5	0%	3	0%
Total	**14,769**	**100%**	**19,833**	**100%**	**10,443**	**100%**

5.4.3 Outcome of appeals lodged by customers

A comparison of the outcomes of Appeals Decisions made by AAT Level 1 shows no significant change over the last three years. There has been a small decline in 'Decision affirmed' (down four percentage points) and a corresponding four percentage point increase in 'Set aside' decisions. Again this would need to be reviewed with another year's set of data to confirm whether this was an emerging trend (Table 5.7). AAT appeals are characterised by long time lags so the cases decided by the AAT in the report period are unlikely to relate to DMAs, and in some cases appeals do not relate to DMAs.

Table 5.7: Outcome of AAT Level 1 appeals

Appeal Decision	July 2013 to June 2014		July 2014 to June 15		July 2015 to March 2016	
	No.	%	No.	%	No.	%
Decision affirmed	2,508	82%	3,222	80%	2,290	78%
Set aside	380	12%	532	13%	466	16%
Varied		0%		0%	2	0%
Withdrawn	149	5%	249	6%	138	5%
Dismissed/No Jurisdiction	17	1%	26	1%	37	1%
Total	**3,054**	**100%**	**4,029**	**100%**	**2,933**	**100%**

5.4.4 Outcome of appeals made by AAT Level2

A comparison of the outcome of appeals made by AAT Level 2, illustrates a downward trend in the category 'Settled/Decision by Consent' and a corresponding upward trend in 'Decision affirmed'. As many appeals are settled by consent it is difficult to know whether they were settled in favour of the customer or the Secretary. This appears to have been a trend that had already commenced from 2013/14 and not a result of the revised DSP assessment process. Again this would need to be reviewed with another year's set of data to confirm whether this was an emerging trend.

Table 5.8 Outcome of AAT Level 2 appeals

Appeal Decision	July 2013 to June 2014		July 2014 to June 2015		July 2015 to March 2016	
	No.	%	No.	%	No.	%
Customer Appeals:						
Affirmed	147	19%	190	23%	205	31%
Dismissed/No Jurisdiction	54	7%	59	7%	51	8%
Set Aside	26	3%	45	5%	21	3%
Settled/Decision by Consent	167	22%	101	12%	92	14%
Varied	0	0%	1	0%	0	0%
Withdrawn	358	47%	423	50%	270	41%
Total Customer Appeals	**752**	**98%**	**819**	**97%**	**639**	**97%**
Secretary Appeals:						
Affirmed	1	0%	2	0%	2	0%
Set Aside	2	0%	8	1%	10	2%
Settled/Decision by Consent	3	0%	3	0%	1	0%
Varied	0	0%	0	0%	1	0%
Withdrawn	9	1%	9	1%	8	1%
Total Secretary Appeals	**15**	**2%**	**22**	**3%**	**22**	**3%**
All Appeals	**767**	**100%**	**841**	**100%**	**661**	**100%**

A

APPENDIX A – CONSULTATION FINDINGS

This appendix presents qualitative feedback from key stakeholders to the DSP assessment process including General Practitioners (GPs), Psychologists, National Welfare Rights Network members and DHS personnel. The information provided simply represents the key feedback provided by each stakeholder in written form as HOIs evaluation processes did not include direct consultation with the stakeholders. Where appropriate we have noted where the feedback is aligned to issues observed in the data or with other stakeholder feedback.

GENERAL PRACTITIONERS

The key change for the GP from the revised DSP assessment process is the shift from completing a Treating Doctor's Report (TDR) to assisting the applicant to access and compile the raw medical evidence/records. The Department met with and invited feedback on behalf of GPs through the Australian Medical Association (AMA) in relation to the impact of this revised process.

The following represents the key issues as provided by the AMA. It should be noted that it is not certain how many GPs' views are captured by the feedback provided.

- GPs expressed concern that there is no remuneration available to GPs for compiling and synthesizing clinical information that is relevant to their patient's DSP claim; either initially or subsequently should further information be required. In contrast, the DHS advised that assessors offer treating health practitioners an $80 remuneration fee. This existed prior to the introduction of this measure. GCDs can also offer this remuneration when requesting further clarification.
- There were concerns raised by GPs in relation to various privacy aspects associated with the new DSP assessment process including:
  - To what extent were patients informed and understood who the information would be used by and shared with during the assessment process. In contrast, the DHS advised that this procedure has been used for a long time, and did not change as a result of the revised assessment process. The department's procedures around faxing evidence are designed to minimise risk to security of information. The DHS considered that most of these concerns have been addressed by the revised SA472 Consent to disclose medical information form published on the department's website in May 2016. All customers who attend a Job Capacity Assessment are asked to complete this form. The form will be included in future updates to the DSP paper claim form, and as part of the new DSP online claim process currently in development.
  - Were there any privacy implications for the GP who was providing information to an applicant that may have been provided to them 'in confidence'. For example, a specialist may have sent a letter to the GP regarding the applicant in confidence, however, this would need to be provided to the applicant in order to furnish all of the raw medical evidence.
  - Requests had been made by DHS for GPs to provide sensitive medical information regarding the applicant via fax. Concern was held amongst GPs as to the security of this medium.
  - Related to direct requests for information, GPs were not being provided with evidence of the applicant's consent to the sharing of their personal information. The DHS advised that this

issue is not new to the revised assessment process. It is readily addressed through provision of the SA472, which was previously available in a different form.

- The terminology of 'fully diagnosed, treated and stabilised' is not the language of clinical reports and hence there was concern among GPs that those initially assessing claims may not have the skills to interpret the clinical information provided, potentially preventing patients from being fully assessed.
- GPs (particularly those with mental health skills training) expressed frustration that their diagnostic skills and knowledge of the patient are considered inadequate for making a mental health diagnosis and that there is a requirement for this to be confirmed by a psychiatrist or a clinical psychologist. GPs consider this to be a particular challenge in rural and remote areas where the GP is primary provider of care and access to either a psychiatrist or a clinical psychologist is limited, expensive and inconsistent (i.e. visiting psychiatrist/psychologist is not always consistently the same person).
- GPs are being asked to provide their professional opinion in relation to the applicant's functionality in day to day life. There was concern that this appeared to be more in line with the form of questioning from the previous Treating Doctor Report. The AMA understood that the Department wanted to 'purify' the assessment process by focussing on clinical evidence and the findings of an independent assessment. Accordingly, this questioning is one only the assessor should be posing and that the applicant or their carer is best placed to answer.

The Department has committed to the AMA to continue working through any issues with them in order to minimise the impact of the revised DSP assessment process on GPs.

Psychology Professionals

The Department received feedback from Psychologists through the Australian Psychological Society (APS). The APS noted that they have received, *'a considerable amount of feedback from members across Australia about difficulties with the revised process (and with the previous process that restricted the capacity to diagnose a mental illness to clinical psychologists and psychiatrists).'* Further, the APS has written to the Minister about their concerns and commenced discussions with DHS regarding the key issues. The key concerns of Psychologists as documented by the APS include the following:

The overarching revised application process

- the overwhelming concern for APS members is that **equity of access** to health practitioners for customers to undertake the application process has been greatly compromised, particularly for people residing in rural and remote Australia;
  - although workforce data indicates that there is a considerably better distribution of psychologists in rural and remote Australia than psychiatrists – the majority of psychologists in these areas are not clinical psychologists, the only group authorized to provide evidence of a mental health condition (i.e. that the condition is fully diagnosed, treated and stabilised, and that the condition is permanent). This situation does not align with the competencies of many psychologists in Australia. APS members are extremely concerned about access issues for rural applicants to obtain acceptable evidence even where the applicant has access to a public mental health service.
- there are **increased costs to the applicant and the treating practitioner** of obtaining the relevant documentation.
  - APS members from rural and remote locations report that members of the public are heavily disadvantaged by having to travel long distances to access a psychiatrist or clinical psychologist to provide supporting evidence when they are already being treated by a psychologist (who does not hold an endorsement in clinical psychology).

  - some customers have presented to APS members having been told by Centrelink staff to obtain a referral to a clinical psychologist under the Better Access initiative (Medicare) in order to obtain supporting evidence at minimal cost. The Better Access initiative only provides rebates to patients for psychological interventions and thus attendance for the provision of 'evidence' is not eligible for a rebate. Communication with and/or further training of frontline Centrelink staff should be undertaken to ameliorate this situation.
  - the lack of remuneration from Centrelink to the treating practitioner for the provision of 'evidence' is of considerable concern to both psychologists and the customer as it is now the applicant that funds the provision of 'evidence'. This situation places psychologists in a very difficult situation as the collation of 'evidence' is not rebateable under Medicare yet many applicants for the DSP are unable to self-fund a report. Some psychologists report feeling pressured to provide evidence at no cost in order to minimise further stress and anxiety on the applicant.

- the revised application process has **increased the likelihood of exacerbating mental health problem(s)**. Many applicants seeking evidence are confronted with very challenging circumstances that are stressful and likely to exacerbate mental health condition(s) and contribute to 'making the sickest people sicker';
  - where the treating psychologist is not a clinical psychologist the customer must be referred on to a clinical psychologist who does not have historical knowledge of the applicant. Given the requirement for the evidence to show that the condition is fully diagnosed, treated and stabilised, it is very difficult for a new treating practitioner (clinical psychologist) to make a judgement based on their limited knowledge of the applicant. The need for the usual treating psychologist to make this referral also impinges on the therapeutic relationship and contributes to the potential to 'make the sickest people sicker'
  - placing the onus on the applicant to obtain evidence can be very challenging for many individuals with severe and complex mental illness who are likely to be eligible for a DSP. Many of these individuals will have significant cognitive, emotional and behavioural symptoms that make it very difficult to plan and execute collection of appropriate evidence. For individuals without adequate social support, the collection of evidence presents a barrier to many potential applicants.

The DMA process by Government Contracted Doctors

The following feedback was received through the APS, however, it is apparent that this has come from their members working as psychologists within the DSP assessment process.

- the training provided to clinical psychologists (as Government-contracted doctors) by Medibank Solutions is adequate, however, the **training on the Impairment Tables** (Course Code EXT00003) does not sufficiently detail the impairment rating descriptors or how to apply the points in practice. We note that the DHS considers that the training packages for GCDs adequately address these matters, and that these matters do not affect the conduct or quality of the DMA process.
- The Disability Medical Assessment Services information on Joining the Provider Network outlines that "**the DMA is a single appointment, which averages 45 minutes**". Whilst this is considered sufficient for a straightforward application, **in complex or atypical cases this amount of time is insufficient**. While the evaluation recognises that this does not affect policy intent, the concern of members is the impact on applicants in terms of additional stress and anxiety when there is insufficient time available to understand complex issues. This is also perceived as an administrative burden by members who spend considerable follow-up time addressing the complexities of the case. The lack of recognition that some assessments require additional time is likely to become a deterrent to psychologists taking up this role in the future.

MEDICAL EVIDENCE

- As discussed earlier, issues were raised around the definition of what constitutes appropriate and sufficient raw medical evidence is a concern raised by all stakeholders.

NATIONAL WELFARE RIGHTS NETWORK

The Department invited feedback from the National Welfare Rights Network (NWRN) who provided feedback in relation to the impact of this revised DSP application process on behalf of the membership and their customers.

The NWRN members noted that the main impact of the revised application process has been the delay in processing DSP claims, due to long wait times for appointments with a GCD following a JCA. To support their concerns, the NWRN provided four case studies of specific applications that had taken an extended period for a DMA to be conducted.

Two of the case studies raised concern about equity of access for those living in regional, rural and remote areas, particularly with regard to having a full assessment by the GCD, face-to-face. Whether there is appropriate resourcing to support the DMA process in non-metropolitan areas, so that face-to-face appointments are available and a full assessment is conducted was a concern identified in two of the case studies. It was further noted that Centrelink CSC video-conferencing facilities previously available for assessment purposes were now no longer available. We note that the DHS consider that this lack of access to video-conferencing facilities appears to be a misunderstanding.

A final issue identified by the NWRN membership (and common to all stakeholders) relates to the challenge for applicants of collecting raw medical evidence.

DHS PERSONNEL

HOI developed a survey for distribution amongst DHS personnel (8 respondents) who have been involved in the conduct of job capacity assessments or DMAs under the revised assessment process prior to the transition to Medibank Solutions. *This survey is focussed on the transition period for the new DSP assessment process covering the period 1 January 2015 – 30 June 2015*. The following provides the key findings from the feedback provided.

THE OVERARCHING REVISED APPLICATION PROCESS

Whilst there are some specific issues in relation to the revised application process, all respondents consider that it has brought about both enhanced integrity and better decision making in the assessment process. Whilst we note below some of the information gathering challenges of the process, for the JCAs, the opportunity to speak directly to the treating Doctor/Health professional with respect to the raw medical evidence provided (as opposed to relying on the TDR), they consider has facilitated, *'both sides getting a better picture of what the person is about and is able to do in real life'*. Other views to support this notion include:

> *'Better quality, more relevant information when speaking to the doctors personally than what was in a TDR which leads to better informed assessments/recommendations.'*
>
> *'When contact is made with health professionals, it enables the assessor to obtain information directly related to the impairment tables and assign an appropriate impairment rating. This removes that ambiguity of some decisions.'*

In line with having direct access to the treating Doctor/Health professional, the most significant enabler to the revised DSP process was said to be the $80 fee that can be offered to health

professionals for consultation with the assessor. This has provided an incentive for health professionals to respond to assessors' calls and requests for further information.

Raw medical evidence

As has been noted by other stakeholder groups, the single most challenging aspect of the new assessment process is the assessing what constitutes raw medical evidence. Given this, the types of issues being encountered by JCAs include:

- Significant variability in the quality and quantity of information provided by the applicant; often there is too little and on other occasions the volume of information is great and proves challenging to find the pertinent pieces of evidence.
- Information on functional ability in the raw medical evidence is rare. Usually, information does not advise about functional abilities, as needed per impairment tables, so the treating doctor needs to be contacted and sometimes they won't know either.
- The term "raw medical data" often gets interpreted as blood tests, x-rays etc. without any interpretative summary or commentary regarding the functional impacts of these conditions.
- While not a new issue, perceptions that certain medical conditions and diagnoses will automatically qualify the applicant for the DSP (e.g. neurodegenerative conditions).
- An increase in "advocacy letters" from treating professionals.
- An increasing number of doctors and psychologists have started providing letters with their opinions about what impairment ratings customers should be given on the impairment tables; something that rarely happened previously. This is despite the fact that they have limited understanding in most cases of the fully diagnosed, treated and stabilised criteria that must first be considered and of issues associated with double counting etc.
- Additional information is brought in on the day of assessment for consideration (noting that this is not a new issue).
- On occasion, there is no current evidence available as applicants have not had any recent treatment or contact with their treating health professionals e.g. intellectual disability diagnosed as a child (noting that this is not a new issue).

Impact on Manifest determinations

Most respondents were of the view that some manifest determinations are being impacted and again this is directly associated to the quality and quantity of information provided. Respondents noted that where numerous attempted contacts with the treating medical Doctor to obtain essential medical evidence are not responded to, the application is rejected on that basis. While they considered this was the only option available to facilitate the application being progressed, DHS advise that other options exist, including referral to HPAU or Triage teams, and discussion with the customer.

While the medical evidence requirements for claimants with an intellectual disability have not changed under the revised DSP assessment, there are cases of insufficient evidence being brought by claimants that results in eligibility requirements being missed. This was observed as a particular issue with customers who had or were attending a special school for intellectual disability. *'They didn't have any recent cognitive assessments and were being sent through for JCAs and DMAs because they didn't provide the right evidence at the start of their claim to make it clear they should have been manifestly eligible'.*

Where the previous SA012 document provided certain areas where a health professional could indicate manifest grants (i.e. does the customer have an expected life span of less than 24 months), the

raw data does not provide this information leading to customers being referred for JCAs when not needed (i.e. Metastatic end stage cancers etc.). As one JCA noted; '*It is hoped that these conditions can be picked up prior to the assessment and the assessor contact the GP to verify if the case fulfils the manifest criteria (in which case, there would be no need for a JCA) but in most cases, the assessor rarely has the opportunity to review upcoming appointments several days in advance and have time to contact the GP and await their reply prior to the assessment. This has led manifest eligible customers attending appointments. However, Assessment Services has introduced a "Triage Team" that will do this preparation work and hopefully eliminate referrals for likely manifest grants prior to approval for appointments to be booked.*'

Specific impacts on customers

The survey canvassed what impact the revised process had on customers. In congruence with that noted by the APS and the NWRN, the biggest impact on the customers is the time and financial impacts of gathering the raw medical evidence. Understandably, it was reported that complaints from customers tend to come from those who have had a previous experience of the TDR and are now required to collect raw medical evidence themselves.

As was noted by other stakeholders, DHS personnel observed that the biggest challenge for customers appear to be in collecting evidence from hospitals and specialists, who often are placing a charge on the customer for the provision of the information. The time required to collect the evidence may affect the total time period for their application to be determined. For this reason, the department strongly encourages potential claimants to lodge any available medical evidence with their claim.

Summary

Across the stakeholder groups there are some common concerns associated with the new DSP application process; definition of raw medical evidence, challenges of collecting the evidence, and the total time period involved.

Issues around the definition of what constitutes appropriate and sufficient raw medical evidence is a concern raised by all stakeholders. Accordingly, these stakeholders sought clear guidance to provide clarity to the information providers (e.g. treating health practitioners, specialists, hospitals) and customers as to the type and extent of the evidence that is required. The view of the Department of Human Services (DHS) is that any such issues have been addressed by publication of guidelines which clearly explain the medical evidence requirements for DSP new claims.

.

B

APPENDIX B – ANALYSIS OF MANIFEST DETERMINATIONS

Table B.1: Manifestly granted determination by manifest code

Manifest Code	July-13 – March-14		July-14 – March-15		July-15 – March-16	
	No.	%	No.	%	No.	%
Blind	366	5.5%	343	5.0%	274	4.7%
HIV	9	0.1%	1	0.0%	8	0.1%
Intellectual/Learning	2,041	30.6%	2,098	30.7%	1,906	32.8%
Nursing Home Level of Care	649	9.7%	719	10.5%	645	11.9%
Terminal Illness	3,573	53.5%	3,617	52.9%	2,935	50.5%
Total Permanent Incapacity	42	0.6%	57	0.8%	47	0.8%
Total	**6,680**	**100.0%**	**6,835**	**100.0%**	**5,815**	**100.0%**

Table B.2: Manifestly rejected determination by manifest code

Manifest Code	July-13 – March-14		July-14 – March-15		July-15 – March-16	
	No.	%	No.	%	No.	%
Can work 15 hours a week	183	9.7%	255	5.2%	160	18.5%
Can work 30 hours a week	10	0.5%	30	0.6%	18	2.1%
Conversion	48	2.5%	56	1.1%	41	4.7%
Diagnosis criteria not met		0.0%	70	1.4%	111	12.9%
No continuing inability to work		0.0%	3	0.1%	23	2.7%
Not Sufficient Impairment	300	15.9%	394	8.0%	35	4.0%
Temporary Condition	1,348	71.4%	4,087	83.5%	478	56.3%
Total	**1,889**	**100.0%**	**4,895**	**100.0%**	**866**	**100.0%**

Table B.3: Time between claim lodgement and claim decision for all manifestly granted

Days	July-13 – March-14			July-14 – March-15			July-15 – March-16		
	No.	%	Cumulative %	No.	%	Cumulative %	No.	%	Cumulative %
0-7 (week)	852	13%	**13%**	1,551	23%	**23%**	509	9%	**9%**
8-14 (2 wks.)	1,292	19%	**32%**	1,151	17%	**40%**	740	13%	**21%**
15-21 (3 wks.)	705	11%	**43%**	868	13%	**52%**	622	11%	**32%**
22-31 (1 mth)	821	12%	**55%**	881	13%	**65%**	703	12%	**44%**
32-62 (2 mths)	1,732	26%	**81%**	1,392	20%	**85%**	1,716	30%	**74%**
63-93 (3 mths)	650	10%	**91%**	515	8%	**93%**	727	13%	**86%**
94-124 (4 mths)	368	6%	**96%**	240	4%	**97%**	484	8%	**95%**
125-155 (5 mths)	139	2%	**98%**	123	2%	**98%**	207	4%	**98%**
156-186 (6 mths)	49	1%	**99%**	65	1%	**99%**	78	1%	**100%**
187-217 (7 mths)	27	0%	**100%**	19	0%	**100%**	18	0%	**100%**
218-248 (8 mths)	20	0%	**100%**	11	0%	**100%**	9	0%	**100%**
249+ (9 mths +)	25	0%	**100%**	19	0%	**100%**	2	0%	**100%**
Total	**6,680**	**100%**		**6,835**	**100%**		**5,815 5**	**100%**	

Table B.4: Time between claim lodgement and claim decision for all manifestly rejected

Days	July-13 – March-14			July-14 – March-15			July-15 – March-16		
	No.	%	Cumulative %	No.	%	Cumulative %	No.	%	Cumulative %
0-7 (week)	184	10%	**10%**	1,244	25%	**25%**	68	8%	**8%**
8-14 (2 wks)	529	28%	**38%**	1,202	25%	**50%**	132	15%	**23%**
15-21 (3 wks)	245	13%	**51%**	662	14%	**63%**	71	8%	**31%**
22-31 (1 mth)	239	13%	**63%**	692	14%	**78%**	151	17%	**49%**
32-62 (2 mths)	437	23%	**87%**	819	17%	**94%**	283	33%	**81%**
63-93 (3 mths)	118	6%	**93%**	199	4%	**98%**	79	9%	**90%**
94-124 (4 mths)	75	4%	**97%**	50	1%	**99%**	52	6%	**97%**
125-155 (5 mths)	30	2%	**98%**	14	0%	**99%**	16	2%	**98%**
156-186 (6 mths)	22	1%	**99%**	6	0%	**100%**	7	1%	**99%**
187-217 (7 mths)	7	0%	**100%**	4	0%	**100%**	5	1%	**100%**
218-248 (8 mths)	1	0%	**100%**	2	0%	**100%**	2	0%	**100%**
249+ (9 mths +)	2	0%	**100%**	1	0%	**100%**	-	0%	**100%**
Total	**1,889**	**100%**		**4,895**	**100%**		**866**	**100%**	

Table B.5: Analysis of manifestly granted claims for females

Year	Manifest Granted to Females	All Manifest Granted (M & F)	All Granted to Females	All Claims by Females	Manifest granted to F as a proportion of All Granted	Manifest granted to F as a proportion of all granted to F	Manifest granted to F as a proportion of all Claims by F
July-13–March-14	2,681	6,680	19,872	48,996	40%	13%	5%
July-14–March-15	2,789	6,835	15,407	42,780	41%	18%	7%
July-15–March-16	2,394	5,815	4,619	24,307	41%	43%	10%

Table B.6: Analysis of manifestly granted claims for males

Year	Manifest Granted to Males	All Manifest Granted (M & F)	All Granted to Males	All Claims by Males	Manifest granted to M as a proportion of All Granted	Manifest granted to M as a proportion of all granted to M	Manifest granted to M as a proportion of all Claims by M
July-13–March-14	3,999	6,680	23,007	53,986	60%	17%	7%
July-14–March-15	4,046	6,835	18,335	48,012	59%	22%	8%
July-15–March-16	3,422	5,815	5,951	27,561	59%	58%	12%

C

APPENDIX C – DHS RESPONSE

Department of Human Services' response to the final report of the Evaluation of the Revised Disability Support Pension (DSP) process.

The Department of Human Services appreciates the opportunity to comment on the Final Report of the Evaluation of the Revised Disability Support Pension Assessment Process. The Department has provided detailed comments on the report and acknowledges that this feedback has largely been incorporated.

Assessing qualification for DSP is complex because of the need to establish the permanency of conditions, the functional impairment they cause, and the impact on a person's ability to work. The Department welcomes feedback from stakeholders, and works to implement the suggestions of both peak bodies and recipients in order to continually improve processes.

The introduction of Disability Medical Assessments affords an additional level of rigour in the DSP eligibility assessment process and offers further protection for the integrity of Government outlays. Feedback in the report, which is relevant to the introduction of the measure, has been considered as part of the Department's work to refine the processes introduced to support this policy change.

- The requirement to conduct a second assessment will add to the overall timeframe to finalise a claim for those claimants who are required to attend a Disability Medical Assessment. The contracted provider for Disability Medical Assessments has contractual performance obligations and consistently meets those targets to keep average claim processing within parameters agreed with the Departments.

- The provider was contracted on the basis of a geographic footprint and service capabilities that included video conferencing. Disability Medical Assessments are not conducted on DHS premises and have never relied on DHS facilities.

- The ability to contact a Treating Health Professional is a long-standing option for department staff who are assessing DSP claims.

- The Department takes its responsibility to provide services and support, particularly to those who are vulnerable, very seriously. There are numerous processes in place to help staff identify claimants who may face barriers, and require additional assistance to gather necessary information or submit complete claims.