Submission to the Review of the Disability Support Pension (DSP) Impairment Tables – responses to questions posed in discussion paper

What aspects of the current Impairment Tables do you feel work well and why?

What aspects of the current Impairment Tables do you feel require improvement and why?

The preamble

The need for a condition to be fully diagnosed, fully treated and fully stabilised

We propose that the preamble to the Impairment Tables needs to be reviewed to ensure that issues raised by EJA and other organisations in submissions to the DSP Senate Inquiry are addressed in the new version.

The current preamble states that an impairment rating can only be assigned if the condition causing that impairment is 'permanent', and the impairment resulting from that permanent condition 'is more likely than not, in light of available evidence, to persist for more than 2 years'. It then states that a condition is 'permanent' if:

- it has been 'fully diagnosed' by an appropriately qualified medical practitioner;
- it has been 'fully treated'; and
- it been 'fully stabilised'.

As outlined in EJA's submission to the Senate Community Affairs References Committee – Inquiry into the purpose, intent and adequacy of the Disability Support Pension (Senate inquiry), the requirement under the Impairment Tables that a condition be 'fully diagnosed', 'fully treated', and 'fully stabilised' to be assessed, is central to many appeals against DSP rejections and the source of considerable confusion among claimants, treating doctors, Services Australia delegates and AAT members alike.

Claimants can provide reports from their GP and specialists definitively attesting to diagnosis of a particular condition, the treatment regime and prognosis, only to have the Job Capacity Assessor effectively question their doctors' diagnoses and assessments.

This tendency to question treating medical professionals' diagnoses, treatment regimens and opinions as to prognosis, is further fueled by the preamble going on to say that

> 'In determining whether a condition has been 'fully diagnosed' and 'fully treated' consideration must be given to whether there is corroborating evidence of the condition; what treatment or rehabilitation has occurred in relation to the condition; and whether treatment is continuing or is planned in the next two years'.

The preamble then goes on to prescribe the criteria that must be met for a condition to be considered 'fully stabilised' and what constitutes 'reasonable treatment'.

As shown in the case studies included in EJA's submission to the DSP Senate inquiry, the word 'fully' as a qualifying adjective before 'diagnosed', 'treated' and 'stabilised' creates ambiguity and uncertainty in assessing medical evidence, for reasons including that:

- The concept of diagnosis is an absolute – a condition has either been diagnosed, or a diagnosis is pending, or a diagnosis accounting for a person's symptoms has not been possible. If a person's treating medical professional has made a diagnosis, and attests to that diagnosis in a report, a JCA or CGD is in no place to dispute that diagnosis
- Diagnoses in the light of particular symptoms may change - e.g. bipolar disorder with psychosis, to schizophrenia with psychosis; or bipolar disorder to borderline personality disorder - but the change does not necessarily mean that the current or former diagnosis was invalid or incomplete. Diagnosis of the underlying condition causing physical impairment may also change, e.g. for people with chronic fatigue syndrome, or multiple sclerosis
- Treatment for a particular condition may arguably be less than 'full' where, for example a person who has episodes of or ongoing severe psychosis with delusions and paranoia, or depression, cannot or will not adhere to a treatment regime; or where the person's physical or psychiatric condition is resistant to treatment, and new treatment strategies are tried from time to time
- 'Full' stabilisation of symptoms associated with a condition may be impossible, especially where instability of symptoms, or the episodic nature of symptoms, is a feature of the condition
- Any clarification as to whether a condition has been or is being treated should be sought from the applicant's treating doctor(s), as should information regarding planned, viable treatment options
- Only the applicant's treating medical professionals are in a position to make an assessment as to prognosis.

➢ ***Recommendation:***

- *That the preamble to the Impairment Tables be amended so as to delete all references to 'fully' as a qualifier to 'diagnosed', 'treated' and 'stabilised'*

Episodic or fluctuating conditions

The preamble states that:

> For conditions that have stabilised as episodic or fluctuating, a rating must be assigned which reflects the overall functional impact of impairments relating to the condition, taking into account the severity, duration and frequency of the episodes or fluctuations.

This guidance is appropriate, including for episodic psychiatric conditions, but in our experience is effectively nullified by the requirement that a condition be 'fully' stabilised for an impairment rating to be assigned.

- ***Recommendation***:
  - *In addition to removing the 'fully' qualifier before 'stabilised', as per the recommendation above, we suggest that guidance be provided as to what it means for a condition to have stabilised as episodic or fluctuating, with examples of relevant medical and psychiatric conditions.*

What changes do you think would improve clarity and ease of interpretation in the application of the Impairment Tables for the purposes of a DSP claim?

- ***Recommendations:***
  - *Presentation of the tables with zero rating descriptors coming first, then 10-20-10, can lead to under-assessment of the functional impact of impairment, especially where each level of ratings do not explicitly relate to one another. We propose that the order in which the ratings are presented be reversed – with the highest level coming first, and zero last. This would guard against inadvertent assignment of a zero or low rating for a person with significant functional impairment, when their level of impairment in fact meets the descriptors for assigning a higher rating. It would also mean that people with multiple impairments would be less likely to be given unrealistically low ratings under the tables, and people with little if any work capacity would be less likely to be inappropriately required to engage in a POS before being able to access DSP.*
  - *Further, we endorse the recommendations made by our member centre, Social Security Rights Victoria, in its submission to the Senate inquiry, namely that:*
    - *The Impairment Tables be reviewed and rewritten in a way that is consistent with the rest of the eligibility criteria. Specifically, that a 20 point impairment rating under any table be consistent with a person who has some work capacity, but is still prevented from being able to do 15 or more hours per week, rather than someone with no work capacity at all.*
    - *Any review of the Impairment Tables be done in consultation with relevant experts and stakeholders, including health professionals, disability organisations, and most importantly people living with disability.*
    - *The types of mental health professionals and medical practitioners who can diagnose and give evidence for mental health conditions be broadened. Diagnostic requirements contained within the Impairment Tables should be set with reference to the actual professionals people see about their conditions, and the professionals that are realistically accessible under Medicare.*

Is there any specific table you feel requires a greater level of analysis and possible re-wording? If so, which one and why?

Although the Impairment Tables are function based rather than condition based, are there specific impairments/conditions you think are not given due consideration within the existing 15 tables?

EJA's comments below are observations regarding issues in applying some of the tables as informed by our members' experience advising and advocating for DSP applicants and appellants, speaking with community disability advocates, and liaising with clients' treating medical professionals.

We understand that the Department is consulting widely regarding the review of the Tables, including with people with disability, representative peaks, and medical professionals. These people and organisations will no doubt have detailed recommendations regarding particular Tables, including those mentioned below, drawing from their expertise and experience.

Part 1 – Preliminary

Allied health practitioner includes, but is not limited to, a person who practises chiropractic, exercise physiology, physiotherapy, psychology, occupational therapy, osteopathy, pharmacy, podiatry or rehabilitation counseling.

Comments

- We understand that the definition of allied health practitioner is solely relevant regarding the professional qualifications of Job Capacity Assessors. In our view, whilst certain of these allied health practitioners may provide useful input into job capacity assessments in respect of particular conditions and impairments, they should never be solely responsible for making an assessment.
- Apart from the fact that an allied health practitioner is not qualified to diagnose medical or psychiatric conditions, we understand that there is no matching of a JCA's allied health qualifications with a claimant's condition/impairments with the result that a physiotherapist may be responsible for reviewing medical evidence and making an assessment for a claimant whose primary condition is psychiatric; and a podiatrist may be making an assessment for a person with drug dependency. This is inappropriate and can result in flawed assessments based on incorrect weighting of evidence, and ill-informed critiques of medical reports.
- We propose that the role of allied health professionals in JCAs be reviewed, and that consideration be given to reintroducing a panel process.

Condition means a medical condition.

Comments

- Given that impairment may relate to non-medical conditions, such as intellectual disability or personality disorders, the definition of condition needs to be revised.

Part 2 – Rules for applying the Impairment Tables

The Tables may only be applied to a person's impairment after the person's medical history, in relation to the condition causing the impairment, has been considered.

Comment

- As noted above, we propose that this clause be revised to take into account that the person's medical history may not be relevant, e.g., where the person's primary impairments relate to intellectual disability, or to a personality disorder.

An impairment rating can only be assigned to an impairment if the person's condition causing that impairment is permanent

Comments

- As discussed above, reference to the need for a condition causing an impairment to be 'permanent' is misleading and confusing - in terms of the DSP qualification criteria (s94 of the SS Act), which makes no such requirement (requiring instead a "continuing inability to work" for two years); and in terms of clause 3(b) of the Tables, which follows (the latter requires that for an impairment rating to be assigned, the impairment resulting from a condition needs to be "likely to persist" for two years.
- We propose that the Tables be amended so as to remove reference to requiring that a condition be 'permanent' for a rating to be given. The preamble should instead explain the legislation, including the concept of CITW, and provide context to the Tables.

For the purposes of paragraph 6(3)(a) a condition is permanent if:

(a) the condition has been fully diagnosed by an appropriately qualified medical practitioner; and

(b) the condition has been fully treated; and

Note: For fully diagnosed and fully treated see subsection 6(5).

(c) the condition has been fully stabilised; and

Note: For stabilised see subsection 6(6).

(d) the condition is more likely than not, in light of available evidence, to persist for more than 2 years.

Comments

- As noted above regarding impairment, it is contradictory and confusing to note the need for permanency of a condition, and then proceed to define 'permanent' as "likely ... to persist for more than 2 years."
- In EJA's members' experience, this is a source of confusion for DSP applicants, their doctors, and SA delegates alike.

In determining whether a condition has been fully diagnosed by an appropriately qualified medical practitioner and whether it has been fully treated for the purposes of paragraphs 6(4)(a) and (b), the following is to be considered:

(a) whether there is corroborating evidence of the condition; and

(b) what treatment or rehabilitation has occurred in relation to the condition; and

(c) whether treatment is continuing or is planned in the next 2 years.

Comments

- For the reasons outlined above, and in our submission to the DSP Senate inquiry, we propose that the qualifier "fully" be deleted from all references to "diagnosed", "treated", and "stabilised" in the Tables.
- We further note that a JCA, or indeed a Government Contracted Doctor (GDC), should not be required to effectively review and second guess a diagnosis duly made by a person's treating doctor or specialist on the basis of their patient's history, presenting symptoms, investigations and examination. Evidence submitted by the claimant may not be "corroborating" merely because they do not have or are not privy to the evidence on which the GP, clinical psychologist or specialist made their expert diagnosis.
- If the person has provided a report showing that they currently have a condition that has been diagnosed by an appropriately qualified medical practitioner, and that the condition is likely to persist for more than two years, this should suffice. We propose that the text of the Tables be revised accordingly.

For the purposes of paragraph 6(4)(c) and subsection 11(4) a condition is fully stabilised if:

(a) either the person has undertaken reasonable treatment for the condition and any further reasonable treatment is unlikely to result in significant functional improvement to a level enabling the person to undertake work in the next 2 years; or

(b) the person has not undertaken reasonable treatment for the condition and:

(i) significant functional improvement to a level enabling the person to undertake work in the next 2 years is not expected to result, even if the person undertakes reasonable treatment; or

(ii) there is a medical or other compelling reason for the person not to undertake reasonable treatment.

Note: For reasonable treatment see subsection 6(7).

Comments

- As outlined above, the "fully" qualifier needs to be removed
- Further, this is a case in point regarding the need to reintroduce treating doctor reports as part of the DSP claim package (see EJA's submission to the DSP Senate inquiry). As the situation now stands, it may take an AAT appeal, and provision of costly medical reports, to

inform a decision as to stabilisation of a person's condition when this could have been attested to at claim – by the person's treating doctor in a TDR.

Assessing functional impact of pain

(9) There is no Table dealing specifically with pain and when assessing pain the following must be considered:

(a) acute pain is a symptom which may result in short term loss of functional capacity in more than one area of the body; and

(b) chronic pain is a condition and, where it has been diagnosed, any resulting impairment should be assessed using the Table relevant to the area of function affected; and

(c) whether the condition causing pain has been fully diagnosed, fully treated and fully stabilised for the purposes of subsections 6(5) and (6).

Comments

- As noted in our commentary on specific Tables, below, pain can impair function.
- There is a pressing need for reintroduction of a table for assessment of the extent to which pain impairs function.

7 Information that must be taken into account in applying the Tables

Example: Unless specifically referred to by a descriptor in a Table, the following must not be taken into account in assessing an impairment: the availability of suitable work in the person's local community; English language competence; age; gender; level of education; numeracy and literacy skills; level of work skills and experience; social or domestic situation; level of personal motivation; or religious or cultural factors.

Comment

- Given that lack of motivation to be an aspect of psychiatric conditions, reference to lack of motivation should be removed from the example.

9 Use of aids, equipment and assistive technology

A person's impairment is to be assessed when the person is using or wearing any aids, equipment or assistive technology that the person has and usually uses.

Comment

- This requirement lacks nuance and leads to problematic assessments under particular impairment tables, including for people who use a wheel chair. Please see comments below.

10 Selecting the applicable Table and assessing impairments

Single condition causing multiple impairments

(3) Where a single condition causes multiple impairments, each impairment should be assessed under the relevant Table.

Example: A stroke may affect different functions, thus resulting in multiple impairments which could be assessed under a number of different Tables including: upper and lower limb function (Tables 2 and 3); brain function (Table 7); communication function (Table 8); and visual function (Table 12).

(4) When using more than one Table to assess multiple impairments resulting from a single condition, impairment ratings for the same impairment must not be assigned under more than one Table.

Comment

- This guidance is confusing and needs to be clarified, with an example.

Multiple conditions causing a common impairment

(5) Where two or more conditions cause a common or combined impairment, a single rating should be assigned in relation to that common or combined impairment under a single Table.

(6) Where a common or combined impairment resulting from two or more conditions is assessed in accordance with subsection 10(5), it is inappropriate to assign a separate impairment rating for each condition as this would result in the same impairment being assessed more than once.

Example: The presence of both heart disease and chronic lung disease may each result in breathing difficulties. The overall impact on function requiring physical exertion and stamina would be a combined or common effect. In this case a single impairment rating should be assigned using Table 1.

Comment

- In EJA members' experience, this commentary can lead to under-assessment on relevant Tables, with the result that people with significant disability are required to meet the POS requirement despite the fact that they have no capacity to engage in POS.

11 Assigning an impairment rating

(1) In assigning an impairment rating:

(a) an impairment rating can only be assigned in accordance with the rating points in each Table; and

(b) a rating cannot be assigned between consecutive impairment ratings; and

Example: A rating of 15 cannot be assigned between 10 and 20.

(c) if an impairment is considered as falling between 2 impairment ratings, the lower of the 2 ratings is to be assigned and the higher rating must not be assigned unless all the descriptors for that level of impairment are satisfied

Comment

- This guidance is confusing and it in fact makes no sense to provide that "the higher rating must not be assigned" given that it would only be assigned if all the descriptors for that level of impairment were satisfied.

Episodic and fluctuating conditions

(4) When assessing impairments caused by conditions that have stabilised as episodic or fluctuating a rating must be assigned, which reflects the overall functional impact of those impairments, taking into account the severity, duration and frequency of the episodes or fluctuations as appropriate.

Comment

- This is a useful guideline but in EJA members' experience can be overlooked by assessors.
- Given the problems that people with episodic disability can encounter in providing evidence that their condition has been "fully stabilised", we propose that this section be expanded, with more detailed guidance, and examples including both physical episodic conditions (such as chronic fatigue syndrome), and psychiatric conditions.

Part 3 – The Tables

Table 1 - Functions requiring Physical Exertion and Stamina

Comments

- As with all the Tables, the introductory notes for Table 1 point to the problems associated with effectively asking JCAs and GCDs to second-guess, dispute or invalidate a diagnosis made by a person's appropriately qualified medical practitioner (see comments above).
- The Table 1 descriptors for a 10 rating are confusing, with a) describing day-to-day functional impairments, and b) describing abilities relevant to work/the workplace.
- We propose that the 10 descriptors should clearly relate to and progress from the 5 descriptors.
- At the very least, should the "and" at the end of a) be "but", or "however"?
- For the 30 rating, we propose adding a progression from the 20 point rating at (1)(c), to enable a rating in relation to capacity to undertake or sustain work-related tasks of a "clerical, sedentary or stationary nature".

- This is an example of where the descriptors for rating levels do not progress logically from 10 to 30.

Table 3 – Lower Limb Function

Comments

- We believe that descriptors for this Table set an unrealistically high bar for the ratings, including by assessing whether a person is able to undertake a particular movement. For example, a person with cerebral palsy who does not use walking aids may be able to walk around a shopping centre or carpark without assistance, potentially each day, but they may do this at risk of falling and may regularly stumble or fall when doing such things in their private life. Choosing to walk around shops does not correlate with a workplace situation where a person may be required to undertake tasks that that would pose risk of falling.
- The ratings in this table also need to be reconsidered in light of the variable capacity of people to undertake tasks or activities despite pain. A person may choose to do things in their private life although these activities cause or exacerbate pain but they should not be expected to undertake work that causes pain.
- There is a need for a pain Table to be reintroduced, including to take into account pain associated with conditions of the lower limb, and pain associated with nerve damage and amputations.

Table 4 – Spinal Function

Comments

- This Table is another example of the need for a specific Table for pain.
- A spinal condition/injury causing intense pain may have no functional impact on activities involving spinal function in terms of these criteria because their pain is constant, and they do not avoid any of the movements listed.
- "Unable to bend forward to pick up a light object from a desk or table" is an unreasonably high bar for a person to be rated as severely impaired in the context of the workplace. For example, if a person is able to bend forward to pick up a light object (such as a pen on a table) as a one-off action), they do not meet this descriptor.
- We propose that a descriptor referring to inability to undertake multiple or repeated tasks would be a more reasonable test. A descriptor that relates to capacity to do that task repeatedly would more accurately reflect a workplace situation where people are required to undertake a range of activities in a day.
- Also, the descriptor takes no account of whether a person may be prepared to perform such tasks intermittently, despite pain, but could not countenance performing the task that causes pain repeatedly.

- We propose that the ratings in this table need to be reconsidered in light of the variable capacity of people to work through pain or sustain activities.
- There is a need for a Table assessing impairment related to pain to be reintroduced.
- Again, intense pain from a spinal condition can have extreme functional impact despite minimal impact on mechanical movement; and a person may choose to perform activities involving spinal function in spite of pain. This does not mean such a person in constant severe pain due to a spinal condition is fit for work.

Table 5 – Mental Health Function

Comments

- As discussed in EJA's submission to the DSP Senate inquiry, people with psychiatric conditions face significant barriers accessing DSP, primarily in relation to evidence requirements, and to the need to establish that a condition has been 'fully' diagnosed, treated and stabilised. Please refer to the comments regarding the preamble to the Tables, above.
- Although the guidance regarding episodic conditions is useful, it is often overlooked. See comments above regarding episodic conditions.

Table 7 – Brain Function

Comment:

- People with cognitive impairment face significant difficulty satisfying evidence requirements for claiming DSP, and establishing qualification. Please refer to EJA's submission to the DSP Senate inquiry for discussion of the many reasons why there is a need for reintroduction of a treating doctor report as a part of the DSP claim package.

Table 9 – Intellectual Function

Comment

- People with intellectual disability face significant difficulty satisfying evidence requirements for claiming DSP, and establishing qualification. Please refer to EJA's submission to the DSP Senate inquiry for discussion of the many reasons why there is a need for reintroduction of a treating doctor report as a part of the DSP claim package.

Table 10 – Digestive and Reproductive Function

Comment

This is another Table indicating the need for the impact of pain to be better assessed under the Tables, and the need for reintroduction of a specific pain table.

Table 13 – Continence Function

Comment

- The descriptors for this Table under-rate the impact of functional impairments such as incontinence on work participation.

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