Australian Government
Productivity Commission

Disability Care and Support

Productivity Commission
Draft Report
Volume 2

February 2011

This is a draft report prepared for further public consultation and input.

The Commission will finalise its report after these processes have taken place.

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An appropriate citation for this paper is:

Productivity Commission 2011, *Disability Care and Support*, Draft Inquiry Report, Canberra.

The Productivity Commission

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The Commission's draft report is in two volumes. **This volume 2 contains chapters 9 to 17, Appendix A and the References.** Volume 1 contains the Overview, the draft recommendations and chapters 1 to 8. Appendices B to J will only be available on the Commission's web site http.www.pc.gov.au. Below is the table of contents for both volumes.

Volume 1

Volume 2

9 Disability within the Indigenous community

Key points

- After correcting for differences in age structure, Indigenous Australians require assistance with a core activity at almost twice the rate of non-Indigenous Australians. In part, this is driven by socio-economic disadvantage and exposure to risk factors such as smoking, high body mass, physical inactivity, poor nutrition and substance abuse.
- There is some scope for the National Disability Insurance Agency, in cooperation with government agencies, to attempt to address the high rate of Indigenous disability through prevention and early intervention. However, addressing the socio-economic disadvantage that underlies the higher rate of Indigenous disability is an issue for all of Australian society and requires a long term whole-of-government approach.
- Indigenous Australians also face significant barriers to accessing disability support services. This occurs due to insufficient services in metropolitan and regional areas, social marginalisation, cultural attitudes towards disability and culturally inappropriate services.
- These barriers to service delivery access suggest that the market based service delivery system underpinning the proposed National Disability Insurance Scheme may not deliver adequate care and support to Indigenous people with a disability. While Indigenous Australians will have access to individualised funding on the same basis as non-Indigenous Australians, it may also be necessary to block fund some service providers in order overcome the additional barriers that Indigenous Australians face.
- A number of strategies can be used to improve accessibility of services for Indigenous people, including embedding services within local communities, employing Indigenous staff and developing the cultural competency of non-Indigenous staff.

Indigenous Australians have high rates of disability but access relatively few services or supports. The consequences of this are compounded by broad socio-economic disadvantage and the geographical isolation that many Indigenous Australians experience. This chapter highlights the importance of addressing

Indigenous disability, and provides a starting point for developing a strategy to best support Indigenous Australians under the NDIS. It does so by examining

- the extent and nature of Indigenous disability (section 9.1)
- some of factors underlying Indigenous rates of disability and preventing the uptake of existing supports (section 9.2)
- some of the options available to the NDIA in response to this challenge (section 9.3).

9.1 A snapshot of Indigenous disability

It is very difficult to provide an accurate depiction of disability within the Indigenous community. Prior to the 2002 National Aboriginal and Torres Strait Islander Social Survey (NATSISS), there were no national surveys of Indigenous disability. Two further data collections have occurred since this time, the 2006 Census and the 2009 NATSISS. However, there is reason to suggest that these surveys understate the extent of disability amongst Indigenous Australians.

First, surveys of Indigenous Australians are affected by higher rates of non-response. The estimated undercount (not responding to survey at all) in the 2006 Census was 2.7 per cent for non-Indigenous Australians and 11.5 per cent for Indigenous Australians (ABS 2006a). In addition, the non-response rate for the question about the need for assistance was 2 per cent for non-Indigenous Australians and 7 per cent for Indigenous Australians (ABS and AIHW 2008). This reduces the general accuracy of the estimate of disability and can also introduce sample selection bias. For example, if Indigenous people with a disability are less likely to respond to a survey than those without a disability, then the overall disability rate will tend to be underestimated.

Second, some Indigenous Australians find the concept of disability hard to understand or irrelevant, reducing the likelihood that the surveys accurately recorded disability. For example, the First Peoples Disability Network suggested that ‘in traditional language there was no comparable word to disability which suggests that disability may have been accepted as part of the human experience’ (sub. 542, p. 8).[1]

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[1] Similarly Arioti (1999) finds that while there are Pitjantjatjara word for specific impairments, there is no traditional word for the general concept of disability.

While the existing data may tend to understate the problem, they still suggest that disability is a serious issue for Indigenous Australians. There are two main dimensions to this:

- the reported rate of disability is considerably higher for Indigenous Australians than non-Indigenous Australians
- Indigenous Australians face greater barriers to accessing disability supports than non-Indigenous Australians.

Disability amongst Indigenous Australians

It is estimated that there are around 19 500 Indigenous Australians that need assistance with a core activity (Census 2006). This represents 4.6 per cent of the Indigenous population, which is higher than the rate of 4.4 per cent for the non-Indigenous population. However, Indigenous Australians have a much younger age profile than non-Indigenous Australians (due to a combination of a higher fertility rate and lower life expectancy). As disability rates tend to increase with age, unadjusted population estimates of disability rates will understate the difference between Indigenous and non-Indigenous Australians. Indigenous Australians between the age of 15 and 24 require assistance with a core activity at around 1.7 times the rate of non-Indigenous Australians, and this gap widens as they grow older. After standardising for differences in age structure, estimates based on the 2006 Census suggest that the rate of the need for assistance with a core activity is almost twice as high overall for Indigenous Australians as it is for non-Indigenous Australians (figure 9.1).[2]

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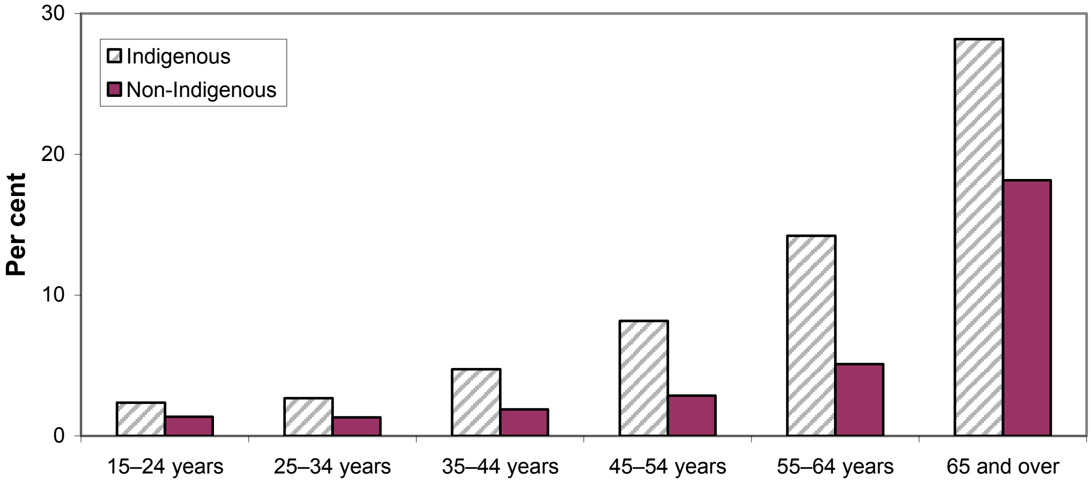
[2] ABS and AIHW (2008), have a slightly higher estimate, with Indigenous Australians requiring assistance with a core activity at 2.1 times the rate of Non-Indigenous Australians.

Figure 9.1 **Needs assistance with core activities**



Data source: SCRGSP (2009).

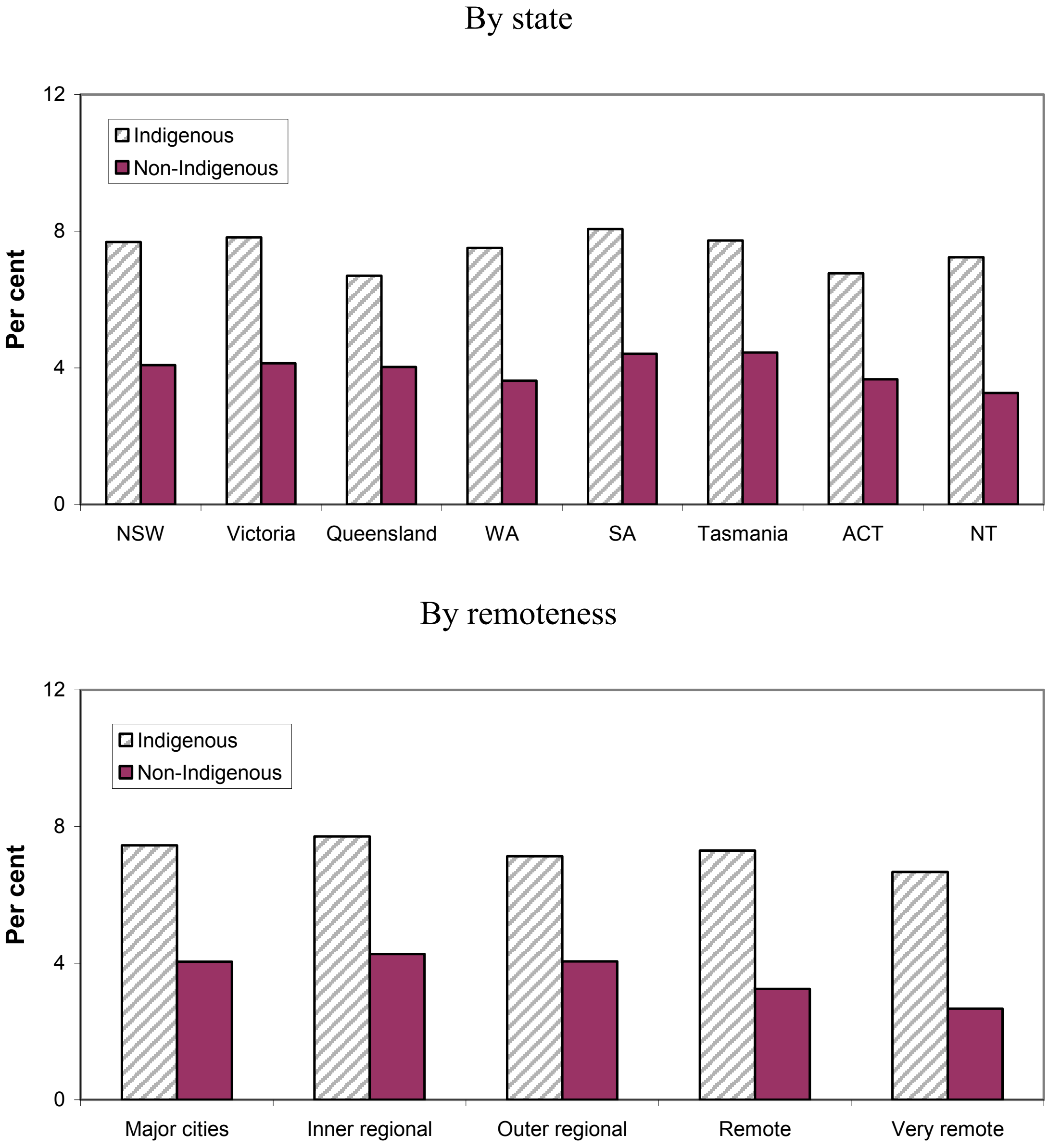
Indigenous Australians were more likely to require assistance with a core activity than non-Indigenous Australians in all states and at all levels of remoteness. The gap is greatest in the Northern Territory and Western Australia, and in remote and very remote areas (figure 9.2).

A range of health conditions and disabilities underlie the aggregate rate:

- Despite comprising only 3.8 per cent of the Western Australian population, Aboriginal children make up 8.4 per cent of all children born there between 1980 and 1999 with cerebral palsy (sub. 290, p. 3)
- Indigenous children (under 15) are 3.4 times more likely to be deaf (SCRGSP 2009 - Table 5A 7.2). Over 70 per cent of Indigenous children in remote communities suffer from chronic otitis media that can cause permanent hearing loss and inhibit language and literacy development. (Department of Education and Training, Western Australia 2006)
- In non-remote areas, Indigenous people are twice as likely to be obese as non-Indigenous people (SCRGSP 2009)
- Indigenous Australians are almost 12 times as likely to be hospitalised for care involving dialysis (SCRGSP 2009)
- Indigenous Australians are nearly four times as likely to have an intellectual disability (ABS 2006b)

- 28.2 per cent of Indigenous Australians self-reported their health as fair/poor, as compared with 14.5 per cent of non-Indigenous Australia's (ABS 2008b).

Figure 9.2 **Needs assistance with a core activity**



Data source: SCRGSP (2009).

Considerable resources are dedicated to supporting Indigenous Australians with a disability. In 2001-02 a total of $95.7 million was spent on Indigenous welfare services (CSDA funded disability services and HACC). This represents 3 per cent of total expenditures and around 30 per cent more was spent on Indigenous Australians per person, than non-Indigenous (table 9.1). However, given the higher rate of disability and multiple disability, as well as the significantly higher costs involved in servicing remote Indigenous communities, it is likely that this level of expenditure is still associated with significant under-servicing.

Table 9.1 **Total recurrent health-related expenditure, by program and Indigenous status, 2001-02**

	Expenditure ($m)			*Expenditure per person ($)*		
	Indigenous	Non-Indigenous	Indigenous Share	Indigenous	Non-Indigenous	Ratio
Total welfare services for people with a disability[a]	*95.7*	*3,013.90*	*3.1*	*208.66*	*159.01*	*1.31*
CSDA services						
Accommodation	37.2	1,374.80	2.6	81.22	72.53	1.12
Community support	16.9	282.2	5.6	36.76	14.89	2.47
Respite	9.1	142.4	6	19.84	7.51	2.64
Community access	6.7	292.3	2.3	14.72	15.42	0.95
Employment	5.1	256.2	2	11.11	13.51	0.82
Other	11.2	322.7	3.3	24.33	17.02	1.43
Other services						
HACC	8.7	208.9	4	18.93	11.02	1.72
Australian Government rehabilitation services	0.7	103.3	0.7	1.53	5.45	0.28
Low-level residential care	0.1	31	0.3	0.23	1.64	0.14
Health-related ACCHS services[b]	13.7	1.7	89.1	29.87	0.09	339.24

[a] Includes Australian Government administrative costs, excludes state and territory administrative costs, concession expenditure and services for older people. [b] Excludes state and territory government expenditure on ACCHSs.

Source: AIHW 2006, Expenditures on health for Aboriginal and Torres Strait Islander peoples, 2001-02.

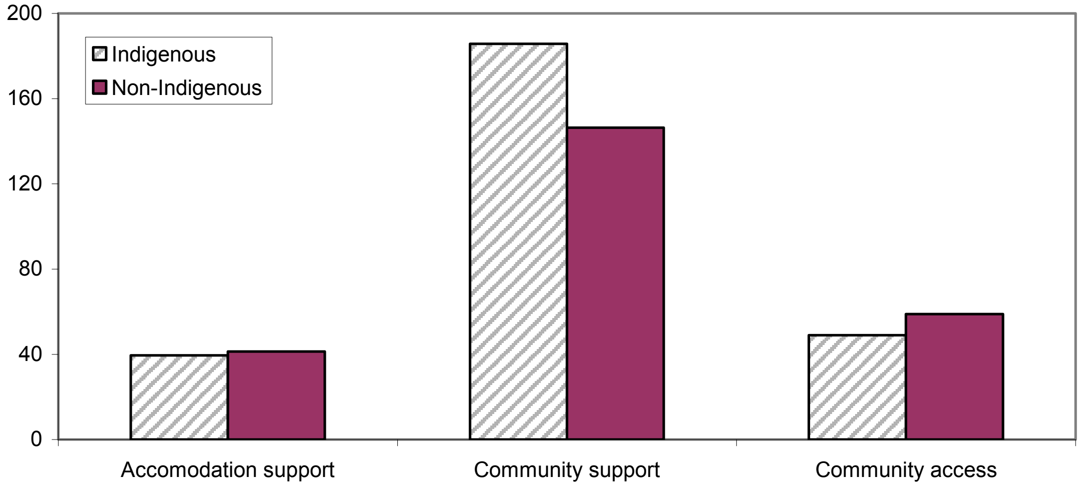
Use of services

The main source of data on the use of disability support services is the Disability National Minimum Data Set (NMDS). The NMDS data suggests that, given the underlying population with a disability, less Indigenous Australians with a disability use accommodation and community access services than non-Indigenous

Australians.[3] However, the gap is relatively small (figure 9.3). Use of community support services appears greater for Indigenous Australians than non-Indigenous Australians (SCRGSP 2010).

Figure 9.3 **Users of state and territory administered CSTDA funded services**

Users per 1000 potential population



Data source: (SCRGSP 2010).

This is somewhat at odds with the broad anecdotal evidence that Indigenous people with a disability face significant barriers when trying to access support (particularly in rural or remote settings) and are marginalised within the disability sector more generally (First Peoples Disability Network, sub. 542, p. 6, Australian Disability Network 2007, NSW Ombudsman 2010, Stopher and D'Antoine 2008,). This view was echoed in consultations between the Productivity Commission and State and Territory government agencies, as well as Indigenous-focused service providers.

The NDMS may inadequately reflect Indigenous Australians' access to disability services (or conceal the barriers that some Indigenous Australians face):

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[3] As expected given the higher incidence of disability, Indigenous people access CSTDA funded services at a considerably higher rate per 1000 population. If Indigenous people face additional barriers to access, it would be expected that this gap would also be observed in terms of the estimated population of people with a disability — referred to as the *potential population*. The NMDS data suggest that per 1000 potential population fewer Indigenous people with a disability access accommodation support (39.5 per cent versus 41.3 per cent) and community access (49.0 per cent versus 58.9 per cent) (SCRGSP 2010).

- as noted above, it is likely that the estimated number of Indigenous people with a disability significantly understates the real figure. If this is the case, the rate that Indigenous Australians access services will be overstated.
- there are wide variations in Indigenous service use by state, suggesting that access may be more of an issues in some areas than others (notably access is relatively low in New South Wales and relatively high in Victoria).

9.2 Challenges to supporting Indigenous Australians with a disability

High level of Indigenous disadvantage

Indigenous disadvantage across a range of indicators is broad in scope, profound and entrenched. In addition to higher rates of disability and chronic disease described above, gaps persists between non-Indigenous and Indigenous Australians in terms of life expectancy, child mortality, education attainment, income, employment and interactions with the justice system. Socio-economic disadvantage interacts with disability in a circular fashion (SCRGSP 2009). On the one hand, socio-economic factors contribute to the higher incidence of disability in the same way as they do in other disadvantaged groups in society. For example, low education attainment is linked to a higher rate of smoking, excessive alcohol consumption and poor nutrition amongst Indigenous Australians (ABS and AIHW 2008). These risk factors increase the chance of acquiring a disability. On other hand, disability entrenches socio-economic disadvantage. For example, Indigenous children with hearing loss suffer poorer education outcomes, which in turn limits their employment and income prospects.

Both socio-economic disadvantage, and higher levels of exposure to risk factors (such as tobacco, alcohol and violence) have been linked to the history of dispossession and marginalisation that has contributed to the breakdown of traditional family or societal structures, feelings of loss or despair and the social dysfunction that afflict some Indigenous communities (Salvatori 2010, Bostok 2004, sub. 542, p. 7). Indigenous Australians are twice as likely (on average) to engage in or be exposed to a range of activities that that can lead to disability, including smoking, binge drinking, using illicit drugs, and being victims of violence. Indigenous Australians are also more likely to be physically inactive and subject to more than one of these risk factors (AIHW 2008). These risk factors explain a large proportion of the difference in health outcomes and rate of disability between Indigenous and non-Indigenous people (table 9.2).

Table 9.2 Risk factors contributing to the difference in Disability Adjusted Life Years[a] between Indigenous and non-Indigenous Australians

Risk Factor	*Percentage contribution to the gap in DALYs between Indigenous and non-Indigenous Australians*
Tobacco	17.4
High body mass	15.9
Physical inactivity	11.6
High blood cholesterol	7.1
Alcohol	6.8
High blood pressure	5.7
Low fruit and vegetable intake	5.1
Illicit drugs	3.8
Intimate partner violence	3.3
Child sexual abuse	1.5
Unsafe sex	1.6
11 Risk factors combined[b]	48.5

a Disability Adjusted Life Years are a measure of the burden of disease that takes into account the effect on life expectancy and the amount of time spent with a disability

b This estimate takes account of the combined causal pathways between many of these risks factors, and thus is lower than the sum of each effect considered in isolation.

Source: Calculations based on Vos et al. 2003.

Social marginalisation and mistrust of authority

Numerous participants in this inquiry noted that negative experiences within communities and with government agencies or service providers can make Indigenous Australians with a disability reluctant to seek support. As noted in the NSW Ombudsman’s report:

> For Aboriginal people, a collective legacy of negative experiences with mainstream agencies and services has led to a significant degree of fear and mistrust (2010, p. 27)

This issue was also noted at the first state conference of the Aboriginal Disability Network of New South Wales was that:

> Some Aboriginal people retain the fear that their children will be removed by government authorities. Furthermore that Aboriginal children remain over represented as wards of the state and that Aboriginal children with disability and Aboriginal parents with disability remain vulnerable to this fact. (ADN 2002, p. 8)

Even in the absence of specific negative experiences, Indigenous Australians may be reluctant to seek services because of a general sense of social exclusion, or a feeling that services are there for white people and not them. Hepburn (2005) relates the following view from a rural worker:

> Indigenous people in rural country areas don't feel they are part of, or are welcome, in the rural towns. They feel that mainstream services do not or are not willing or able to provide a service for them. If they need assistance or support they are afraid to ask for help or they feel that it would be a waste of time and effort. Many people have a defeatist attitude towards services. They are more likely to say things like 'They won't help me". (p. 20)

Similarly, Stopher and D'Antoine (2008) quoted once participant in their study who stated 'Aboriginal people are reluctant to use services as they feel they are for whitefellas'. (p. 13).

In other situations, some mainstream providers may be unwilling to take on Indigenous clients because they feel there are specialised services funded to do so (NSW Ombudsman, p. 30).

Indigenous perceptions of disability

Some Indigenous Australians, particularly those living a more traditional way of life, have a different perception of disability to non-Indigenous Australians (First Peoples Disability Network, sub. 542, p. 8). Indigenous views on disability are diverse, matching the diversity of Indigenous cultures and beliefs, the diversity of individual lived experience with disability and individual's economic and social standing (Senior 2000). Nevertheless, two frequently cited generalisations about Indigenous perception of disability may be relevant to the delivery of disability support services in some areas:

- some Indigenous people may not have a general concept of disability, which can result in under-reporting (as noted above) and, potentially, under utilisation of the available supports from government or service providers.
- some Indigenous communities view some types of disability (such as congenital disabilities) as a consequence of 'marrying wrong' (First Peoples Disability Network, sub. 542. p. 8), or attribute it to supernatural causes stemming from eating certain foods or doing certain activities while pregnant (Senior 2000). While this is a potential source of shame that may dissuade some Indigenous Australians from seeking support, Elliot (1994) and Senior (2000) suggest that stigmatisation within communities is limited.

Like many groups in Australia, Indigenous Australians have a strong cultural belief that it is the responsibility of family to provide care and support. As noted by O'Neil, Kirov and Thomson (2004), 'throughout Australia — in remote, rural and urban areas — most Indigenous people with a disability were, and are, cared for within their extended family'. This presents a particular challenge for supporting Indigenous Australians with a disability. On the one hand, a core component of a 'good' disability system is respecting the wishes of people with a disability and those who care for them — including the cultural beliefs about the appropriate role of family. On the other hand, there is a risk that assumptions about Indigenous family care could result in an excessive burden of caring, and/or inadequate levels of care. This is a particular issue when families' capacity to offer care and support is affected by socio-economic disadvantage (such as poverty), carers' own health problems, family breakdown or social dysfunction. The death of Kate Bugmy in 2007 presents a tragic example of this. As noted by State Coroner Mary Jerram (2010):

> The extreme disabilities with which Kate Bugmy was born required fulltime care, with which her family struggled to cope, staunchly resisting alternative, outside care. Although that resistance clearly arose from love, it came at a price and may not have been best for Kate, at least in her later years (p. 11).

Cultural competence

The norms, beliefs and expectations embodied within a culture have value within their own right. They also make it easier for people within a cultural group to communicate, and for human interaction and ordinary social exchange to take place (including marketplace exchange). Conversely, people from different cultural backgrounds may find such interactions more difficult and miscommunication more frequent. Many Australians who identify as Aboriginal or Torres Straight Islander experience little difficulty in understanding or interacting with non-Indigenous Australians, including those providing disability support services. However, in some cases, differences in cultural background between service providers and Indigenous Australians can form an impediment to effective delivery of support services. Indigenous culture is diverse (meaning cultural competence within one area may not be relevant to another), but some commonly identified areas where cultural differences impact on the delivery of disability support services include:

- perception of disability (discussed above)
- relationship to the land
- triggers and responses to shame (O'Neill, Kirov and Thomson 2004; Jenkins and Seith 2004)
- rules governing the interactions between men and women, and within kinship systems (SNAICC 2010)

- styles of communication, including the use of eye contact, silence within conversation, and appropriate ways of requesting information (Pheonix consulting, sub. 311, p. 1; Jenkins and Seith 2004; McConnel 2010; SNAICC 2010)

Such cultural differences can result in service offerings that are not attractive to Indigenous Australians,[4] or misunderstandings that give Indigenous Australians a negative impression of disability support services. It can also make service providers tentative about proactively seeking Indigenous clients. As noted by Regan and Harriden (2008):

> In general, non-Aboriginal service providers appeared to be anxious about their ability to engage with Aboriginal people and services in a culturally appropriate manner. This idea is perhaps best summed up by a respondent who noted that the "fear of 'doing the wrong thing' by non- Aboriginal service staff" was one of the dominant issues limiting their work with Aboriginal communities. (p. 14)

Conversely, some Indigenous Australians who want to engage with the disability system may be constrained by a lack of knowledge about the necessary requirements (such as paper work and personal information), or lack confidence or understanding of their rights or entitlements.

Salvatori (2010), describes how the feeling of cultural misunderstanding, combined with broad disadvantage and negative past experiences can be a powerful deterrent to seeking support:

> When accessing mainstream services, the effects of trans-generational trauma can be evidenced when clients feel inferior, shamed, misunderstood, not educated enough and feel that they have no voice. Aboriginal people have different ways of communicating and thinking and feel that the Aboriginal 'way of being' is not understood. Feelings of intimidation, racism and fear due to past history often stand in the way and keep our clients from using mainstream services. Many do not feel safe.

Isolation

Almost half of Indigenous Australians live in outer regional, remote or very remote areas, compared to around 10 per cent of non-Indigenous Australians (figure 9.4). There is significant variation across jurisdictions. For example, Victoria has a relatively urban Indigenous population, with 84 per cent living in a major city or

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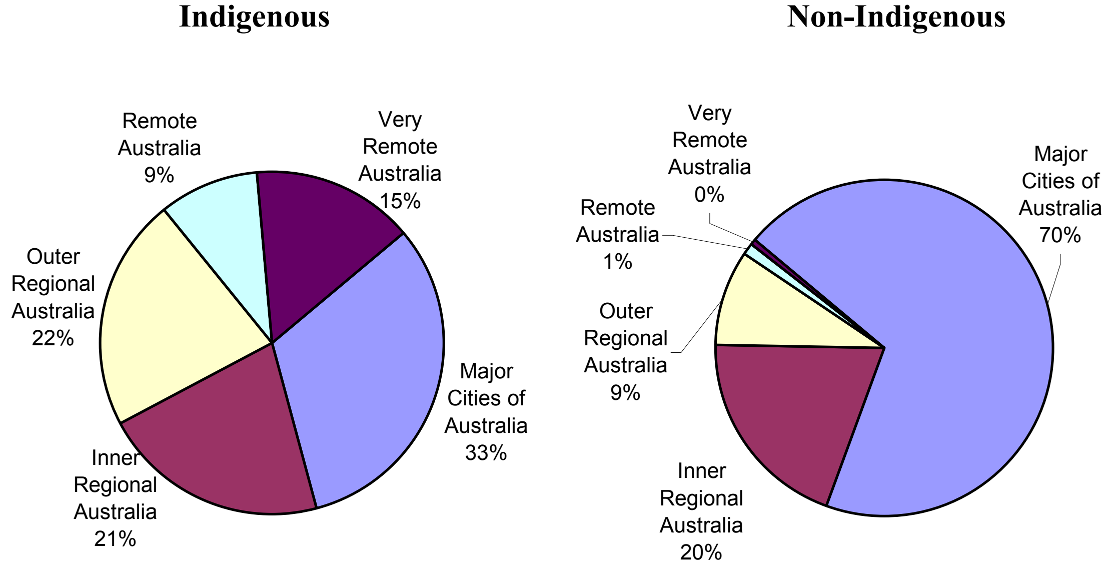
[4] For example culturally inappropriate activities at day care centres (O'Neill, Kirov and Thomson 2004, p. 7).

inner regional area.[5] Conversely, around 80 per cent of Indigenous Australians in the Northern Territory and 42 per cent of in Western Australia, live in remote or very remote areas.

Figure 9.4 **Proportion of the population by remoteness area, 2006**



Data source: Experimental Estimates of Aboriginal and Torres Strait Islander Australians, ABS, Cat. no. 3238.0.55.001.

As with other services (such as health and education) remoteness creates particular difficulties in providing disability services to Indigenous Australians. These difficulties are compounded by

- lower levels of vehicle ownership by Indigenous Australians (77 per cent versus 90 per cent). In very remote areas vehicle ownership is 47 per cent for Indigenous people
- inadequate or no public transport options (with taxi drivers sometimes reluctant to enter Indigenous communities - Australian Disability Network 2007)
- difficult weather conditions in some areas, including regular periods of heavy rain and flooding.
- lack of access to appropriate housing and urban infrastructure (including clean water and sanitation)
- lack of access to specialists.

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[5] Interestingly, Victoria has a dramatically higher rate of usage of CSTDA funded services by Indigenous Australians than other states and territories.

Remoteness reduces the scope of the services that can be delivered, and dramatically increase their costs. In some communities, only ‘fly in fly out’ services are available — for example for respite or specialists. This approach cannot provide adequate support for people with a high level or complex needs on an ongoing basis and Indigenous Australians with disabilities will sometimes need to move to regional centres to receive the supports they need. However, as many Indigenous Australian’s have a strong bond with both the land and their local community, they may be very reluctant to do so.

Language barriers

For many Indigenous Australians, particularly in remote areas and among older people, language can be a barrier to accessing services, or can lead to misunderstandings or ineffective service provision. For some Indigenous Australians, English was not the first language learnt, nor is it the main language used. In other areas, local varieties of English are spoken, which can also make communication difficult. The NATSISS (2008) suggests that around 11 per cent of Indigenous Australians aged 15 and over speak an Aboriginal or Torres Straight Islander as their main language overall, and around 40 per cent in remote areas.

9.3 Indigenous disability and the NDIS

Addressing the high rate of Indigenous disability

The most important issues surrounding Indigenous disability is its relatively high incidence compared with the non-Indigenous population. This gap is driven by complex combination of socio-economic disadvantage and exposure to a broad range of risk factors (such as smoking, binge drinking, obesity, substance abuse and violence). Addressing Indigenous disadvantage has been a longstanding (and so far largely unsuccessful) policy objective of a broad range of government initiatives. This effort was formalised in 2008, in the form of the COAG agreements that make up the Closing the Gap initiative (box 9.1). This initiative commits governments to working toward reducing Indigenous disadvantage as revealed through a set of specified indicators. Closing the Gap is aimed at providing greater transparency and accountability of government, greater coordination of effort, increased and more consistently maintained resources, and improving the knowledge base.

Addressing broad disadvantage requires the ‘whole-of-government approach’ contained with the Closing the Gap initiative, which raises the question as to the appropriate role of the NDIS. Many areas (such as increasing year 12 attainment rates) are clearly beyond the scope of the NDIS. However, other initiatives, particularly in the health area, are more closely aligned to the objectives of the scheme. Specifically, part of the function of the proposed NDIA is to fund early intervention and prevention approaches in areas where there is robust evidence of both effectiveness and cost effectiveness (chapter 11). While not a frontline provider of such interventions, there may be a role for the NDIA, in cooperation with other government agencies (such as the Australian National Preventive Health Agency), to fund preventative measures with an Indigenous focus. There may also be a role for the NDIA to fund or conduct research specifically directed towards the prevention or treatment of conditions that are pervasive in the Indigenous community and could potentially result in long term disability.[6]

For example, early intervention targeting otitis media (which can lead to deafness) among Indigenous children could potentially decrease the rate of disability and have important socio-economic flow on effects (such as improved educational outcomes). The NDIA, in co-operation with Indigenous communities, state and territory health agencies and Australian Hearing, could expand initiatives aimed at reducing the incidence of otitis media in children through:

- Indigenous community led ear health education programs
- early intervention through mobile ear health clinics
- other types of preventative interventions with demonstrated benefits, such as the provision of swimming pools in local schools (SCRGSP 2009).

However, it is not obvious the extent to which responsibility for such prevention activities should lie with the NDIA or with existing government agencies, or how collaborative efforts could be encouraged and facilitated. It would obviously be undesirable for the NDIA to duplicate the efforts of existing agencies with greater expertise, or to run programs that are inconsistent or conflict with existing ones.

The Commission seeks further feedback on the merits of the NDIA funding prevention and early intervention measures specifically targeting Indigenous communities, and how this could work in practice.

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[6] For example, based on insights yielded from the NDIS database.

Box 9.1 **Closing the Gap**

The Closing the Gap initiative is a joint effort by all levels of government to reduce the disadvantage experienced by Indigenous Australians. It is underpinned by a set of agreements by the Council of Australian Governments (COAG) to work towards reducing the disparity revealed by a set of specific indicators within a nominated time frame. The National Indigenous Reform Agreement (NIRA) commits COAG to

- closing the life-expectancy gap within a generation
- halving the gap in mortality rates for Indigenous children under five with a decade
- ensuring access to early childhood education for all Indigenous four year olds in remote communities within five years
- halving the gap in reading, writing and numeracy achievements for children within a decade
- halving the gap for Indigenous students in Year 12 (or equivalent) attainment rates by 2020 (amended to 2015 in April 2009)
- halving the gap in employment outcomes between Indigenous and non-indigenous Australians within a decade.

NIRA also contains the over-arching framework for Closing the Gap, including the service delivery principles that should be adhered to and the basic ‘building blocks’ that governments should focus on in order to make progress on the Closing the Gap targets. These are early childhood, schooling, health, economic participation, healthy homes, safe communities and governance and leadership.

These objectives are pursued through a number of specific agreements that commits governments to a common framework of outcomes, progress measures and policy directions’ and ‘ builds on current initiatives, address shortfalls and in many cases provide significant additional funds’ (FaHCSIA 2011). These agreements relate to health, housing, early childhood development, economic participations, remote service delivery, remote internet access, and closing the gap in the Northern Territory.

Source: (FaHCSIA 2011).

Getting services to Indigenous people with a disability

While the obstacles to service delivery described in section 9.2 are frequently noted in the literature, there is no clear guide as how prevalent or important they are in practice. For health services, it appears that scarcity and proximity are more important issues than mistrust or culturally inappropriate services (table 9.3).

Table 9.3 Types of problems faced by Indigenous Australians aged 15 years and over seeking health services years, 2008

	Non-Remote	*Remote*
	%	%
Waiting time too long/not available when needed	55.0	33.2
No services in the area	27.3	50.9
Not enough services in area	34.0	47.1
Transport/distance	24.7	45.8
Cost of service	37.5	16.5
Don't trust services	7.3	5.6
Services not culturally appropriate	5.5	4.7

Source: ABS and AIHW (2008).

To the extent that this holds true for disability services, the increased resources under the proposed NDIS, combined with support from case managers and advocacy groups, will bring about a dramatic increase in the supports they receive. Indigenous Australians living in rural areas will be supported by regional NDIS offices and will be able to access self-directed funding on the same basis as all other Australians. More generally, the increased choice and flexibility of the proposed scheme will empower many to seek out the supports that best suit their individual situation.

Nevertheless, the cultural appropriateness of disability services and perceptions of government, service providers and the NDIA itself may become relatively more important as shortages in the disability sector are eased. It is not clear that the proposed consumer choice model would, on its own, adequately facilitate the delivery of such services. The remoteness of some Indigenous communities is one factor inhibiting the emergence of a competitive market for disability support services. However, in both rural and urban settings, socio-economic disadvantage, marginalisation and a lack of culturally appropriate services are a major barriers inhibiting many Indigenous Australians from accessing the services and supports available to them and exercising their consumer rights effectively.

For this reason, block funding the provision of disability support services specifically focussed on ensuring Indigenous people with a disability can access the supports they need, is likely to remain a feature of the disability system under the NDIS, at least over the short to medium term. In order to make good funding decisions and provide guidance for service providers, the NDIA will need to develop an understanding of the characteristics of effective service delivery to Indigenous Australians. While the experience of state and territory government agencies will be a valuable source of expertise, the Commission recognises the difficulty and complexity of this task. There are no easy or comprehensive answers. Moreover, it is often unclear how broadly the lessons from local solutions can be applied — often solutions will be specific to circumstances of a specific community and place based planning will be the appropriate approach. Nevertheless, there is a growing literature describing the basic strategies that can assist in meeting the needs of Indigenous people. Some of these are discussed in the following section.

Embedding services within the community

The extent to which disability services are 'in and of' the Indigenous communities they serve is a critical factor to their acceptance and success. The capacity of not-for-profit providers to be representative of the communities they serve suggest they may have an advantage over government run services in this area (Productivity Commission 2010a), particularly if they are managed by the Indigenous community themselves. Also, having staff that are culturally competent or Indigenous themselves is clearly an important part of service providers gaining acceptance (discussed below).

Beyond this, establishing trust and rapport with Indigenous communities is a long-term task involving integration into the social, political and economic activities of the community (NDS 2010, Gilroy 2008). While there is no one way to achieve this, some common strategies includes:

- participating in local events and community meetings
- establishing relationships with other Indigenous services providers, schools and medical centres. In particularly, in remote communities Aboriginal Medical Services[7] may be a hub of 'community activity connection and organisation' – making them a useful contact point for newly established disability support service providers (SNAICC 2010, p. 41). However, an evaluation of coordinated care trials suggested that the effectiveness and community acceptance of these organisations themselves can be mixed DOHA (2007).
- using existing networks, getting referrals from trusted sources within the community and establishing a mechanism through which ongoing communication with key elders, community workers and other service providers can occur (Regan and Harriden 2008).

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[7] Sometimes referred to as Aboriginal Community Controlled Health Organisations.

- effective and authentic consultation with the community.[8] The Community Health Committees used in the Sunrise Health trial is useful example of this (DOHA 2007)
- developing an understanding of local community. This includes community and family structure, the identification of influential community members and elders and an awareness of community politics and factions (NDS 2010).

Indigenous staff

The value of Indigenous staff to service providers and their clients is widely acknowledged (O'Neil, Kirov and Thomson 2004). Gilroy (2008) outlines a number of reported benefits to service providers from having Indigenous staff, including:

- increased-cross cultural awareness of the organisation
- greater awareness of local indigenous issues (both cultural and political)
- greater capacity to network with Aboriginal community services and develop programs that effectively target and cater for Indigenous clients.

While hiring Indigenous staff members may lead to complications arising from broader community tension in some areas (for example between kinship factions)[9], overall the presence of Indigenous staff appears to have a strong affect on use of services by Indigenous people (NDS 2010, p. 28). Similarly, the NSW Ombudsman (2010) states:

> While it is a myth that Aboriginal people will not utilise mainstream services simply because they do not employ Aboriginal staff, it is clear that employing Aboriginal workers is one of the most effective ways for organisations to demonstrate that they welcome Aboriginal clients and are capable of providing culturally responsive services. (p. 23)

For this reason, there is merit in both the NDIA (for example as case managers attached to regional NDIS offices), and service providers in communities with

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[8] The NSW Ombudsman (2010) noted that a common criticism by Indigenous people is that communities are not consulted until after decisions are made about the development and implementation of programs (p. 7).

[9] The NDS (2010) suggested that in areas where kinship factions are prominent, employing an Indigenous Australian from one family group can reduce the prospect of recruiting from or delivering services to another. the NDS (2010) and ADN (2007) suggest that in some cases Indigenous run service providers face similar issues. Potential responses to this is are deliberately hiring from multiple family groups, and involving elders in conflict resolution. ADN (2002).

substantial Indigenous populations, establishing dedicated positions for Indigenous people within their organisations.

Success in recruiting Indigenous staff is dependent on a number of factors, such as reputation in the community (NDS 2010) and whether there are already Indigenous staff within the organisation (Gilroy 2008). The NDS (2010) provided a number of recommendations to assist recruitment, including having Indigenous Australians on the recruitment panel, working with Aboriginal job network services and offering traineeships. Gilroy (2008) argued that a lack of skills or qualifications is common barrier to recruiting Indigenous Australians and suggested a greater role for government to assist service providers with the costs of training and development.

Working conditions can also be difficult for Indigenous staff, which can cause problems with staff retention. This has a number of facets:

- Indigenous staff being ‘pigeon holed’ into positions that solely deal with indigenous communities. This can reduce career opportunities and impact upon workplace satisfaction (NDS 2010).
- A shortage of Indigenous staff can result in them being overloaded with work, which, combined with cultural expectations, can lead to staff working significant unpaid overtime (Hepburn 2005).
- Indigenous staff may be caught between the conflicting demands of their employers and their community. For example, member of the Indigenous community may ask Indigenous staff for things that agency policy forbids from providing, such as money, transportation or simply taking the time visit elder groups and socialise with Aboriginal community members while at work (O’Neil, Kirov and Thomson 2004; NDS 2010). However, refusing such requests may undermine their standing in the community.
- standard working conditions may be difficult to reconcile with personal cultural responsibilities (such as attending funerals). Conversely, Indigenous staff who can access more flexible working conditions may experience friction with non-Indigenous staff, who feel they receive preferential treatment (ARP 2010).

Appreciating the additional pressures that Indigenous staff may be facing will be an important factor in developing strategies for staff retention. Beyond this, the NDS (2010) also recommended building the capacity for non-Indigenous staff to serve the needs of the Indigenous community, thereby alleviating some of the demands made on Indigenous staff. This is reliant on non-Indigenous staff developing a sufficient level of ‘cultural ‘competence’ and understanding of the Indigenous community they serve. This is discussed in the following section.

Indigenous Cultural Awareness Training

Cultural competency arises from a number of sources, including

- individual staff experience with Indigenous communities
- the institutional knowledge base developed by providers as to what service delivery strategies are most effective and appropriate in meeting the needs of Indigenous clients in different situations (itself derived through organisational experience and consultation).

Beyond this, Indigenous Cultural Awareness Training (ICAT) is an important and widely used strategy for improving cultural competency in dealing with Indigenous clients or staff. It is offered within the mainstream education system (such as university and TAFE), by specialist training providers and sometimes ‘in-house’ by organisations themselves. In some cases, funding agreements between government agencies and disability service providers require a certain proportion of staff to have undertaken ICAT (Gilroy 2008). Courses tend to follow a short workshop format and aim to provide a better understanding of Indigenous culture and history, to develop skills and strategies for better service provision and to improve cross cultural communication skills.

Whilst an important strategy, a number of studies caution against assuming that ICAT can provide a stand alone solution to the achieving cultural competency and that a tokenistic, ‘rubber stamp’ approach to ICAT is contrary to its stated objectives (NDS 2010, Gilroy 2008). Moreover, like other education and training services, the quality of ICAT providers, and the applicability of course content to disability support services providers, is likely to be varied. In particular, the NDS (2010) noted that courses with generalised (rather than specific to disability support services) and non-local content were less effective. In some instances, ICAT appeared to have been counter-productive:

> Many disability services reported that aboriginal cultural awareness training (ACAT) can make disability workers feel intimidated and apprehensive in working with Aboriginal people. The ARP received reports of disability service staff leaving ACAT feeling averse and disinclined to engage with the Aboriginal community for fear of insulting people. Some disability service staff reported that ACAT reinforces the perception that Aboriginal people are difficult service users. (pg. 18)

These issues highlight the point that the ICAT should be an output, rather than input based exercise (that is the goal should not be to ‘tick the box’ but rather to develop cultural competence in a practical way that improves the service offering). Nevertheless ICAT should remain a key tool to improving cultural competency, alongside an ongoing commitment by service providers to developing their own local knowledge base about cultural competent services practices that can be used as guide by staff. Gilroy (2008) and the NDS (2010) suggest a number of features that are likely to increase the usefulness of ICAT to service providers, including:

- being locally focused
- being practical in nature and relating specifically to disability services
- involving the local community in training
- providing information on important people (such as elders) and organisations (such as other not-for-profit service providers or aboriginal-owned business) with whom to establish networks
- covering other relevant topics such as appropriate communication styles, appropriate topics for conversation, myths and misconceptions, cultural taboos or sensitivities, and gender roles (such as men's business and women's business).

Conclusion

Supporting Indigenous Australians with a disability should be an important, specific goal of the NDIS. A key challenge to achieving this goal is overcoming the barriers to accessing services experienced by Indigenous people experience. The market based service delivery system underpinning the proposed NDIS will not always be the most appropriate funding method, at least for the medium term. In such cases, the NDIA should block fund service providers to deliver disability supports to Indigenous Australians. In doing so, it should work with existing government agencies, Indigenous advocacy groups, funded service providers and the Indigenous community.

Indigenous people themselves are a key resource in addressing Indigenous disability. There are considerable advantages in employing Indigenous staff, and from fostering the development of not-for-profit service providers managed by Indigenous members of the local community. However, this can present a governance and accountability challenges where the skills and experience necessary to run such organisations are limited. One potential response to this is to use a lead agency type model, whereby a larger experienced service provider supports smaller community based operations that engage local staff . This could allow local Indigenous service providers to build their administrative and organisational capability, with the long-term objective of handing over control entirely.

While the proposed scheme will seek to dramatically improve the standard of living for many Indigenous Australians with a disability, there are limits to what can realistically be expected to be achieved. First, the diversity and level of care and support available in major cities cannot be replicated in very remote areas. In some cases, Indigenous Australians with complex needs will have to move to regional centres or major cities to receive the appropriate care and support (as is also the case with non-Indigenous Australians). Additionally, in some cases non-government service providers may be unable or unwilling to service very remote communities. In such cases government run service providers may be the only practical option. Similarly, in remote settings, sharing infrastructure (for example with health or aged care), while not ideal, may also be necessary.

Second, as the NDS is (by definition) primarily focused on offering support to people with a disability, it does not directly address the underlying issue of the relatively high rate of Indigenous disability. The causes of this lie in the socio-economic disadvantage and marginalisation experienced by many Indigenous Australians and the risk factors to which they are exposed. While the NDS may have a role in funding early intervention and prevention approaches, it is not a panacea for broad Indigenous disadvantage. Addressing Indigenous disadvantage is an issues for all of Australian society and requires an ongoing cooperative approach from all levels of government and the Australian people (both Indigenous and non-Indigenous) more generally.

DRAFT RECOMMENDATION 9.1

The Australian Government and state and territory governments should consider the feasibility of overcoming the barriers to service delivery in the NDIS for Indigenous people with a disability by:

- ***fostering smaller community-based operations that consult with local communities and engage local staff, with support from larger experienced service providers***
- ***employing Indigenous staff***
- ***developing the cultural competency of non-Indigenous staff.***

In its initiatives for delivering disability supports to Indigenous people, the NDIS should be mindful of the wider positive measures addressing Indigenous disadvantage being adopted throughout Australia.

10 Collecting and using data under the NDIS

Key points

- An effective evidence base under the National Disability Insurance Scheme (NDIS) will be critical to ensure the financial sustainability of the scheme, the provision of cost-effective services and interventions (that which yields the best outcomes for clients at low cost), and good performance from service providers.
- A crucial component of an effective evidence base will be extensive and robust data systems that:
  - are compatible across jurisdictions and within the disability system
  - supported by adequate information technology (IT) and administrative systems
  - include outcomes data
  - involve the creation of a longitudinal database of clients' information, which includes one time registration and clear rules on data entry (to ensure data integrity) and access (to ensure confidentiality and privacy for the client).
- As well as good data and associated IT and administrative systems, an effective evidence base under the scheme will include:
  - a capacity for independent research
  - the application of appropriate methods of analysis
  - transparency of data and research findings, subject to meeting requirements for confidentiality and privacy, and responsible and ethical research conduct
  - effective integration of data and research findings with decision making by scheme administrators, clients and service providers.
- Implementation of an effective evidence base under the NDIS will be a large and complex endeavour, requiring careful planning and sequencing as well as considerable consultation and cooperation among stakeholders within the disability system.
  - The National Disability Insurance Agency should drive implementation, which needs to commence as soon as possible after the Agency's establishment.

10.1 Introduction

Data are a key aspect of a good insurance scheme (and badly lacking in the current disability system). As one participant remarked to the Commission, data are the 'lubricant of a well-functioning system'. Its absence would undermine the efficiency and effectiveness of the National Disability Insurance Scheme (NDIS) and, in particular, pose a threat to the capacity of the scheme to remain financially sustainable. This reflects the fact that, by its nature, most people with disability (who would be covered by the scheme) require funded supports over their lifetime. A cost pressure today creates ripples throughout the future. Real-time monitoring of claim patterns and cost pressures, and the likely long-term implications of these patterns for the scheme's future liabilities is essential to maintain the financial sustainability of the scheme. As the Victorian Government said, the financial dynamics of insurance schemes with liabilities of this type are complex:

> … the estimates of liabilities and required funding are highly uncertain, and the nature of what services are provided — and at what cost — evolves over time. … An understanding of the very long-term nature of the liabilities and the financial implications of strategies and decisions are essential if the scheme is to be sustainable. (sub. 537, p. 24)

Quite apart from their central role in financial sustainability, data and other aspects of an effective evidence base — such as good quality research and analysis — under the scheme are crucial to ensure:

- the provision of cost-effective services and interventions — that is, supports that yield the best outcomes for clients at low cost — including:
  - when to make investments in aids, appliances, home and vehicle modifications, training or other non-recurrent expenditures to reduce future recurrent spending
  - monitoring outcomes for clients
- good performance from service providers, while controlling costs, including:
  - the identification of over and under-servicing by service providers and assessors, and fraud more generally among all stakeholders.

To achieve an effective evidence base, the NDIS will need extensive and robust data systems that are consistent across jurisdictions and different parts of the disability system. Information technology (IT) and administrative systems will be needed to underpin data systems as well as to provide effective and secure communication channels between clients, scheme administrators, service providers, and agencies in the health sector.

As well as good data and associated IT and administrative systems, an effective evidence base under the scheme will include:

- a capacity for independent research
- the application of appropriate methods of analysis
- transparency of data and research findings, subject to appropriate confidentiality and privacy safeguards as well as requirements on responsible and ethical conduct by researchers
- the effective integration of data and research findings with decision making by scheme administrators (as well as clients and service providers).

The remainder of this chapter discusses in further detail deficiencies in the existing evidence base of the disability system as well as the objectives, features and implementation of an effective evidence base under the scheme.

10.2 Deficiencies in the existing evidence base

There are isolated pockets within the disability system where the evidence base is currently of high quality. Indeed, high quality data, together with their analysis, are critical to the activities of commercial insurers and government agencies that administer accident compensation schemes such as compulsory third party (CTP) and workers compensation schemes. Insurers and agencies in these schemes typically:

- centre on the client
- collect data to help them contain costs and improve outcomes
- accumulate evidence as to what works and what is less effective, allowing ongoing changes in the approaches taken to their clients
- are informed and active purchasers, getting good deals from service providers
- more closely monitor the performance of their claims managers, assessors and contractors than might otherwise be possible
- apply information constantly throughout their organisations and encourage a culture of continuous learning and improvement.

There has also been growing recognition of the need for improvement in the evidence base of the disability system. As National Disability Services noted:

> Recognition of the need for improved data is growing. The National Disability Agreement includes a commitment to improve data collection on the need for services and the development of population-based benchmarking. Work has progressed on both these commitments. In addition, for the first time, a national workforce census and

> survey of the community services workforce has been recently conducted. (sub. 454, p. 15)

In the main, however, the quality of the evidence base is widely considered to be deficient. For example, in its recent reports on a national disability insurance scheme, the Disability Investment Group (DIG) noted:

- a 'disturbing lack of useful data and low research on disability issues'
- although data are 'slowly improving', what are currently available and planned are 'still inadequate for robust policy analysis and development'
- despite 'pockets of valuable research', overall, research appears 'scarce, limited in scope, not always identified as disability-related, uncoordinated and poorly disseminated'
- even if there were information available, there is no mechanism for reporting it or making the system accountable (2009a, p. 145; 2009b, p. 49).

Similar and other flaws in the existing evidence base were noted by participants in this inquiry (box 10.1), including that:

- there are inconsistent methods of, and systems for, data collection across the states and territories
- data that are collected are of poor quality
- there are gaps in data
- there is a lack of public access to data that are collected
- there is insufficient investment in disability research
- there is a lack of 'independent and expert' economic and clinical analysis
- there is a lack of clinical evidence on best practice pathways for rehabilitation and recovery for particular disabilities such as acquired brain injury
- particular disability services and policies do not have an evidence base, have an under-developed evidence base, or are not subject to independent analysis or evaluation
- there is little scope for clients to provide advice or feedback on disability services
- research is not integrated or 'translated' into disability policy or decision-making.

These existing deficiencies will need to be addressed in the NDIS.

Box 10.1 **Participants views: deficiencies in the evidence base**

Anglicare Australia:

> … At present, there are notable gaps in the areas of data collection (focusing on client wellbeing), evaluations of best practice service delivery models, and in emphasising person-centred outcomes. (sub. 270, p. 22)

Autism Victoria:

> … CSTDA statistics are currently [of] no worthwhile use in relation to disability and unmet need for policy-makers Australia‑wide and in certain States and Territories due to the poor data collect methods and inertia on the part of many service providers.
>
> … HACC data does not capture unmet need …
>
> … HACC files on individual community care recipients … [are] kept filed away with no analysis done of disability subsets and needs. Therefore policy making is hindered at local government level by the non-use of this data. …
>
> … [T]here is no National Autism Register. (sub. 468, pp. 2–3)

Australian Orthotic Prosthetic Association:

> Independent and expert economic and clinical analysis is urgently required, and benchmarks from nations who have best practice models in place need to be set in Australia. Unless realistic and independent analysis can be performed, we cannot move from the current adversarial position which exists between state health department funding bodies, amputees, and service providers. (sub. 237, p. 3)

Brain Injury Australia:

> … [There is] virtually no investment in disability-related research, including surveys of [acquired brain injury] prevalence, … (sub. 371, p. 8)

Insurance Council of Australia:

> … there is a lack of robust actuarial data in regards to the cost of care. There is also a lack of data concerning the prevalence of the various disabilities potentially covered by the scheme. (sub. 553, p. 15)

National Council on Intellectual Disability:

> Currently, each of the States and Territories in Australia are left to independently interpret and implement disability services policy under the Disability Agreement 2009. This leads to a lack of consistency in the scope and quality of services provided across the country. It also means that there is little in the way of any evaluation at the national level of what is being achieved and particularly what and where any quality outcomes may be. (sub. 571, p. 11)
>
> … there is no process in place for independent evaluation of the implementation of the policy and service delivery. There is no independent process for families to feed into the system to provide either advice or feedback on the implementation and outcomes of the policy. (sub. 571, p. 12)

National Ethnic Disability Alliance:

> There has been an inability and/or unwillingness by successive Governments and their respective Departments to improve the data collection, consistency and analysis on disability as it pertains to people from [non-English speaking backgrounds]. (sub. 434, p. 16)

10.3 Why an effective evidence base under the NDIS is needed?

Participants commented variously on the need for good data as well as research and analysis capability under the scheme (box 10.2). In essence, there are three main arguments:

- Facilitating financial sustainability.
- Ensuring cost-effective services and interventions.
- Monitoring the performance of service providers.

Box 10.2 **Participants' views: the need for good evidence**

Data

Australian Blindness Forum:

> … Better data enables improved planning and efficient delivery of services where and when needed, reducing waste and improving outcomes for people with disability. … Efficient data systems keep compliance costs for service providers to a minimum and also feed information back to the sector to inform the development of good practice. (sub. 438, p. 21)

Australian Human Rights Commission:

> As noted by the Disability Investment Group report, collection of data and statistics as is required by article 31 is fundamental to the operation of social insurance schemes. This would assist in providing an evidence base for implementation actions and in monitoring progress achieved. (sub. 72, p. 40)

Municipal Association of Victoria:

> ... reliable data at a local government level will enable more effective local planning for local community service development initiatives and to support broader support access and inclusion initiatives for people with disabilities. (sub. 491, p. 3)

National Disability Services:

> … Data generated under the scheme should be used to build evidence on trends in service demand; which interventions provide the best outcomes for people with disability; benchmarking for service providers; as well as strategies to recruit, train and retain staff. (sub. 454, p. 15)
>
> … Improvements in available data — their relevance, quality, quantity and timeliness — are needed to support disability service planning, the development of quality improvement systems and workforce planning. (sub. 454, p. 21)

Suncorp:

> To monitor the financial viability of any proposed [national scheme], it is vital to establish a comprehensive data base. A comprehensive data base has the capacity to monitor and compare scheme performance over a period of time and against the results of other schemes, where appropriate … (sub. 592, p. 6)

(Continued next page)

Box 10.2 **(continued)**

Research

Anglicare Australia:

> Research contributes to the evidence base on which decisions should be made and tested. … Research and its translation for application can improve service delivery, thereby contributing to its efficiency and cost effectiveness. Furnishing all stakeholders — Government, service deliverers, informal support networks — with the relevant knowledge and ensuring that knowledge is accessible can, in the first instance, target services to those who will benefit most from them and second develop services which will return the greatest effect. It is reasonable to expect that in doing so the sector would engage in continuous improvement processes resulting in reductions in service usage and demand; not to mention other incidental efficiencies such as minimising duplication, increasing resource leverage, growing capacity for quality improvement including reporting and evaluation, and minimising unmet need. (sub. 594, p. 12)

Australian Blindness Forum:

> Investing in research and development capacity encourages the development of supports which maximise independence, realize individual potential and reduce demand for higher levels of care. …
>
> … [funding] is especially relevant for the issue of exploratory or ‘blue sky’ research — which is often needed to make significant leaps forward to improve long-term outcomes for people with disability. (sub. 438, p. 20)

Bedford:

> There is a need to ensure that relevant research and analysis of data and service delivery performance is undertaken, to inform the strategic direction of the system and provide the community and system users with information about the state of affairs.
>
> This will not only drive continuous performance and standards but also assist users in decision making about preferred service options. (sub. 287, p. 12)

Brain Injury Australia:

> … research is the only way that evidence-based policy and best practice can be developed leading to substantial cost savings for any proposed scheme. (sub. 371, p. 8)

Disability Advocacy Network Australia:

> Research funding needs to be allocated under the scheme to identify gaps, program failures and successes to inform progressive improvements in both structural reform and models for individualised support. (sub. 490, p. 12)

National Disability Services:

> … Improvements in research and its dissemination are needed to inform improvements to the delivery of support for people with disability — at a system-wide level and in relation to the efficacy of specific therapies, service models and interventions. (sub. 454, p. 21)

Facilitating financial sustainability

The NDIS would operate under a quite different management and funding arrangement to budget-based, pay-as-you-go disability and community services. In the latter cases, a budget is typically provided for a set period, claims are assessed and paid until the budget is exhausted, and the cycle begins afresh in the next budget period.

However, while not fully-funded, the Commission has recommended that the NDIS would effectively lock in tax revenue to meet its annual liabilities, without a yearly battle through the budget process to secure sufficient funding in competition with other government spending initiatives (chapter 12). In effect, the NDIS will be funded by a mandatory annual insurance premium. But no government would commit unconditionally to any premium level. That would provide an excuse for lax cost control and permissive benefit levels by the scheme. Any scheme that did not control premium pressures would not be sustainable or acceptable to governments and taxpayers.

In that context, good quality data and their analysis will be critical to maintaining a financial balance between costs and revenues over a long timeframe — this is why it is a major component of the governance of the scheme. Good data will permit, for example, more accurate estimation of likely long-term costs (including by allowing the accumulation of data on the typical lifetime[1] profile of costs for a particular disability). And greater accuracy in predicting costs can allow the scheme to function with less volatility in respect of revenue needs than might otherwise be the case. Indeed, the financial performance of commercial insurers and government agencies responsible for accident compensation schemes depends upon the quality of their data, and how well that data are analysed and integrated into day-to-day decision-making.

For the NDIS to achieve financial sustainability requires a thorough and ongoing understanding of the short- and long-term financial pressures and risks involved. It also needs comprehensive data collection and analysis systems to underpin that understanding, and to facilitate its incorporation into decision-making under the NDIS (including in the areas of administration, purchasing and contracting, investment management, as well as monitoring experience, utilisation and outcomes). As the Victorian Government said, the financial sustainability of a scheme can quickly be compromised by even a modest deviation in claims experience from the expected level.

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[1] Assuming that people choose to stay on in the NDIS after age 67.

> This is particularly true of a scheme focussed on individuals with severe disabilities and high cost needs, as the experience is volatile and the long-term costs are inherently difficult to estimate. (sub. 537, p. 22)

An effective evidence base consisting of good data and their analysis would permit the early identification of such developments.

Ensuring cost-effective services and interventions

An important use of quality data is to assess the efficacy, effectiveness and cost-effectiveness of particular services and interventions. This might involve identifying better alternatives, facilitating innovation, allowing controlled experiments to be undertaken, and establishing (and revising) benchmarks for best practice. It might also involve identifying alternatives that reduce future scheme costs. (It also implies some form of research function for the NDIS, a matter that is discussed later.)

Such assessments can better inform decisions by people with disabilities, service providers and scheme administrators. It allows scheme administrators and service providers to fine-tune the mix of services offered to clients. It can also guide people's purchasing decisions. For example, People with Disability Australia emphasised the need for people who direct their own funding to have ready access to the kinds of information and support they need in order to take control of purchasing decisions:

> … People do not become empowered simply by knowing the cost of their support services. They need to be aware that they can make different choices, have the information to make the choices that suit them best, and be able to put those choices into action. (sub. 524, p. 20)

Assessments can provide evidence of the opportunities for better outcomes for clients from alternative services and interventions. For example, the greater use of machines to turn people in their beds can reduce the need to make calls on attendant carers for this purpose, or improved practices that reduce the incidence of pressure sores can reduce the incidence of hospitalisation.

Assessments might also better identify lower cost choices among equally effective services and interventions. This is important both for identifying better outcomes for clients, and for keeping control of scheme costs.

Assessments can also relate to the processes used by the NDIS, rather than to services and interventions per se. For example, do personal plans or paying family members achieve better outcomes or lower costs?

Monitoring the performance of service providers

Good quality data would allow more systematic and detailed assessment of the performance of different service providers. Do they deliver services cost-effectively and get good outcomes? Do they treat their clients with respect and do workers turn up on time? (Chapter 8 describes some aspects of assessing the performance of service providers.) Such assessment can also encompass monitoring adherence to national minimum standards. It would also underpin the NDIA's role as a purchaser of services under the scheme.

The evidence generated from performance assessment may also suggest new approaches to service delivery as well as provide information on the use of services. For example, performance assessment should pick up 'overuse' of particular services, or of services where the evidence as to their efficacy may be doubtful. It may also highlight if there are greater numbers of cases that require accompanying services from other parts of the health/community services sectors (for example, in respect of mental health services).

10.4 Data systems

Some important features of data systems to be established under the scheme are that they:

- are compatible across jurisdictions
- are supported by adequate IT and administrative systems
- include outcomes data
- involve the creation of a longitudinal database of clients' information, which include clear rules on data access and use.

Compatible data systems

Data systems under the NDIS would need to involve compatible data standards, definitions and collection processes (such as data registers). This would need to be developed in consultation with stakeholders in the disability system and should be a priority task for the NDIA following its establishment.

Information technology and administrative systems

A significant task will be to implement changes to existing IT and administrative systems to ensure that they are capable of implementing compatible data systems across jurisdictions. Towards this end, standards for inter-connectedness of IT systems among the NDIA, other relevant government agencies (such as the NIIS and health agencies) and service providers will need to be developed by the NDIA in consultation with stakeholders in the disability system.

IT systems will also need to be able to deliver other administrative aspects of the NDIS, such as real-time updating and sharing of electronic client records, and providing for the portability of entitlements between jurisdictions.

It may also be desirable for future IT systems to be designed to be compatible with the increasing shift towards delivery of some services by way of telecommunications technologies (see, for example, the Australian Physiotherapy Association on the uses of 'tele-rehabilitation' in physiotherapy (sub. 503, p. 11) and the Medical Technology Association of Australia on the clinical benefits and cost savings of 'tele-monitoring' (sub. 479, p. 14, pp. 15–7).

Outcomes data

An important component of the evidence base under the NDIS will be the systematic collection of data on outcomes of particular services or interventions for people with disabilities. Data on outcomes in employment, education, social participation, and capacity for self-care, and on the measures that contributed to those outcomes, would help to build an evidence base for assessing which interventions or forms of assistance are more effective, and why. Several participants noted the desirability of collecting such data (box 10.3).

As KPMG observed, generating information that can lead to improved outcomes for people with a disability and their families through, for example, improvements in services and responses, or development of new models of support, is a component of all best practice service systems. But there is currently a gap in the extent of program evaluation that focuses on outcomes.

> This makes the development of evidence based interventions more difficult and limits the capacity of jurisdictions to share learning from particular programs. (2009, p. 19)

Box 10.3 **Participants' views: outcomes data**

APC Prosthetics:

> … With an improved understanding of the outcomes [for amputees] there will be a greater ability to provide appropriate resource application & development. It would remove the uncertainty as to whether all clients are being referred appropriately — whether [for] rehabilitation with a prosthesis or without. It would also help remove the current uncertainty around who is accessing services. Is everyone being given the appropriate information around services that are provided for amputees? (sub. 241, p. 11)

Australian Physiotherapy Association:

> Embedding harmonised data collection systems and standardised measurement of process and outcomes in models of service will collect evidence that can be used to demonstrate efficacy and cost-effectiveness. (sub. 503, p. 15)

Cerebral Palsy League:

> [There should be] Built in and funded program logic evaluation research and personal outcome measures to systematically collect data related to outcomes and impacts and not only inputs and outputs. (sub. 505, p. 34)

Julia Farr Association:

> Outcomes appear to have been elusive in the disability support sector, as they often are in other areas of human services. Often other measures are used as proxies, and such measures are often output measures (for example how many day places, respite hours, accommodation places etc), process measures (for example how plans are written, how complaints are managed etc), or even input measures (for example what qualifications in what types of staff).
>
> …
>
> Therefore, it is of critical importance that the national scheme considers an authentic outcomes measurement framework that captures the degree of impact on disability funding in people's lives. (sub. 494, p. 55)

National Disability Services:

> Growing acceptance of the need to focus on outcomes for people with disability is a significant development within the sector, even though information about how to measure outcomes is quite limited. Together with the information we have about inputs and outputs, improved data on outcomes will provide a richer picture of the impact of disability (and other services) on the quality of service users' lives.
>
> It will, however, take time to build knowledge about outcomes and impacts. But they are worthy of significant attention—the importance of ensuring that people with disability who have difficulty articulating their opinions are provided with the supports they want in the manner they prefer is key to high quality service provision. (sub. 454, p. 21)

Within the disability system, many jurisdictions are undertaking reforms to improve their understanding of how to achieve better outcomes (KPMG 2009, pp. 2, 82–8). For instance, TAC indicated that, as part of a six year strategy, it wants to shift from its current 'passive' approach to one where, for the first time, it systematically measures client outcomes:

> In the past, we have taken a more passive approach to supporting clients in achieving their goals — intervening at various points to review if treatment or service requests are appropriate, but otherwise performing as an arm's-length 'payer' of funded services. … For the first time the TAC will use standardised measuring tools to understand and predict what factors might hinder a client's ability to recover or get back to work. As a result, the TAC will be more proactive and intervene earlier than we ever have. (*TAC 2015*, p. 4)[2]

TAC said that this change reflects a trend overseas and locally by compensable scheme providers to play a more active part in setting, managing and achieving desired client outcomes (TAC 2015, p. 3).

A longitudinal database

There will be a need to establish a comprehensive national longitudinal database of clients' information under the scheme. Such databases already exist within existing accident compensation schemes.

The database would contain such information as:

- details of a client's disabilities and capacities
- details of their personal plan
- the cost of their plan or their self-directed budget
- a history of transactions and payments made
- a history of the provision of services to them
- a record of outcomes
- relevant information about a client's natural supports (including availability)
- details of any review and entitlement assessments (DIG 2009a, p. 160).

The key elements of the database are briefly reviewed below. Further details are covered in chapter 8 on delivering disability services.

One-time registration only

The database should be organised so that it requires each client to be registered at one time only. (This would keep the regulatory burden on clients, providers and suppliers to a necessary minimum.) After that, the system should allow the client's data records to be retrievable (and updateable) from anywhere within the NDIS,

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[2] *TAC 2015* is a six-year strategy, approved by the TAC board in 2009, to improve all major aspects of the TAC's operations (www.tac.vic.gov.au).

subject to clear rules about access and use (see next), therefore requiring compatible IT systems. And ideally, these systems would be designed so as to be compatible with future eHealth developments. This would permit clients to move in and out of the NDIS, and between it and the health sector, without needing to re-register all of their details each time.

Clear rules on data entry and access

Detailed rules would be needed to determine who, to what extent, and by what means health practitioners, service providers, clients and others might be entitled to enter, access, and amend data on a client's electronic record.

These rules would need to ensure the integrity of the data as well as confidentiality and privacy for the client.

In particular, rules ensuring confidentiality and privacy for the client should be carefully articulated in consultation with Australian Privacy Commissioner. For example, service providers should not be able to access all of a client's electronic record, only those parts that are relevant (chapter 8). The client should also be entitled to make complaints were their data to be used inappropriately (chapter 7). Ensuring confidentiality and privacy of data is further discussed at the end of this chapter.

DRAFT RECOMMENDATION 10.1

Prior to the implementation of the NDIS, the NDIA should design and establish extensive and robust data systems, underpinned by the associated information technology and administrative systems. The systems should be used to develop a central database that would:

- ***guide financial management of the scheme, and in particular, to continuously manage risks to scheme sustainability and to pinpoint areas of inefficiency***
- ***inform decisions about disability services and interventions***
- ***enable performance monitoring of service providers***
- ***monitor and evaluate outcomes***

Disability support organisations and service providers would be required to provide timely relevant data to the NDIA.

10.5 Research

Establishing a good data system under the NDIS would provide opportunities to undertake routine analysis as well as research into substantial matters. This section considers the latter function.

Research can focus on such matters as data definition, methods of analysis as well as the efficacy, effectiveness and cost-effectiveness of particular disability services and interventions.

Research independence

An essential feature of an effective evidence base under the scheme is the independence of research. Given the need to make judgements about such matters as the choice of data, methods of analysis and assumptions, research is more likely to be credible, and seen to be so, if it is not subject to influence from particular sections within the community.

The desirability of research independence will affect the choice of models for undertaking research under the scheme.

Who should undertake research?

How research is undertaken under the NDIS would be a matter for the NDIA to determine, following public consultation.

There are several models for undertaking research.

One model is centred on the creation of an in-house expert body to undertake effectiveness and economic assessments, as well as to provide advice to the administrators of the scheme and to persons with a disability. The 1974 National Committee of Inquiry into Compensation and Rehabilitation in Australia (Woodhouse Report) effectively supported this model.[3] Some participants supported this model (for example, the Australian Physiotherapy Association, sub. 503, p. 15).

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[3] The Woodhouse Report recommended the creation of Rehabilitation Division within the then Commonwealth Department of Social Welfare Policy and Planning, which would ‘sponsor and conduct research’. The Division would ‘systematically evaluate rehabilitation methods, procedures, programmes, new techniques, disability management and delivery of services and also the development of new types of artificial aids and appliances’ (1974, vol. 2, p. 2). It also recommended that the Rehabilitation Division establish a ‘sophisticated and substantial research centre’ (p. 10).

One advantage of this model is that an in-house body is able to apply a consistent approach or method to the assessment of different services or interventions, which enables comparisons across services or interventions. A further advantage is that the objectives of an in-house body are likely to be closely aligned with the overall scheme's objectives (such as ensuring financial sustainability and cost-effective services or interventions).

A second model is for the NDIA to commission effectiveness and economic assessments from experts within existing universities, hospitals, and centres of excellence. Several participants supported this model (for example, People with Disability Australia, sub. 524, p. 44).

An example of this model is the UK National Institute for Health Research (NIHR), which funds, commissions and coordinates National Health Service and 'social care'[4] research from a range of research institutions.

This model avoids the cost of establishing a new body. However, without clear guidelines for research practices and reporting among contracted parties, it could lead to inconsistent methods for undertaking assessments, making it difficult to compare across services or interventions.

A third model is for the scheme to fund the establishment of an external research institute dedicated to undertaking disability research. DIG in its report on a national disability insurance scheme recommended that governments should allocate funding for a National Disability Research Institute as a centre of excellence to promote disability research in Australia (2009b, p. 49). Many participants supported this model (for example, the Australian Human Rights Commission, sub. 72, p. 4; Cerebral Palsy League Queensland, sub. 505, p. 24; Melbourne City Mission, sub. 283, p. 5; Multicultural Disability Advocacy Association of NSW, sub. 604, p. 16).

An example is the UK School of Social Care Research, which is funded by the NIHR to increase the evidence base for adult social care practice.

A fourth model is for service providers to submit efficacy, effectiveness and economic assessments as part of their application for including services or interventions under the scheme.

The advantages of this model are that the costs of undertaking the assessments are borne by the providers of the early intervention and that intelligence on prospective new interventions can come from outside the NDIS. However, assessments may not be independent, which may reduce their credibility.

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[4] 'Social care' includes disability care.

This model is similar to arrangements for the Australian Government's autism early intervention program, in which service providers must apply to FaHCSIA to seek membership of an Early Intervention Services Providers Panel and demonstrate that their services are value for money (chapter 11).

It is possible that the best approach to undertaking research under the NDIS would be a mix of these four models above. For example, the New Zealand Accident Compensation Corporation (ACC) has a research unit established within it that:

- commissions research from external researchers
- co-funds research projects of mutual interest to the ACC and other funding organisations
- undertakes research internally such as evidence-based healthcare reports (ACC 2010e).

Research priorities

Specific areas for research would need to be identified and prioritised by the NDIA through a process of public consultation. Some areas identified by participants (box 10.4) relate to assistive technology, early intervention, the needs of people with disability from particular cultural backgrounds, particular disabilities such as acquired brain injury, and methods of measuring outcomes.

A particular area that the Commission considers should be a priority for research relates to early intervention. This is due to the potential for early intervention to yield beneficial outcomes for persons with disability as well as cost savings for the scheme — see chapter 11. Research on early intervention should guide the development of protocols governing the timing, intensity and duration of particular interventions. Research might involve running pilots on particular interventions to generate the necessary data.

As these and other areas of research are not exclusive to the disability system, the commonality with similar work in the health and community services sectors would need to be coordinated.

Box 10.4 **Participants' views: some areas for research**

Cerebral Palsy League:

> [There should be] Research into best practice and prevention strategies to drive effectiveness, efficiency and to reduce long term costs, as happens now, for example, with the Victorian Transport Accident Commission. (sub. 505, p. 34)

Headwest Brain Injury Association of WA:

> [The scheme should] be designed to commission research to identify inter-sectoral (health, mental health, disability) best practice pathways to rehabilitation and recovery … (sub. 448, p. 10)

Multicultural Disability Advocacy Association of NSW:

> … recommends that a research agenda be created which includes: [r]eview and enhancement of data collection methodologies, including Minimum Data Set and Census, to ensure better capturing of the intersection of cultural diversity and disability.
>
> [one of the tasks of a new research institute should be] to develop a culturally competent disability assessment tool. (sub. 604, p. 16)

National Disability Services:

> Innovation in assistive technology — in particular, computer-based technology — has had a profound effect on the quality of life of some people with disability.
>
> … Assistive technology — and the policies for provision to people with disability — should be underpinned by evidence of effectiveness. Research must inform the development of innovation in assistive technologies as well as the items which should be available under the new scheme. (sub. 454, p. 22)

SA Government:

> Research into clinical practices, particularly those that can help contain long-term costs would be a desirable responsibility of the national scheme body. (sub. 496, p. 20)

Victorian Government:

> Early intervention is a relatively new focus in heath care, and the evidence of what is effective and yields return on investment is still under-developed. It would be valuable for any national disability scheme to draw on existing evidence and contribute to the capacity to research and develop innovative models and evaluate interventions and outcomes. (sub. 537, p. 18)
>
> Any national scheme should … contribute to research on successful early intervention and prevention strategies. (sub. 537, p. 19)

DRAFT RECOMMENDATION 10.2

The NDIA should establish an independent research capacity under the NDIS. It should determine how research is undertaken and the research agenda, following public consultation.

10.6 Methods of analysis

Administrators of the scheme need to know what is safe, what works, for whom, when and how.[5] They need to establish whether costs and revenues are in tune and, if not, the best response. They need to know whether the benefits of given services and interventions are worth the costs. There are many methods to explore these issues:

- Financial (or actuarial) models measure any discrepancies between expected and actual costs and outcomes, and the adequacy of revenues to meet projected costs over the long-term. The models explain why such discrepancies may have occurred, and assess their implications for the financial sustainability of the scheme and its objectives for achieving outcomes for people with disability (either in aggregate or in specific categories). They would be used to inform actions by the NDIS to seek premium increases, to control certain costs or over-servicing, to expand (or contract) certain interventions with good (poor) outcomes, and to assess risks to the scheme rather than just expected outcomes. Such modelling is often performed by actuaries and generally occurs as part of monitoring the financial sustainability of the scheme but, like economic assessments (below), are used to identify services and interventions that are cost-effective.
- Studies about efficacy consider the extent to which a service or intervention under ideally controlled conditions has a beneficial effect on the course or outcome of disease or disability compared with no service or intervention, or with usual care.
- Effectiveness (or outcomes) studies consider the extent to which a service or intervention, when used under usual or everyday conditions, has a beneficial effect on the course or outcome of disease or disability compared with no service or intervention, or with usual care. As well as health or clinical outcomes, effectiveness studies may also consider other outcomes such as employment, educational, housing, income and other non-health/clinical outcomes. Effectiveness studies can be an important input to economic and actuarial assessments.
- Economic assessments consider whether an intervention or service is value for money in that a service or intervention yields net benefits to the broader community compared with using resources in alternative ways.

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[5] Most of these are probably obvious, with the exception of the ‘how’. But knowing *how* a particular intervention works is useful because an understanding of the ways in which interventions work may open doors to new interventions.

This section considers actuarial modelling and economic assessments in further detail.

Actuarial modelling

As in insurance schemes generally, actuarial modelling would have an integral role in monitoring and evaluating the performance of the NDIS. Actuarial modelling covers a broad set of approaches, but it particularly aims to ensure that long-run scheme revenues (premium income) remain aligned with scheme costs (reflecting service utilisation and unit costs).

It does this by using data to estimate the future supports (and cost of these supports) required by groups of individuals over their lifetime. When these costs are added over all individuals, it provides an estimate of the annual costs of the scheme over future years. Consideration of the future lifetime cost for all people in a system is the notional liability of the system (essentially the future revenue requirement of the system to meet the needs of people at a point in time). Constant monitoring of experience is required in order to identify trends in incidence and service utilisation, and departures from projections. Comparison of actual costs compared with expected costs and the reasons for divergence are analysed. Emerging trends and experience are then incorporated into future assumptions where credible.

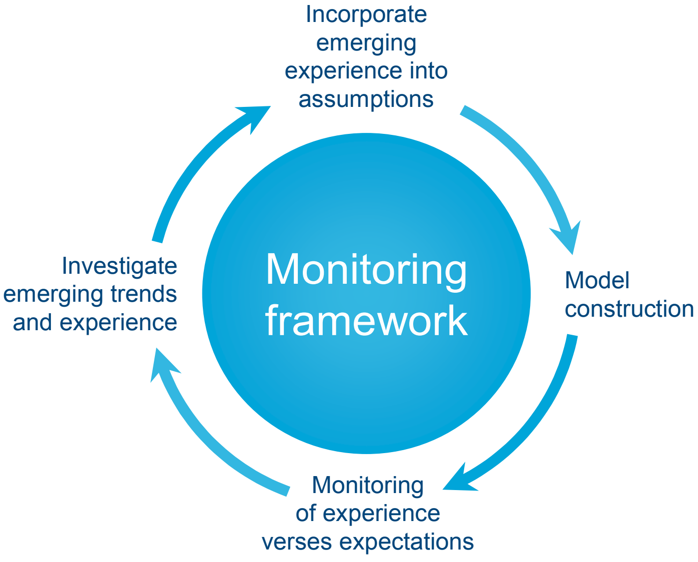
This constant monitoring and adjustment process — illustrated in figure 10.1 — allows increasing or decreasing costs to be identified (for example, increases in allied health service utilisation), unexpected and unreasonable growth in liabilities to be contained, and specific interventions to be evaluated (such as transition to work programs). It could lead to requirements for premium increases or indeed, dividend payouts to government.

More specifically, the 'cycle of governance' would broadly have the following five stages:

- *Estimate numbers of users*. As a starting point, projections of expected distributions of clients by group (for example, age group, disability group, severity bands), over say a five year period, are determined. These projections reflect past experiences and projected relevant populations. For example, historical data might show that age-sex incidence rates for a particular disability of a particular severity were stable, as were mortality rates for people already with that disability. It would be possible to estimate the future number of people with that particular disability and with that degree of severity by applying those rates to population projections. This approach could be extended — to the extent that data were available — to all groups of people with disability.

- *Estimate expected costs and outcomes*. Past data and knowledge about key cost pressures (expected prices, trends in utilisation) would enable estimates of service 'quantities' (for example, hours of attendant care and numbers of vehicle modifications) and the average costs for the relevant population groups. In turn, that would provide an overall estimate of expected costs. Data could also be collected on some outcome indicators — for example, employment, hospitalisation rates, and community participation — which would give an indication of expected outcomes.
- *Find out actual users, costs and outcomes*. Data on system performance would be continually collected and recorded. The database should include both utilisation data (services, costs) and outcome data (health status, employment or community participation, satisfaction). Data should be collected on both scheme participants and any external or environmental supports (including carers). This would provide a benchmark against which to assess in an absolute sense whether people were achieving good outcomes and whether service provision was efficient (but it would also be used for comparative purposes).
- *Compare expected and actual outcomes.* The comparisons would be made for and each population group based on the appropriate grouping (such as age, and severity). The reasons for any discrepancies would be examined, as would the implications of any differences on long-run liabilities.
- *Check the data*. A significant component of this analysis comprises data checking for integrity, cleansing where necessary, and mining to identify meaningful trends and opportunities for new or alternative grouping.

Figure 10.1 **The actuarial monitoring framework**



This approach would be repeated period by period, and would become more refined with collection of better data and with new analytical techniques.

Transition pathways

Actuarial modelling and analysis would also play an important role in evaluating specific services and interventions funded under the NDIS.

At the micro level, the life of someone with a disability (or indeed anyone) can be considered as a series of transition pathways — some more critical than others. For people with disabilities, key transition points include early childhood, starting school, finishing school, entering the workforce, leaving home, and ageing. Building appropriate supports at these transition points, for both the person with a disability and the family, can dramatically alter the future pathway and participation of that person and their family. How these pathways might be altered by various interventions and life events can have considerable impact on outcomes (including employment and social participation) and liability under the NDIS. Box 10.5 presents an evaluation of a hypothetical transition to work program as an illustration of actuarial modelling of interventions.

Box 10.5 **A hypothetical transition to work program**

Consider a hypothetical transition to work (TTW) program, which is an intensive program targeted at providing school leavers with appropriate skills to enter the workforce.

Actuarial modelling is used to determine whether the TTW program or other community participation (CP) programs (such as day programs) are suitable for school leavers.

The figure below compares the hypothetical total costs to the NDIS (or NIIS) from age 18 to 65 years based on different employment pathways.

The following assumptions were used:

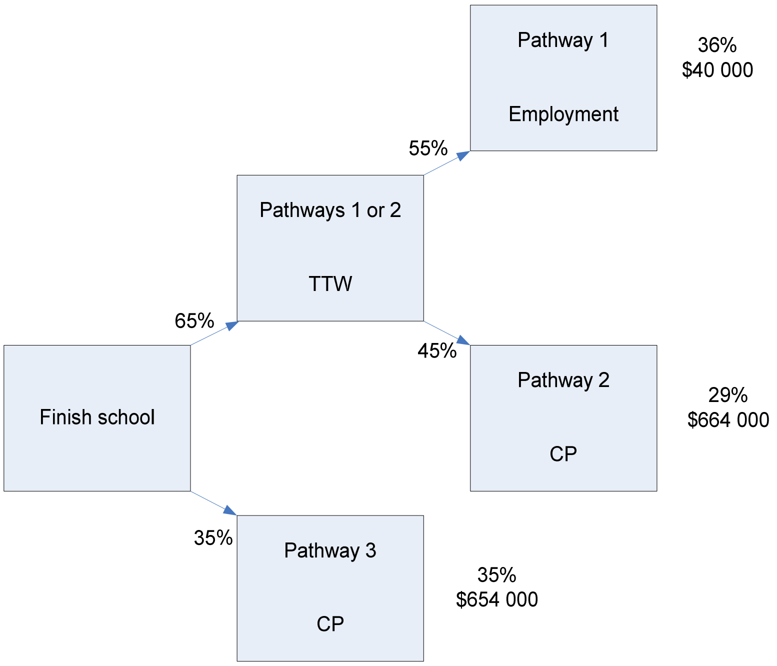
- The annual average cost of the TTW program is $20 000 (for two years) and the annual average cost of a CP program is $15 000 until age 65.
- People who enter employment do not require a CP program.
- 65 per cent of people eligible for post-school programs enter the TTW program and 35 per cent enter a CP program.
- 55 per cent of people who enter the TTW program exit to employment (or further education).
- All people who do not exit to employment enter a CP program.

(Continued next page)

Box 10.5 **(continued)**

- The life expectancy of a person with a disability was considered.
- No allowance for inflation or interest was incorporated.

This example is overly simplified. In practice, some people who enter into CP programs straight after school will enter into employment later in life and people who enter employment after completing the TTW program will not always remain in employment.



Economic assessments[6]

There are many economic methods for evaluating health interventions that could be used for disability services and interventions (such as early intervention). These methods can help scheme administrators (and persons with a disability or their advocates) make informed decisions about particular types of services and interventions. However, all involve different challenges in their application, particularly in relation to obtaining data and applying monetary values to certain types of benefits and costs. Chapter 11 provides specific examples of the use of different economic methods in relation to reducing the risk and impact of disability such as through early intervention.

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[6] This section draws on AHRQ (2005), Murray, et al. (2000), NICE (2008), PBAC (2006), SCRGSP (2011, chapter 14) and Weinstein et al. (1996).

Benefit–cost analysis

This form of analysis identifies all the benefits and all the costs of a service or intervention, and measures them in monetary terms compared with the alternative, such as usual care or no service or intervention. It can be used to assess most policies, programs or projects (particularly infrastructure projects).

It is rarely used in relation to health interventions[7] — largely because of community concerns about placing dollar values on the health and well-being of a person. That said, the benefit-cost analysis framework enables identification of the types of benefits and costs that are relevant to services or interventions (such as the particular contribution to educational, employment, life quality and cost saving benefits).

Cost-effectiveness analysis

This focuses on the costs of achieving a particular type of benefit (or outcome) compared with an alternative service or intervention. Some government health agencies use cost-effectiveness analysis as their main method (for example, the Pharmaceutical Benefits Advisory Committee and the UK National Institute for Clinical Excellence). The NDIS could readily adopt this method for rigorously assessing alternative services or interventions. The actuarial modelling of the transition to work program described above is also a form of cost-effectiveness analysis.

A variant of cost-effectiveness analysis is cost utility analysis. For any given intervention, this measures the dollar costs of (compared with an alternative) achieving a quality of life year (QALY) or avoiding a disability-adjusted life year (DALY).

Other less data-intensive methods

There are several other methods that could be employed to assess services or interventions that are relatively less data intensive than those above.

A common method (often used in the health area) is to measure the direct cost savings of an intervention. This method compares the financial costs (usually government outlays) of the intervention compared with an alternative (such as no intervention or treatment as usual).

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[7] Indeed, health agencies like the Pharmaceutical Benefits Advisory Committee appear to discourage the use of benefit-cost analysis.

The second method involves the use of performance indicators that capture the objectives of the service or intervention. Within the disability context, performance indicators could, for example, cover:

- usage or access — for example, measured by the number of users of a service or intervention as a proportion of the population of people with disability or by surveys of client satisfaction
- health and/or clinical outcomes — for example, by using measures of social functioning, specific behaviours, self-help or independence, physical ability, and verbal communication
- housing outcomes — for example, measured by the proportion of users living independently and those not living in hospital or residential aged care facilities
- educational outcomes — for example, measured by completion of primary, secondary or tertiary education
- employment outcomes — for example, measured by labour force participation rates, return to work rates, or work retention rates after one or five years
- quality — for example, measured by client, parent or employer satisfaction with the service or intervention
- cost — for example, measured by government expenditure on the service or intervention per user of the service or intervention.

The indicators can be used to measure how well a particular service or intervention is performing when compared with other services or interventions, or against a specific threshold or benchmark. For example, an injury prevention program to raise community awareness could be assessed by comparing the rate of injuries/claims for funding support both before and after the program was introduced.

A final more targeted approach is to identify low-cost services or interventions for a high prevalence disability group and then assess them in terms of their effects on various outcomes and future costs. The service or intervention with the greatest improvement on outcomes or future costs can then be chosen.

Such a targeted analysis involves addressing the follow questions:

- Is the prevalence/incidence of the disability that the service or intervention is intended to assist high? A disability of relatively high prevalence/incidence indicates that the intervention could be used by, and benefit, a large number of people with the disability.
- Is the total financial cost (to government and to the person with the disability) of funding/accessing the service or intervention low (that is, below a certain

threshold)? A low financial cost service or intervention indicates that the overall cost of the service or intervention could be relatively low.

- What are the main beneficial outcomes of the service or intervention for a person with disability? To what extent would the service or intervention improve upon these outcomes? A service or intervention that significantly increased the independence/self-help skills of a person would suggest that their future personal attendant care needs would be reduced.
- What types of future financial costs of disability care and support are likely to be lowered by the service or intervention? To what extent are these future costs lowered? If the service or intervention significantly lowers the future financial cost of providing personal attendants — a relatively high cost item of disability care and support — this would strongly suggest cost savings.

What standard of evidence?

Assessments of the efficacy or the effectiveness of services or interventions are an important input into economic (and actuarial) evaluation, but studies are not all equal in their credibility. The NHMRC (2009) issued an interim 'levels of evidence and grading system' for developers of health and medical guidelines. That system indicates that the evidentiary strength of efficacy/effectiveness studies can be seen in terms of a hierarchy — with systematic reviews of randomised controlled trials being at the top and representing the strongest evidence, randomised controlled trials being the next strongest, and case series (or case studies) being at the bottom of the hierarchy and representing the weakest evidence (NHMRC 2009, part A, p. 6).

The standard of effectiveness and economic evidence, as apparent from table 10.1, can range from a systematic review of randomised controlled trials on effectiveness combined with benefit–cost analysis, to a case study of effectiveness combined with a cost-savings study.

However, the most robust standard of evidence — a systematic review of randomised control trials combined with benefit–cost analysis — is likely to be the most costly and slow to obtain (except where existing international studies have already been undertaken). This is a concern if the initial outlay required for a service or intervention is relatively low or if there are large prospective benefits that may be lost by acting too slowly.

Accordingly, a selective evidence-based approach may be appropriate for deciding whether to fund a service or intervention (including early intervention) under the NDIS. This seeks to ensure there is sufficient evidence upon which to base a decision to fund a service or intervention, while reducing the risk of making costly errors.

Table 10.1 **Different standards of evidence**

Type of effectiveness study	*Type of economic assessment*			
	Benefit-cost	*Cost-effectiveness*	*Cost-savings*	*Targeted*
	(high level evidence)	*(high level evidence)*	*(moderate level evidence)*	*(moderate level evidence)*
Systematic review of randomised control trials (high level evidence)	Very high	Very high	High	High
Randomised control trial (high level evidence)	Very high	Very high	High	High
Case study (very low level evidence)	Low	Low	Very low	Very low

As a minimum, there should be good evidence of the efficacy and effectiveness of a service or intervention in achieving improved outcomes for a person with disability. Efficacy and effectiveness goes to the heart of whether a service or intervention is safe and works, or not. Such evidence can protect persons with disability from using unsafe or ineffective services or interventions. For the NDIS to fund a service or intervention whose clinical and other effects are unknown or ambiguous raises the risk that public money is wastefully expended. Moreover, it could undermine the public credibility of the NDIS.

Cost-effectiveness analysis is the economic method that should also be used for choosing among services or interventions. The ACC is required by legislation to focus its injury prevention investments on those activities expected to result in levy reductions (rather than on those that could also result in wider benefits). To meet this requirement, the ACC assesses the cost-effectiveness of its injury prevention activities by estimating a return on its investment based on the number of claims reduced, divided by the cost of programs and associated overheads (ACC 2010d, p. 35).

The establishment of a longitudinal database under the NDIS presents a good opportunity for the NDIA to interrogate its own data and examine the cost-effectiveness of interventions and services that it already funds. (Accordingly, as part of planning the establishment of the database, a consideration should be its proposed use by the NDIA for assessing the cost-effectiveness of interventions and services.)

However, for proposed new services or interventions, a full cost-effectiveness analysis (using ‘gold standard’ randomised techniques) would be costly to undertake. The NDIA should instead undertake an initial appraisal of the likelihood of cost-effectiveness of a proposed new service or intervention. This would involve the NDIA addressing the following questions:

- what is the initial outlay required for the service or intervention?
- what is the prevalence of the relevant disability in the community?
- is there sufficient evidence that the service or intervention would yield improved health and/or clinical outcomes for people with disability?
- is the service or intervention likely to have benefits in the following three areas:
  - reduced future private and government expenditure on disability care and support?
  - productivity gains?
  - reduced government expenditure on other services?

A judgment would then be made about the likelihood that the service or intervention was cost-effective, or if the information to make an assessment was insufficient to reach a conclusion. In the latter case, the NDIA would need to assess the merits of collecting further evidence.

10.7 Other features of the evidence base under the NDIS

An effective evidence base under the NDIS will also need to cover transparency, confidentiality and privacy (already dealt briefly in relation to service providers accessing a client’s electronic record), responsible and ethical research conduct, and eHealth initiatives.

Transparency

An essential feature of an effective evidence base is transparency of data, research findings and methods.

Transparency would enable scheme administrators, persons with disability, service providers and others to:

- make more informed choices about services or interventions and policies
- provide feedback on the data, research findings and methods used, which in turn can be used to improve the quality of the evidence base.

It would also enable researchers outside the NDIS to analyse the data afresh, and to replicate and verify already published research findings.

Transparency of data, research findings and methods under the scheme can also benefit allied policy areas such as those administered by the health and community sectors.

Confidentiality and privacy

Although transparency should be an important feature of an effective evidence base under the NDIS, there would also be a need to:

- preserve the confidentiality of specific data provided by clients and service providers (for example, data of a personal or commercial nature)
- comply with privacy regulation, such as the Australian Government's *Privacy Act 1988,* which involves limits or conditions on the collection, storage, access, use and disclosure of personal information as well as requirements on the handling of health information for health and medical research purposes.

Confidentiality and privacy can be managed through:

- 'de-confidentialisation' of the data, including by removing data that can lead to identification of particular clients and service providers and by aggregating data into larger groups, and
- imposing conditions on how data can be used by researchers — such as through enforceable undertakings, and
- requiring researchers to comply with principles on responsible and ethical research conduct — see next.

Responsible and ethical research conduct

Principles governing the responsible conduct of research and the ethical conduct of human research will need to apply to data collected and research undertaken under the scheme.

Two main sources of such principles are the:

- Australian Code for the Responsible Conduct of Research (Australian Government 2007a). The Code sets out principles on how to: manage code breaches and allegations of research misconduct; manage research data and material; publish and disseminate research findings; conduct effective peer review; and manage conflicts of interests.

- The National Statement on Ethical Conduct in Human Research (Australian Government 2007b). This sets out principles in relation to: risks and benefits from the research; obtaining consent from participants; databanks; interventions and therapies including clinical and non-clinical trials and innovations; research involving children and young people; research involving people highly dependent on medical care who may be unable to give consent; and research involving people with a cognitive impairment, an intellectual disability or a mental illness.

Links with the eHealth initiatives

The evidence base of the scheme should ideally mesh with eHealth initiatives (for example, the use of common personal identifiers) and interface effectively with the broader health sector. The latter would allow, for example, better information on those people who enter the disability system, but later withdraw. They may subsequently re-enter the mainstream health sector but, under current arrangements, their medical experiences and history can become ‘lost’ in a bureaucratic sense. This issue is examined in greater detail in chapter 8.

RECOMMENDATION 10.3

The NDIA should make relevant data, research and analysis publicly available, subject to confidentiality, privacy and ethical safeguards.

10.8 Implementation

As several participants have observed, setting up a good evidence base for the NDIS will be a large and complex endeavour. It will require careful planning and sequencing. It will also require considerable consultation with, and cooperation among government agencies, service providers and other stakeholders in the disability system.

The NDIA should drive this process and it needs to commence as soon as possible after the Agency’s establishment.

The first step — plan what needs to be done

An early and initial task will be for the NDIA to plan what is needed. This will involve determining:

- what the objectives of data collected under the NDIS ought to be
- the types of data that should be collected to support these objectives
- data standards, definitions as well as collection processes (such as data registers)
- service provider reporting requirements
- standards for inter-connectedness of IT systems among the NDIA, other relevant government agencies and service providers
- rules for accessing data, including confidentiality and privacy safeguards, by health practitioners, case managers, service providers and others
- requirements governing the public reporting of data.

Consultation with stakeholders will be crucial during this step, particularly to ensure compatibility in data and IT systems across jurisdictions and different parts of the disability system.

The second step — implement compatible systems

A significant and lengthy task will be to implement compatible data and associated IT and administrative systems across jurisdictions as part of a major upgrade of existing systems. A key consideration will be that data reporting, processing and analysis will need to be continuous, with well-established channels for regular and meaningful reporting to various operating areas within the NDIS.

To achieve this will require:

- linking all relevant government agencies and service providers responsible for disability services in all jurisdictions by compatible IT systems (even if different from their own systems)
- setting up data collection and reporting arrangements (including agreed service provider reporting)
- regularly reviewing how well implementation of upgraded data collection and associated IT systems is working.

The cooperation of government agencies, service providers and other stakeholders will be vital to the successful implementation of this step.

IT systems will also need to deliver on other administrative aspects of the NDIS, such as real-time updating and sharing of electronic client records, and providing for the portability of entitlements across jurisdictions.

Implementation of compatible data collection and associated IT administrative systems may gain some guidance from the experience of other established networked systems such as the Job Network (now Job Services Australia). However, implementation is likely to be a difficult task, particularly where manual systems of data entry are currently used.

The third step — establish an analytical and research capability

A third and later task for the NDIA will be to establish arrangements for the routine analysis and research of the data collected. This will involve determining:

- what types of analysis and research are required
- how analysis and research are to be undertaken (for example, in relation to research, through the establishment of an in-house research body or from commissioning research from existing bodies)
- a research agenda
- how analysis and research are to be integrated in decision making under the scheme
- processes for the public reporting, or dissemination, of research findings.

DRAFT RECOMMENDATION 10.4

In implementing draft recommendation 10.1, the NDIA should determine after consultation with relevant stakeholders, including the Australian Privacy Commissioner:

- ***the key actuarial information needed to underpin sound scheme management***
- ***data standards, definitions, terminology and collection processes***
- ***data reporting standards, taking into account the Australian Government's initiatives for standard business reporting***
- ***arrangements for achieving inter-connectedness of information technology systems among the NDIA, other relevant government agencies and service providers***
- ***rules for accessing data, including confidentiality and privacy safeguards***
- ***arrangements for integrating data and associated information technology and administrative systems with eHealth initiatives.***

The NDIA should then establish data collection and associated IT and administrative systems that link all agencies and service providers within the disability system.

The Commission is conscious that the NDIS could not feasibly cover all people immediately at implementation (chapter 17). That means that during the implementation phase of the scheme, the amount of data (and to some degree, its quality) would be significantly lower than when a full scheme was operating. That said, the ‘cycle of governance’ described earlier would start with the available data and become more sophisticated as the scheme extended its intake into tier 3 (as described in chapters 5 and 17).

11 Early intervention

Key points

- Early intervention can potentially improve outcomes for persons with a disability as well as yield cost savings for the National Disability Insurance Scheme (NDIS) and the wider community.
  - Early interventions seek to reduce the impact of disability for individuals and the wider community, for example, by mitigating or alleviating the impact of an existing disability, and/or preventing a deterioration in an existing disability. They may occur: as soon as the disability is first identified or appears, where there is a discrete change in the disability, or at particular lifetime transition points.
- Assessments of early interventions can provide valuable information to people with disability, the National Disability Insurance Agency (NDIA), and others about whether they are safe and lead to improved outcomes, and are 'value for money'. There is a particular need for undertaking cost-effectiveness assessments.
- Funding of early interventions under the NDIS should be based on good evidence of effectiveness and an initial assessment of likely cost-effectiveness. Absent such evidence and initial assessment, the NDIA should not fund the intervention.
- Where there is evidence to support funding of an early intervention approach, this funding should be in addition to funding provided for on-going care and support and not be able to 'cashed out' by people with self-directed care packages.
- The NDIA should commence building an evidence base on early intervention and develop linkages with relevant agencies responsible for other early interventions as well as interventions to reduce the risk of disability (such as injury and health prevention measures).

11.1 Introduction

An important deficiency of many Australian disability services is their predominantly static and crisis-driven approach to funding needs. This frustrates a longer-term approach to achieving beneficial outcomes for individuals and the community generally.

Australian governments have in recent years attempted to address this deficiency by seeking to incorporate 'early intervention' in their disability services. At the national level, governments have agreed to develop a framework for 'early intervention and prevention' within the context of disability services (National Disability Agreement 2009 and CDSMC 2010). Governments have also agreed to a five year program that, among other things, seeks to divert younger people with disability who are at risk of admission to residential aged care into more appropriate forms of accommodation (COAG 2006).[1] Many individual governments have also funded early interventions in their disability services, including that which targets children with disability and their families (box 11.1).

Box 11.1 **Some recent government early intervention initiatives**

- Australian Government initiatives include: the Better Start — Early Intervention for Children with Disability initiative (from July 2011), Helping Children with Autism Program (including the establishment of an early intervention service provider panel); the establishment of 6 autism-specific early learning and care centres; and the Outside School Hours Care for Teenagers with Disability Program.
- The NSW Government's Stronger Together: a New Direction for Disability Services in NSW 2006–2016 sought to increase (among other things): intensive, innovative and flexible support packages for children and young people with disability and their families; therapy places for children with disability; respite places for children and young people with disability. Associated funding programs include the NSW Intensive Family Support Program, Families First Program, Family Assistance Fund, Family Solutions Pilot Program and Early Childhood Intervention Coordination Program.
- The Queensland Government's Growing Stronger: Investing in a Better Disability Service System, 2007–2011 and Disability Services Queensland Strategic Plan 2008–2012 committed the Government to pursuing early intervention. For example, there has been: more funding support for people at key lifetime transition points of an individual's life — by expanding accommodation support, family support, post-school services, support to young adults leaving State care, and respite and day services); more funding support for children with a disability (through Building Bright Futures Action Plan for Children with Disability 2010–2013 and the Early Intervention Initiative) through education and information services for families, exercise programs, social skills programs, therapy services and programs, and support to access local play groups and other education and care services; and support for autism early intervention in regional Queensland. Associated funding programs include the Family and Early Childhood Services Program, Family Support Program, and the Autism Early Intervention Initiative.

Sources: FaCHSIA (2010d); NSW Government (2006; sub. 536); Queensland Government (2010a, b, c, d, e; 2007).

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[1] In addition to these examples is COAG's 2008 National Partnership on Preventive Health. This Agreement seeks to address the rising prevalence of lifestyle-related chronic diseases through social marketing efforts and the national roll out of programs supporting healthy lifestyles, and 'enabling infrastructure for evidence-based policy design and coordinated implementation.' An element of the Agreement is the Australian National Preventive Health Agency, which was subsequently established in November 2010.

In this inquiry, many participants have noted the benefits of 'early intervention' and called for its incorporation in a new national scheme (for example, Anglicare Australia, sub. 594, p. 20; Down Syndrome Victoria, sub. 492, p. 6; National Disability Services, sub. 454, p. 13; Victorian Government, sub. 537, p. 18). For example, the NSW Government said:

> A national disability service system should have an early intervention and prevention focus. Research highlights the importance of early intervention and prevention in preventing problems escalating, for the person with a disability and families. The outcome for individuals can be seen in a reduction in the impact of disability and improved transitions through life stages. (sub. 536, p. 76)

This chapter considers early intervention, particularly:

- the nature and benefits of early intervention
- how it might be possible to identify and target beneficial early interventions for funding under the National Disability Insurance Scheme (NDIS), including how such funding would 'sit' with funding for ongoing care and support.

Many early interventions (and, indeed, interventions to reduce the risk of disability — such as health and injury prevention measures) are the responsibility of agencies outside of the disability services sector. The Commission does not see the NDIS as being the primary funder or coordinator of these interventions. Nonetheless, as considered at the end of this chapter, there is potential for forming linkages between the National Disability Insurance Agency (NDIA) and other agencies responsible for such interventions.

Early intervention is just one aspect of the care and support provided to people with disability. In taking such a focus, the Commission wants to emphasise that ongoing care and support for people with disability is also crucial (and dealt with in other chapters). As Brain Injury Australia observed:

> … whilst early intervention does bring measurable gains, recovery from a "severe" or "profound" ABI [acquired brain injury] may take considerable time and service support needs will be long-term. This is particularly the case with those who experience an ABI early in life: a study [Tate et. al 2003] has shown that service use is high even 20–26 years post-injury, with 85% having used at least one service, such as financial, transport, home support in the previous 12 months. Therefore, a potential limitation to the emphasis on "early intervention" in the Commission's thinking could be that the episodic and lifelong needs of people with an ABI will be forgotten. For some people with an ABI, no amount of early intervention will alter those service requirements. (sub. 371, p. 18)

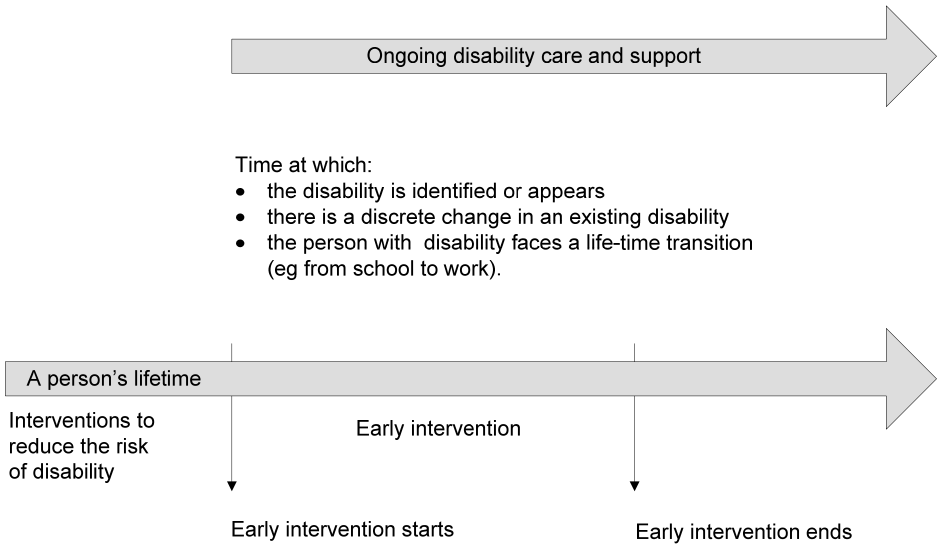
Throughout this chapter, the Commission has used examples of early interventions provided by participants to illustrate particular points — such as the nature of early intervention or how a particular method can be used to assess a particular intervention. While the Commission has endeavoured to verify with participants that the examples provided have been subject to an assessment or evaluation, this has been difficult to do in every case. That the examples are given should thus not be seen as representing the Commission's endorsement of their effectiveness or cost-effectiveness.

11.2 Nature and scope of early intervention

It became evident to the Commission from participants' comments and from government policy documents and reports that 'early intervention' is not easy to define precisely in relation to disability care and support.

The Commission found it helpful to 'unpack' the meaning of early intervention by addressing the following questions. Figure 11.1 captures the Commission's view.

Figure 11.1 **A depiction of early intervention**



What does early intervention seek to do?

In general, the overarching objective of early intervention is to incur expenditure on a particular intervention today that, not only improves individual outcomes beyond that which would occur in the absence of the intervention but, lowers the costs and impacts associated with the disability for individuals and the wider community over the longer-term.

This is an objective that should apply to all care and support for people with disability. It should not be restricted to specific interventions just because they occur at a certain time relative to the identification or appearance of a disability (say).

More fundamentally, early intervention seeks to reduce the impact of disability for individuals and the wider community — for example, by:

- mitigating or alleviating the impact of a newly acquired, newly diagnosed or an existing disability, and/or
- preventing a deterioration in an existing disability.

Early intervention may also be seen as including interventions to reduce the risk of new disability. For example, the early provision of an appropriately-fitting wheelchair to a person with cerebral palsy or quadriplegia can also be seen as reducing the risk of a second disability such as back pain or physical deformity (Ian Barker, trans., p. 174; Susan Freeme, trans. p. 535). However, in this chapter, the Commission has mainly considered those interventions that seek to reduce the impact of a new or existing disability, rather than seek to reduce the risk of a new disability.

What types of services would early intervention cover?

Early intervention within the NDIS would encompass the full range of disability services and supports funded under the scheme (described in chapter 4), including: accommodation support; aids and appliances; behaviour and specialist interventions; and case management, local coordination and development; and home and transport modifications.

Early intervention could be provided as a package of these services and in a range of settings including in hospitals, residential care facilities, community health centres, and in a person's home, school and workplace.

Some examples of early intervention approaches are given in box 11.2.

What should be the timing and duration of early intervention?

The precise timing and duration of early intervention will need to be informed by good evidence, such as from studies on efficacy and effectiveness (section 11.3). Moreover, it will depend on a range of factors including the particular disability, the type of intervention and the individual's particular circumstances.

Box 11.2 **Examples of early intervention approaches**

Autism Behavioural Intervention (NSW) — Footprints Program

The Footprints Program is a home-based early intervention program for families with autistic children, covering a 20 week period. It provides training for families and any other person that a child may interact with, the development of an individualised assessment and behaviour plan, and the implementation of that plan to achieve the family and child's goals. Individualised assessment and planning are done in collaboration with the child's family and may cover such target areas as: challenging behaviour, communication skills, attention, school skills, play schools, socialisation and relationship building, gross and fine motor skills, self help/independent living skills and community access skills. The Program has been subject to a service review in 2007. A longitudinal study of the Program funded by the NSW Department of Ageing, Disability and Home Care is expected to commence in 2011.

Brightwater Care Group — Oats Street Program

The Brightwater Care Group provides residential, rehabilitation and respite accommodation services for people with predominantly neurological disabilities, between the ages of 18 and 60 in Western Australia. Its Oats Street Program is a 27-place rehabilitation facility for people aged 16 and over with an acquired disability as well as cognitive impairment, which aims to facilitate return to community living, with an environment suitable to each client's needs. Clients are expected to participate in the Program for a period of one to two years with a short end phase of community integration. This Program has been subject to an evaluation of its benefits and costs (box 11.7).

New South Wales Brain Injury Rehabilitation Program

This Program (BIRP) was established by the NSW Department of Health and the Motor Accidents Authority in 1990 as a specialist network of agencies that provide services to people suffering from traumatic brain injury and to fill gaps left by general rehabilitation services. Services provided include inpatient treatment, community outreach support and a transition living program. The BIRP has early intervention 'as a key principle to maximise spontaneous recovery and the multi-intra disciplinary approach to the client, their family and environment reduces activity limitations and achieves social participation' (sub. 93, p. 6). The BIRP also operates as a continuum of care model for community resettlement and ongoing support. There has been no evaluation of the early intervention component of the BIRP. However, there are, or will be, projects on particular aspects of the BIRP — for example, a scoping project has been commissioned by the Lifetime Care and Support Authority to assess the fees charged to it by NSW Health for services, including BIRP services; an evaluation of the Transitional Living Program under the BIRP will commence in mid-2011; and a report on rural and remote rehabilitation service delivery is expected in early 2011.

(Continued next page)

Box 11.2 **(continued)**

New Zealand Burwood Hospital Spinal Unit — Kaleidoscope Program

The Spinal Unit implements the Kaleidoscope Program, which is a vocational rehabilitation program of which an element is to make initial contact with people with spinal cord injuries within a week of acute hospital admission to identify their future employment and other expectations. The rationale of this approach is that without this, the client has no framework or target through which to judge and engage with services or interventions that were offered (or just applied to them). There is no published evaluation of the Program. However, Dickson et al. (2010) said that their findings on the employment experience of people following spinal cord injury, including return to work outcomes, endorsed the Program's 'founding principle', which is to 'foster hope that employment is both realistic and likely' following spinal cord injury (p. 2).

Novita Children's Services — early childhood services

Novita Children's Services provides a wide range of services to children and young people with disabilities in South Australia. Its early childhood services, for example, involves a Welcome Program (which provides information about services to parents, links to other families through a parent-to-parent initiative, and the establishment of goals and intervention programs with families). Dependent on the family need, a case manager or contact person is allocated to the family. The family is then also allocated a therapy team and services being, ranging from home and school visits, group programs, to referral to specialist service teams where complex equipment or post medical intervention follow up is required.

Victorian Transport Accident Commission (TAC) — claims management

Over the past fifteen years, TAC has instituted changes in the management of its claims from clients with severe injuries from road traffic accidents. In 2009, TAC announced TAC 2015, which included an 'independence' initiative relating to claims management for seriously injured clients. This initiative seeks to help seriously injured clients achieve individual goals and independence. Characteristics of this initiative include the development of a single 'one plan model' and of a 'claims practice framework' that features 'early, proactive interventions' in the initial post-accident period. TAC considered that this initiative will enable decisions to be made in consultation with the hospital and improve discharge processes. The Institute for Safety and Compensation and Recovery Research is currently undertaking an evaluation of the TAC's 2015 new claims model.

Sources: Autism Behavioural Intervention NSW (sub. 331; pers. comm.); Brightwater Care Group (sub. 398; pers. comm.); ISCRR (2010b); Kaleidoscope Consulting International (pers. comm.); Novita Children's Services (sub. 560); Agency for Clinical Innovation (NSW) (sub. 93; pers. comm.); TAC (pers. comm.); Tech4Life (sub. 261).

For example, the Victorian Coalition of Acquired Brain Injury Service Providers and Victorian Brain Injury Recovery Association said:

> There are several aspects to the timing and nature of rehabilitation and disability support [for people with acquired brain injury]:
>
> - People who are poorly managed in the beginning of care and support can require increased costs and experience poorer outcomes. This is particularly so with people with severe physical impairments who, if they do not have access to treatment and therapy shortly after their injuries are more likely to develop severe contractures of their limbs – which results in increased care needs, equipment needs and them experiencing pain.
> - It is important not to reduce support too early as this may also prevent maximum recovery.
> - People may recover function and have heightened support requirements due
> - to their greater mobility and independence, for example, someone who wasn't mobile and now is able to move about. (sub. 320, p. 11)
>
> … It is also clear that every individual's recovery process is unique and is built upon a whole range of pre-injury skills, connections, family supports (or lack of them), and is highly aligned to the age when the injury was received (paediatric, juvenile, and adult injuries are very different in the way they effect recovery patterns). (sub. 320, p. 32)

CASA said:

> Early interventions should be provided as soon as possible after diagnosis or acquired brain injury, in order to secure the best outcomes and should be continued as long as the intervention is deemed helpful, not cut off at a certain age, no matter what the person's ability or progress. For example, the school leaver age is nonsensical for people with intellectual disabilities, as they continue to learn slowly, and often, at the time they are required to leave, are just starting to mature and pick up on language and other skills. As there is nowhere else for them to go, and work is not usually an option, remaining in a school or learning environment is sensible, would provide structure and purpose, and allow the person to continue to develop life skills. To cease therapy at a particular age, with no regard for the individual's circumstances, is also nonsensical and continued therapy could often lead to maintaining mobility, for example, thus keeping the person with a disability out of a hospital or a more intensive care facility. (sub. 54, pp. 3–4)

That said, there are several aspects about the timing of early intervention that need clarification.

Early in life or early relative to the identification or appearance of a disability?

In relation to early intervention, 'early' can broadly be understood in two ways — namely, early in the life of a person (for example, newborns, children and youth) or early relative to the identification or appearance of the disability.

The main implication of defining early intervention as early in life is that the duration of the intervention could be fairly lengthy and potentially last from birth to age 18 years.

Many participants equated early intervention with early in life intervention (such as Novita Children's Services, sub. 560, p. 25; and Yooralla, sub. 433, pp. 69–70). For example, Early Childhood Intervention Australia said:

> The provision of appropriate supports and services for young children with disabilities and their families has personal benefits and potential longer term savings from improved educational outcomes, better labour market participation, reduced dependence on public assistance and lower levels of criminal activity.
>
> Access to timely and adequate early childhood intervention … has been demonstrated to improve outcomes for children with developmental delays and disabilities and their families. (sub. 450, p. 2)

Their views are generally founded on studies into the factors affecting child development and wellbeing, as well as benefit-cost and cost-effectiveness studies into specific interventions in respect of children and their families.[2]

These studies suggest that early intervention applied in many different service sectors — family and community services, health care, the justice system, education services as well as disability services — and potentially involved the coordination of all of them. This raises the question of the specific role for the NDIS in this area.

That said, in this chapter, the Commission assumed that early intervention under the NDIS should generally encompasses interventions occurring early relative to the identification or appearance of a disability rather than specifically early in life. In any event, funding under the NDIS of either types of these interventions should be evidence-based.

When there is a discrete change in the disability

Some disabilities such as Multiple Sclerosis, Parkinson's Disease or Muscular Dystrophy involve a progressive deterioration in the person. There might also be a discrete change in a person's condition — such as a sudden deterioration in mobility, vision or brain acuity. In these cases, early intervention can occur not only after the disability is identified or appears, but soon after there is discrete change.

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[2] These are principally studies from the United States into models of early education and care, including the Perry Preschool project, the Caroline Abecedarian project and Chicago Child Parent Centres — see Hifferty et al. (2010) and Katz and Valentine (2007) for reviews of these and other studies.

An example of early intervention of this kind is the Continuous Care Pilot run by MS Australia and Calvary Health Care Bethleham (2009) (box 11.3). This program sought to 're-route' the pathway into aged care for young people with progressive conditions through a set of interventions. An evaluation of the program suggests that it has led to benefits for participants — for example, the program 'almost certainly' prevented between two and five admissions to aged care.

Box 11.3 **The Continuous Care Pilot**

The objective of this program is to 're-route the pathway into aged care for young people with progressive conditions through the implementation of a comprehensive set of interventions' (MS Australia and Calvary Health Care Bethleham 2009, p. 2).

There were 19 participants in the program, under 50 years of age, who had a diagnosis of a progressive neurological condition (such as Spino-Cerebellar Ataxia, Cerebral Palsy/Cervical Dystonia, and Multiple Sclerosis) and who lived in Victoria.

The program had six steps: transition to the program, specialist health and social assessment, information sharing and knowledge transfer, decision making and implementation of plans, planning to meet contingencies (including the provision of brokerage funds); and monitoring and review.

The step covering transition to the program involved:

- defining criteria' for different diagnostic groups to identify the point at which a person with a chronic neurological condition should be offered a continuous care program
- identifying 'red flags' for this 'at risk' group and educate health and community providers to recognise risks
- informing public and consumers (including consumer groups).

An evaluation of the program (Batterham 2009) found, among other things, that the program:

- 'almost certainly' prevented between two and five admissions to residential aged care during its period of operation
- achieved 'other substantial benefits' for a number of participants including resolving problems with service providers, accessing additional or more appropriate services, accessing larger and more adequate funding packages, identifying and resolving outstanding equipment issues, establishing more acceptable respite arrangements (pp. ii–iii).

Sources: MS Australia and Calvary Health Care Bethleham (2009); Batterham (2009); Calvary Health Care Bethleham (sub. 436).

What about lifetime transition points?

As advocated by several participants (for example, Anglicare Australia, sub. 594, p. 20; Disability Council of NSW, sub. 489, p. 16; and Life Without Barriers, sub. 512, p. 7), the Commission considers that early intervention should also encompass interventions to help people with disability to transition to typical lifetime milestones — such as beginning school, leaving education and entering the workforce, retiring and ageing.

11.3 The benefits of early intervention

Many participants emphasised the benefits of early intervention, and considered these to include:

- reduced public expenditure on the lifetime costs of care and support for people with disability (for example, Australian Rehabilitation Providers Association, sub. 523; Down Syndrome Victoria, sub. 492; Melbourne City Mission, sub. 283; Scope, sub. 432; Victorian Government, sub. 537)
- reduced public expenditure on welfare, health services and other programs outside of the disability services sector (for example, Cerebral Palsy League, sub. 505; NSW Government, sub. 536)
- greater independence for the individual with disability (for example, Centacare Townsville, sub. 485; MND Australia sub. 264; Vision Australia, sub. 352)
- improved quality of life (for example, MND Australia sub. 264; Melbourne City Mission, sub. 283)
- improved health outcomes (for example, Insurance Council of Australia, sub. 553)
- reduced impairment, secondary disablement and risk of injury (for example, Queenslanders with Disability Network, sub. 166; Scope, sub. 432; Melbourne City Mission, sub. 283)
- improved rehabilitation outcomes (for example, Insurance Council of Australia, sub. 553)
- improved school or educational performance (for example, NSW Government, sub. 536; Novita Children's Services, sub. 560)
- better employment outcomes, such as higher employment and skill levels (for example, Australian Rehabilitation Providers Association, sub. 523; Brain Injury Australia, sub. 371; Cerebral Palsy League, sub. 505; Queenslanders With Disability Network, sub. 166)

- greater community participation, reduced community exclusion and reduced loss of established networks (for example, Cerebral Palsy League, sub. 505; Down Syndrome Victoria, sub. 492; Queenslanders with Disability Network, sub. 166; Vision Australia, sub. 352)
- lower criminality rates, reduced child abuse and neglect notifications (for example, NSW Government, sub. 536)
- reduced breakdown in family relationships (for example, Scope, sub. 432).

These and other participants provided the Commission with examples of their own experiences, or of particular studies, as evidence of the benefits (box 11.4).

Box 11.4 **Participants' views: benefits of early intervention**

Slow stream rehabilitation for people with acquired brain injury

> … We have a documented model of practice entitled the Community Approach to Participation (CAP). Three articles on the CAP provide both case study and group data evidence regarding the potential of people with severe to catastrophic brain injury to benefit from community based, slow stream rehabilitation, both in terms of reducing long term care and support and increasing participation and community living skills [Sloan et al. 2009a, b; Sloan et al. 2004]. In contrast, for people who do not receive this targeted rehabilitation, we found that, over an eight-year period, hours of support remained the same. However, there was a shift from paid care to gratuitous support, with associated increasing caregiver burden [Sloan et al. 2007]. (Callaway, Sloan and Winkler, sub. 526, p. 9)

Transition planning

> Paediatrics is well supported until the young person reaches adolescence. The problem really start once they leave paediatric care. Transition planning is increasingly being shown to provide long term solutions for young people with chronic illnesses. Transition clinics for conditions such as diabetes, spina bifida, cerebral palsy improve health and social outcomes. … [The] State-wide Spina Bifida Adult Resource Team … (210K/annum) … has in one year of operation connected 185 young people to adult services who had not previously been connected or who have fallen through the gaps. This early intervention approach potentially saves hundreds of thousands per year in preventable admissions through early detection and treatment of shunt problems, renal complications and pressure areas. (Agency of Clinical Innovation (NSW), sub. 93, p. 6)

Early provision of assistive technologies

> …. Independent Living Centre of Western Australia … put forward a submission [to the Western Australian Government] to trial early provision of AT [assistive technologies] based on predictive prescription to prevent hospitalisation and reduce carer burden. This is based upon evidence that AT devices such as the introduction of mobile hoists can impact significantly on the ongoing health of the carer and to prevent breakdown of the [carers]. (Occupational Therapy Australia, sub. 510, p. 7)

The method used matters

In examining this evidence from participants and other sources on the benefits of early intervention, it is necessary to distinguish among the different methods of assessment. As noted in chapter 10, there are many possible methods, depending on the particular issue being addressed. Assessments based on these methods can provide valuable information to persons with disability, the NDIA and others about whether a particular intervention is safe, works, or represents ‘value for money’.

Financial (or actuarial) modelling measures any discrepancies between expected and actual costs, and the adequacy of revenues to meet expected costs over the long-term. Such modelling generally occurs as part of monitoring the financial sustainability of the scheme but can be used to identify interventions that are low cost and yield beneficial outcomes for people with disability. Box 11.5 presents an example of financial modelling of the 1999 changes to the NSW Compulsory Third Party (CTP) scheme to the handling of whiplash claims, which included early intervention approaches. The modelling found that the changes led to lower claims costs (as expected) as well as improved outcomes for claimants.

Box 11.5 **Actuarial modelling of changes to the handling of whiplash claims under the NSW CTP scheme**

Walsh et al. (2007) assessed the impacts of changes in 1999 to the NSW compulsory third party (CTP) scheme on long-term health outcomes and on the cost for claimants with whiplash from motor vehicle accidents.

The main changes to the scheme were: the removal of payment for non-economic loss for claims; the introduction of clinical practice guidelines for whiplash treatment; earlier acceptance of claims; and earlier access to treatment for all types of injury.

The assessment was based on claims data as well as on data collected from telephone interviews with claimants (on their health outcomes). Three independent groups of claimants were compared in 1999 (before the changes took place), 2001 and 2003.

The primary measure of health outcomes used was the Functional Rating Index (FRI), which has 10 items that measure disability due to neck and back pain. A FRI score of 25 or less indicates recovery. Two secondary health outcome measures used were the Medical Outcomes Study Short Form (SF) 36, which measures physical and mental health status, and the Core Whiplash Outcome Measure (CWOM), which measures symptom ‘bothersomeness’, interference with normal work, attitude if injury lasted for life, normal activities cut down, and work absence.

Walsh et al.’s findings included the following:

(Continued next page)

Box 11.5 **(continued)**

Long-term health outcomes

- Using FRI, at 2 years after injury, there were improvements in recovery from whiplash and reductions in disability due to whiplash for the 2001 and 2003 groups compared with the 1999 group.
- After adjusting for age, the physical component scores of the SF 36 for the 2001 and 2003 groups were significantly higher than for the 1999 group, but there was no significant difference in the mental component scores.
- There were significant improvements in the CWOM item measuring global perceived change in whiplash symptoms in the 2003 and 2001 groups at 2 years after injury compared with the 1999 group. There were significantly more favourable outcomes in 4 of the 5 items of the CWOM for the 2001 and 2003 groups compared with the 1999 group.
- At least half of claimants in the 2001 and 2003 groups were not recovered at 2 years after injury. The main predictor of non-recovery for this group was high initial disability. Psychological factors or claim-related factors were not as relevant. Thus 'greater emphasis should be placed on assessing disability soon after whiplash and, if high, directing resources to these patients' (2007, p. 25).

Cost outcomes

- Estimated average claim size on all claims (using case estimates) declined by 40 per cent from $47 768 in 1999 to $28 824 in 2001.
- The pattern of costs changed, reflecting the changes to the scheme, namely earlier access to treatment, reduced legal fees and reduced non-economic loss payments.
- Small claims finalised faster after the changes. For example, 12 months after injury, 17 per cent of 1999 claims were finalised compared with 43 per cent of 2001 claims, and 44 per cent of 2003 claims.
- The changes were 'effective' in reducing the average size of the smaller claims that finalised relatively quickly, yielding 'substantial savings' to the scheme due to their high frequency.
- For large slow to finalise claims, there were higher medical and economic loss payments after the changes.

Effectiveness (or outcomes) studies consider the extent to which intervention, when used under usual or every day conditions, has a beneficial effect on the course or outcome of a disease or disability compared with an alternative. Box 11.6 presents an example of an effectiveness study in 2010 of the Western Australian Government's early intervention services for children with intellectual disability and their families. The study concluded that the services met families needs to at least a moderate extent for most process measures of care.

Box 11.6 Evaluation of the effectiveness of the Western Australian Government's early intervention services

Wilkins et al. (2010) examined the quality of Western Australian Government early intervention services for young children with intellectual disability (including Down syndrome and autism), which are based on a 'family-centred care model'.

The specific objectives of Wilkins et al.'s study were to evaluate parental perceptions of the processes of family-centred care for children aged 0 to 6 years who were registered with the Western Australian Disability Services Commission because of the presence of, or potential for, intellectual disability. The study aimed to describe the pattern of service utilisation and compare differences in the results of evaluation between groups defined by the type and frequency of service provided.

The results of the study were based on the responses of 165 families to a postal survey. The survey questions covered the frequency and type of services received as well as perceptions of services using a 'Measure of Processes of Care (MPOC) questionnaire (which looks at 5 areas of care — 'enabling and partnership', providing general information, providing specific information, coordinate and comprehensive care, and respectively and supportive care). MPOC scores range from 1 to 7, with 1 indicating the family's needs are never met, 4 indicating that the family's needs are only sometimes met, and 7 indicating that the family's needs are met to a great extent.

The main results were the following:

- Contact with disability professionals. Over two thirds of families had contact with both speech pathology and occupational therapy at least once per month, while under half had contact with a physiotherapist at least once a month. Contact with other health professionals (medical doctors, clinical psychologists and dentists.) were less frequent. Just over 15 per cent of families had contact with their local area coordinator at least once a month.
- Measure of processes of care scores. Mean scores for the five MPOC areas were 3.97 for the provision of general information, 5.20 for provision of specific information, 5.28 for coordinated and comprehensive care, 5.44 for enabling and partnership, 5.76 for respective and supportive care.

Wilkins et al. concluded that early intervention services for young children with intellectual disability in Western Australia are implementing family-centred care to a standard that meets families' needs to at least a moderate extent for most aspects of care. They said that the 'perceptions of families receiving family centred care are generally positive and provide an argument for retaining and strengthening family-centred practice' (2010, p. 716).

Economic assessments consider whether an intervention is value for money. There are different types of these assessments.

Benefit–cost analysis identifies all the benefits and all the costs of an intervention, and measures them in monetary terms compared with the alternative. Box 11.7

presents a benefit–cost analysis of Brightwater Care Group's Oat Street Program in 2010. The analysis estimated a benefit–cost ratio for the Program of around 4:1.

Cost-effectiveness analysis focuses on the costs of achieving a particular type of benefit (or outcome) through an intervention compared with an alternative. Box 11.8 presents a variant of cost-effectiveness analysis — cost utility analysis — in 2010 of an early intervention program in Zambia for young children at risk of neuro-developmental disability. The analysis estimated an incremental cost of around $8.50 per DALY (avoiding a disability-adjusted life year) for the program.

Cost savings analysis compares the financial costs (usually government outlays) of a service or intervention compared with an alternative. (An example of such an analysis is given later in box 11.10 of a rugby injury prevention program.)

Box 11.7 **Benefit-cost analysis of a rehabilitation program for people with acquired brain injury**

Brightwater Care Group, a Western Australian service provider, commissioned a benefit-cost analysis (ACIL Tasman 2010) of expanding its Oats Street program (described in box 11.2). The expansion would involve the construction of a new 43 bed residential facility to house a cohort of 20 clients with acquired brain injury over one year. (Currently the program houses around 20 clients over 2 years).

Key assumptions of the analysis were: 20 new clients a year, the counterfactual being either no rehabilitation or rehabilitation as in an outpatient setting, an hourly cost of care of $33.50, a value of statistical life year at $166 603, a reduction in disability burden as a result of rehabilitation of 10 per cent, a real discount rate of 7 per cent, and a daily cost of rehabilitation per client of $400.

The client base was divided into 5 types and the outcomes from the program for each type were examined using case studies.

The analysis found that the:

- net present value of benefits for a cohort under the program was estimated at $25.67 million, comprising of a reduction in costs of care, improvements in employment opportunities and improvements in the quality of life of clients.
- net present value of costs was estimated at about $6.2 million (assuming a daily cost of rehabilitation of $400 per client).
- benefit cost ratio was around 4:1.

Box 11.8 **Cost-effectiveness of an early intervention program for young children at risk of neuro-developmental disability**

Wallander et al. (2010) undertook a block-randomised controlled trial — the *Brain Research to Ameliorate Impaired Neurodevelopment — Home-based Intervention Trial* — to evaluate the effects of an early developmental intervention program on young children in low- and low-middle income countries (India, Pakistan and Zambia) who were at risk for neuro-developmental disability because of birth asphyxia.

Birth asphyxia is a leading specific cause of neonatal mortality in low and low-middle income countries and the main cause of neonatal and long-term morbidity, including mental retardation, cerebral palsy and other neuro-developmental disorders.

The early developmental intervention program was delivered in home visits every 2 weeks by parent trainers from 2 weeks after birth until age 36 months. The primary outcome of the trial was cognitive development, and secondary outcomes included socio-emotional and motor development. These outcomes were measured at child ages of 12, 24 and 36 months.

The trial enrolled 174 children with birth asphyxia and 257 without peri-natal complications. The control group received health and safety counselling only.

The authors compared the incremental cost of sustaining a home-based early intervention program with the willingness to pay for a disability adjusted life year (DALY). The authors noted that maintenance of a home-based intervention program had a relatively low incremental cost. The incremental cost per year once the program was established consisted of the salary of a full time trainer, training equipment, transportation and supplies. For example, the research data for Lusaka, Zambia showed that, if the rate of mental disability index less than 70 due to birth asphyxia was reduced from 7 to 3.5 per cent, the incremental cost of the early intervention program would be around $8.50 per DALY — consisting of $22 000 divided by (3.5/100 absolute risk reduction X 2000 survivors of asphyxia enrolled per year x 37 years life expectancy). The authors considered that this cost compared favourably with that of other medical procedures.

Performance indicators measure how well an intervention is performing against a specific benchmark. The Victorian Transport Accident Commission uses client satisfaction and 'actuarial release'[3] as performance indicators for the management of its claims by persons with serious injury. The Australian Government's Early Intervention Services Provider Panel also uses performance indicators in assessing outcomes for children with a diagnosis of autism spectrum disorder (box 11.9 later).

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[3] The difference between the actuarial projected claims incurred and the actual claims incurred.

What does the economic evidence say?

The Commission's internet-based searches of websites such as PubMed, BioMedCentral, Social Care Online, NHS Evidence and NHS Economic Evaluation Database revealed what appears to be a large number of efficacy/effectiveness studies of a wide range of interventions to reduce the impact and risk of disability for many different types of disabilities.

However, the Commission found much fewer economic assessments of early intervention, particularly in Australia. (The results of some recent economic assessments of interventions relevant to disability are summarised in table 11.1.)

Those that it uncovered involved different types of interventions for different disabilities using different methods of analysis. This makes it difficult to reach any general conclusions about whether an early intervention constitutes value for money.

That there is a poor evidence base of economic assessments of early intervention in particular, was corroborated by the views of some participants and by a 2006 report on early intervention in autism. The Victorian Government said:

> Early intervention is a relative new focus in health care, and the evidence of what is effective and yields a return on investment is still under-developed. (sub. 537, p. 18)

A report commissioned by the Australian Government Department of Health and Ageing on early intervention in autism noted:

> To date, no studies have examined the cost-effectiveness of treatment programs provided in Australia. Consequently, there is no evidence to suggest that one program is more effective than another based on cost versus benefit. … (Roberts and Prior 2006, p. 79)

Given the potential for early intervention to yield beneficial outcomes not just for persons with disability but also yield cost-savings for the NDIS, the Commission considers that establishing an evidence base that encompasses economic assessments should be a matter of priority for the NDIA. How this could be done is considered next.

Table 11.1 **Some recent economic assessments**

Study (date, country)	*Type of intervention*	*Economic method/s used*	*Alternative/s*	*Economic assessment of intervention*
Access Economics (2008, Australia)	Early intervention for people with psychotic illness (involving low-dose atypical antipsychotics, CBT, programs for vocational recovery, continuing care, relapse prevention and substance misuse harm reduction, family based intervention services, and services to families).	Cost utility analysis and cost savings analysis (with data from 3 Randomised Control Trials — RCTs).	Treatment as usual.	Cost savings over 5 years of $39 934 per patient. Cost savings over five years of $212.5 m ($82.5 m in financial savings and $130 m reduced disease burden).
ACIL Tasman (2010, Australia)	Expansion of Brightwater Care Group's Oats Street Program (involving residential and rehabilitation services for people with mainly neurological disabilities in Western Australia) to accommodate 20 new clients a year	Benefit–cost analysis.	No expansion — accommodate 20 new clients over two years.	Net present value of benefits of $25.6 million. Net present value of costs of $6.2 million. Benefit-cost ratio of 4 to 1.
Chasson et al. (2007, Texas, US)	Early intensive behavioural intervention for children with autism.	Cost savings analysis.	18 years of special education.	Cost savings of $US208 500 per child Cost savings of more than $US2 billion.
McDermott et al. (2010, Australia)	NSW Integrated Services (Pilot) Project for Clients with Challenging Behaviour (eg people with intellectual disabilities, mental health problems and other disabilities who have accommodation and criminal justice problems). Support is for 18 months.	Form of cost effectiveness analysis.		Recurrent cost per client of $207 000 that achieved improved outcomes for clients (eg reduced challenging behaviours and reduced hospital use and costs).
Romeo et al. (2009, UK)	Health check intervention for people with intellectual disabilities, involving a nurse reviewing a patient's GP records against a semi-structured form, discussing findings with specialist GP, then issuing report with recommendations to patient's GP.	Cost savings analysis.	Standard care.	Cost of care savings was £37 569 per annum.
Wallander et al. (2010, US)	BRAIN-HIT. Early intervention program for children at risk of neuro-developmental disability because of birth asphyxia. Program delivered in home visits every 2 weeks by parent trainers from 2 weeks after birth until age 36 months.	Cost utility analysis (with RCT).	Control group received health and safety counselling only.	For a site in Zambia, $US8.50 per DALY.

11.4 Targeting beneficial early interventions under the NDIS

The NDIS as proposed by the Commission will have many features that are likely to be conducive to improved early intervention.

- A more thorough, consistent and timely needs-based assessment (chapter 5) would include an assessment of the scope for early intervention. In effect, the NDIS would search for cost-effective interventions across all people with disability, regardless of their age or severity of condition. Many participants pointed out the importance of interventions over the whole life of a person where they produced good outcomes (Anglicare Australia, sub. 594, p. 20; Life Without Barriers, sub. 512, p. 7).
- Individualised support packages and greater self-direction over care funding (chapter 6) would enable individuals themselves to have greater control in initiating interventions suited to their own specific needs. In the United Kingdom, for example, a woman with a disability was able to use her funds to buy an air conditioner, which reduced her subsequent hospitalisation rates and quality of life (Leadbetter et al. 2008, p. 39).
- The public reporting and modelling of future expected liabilities as a key performance indicator, rather than just of current claims (chapter 7) would allow decision-makers to estimate the effects of early investments on future liabilities.
- Systematic data collection on outcomes for people with disability (such as employment, education, and self-care capabilities) and on the inputs and processes that may have led to these (such as aids and appliances, self-directed support, particular programs, and case management approaches) (chapter 10) would help build up an evidence base for assessing which particular interventions work well, as a basis for their greater diffusion or withdrawal.
- The replacement of fault-based injury insurance arrangements with no-fault systems would encourage improved rehabilitation outcomes (chapters 15 and 16).

A particular challenge for the NDIA (and for people with disability) is how to choose or target early interventions that should be funded or purchased. Undertaking assessments based on the methods described in section 11.3 would in principle indicate those interventions that are safe and works, and that are most likely to yield the highest benefits or lowest costs for persons with a disability and the wider community.

However, from a pragmatic perspective, there are the following inter-related issues.

- What standard of evidence is required in deciding whether or not to fund or purchase a particular intervention?
- How should the evidence be obtained?
- How would the funding of proven interventions sit with the funding of other disability supports?

What standard of evidence?

The most robust standard of evidence — a combination of a systematic review of randomised controlled trials on effectiveness and benefit-cost analysis — is likely to be the most costly and slow to obtain (apart from where there are already international studies) (chapter 10, table 10.1).

Accordingly, a selective evidence-based approach is appropriate for deciding whether or not to fund or purchase a particular early intervention under the NDIS. This approach would consist of the following.

- As a minimum, there should be good evidence of the effectiveness of the intervention — that is, the intervention is safe and achieves improved outcomes for people with disability. Without such evidence, there should be no funding of the intervention.
- The NDIA would interrogate its own data — available from the electronic database that the Commission proposes in chapter 10 to be established — to examine the cost-effectiveness of interventions that it already funds.
- In relation to new interventions, there should be an initial appraisal by the NDIA of the likelihood of cost-effectiveness of the intervention. This initial appraisal would follow the steps set out in chapter 10 (section 10.6). Where the NDIA found that the intervention was likely to be cost-effective, that would be enough justification to fund the measure, knowing that there was a reasonable low risk of decision error. Subsequent evaluation would determine whether the initial assessment was well founded. On the other hand, where the NDIA assessed the intervention as unlikely to be cost-effective, it should not fund that without further evidence.

How to obtain the evidence?

Chapter 10 canvassed a broad range of matters relevant to the building of an evidence base under the NDIS.

In respect of early intervention, there are at least three ways of building the evidence base.

- As noted, the NDIA interrogates its own data to search out cost-effective interventions.
- The NDIA commissions or undertakes research on specific interventions. This research could involve systematic reviews of the evidence on existing interventions, or pilots of promising new interventions.
- Service providers apply for funding of an intervention under the scheme and, as part of that application, submit efficacy, effectiveness, and economic assessments to the NDIA. This is similar to arrangements for the Australian Government's autism early intervention program, in which service providers must apply to FaHCSIA to seek membership of an Early Intervention Services Providers Panel and demonstrate that their services are 'value for money' (box 11.9). There would be a need for the NDIA to independently vet the quality of the assessments.

Regardless of what combination of these ways is used, after its establishment, the NDIA should start building an evidence base. It could be guided in identifying suitable interventions for research by considering such factors as the prevalence of the disability that the intervention is intended to assist, the extent of potential improvements in outcomes for people with disability, and the type of future cost that the approach has the potential to alleviate. Consultations with stakeholders would help the NDIA identify suitable interventions for research.

Funding a proven early intervention approach

Where the NDIA is satisfied that there is good evidence that a particular intervention is safe and leads to beneficial outcomes for people with a disability, and has assessed the intervention to be likely to be cost-effective, the NDIA should allocate funding to it.

Such funding would:

- be additional to that allocated to people with disability for their ongoing care and support under needs-based assessment
- not be able to be cashed out by people with self-directed care packages (as discussed in further detail in chapter 6).

Box 11.9 **The (autism) Early Intervention Services Providers Panel**

The Australian Government Helping Children with Autism package includes funding for early intervention services for children aged 0 to 6 with an autism spectrum disorder of up to $12 000 (which can be used until the child's seventh birthday to a maximum of $6000 a financial year).

Early intervention services that are eligible for funding are defined according to Roberts and Prior (2006) as: behavioural interventions; development and social learning interventions; therapy-based interventions; and family-based interventions.

In order to access funding, families must first contact an Autism Advisor in their state or territory for information about their eligibility. Eligibility criteria include the age of the child, the availability of a diagnosis and meeting residency requirements. Eligible families can then access service providers from an Early Intervention Services Providers Panel.

Services providers seeking membership of the Panel must submit an application to FaCHSIA. Their applications will be accepted if the provider meets certain eligibility criteria, which include meeting best practice guidelines on the following:

- demonstrating that its services are 'value for money'
- conducting assessments of the child before, during and at the end of the intervention to determine the effectiveness of the intervention and to inform the decisions made by the family or carer about those interventions that might best suit their child and family
- meeting reporting requirements against performance standards and specified outcomes of the early intervention service including — wait lists, time to receive services, unmet needs, cost of providing services; complaints; staffing; barriers to service delivery; workforce capacity issues; and performance against the purpose and planed outcomes of the strategy
- collecting performance indicator data through client surveys on increased access to early intervention for children aged zero to six years diagnosed; improved overall well-being of eligible children; improved strategies and skills of parents and carers to meet the needs of eligible children; and improved capability of eligible children to attend full time formal school and participate in everyday life.

Sources: FaHCSIA (2010a, b, c).

DRAFT RECOMMENDATION 11.1

Early intervention approaches used by the NDIA should draw on evidence of their impacts and be based on an assessment of the likelihood of cost-effectiveness. NDIS funding for early intervention should be additional to that allocated to clients for their ongoing care and support and should not be able to be cashed out under self-directed care packages.

DRAFT RECOMMENDATION 11.2

The NDIA should build an evidence base on early intervention. It should commence this task by identifying, in consultation with stakeholders, existing or potentially promising approaches for further research.

11.5 Interventions outside the NDIS

Many early interventions and interventions to reduce the risk of disability would continue to be under the control of agencies outside the NDIS. These include agencies responsible for health, education, child protection, housing and criminal justice services, the newly established Australian National Preventive Health Agency,[4] as well as agencies responsible for accident insurance arrangements.

Interventions to reduce the risk of disability cover a wider range:

- Community awareness campaigns associated with the risk of injury and accidents (like safer sports and driving practices). In some cases, these may be targeted at particularly vulnerable populations (such as Indigenous programs addressing petrol sniffing and foetal alcohol syndrome).
- Regulations prohibiting, or setting standards for, activities associated with significant risks for injury and disability. While many of these are obvious, such as motor vehicle standards and driving laws, and occupational health and safety regulations, some, like mandatory fortification of foods, are less so.
- Regulators taking a precautionary approach to the approval of new products involving potentially high risks and where the effects may take some time to appear (for example, requirements for assessment of the safety of new drugs).
- Public funding or provision of services — such as better roads, health services or child protection services — that help to avoid or screen for the risk of disability.[5]

Participants identified a variety of potentially beneficial interventions in these areas, including:

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[4] See footnote 1.

[5] Some participants considered that premium-setting and the availability of common law redress for negligence necessary to create incentives for employers and motorists to modify their behaviour to mitigate disability risks (for example, Maurice Blackburn Lawyers & Slater and Gordon, sub. 409 and the Victorian Government, sub. 537). This is discussed in chapter 15.

- increased investment in effective prevention, early intervention and support services for people with mental illness to reduce the disabling impacts of mental illness (Mental Health Coalition SA, sub. 513, pp. 4, 5)
- priority to oral health care [of special needs' groups], to ensure effective preventative care and early intervention (Australian Dental Association sub. 552, p. 10)
- awareness of macular degeneration risk factors, such as smoking, maintaining a healthy weight, protecting eyes from sunlight, fitness and blood pressure to reduce the risk or slow progression of the disease (Macular Degeneration Foundation, sub. 77, p. 11)
- interventions in the education system (Australian Blindness Forum, sub. 438, p. 19)
- the timely provision of appropriate accommodation for people with disability, which could lessen the time spent by persons with disability in hospitals and residential aged care facilities and enable families who would otherwise care for them to obtain employment (CASA, sub. 54, pp. 1–2).

Economic assessments of such interventions can also illuminate these benefits. For example, box 11.10 presents a cost savings analysis in 2007 of a New Zealand program to prevent rugby injuries. This analysis estimates (actual) cost savings of up to $NZ700 000 and a return on each dollar invested of around $NZ12.70 for the program.

There are many other prospective gains to the NDIS from interventions occurring outside the scheme, some of them not immediately obvious. For instance, child protection agencies could provide services that target vulnerable families where there is a risk of children acquiring inflicted traumatic brain injury or other disabilities due to physical abuse, such as shaken baby syndrome (BIA 2010).

It is likely to be impractical for the NDIS to fund or coordinate many of the above interventions. This is mainly because many of them often have purposes other than addressing the impact or risk of disability (as in child protection), or the agencies responsible for them already have well-developed expertise (such as health agencies in respect of early and preventative interventions for people with mental illness).

The problem of delineating the responsibilities of the various agencies for early interventions and interventions to reduce the risk of disability is not a new one. It is notable that the Queensland Early Intervention Initiative, aimed at funding new services or the expansion of existing services for families with children with a disability, expressly excluded the use of the funds for medication, rehabilitation, school and education support and other services (Queensland Government 2007, p. 14).

Box 11.10 Cost savings from a concussion management education program in rugby

Gianotti et al. (2007) assessed the impacts of a concussion management education program in rugby in reducing the number and cost of moderate to serious concussion/brain injury claims to the New Zealand Accident Compensation Corporation (ACC). The program consisted of a RugbySmart educational video and a sideline concussion check tool developed by the ACC. The tool was designed to be small enough to be carried in the coaches', referees' or match officials' pockets and to be waterproof.

To evaluate the effectiveness of the program, rugby concussion/brain injuries in 2004 and 2005 were compared with claims in 2003. A comparison was also made for other groups of moderate to serious concussion brain/brain injury claims from 1999 to 2005.

Over the 2 year period of implementation of the concussion management education program, the authors found that:

- new rugby concussion/brain injury moderate to serious claims reduced by 11 per cent (actual) and 58 per cent (forecast). Rugby player numbers increased by 14 per cent over this time
- other non-rugby claims for moderate and severe concussion/brain injury claims climbed steeply
- the median number of days between a concussion/brain injury and the player seeking medical treatment decreased from 6 to 4 days.

Gianotti et al. also undertook an investment and cost-savings analysis of the programme. They estimated that the:

- cost savings after the program was implemented were $NZ690 690 (actual) to $NZ3 354 780 (forecast).
- the two year cost of the program was $NZ54 810, returning between $NZ12.70 (actual) and $NZ61.21 (forecast) for every $NZ1 invested.

That said, there are strong grounds for defined linkages between the NDIS and other agencies in undertaking early interventions and interventions to reduce the risk of disability. The linkages might involve consultation in the funding and design of programs (for example, in relation to inflicted acquired brain injury in children, sporting injuries, and preventative health) as well as the provision by the NDIA of data as appropriate. Such an approach would require the formalisation of links between the NDIS and health, education and other relevant agencies.

12 Where should the money come from? Financing the NDIS

Key points

While private insurance policies can provide useful cover for income loss for people experiencing disability, they are not suited to universal coverage of the population against the potential costs of long-term care and support associated with disability.

In the absence of collecting additional tax revenue to fund improved disability services, the Australian Government should reduce other, lower priority, areas of spending to finance the NDIS.

People with disability need much more certainty about getting reasonable supports over their lifetime and governments need a sustainable revenue source to achieve that. That fact, combined with the need for a stable funding source to underpin a proper governance arrangement for the NDIS, means that funding for the NDIS should not be subject to the annual budgetary review process. It should be hypothecated from a new or existing tax, or from general revenue using a specific formula.

Most tax bases are ill-suited to hypothecation because they are either too small relative to the demands of the NDIS or involve significant inefficiencies. The Commission has ruled out all state and territory government taxes for this purpose. At the Australian Government level, only personal income tax or consumption taxes would be suitable.

However, better still, the Commission favours an arrangement in which — according to a legislated formula — the Australian Government directs payments from consolidated revenue into a 'National Disability Insurance Premium Fund'. This approach means that the Australian Government can use whatever is the most efficient tax financing arrangement at the time, or fund the NDIS from savings in spending elsewhere.

The Commission prefers a partly-funded scheme over a fully-funded one. The latter would involve too high an initial cost for the budget, while the former still has the advantage of building up reserves for prudential reasons.

The Commission proposes that the Australian Government enter into an Intergovernmental agreement with state and territory governments specifying that:

- the Australian Government would collect the full amount needed to fund the NDIS through the National Disability Insurance Premium Fund
- State and territory governments should offset the Australia-wide tax implications of the NDIS by reducing state taxes by the amount of own-state revenue they used to provide to disability services (recognising that many state taxes are not efficient), or, as a less preferred option, by transferring that revenue either directly or indirectly to the Australian Government.

The Commission has proposed sweeping changes to current arrangements for disability services. While many of these changes are to the way the system operates, nevertheless one of the most important changes in a national disability scheme is much more public funding. (How much more is the subject of chapter 14.)

This chapter focuses on how to create a sufficient pool of money for the NDIS — and the options for bringing together 'old' money already allocated to disability care and support by the Australian and state and territory governments, with 'new' money financed in any number of ways.

Section 12.1 discusses the various possible sources of funding for an NDIS, including private insurance. Section 12.2 considers the tax design criteria unique to collecting revenue for an NDIS, while section 12.3 explores the realistic options for collecting revenue. Section 12.4 considers how to achieve greater certainty about long-term support for people with disability, exploring the advantages and disadvantages of hypothecation, and how sustainable revenues might be achieved. Section 12.5 examines whether the NDIS should be funded on a pay-as-you go basis, partially funded or fully funded. Section 12.6 discusses how financing arrangements would occur when the most important current financers are state and territory governments, while section 12.7 considers the related question of how to take into account the significant variations in existing state allocations of resources to people with a disability.

A warning for readers

While there are various estimates of tax rates and monetary flows between various jurisdictions in this chapter, these are not intended to represent the real flows that would follow the implementation of the NDIS. They are intended to illustrate concretely the processes involved in financing. Estimates of the costs of the NDIS are in chapter 14, while the ultimate determination of monetary flows between the Australian Government and state and territory governments will occur some years from now and involve different base values.

12.1 The money can only come from several sources

What about private funding?

Some might argue that disability care and support should be funded privately. Most things can be insured. People insure their lives, their capacity to pay mortgages, their travel, their possessions and the consequences of their mistakes.

People insure against disability too. There are a host of Australian insurers offering insurance payouts for total and permanent disability (including superannuation schemes). These mostly emphasise income replacement, but they also can fund limited care and support. The policies typically relate to disability arising from injury or illness in later life, and to that extent resemble life insurance products. However, some do provide insurance cover for disability at birth. The Commission is aware of one product that provides a lump sum payment of $50 000 in the event of the birth of a child with a congenital abnormality.[1] This amount would be a very small fraction of the extra costs of care and support for a child with a significant disability.

It is important to understand how such insurance products work in order to assess the extent to which they could be potential substitutes for (or complements to) a taxpayer-funded scheme.

These insurance policies are all 'risk-rated' — attempting to set premium levels for groups of people with similar risk profiles. Careful risk rating is required because setting the same premium for a group of people with very different risk levels would mean that insurance would be most attractive to people with the highest risks of disability, while deterring low risks (so-called 'adverse selection'). This problem affected voluntary community-rated (non-risk rated) health insurance in Australia prior to the implementation of lifetime rating (PC 1997).[2] In the previous system, older, higher-risk people were being subsidised by young low risk people. The young stopped buying health insurance, the diminishing pool of insured people was increasingly sick, and premiums were rising as the average risk increased. Therefore, any voluntary insurance policy *must* use risk rating to be commercially viable.

Risk rating takes account of any factor objectively observable by the insurer that affects the risk of a claim. These include lifestyle factors under the control of the person (like smoking or risk-taking activities like scuba diving), but they also take account of factors, like age, sex and pre-existing conditions, that are not. Premiums tend to rise steeply with age, or any other factor predisposing a person to a higher claim risk. For example, where parents are seeking cover for disability or ill health of a yet-to-be-born child, the insurer may request information about past cases of birth defects, hereditary medical conditions or any other aspect of the family that may lead to greater risks.

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[1] The Baby Care Option provided by OnePath insurance (accessed from https://www.ing.com.au/public/pdfs/L3766_ma_oc_family.pdf on 9 January 2011)

[2] And it also affected similar arrangements in other countries, such as the community-rated New Jersey Individual Health Coverage Program.

Moreover, while private insurance can cover some risks, it is notable that:

- coverage for some severe disabilities is very modest. For example, a baby with a very severe disability may need lifetime supports exceeding many millions, but coverage would usually be a fraction of this (for example, the $50 000 dollars cited above)
- children are not in the position to even make decisions about whether to insure at all, but rely on the imperfect decisions of their parents
- some risk factors are not observable by insurers, but are known to the person seeking insurance. Insurers know they don't know some things that lead to higher risks for their clients. They respond to this by (a) introducing co-payments to discourage behaviour that may lead to higher risk taking and (b) increase premiums to reflect the higher costs of imperfect risk rating. The latter drives some people with lower risks from insuring. (In other words, even in the absence of laws limiting risk rating, adverse selection still occurs.)

Viable commercial insurance products will be costly for people with high risks, even if those risks are beyond their control (or effectively so). Many people in high-risk groups could not afford to insure. High risk often also coincides with low income, as is the case with many Indigenous or other disadvantaged groups. So risk rating will leave large gaps in coverage among those people most exposed to risks — the price is too high at the point that the risks are apparent. There are several aspects to community norms relevant in these cases. In the main, the community would see the consequences of the fact that some people cannot afford insurance as unacceptable:

- participants in this inquiry — governments, service providers, and people in the community strongly argued that people with a disability should be supported adequately. This is consistent with Australian social norms about giving all people — not just those with a disability — rights and opportunities. Notably, the Federal Treasury department has adopted a wellbeing framework as its foundation for public policy analysis, with the most important aspect being that 'society should aspire to provide all individuals with the capabilities necessary to be able to choose a life they have reason to value'(McDonald and Gorecki 2010), a concept drawing on Amartya Sen's work. Against a backdrop of such values, the community would be unlikely to tolerate low quality care were relatives unable to provide it, or to accept that parents and others should be solely responsible for providing support for someone with a disability
- in the absence of a workable private insurance market for many people, the community has a role in pooling risks through the government.

Moreover, some people who *could* afford private insurance will not do so or tend to underinsure (due to poor judgments about risks, or simply consumer miscalculation). Were the insurance for a personal possession — a car for example — then the community would generally be reluctant to act as insurers of last resort for a person failing to take out a policy. However, few in the community would accept leaving a person without supports because they failed to take out disability insurance when they could have.

The implications of the above is that once taxpayer-funded insurance exists as a fall-back (for which there are strong grounds), people have weakened incentives to insure privately, even if they value insurance highly. In effect, the availability of government insurance crowds out private insurance.

Against all of the above considerations, there are grounds for some form of mandatory insurance. That could take several forms. People could:

- pay for a universal system through their general taxes. This is what happens for Medicare in Australia[3] and for the National Health System in the United Kingdom
- contribute through European-style social insurance arrangements. Social insurance is financed typically by employer contributions based on payrolls and by employees through a share of their wages (sometimes with concessions at lower wage levels and with contributions sometimes limited by a ceiling). Regardless of the actual point of collection, wages are the ultimate source of revenue. People who are unemployed or pensioners also pay contributions in some European countries. Governments may provide taxpayer-funded contributions to the insurance pool on behalf of some people (such as those without any means). The funds are pooled and then meet disability supports on a needs basis across the whole population. Contributions are collected separately from taxes, are not described as taxes, and are intended to separate revenue streams from the usual political debates surrounding other budgetary items
- be required to take out insurance with community-rated premiums and minimum coverage requirements. People could purchase policies from insurers offering the lowest premiums and the best services. The government may assist people with low means to purchase insurance.

There are also hybrids of such systems. For instance, where people do not have sufficient means to make premium payments under the third option above, the government might set up a separate public insurer — like Medicaid in the United States. Or people may choose to add to 'basic' supports by taking out additional

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[3] As discussed later, the Medicare Levy only partly meets the costs the health care system.

voluntary private insurance. (This is the main role of private health insurance in Australia.)

However, all of these schemes have a common thread — they all involve *compulsion* to contribute and at a rate that is not related to the expected level of individual risk. All essentially act as 'taxes' (while sometimes being explicitly distinguished from them), because they are mandatory monetary contributions underpinned by government legislation.

In summary, voluntary private disability insurance may well serve a valuable role for people — especially in providing reasonable income streams after the onset of disability. (The Australian Government only provides safety net protection through Centrelink for income loss from disability.) However, voluntary insurance has several weaknesses that make it unsuitable as the sole financing method for disability care and support. That leads to the desirability of government financing.

How could governments finance disability care and support?

Ultimately, governments can only provide new funding for disability by increasing taxes, borrowing, or by cutting some other area of spending. Of these, borrowing is not a realistic long-run option. This is because the NDIS is not a conventional investment that produces a financial return to cover the initial investment — but rather an expense incurred year after year. Borrowing for such spending is equivalent to either taxing people in the future or withholding other services from them at that time. For that reason, government could not sustain this strategy as a permanent financing strategy. (*Were* the NDIS financed from general revenue, then borrowing could have a role over short-run periods where there was insufficient current revenue.)

That leaves financing from taxes and from reducing government spending in unrelated areas.

The idea of cuts to other areas of spending has some attractions. Were governments to be starting with a blank slate in determining its funding priorities, there would be a strong rationale for provision of disability services to be one of its highest priorities. That reflects the strong ethical and wellbeing underpinnings of policy in this area, and the genuinely low capacity of people to self-fund their support needs in the bulk of cases. Moreover, inadequate and poorly structured funding of disability supports can have adverse economic impacts, for example, by undermining the informal system of care that underpins much of the affordable provision of support to people with a disability (chapter 2).

So, *were* governments unable to increase taxes, there would be strong grounds for funding for disability services to displace other, lower priority, areas of spending, with the source of the cuts being determined using the annual expenditure review process. There are also possible savings in the disability area itself that may partially fund the NDIS — arising from greater efficiency and from reforms to the Disability Support Pension. These are not factored into considerations of financing in this chapter.

While the 'no tax' option has some advantages, it would result in the displacement of government spending that government might still regard as worthwhile. (If not, it would beg the question as to why government did not make the savings before through the annual expenditure review process.)

In that context, the bulk of this chapter addresses how to marshal the old money in the best way and what taxes the Australian Government should use to finance the new money. However, if tax increases are not feasible, the Australian Government should finance the NDIS by relinquishing other, lower priority, spending.

12.2 Tax design criteria

There are many criteria for determining the appropriate tax financing method — sustainability, certainty (for government, people with disabilities and taxpayers), simplicity, administrative and compliance costs, equity, economic efficiency, community acceptance, and a capacity to avoid unintended consequences. In general, these criteria apply to *any* tax, regardless of where government spends the money. However, there are two aspects of the NIIS and NDIS that have special implications for tax.

In the case of the NIIS, there are grounds for the taxes imposed on people to take account of their choices of risk (such as buying a motorcycle rather than a car). That suggests that a mandatory risk-rated insurance premium would be an appropriate 'tax' in that context (chapter 16).

In the case of the NDIS — the focus of this chapter — there are several particularly important aspects that affect the desirable form of taxation.

The importance of certainty for people

There are strong arguments for a *certain and sufficient* source of future revenue. People with disability usually know with certainty that they will need care and support for the rest of their lives. What they are uncertain about is whether they will get the support they need — and indeed, currently they can almost be certain that they will not. That reflects the fact that public funding has not been historically adequate or stable (figure 12.1). It is implausible that these variations reflect changing patterns of demand for services for what are often stable requirements for support. (The extent of uncertainty appears to be significantly greater than for health care services.)

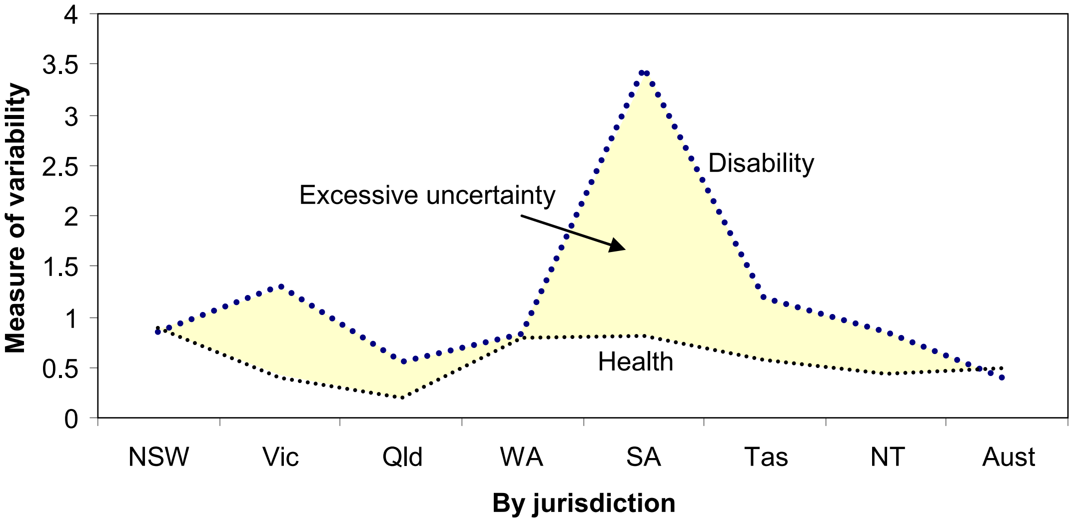
These aggregate variations in funded spending reflect the fact that:

- governments develop new initiatives in disability periodically, which have significant effects on growth rates for the life of the initiatives. Sometimes the effects of these initiatives have significant impacts on growth in a particular jurisdiction (such as in the NSW Government's *Stronger Together* initiative). (See section 12.7 for more information about patterns of spending by different jurisdictions.)
- governments with low initial average spending tend to make additional efforts to increase
- decisions about how to allocate overall government budgets reflect a battle of competing interests, and from time to time extra packages are announced. As one participant commented: 'shortfalls in disability funding are also determined by political priorities' (National Federation of Parents, Families and Carers, sub. 28, p. 3)
- revenues vary depending on the growth rate of the economy. Governments borrow during downturns in the economy, and build up surpluses during the good times
- there is no buffer of funds that allow disability spending to smooth variations in funding from government. The only 'buffer' is further informal (unpaid) support.

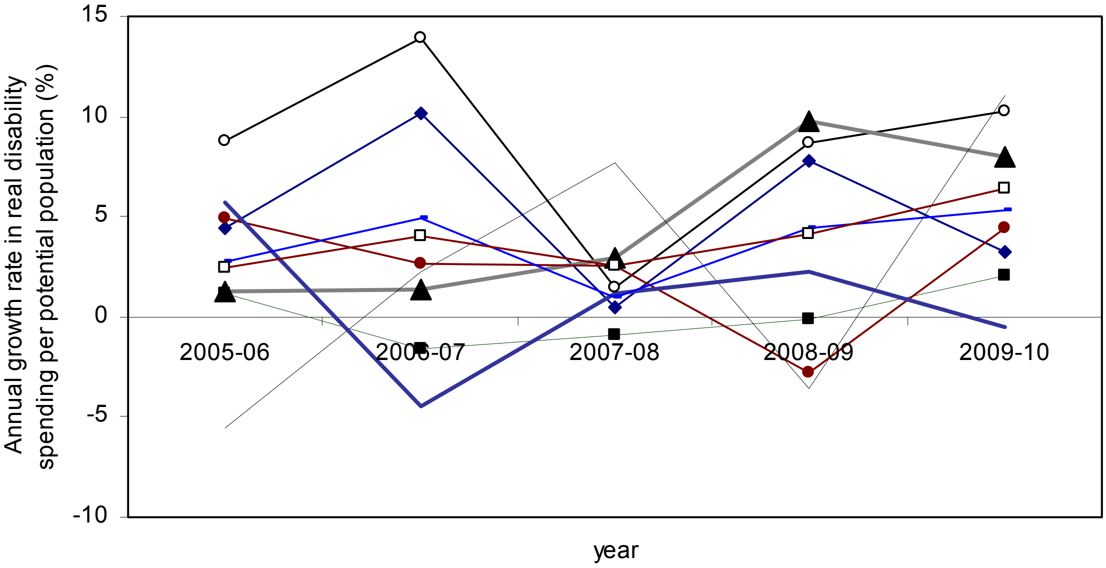
Moreover, variations are even greater at the local level, where what people get is a lottery depending on the availability of local resources and the origin of their disability. In many other (though not all) critical government expenditure areas, people can be guaranteed to get benefits that do not vary significantly depending on where they live. Unemployment benefits, family tax benefits, DSP or any other government income support arrangements are paid at the same rates (with a few exceptions) wherever people are in Australia. These payments do not change suddenly from year to year and they are not budget-capped (that is, if more people become unemployed, they will still be able to get unemployment benefits at the same rate as others).

Figure 12.1 **An illustration of uncertainty** [a]

Disability spending is more volatile than health spending



Spending on specialist disability services varies greatly year by year for different jurisdictions



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[a] The measure of variability is the coefficient of variation of (the standard deviation of a series of data divided by the mean of that series) the annual growth rates of real spending per potential service user. Disability spending is by all governments on specialist disability services per person with a profound or severe disability. Health care spending is from all funding sources and is per person in the Australian population. The data used to calculate the variability measures are from 2004-05 to 2008-09 (given that the latest AIHW data for health spending is for 2008-09). The measure of uncertainty only relates to the aggregate volatility of resources for taxpayer-funded disability supports, and does not pick up the fact that there are many other sources of uncertainty at the individual level (such as when someone applies for funding or where they live). Data on yearly growth rates on disability services relate only to specialist services covered under the National Disability Agreement for the period from 2005-06 to 2009-10. Individual jurisdictions are not identified, since the purpose is to show variability as simply as possible. The Northern Territory is excluded from the graph, because there was a very large (unprecedented) growth in spending in 2009-10 that masked the patterns for other jurisdictions.

Data sources: AIHW (2010, p. 20) and SCRGSP (2011, Excel attachment for chapter 14).

The lack of certainty about future disability funding imposes significant costs on people. The size of that effect is hard to measure, but it is worth considering examples in everyday life to illustrate how much people value certainty in many lesser circumstances:

- people are willing to pay a premium for fixed rate versus variable mortgage rates
- people rank job security as one of the most important aspects of their job, and are willing to accept less income to achieve higher security (for example, for a recent survey see the Society for Human Resource Management 2010)
- people insure against risks, even ones that represent small shares of their lifetime expected income.

Notably, most of the above strong preferences for greater certainty relate to relatively short horizons. For many people with disability, the horizon is to death. In addition, the consequences of insufficient future benefits are worse than in many other cases where people seek assurance — uncertainty about the timely replacement of an ageing and increasingly worn-out wheelchair; unmanageable carer pressures; and the fear of inadequate or low quality care without respect or dignity for a partner or a child. Accordingly, while people value the supports they might get today, they value highly the guarantee that they will get adequate supports tomorrow too. This implies that a properly designed NDIS must reflect those preferences.

A long-run approach to managing costs and outcomes

One of the key elements of the Commission’s proposed NDIA is that it looks forward, and ensures that it systematically manages *unwarranted* demand and price pressures on an ongoing basis (for example, over-servicing, weaknesses in assessment methods and assessor practices) to ensure that overall costs are reasonable and efficient. Those reasonable and efficient costs, combined with the reality that reserves will be necessary to address uncertainty, are the basis for setting ‘premiums’. In effect, the process of managing costs and revenues is like a dance of a pair of ballroom dancers — they are not always in the same position, but the pattern of their movements are orderly and they always remain linked.

This approach to the scheme has other forward-looking aspects, such as discovering those interventions that lead to good outcomes, and the scope to assess where initial investments might reduce future liabilities (for example, a modified vehicle that saves on future attendant care and taxi costs).

These forward-looking approaches are not fully (or in some cases, at all) feasible where future revenue sources are subject to the fickle processes of annual budgets. For example, long-run revenues may fall below expected efficient levels during (potentially long) periods of budget austerity, or when there are changes in budget priorities. In that case:

- the incentives to create a well run *system* for continuous cost management — a considerable managerial investment — are weakened if the results of that system are often undermined by effectively whimsical determinations of revenues bearing no systematic relationship to efficient costs. Indeed, it may lead to perverse cost minimisation behaviours. In a planned and coherent scheme, good cost management can add to the funding reserve, providing additional protection for a later 'rainy day'. However, if the scheme anticipates that government will automatically take back any surplus, then it reduces the NDIA's incentives for ongoing cost minimisation
- the scheme has to cut spending in ways that deny people appropriate assessed supports for indeterminate periods — re-introducing the significant rationing that is one of the persistent flawed features of the current arrangements. Uncertain funding at the individual level also re-creates many of the structural problems of the current scheme, such as incentives to overdramatise problems in order to get a 'fair' amount of the diminished pool
- the motivation in a disability scheme to make tradeoffs between investments now and savings later can also be undermined if there is too much uncertainty about future revenue. As an illustration, say that a vehicle modification costs $25 000 and would save $35 000 in present value terms in future transport subsidies in a system in which people get their assessed needs met. However, if in fact, future revenue may not be sufficient to actually fund those long run assessed needs and could only fund $23 000 in present value terms, it would not make sense to make the vehicle modification from a fiscal savings perspective
- it could weaken the capacity for making effective therapeutic interventions. Such interventions may require sustained funding over several years — for example, in addressing learning problems by someone with an intellectual disability. Erratic future funding may mean that insufficient resources are available to maintain the intervention at the right intensity to maximise its effect. As an analogy, this would be like varying the dose of a drug from the clinically recommended amount because the clinician did not have access to enough money to fund the appropriate drug regimen.

Implications

People with disability need a financing source with several characteristics:

It needs to be sufficient

The tax revenue must be high enough to meet people's reasonable year-to-year needs, as assessed using the tools described in chapter 5. This means that the tax rate must be high enough and that the tax base is growing at the same long-run rate as the costs of the NDIS.

It needs to be predictable

Given the concerns raised above, the revenue must not vary substantially from year to year or be subject to significant risks that future governments will cut it as part of changing budget circumstances. That implies the need for governments to make a binding commitment that makes it very difficult for them to divert the funding subsequently to other areas of spending. Where a specific tax is used to achieve the commitment, this is called 'hypothecation' — specifying the way that revenue from a given source is spent. The Councils of Social Services in Australia (sub. 369, p. 11) noted that 'there must be a clear "fund" specifically for the proposed disability scheme'.

Treasury departments and tax economists often question the appropriateness of hypothecated taxes. In responding to proposals for taxes to be earmarked for environmental purposes, the 2010 Henry Tax Review remarked:

> While [hypothecation] may promote public acceptance of a tax, it constrains the ways in which the government can allocate limited revenue between competing priorities. It can result in revenue being spent on hypothecated programs when it could have delivered greater social benefit if directed elsewhere, including through lowering existing taxes. (vol. 2, p. 355)

This argument is often appropriate, but it needs to be balanced against the historically fragile nature of public funding for disability supports (despite the strong permanent rationale for those supports) and the economic and social value of greater certainty of funding. For example, Barr observed that it was hard for social expenditures outside of health to command as much public attention as healthcare:

> Health care is better placed in this context, since many of its users are articulate and well-connected. It is no accident that social care, not health care, is sometimes described as the 'Cinderella service'. (2010, p. 369)

To put hypothecation in perspective, while governments often allocate budgets for a short period, sometimes they engage in medium-term earmarking of revenue. For instance, the Australian Government has committed funds over four years to the Aboriginal and Torres Strait Islander Education Action Plan.[4] A former government made a ten-year commitment to fund a 'hardened and networked army'. While governments may revoke such spending commitments, the fact that they make them at all is a reflection of a basic principle: There can be efficiency and other gains from a predictable set of outlays over more than the current budget year. Accordingly, the issue at stake is not earmarking per se, but its duration and the degree to which it is ironclad. Given the characteristics of disability system, that principle justifies earmarked funding of disability supports without a time limit, and with a greater degree of certainty than the (revocable) commitments governments sometimes make over medium terms periods under current budget processes.

The need for a stable revenue source also suggests that a funding buffer is required, since there will be annual fluctuations on the cost side. In those periods, the NDIS would need to run down a funding 'buffer' to meet those needs, while it would need to build up the reserve level at other times. (It would be prudent to accumulate reserves in the early stages of the implementation of the NDIS, when the outgoings would be limited.)

Quite apart from the need to offset volatility in tax revenues, the tax rate should be set to take account of downside risks, noting that it would be harder to change tax rates flexibly from year to year compared with commercial insurance. These risks arise from uncertainty about the actual costs of the NDIS when it commences, particularly stemming from uncertainties about the utilisation rates of services, future cost pressures and the actual uptake of services by people with disability. For instance, it would be difficult to know with precision what reasonable assessed needs would be (at least in the start-up phase of the scheme).

An implication of the need for a buffer is that there will need to be an investment fund for the reserve, overseen by the NDIA and by government (a matter addressed in chapter 7).

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[4] Indeed, the Australian Government made a five year commitment of funds under the National Disability Agreement (though that commitment cannot provide certainty of funding across disability services because the Australian Government is only a part funder of the system). Of course, for parents of a child with lifelong disabilities a five year commitment is of limited comfort.

12.3 Tax and revenue options

Where is tax policy going?

The NDIS will be an enduring scheme. The tax landscape of Australia is not likely to remain fixed, and the likely policy directions should at least be considered in choosing an appropriate financing method. While the review's recommendations may not be implemented soon (or ever), the recent Henry Tax Review (Overview 2010, p. xvii) has outlined the desirable direction of tax policy. It argued that governments should concentrate revenue raising on four 'robust and efficient' tax bases:

- personal income, assessed on a more comprehensive base
- business income, with more growth-oriented rates and base
- private consumption, through broad, simple taxes
- economic rents from natural resources and land, on comprehensive bases.

The review also recommended the ultimate removal of a host of taxes, such as transfer taxes (like stamp duty), payroll taxes, and fuel and registration taxes. The Henry Review also recommended that the Medicare levy should be removed as a separate component of the income tax system, and the revenue it raised collected as part of standard income tax (Henry Tax Review, vol. 2, p. 32). It indicated that:

> … the levy does not apply to all taxpayers and it interacts with the marginal tax rates in complex ways, creating high effective tax rates at some income levels. (Henry Tax Review, vol. 2, p. 30)

More generally, the review proposed simplification of income tax, with the recommended removal of a host of tax offsets. This suggests that any new hypothecated tax would be swimming against the tide of the review's proposed tax policy. That need not matter if there is a special case — but the expert views need to be considered.

What did participants think?

In contrast to the general thrust of the Henry Review, many participants in this inquiry proposed either supplementing the existing Medicare levy or creating a new levy as a dedicated funding source for the NDIS (box 12.1). In many cases, people envisaged the levy income as an add-on to existing revenue, rather than a replacement for all existing funding sources.

Box 12.1 **Participants' views about financing**

There are two obvious options: 1. through a specific purpose tax/levy as with Medicare, our allegedly universal health system 2. from general revenue as for our allegedly universal education system. The level of funding required is probably beyond what could be raised through lottery profits. (Bob Buckley, sub. 111, p. 17)

But it mustn't be funded through yet another levy, which is simply a flatrate tax and therefore inequitable - poor people pay a greater proportion of their income than rich people. Funding should come from general taxation revenue - if we need to increase tax, then do it as part of the stepped-rate income tax, not the flat-rate medicare levy. (contributor to Australians as Mad as Hell, sub. 153, p. 14)

[Funding should be through] (i) a separate levy similar to Medicare or (ii) an increased Medicare levy which would be set aside for people with a disability and their carers and targeted only at people with a disability and their carers. (City of Kingston, sub. 177, p. 8)

We believe that it should be similar to the Medicare levy – imposed by a similar taxation method. It must be seen as being different to and separate from the Medicare levy. We believe that it must be independent of the Medicare levy. (Valued Independent People sub. 201, p. 7)

There should be a clear and transparent method of funding the SCHEME through treasury with the funding being sourced via a levy, such as a Medicare levy, that could be imposed on all working Australians. (Spinal Cord Injuries Australia, sub. 214, p. 11)

I think a levy similar to the Medicare levy is the only way to go. (Sally Richards, sub. 26, p. 6)

For congenital conditions, ANGLICARE supports incorporating a scheme as part of the Medicare levy so that it is equitably shared across the community. (Anglicare, sub. 270, p. 24)

In relation to the funding source for the national disability insurance scheme the ANF agrees that income tax is the most appropriate for spreading the load proportionately across the income levels. Were the option of adding to the Medicare levy to be chosen the ANF does not consider that a name change would be appropriate as suggested – Medicare and Disability Levy – as this would contribute to the marginalisation of disabled people and reduce the sense of integration into mainstream activities and services. (Australian Nursing federation, sub. 335, p. 2)

(Continued next page)

Box 12.1 **(continued)**

Participants were divided as to whether they would prefer a contribution of those who are in the workforce and should pay a levy like the Medicare levy or whether they prefer that everybody pays through the GST. That way the NDIS would not be based on a charity principle, because everybody, including people with disabilities in receipt of the NDIS, would make a contribution to it. The other advantage of a GST like contribution would be that the burden of financing this scheme would not fall on those of working age. In view of a hugely increasing aged population it may be very important to distribute that burden more evenly. (Dignity for Disability, sub. 360, p. 9)

We have advocated a taxpayer contribution to the costs of health, ageing and disability though a Medicare-style health and disability services levy that rises slowly as the population ages. The levy would increase automatically as the percentage of mature age people in the community rises, with contributions coming straight off their gross incomes. (Councils of Social Service in Australia, sub. 369, p. 10–11)

Such a scheme could be based on a ‘surplus’, levied against tax payers in a similar fashion to the Medicare levy surplus, or funded from income tax revenue generally. (Law Council of Australia sub. 375, p. 5)Because disability can affect anyone at anytime, the most equitable way is based on a form of social insurance. This would be most readily achieved by adding a disability surcharge to the Medicare levy or from general revenue. (Yooralla, sub. 433, p. 11)

Australian society should pay directly for disability support through a specific tax like the Medicare levy. Set at between 1% and 1.5% of income (excluding the Medicare surcharge), the Medicare levy brought in $8.2 billion in 2009-10 , a figure projected to rise to $8.47 billion in 2010-11 and $10.5 billion by the 2013-14 financial year. (Australian Federation of Disability Organisations, sub. 495, p. 39)

The National Disability Insurance Scheme be funded by additional amount attached to the existing Medicare levy. (Physical Disability Australia sub. 543, p. 8)

Occupational Therapy Australia support the notion of a national disability funding scheme, funded via an increase to the Medicare levy, to improve disability care and support in Australia. (Occupational Therapy Australia, sub. 510, p. 19)

My concern is only increased when you suggest that there might be mandatory contributions similar to superannuation, or a Medicare-style levy … In proceeding down such a path of using the tax and transfer system, the Commission will invariably create anomalies and injustices [citing high marginal and effective tax rates for low income people in the Medicare Levy because of its exemptions]. (Adam Johnston, sub. 55, p. 8)

Northcott supports that the financing system for this scheme must be a national system, and not just a Council of Australian Governments (COAG) agreement or initiative. To contain costs and ensure sustainability, the scheme should have fixed parameters, and there should be periodical assessment as to changing needs and level of funding. (Northcott Disability Services, sub. 376, p. 21)

What are the options?

There are several broad ways of ensuring that the NDIS is properly funded.

A hypothecated tax

The first is to introduce a single hypothecated tax, using an existing tax base, like income tax (model 1 in figure 12.2). The Medicare Levy is an example — of sorts. It is an addition to income tax, with some concessions for some taxpayers. However, since this levy does not come close to funding health care, it is not a genuine example of hypothecation. That said, the Medicare Levy could be supplemented to (fully) fund the NDIS. As shown above, such an addition to the Medicare Levy, or a similar hypothecated tax on income tax, is the preferred position of most participants.

Notably, the Treasury raised the possibility of effective hypothecation to health, so the principle could be extended to disability:

> However, to increase the transparency of the costs of health, a share of revenue raised from personal income tax could be allocated to health expenditure. This allocation could be made whether or not the funds were hypothecated formally to health. (Henry Tax Review 2010, vol. 1, p. 31)

While income tax is one base for a new hypothecated tax, there are many other possible candidates. However, many of these would not be appropriate.

A $12.5 billion NDIS cost implies that the corporate tax rate would rise from its current 30 per cent to around 36 per cent.[5] This is problematic because it is contrary to current policy directions for lower capital taxes, which are particularly inefficient given high levels of capital mobility. This is shown by the evidence that for every dollar of revenue raised by an increase in the corporate tax rate, around 40 cents is lost through inefficiency (table 12.1).

Other Australian Government taxes — taxes on non-residents, taxes on imports and various excise taxes — would have to increase dramatically to fund an NDIS. For example, income tax rates on non-residents would need to be increase by more than eight-fold.

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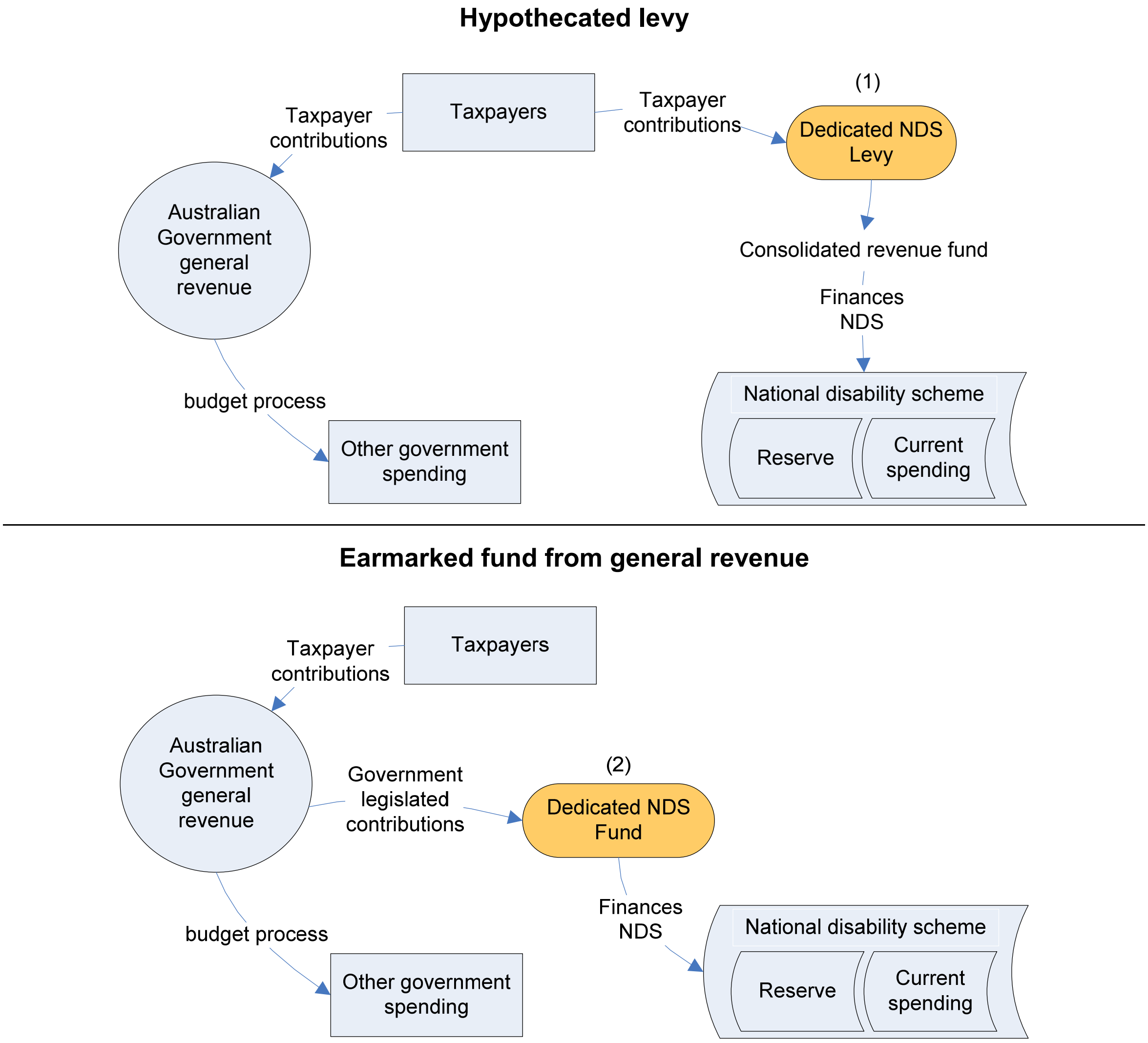
[5] We have used the gross rather than the net cost of the NDIS estimated in chapter 14 as the base for these calculations, since the Commission is recommending that the Australian Government fund the full costs of the scheme, obtaining offsets elsewhere (section 12.6).

Figure 12.2 **Two broad government earmarking approaches**



Similarly, state and territory governments have relatively limited tax options for raising any significant additional revenue (table 12.2). This is why state and territory governments receive most of their finances through distribution of the GST through the Commonwealth Grants Commission process or through special purpose payments made by the Australian Government. Funding of the NDIS would require large increases in the existing state and territory taxes. With the exception of land taxes and municipal rates, such increases would be highly inefficient. Moreover, different states and territories have varying capacities to increase tax rates, which would make it difficult to coordinate the collection of the very significant amounts needed.

Table 12.1 **How do Australian Government taxes fare?**

Tax	*Trend growth rate 2000-01 to 2008-09*[a]	*Revenue raised in 2008-09*	*Increase if $12.5 billion additional revenue needed*[b]	*Measure of inefficiency of tax (MEB)*[c]
	%	$m	%	%
Personal income tax	6.1	124 029	10.1	24
Company income tax	10.0	62 784	19.9	40
Income tax paid by superannuation funds	13.7	9 201	135.9	24
Total income taxes levied on non-residents	7.2	1 774	704.6	..
Goods and services tax (GST)	7.4	42 626	29.3	8
Total excises and levies	2.8	25 137	49.7	..
Taxes on international trade[d]	2.7	6 289	198.8	-3
Total	**6.7**	**278 002**	**4.5**	**..**

[a] This is the trend rate based on regressing the logged values of the taxes against a time trend. [b] This is the percentage increase in tax revenues were an additional $12.5 billion of revenue required (roughly the gross revenue requirement of the NDIS). [c] This is the ‘marginal excess burden’ of a tax. It is the loss to the economy in cents for every dollar of revenue raised. So, as an example, a value of 8 means that for every dollar of revenue, 8 cents is lost through inefficiency. [d] The MEB for international taxes is low when the tax increase is 5 per cent — reflecting the fact that the current tariff rate is below the optimal tariff rate. However, the optimal tariff rate ignores the potential for trade retaliation, and the fact that the increase required to finance the NDIS would require tariffs to be more than doubled. MEBs roughly rise disproportionately with increases in the tax rate.

Source: Commission calculations; KPMG Econtech 2010, *CGE Analysis of the Current Tax System*, Report to the Australian Treasury; ABS 2010, *Taxation Revenue, Australia, 2008-09*, Cat. No. 5506.0.

Given the limitations of the above tax bases, realistically there are only several possible tax bases for a standard hypothecated tax. The most straightforward is to use personal income tax as the base, as noted above. The Australian Government would create a disability care and support premium — as a hypothecated contribution to the NDIS. In effect, this would be like the Medicare levy, but with its marginal tax rates ‘aligned’ so that an increment would be added to the existing marginal income tax rates (rather than with the current complex exemptions) and with enough revenue to meet the full needs of the NDIS. The increment to meet the *gross* costs of the scheme would be relatively significant (which is another reason why the Commission favours the other option discussed below).

We provide an illustration of how this could work in figure 12.3, using the Henry Tax Review’s preferred structure for personal income tax as the starting point. (A variant on this model could add a supplement to the existing Medicare levy, recognising that tax reform has not yet been implemented along the Henry Tax Review lines. However, that would entail more significant inefficiencies.)

Table 12.2 **How do state, territory and local government taxes fare?**

Tax	*Trend growth rate 2000-01 to 2008-09*	*Revenue raised in 2008-09*	*Increase if $12.5 billion additional revenue needed*	*Measure of inefficiency of tax (MEB)*
	%	$m	%	%
Employers payroll taxes	7.8	16 922	73.9	41
Land taxes	12.0	5 565	224.6	8
Stamp duties on conveyances	8.6	9 534	131.1	34
Gambling taxes	4.5	5 028	248.6	92[a]
Taxes on insurance	6.9	4 505	277.5	67
Stamp duty on vehicle registration	5.0	2 026	617.0	38
Municipal rates	6.6	10 946	114.2	2
Local government and other state & territory taxes	3.4	17 805	70.2	..
Total[b]	6.4	61 385	20.4	**..**

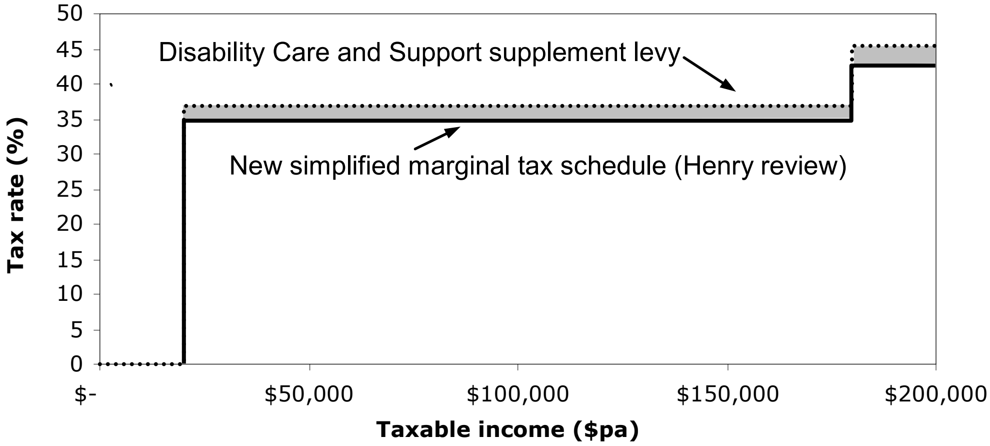
[a] As noted by KPMG, the excess burden estimates for gambling taxes are likely to be overestimates given the negative impacts of gambling on some people. [b] Excludes taxes on other levels of government and on public corporations.

Source: Commission calculations; KPMG Econtech 2010, *CGE Analysis of the Current Tax System*, Report to the Australian Treasury ; ABS 2010, *Taxation Revenue, Australia, 2008-09*, Cat. No. 5506.0.

Another option suggested by some is to use consumption spending as the tax base. In theory, this could be achieved by creating a broad-based cash flow tax as raised by the Henry Review (vol. 1, p. 276), changing the present GST rate, or eliminating some the exemptions applied to the GST, and again set aside the additional income as a hypothecated amount for the NDIS. Such consumption taxes are generally efficient, and the Australian consumption tax rate is set at a low level compared with other countries that use value-added taxes. However, existing consumption tax arrangements are entrenched and are unlikely to be changed in the near future. Realistically, a hypothecated tax would probably relate to taxable personal income.

Regardless, under section 81 of the Australian Constitution, any revenue collected by a levy would have to enter the consolidated revenue fund (CRF), but would then be earmarked for disability supports.

Figure 12.3 **How an income tax levy might work**



Data source: Adapted from Henry Tax Review (2010, p. 30).

Commitment of general revenue

Beyond the two tax bases described above, there are few tax bases big and efficient enough to support a new hypothecated tax sufficient to finance the NDIS. However, an alternative strategy is not to specify any specific tax base, but leave it to the Australian Government to divert a specific funding amount from general revenue into an earmarked fund for the NDIS (model 2 in figure 12.2).

This has several major advantages:

- it can take account of any efficiency improvements in the tax system over time. For instance, if the tax system moves in the directions suggested by the Henry Tax Review then many taxes would be removed, and revenue would be mainly collected through revised corporate and personal income taxes, a broad-based consumption tax, and resource rent taxes. All of these would be more efficient than current taxes. Given the possibility for future tax reform, there could be substantial gains from not locking in a particular tax base as the source of revenue for the NDIS
- it leaves it open for government to fund the NDIS by cutting what it sees as wasteful or less necessary expenditures, without any tax increase at all.

The Commission has not nominated a specific source of additional tax revenue or cuts in expenditure elsewhere. The reality is that the Australian Government will come under increasing fiscal pressure as a result of an ageing population (Treasury 2010 and earlier Intergenerational Reports), and the arrangements for financing the NDIS would need to be considered against that background.

However, the earmarked funding approach leads to a quandary. A genuinely hypothecated tax can be a way of increasing certainty that government would provide adequate funding in the future. Just identifying the tax as something like a ‘National Disability Insurance Premium’ would make it hard to eliminate the tax or to divert it to other purposes, since most would accept the legitimacy of dedicated public funding in this area.

Could government achieve certainty of adequate insurance coverage without a hypothecated tax? One option would be for the Australian Government to specify in legislation a special fund — the ‘national disability insurance fund’ that would earmark a share of general revenue according to some formula to the NDIS. The legislative provision would make the requirement to earmark funds according to the prescribed formula. The elements of this approach that ensure a stable revenue stream are its legislated basis and that the amount earmarked for the fund would not be an absolute amount of dollars, but act effectively as a rate applied to a growing income base. Without the latter, the amount of revenue would fall relative to the costs of the NDIS, and making up the shortfall would require new legislation — leaving too much scope for future governments to renege on a stable source of revenue.

Labels can matter

Labels can sometimes be important in public policy. Some participants did not want to label the revenue source as specifically for people with disability; and others did not like the idea of insurance because it might stigmatise disability. However, in a European context, the idea of insurance for costly life events is now customary and widely defended (Danzon 2004, p. xiii). In that context, there is some value in using the word ‘premium’ instead of tax or levy because it would make it clear that every taxpayer is getting a service — namely an insurance product, that provides him or her with disability supports if they are required. The fact that there are costs associated with meeting people’s support needs does not make any judgment about the value of people with disability.

The label ‘premium’ is most obviously suited to model 1 above. Nevertheless, the concept of insurance and premiums could still feature in the second model, by naming the fund something like ‘National Disability Insurance Premium Fund’, with the Australian Government’s transfers from general revenue being explicitly framed as premium contributions on behalf of all Australians.

Does the Australian Government have the power to raise hypothecated revenue for disability care and support?

The Commission understands that the Commonwealth would have the power to collect a hypothecated tax using its taxation powers, would be able to provide disability benefits (with benefits interpreted as either money or goods and services), and that there would be no restriction on its capacity to make payments from the Consolidated Revenue Fund to the NDIS.[6]

12.4 Ensuring sustainable returns

The NDIA's main financial responsibility is to manage the costs of the scheme. The Australian Government's main responsibility is fiscal — to collect the required revenue of the scheme. This means that unlike private insurers, the capacity to raise 'premium' rates (in the NDIS, effectively higher tax rates or permanent cuts in other spending) would be a matter for government (though it would take advice from the NDIA).

Were the Australian Government to commit to meeting the annual (efficient) costs of the scheme, regardless of whether this required a tax rate increase, then the fiscal problems for the scheme would be resolved. (Whether such an approach would be desirable from a public policy point of view is another matter. We touch on some of these problems when considering the desirability of fully-funding of the scheme in section 12.5.)

However, there are compliance and administrative costs in changing tax rates, and political costs in increasing them. Moreover, in reality, an easy mechanism for changing revenue annually might encourage less than diligent oversight of costs. And past tax policy reveals that successive Australian Governments tend to prefer

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[6] While the High Court's recent decision in *Pape v Federal Commissioner of Taxation (2009) 238 CLR 1* did not restrict the Commonwealth's power to spend, it requires that the spending be supported by the Commonwealth's legislative powers or its executive power, rather than by what was previously thought to be an unrestricted 'appropriation' power in s 81. That said, various legislative powers would support spending on disability related matters, as would the executive power in certain circumstances. Under s. 51(xxiiiA) of the Australian Constitution, the Commonwealth may make laws providing for, amongst other things, 'sickness and hospital benefits, medical and dental services … , benefits to students and family allowances'. While specialist disability services are not listed in the Constitution, by inference they share qualities with the other categories, and would be covered. The Commonwealth can set the qualifications and disqualifications for the receipt of such benefits or services. The notion of 'benefits' is a very broad one and is not confined to providing money; it may encompass the provision of a service or services, as well as goods.

stable or decreasing tax *rates*.[7] Accordingly, the NDIA cannot rely on governments to fund reasonable costs in the future if these entail significant hikes in tax rates. In any case, there will be other calls for more general tax rate rises to fund the substantially increased health costs associated with ageing. Achieving tax rate increases for disability might be hard in such a fiscal environment.

In that context, it may be necessary for any scheme to limit tax rate increases over a reasonable future period. Assuming the desirability of a stable tax rate, then that rate applied against some tax base must:

- ensure tax revenue that is enough to fund the expected present value of the payments of the scheme over a reasonable time horizon
- build in reserves to take account of various risks, arising from:
  (i) variations in annual revenue needs because of temporary cost and utilisation pressures (for example, the actual incidence of disability may vary randomly from year to year around an average)
  (ii) unanticipated permanent shocks (such as cost pressures, changes in prevalence rates and long-term changes in the capacity for people to provide informal support as family structures and preferences change)
  (iii) incorrect assumptions about people's real needs, so that there needs to be a special reserve for cases that legitimately lie outside the benchmark range.

The information to do this would be the same that the scheme's actuaries would use in managing costs (discussed in chapters 7 and 10), except that they would have to do it correctly in the first year in which the tax rate was determined (assuming again that a fixed tax rate is being set). That is a hard task because the scheme would need funding prior to the time when the information for making good projections would be available. Even setting a large provision for reserves might not adequately address the uncertainty.

As a result, it may be necessary for the government to fund the scheme through general revenue in the initial few years, with an agreement by government to shift to a sustainable tax arrangement by a specified date. One of the values of the Commission's proposal to test the NDIS in a given geographic area in the first year of its operation (chapter 17) is that this should allow more accurate calibration of the appropriate rate of contribution into the national disability insurance fund.

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[7] For example, the first two marginal tax rates for personal income tax were 15 and 30 per cent from 2005–06 to 2009–10 (and this will continue through to 2010–11). And, where there have been movements in personal and corporate tax rates, they have generally been downwards.

An illustration of sustainable returns using hypothecated taxes

It is possible to illustrate the implications for revenue flows and potential fiscal gaps in the NDIS from using a hypothecated levy based on personal income or consumption. The calculations are stylised, rather than attempts to model exactly the fiscal gaps — but they approximate some possible scenarios. The calculations (initially) assume a pay-as-you-go scheme. **It should be emphasised that the Commission's preliminary estimates of the range of actual costs of the scheme are in chapter 14.**

The first simulation examines the gap between NDIS revenue and outlays if the consumption and income tax rates were set at the rates that provide just enough revenue to meet costs in each year, and then compare the rates in 2050 with 2010.[8] If the tax base grows sufficiently with NDIS costs, then the differences between the 2050 and 2010 rates should be small.

The assumptions underlying the calculations are set out in box 12.2. They use the underlying methodology of the Australian Government Treasury's Intergenerational Report (IGR), supplemented by some additional assumptions about factors relevant to disability. The model is relatively simple and not comprehensive,[9] with its goal to show some of the issues that government and the scheme actuaries will need to address in devising the appropriate tax rate.

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[8] It should be emphasised that the choice of end date is illustrative. The assumption in the bottom two rows in table 12.3 is that tax rates would be fixed to 2050. This end date is consistent with the Intergenerational Report, which is the source of many of the assumptions of the model. Of course, the tax rates could be reviewed and recalibrated more regularly than this assumption implies. However, the qualitative results would be similar were a shorter time horizon to be used in the illustration.

[9] Some of the simplifying features of the approach we illustrate here are that it (a) uses only approximate tax bases (b) uses just one overall prevalence measure, with no account for changing prevalence rates for different types of disabilities (c) assumes relatively smooth long run paths to the long-run (usually following wither exponential or logistic growth curves) (d) ignores more complex stochastic features that would be relevant to a proper risk model. For example, some series may follow a local linear trend (Harvey 1990), in which random errors affect the trend growth rate as well as the level of any relevant variable. There may also be correlations between errors in one period with others, and between errors affecting one variable and those affecting others. For instance, on the latter score, if unemployment rates were to rise, then labour force participation might also fall due to the 'discouraged worker' effect. While there are limits to what can be modelled, reserves are intended to cover all of these stochastic elements.

Box 12.2 **Illustrating fiscal gaps with fixed tax rates**

The basic projection methodology is similar to that of the IGR.

The tax bases used for estimating the GST revenue and personal income tax are approximated using ABS National Accounts data. The personal income tax base is estimated as National Accounts household income comprising wages and supplements, interest, dividends, and social assistance (but excluding imputed rental income, which is not taxed). All data are in constant 2010 prices. Actual tax bases will vary from these, with the implication that the tax rate increases needed to fund the NDIS would vary from those shown. The point of this analysis is not the actual tax rates required, but a qualitative illustration of the impacts of various scenarios associated with the financing of the NDIS.

It is assumed that the consumption and household income ratios remain as a constant share of gross domestic product (GDP) over the long run. The long-run shares are estimated as the average of the ratios from 2000-01 to 2009-10. Real GDP was estimated by assuming:

- long-run populations from the ABS series B population projections. This involves growth of 1.1 per cent trend growth per annum, only slightly below the IGR 2010 estimate of 1.2 per cent per annum
- a change in the ratio of the working age population (those aged 15 years and over) to the total population (from 80.9 per cent to 83.3 per cent), based on the ABS series B population projections (and close to the IGR 2010 estimates)
- a shift in the participation rate from 0.65 to 0.61 from 2010 to 2050 (based on Treasury 2010, p. 11). (The participation rate is the ratio of labour force to working age population (those aged 15 years and over)
- a shift in the unemployment rate from 6.25 per cent to 5 per cent from 2010 to 2050 (based on Treasury 2010, p. 2).
- a shift in average hours per worker from 34.1 to 33.6 hours from 2010 to 2050 (Treasury 2010, p. 13)
- labour productivity growth in the economy as a whole of 1.6 per cent per annum (Treasury 2010, p. 13).

The model allows the average care and support costs for people with disability to differ across age groups, but in the scenarios shown below, it was assumed that the costs did not alter over age.

The model incorporated some general cost pressures due to:

- long-run economy-wide real wage growth, which in itself was equal to long-run labour productivity of 1.6 per cent. The usual Treasury assumption is that in services, such as aged and disability services, wages follow the national productivity growth rate (in order to keep labour in the sector), but that these wage pressures are not significantly offset by productivity growth in the service sectors concerned. The model allows this assumption to be varied

(Continued next page)

Box 12.2 **(continued)**

- the withdrawal of informal carer supports as family structures and expectations change. The annual percentage effect of this, V, is:

  $$V_t = 100 \times \left(\frac{1-\lambda(1+\delta)^t}{1-\lambda(1+\delta)^{t-1}} - 1\right)$$

  where λ is the share of total hours of support provided by informal carers, and δ is the annual growth rate in average unpaid carer hours per person with a disability (assumed to be negative), with the assumption that any shortfall in informal hours must be made up by paid support. In this model, it is assumed that λ=0.75 and δ = -0.002 (that is -0.2 per cent), but clearly alternatives could be used. It should be noted that the withdrawal rates of informal care under the NDIS is assumed to be much lower than the high rates apparent in the current under-funded system. That reflects the fact that informal carers will be much better supported in the NDIS
- the impact of other cost pressures, such as rising expectations of standards of support and above economy-wide average wage increases as labour shortages bite. In this illustrative model, we have assumed a cost pressure rate of 0 per cent per year in the base case, but describe what might happen under an alternative scenario.

The numbers of people with disability were estimated by applying the age-specific disability rates from the 2009 ABS Survey of Disability, Ageing and Carers to the ABS series B population projections. It was assumed that age-specific rates remained fixed over time. However, population ageing means that the aggregate prevalence rate increases (slightly) based on the B series. The model allows a general trend factor to moderate up or down the age-specific rates (but this is zero in the base case). The overall severe and profound disability population numbers are multiplied by a fixed adjustment rate of around 0.53, as a simple proxy for the relevant measure of disability discussed in chapter 3, and indicating 360 000 eligible people in 2010. (As in other aspects of the model, we have used rounded estimates that are reasonable but also easy to use as a metric against which to measure change easily.)

It is then possible to calculate the notional personal income and consumption tax bases, and for any assumed tax rates, the amounts of revenues and how these compare with NDIS outlays.

Were an income tax levy to be used to finance the NDIS, the actual rates faced by individual taxpayers could be lower or higher than those shown, depending on their income. If the shape of the existing marginal rate schedule was maintained under the NDIS (as in figure 12.3), then some people would pay no tax because they would be under the tax free threshold.

The earnings associated with reserves assume that a real rate of return of 3.5 per cent is used, based on the rate used in the IGR 2010 model and the long term cost report on Commonwealth superannuation.

In the case of a hypothecated levy on personal income, the average pay-as-you-go rate required for budget neutrality climbs from around 1.60 per cent to 1.78 per cent. For a hypothecated consumption tax, the rate for budget neutrality rises from 2.28 per cent to 2.54 per cent. Were the government to not change rates over time, but stay with the 2010 rates, there would be increasingly substantial fiscal gaps in later years and a cumulative debt in 2050 of $85 billion (in constant 2010 prices) or a debt of around $2500 for each Australian at that time (and 2.3 per cent of GDP).

However, a small addition to the initial tax creates a reserve, which then accumulates with later surpluses and with earnings on the balance. This can then be run down in later years as demographic pressures erode the tax bases and pressures (beyond normal wage increases) raise costs. For example, given the parameters in box 12.2, changing the income tax levy to 1.67 per cent or the consumption tax to 2.38 per cent would mean that the cumulative debt in 2050 would be zero (table 12.3). (Of course, ultimately the effects of population ageing on GDP growth will decrease, as will some of the pressures on disability costs. So, in the longer run, it would be possible to have a stable reserve relative to annual scheme costs.)

The implication of this analysis is that adding a suitable margin to the initial tax rate can address long-run sustainability. That margin would be somewhat more than that given in the base case example above because there are various risks to the scheme — (i) to (iii) discussed above. As an illustration, were there to be a genuine risk of additional unanticipated (but legitimate) cost pressures of one per cent per annum, then the constant income tax rate needed to ensure no scheme debt in 2050 would be 1.90 per cent. That is around 15 per cent higher than the rate (1.67 per cent) under the base case.

If subsequent information emerged that suggested that this risk was lower than thought, then the scheme could run down its reserves through dividends to government or by lowering the tax rate. (Getting agreement for *lower* tax rates would probably not be difficult.)

Alternatively, if independent actuarial assessments indicated that, even with risk reserves, the scheme was not sustainable in the long run, and that costs were *efficient and reasonable*, then the NDIA could seek a premium rate increase.

It is also worth spelling out the very substantial fiscal dangers of not controlling costs diligently. Suppose that excess cost pressures were 2 per cent per annum and could *not* be justified as efficient and reasonable. If all other settings remained as in the base scenario, and the government did not change rates over time, but stayed with the 2010 rate of 1.60 per cent of personal income, there would be increasingly substantial fiscal gaps in later years and a cumulative debt in 2050 of $640 billion (in constant 2010 prices) or a debt of around $20 000 for each Australian in 2010 prices at that time (and around 18 per cent of GDP). That would be untenable fiscally. This why the Commission has proposed a raft of measures to ensure scheme sustainability.

Table 12.3 **Some illustrations of fiscal consequences under different scenarios**

	Base case	*1% per annum additional cost pressure*	*Participation rate falls to 57%*	*Reduction in age-sex prevalence rates of 0.2% pa*	*No trend decline in informal care rates*
PAYG: Where tax rates are set to equal costs in each year[a]					
2010					
Income tax rate (%)	1.60	1.60	1.60	1.60	1.60
Consumption tax rate (%)	2.28	2.28	2.28	2.28	2.28
2050					
Income tax rate (%)	1.78	2.18	1.91	1.67	1.53
Consumption tax rate (%)	2.54	3.10	2.72	2.38	2.18
Debt in 2050 if 2010 tax rate is used for all years ($billion)[b]	85	342	161	20	-66
Where a common tax rate is used for each year to achieve no long-run debt[c]					
Income tax rate (%)	1.67	1.90	1.75	1.61	1.54
Consumption tax rate (%)	2.38	2.71	2.49	2.30	2.19

[a] These values given the tax rates for 2010 and 2050 that are enough in those years to exactly meet estimated costs in those years. So the income tax rate under the base case would need to rise from 1.60 to 1.78 per cent in order to ensure costs were met under a PAYG system. [b] This gives the debt in billions of dollars in 2010 constant prices if the tax rates for any given scenario are kept fixed at their 2010 rate. For example, under the base case, keeping the consumption tax rate at 2.28 per cent for all years would lead to a debt equal to $85 billion by 2050 (or 2.3 per cent of GDP at that time). [c] This is the tax rate that were it applied for all of the years between 2010 and 2050 would mean that the net debt of the scheme was zero. In effect, it means that the scheme would be a hybrid of a fully-funded scheme and a PAYG, in that while different generations pay more than each other, their tax rates do not change. For instance, under the base case, setting the rate at 1.67 per cent of personal income means zero debt. That means the rate is 0.07 percentage points higher than the PAYG tax rate in 2010, and in the year 2050, the rate is 0.11 percentage points lower than the PAYG rate that would have applied in 2050.

Source: Commission calculations.

Sustainable returns using an earmarked fund

The above approach applies readily to hypothecated taxes. How would it work for an earmarked fund? There could be several approaches, both underpinned by legislation specifying the exact method, and similar in nature to that described above.

Method 1

The easiest method would be simply to act *as if* the earmarked fund was collected as income or consumption tax and work out the amount to put into the fund annually using the approach described above.

Method 2

While there is a virtue in government committing to a fixed hypothecated tax rate, as discussed above, it presents a problem for the actuaries and treasury officials advising the government because the decision about that tax rate must be made at a single point in time early in the scheme's life. A year or two later, those advisers may be saying that a different tax rate would be better, and a year or two after that, another rate. That flexibility is a feature of commercial insurance products, but it is a problem for governments reluctant to increase tax rates visible to the public. That is why the government would need to build a big margin of error into any scheme whose funding source was a fixed rate tax.

An earmarked fund may allow more flexibility because it might be easier to achieve changes in effective tax rates because the flow into the fund need not be represented as a tax *rate*. It is simply an amount, based on a legislatively specified approach. This approach could permit the use of new information to update the right amount — say on the application of a particular method by the Australian Government Actuary (or overseen by that office). The capacity to use new information in such an approach *must* reduce uncertainty and therefore should reduce the reserves required, and accordingly lower the average implicit tax rate. Moreover, were it deemed desirable, this approach would allow the introduction of full funding for a share of the new incidence of cases in the NDIS along the lines discussed in the DIG report.

An important element in any such updating process would be to avoid incentives for the scheme to cost pad because government was perceived as accommodating. That might arise from soft assessment by assessors or the NDIA, and from excessive wage demands. That is less likely to happen under method 1 above or through fixed hypothecated taxes because, by definition, the tax rate cannot readily be changed, and because reserves would suddenly start collapsing below predicted levels, providing a very visible indicator of a scheme in trouble.

Accordingly, there is a trade-off in method 2 between its capacity to provide and use better intelligence about the scheme, and its potential vulnerability to manipulation.

A slow start will help

The Commission has proposed a gradual implementation of the NDIS (chapter 17). While it would be appropriate to immediately set aside some funds to be delivered through existing state and territory disability arrangements and to meet the assessed needs of those who will initially use the scheme, the scheme should collect revenue in excess of its immediate needs to build up a significant buffer.

12.5 Fully-funded, pay-as-you go or a hybrid?

Fully-funded schemes allocate to a fund the estimated long-term liabilities associated with care and support for members at entry to the scheme. This is the approach used in the NSW Lifetime Care and Support Scheme for catastrophic motor vehicle accidents. In any pay-as-you-go (PAYG) government scheme, the current group of taxpayers meet the current obligations of the scheme.

Deciding between PAYG and fully-funded schemes (and hybrids of the two) has to balance several factors.

Lowering the risk of insolvency and increasing certainty for current users

Fully-funded schemes do not rely on future premium contributions to fund existing claimants. Accordingly, subject to good management and appropriate determination of premium levels, people using the scheme can be assured that their long-term needs will be met. This approach also compels scheme managers to look forward when managing the scheme to ensure its solvency.

In contrast, if a PAYG scheme has large contingent liabilities — which are off budget for the Australian Government — scheme managers would focus on the next 12 months and then the next three years, and not beyond that. Moreover, there is a risk the scheme would make increasingly large claims on the Australian Government’s budget. Those claims would be ultimately politically vulnerable, as would be the scheme for coming generations.

Scheme managers can overcome this problem in less than fully-funded schemes, but it requires appropriate governance arrangements, including careful data collection and analysis. The Commission discusses how this would be achieved in detail in chapters 7 and 10. This would be a crucial component of a sustainable scheme.

Fairness for different generations – ‘intergenerational equity’?

In any given year, most taxpayers were born more than three decades earlier (simply because workforce participation rates are zero or low for the young). Under PAYG arrangements for the NDIS, people born in later years (younger ‘cohorts’) would tend to make greater lifetime tax contributions for the same benefits than do older cohorts. That means there are transfers between successive generations. This cannot happen to any degree in private insurance schemes because younger cohorts cannot be compelled to pay for older cohorts.

There are several pressures that can lead to transfers between the generations, but in contemporary Australia, the most important is population ageing. The age distribution of the population is changing, and a much greater proportion of people will be old in future years. They will no longer be in the workforce, and while still receiving some private income, their tax contributions will be less than their claims on government — particularly through the health and aged care system if the current arrangements remain in place (Treasury 2010).

On the face of it, any such transfers — whatever their origin — do not seem ‘fair’. Fully-funded schemes overcome this because — so long as scheme managers maintain a solvent scheme from year to year — there is no rump of debt for later generations to meet. For example, the Australian Government’s Future Fund is intended to avoid large budget pressures associated with future obligations to meet public sector pensions.

However, from an economic welfare viewpoint, the desirability of spreading tax obligations across generations is not straightforward. At least historically, the lifetime earnings of new generations has significantly exceeded that of older generations. That reflects productivity growth and the increasing levels of age-specific female workforce participation rates. A strong principle of tax policy is that people with higher incomes should pay increasingly higher tax contributions (‘progressivity’) to improve fairness (so-called vertical equity). The consistent use of that principle would apply to both a population of taxpayers at a given time and to populations of taxpayers at different times. So, in fact, it might be fair for newer richer generations to make contributions to the NDIS at higher tax rates than older generations. As it happens, the pressures of population ageing on the NDIS appear to be small because high age-specific disability rates mainly occur among people aged over the pension age, and the NDIS would not *fund* care and support for these people (chapter 3). The major demographic pressure on the NDIS is the withdrawal of informal unpaid care — with its disproportionate impact on the need for paid formal care (chapter 2). That is one of the reasons why it is critical for the NDIS to support informal carers in their role.

Moreover, the situation is far more complex than this. From a policy perspective, *all* transfers between generations (such as all social welfare transfers, changes in technology, changes in the environment, and private bequests) are relevant to a judgment about whether there is fairness between successive generations. As Doran (2008) has noted:

> To pose the question of intergenerational equity is necessarily to pose a question that cannot be answered meaningfully without considering the entire distribution of benefits and burdens among generations. (p. 23)

So whether it is fair or not to fully-fund the NDIS cannot be determined by looking at the NDIS in isolation. No one has undertaken a comprehensive analysis of intergenerational equity in Australia, so we do not know whether fully-funded or PAYG schemes, or a hybrid of these, would be fair or not.

Efficient taxes

Taxes can reduce efficiency because they affect people's investment, consumption and employment incentives. The Commission has mooted several relatively efficient tax bases. Even so, those inefficiencies can rise more than proportionately with increases in tax rates. This implies that shifting obligations to later years through PAYG arrangements and funding these from higher tax rates would adversely affect economic efficiency — at least one consideration in deciding how much to smooth tax obligations over time (Davis and Fabling 2002). That would justify setting relatively stable taxes over the longer horizon — and that would then entail building up early reserves and running them down later.

However, as shown above, the degree of tax rate variation to finance a scheme is relatively modest, say compared with health care, and there are methods, other than fully funding, that can smooth tax rates.[10]

Planning over a lifetime

One way of thinking about fully-funded schemes is to see how they could operate at the individual level. In effect, people have a notional savings account intended to meet their reasonable long-term support needs. Just as with normal savings accounts, various expenditures can be brought forward (or deferred) as people's life

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[10] Moreover, the literature on tax smoothing is contested, with concerns, for example, about the effects of large accumulation of reserves on rates of return, though that is likely to be less important for the NDIS, which builds up relatively small reserves from an economy-wide perspective (Sadka and Tanzi 1998).

plans change, without that affecting long-run scheme liabilities. In that sense, fully-funded schemes are conducive for lifetime planning that is less constrained by an annual budget.

However, this advantage of fully-funded schemes over less than fully-funded schemes is more apparent that real. Less than fully-funded schemes could achieve the same benefit by having sufficient reserves that allow shifts in spending from one period to another. Under this approach, it would be critical for scheme managers to estimate that reserve reasonably well, and to ensure that bringing forward spending by groups of individuals had a quid pro quo of reducing spending by those groups on average at a later date. This is not a comparative weakness of partially funded schemes over fully-funded schemes, because the same imperative for careful management equally applies to a fully-funded scheme.

This is because a fully-funded scheme would include risk pooling, with accounts only *notionally* allocated to the person (unlike Medical Savings Accounts without risk pooling). So, someone might have an expected long-term liability of $5 million, but with changes in his or her life circumstances might only need $4 million. This person would not get to pocket the saved $1 million. Instead, the money would enter a risk pool to cover the costs of people whose lifetime circumstances meant they needed higher supports than anticipated. Accordingly, the incentives for people to be prudent in bringing forward expenditure are as weak as they are in a partially funded scheme. As one insurer told the Commission, managers must administer their schemes with an ‘eagle eye’.

Feasibility

The NDIS will provide supports to hundreds of thousands of people, many of whom receive inadequate resources. A fully-funded scheme would meet the remaining long-term liabilities of these people. In the Commission’s proposed design, that would be small for those people approaching the pension age. But for many, such as a five year old with cerebral palsy, fully-funding of long-term liabilities would be very high. Given its costs, a fully funded scheme would only be tenable for new entrants to a scheme — the approach taken in the NSW Lifetime Care and Support Scheme. It would take decades to cover a significant share of people with disability. In this context, the DIG report noted:

> On costing, the resulting Scheme (of new incidences of disability and pre-existing disability) on a fully-funded basis was seen to be both beyond an affordable level of acceptability at the present time (as discussed with the DIG), and also probably not necessary to achieve the objectives of the Scheme. (p. 7)

As a result, a *pure* fully-funded model cannot realistically be implemented. Its existence is not essential to achieving the goals of the NDIS so long as the scheme has an appropriate governance structure and a capacity for partial funding of future liabilities to build up reserves and to smooth tax rates. There are several ways of achieving sustainable partial funding of future liabilities:

- The DIG report investigated partially-funded coverage of a share of new incidence, while also collecting enough revenue to meet the reasonable needs of the stock of people with disability on a year by year basis. This form of partial funding would depend on the pattern of new incidence.
- An alternative partial funding arrangement would be based on the actuarial and economic determination of optimal reserves, which may not be related to the pattern of new incidence.

On balance, the Commission favours the latter because it explicitly attempts to achieve optimal reserves.

12.6 Gross versus net taxation arrangements — and the implications for intergovernmental financial relations

The discussion and illustrative modelling above is based on the assumption that the Australian Government would finance the full (or gross) costs of the NDIS, rather than maintaining funding sources from states and territory governments and from standard Australian budget appropriations.

To illustrate the scope of the funding and spending issues at stake, overall spending on disability services and supports was about $6.2 billion in 2009-10, of which the states spent around $5.4 billion (table 12.4). The preliminary estimate of the gross amount required to meet people’s reasonable needs in 2009-10 ranges between $10.8 billion and $14.2 billion, with a ‘base’ estimate of around $12.5 billion (chapter 14). This is roughly twice the actual resources currently committed.

State and territory governments *funded* around $4.5 billion of the total current expenditure, while the Australian Government funded around $1.7 billion. (Of this, $900 million were transfers to the states and territories through a ‘special purpose payment’ or SPP.)

Table 12.4 Funding and spending on disability supports

Estimates 2009-10[a]

National Disability Agreement (excluding employment services)[b]	*$m*
Spending:	
State and territory governments	5 062
Australian Government	148
Total	5 210
Funding	
Australian Government transfers to states under SPPs	904
Australian Government funding of own direct spending on disability supports	148
State and territory governments	4 158
Total	5 210
Disability supports outside the NDA[c]	
Spending:	
State and territory governments	323
Australian Government	668
Total	991
Funding	
State and territory governments	323
Australian Government	668
Total	991
All disability supports[d]	
Spending:	
State and territory governments	5 385
Australian Government	815
Total	6 200
Funding	
State and territory governments	4 481
Australian Government	1 719
Total	6 200

[a] The purpose of this table is to indicate the current level of spending on disability services and supports that *would be covered under the NDIS*. That is important because only such spending is an offset for the projected gross expenditure of the NDIS. [b] Under the NDA, the Australian Government spent $630 million on employment services in 2009-10 (SCRGSP 2011). While some of this spending related to specialist employment services, which would be included under the NDIS, some relates to mainstream employment services, which would lie outside the NDIS. The AIHW (2011) indicates that users of supported employment services accounted for around 20 per cent of the total users of disability employment services. Accordingly, not including *any* spending on employment services means that the total value of offsets of $6.2 billion would be higher, but by only some proportion of the $630 million. [c] Among other things, these include HACC services for the non-old, taxi vouchers and aids and appliances. The $950 million estimate and the share funded by the Australian Government are not precisely estimated. They involve estimates about the split of funding between those over and under 65 years, and between the Australian Government and state and territory governments. The data also relate to a mixture of years from 2006-07 to 2009-10. The overall HACC expenditure shown here somewhat overstates the extent to which they act as an offset to the costs of the NDIS. This is because some HACC services would remain after the creation of the NDIS. [d] These numbers exclude various income support and other payments made by the Australian Government, such as the Disability Support Pension, Carer Payments, Carer Allowances, Mobility Allowance and some other payments. These are not included in the financial calculations because this spending would mainly lie outside the NDIA. That said, the Commission has made observations about how some of these payments might be integrated into the NDIS (chapter 4).

Using 2009-10 as an illustrative year, under a 'net' approach, the Australian Government would collect an additional $6.3 billion for disability funding using the hypothecated tax or the earmarked fund discussed earlier. It would add the new revenue to the existing funding from its special purpose payments, and with state and territory governments' financed disability supports and services. The Australian Government's total share of disability funding would rise from 28 per cent to over 64 per cent.

Under a gross financing approach, the Australian Government would collect the full $12.5 billion (with some reserves) using an earmarked financial instrument. It would no longer allocate the $900 million as an SPP, and would save the $800 million it used to spend directly on disability supports and services. It would seek to recover from state and territory governments the $4.5 billion they would have paid into disability. The gross and net approaches would lead to identical funding pools.

However, there are differences between the two approaches, which involve a raft of issues, some simple, others complex. On the simple side, a gross tax has clear transparency and accountability because, unlike the Medicare levy, it would fully finance the NDIS. People would see the real cost of providing disability supports, and that would provide an additional impetus for proper governance.

On the complex side, there several intertwined issues about:

- the respective capacities for pre-commitment under gross versus net financing arrangements
- the relative efficiency of tax collection for state and territory governments and the Australian Government
- intergovernmental financing arrangements
- which levels of government wield power.

Untangling the issues

As discussed above, there are strong grounds to 'lock in' future revenue to provide stable funding for the NDIS. A key advantage of a hypothecated gross financing arrangement underpinned by legislation and branded as a secure funding source is that it makes it difficult for subsequent Australian Governments to renege on that funding.

However, were the net funding arrangement to apply, then any jurisdiction, including the Australian Government, could decide to lower their general appropriations to disability depending on fiscal pressures of the day, reducing the aggregate funding available for disability. That change would be far less visible to the public than an active decision to alter a hypothecated arrangement.

It might seem that the difficulty of obtaining pre-commitment under a net arrangement might be resolved through an intergovernmental agreement. On the face of it, that course of action looks promising. For example, the memorandum of understanding for the recent the *Federal Financial Relations Amendment (National Health and Hospitals Network) Bill 2010*, noted that

> To provide the States with certainty and security about future funding arrangements relating to the GST, the NHHN Agreement requires the Commonwealth to exercise its best endeavours to put in place legislation to prevent it from making any further changes to: the provision of GST revenue to States as untied general revenue assistance; and the amount of GST to be dedicated to health care. (p. 11)

However, expert assessment suggested this would not be a legally binding arrangement (and in fact, new federal arrangements for health care have since been announced):

> However, [the above provision] should be seen as a statement of intent. The provision has no legally binding force because a parliament cannot bind a future parliament. It is likely that that debates about health funding arrangements will remain an ongoing issue. Section 1.3 of A New Tax System (Goods and Services) Act 1999 contained a similar provision. (de Boer and Webb 2010)

More generally, there is a common general view that intergovernmental agreements are policy instruments not intended to have legal effect or be enforceable by a court (Leane, Myers and Potter 1997). As one commentator pointed out in relation to one major intergovernmental agreement (the Intergovernmental Agreement on the Environment), the heads of power are ‘political and moral’ (cited in above).

The heart of the issue is the extent to which a government of the day can bind future governments (regardless of whether they are state and territory governments or the Australian Government). The general consensus is that they could not do so, barring constitutional change (Williams 1999).

Accordingly, while intergovernmental agreements may create barriers against future change, those barriers require political commitment to be maintained. Equally, an Australian Government cannot bind a future Australian Government to a particular course of action. The implication is that it is not realistically possible to create legally binding pre-commitments at either the state and territory government level, at the Australian Government level, or through agreements between the different levels of government. That means crafting laws, agreements or arrangements that constrain, if not fully bind, future governments.

In the Commission's view the best way of creating certainty is for all levels and political persuasions of governments to commit consensually to change, creating a new federal social and economic institution (the NDIA), that would establish a brand recognition that would make it subsequently hard to eliminate (chapter 7). That status currently belongs to institutions like Medicare. That and similarly important institutions are creatures of legislation and, while theoretically susceptible to elimination, that prospect is improbable, bar grave maladministration.

Chapter 7 sets out how the governance arrangements would be structured so the NDIS was a body instituted under Commonwealth law, but with cooperation of state and territory governments — a federated model. The financial arrangements would also need to support that end. The Commission considered several options.

Option 1: the 'free ride' option

The Australian Government would create a 'National Disability Insurance Premium Fund', with the Government obligated under new legislation to make premium contributions on behalf of all Australians to that fund from general revenue, with the funding amounts determined by a pre-specified approach, as discussed earlier.

The Australian Government would fully finance the $12.5 billion needed in the NDIS premium fund. They would do this by withdrawing the NDA SPP ($0.9 billion) and their former appropriation to disability spending ($0.8 billion), and use a mixture of tax increases and cuts in non-disability expenditure to fund the residual $10.8 billion.

State and territory governments would no longer need to spend anything on disability services and supports, and would no longer receive the NDA SPP. Without any change in their income, this would allow them to have either a surplus or allow them to spend an additional $4.5 billion on some other state priority.

Assuming that the Australian Government funding source was a new tax entirely, then there would be a significant Australia-wide increase in taxation of Australians (shown in the third last row of table 12.5). It is unlikely that the Australian Government would agree to the resulting increase in overall Australian taxes or cuts in its own spending elsewhere. This is especially so given that there are going to be mounting pressures on Australia-wide taxes and spending from population ageing. This option is probably untenable.

Table 12.5 Illustrative impacts of various funding options on governments’ budget positions[a]

Spending and income category	*Current*	*Option 1 Free ride*	*Option 2 Give up GST*	*Option 3 A cheque to the Cwlth.*	*Option 4 Cutting SPPs*	*Option 5 Tax swap*
	$m	$m	$m	$m	$m	$m
State and territory budget						
Total outlays (incl. transfers)	165 000	164 100	159 600	164 100	159 600	159 600
Disability spending	5 400	0	0	0	0	0
Other Spending	159 600	164 100	159 600	159 600	159 600	159 600
Transfers to Australian Govt.	0	0	0	4 500	0	0
Income	165 000	164 100	159 600	164 100	159 600	159 600
NDA SPP	900	0	0	0	0	0
Other SPPs	59 100	59 100	59 100	59 100	54 600	59 100
Own Taxes	60 000	60 000	60 000	60 000	60 000	55 500
GST	45 000	45 000	40 500	45 000	45 000	45 000
Budget position	0	0	0	0	0	0
Australian Government budget						
Total outlays (incl. transfers)	280 000	290 800	286 300	290 800	286 300	290 800
NDIS Premium fund	0	12 500	12 500	12 500	12 500	12 500
Disability Own spending	800	0	0	0	0	0
NDA SPP to states	900	0	0	0	0	0
Other SPPs	59 100	59 100	59 100	59 100	54 600	59 100
GST to states	45 000	45 000	40 500	45 000	45 000	45 000
Other Aust. Govt. spending	174 200	174 200	174 200	174 200	174 200	174 200
Income	280 000	290 800	286 300	290 800	286 300	290 800
Old revenue (including GST)	280 000	280 000	280 000	280 000	280 000	280 000
New tax revenue	0	10 800	6 300	6 300	6 300	10 800
Transfers from states	0	0	0	4 500	0	0
Budget position	0	0	0	0	0	0
Combined governments' budget position						
Disability spending	6 200	12 500	12 500	12 500	12 500	12 500
Other spending	333 800	338 300	333 800	333 800	333 800	333 800
Total spending	340 000	350 800	346 300	346 300	346 300	346 300
Total taxes	340 000	350 800	346 300	346 300	346 300	346 300
Budget position	0	0	0	0	0	0
Aust. Govt. share of taxes (%)	82.35	82.90	82.67	82.67	82.67	83.97

[a] It is assumed that governments balance their budgets to make the illustration clearer, and the magnitude of taxes, transfers and spending are also simplified for this reason. The shaded boxes show the spending/funding categories that are show up most clearly the differences between the various options.

Source: Commission calculations.

Option 2: Giving up some GST money

This is similar to that above, except that the Australian Government would seek, through an intergovernmental agreement, to recover the money formerly spent by state and territory governments on disability by no longer paying the NDA SPP and through GST relinquishment, as in the original National Health and Hospitals Network Agreement. In other words, state and territory governments would lose the $0.9 billion of SPP and $4.5 billion from their current GST entitlements (or around 10 per cent of the $47.9 billion of GST payments made to state and territory governments in 2009-10).[11] A 10 per cent permanent forfeiture of GST revenue would provide a reasonably predictable source of revenue for the NDIS.

This approach has considerable attractions. However, given recent experience with this approach, it is improbable that a new arrangement based on this method would attract consensus.

Option 3: A 'cheque' from state and territory governments

This option is similar to that above, with the exception that state and territory governments would lose their NDA SPP and agree to contribute $4.5 billion to the NDIS premium fund. However, any such contribution would need to be permanent and would need to grow at a rate faster than GDP growth (given the negative effect of ageing on GDP growth and its positive influence on disability support costs). As discussed above, state and territory tax bases are not generally big or efficient enough to act as an ideal source of ongoing NDIS disability funding. Moreover, an intergovernmental agreement for a regular 'cheque' from state and territory governments may be more fragile than other such agreements. Were a state to renege, it would be impossible for the Australian Government to discriminate in its service provision to the citizens of that state.

Option 4: Cutting other transfers to state and territory governments

The Australian Government would not attempt to reach any intergovernmental agreement and instead would withdraw SPPs in other areas, with a value equivalent to $4.5 billion.[12] In 2009-10, the Australian Government made payments for specific purposes of just over $60 billion, so the SPP funding pool would certainly be sufficiently large to fund the required state and territory contribution to the NDIS premium fund. State and territory governments would then commit the funds they

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[11] Australian Government, Budget Paper No. 3, 2009–10 Budget (p. 111).

[12] In theory, if a longer-run perspective is taken, the Australian Government would not need to actually reduce SPPs below current levels. Demographic change means that SPPs will need to increase well above real per capita economic growth to meet growing service needs (Treasury 2010, p. 678). This would give scope for the Australian Government to partly finance the NDIS by not increasing SPPs in line with state and territory governments' future service needs.

previously provided to disability to the areas that previously were funded by Australian Government SPPs — a governmental form of musical chairs.

However, this approach could prove to be adversarial, whereas the intention of the Commission's approach is to create an institution (the NDIA) and system (the NDIS) in which all levels of government have a stake. Moreover, there would no guarantee that state and territory governments would in fact divert funds to the areas of need originally funded by SPPs. The Australian Government would therefore lose some control over their capacity to ensure other Australia-wide spending priorities were met.

Option 5: A tax swap

Under this option, state and territory governments would reduce inefficient taxes equivalent to their current funding of disability supports ($4.5 billion). In turn, the Australian Government would agree to fully fund the NDIS, doing so by raising new or existing efficient taxes and/or displacing the least justified spending.

To achieve this, state and territory governments and the Australian Government would sign an intergovernmental agreement:

- It would 'commit' the Australian Government to collect the gross amount discussed above, and would place similar obstacles to unilateral action by the Australian Government as those included in the original GST agreement. These obstacles would not be legally binding, but they would still be powerful.
- It would commit state and territory governments to remove one or more of their most inefficient existing taxes, financed by the revenue they would have otherwise directed at disability services. For example, a state or territory government could remove taxes on insurance, remove stamp duties on motor vehicles or a significantly reduce stamp duties on conveyancing.

Option 5 involves lower Australia-wide taxes than option 1 (table 12.5). While option 5 involves the same Australia-wide tax collection as options 2 to 4, it shifts tax burdens from state and territory governments to the Australian Government, which has better scope to levy efficient growth taxes. And, ideally, part of the funding for the NDIS would come from less high priority areas of spending, further reducing any additional taxes on Australians.

Implementing this option would create both a more efficient national economy and a new social institution. Moreover, the reform process would be hard to reverse. State and territory governments want a reputation for good economic management, so reversing decisions about removing or lowering tax rates would serve them poorly (and would be unpopular with their citizens). State and territory government taxes abolished as part of the GST tax reforms, such as the BAD tax and the FID tax, have not been reinstated. Similarly, any future Australian Government would find it hard to undermine the hypothecated disability insurance fund because it would be a very visible arrangement to Australian taxpayers, underpinned by legislation and subject to an intergovernmental agreement.

In summary

Of the five options, the Commission believes that option 5 has the greatest merit. It leads to:

- a more efficient way of financing the NDIS
- a robust revenue base with greater certainty of long-run funding
- a fair scheme with national entitlements, without unfair variations between the states and territories
- no greater a level of Australia-wide taxes than other options. It would also be easier to police and, compared with most of the alternatives, have a lower risk that jurisdictions would not meet their ongoing commitments.

12.7 Achieving a fair effort by all jurisdictions

State and territory governments make varying contributions to disability services in their jurisdictions from their own funds (table 12.6). In theory, some of the differences could reflect differing levels of effectiveness of state and territories in achieving outcomes for people with a disability, or differing unit costs. So a state might spend less per person because they can achieve the same or better outcomes as some other jurisdiction at a lower cost. Apart from the Northern Territory, where unit costs of delivering supports appear to be significantly higher than elsewhere given its significant indigenous population,[13] there is little compelling evidence that either greater efficiency or higher unit costs have a *major* role in explaining the overall variations in spending between jurisdictions. (The coverage ratios discussed below appear consistent with that view.)

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[13] AIHW (2002, p. 62).

Table 12.6 **Providing specialised supports for people with disability**

State-funded spending under the National Disability Agreement

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*
Own state funded $ per user[a]	32 610	18 437	32 416	27 273	13 896	22 648	15 784	26 526
Coverage (2008-09)[b]	19.0	39.2	15.2	24.6	40.4	20.6	43.5	26.9
Own $ per potential population (2009-10)[c]	6 200	7 232	4 911	6 703	5 617	4 667	6 861	7 146
Spending share less population share (2009-10)[d]	0.8	3.1	-3.3	-0.3	-0.5	0.2	-0.2	0.2
Trend growth rate in real spending from 2004-05 to 2009-10 (%)[e]	6.4	0.9	11.7	6.8	3.3	2.5	1.3	7.0

[a] This uses the 2008-09 user population and 2009-10 own state *funding* of disability supports and services under the NDA (and so does not include the value of transfers from the Australian Government). It includes administrative costs and payroll taxes. Funding of non-NDA disability supports and services by state and territory governments (such as such as HACC services and taxi vouchers) is not included. This is because consistent and accurate data on such funding by states and territories are not publicly available. Since jurisdictions may spend more or less than the average in this area, this would alter the above numbers — but in all likelihood not to a qualitatively different degree. [b] Coverage is the number of users in 2008-09 as a percentage share of the number of people with severe or profound disability aged 0–64 years from the 2009 SDAC. [c] This is own-state spending in 2009-10 per person with a severe or profound disability aged 0–64 years in 2009. [d] Calculated as the difference between a jurisdiction's share of total state and territory expenditure (own-state only) and its share of the Australia-wide population of people with a severe or profound disability aged 0–64 years. Accordingly, a positive number means that a jurisdiction is spending more than its disability population share, and is relatively more generous than the average. [e] This is the trend growth rate estimated by fitting the log of real expenditure (2009-10 prices) using ordinary least squares from 2004-05 to 2009-10.

Source: Calculations based on SCRGSP (2011) and analysis of unpublished ABS 2009 SDAC unit record data.

Several patterns are apparent in the data. Some jurisdictions serve a much higher share of the potential population of service users. For example, the share is high in Victoria while Queensland has a much lower share.

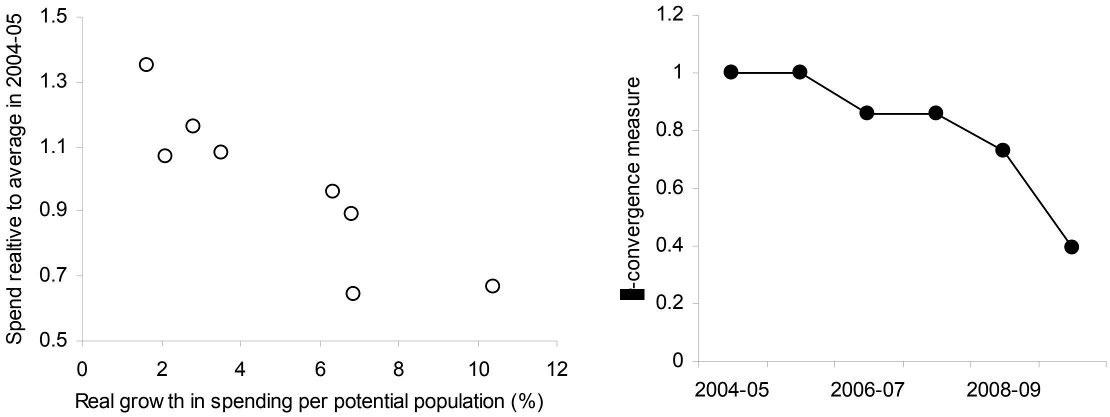
Typically, those jurisdictions that cover relatively small shares of the potential population spend relatively highly on those they do support. So Queensland spends around $32 000 per service user, whereas Victoria spends around $18 000 per user. The most likely reason for this pattern is that states like Victoria also provide supports for people who are not in crisis, and who need lesser amounts. This brings down their average spending.

There are two useful overall measures of the priority different jurisdictions give to supporting people with disability. First, the average spend per potential user shows that Queensland and Tasmania provided significantly less than many other states, and Victoria, ACT and Western Australia more (not counting the Northern Territory given their higher unit costs). Another way of looking at this is to compare the difference between a state's spending share of total (own-state) spending and its share of the population of people with a disability. Where a state makes a contribution that is out of kilter with its population share, then the value is positive for 'generous' states (like Victoria) and negative for less 'generous' states (with Queensland standing out).

Patterns are changing over time, for example with increasing effort by Queensland. Over the five years from 2004-05 to 2009-10, Queensland has rapidly increased its real spending by nearly 12 per cent per annum,[14] compared with Victoria, where spending has risen more slowly. However, a significant gap still remains. That pattern of catch-up in effort is still occurring more generally (figure 12.4).

Figure 12.4 **State efforts seem to be converging**

2004-05 to 2009-10



States with originally low spending have experienced the fastest real growth in disability spending[a]

Convergence is genuine[b]

a This shows that the jurisdictions with spending well below the average in 2004-05, showed the greatest trend growth rate in spending from 2004-05 to 2009-10. Spending is measured as real spending on specialist disability services under the NDA per potential population. Sometimes this method for showing convergence can be an artifice (reflecting statistical reversion to mean) rather than indicating a deliberate policy of catching up (Friedman 1992). **b** However, measures of so-called σ-convergence rigorously test whether convergence is present. σ-convergence occurs when the coefficient of variation between states declines over time, as is the case above:

$$\sigma = \left(\frac{\mathrm{var}(S_t)/average(S_t)}{\mathrm{var}(S_0)/average(S_0)} \right)$$, where S is the spending measure defined above.

Data source: SCRGSP (2011).

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[14] While part of that is population growth, much of it reflects a significant increase in real spending for those needing support.

Notwithstanding the shifting degree of effort by state and territory governments on funding disability support, some jurisdictions would have to increase disability funding a lot more to reach the average level of funding per person provided by jurisdictions as a group (box 12.3). For example, Queensland would have needed to fund around $180 million more in 2009-10 to have parity with the average. These calculations do not account for any variations in unit costs or efficiencies.

Box 12.3 **What is the level of unequal effort?**

An indication of the degree to which states and territories make differential contributions to funding disability supports can be calculated as follows:

- examine the actual own-state funded budgets to disability, excluding all Australian Government transfers (the state contribution S_i)
- calculate the ratio of total spending by state and territory governments on specialist disability services to the total population of people in the potential population (severe and profound in the illustrative example shown below). This is the weighted average of each jurisdiction's per person spending (ω)
- multiply that average (ω) times the potential population in each jurisdiction. This gives the amount of spending ($\tilde{S}_i$) each state would provide to disability services if they made the same efforts, but ensuring that the aggregate budget outlays of state and territory governments remained the same.

The value of $(S_i - \tilde{S}_i)$ indicates the funding deficit or surplus associated with equal effort.

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*S/Ts*
Actual state funded spending $m S_i	1385	1166	705	414	280	103	62	43	4158
Potential population (P_i) ('000)	223.3	161.2	143.6	61.8	49.8	22.1	9.0	6.1	677.0
Same effort spending $m $\tilde{S}_i$	1372	990	882	379	306	136	55	37	4158
Difference (net budgetary impact) $m $(S_i - \tilde{S}_i)$	13	176	-177	35	-26	-33	6	6	0

The calculations are based on the 2009-10 own funding by state and territory governments on specialist disability services (including administrative costs and payroll taxes) under the NDA. The average Australia-wide spending per potential population is:

$$\omega = 1000 \times (\sum_{i=1}^{8} S_i)/(\sum_{i=1}^{8} P_i) = 1000 \times \$4{,}158/677 = \$6{,}143$$

The fair allocation can then be calculated as $\tilde{S}_i = P_i \times \omega$

Sources: Commission calculations, SCRGSP (2011) and analysis of the ABS 2009 SDAC unit record data.

To ensure that all Australians get equal access to disability supports and services under the NDIS, the increment of spending in jurisdictions like Queensland would have to be more than jurisdictions like Victoria. However, it would not be appropriate to reward jurisdictions that have made lower funding commitments to disability supports.

Australia has highly developed arrangements for evening out the *capacity* of state and territory governments to provide comparable levels of services. The Commonwealth Grants Commission (CGC) tries to achieve 'fiscal equalisation' by providing state and territory governments with funding from the GST revenue, such that,

> … after allowing for material factors affecting revenues and expenditures, each would have the fiscal capacity to provide services and the associated infrastructure at the same standard, if each made the same effort to raise revenue from its own sources and operated at the same level of efficiency.

This means that were the Australian Government to provide a level of assistance to one state that would entitle its citizens to more than others, then the GST allocation would be altered to restore equalisation. The process underlying these re-distributive arrangements are complex, but the ultimate point is that, regardless of whether the CGC is the vehicle, there are ways in which to achieve a fair distribution of NDIS gross funds to state and territory governments.

DRAFT RECOMMENDATION 12.1

The costs of supporting people with a disability from year to year should be met from claims on general government revenue (a 'pay as you go' scheme):

- ***but would be subject to the strong disciplines for certainty of funding specified in draft recommendation 12.2***
- ***supplemented by payments to create reserve funds.***

However, the scheme should be managed and reported as if it were a 'fully-funded' scheme in which each year's funding is considered in the context of the scheme's expected future liabilities.

DRAFT RECOMMENDATION 12.2

The Australian Government should direct payments from consolidated revenue into a National Disability Insurance Premium Fund, using an agreed formula entrenched in legislation that:

- ***provides stable revenue to meet the independent actuarially-assessed reasonable needs of the NDIS***
- ***includes funding for adequate reserves.***

If that preferred option is not adopted, the Australian Government should:

- ***legislate for a levy on personal income (the National Disability Insurance Premium), with an increment added to the existing marginal income tax rates, and hypothecated to the full revenue needs of the NDIS***
- ***set a tax rate for the premium that takes sufficient account of the pressures of demographic change on the tax base and that creates a sufficient reserve for prudential reasons.***

DRAFT RECOMMENDATION 12.3

The Australian Government and state and territory governments should sign an intergovernmental agreement specifying that:

- ***the Australian Government should:***
  - ***collect all of the revenue required to fund the NDIS through the National Disability Insurance Premium Fund***
  - ***make no further special purpose payments to state and territory governments for disability supports.***
- ***state and territory governments should offset the Australia-wide fiscal implications of the transfer of responsibility by either:***
  - ***(a) reducing state and territory taxes by the amount of own-state revenue they used to provide to disability services or***
  - ***(b) transferring that revenue to the Australian Government.***

The Commission sees particular merit in option (a).

Any NDIS funding arrangements should ensure that state and territory governments that provide less own-state funding for disability supports than the average should not be rewarded for doing so.

13 Workforce issues

Key points

- The formal disability services workforce currently employs a wide range of people, including direct support workers, nurses, allied health professionals and case managers. The precise number of workers in the sector is not known. The most reliable estimate is around 70 000 employees (and around 34 000 full-time equivalents). Some other estimates suggest double the number of full-time equivalent employees.
- There is mixed evidence about the current severity of shortages in support workers, but in the future, there is the potential for severe shortages as the disability sector expands and with pressures from population ageing.
- One factor alleviating pressure is that a significant number in the workforce would like to work more hours if these were available.
- Strategies to draw more staff into the sector include:
  - paying higher wages, especially given evidence that current wages are low
  - strengthening career paths and improving the public perception of the industry by promoting disability jobs at the time the government implements the NDIS and by subsidising training
  - promoting better working conditions including more favourable shift lengths
  - changing some aspects of police checks to ensure their proportionate use.
- While a major goal of the NDIS is to relieve the excessive stress on informal carers, such carers are still a critical aspect of the supply of support to people with a disability. There should be greater support for (unpaid) carers through properly funded training and counselling services. Barriers to caring by employees should be reduced by allowing more freedom under the National Employment Standards for people to get flexible leave when they provide care to a person with a disability.
- Professional development in the disability services industry involves experience as well as formal training. While formal training plays an important role in developing a skilled workforce, this should not be compulsory for all employees.
- As it will take time for the workforce to grow to meet the demands of a new scheme, changes to the disability system should be implemented in phases to avoid overheating the labour market.

Some jurisdictions were candid about the shortcomings of present workforce development plans. For example, the South Australian Government noted:

> … it is known that the disability sector in South Australia faces challenges in workforce development. The sector is characterised by fragmentation with no sector wide strategy for workforce development. (sub. 496, p. 21)

Those shortcomings could be much greater under an NDIS. Addressing current levels of unmet need will require a significant expansion of the disability sector. Given much of this sector is service based and labour intensive, this entails a corresponding increase in the disability workforce. While attracting and retaining staff is an issue for all industries, the degree of expansion required in the disability sector, along with several other structural factors (such as population growth and competition from other growing industries drawing from similar labour markets) mean labour constraints could potentially undermine the core objectives of the proposed NDIS.

As well as building the workforce, meeting people's support needs also requires staff that are suitably trained and experienced to perform the roles required. This chapter examines the issues surrounding attracting sufficient numbers of appropriately skilled staff. It begins with a snapshot of current disability sector workforce (section 13.1). Next, we discuss emerging labour supply issues (section 13.2), suggest some potential remedies (section 13.3 and 13.4) and sum up the likely difficulties of engaging a larger workforce (section 13.5). Finally, we consider problems with staff education, skills and training (section 13.6).

While the disability sector includes a range of different types of professions and services, the focus of this chapter is on non-professional caring and supporting staff, which comprise the majority of the paid workforce.

13.1 A snapshot of the disability workforce

Size and composition of the formal disability workforce

The most recent survey of the specialist disability sector found that around 68 700 people directly provide disability services or manage those who do so (this survey is described in box 13.1).[1] Many of these employees work part-time, so the raw number of people can give a misleading picture of the overall amount of hours

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[1] Outlets providing disability services also employed other workers who administered the organisations or provided other services. Martin and Healy (2010) estimate that if these workers were included, the outlets providing disability services employed a total of about 97 000 people.

worked by people in paid work in this sector. Considering this effect, there are around 34 000 equivalent full time (EFT) positions. However, while these estimates may be the most reliable, other figures suggest that the sector may employ many more people (table 13.1).

For every person employed on an EFT basis, there were just over 20 people in the potential population of people with a disability (based on the survey of community services — Martin and Healy 2010). However, the actual number of people with a disability receiving services is only a share of the potential population. When that is considered, on average there were around five people with a disability per person employed on a full-time equivalent basis in the disability sector. Of course, not all people in the disability sector deal directly with people with a disability. The largest employment category is non-professional workers (62 per cent) followed by managers and coordinators (25 per cent), and professional staff (12 per cent).

Table 13.1 **Employment estimates for specialist disability workers**

2009

	Method 1	*Method 2*	*Method 3*	*Method 4*	*Method 5*
	NILS[a]	Cost-based method 2[b]	Cost-based method 3[c]	Cost-based method 4[d]	Adjusted NSW[e]
Full-time employment equivalents[f]	34 000	72 000	56 000 to 71 000	78 000	36 000

[a] The National Institute of Labour Studies recently undertook a survey of the community services sector (SCS), including specialist disability services (Martin and Healy 2010). That survey estimated that there were 68 700 workers providing disability services or managing those who provide these who provide these services (with the latter comprising around 8 per cent of the workforce). This equated to around 34 000 full-time equivalent positions, reflecting the high levels of part time work. Outlets providing disability services also employed other workers who provided non-disability services, or administered the organisation. It was estimated that, when such workers were included, outlets providing disability services employed 97 000 workers. This underlines the importance of counting employees specifically providing disability services, rather than counting all employees in organisations that deliver disability services. [b] A second method estimates the total disability workforce from total cost estimates for the sector, excluding payroll and administrative costs (SCRGSP 2011). It was assumed that 75 per of the costs reflected labour costs, that wages were $23 per hour (Australian Government 2010b), full-time hours were 35 hours a week, 52 weeks year, super costs were 9 per cent, and other on-costs were 5 per cent (excluding payroll). [c] A variant on method two was based on the full business costs of providing services equal to $36–$45 per hour. It was assumed that full-time hours per year are around 1800 full-time hours a year. [d] The assumed total sector labour costs (using assumptions from method 2) were divided by the average full-time equivalent wage cost from Fisher et al. (2009). [e] This was based on adjusting the number of people directly employed by DADHC in NSW. As they provide services to about half the population receiving disability services in NSW, this number was doubled. This was then inflated based on the ratio of the population of NSW and Australia (3.1:1). [f] The ABS Census of Population and Housing could, in theory, be used to derive employment estimates, but ambiguity about some of the job classification categories means that it is probably too unreliable.

Box 13.1 **The survey of community services (SCS)**

Most of the statistics cited in this chapter are from a recently published survey of the community services sector (SCS) by the National Institute of Labour Studies (Martin and Healy 2010). The SCS provides detailed and previously unavailable data on workers in the disability sector, separate from employees in other parts of the community services sector. The SCS is based on a sample of 397 service providers and 1507 workers. It disaggregates workers into the following categories:

- *Non-professionals:* Personal carers, home care workers, community care workers and Disability or residential support workers
- *Professionals:* Allied health workers and social workers and disability case managers.
- *Managers and Administrators*: Service and program administrators, managers and coordinators.

The SCS overcomes many of the major deficiencies in past data on the disability workforce, which were hamstrung by ambiguities about the term 'disability worker' and failed to distinguish adequately between people employed in the disability area from the community service sector in general.

Nevertheless, like all surveys, the SCS can be affected by non-sampling and sampling errors, which should be borne in mind when interpreting the statistics in this chapter. The survey sampled around 760 of about 3200 disability service outlets, and achieved a 52 per cent response rate (397 providers) — a high response rate compared with most surveys. That said, there is some risk of non-response error because the number of employees may influence the probability of responding to the survey (that is, larger organisations may have administrative staff better able respond to survey questions). In addition, there is no clearly accepted listing of disability agencies (an observation made by people with a disability when trying to find one suitable to their needs). That could bias results if the number of employees in an agency influences the probability of that agency being discovered for inclusion in the sample frame (that is, it may be easier to find 'big' well-known organisations than small ones). However, Martin and Healy used a very thorough search method to construct the sample frame, so this risk is probably low.

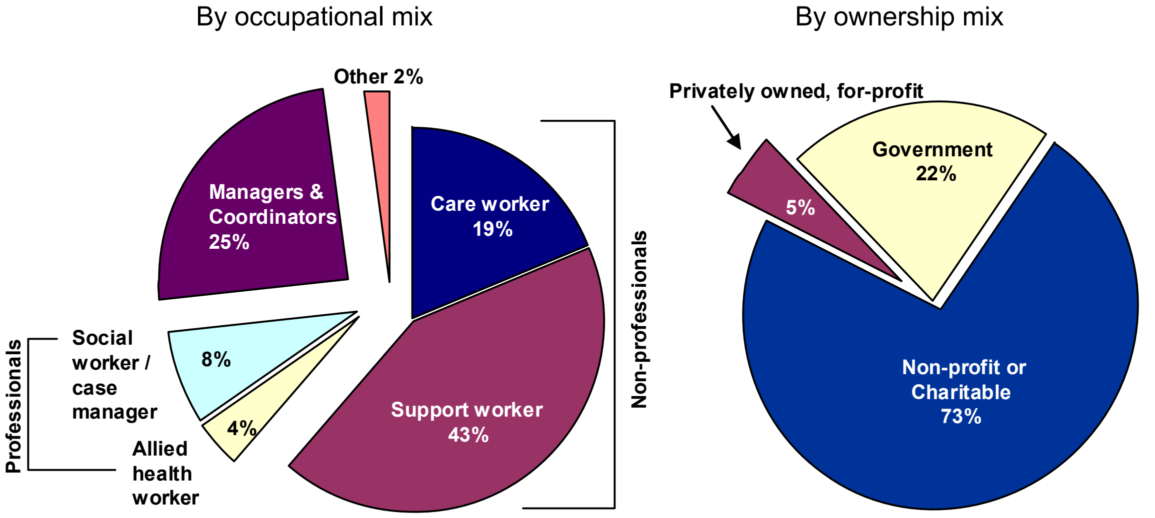
Overall, the SCS yields the best available evidence describing the disability workforce. However, as is the case with all surveys, data about aggregates such as the total number of workers in the industry (table 13.1) will be less reliable than data describing the characteristics of workers. Data at the jurisdictional level are also less reliable, and have generally not been used for that reason.

Moreover, the ratio is an average. Some people with a disability require 24 hour support, and in that instance will require many workers. Others may need only limited support and the caseload per worker would be high for these categories.

Around three quarters of staff work for not-for-profit service providers, while government-run and private for-profit agencies employ the remainder (figure 13.1). The for-profit sector currently plays a particularly small role in the disability sector.

Figure 13.1 **Structure of employment in the disability sector**

Full time equivalent positions[a]



[a] The data includes workers in disability agencies who administered the organisations or provided services other than for disability.

Data source: Martin and Healy (2010, pp. 111–112).

There is currently no good quality time series data for the size of the disability workforce. However, due to its labour intensity, it is likely that the increases in spending in the disability sector have been associated with a considerable expansion of the workforce. Between 2004-05 and 2009-10, spending on specialist disability services rose by 32 per cent in real terms (SCRGSP 2011, attached tables). This long-term trend is consistent with an analysis of the social and community services workforce, which found that in the decade to 2006 the SACS workforce increased 66.2 per cent while the economy wide workforce increased 19.2 per cent (Meagher and Cortis 2010). This rate of growth is not sustainable in the long term and may be the cause of some of the problems, such as the difficulty of finding staff, that are discussed later in this chapter.

An older and female-dominated sector

Irrespective of their job category, females make up around 80 per cent of the disability workforce (Martin and Healy 2010). This is broadly consistent with other studies, which found that females made up 85 per cent, and 69 per cent of the

Western Australian (CCI 2006) and Victorian workforces (Victorian Government 2005) respectively. Similarly, for the wider community services sector, females made up 76.2 per cent of employment in May 2010 (Australian Government 2010, p. 68). It also matches the role of females in informal care. 68 per cent of unpaid primary carers are female.[2]

The disability workforce has relatively few young workers and a more middle-aged profile than does the Australian female workforce overall.

- There is a much lower share of disability workforce aged less than 30 years old (figure 13.2).
- There is a 'middle aged bulge', with the share aged between 40 and 59 years around one third higher than the female workforce generally, and 50 per cent higher than the female population as a whole. This pattern is most obvious among managers and administrators.
- There are roughly equal shares of people aged 60 years and over among the disability and general workforces. The low share of people aged over 60 years old reflects the much lower employment rate of women generally in this age group.

Wages appear low

Notwithstanding some complexities in calculating wage rates,[3] the evidence suggests that employees in the disability sector receive relatively low pay rates compared with employees outside the community services sector:

- The SCS found that the mean hourly wage rate in the Australian disability sector was 13 per cent less than for all female employees (Martin and Healey 2010). Workers in the government sector earned significantly more than workers in the non-government sector, with 65 per cent of government employees earning more than $25 an hour compared with only 35 per cent of non-government employees.

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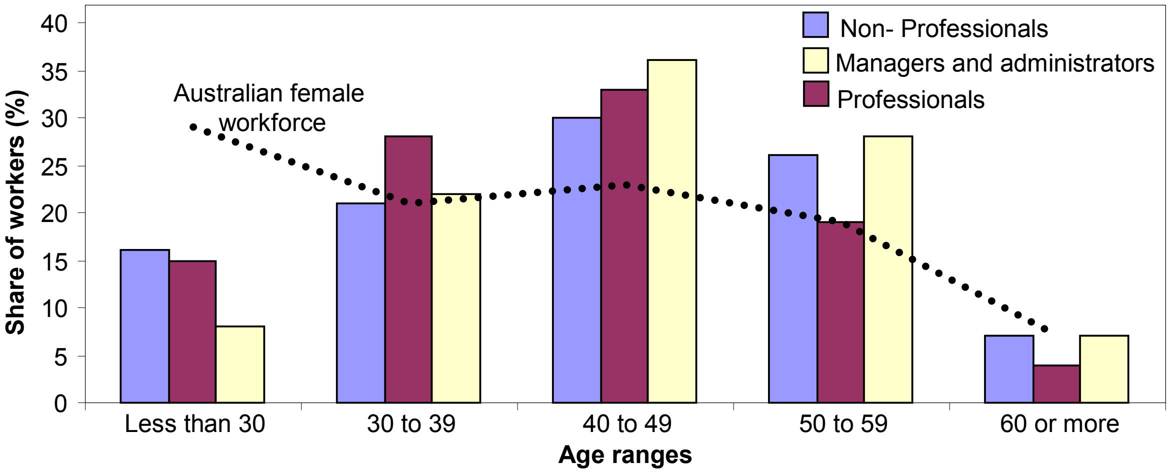
[2] Based on ABS 2010, *Survey of Disability, Ageing and Carers, Australia, Summary of Findings*, cat. no. 4430.0.

[3] The complexities arise because workers in the not-for-profit sector of disability services are eligible for fringe benefits tax concessions. These allow them to salary sacrifice a certain amount of income for any purpose, thus lowering their tax liability and effectively increasing their wage in after-tax terms. The Australian Government (2010, p. 11) notes that almost one third of the overall community services sector use salary sacrifice arrangements, and argued that this should be considered when determining appropriate remuneration by Fair Work Australia in the equal remuneration wage case for community service workers.

- A study of the Queensland disability services sector in 2007 found that 55 per cent are paid award wages.
- Compared with the Australian workforce as a whole, a smaller share of people in the community services sector tended to work overtime and of those who did, a smaller share were paid at overtime rates (Australian Government 2010, p. 75). Further, it appears that the low wages of the sector also reflect a combination of below average bargaining power and a reliance on award rates. It is more generally symptomatic of wage outcomes for other industries dominated by female employees (pp. 10–11). At the wider community services level, the sector contributes 4.4 per cent of Australian employment, but 3.2 per cent of wages (p. 65), suggesting a wage differential of just over 25 per cent. However, after adjusting for the greater likelihood of people working part-time in the community services sector, the wage differential falls to around 13 per cent.[4]

Figure 13.2 **A feminised and older workforce**



Data source: Martin and Healy (2010, p. 116).

Working conditions

Full-time employment is relatively uncommon in the non-professional sector (15 per cent), with around 85 per cent of respondents working in casual or part-time jobs compared to 50.4 per cent of the total Australian female workforce. This

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[4] This was estimated by noting that in the 2006 ABS Population Census data the ratio of FTE to employment in the economy was 91.1 per cent, while it was 76.5 per cent in the community services sector. Assuming that these ratios have remained stable over time suggests that the community services sector accounts for around 3.7 per cent of full-time equivalent employment (cf 3.2 per cent). That means that the real wage differential is approximately 3.2/3.7 implying a percentage difference of around 13 per cent (after removing rounding errors).

difference was less pronounced among professional, manager and administrator categories (52 per cent in the disability sector compared with 68 per cent more generally).

This picture is complicated by the fact that disability support workers are more likely to work in more than one job. Some 24 per cent of non-professional workers in the disability sector worked more than one job (Martin and Healy 2010, p. 121) compared to 6 per cent of employed Australians overall (ABS 4102.0). Of those disability workers with a second job, around half were employed in the disability sector for both positions.

Nevertheless, a large proportion of non-professional workers indicated they wanted to increase their working hours (26 per cent), with around half of these looking for more than ten additional hours per week. (Martin and Healy 2010, p 146). Similarly, while 31 per cent of non-professional staff were casual, this was the preferred option for only 16 per cent, indicating a considerable number seeking more permanent arrangements (p. 145). This suggests that there is a potentially untapped workforce, which will help meet demand after the start of the NDIS.

The nature of disability services means that support may be needed at any time of day, which results in less routine working hours. Often support workers are required to work multiple short jobs during a shift or work during the night. Within the ACT, 35 per cent of support staff expect to work at any time during the day or night in a typical work week (Disability ACT 2004).

Training

Most of the non-professional disability workforce (79 per cent) had some form of post school qualification, typically certificates three or four (figure 13.3). Reflecting that the main tasks involved care and support, relatively few had degrees compared with the Australian workforce as a whole (Martin and Healy 2010, pp. 126–127).

Training appears to have grown in importance:

- The number of people completing VET courses in disability has increased in recent years from 2553 in 2005 to 3785 in 2008.[5]

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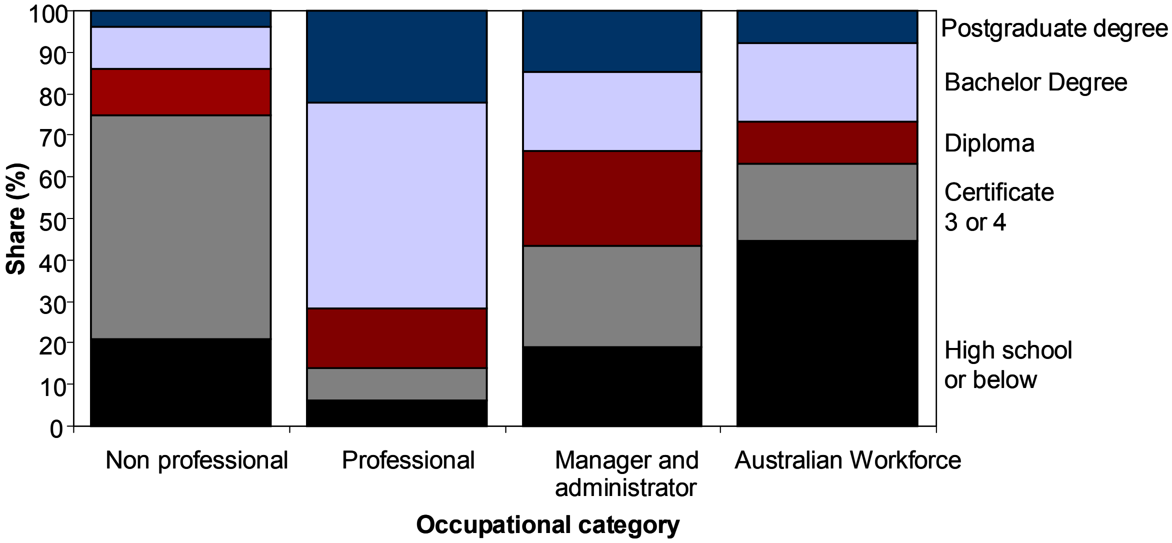
[5] A VET course in disability was one in which the label ‘disability’ was part of the course title, which may miss some relevant courses. There is currently only information available on the VET training sector when the government subsidises (either partially or fully) the costs of the training. We therefore miss any information on VET training delivered by private providers and funded using fee for service. The data were provided by NCVER.

- The majority of government funded training occurs through TAFE (about 60 per cent) while the remainder occurs in private providers, which includes adult and community education. The proportion delivered by private providers has increased in the last year.

Figure 13.3 **Highest level of qualification of the disability workforce**[a]



[a] This may include people who have qualifications that aren't relevant to their work

Data source: Martin and Healy (2010).

Why do people work in the sector?

Across the job categories, most disability workers said they worked in the sector because they wanted to help others (76 per cent) and to do something worthwhile (68 per cent) (Martin and Healy 2010, p. 133–134). Beyond this, people also valued variety (45 per cent); the potential for learning and training (45 per cent); and independence, autonomy and responsibility (39 per cent). These results are consistent with the 2008 Disability Support Worker Survey (Shaddock and Rose 2009) that found that the 'opportunity to be of service to people' was the highest rated response.

By most measures, wages do not appear to be an important motivating factor for working in the industry.

- Pay was ranked last in a list of reasons why respondents were attracted to work in the disability sector (17 per cent for non-professional and 15 per cent for professionals as well as managers and administrators, p. 135).

- Improved pay was rarely listed as the main reason respondents left their last job (4 per cent for non-professionals and 7 per cent for professionals as well as managers and administrators — p. 153).
- Relatively few non-professionals cited financial reasons as a main reason they may leave their employer within the next 12 months (p. 148).

An exception to this is in terms of stated satisfaction with total pay, which was lower for the disability sector than for the Australian female workforce generally. Disability workers gave an average score of 5.5 on scale between 0 (totally dissatisfied) and 10 (totally satisfied), compared with 7 for female employees generally.

Moreover, another survey by the Australian Services Union (ASU 2007) of the non-government social and community sector found that 40 per cent of workers intending to leave the sector gave low wages as the reason. In that survey, most managers thought it was the biggest barrier to recruitment. The differences between the results of this survey and the SCS may partly reflect scope and timing of the different surveys, as well as differences in their design.

High staff turnover

Despite generally positive attitudes to working in the sector, staff turnover rates are relatively high. Staff turnover in the disability sector has been estimated to be 21 per cent in Queensland in 2007 (NDS 2007) and turnover in social services more broadly has been estimated to be 29 per cent (Australian Community Sector Survey), which is high relative to other industries. This could imply scope to alleviate any pressures on the labour force through better wages, conditions, career options or other measures.

However, it could also reflect innate features of the job itself, such as the emotional and physical demands it places on staff. Equally, turnover could be partly driven by the presence of workers who only intend to work in the industry for a relatively short period (such as university students, or people who enter the industry towards the end of their working life).[6]

The SCS suggests that of those who plan to possibly leave their current job, 15 per cent are doing so due to stress or burnout and a further 10 per cent are doing so for financial reasons. Only 20 per cent are leaving for a new job within the disability sector.

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[6] Such workers would not comprise a significant share of the total disability workforce, but can still influence turnover if their average work duration is short.

13.2 Are there, and will there be, labour shortages?

Any sustained shortages of disability workers would undermine the goal of the NDIS and NIIS to deliver more supports to people with a disability. Some consider that significant shortages are already present. For example, the Law Council of Australia noted that there are:

> … already reports of shortages of trained and skilled carers. If the [new scheme] is going to be serious about providing much higher levels of paid care across the board, then there is going to be a vast increase in the demand for carers. Given the supply of trained and skilled carers is already under strain, serious consideration must be given to how this will be managed if there is any move to nationalise care and support arrangements. (sub. 375, p. 17)

The Attendant Care Industry Association of NSW (sub. 268, p. 9) said that the current shortages were already 'chronic', while the National Ethnic Disability Alliance argued there were particular difficulties in getting workers who were culturally aware and respectful or from a non-English speaking background, let alone from specific language or ethnicities within that group (sub. 434, p. 36). A study of the Queensland disability workforce (NDS 2007) found that only 2.5 per cent of organisations rarely or never have difficulty recruiting appropriately trained and skilled staff.

However, other evidence for current shortages is less clear-cut:

- contrary to the above NDS findings for Queensland, the SCS found that vacancies for non-professional disability workers across Australia were filled relatively quickly — with 71 per cent of non-professional jobs being filled within four weeks (Martin and Healy 2010, p. 142)
- as noted above, many people would like to work more hours — which is not consistent with systemic shortages of workers.

People have identified many possible contributors to *future* labour shortages. On the supply side, the concerns are a high labour turnover rate, an ageing workforce, and the impacts of regulations. On the demand side, there are competing pressures from the future demands associated with aged care and the large demands associated with the creation of the NDIS and the NIIS. Some of these concerns are well founded, but others are not.

The supply side

The capacity of the informal sector to supply labour

An important goal of the NDIS is to relieve the excessive stress on informal carers, but to recognise that they will continue to be the main source for supporting people with a disability. While removing excessive demands on informal carers may help sustain the informal workforce, there are other pressures that may weaken its capacity to provide supports. Traditionally, women in the direct or extended family have been the major source of informal care. Several society-wide trends (ABS 2010), including the greater prevalence of two-income households, smaller household sizes and the greater geographic mobility of people, mean that the pool of family members available to provide informal help is likely to diminish.

Given that the informal sector is much larger than the formal sector, a small change in informal support will require a large proportional expansion in the provision of formal disability services. In 2009, there were 2.63 million carers providing an estimated 680 000 full time equivalent carer positions for people with a disability, whether young or old.[7] To give some perspective on these informal carer numbers, in 2007, there were around 210 000 workers providing direct aged care services or 125 000 equivalent full time employees (Martin and King 2008, p. xix, p. 63). In 2009, there were an estimated 68 700 disability workers directly providing services or 34 000 equivalent full time employees (Martin and Healy 2010, p. 6). While the dates of the various surveys vary, the estimates suggest that around a 10 per cent reduction in informal carers supporting all people with a disability — a cut of around 65 000 equivalent workers — would require a 40 per cent increase in equivalent full time formal care employees.

Against that backdrop, measures to support carers will be critical (section 13.4)

An ageing workforce?

Some suggest that the population wide trend towards an ageing workforce is particularly pronounced in the disability workforce (NDA 2006). If this were true and were to persist, it could create significant labour shortages, presenting a problem for the long-run sustainability of the NIIS and NDIS.

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[7] The estimate of 2.63 million is from the 2009 ABS Survey of Disability, Ageing and Carers (SDAC). The Disability Investment Group (2009, p. 1) estimated that the ratio of full-time equivalent employment to total employment numbers for carers was 26 per cent. This ratio was applied to the SDAC estimates.

An ageing workforce could occur for a number of different reasons, some of which would create labour shortages were the trends to continue. Ageing could reflect:

- less recruitment of young staff and a reliance on the stock of current staff, which will inevitably reach retirement age
- the effect of the past bulge in births (the 'baby boom'), which then creates a corresponding, but temporary, bulge in the age distribution of workers at a later time
- a trend towards entry into the workforce later in life, spurred on by an underlying trend of higher workforce participation for older women (PC 2010). The 'middle aged bulge' in the workforce noted above could simply be a reflection of recruitment outcomes.

Of these causes, the first would create the most sustained pressures on the disability workforce, while the others would create temporary or no pressures. There is no longitudinal data to determine decisively which matters most. However, there is some evidence.

The SCS suggests that 63 per cent of disability workers entered the sector at age 30 years or older (Martin and Healy 2010, p. 150), a pattern similar to the aged care sector (Martin and King 2008, p. 28). Analysis by the Commission of successive waves of the ABS population census[8] also suggests an increasing tendency for people to enter the disability and aged care industry at later ages. There has been a dramatic increase in the number of people working in this industry and the increase has been concentrated among people aged between 40 and 65 years. And the net entry rate is much greater for middle aged people in the aged care and disability sector than the female workforce generally (figure 13.4).

Younger cohorts have also increased in number, but not at the same rate as older workers. This suggests that the increase in recruitment of older staff has driven the ageing of the disability sector, rather than a decline in the recruitment of younger staff. Nevertheless, all other things being equal, some (probably minor) pressures can be expected as the baby boomer generation retires.

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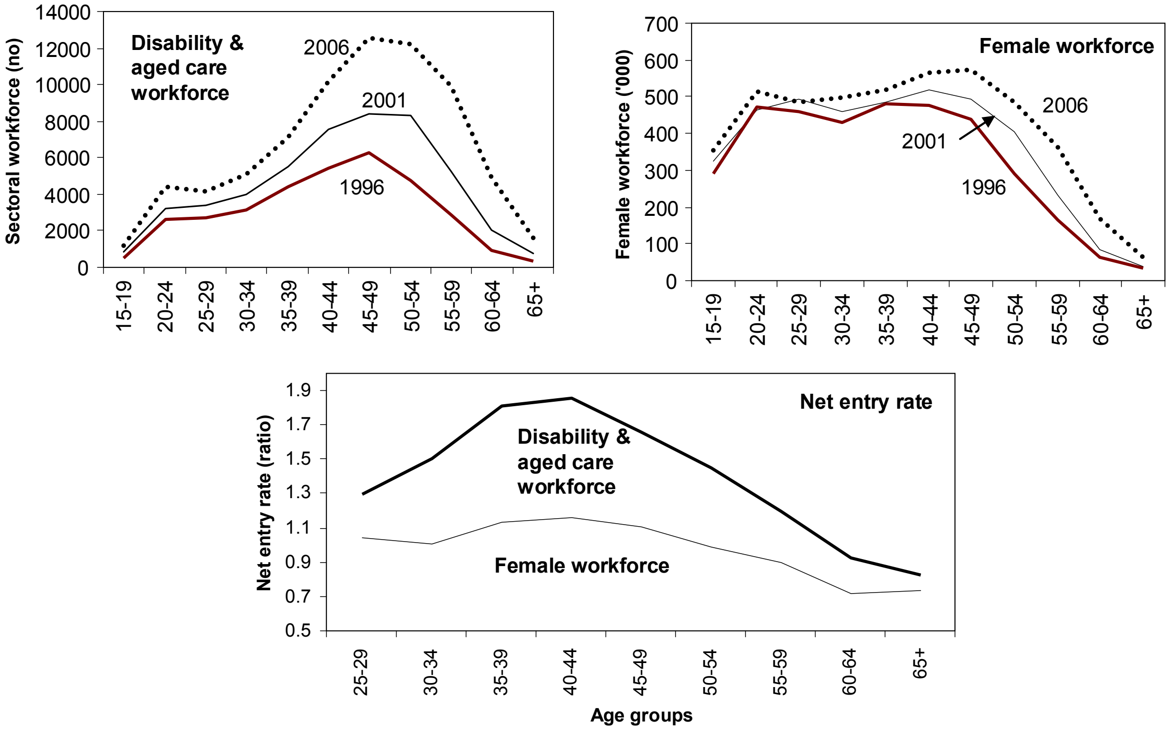
[8] The Australian and New Zealand Standard Classification of Occupations (ANZSCO) used in the census data does not separately identify disability workers, but rather the broader category of aged and disability workers. This category does not capture all those who work in the disability sector as other ANZSCO categories such as nursing support and personal care workers or special care workers would likely include some disability workers.

Figure 13.4 **An ageing workforce?**[a]



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[a] The aged and disability carer category was chosen as it allows for comparable data across multiple censuses. The net entry rate is defined as ($N_{a,2006}$ /$N_{a-5,2001}$), where a are the ages of people in 2006, and are in five year age groups. For example, there were 10 151 workers in the disability and aged care sector aged 40-44 years in 2006 and 5481 people aged 35–39 years in 2001. The ratio is therefore 1.9. While some people aged 35–39 will almost certainly have left the sector between 2001 and 2006, those exits were more than made up by new entries of people who were not in the sector in 2001.

Data source: ABS 6105.0, and other population census data provided on request.

OH&S requirements

Occupational health and safety regulations are intended to ensure safe workplaces. Nevertheless, some have suggested that these regulations can sometimes lower labour productivity and, in turn, aggravate labour shortages, without gains in safety. This could happen in several ways.

- The paperwork and other burdens associated with OH&S could divert time away from providing actual support services, meaning that the number of staff needed to provide required supports must be higher than otherwise. For instance, one participant cited unnecessary OH&S assessments, which used up the time of a highly qualified professional (Adam Johnston, sub. 55, p. 4). OH&S compliance burdens might also add to stresses of families providing informal care. For some families, this could be the 'straw that breaks the camel's back', reducing the sustainability of their unpaid care, with longer run greater calls on paid care. For instance, one submission noted that there were 'copious OH&S notes written up to cover service fears' (S&M Guthrey, sub. 100, p. 2). Another family noted how funding, training, OH&S and liability issues faced by respite agencies meant that the responsibility of caring for their children was too difficult for many respite agencies, meaning that the family's needs were often left unmet, adding to the pressures they experienced (Melinda McFadden, sub. 247).

- More than one worker may be needed to perform a task because of excessive concerns about safety. For example, one participant said that that an inexperienced or overly cautious occupational therapist required two workers to perform tasks that could be 'safely done by one competent care-worker' (name withheld, sub. 242, p. 4).
- OH&S rules may limit the type of worker entitled to supply a service. That can create bottlenecks, can eliminate some of the efficiencies of one worker performing a range of tasks, or it may result in a service not being provided at all, with a need for greater support costs at a later time. For instance, one participant argued that OH&S restrictions for teachers led to poor health outcomes for students at a special school, with greater care needs at a later time, including unnecessary hospitalisation (Gillian Pearson, sub. 313).

That said, it is not clear how often OH&S regulations do have any significant adverse effects on labour productivity or the sustainability of informal care arrangements. In many instances, OH&S standards are likely to *increase* productivity (reducing injury rates for workers and providing better care for people with a disability). However, the capacity for OH&S regulations to minimise risks to staff and clients need to be balanced against the cost they imply — in terms of their impact on quality of care, additional financial cost as well as the additional pressure they place on scarce labour resources. One of the goals of the NDIA would be to monitor the efficiency in the supply of services and to assess the origin of inefficiencies. Where these arose from inappropriate OH&S guidelines, the NDIA could feed that information to the appropriate government regulator.

The demand side

The biggest pressures on the disability workforce are due to increasing demand.

Expansion of disability services

In recent years, the disability sector has expanded in response to a growing awareness among state and territory government of the level of unmet need. Several governments have substantially increased funding to the disability sector, leading to an associated increase in demand for the labour required to deliver disability services.

Nevertheless, the current system is still characterised by a high level of unmet demand with many people with a disability unable to get adequate access to specialised disability supports. The introduction of the NDIS and NIIS to address this unmet need will require a large increase in the supply of disability workers. While these pressures would largely relate to traditional attendant care and support staff, they would also apply to managers, administrators and allied health professionals.

Pressure from a growing aged care sector

The personal attributes suited to caring and supporting people are largely the same in the aged care and disability sectors. Their employees also often have similar skills and qualifications. There are strong emerging pressures on the aged care sector, which will draw workers from the labour pool that is also the source of disability workers. The effect is potentially large. The share of Australians aged 75 years and over is expected to grow from around 6.3 per cent of the population to 12.3 per cent from 2010 to 2050 — an increase in this group of about 2.8 million people.[9] This age group has particularly high care and support needs. Many will need some in-home attendant care services and, given current usage rates, around one in ten will be in residential aged care (AIHW 2009a, p. 23).

13.3 Attracting more workers to the disability services industry

As with other industries, the responsibility of attracting and retaining staff lies mainly with service providers. They can also promote the industry and provide better working conditions, improved career prospects, more flexible hours and greater employee control over their jobs. For example, they could address some of the problems associated with rotating shiftwork.

Paying higher wages as a strategy to address impending shortages

Disability workers' wages appear low (section 13.1). Wages act as a direct financial incentive, as well as a signal that the work itself is valued. Many in the industry suggest that paying higher wages would be necessary to attract more people into the

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[9] Series B from ABS 2008, *Population Projections, Australia*, cat. no. 3222.0.

industry (LHMU, sub. 449; ACTU, sub. 417; Just Better Care, sub. 157; ASU 2007, NDS 2009).

However, as discussed above, workers ranked pay last in a list of reasons why they were attracted to work in the disability sector. That might reflect that:

- working with people with disabilities attracts people for whom money is a low priority compared to the other benefits inherent in the work
- anyone who wanted or needed high levels of remuneration tend to leave the industry (contributing to the labour turnover patterns described above).

It is likely that both are true.

However, this does not mean that an increase in wages will not attract *new* staff to the industry. For instance, those who left the industry because the wages were low might be drawn back if the wages were higher, or it might mean that people do not leave the industry in the first place. Furthermore, an increased wage would make disability services more attractive to young people when choosing between a number of career options.

While it is difficult to determine empirically the overall link between wages and labour supply, several factors suggest workers in the disability sector will be relatively responsive:

- there are relatively low barriers to entry compared to other occupations given generally low educational requirements for non-professional staff
- women comprise a large share of employment in the industry. The supply of female labour tends to be more responsive to wage increases than men (that is, a higher 'labour supply elasticity' — PC 2010 and Birch 2005)
- many staff in disability services choose between work in the disability sector and not entering the labour force. People in this situation tend to be more responsive to wages than if they are choosing between two jobs (Evers et al. 2008).

Periodic changes to minimum and award wages by Fair Work Australia could be expected to partly address low wages. Within the current disability services system, award wages play an important role in determining remuneration levels of staff. This reflects the characteristics of the industry:

- union bargaining appears to be weak
- the way government contracts are organised makes it very difficult to pay staff more than the award wage.

Of particular interest, is the current case being heard by Fair Work Australia. This case is being fought on gender equity grounds and has the potential to dramatically change the base rate of pay for staff in the sector. The results of this case could have significant financial implications for the scheme if there are significant wage increases, but would also tend to encourage greater numbers of people to enter the industry. The case follows a similar case in Queensland in which disability workers were awarded pay increases between 18 per cent and 37 per cent. The resulting funding situation (box 13.2) has some valuable lessons for managing the transition following a large legislated wage rise.

The role of NDIA price negotiations in setting wages

Within the current disability support and services system, block funding arrangements give purchasing power to governments as dominant purchasers. While that can contain costs, it may also have effects on providers' capacity to recruit workers or to pay extra for more experienced or trained employees. For instance funding for client might only cover care from a person at a particular pay level. Providers may then find it difficult to pay even existing market wages, as well as administration and overhead costs.

In the Commission's report into the not for profit sector (PC 2010, p. 280), it was found that the majority of service providers did not think that government funding covered the full cost of providing services. In addition, a number of government agencies admitted to 'making a contribution' rather than fully funding services. The Commission estimated that the overall proportion of costs met by government funding for contracted services was around 70 per cent, while the level of fees and charges varied. In a survey of service providers, only 40 per cent reported that they mostly (34 per cent) or always (6 per cent) got sufficient funding to cover the services that government required them to deliver (Allen Consulting Group 2008, p. 9). The Commission's inquiry into aged care has also found that government sets prices that do not reflect the cost of delivering services (PC 2011, p. lx), with consequences for efficient delivery of services.

While the NDIA would generally not block fund services, at least initially it would play a major role in regulating prices, since it would reimburse service providers for items covered by people's packages (effectively 'vouchers'). This would constrain wages given that labour costs represent a large share of total service delivery costs. It is important that the NDIS avoid the problems that currently affect the community sector. Whether services are delivered through vouchers or individualised funding, service providers should be reimbursed at a price that supports an efficient and sustainable service sector. That, in turn, will support wages that are sufficient to attract workers into the sector.

On the other hand, the NDIS will need to avoid paying excessive prices and wages as the disability system expands. Wages tend to be more flexible upwards than downwards (so-called 'sticky' wages) so that any short-term shortage as the disability sector expands under the new system could result in long-term wage inflation, undermining the financial viability of the scheme.

This highlights the importance of the gradual implementation of the scheme, as well as suggesting a role for government or the NDIS, in alleviating short-term labour force pressure through other means. These are discussed later in the chapter.

Wage growth and the implications for costing a scheme

Wages in the disability sector will probably rise in line with average weekly earnings over the longer run. Otherwise, large wage disparities would occur and it would be hard to attract or retain workers. The Australian Treasury has projected long-run nominal wage growth of 4 per cent per annum (Treasury 2010, p. 18). However, given the current low level of wages and the need to attract significant numbers of people into the disability sector, in the short to medium term, wage growth will probably exceed the economy-wide average. That will need to be considered when costing the future liabilities of the NDIS.

A greater role for flexible wages in the future?

As the scheme evolves and people with a disability adapt to an entirely new system, the NDIA may be able to give up price controls for the competitive segments of the specialised disability services sector (giving people with a disability a budget rather than vouchers to acquire their supports from such specialist agencies). That would allow providers to adopt recruitment strategies akin to those commonly used in other enterprises. And it would also give people with a disability the scope to flexibly trade off aspects of their packages, such as paying more for hours delivered at the preferred time, even if that involves a reduced entitlement to hours overall.[10]

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[10] In the mean time, where people do not use self-directed funding, the vouchers for hours that form part of people's support packages may need to place constraints on the terms and conditions associated with their use. For example, an entitlement to six hours of respite care a week would involve a much greater cost to the NDIA when the hours were used on a weekend than a weekday.

Box 13.2 **Experiences in Queensland following the pay rise**

In May 2009, the Queensland Industrial Relations Council awarded a pay rise of between 18 and 37 per cent to workers in the social and community service industry with a subsequent case extending similar increases to disability support workers. Following this, the Queensland government allocated $414 million in the 2009-10 budget for disability services. This increase was in response to a range of rising costs, including wages, but was not large enough to cover the wage increases fully.

The funding was allocated on a priority basis and was based on estimates of the increased cost of wages. The highest priority was to maintain the level of services for people who were fully supported and dependent on services. In this category, providers were allocated the full estimated cost of wage increases. The second priority was to maximise, given the available resources, services to people with a disability who are assisted and vulnerable. Funding for clients in this group was adjusted to compensate for the full estimated impact in the first year and a smaller proportion in the subsequent years. The government allocated no supplementary funding where no direct services to clients or only generic services were delivered.

In cases where providers thought that this formula threatened their operations, the government considered the situation and, if necessary, adjusted service contracts with affected providers. The government also implemented measures to reduce administrative costs, aimed at enabling organisations to use more of their funding for direct service delivery.

Participants identified several problems with the funding allocation process. First, there was limited transparency, which meant that service providers did not know how much additional funding they were going to receive until it arrived. Also, when calculating the level of additional funding, funds were notionally attached to service recipients based on the hours of care and other services that person received. However, this information was not provided to service providers. Rather they received a sum that covered their entire operation. This meant that if a client chose to change service providers during a funding period (a not uncommon event), the provider would have to refund the funds attached to this client, including the supplementary funds, even though until this point they were unaware of this amount.

Second, some providers who were required under the relevant award to pay the higher wage costs were given no funding supplementation, as they did not provide direct client services. While they may have been in a lower funding tier, this still adversely affected their operations and meant an effective service reduction in these areas.

The situation was made more complicated because agencies employed staff on a variety of awards and enterprise bargaining agreements so the wage decision affected some staff but not others. In addition, this process coincided with the gradual introduction of a national award. These factors combined to create a complicated industrial relations framework that needed to be negotiated by service providers. This was particularly problematic for small providers who may not have employed experts in these matters.

Lessons to be learnt

- Funding provided directly to people with a disability (either in cash or in support packages) based on an objective assessment process and adequate scheme funding would mean that prescriptive rules about what services would be fully funded would no longer be relevant.
- Where block funding is continued:
  - funding formulas should be transparent and good information provided to suppliers
  - funding processes should be simple, to avoid excessive transaction costs payments, and should be based on the requirement to ensure delivery of necessary services, rather than be subject to artificial constraints — which is one reason why the NDIS should not be subject to uncertain funding through the usual budget process.

Even over the short run, there would be some scope for people using self-directed funding to negotiate flexible wages. For example, people using self-directed funding might be willing to pay more for workers that have greater experience or training. Equally they might be happy to pay lower wages for a worker with no training or limited experience, provided that they have the appropriate personal skills — thereby getting a few more hours of care. This form of wage flexibility also gives incentives for more experienced staff to remain in the industry. Ultimately, the extent to which this occurs would depend on the take up rate of self-directed funding, which is likely to be low initially.

Improving working conditions

Working hours

The working hours required for some positions in the disability sector represent another potential obstacle to attracting and retaining staff. There are periods of peak demand in the morning and evening, and some people with a disability require assistance throughout the night. Employees may get shifts that have several one or two hour long breaks between clients to fit with complicated timetabling arrangements. This is particularly common in community care and home based respite. The desire for better shifts or hours was the third highest ranked motivating factor for people leaving their jobs (Martin and Healy 2010, p. 153).

The length and variability of shifts

The existing difficulties people face in getting services at peak times suggests that demands for staff to work irregular hours will increase under the proposed, more client-centred, NDIS. However, in some respects, working conditions may actually become more attractive. This is because:

- many staff would currently prefer to be working more shifts. The expansion of services delivered under the proposed scheme is likely to better accommodate this
- in some cases, undesirably short shifts are a result of rationed services. Again, as rationing decreases, staff may be allocated to longer shifts
- it may become possible to have job sharing, flexitime, split shifts and more frequent shifts.

Offering attractive shifts to staff is an ongoing challenge for service providers, just as it is in most industries. For instance, one service provider found that:

> … changes to the Award requiring direct care workers to have a 10 hour break between shifts and complete their hours for a broken shift within a 12 hour span have presented a real challenge. (The Disability Trust, sub. 230, p. 8)

As such, the benefits of attractive shifts (such as improved recruitment and retention of staff) must be weighed against the timetabling difficulties that they imply.

It is also possible that improving work flexibility to meet the needs of workers can constrain flexibility for users of the services, which would undermine one of the major goals of the NDIS. The importance of flexibility in receiving support services is highlighted by one participant in the inquiry:

> Heaven forbid I should have an early meeting because my carers don't arrive before 7am. And how would I get to bed past 10pm without my Mum?" (Disability Connections Victoria, sub. 246, p. 5)

It is evident that there are potentially conflicting needs between staff who wish to work regular hours, service providers who are trying to manage complicated timetables and clients who rely on the flexibility of services to allow them to manage their lives. To some degree, this conflict can be resolved by appropriately pricing the required flexibility.

In the early phase of the NDIS, the NDIA will have a role in negotiating contracts with service providers. During this period, it would be important for the NDIA to consider the desirability of shifts when setting prices. For example, a midnight service should cost the NDIA more to purchase than one in regular working hours. Similarly, a one-hour long shift should attract a higher per hour price than a longer shift to account for travel time and the timetabling difficulty of fitting that service into the shift of a worker.

In the longer term, it is envisaged that prices would be more flexible and negotiated directly between the service provider and consumer. In this setting, flexible shifts will attract a price premium meaning that people will have to pay more for flexibility and staff will be rewarded financially for working less desirable shifts.

Other changes to conditions

Working conditions would also be improved by addressing the rationing in the system. This is likely to reduce stress for overworked employees and give them the capacity to provide higher quality care and support to people — with the greater job satisfaction that produces. Moreover, a better-funded system means that essential equipment and modifications — hoists, home modifications, aids and appliances — are appropriately funded, allowing the efficient use of carers' time, and greater safety for them.

Encouraging career paths in the disability services industry

Numerous participants have highlighted the importance of an established and clearly articulated career path in order to attract and retain staff (MND Australian, sub. 264, p. 18; Scope, sub. 432; and ACTU, sub. 417 among others). The promotion of career paths may also occur naturally with more consumer choice and a less bureaucratic service system. That said, while it is not usually the role of government to influence career progression outside of the services it directly provides, there may be some merit in governments:

- marketing the benefits of a career in the disability sector and the value the community places on such jobs
- promoting (though not requiring) certification in order to signal that it is a profession with the potential for career progression
- improving recruitment services.

An advertising campaign for the disability services sector

As a major policy initiative, the introduction of a new disability insurance scheme would require a media campaign that explained the changes to the system, what it meant for different people and how to use the new system generally. This campaign could also raise the profile of the disability sector and improve community perceptions about working in this sector. The idea of advertising the sector has a recent precedent in the Carecareers campaign run in NSW. Northcott Disability Services suggested that this initiative has:

> … enabled the general public to see through the misconceptions and understand the benefits of working in the sector' (sub. 376, p. 22).

As well as improving the general perception of the industry, the NDIA could use a media campaign to recruit specific groups, such as:

- university students. University students are good candidates for short-term work as they are more likely to be able to cope with irregular working hours (and their hours worked may sometimes be recognised as part of their degrees — such as in nursing and counselling)
- newly retired people who may find part time work a meaningful experience and a way to ease into retirement.

There is a need for care in any targeting arrangement. In some countries, unemployed people and others with weak job prospects have been targeted in recruitment drives (Stone and Weiner 2001). However, it is important to emphasise the right personal and other skills for care and support jobs, rather than trying to recruit people with few alternative labour market prospects. That approach would severely undervalue the role of care and support workers, and people with a disability generally. One possible exception to this may be to recruit some people currently on (or about to enter) the Disability Support Pension. Government policy is increasingly aiming to re-connect pension recipients to the labour market. The disability sector has some advantages in that respect:

- DSP beneficiaries are aware of disability from their own lived experiences
- there are no minimum qualifications, making it suited to the population of DSP beneficiaries, many of whom have limited qualifications
- there is a lot of flexibility in when and how many hours are worked
- the demand for disability service jobs occurs in all locations, so many of the problems of mismatch between the location of jobs and job seekers do not affect this sector.

In making the transition from the DSP to paid employment, the Commission recognises the need for support and training.

Promoting certification through training and education subsidies

Another way to encourage people to enter or remain in the disability sector is through supporting the acquisition of the skills required to excel in the industry. This could include the free provision of training and stipends to targeted groups, such as school leavers or people considering returning to the labour market after a period of absence. It could also include HECS relief for some students entering the sector after graduation. The risk is that large amounts could be spent on people who would have entered the disability sector in the absence of any subsidy, and for that reason, this strategy probably would not be cost effective as an industry-wide measure. However, it may be useful in alleviating specific shortages, such as professional services in rural areas or in specific skill sets.

Improved recruitment services

Disability service providers predominantly attract staff using traditional methods, such as newspaper advertisements and online bulletin boards (NDS 2007, Martin and Healy 2010 p. 141). The process of finding new staff is costly and time consuming and, for many service providers, is an ongoing process. As the NDIA would already provide online information to producers and consumers, there is also the potential for it to ease the costs of employers and employees finding each other. In particular, it would be relatively straightforward to extend the national database of service providers (discussed in chapter 8) such that it also offers a ‘job search’ facility. Alternatively, state-based online facilities such as the Carecareers website in NSW could be offered in each jurisdiction.

Immigration

Several countries, particularly in Europe, have used immigration to ease shortages for long-term care workers, drawing on agreements between European Union countries that allow free movement of labour. However, in Australia there are significant obstacles to employing foreign workers to address skill shortages in the disability sector. While Australia's skilled migration program allows relatively easy entry for some workers, such as nurses and allied health professionals, the South Australian Government commented on the barriers to entry to these groups posed by accreditation of overseas qualifications (sub. 496). In other employment categories (such as carers), workers would need to be sponsored by an employer, as well having at least a diploma from a VET institution (a condition of 457 visas).[11]

Several submissions in the Commission's inquiry into aged care proposed that labour shortages for nurses and care workers should be alleviated through immigration (Alzheimer's Australia NSW 2010; Catholic Health Australia 2010; and DutchCare 2010).

That said, immigration should not be seen as an appropriate automatic response to labour shortages. Nevertheless, were *serious and enduring* labour shortages appeared during the expansion of the disability sector associated with the introduction of the NDIS, there would be grounds for considering easier working visas as a temporary measure to assist during the implementation phase of the scheme. One potential model to consider is the Live-In Caregiver Program in Canada. This program allows entry by foreign workers to provide care and support for children, the aged, and people with a disability. People who meet certain criteria (hours worked and duration of work) can apply for permanent residency. (The latest government report available suggests that the Canadian Government expected to grant residency to around 10 700 to 11 400 foreign workers in 2010.) To be eligible for participation in the program, a person must have completed high school, have experience or training in care giving, and be able to speak English or French. The bulk of caregivers have been Filipinos. While it has its risks and there have been concerns about the abuse of some caregivers, overall the program has been regarded as a successful way of overcoming significant shortages of caregivers in Canada. A

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[11] People from a select number of countries could also work for up to one year in Australia as part of the holiday working visa (a 417 visa).

recent report has identified ways to address the flaws in the program (Standing Committee on Citizenship and Immigration 2009).

Immigration of support workers should be considered, but only if acute and persistent shortages occur. Were that to occur, the experience of the Canadian Caregiver program would provide a useful lesson for Australia in implementing any similar program.

DRAFT RECOMMENDATION 13.1

The Australian Government should attract further support workers into the disability sector:

- ***by marketing the role and value of disability workers as part of the media campaign launching the creation of the NDIS***
- ***by providing subsidies to training of disability workers***
- ***through immigration of support workers, but only in the event that acute and persistent shortages occur, and drawing on the lessons from the Canadian Live-In Caregiver program and other similar programs.***

Maintain low barriers to working in the sector

As shown above, while there are requirements for highly skilled professionals in the disability sector (such as occupational therapists) with associated specialist training, most employees need relatively simple formal qualifications, if any. Their most important skills are informal — a capacity for empathy, an interest in working with people, flexibility and personal experience — skills that are less readily taught or testable in educational institutions. The small requirements for credentials mean that for much of the industry, barriers to entry are relatively low and on-the-job training and experience play a relatively greater role. Some measures that aim to promote quality service provision (such as certification) and to minimise risks make it more difficult to enter the industry. As such, the benefits of these measures need to be weighed against the potential labour supply effects (section 13.6).

Maintaining the appropriate 'scope of practice'

Sometimes consumers lack information about the quality or appropriateness of sophisticated services (like the best therapies for autism or acquired brain injury). Equally, in some jobs, there are risks of malpractice where people do not have adequate training. Regulations sometimes deal with these concerns by mandating what a particular worker can do — their 'scope of practice'. For instance, the title and practice of physiotherapy is restricted by statute to those registered to practice within a particular jurisdiction (Bundy et al. 2008, p. 12).

In many instances, the defined scope of practice is appropriate. However, as noted in the Commission's parallel inquiry into aged care (PC 2011), the scope of practice for non-nursing staff has been widened — for example, in management of medication. That can cut the costs of services, increase the skills and satisfaction of support workers, and address shortages in particular areas. It is not clear whether there are more opportunities to widen the scope of practice.

One participant in this inquiry argued that restrictions on the scope of practice still posed some problems. She said that she was forced to rely more heavily on her parents to perform relatively simple tasks (such as giving medication or changing dressings) because rules prevented the care workers from doing these things, even though in the past they had done them without issue (Jess Evans, sub. 585, p. 3).

The NDIA should continually review any opportunities for the relaxation of restrictions on the scope of practice, especially where new technologies allow it (such as electronic adherence monitoring and electronic medication reminders — Marek and Antle 2008). *Any changes would have to involve low risks for people with a disability and for the workers concerned.*

Excessive screening of workers might act as a potential barrier

People with a disability are often vulnerable to physical or emotional abuse and to theft or other crimes. This reflects the fact that services are often provided in the home and are not easily observed by other parties, may involve personally intimate care (such as bathing or dressing), and may involve people with a limited capacity to tell others what has happened to them. Screening potential disability workers for past criminal behaviours through police checks is a critical way of addressing this risk, and appears to be a relatively low cost measure.[12]

The current system of criminal history checks varies greatly between states and territories, although requiring some form of police check is the minimum standard across Australia.[13] New South Wales and South Australia have a point-in-time

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[12] Costs vary by state but are generally about $40 for paid staff and less (sometimes free) for volunteers. This is generally subsidised by government – the Tasmanian Government has estimated that the full cost of processing a check is about $100 (Tasmanian Department of Health and Human services 2010).

[13] The only state that has a statutory requirement for a police check is Queensland, although other jurisdictions achieve the same result by making such checks compulsory through funding arrangements.

check. Western Australia, Northern Territory, Queensland and Victoria have a register that allows a person to work for a certain period (ranging from 2–5 years). Different jurisdictions also use police checks of varying scope. In some places, such as Victoria and NSW, governments require only the basic Australia-wide police check. Others, such as the ACT and Queensland, require a check that includes spent convictions and information on repeated accusations of serious crimes.

Police checks raise some vexing issues.

Requiring criminal history checks for *all* staff providing disability services may limit the flexibility of disability services and the capacity to recruit workers. While service providers are not necessarily obligated to reject applications from people with some kind of criminal history, the mere requirement for disclosure may well deter people from applying, even if the crime was old and minor, and they are now safe and responsible people. In general, minor distant convictions are not included in police checks under so-called 'spent convictions' legislation. However, there are sometimes exclusions, which mean that the police report given to a disability agency would include records of distant minor crimes — such as shoplifting committed by a person 40 years previously. For example, s. 19 of the *Spent Convictions Act 2000 (ACT)* specifies an exclusion for people working in disability services.

When designing a system of criminal history checks, the key design questions are:

- Who would need to have a criminal history check? This includes whether mainstream workers providing home-based services — cleaners and gardeners, for example — would be included in the process. Arguably, governments should require background checks only for staff providing traditional disability services (such as personal care and organising finance). This means that people providing mainstream services to people with a disability, such as mowing the lawn, would be able to work without a police check. In these cases, the person is acting more like a consumer of mainstream services and less like a recipient of care.
- Would a police check be required in circumstances where the person with a disability was not likely to be vulnerable? In principle, vulnerability should be the key criterion for the necessity for a police check. Many people with physical disabilities are able to complain if they are subject to any harm, just like people generally. Vulnerability is potentially much higher among people with an intellectual or mental health disability. To include all people with a disability as implicitly vulnerable could well be seen as stereotyping disability. In that case, one approach would be to assess a person's vulnerability through the NDIS process, and where they are not vulnerable, allow them to determine whether they want a police check undertaken.

- Would the police check be a point-in-time clearance for a particular job or a register that allowed people to work for a certain period? Arguably, the latter is more efficient and reduces the costs of additional checks, especially for people engaging in short-term working arrangements.
- Should family members providing paid care be required to have a police check? On the one hand, governments have no such requirements for informal carers, for parents of children without disability, or for those receiving carer payments (de facto 'paid' workers). Such checks would not be regarded as appropriate by the community, and given the numbers of people involved, would be unlikely to be cost effective. However, the context for paying family members under self-directed funding would be different. Such families would already have to jump through some administrative hoops to be eligible for such direct payments (chapter 6), and it would not be costly to include a police check for serious crime as an element of that scrutiny. Moreover, even though the likelihood of abuse appears low (based on the evidence discussed in chapter 6), even rare instances might turn public opinion away from a capacity to self-direct in this way. The Commission considers that governments should require family members to obtain a criminal history check if they are working as formal carers. The proposed trial of paying family members (draft recommendation 6.5) will also be useful in addressing the risks in this area.

DRAFT RECOMMENDATION 13.2

Australian governments should ensure that, across all jurisdictions, police check arrangements for paid workers providing services to people with a disability:

- ***apply only in cases where both the person with a disability is vulnerable AND the risks associated with delivery of services are sufficiently high***
- ***not include disclosure of crimes covered by spent convictions legislation***
- ***cover people for a given period, rather than for a particular job.***

13.4 Alternatives to increasing the formal workforce

There are several other ways to alleviate pressure in the formal labour market beyond expanding the supply of the formal disability workforce.

Supporting the informal workforce

Many people want to provide care and support to family members with disability, but may need support to sustain their caring role (or to relieve the isolation and stress that often comes with that role — chapter 2). For example, bed block in respite care facilities — a costly outcome — is a symptom of inadequate support for family carers. Chapter 2 and section 13.2 also shows that a failure to support the informal workforce can be a source of substantial later costs for government, as those informal carers unable to cope shift all of the caring responsibilities to government. In that sense, there is a strong economic as well as social basis for providing support for informal carers.

One aspect of this support is that the NDIS will lead to greater provision of quality respite services and accommodation options than under current arrangements. However, there are other important aspects of support to sustain the informal workforce.

Counselling services for carers serve an important role, and to some extent, the National Carers Counselling Program addresses this function. The NDIS assessment process should refer carers to that program where it is needed. (The Australian Government should not fold this program into the NDIS because it caters for carers in the aged care as well as the disability system.) However, as discussed below in respect of training, the NDIS could also set aside funds so that carers and people with a disability can have some choice about counselling beyond those provided by the National Carers Counselling Program.

Several other strategies could also be important.

Paying family members

First, paying family members may sometimes be an appropriate way to maintain family care, although there are several complex issues with doing this. We deal with this issue at length in chapter 6 and appendix E. The Commission proposes a trial.

Training for carers

Second, there are grounds for providing training to informal carers, and not just to the formal workforce. Sue Aiesi from Carer’s Australia noted:

> We believe carers need education and training and they need access to appropriate education and training right throughout the caring role. It could be at the beginning of a diagnosis, the birth of a child, it can be throughout when conditions change, but that's a really important part for carers. It's more than just supporting carers to do that. We believe strongly there's savings associated to the government with having carers trained properly. For example, even something like manual lifting, if carers hurt themselves, the person they are caring for is likely to end up in hospital, the carer could end up in hospital, so there's a double whammy. (trans., p. 399)

Care and support for people with a disability require new skills and knowledge that many people do not know because it is not a customary experience of their friends or family. For example, the skills may relate to safe lifting, mobility training, or dealing with challenging behaviours (Carers NSW, sub. 244, p. 9). Peak bodies often provide some assistance, as do informal support groups. However, there are strong grounds for the NDIS to provide and fund training to interested carers across Australia in a coherent way (chapter 4). There is sound evidence for carer interventions (box 13.3), which would inform the nature of training and other assistance to carers. The NDIS website could provide some training remotely.

The inquiry by the House of Representatives Standing Committee on Family, Community, Housing and Youth recommended a national strategy to address the training and skills development needs of carers (SCFCHY 2009 p. xxiii). The Australian Government agreed with this recommendation, but proposed that it would 'build on existing' training and skills programs' provided through Respite and Carelink Centres (Australian Government 2009, p. 12). The Commission's parallel inquiry into aged care has recommended a somewhat different approach in which carers would be referred to 'Carer Support Centres' (draft recommendation 11.1 from PC 2011). The Commission recommends that the NDIA would also refer carers to these centres where that was appropriate.

However, as discussed above in relation to counselling, there are grounds for the NDIS to provide some additional funding for training of carers. Carer centres may be only one way of meeting the training needs of carers. By providing an additional source of funding, the NDIS and carers could determine where training would best meet people's training needs.

Furthermore, as part of its research and data collection function, the NDIS should assess the best training options for carers of people with a disability. (These approaches may sometimes diverge from those best meeting the needs of carers of older people.)

The Australian Government is pursuing a national carer strategy. Some parts of that strategy would lie mainly outside the NDIS — such as better recognition of carers — but others would be at least partly met by the NDIS itself (for instance access to respite care and, as noted above, training and counselling services). The strategy will need to recognise the role of the NDIS is supporting carers.

Box 13.3 **Support and training for carers**

It is now widely recognised that support and training of carers can improve outcomes for carers and for people with a disability.

A meta analysis of 78 caregiver intervention studies for six outcome variables and six types of interventions found significant benefits for caregiver 'burden', depression, subjective well-being, perceived caregiver satisfaction, ability/knowledge, and for the person with a disability. Intervention effects were larger for increasing caregivers' ability/knowledge than for caregiver burden and depression. The effects were smaller where dementia was involved (Sorensen et al. 2002).

Another review of the effectiveness of caregiver interventions found that (a) information provision alone did not have any significant benefits (b) individual rather than group interventions had better outcomes (c) case management and care coordination appears to be beneficial (d) counselling and psychosocial interventions are usually beneficial (though having no effect in some studies) as are educational and psycho-educational interventions and family support interventions (Eagar et al. 2007).

In a meta-analysis of carers of people with dementia, Brodaty et al. (2003) found that carer interventions improved caregiver knowledge, main caregiver outcomes, the mood of the person with a disability (but did not reduce the care requirements of the carer). Some interventions delayed entry to residential care.

In another meta-analysis involving carers of people suffering dementia, researchers found robust evidence for the benefits of six or more sessions of individual behavioural management therapy. Teaching caregivers coping strategies either individually or in a group also appeared effective in improving caregiver psychological health both immediately and for some months afterwards. Group interventions were less effective than individual interventions. Education about dementia by itself, group behavioural therapy and supportive therapy were not effective (Selwood et al. 2007).

Even brief interventions have been shown to have some beneficial effects, such as the trial of an individualized problem-solving intervention for family with caregivers of persons with recent-onset spinal cord injury (Elliott and Berry 2009).

Psychosocial interventions for the carers closest to a person with a disability associated with chronic disease reduced care giving 'burden', depression, and anxiety. These effects were strongest for non-dementia cases and for interventions that targeted only the family member and that addressed relationship issues (Martire et al. 2004). In this case, the overall effects were small.

DRAFT RECOMMENDATION 13.3

In order to promote training and counselling for carers, the NDIS should:

- ***assess carer needs as well as those of people with disabilities (draft recommendation 5.6) and, where needed, use the assessment results to:***

  - ***refer people to the 'Carer Support Centres' recommended in the Commission's parallel inquiry into aged care and to the National Carers Counselling Program***
  - ***include the capacity for accessing counselling and support services for carers as part of the individual support packages provided to people with a disability***
- ***assess the best training and counselling options for carers of people with disabilities as part of the NDIS research and data collection function.***

More scope for people to work flexible hours

Thirdly, there are grounds to increase the ability of family carers to work flexible hours. Under the National Employment Standards (NES), people are entitled to request flexible work hours if they have a child with a disability age under 18 years (s. 65(1) of the *Fair Work Act 2009*). The caring responsibilities of a parent of a child with a disability extend beyond the time their child turns 18 years. In fact, the responsibilities often increase when children with disability leave school, as school provides a de facto form of respite. Accordingly, the rationale for flexible working hours is stronger where a person is caring for a child with disability.

However, the Australian Government has recently rejected an inquiry's recommendation to expand coverage to children aged over 18 years (Australian Government 2009, pp. 46–47 in response to the House of Representatives inquiry into better support for carers). The main grounds for the rejection were that, under the NES, people could get access to ten days of paid carer's leave a year, two days of unpaid leave and the capacity to reach an agreement about any work arrangements if the employer consents to it. However, were those grounds compelling, they would apply equally (if not more) to the care of children with a disability, and would make it hard to justify s. 65(1). On the face of it, the existing rights under the NES do not meet the legitimate needs for greater flexibility for parents with caring roles for children aged over 18 years old. It should be emphasised that the inclusion of this group in s. 65(1) would still only entail the right to *request* flexible arrangements from an employer, not the guarantee that the employer would grant it.

There could be one possible unintended impact of widening the scope of s. 65(1). Given disability is not always well defined, it is possible some parents might use the Act to request flexible arrangements for their own purposes, when the degree of disability is relatively low and where they do not undertake any significant caring role. One way of addressing that possible problem is to tie the right to request flexible leave to a certain level of assessed need — which is objectively determined in the NDIS.

While parents are the focus of the current arrangements under the NES, there are also grounds to extend flexibility to employees caring for people other than children. The Commission considers that the Australian Government examine this following the outcomes of the amendment to the *Fair Work Act 2009* in recommendation 13.4 below.

Increased flexibility generally has the advantage of reducing stresses on carers, but also of encouraging their workforce participation.

DRAFT RECOMMENDATION 13.4

The Australian Government should amend s. 65(1) of the Fair Work Act 2009 to permit parents to request flexible leave from their employer if their child is over 18 years old, but subject to an NDIS assessment indicating that parents are providing a sufficiently high level of care.

After monitoring the impacts of this legislative change, the Australian Government should assess whether it should make further changes to the Act to include employees caring for people other than children.

Productivity increases

Labour productivity measures how much can be produced with a given amount of labour. In disability support:

- 'how much' refers to the number of clients served or care tasks performed, *and*, importantly, the quality of disability services delivered
- labour is the time spent by care and support workers, administrators, supervisors.

While most attention on labour productivity relates to formal (paid) disability workers, it can also relate to informal (unpaid) carers. Gains in productivity for the latter can reduce the requirements for support through the formal disability sector, or increase the long-run sustainability of unpaid care.

Productivity improvement may alleviate the potential shortages of labour in several ways:

- more efficient use of existing resources (for example, by reducing underutilisation of some services or by addressing costly bottlenecks in the system)

- more intensive use of capital (existing aids, appliances, and vehicle and home modifications)
- innovation through new forms of capital and improved knowledge about how to get better or less costly outcomes. For example, new knowledge about how to reduce bedsores or to maintain bladder control can avoid costly subsequent interventions, as well as enhancing the quality of life of people with a disability. Encouraging the use of mainstream rather than specialist services can be very cost-effective. So one of the benefits of self-directed funding, an innovation in how disability systems are run, is that people can choose mainstream services that employ workers outside the disability sector, such as gyms.

Many tasks performed by carers cannot be easily substituted with aids and appliances, and so the scope for dramatic increases in productivity from more intensive use of capital and technological innovation cannot be expected over the short term. In a report entitled ‘How many wheelchairs can you push at once?’, Allen Consulting (2008, p. v) argued that there was poor scope for short-run productivity improvement in Victorian social services:

> … further productivity gains are unlikely in the sector without jeopardising service delivery outcomes … Unlike productivity gains in the rest of the economy, productivity gains in the community services sector are difficult to achieve given the labour intensive, people-oriented nature of the service.

The wheelchair example oversimplifies the scope for productivity gains over the longer run. The history of the wheelchair illustrates the progress of technology for people with a disability. Prior to the Second World War people with a disability only could get heavy manual wheelchairs, which would often have required the aid of a support person. However, with the invention of the motorised wheelchair during WWII (Bourgeois-Doyle 2004), people have had access to increasingly sophisticated and lighter wheelchairs over which they have complete control.

Equally, modification of motor vehicles and driver training has allowed some people with a disability to be mobile without having to use specialist disability transport services. Moreover, increased mobility can enhance labour market and social participation, which in turn can have wellbeing effects (and greater income) that reduces the need for formal support services.

Over the long term, productivity improvement is likely to play a bigger role:

- should labour shortages cause wages to rise, more capital intensive or technology based alternatives will become viable
- higher wages may increase staff morale, and reduce absenteeism and staff turnover, providing a direct offset to additional labour costs

- the greater scope for competitive pressures under the NDIS will tend to shift people from less productive agencies to more productive (noting that productivity includes the quality of outcomes). There may be further shifts away from government-owned services, which appear to operate at lower productivity (Allen Consulting 2008, p. 4)
- after their initial introduction, manufactured aids and appliances tend to decrease in price over time, encouraging their wider adoption. This process may be enhanced by bulk purchasing or other procurement strategies used by the NDIA or DSOs
- as part of the NDIS, significant investment into IT infrastructure is being proposed, which could reduce administrative costs and encourage more efficient use of existing resources
- technological developments generally have many potential benefits for people with a disability, and for labour productivity. For example:
  - information and communications technology may reduce travelling time for care coordinators and allied health professionals, while maintaining the quality of their services (for example, telehealth is one emerging area of interest — see below)
  - substitutes to human services will be attractive to many people with disabilities as it enhances their independence (so uptake is likely if such alternatives are offered at cost-effective prices). Among many other technological developments, personal emergency response systems, refreshable Braille displays, Cochlear implants, computer eye trackers, automatic turning beds, and text-to-speech software have given people with a disability a much greater capacity for participation in society and reduced dependence on others. Many other technologies are likely to develop — for example, in areas like assistive robot technology
  - technological aids will make it easier for a broader range of workers to support people with a disability. Lifting aids have become more sophisticated over time, and developments in robotics may offer additional scope to assist with lifting and other tasks
- in the past, decisions about expensive one-off capital investments have often not given sufficient weight to their effect on lifetime costs, or on the potential to make significant improvements to peoples lives. The capacity to do this will be much greater under the NDIS
- the research conducted by NDIA itself and the money made available to others in the sector for research and innovation will also facilitate growth in productivity

- by simplifying the system of assessment for disability services, service providers and in particular allied health professionals, will be able to spend more time with patients and less time completing paperwork
- innovation will come from people with a disability as users of generic technologies. The internet and Short Message Services (SMS) on mobile phones have allowed easier communication for deaf people. Skype and other video technologies can enable people to interact with others more readily (and was indeed used by one participant in the Commission's hearings)
- from a wider perspective, risk reduction strategies, such as safer motor vehicles, can reduce the prevalence of catastrophic accidents and severe disability.

We discuss the capacity to make (some of) these improvements in other chapters in this report. That said, the overall impact of such prospective changes on labour productivity is not clear. In most areas of human activity, predictions about future technologies have been overly optimistic or pessimistic. For example, in 1965, Herbert Simon of Carnegie Mellon University, a founder of the field of artificial intelligence, indicated that by 1985, 'machines will be capable of doing any work man can do', while the US postmaster general said in 1959 that 'we stand on the threshold of rocket mail'. Other commentators have been unduly pessimistic.

The Commission has recommended the creation of an 'innovation fund' for service providers to encourage productivity in the disability sector.

Volunteers as a source of support

Volunteers often provide support to people with a disability. In 2006 there were 5.2 million people volunteering in Australia. Of these, 1.1 million volunteered their time and effort to the area of community welfare. Social services tend to attract older volunteers, while younger people tend to volunteer their time to areas such as sport and emergency services.[14]

In its previous work on the implications of population ageing, the Commission predicted that national volunteering rates in the area of social services would increase in years to come due to demographic effects associating with the baby boomers retiring and newly retired people having a high propensity to volunteer in this area (PC 2005).

While this increase would alleviate labour shortages in some areas, it would be less influential in others, as volunteers cannot perform all the roles of paid staff. In the

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[14] ABS 2007, *Voluntary Work, Australia, 2006*, cat. no. 4441.0.

disability sector, volunteers tend to be better suited to supporting roles such as transportation, assisting with household chores, shopping and companionship. However, jobs that have higher demands in terms of education and training, difficulty or unpleasantness are unlikely to be significantly bolstered by volunteers.

It is likely that some volunteers would be willing to move into paid employment in the sector — taking on additional hours, responsibilities and training — if funding was available to do so. The SCS estimated that 20 per cent of current staff has, at some point, worked in an unpaid role within the sector. As such, volunteers themselves represent a potential source of additional formal labour to the disability sector. Conversely, some participants have suggested that the 'commercialisation' of the disability sector may undermine its capacity to attract volunteers in the first place (Northcott Disability Services, sub. 376, p. 23; South Australian Government, sub. 496). This may occur to some extent, although NGOs in a wide variety of sectors commonly employ a mix of a paid and unpaid staff. (In many cases, volunteer work is used as a stepping stone to paid employment.) As such, it could reasonably be expected that volunteers will continue to play a valuable role in the disability sector.

As a self-initiated altruistic activity, the capacity for the NDIS to encourage the voluntary supply of labour is limited. However, it can make volunteering attractive and easier by:

- promoting volunteering opportunities through marketing campaigns
- reducing search costs by fulfilling a matching function between volunteers and service providers (but only to the extent that there are any gaps in existing state infrastructure, which already perform this task reasonably well)
- reducing burdens to entry.

The impacts of these kinds of initiatives are likely to be modest. Service providers, often already have programs for attracting and integrating volunteers into their organisations.

Self-directed funding may recruit new people

While its role should not be overstated, self-directed funding may somewhat reduce the impact of excess demand for workers in the disability sector because people could switch to mainstream services that may be more readily available, offer better value or simply be a more attractive alternative than specialist disability services.

In addition to facilitating access to mainstream services, self-directed funding would allow people to hire friends or neighbours as support workers — recruiting a new group into the labour market. Importantly, these employment options would be available in situations where, due to isolation or strong demand for staff from other sectors (such as in mining areas), there may not be a well operating formal care market. The Commission has also proposed that payment of family members be trialled as part of self-directed funding. If that were successful, it would further deepen the pool of potential workers in disability services.

13.5 Are labour supply concerns surmountable?

Finding enough labour to meet the expected growth of the disability sector is one of the key challenges for the NDIS and NIIS. In order to minimise the problems that will occur and the potential for excessive wage pressures, it is important that the NDIS has effective management processes in place and that the implementation of the NDIS is not too rapid.

Increased funding of the sector, the shift away from block funding, greater consumer choice, together with low barriers of entry to the workforce, will facilitate a much more responsive labour market than is currently the case. In particular, current and emerging shortages are likely to be replaced by upward pressure on wages. While this is presents a financial risk to the scheme, it is both necessary and desirable to attract more workers to an underpaid and understaffed industry. The gradual implementation of the proposed scheme should reduce the likelihood of wage ‘overshooting’.

Also, as previously discussed above, the current workforce is sometimes underutilised. In that context, Martin and Healy (2010, p. 146) concluded:

> … there is significant scope for disability providers to increase the working hours of their current non-professional workers, without facing the high costs of recruiting new workers.

Beyond this, there are several supporting measures that can ease labour supply constraints including supporting the informal workforce and volunteers, and programs aimed at assisting training and education, recruitment and perceptions of the industry. Immigration and employment of international workers are likely to be a particularly effective instrument, should acute shortages emerge.

13.6 Qualifications, working knowledge and career paths

The attributes of the staff — their training, experience, abilities and personality — largely determine the quality of care in the disability sector. This section examines how workers acquire these attributes and how to deliver an appropriately skilled workforce.

What skills are needed?

Staff in the disability sector require a diverse range of skills, knowledge and personal attributes, with tiered degrees of specialisation.

One segment of the sector involves people with professional credentials and requirements for tertiary training and accreditation (such as occupational therapists).

However, for many employees, their skills often involve the combination of practical generic skills (such as cooking, cleaning, driving, and general communication skills) with critical intangible skills, such as the capacity to treat people with dignity, respect, compassion and patience.

In other cases, the skill set will be more specific to the disability sector, such as:

- lifting safely
- bathing
- protocols for providing care in different settings (such as in home care, residential care)
- supporting people who have challenging behaviours, such as self-harm
- providing disability support appropriate for specific groups, such as Indigenous people or those from cultural and ethnic backgrounds with different social attitudes to disability.

Beyond this, attendant carers and support workers need to acquire more specialised expertise about specific conditions to understand their client’s care needs better and the most effective way to support them.

However, a large part of working in the disability sector (particularly as a support worker) involves knowledge and skills that are specific to a single client. This reflects:

- the diverse life circumstances of their clients

- how their personality and preferences influence their care and support needs
- the unique ways in which disability manifests itself
- the fact that many conditions underlying disability are rare, so that particular knowledge learned with one client may never be used again
- the service-based nature of the industry that, like all services, should be as responsive to the individual needs of clients as possible.

Familiarisation with a new system

The NDIS is a new system underpinned by different ways of funding and overseeing disability supports, greater devolution of power to people with a disability, and new sets of rules and procedures. These differences mean that in the transition to a new system, existing workers will need to know how the new system will work, their roles in it, and the changes it implies for their everyday practice. Accordingly, there will be some training requirements associated with the shift to the NDIS. This should be supported through web resources (a part of the tier 2 function of the NDIS — chapter 3), as well as through direct training and awareness arrangements.

How does the workforce attain the skills they need?

While personal traits, such as empathy, patience and good communication skills are highly important, disability workers must also acquire other practical skills. This mainly occurs through on-the-job experience, which embodies several different types of learning:

- *learning by doing*. Staff will naturally progress over time as they learn from the situations and challenges they encounter. The skill of adapting to individual client needs can also be developed alongside a flexible range of strategies to address them. Together, this allows experienced staff to take on clients with more complex needs, be capable of working in more challenging environments and have the confidence to deal with emergencies or unexpected situations
- *learning from clients and their family.* The person with a disability and their families are often the most informed about the medical condition underlying disability and the appropriate support needs (a fact that participants in this inquiry demonstrated). Similarly, family members of people with an intellectual disability will often have all the crucial information about how to gain their trust, communicate and productively interact with them in general

- *learning from experienced staff members*. This can occur through formal relationships, such as supervisors or mentors, or merely through informal workplace exchanges and advice. However, this type of skill acquisition is not applicable in all settings, as staff often work with a single client, or outside an organisation's structure.

In large part, this type of learning occurs organically. However, governments can also influence the minimum quality of a workforce through mandatory training and screening, the subject of the next few sections.

Learning through formal training

There are several formal VET training programs designed to prepare someone to work in the disability workforce. These include certificates I–IV, diplomas and advanced diplomas. These must conform to the Australian Quality Training Framework and are regulated by the National Quality Council to maintain standards. The diversity of the tasks performed in the industry is reflected in the topics covered, including: practical skills about personal care needs (such as bathing and lifting), behaviour support, individual health and emotional wellbeing, occupational health and safety, empowerment of people with disabilities and community participation and inclusion (TAFE NSW website).

So far, no jurisdiction has made such certification compulsory for all support staff. However, governments have indicated that it would be desirable that all new staff achieve at least a certificate three level qualification either before starting work or soon after (NDA 2006). Also, several service providers will only employ staff with a basic qualification.

Formal training can enhance quality of care in two ways. Formally trained staff may be more proficient in performing caring tasks, and may have a greater sensitivity and awareness in how they interact with people with a disability. Formally trained staff can also be a source of information to service providers about emerging best practice, and how current organisational processes could be improved. It is often suggested that formal training contributes to 'better' service. The Commission has proposed a shift towards a person-centred model of support services and for people to choose providers freely (or to manage their funds by themselves). Training may help change the ethos of the disability workforce, not all of whom understand the importance of self-determination for people with a disability (or their proxies).

Formal training may also reduce the risks to clients as well as staff themselves (for example, safety risks arising from poor lifting technique). It also potentially reduces risks to service providers and funding bodies, which may be held accountable when incidents occur.

Some participants have pointed to other benefits of formal training and credentials in changing perceptions and worker aspirations. Training may improve community perceptions about the professionalism of the sector and increase the career prospects for those entering it (Blue Mountains Working Party, sub. 142; Attendant Care Industry Association, sub. 268; Lesley Baker, sub. 188; Liquor, Hospitality and Miscellaneous Union, trans., pp 809).

Despite these benefits, some participants expressed the view that formal qualification fell well short of providing 'work ready' applicants. For example:

> ACiA conducted a survey of its members last year on the issue of training and qualifications. Most providers stated that they generally employed people with a Certificate III. However, this appeared to not be because of the skills or knowledge that workers had obtained, but because it demonstrated some level of commitment to the work to be undertaken. They therefore mostly felt that they still had to train staff 'from scratch. (ACiA, sub. 268, p. 11)

Some service users, went further and suggested that in some cases formal training could be counter productive:

> My preference is to get people who have not had this training with other people as there is often a lot of unlearning needed to make it work for me (Dr Phillip Deschamp, sub. 136, p. 2)
>
> My experience with 'trained' staff is that there is an overly medicalised relationship, which results in a 'worker knows best' power structure instead of a mutually satisfactory and equal relationship between workers and the person with a disability. (Ben Lawson, sub. 103)
>
> It is the experience of most people with disabilities and their families who have achieved the right to select and appoint their own support staff, that workers drawn from outside the disability sector, with no disability training, who do not think in terms of 'disability' are invariably preferred as personal support staff. This suggests that a 'de-industrialisation' of disability staffing is needed, so that support roles more closely resemble community-based neighbour and peer relationships rather than industry relationships. (National Federation of Parents, Families and Carers, sub. 28)
>
> I never ask anybody I employ if they have got any training in disability because it doesn't matter to me. I'm one of the people who talk to the person; it's their attitude. Do they speak to my son? Do they acknowledge he exists? Do they have the right sense of social justice? That comes first. I can teach them how to work with Jackson. I can do that, and everybody — this whole individual thing, you know, it doesn't matter if you get somebody with 15 certificates in disability, you still have to teach them about your person, because they all have their idiosyncrasies. (Sally Richards, trans., p. 402)

While formal training does not appear to be a substitute for on-the-job training and experience, it is likely that it delivers some benefits to staff and clients.

These benefits have led some participants in this inquiry to suggest there should be a minimum qualification required for people to work in the disability sector — usually certificate III (Trevor Robinson, sub. 127, p. 6; Northcott Disability Services, sub. 376, p. 23).

However, the costs associated with mandatory qualifications need to be assessed against the benefits.

- The overall costs of the qualification itself can be high. The direct *costs* are relatively small in monetary terms,[15] and is usually subsidised by government or a service provider. Nevertheless, it still involves time spent on training rather than doing other tasks — which can be a much bigger cost. The period of study at TAFE for a certificate III in disability work is 565 hours, or roughly 20 weeks full time (TAFE NSW 2011). For those only seeking to work in the industry for a short period (for example while they are at university, or people re-entering the labour force late in their working lives), such costs are potentially prohibitive if certification is made mandatory.
- Mandatory certification may constrain the choices available to people with a disability, if applied to all potential uses of their entitlement. For example, requiring that staff of a local yard maintenance business obtain a certificate III in disability work would be unlikely to improve service quality, but would increase costs. Similarly, requiring certification would also undermine the capacity of people with a disability to hire friends and family to assist in their care needs, reducing the flexibility of the self-directed funding model considerably. In both cases, mandating certification of staff also reduces the competition faced by specialist disability providers — to the potential detriment of consumers.
- As noted above by ACiA (sub. 268), one of the benefits of the current voluntary system is that certification provides a signal to service providers about the commitment and career intentions of staff. Under a mandatory system, this signalling function is lost.
- Finally, while many people prefer qualified staff, some attach little significance to qualifications. Indeed, as noted above, some participants in the inquiry saw formal qualifications as undesirable. Mandatory certification effectively compels the latter group to pay for something they do not actually want.

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[15] We examined the course costs from a number of TAFEs and private providers. These showed that a course from TAFE NSW cost $352 in 2011. A number of private providers offered courses in the range of $2000.

Combined with the varied and practical nature of skill acquisition in the disability sector, the potential to worsen labour shortages and the problems it might pose for choice by people with a disability, the costs associated with mandatory staff certification are likely to exceed the benefits. As such, the Commission does not recommend that certificate III (or any other qualification) be a pre-requisite for non-professional workers in the disability sector.

Nevertheless, formal training is likely to continue to be an important part of skill acquisition for many workers in the disability sector. Government can assist formal training in ways that avoid the problems of compulsion. For example, the current subsidies provided to those attending TAFE institutions or other education providers should continue under the proposed disability scheme.[16]

Specialist staff

While the bulk of this chapter focuses on (relatively lower-skilled) disability support workers, several professions — doctors, nurses, occupational and speech therapists and other allied health professionals — also provide services for people with a disability. These professions generally require university degrees and have professional bodies that govern entry and maintain standards.

There is an ongoing shortage in some of these professions. Health Workforce Australia pointed to the:

> … significant challenges that workforce shortages present to the quality and sustainability of Australian health care. (HWA 2010, p. 5)

While this adversely affects people with a disability, it also has much wider impacts on the community as a whole. Consequently, a detailed analysis of this problem is beyond the scope of this inquiry. That said, the NDIS would need to engage a significant number of suitably qualified people as assessors. Some of the measures proposed above — such as paying market wages and incentives to undertake certain courses of study at university — may play an important role in encouraging supply of the relevant workers. Moreover, there will be requirements to train any professionals in the use of the assessment toolbox described in chapter 5.

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[16] It is difficult to estimate precisely the proportion of courses that governments subsidise because fee-for-service courses provided by private institutions are not recorded in the relevant statistics. However, it appears that the majority of people undertaking formal training receive some form of government subsidy, either by attending a TAFE or through the Productivity Places Program, which has subsidised private providers.

Case managers

Case managers will play an integral role within the NDIS because they are the main contact point between the system and people with disabilities. Given the diversity of clients within the NDIS, the work (and caseloads) of case managers will vary greatly. For example, the Transport Accident Commission and the New Zealand Accident Compensation Corporation have some specialisation of case managers, with low client numbers per case manager for complex cases or when conditions are not stable.

In a system as large as the NDIS, there would be greater scope (and grounds) for specialisation, at least in major urban areas. For example, case managers might deal with specific types of disability (like acquired brain injury or intellectual disability), differing levels of functional impairment (for example, people with limited mobility), specific types of support needs (for example, people whose only support needs are community participation); different cultural groups (such as Vietnamese people with disabilities) and different backgrounds (for example, ex-prisoners with disabilities). The scope for specialisation would necessarily be less in some regional parts of Australia.

Regardless, the diversity of people with a disability (and the environments in which they live) suggest that case managers will be drawn from a variety of different fields and require training that is relevant to any specialised function they perform. The fields would include allied health professionals such as occupational therapists and physiotherapists, counsellors, nurses or experienced support staff (who may or may not have any formal qualifications). Agencies like the TAC have processes for training case managers that could be scaled up for the NDIS. There is also a range of accredited courses in case management, such as the Diploma in Community Services.

14 The costs of the scheme

Key points

- The Commission's preliminary analysis estimates that the *net* cost of introducing the NDIS would be around **$6 billion** per annum.
- The Commission at this stage only has partial access to the 2009 Survey of Disability, Ageing and Carers (SDAC) and even with full access to these data, there will still be uncertainty in the numbers. Accordingly, a variety of data sources were used to derive the NDIS cost estimate, including the 2003 SDAC. Data uncertainty is common in designing new insurance products and schemes. For example, similar data issues were faced by the NSW Government when it agreed to implement the Lifetime Care and Support Scheme.
- In addition to uncertainties arising from data quality, assumptions are necessary in building an operational model. For example, we have made assumptions about the wage rate for attendant care costs (noting that attendant care costs amount to 80 per cent of costs in comparable schemes), and in estimating the expected hours of daily care required in a new system by people with different types of support need. The Commission has modelled and presented high and low scenarios by varying wage rate assumptions.
- It is estimated that there are 359 000 people under the age of 65 years accessing NDIS-funded, individualised supports (tier 3 of the scheme). Of these, approximately:
  - 227 000 require daily assistance with at least one of the three core activities of daily living (self-care, mobility and/or communication)
  - 82 000 people would be supported by early intervention programs
  - 50 000 are people with intellectual disability (who do not require daily assistance with at least one core activity).
- The annual *gross* cost of the NDIS is estimated to be $12.5 billion, comprising $10.6 billion in care and support (accommodation support, attendant care, day programs, respite, therapy and other supports), $0.58 billion in aids and appliances, $0.12 billion in home modifications, $0.08 billion in transport and a 10 per cent administration loading.
- The estimated direct offsets to this gross cost is $6.2 billion. This takes into account the current spending on people aged less than 65 years (comprising spending from the National Disability Agreement (NDA), Home and Community Care (HACC), residential and community aged care, aids and appliance schemes and transport taxi subsidy schemes). The net cost of the scheme is therefore around $6 billion.

14.1 Introduction

This chapter estimates the cost of the National Disability Insurance Scheme (NDIS). The cost estimates take into account who the NDIS is for (chapter 3) and the types and level of formal supports required (chapters 4 and 5). Specifically this chapter outlines:

- the data available to undertake the costing (section 14.2)
- the estimated number of people accessing NDIS-funded, individualised supports (tier 3 of the NDIS) (section 14.3)
- the cost of the NDIS, considering the types and levels of support for people in tier 3 (section 14.4)
- the offsets to the gross cost of the NDIS, that is, current government funding on people likely to be in tier 3 of the NDIS (section 14.5)
- scenario analysis (section 14.6).

There are two key sources of significant uncertainty in the costings. The first is the estimated number of people likely to be in tier 3 and the second is the appropriate nature and cost of supports to assign to people in tier 3. The reason for this uncertainty is a lack of available data to undertake the calculations. No data source contains the exact information required to cost the NDIS, and hence a range of data sources are used, none of which were specifically designed for this purpose. The main data source used to estimate the number of people in tier 3 is the 2009 ABS Survey of Disability, Ageing and Carers (SDAC). These data were only made available recently and hence the Commission has not had long to undertake its analysis.

More extensive modelling will be undertaken for the final report. The 2009 SDAC Confidentialised Unit Record File (CURF) will be available before the release of the final report and will allow for more detailed analysis.

14.2 Data

At present, the Australian disability system operates within a planning framework that could be significantly enhanced through greater investment and more planning for data management and reporting (discussed in more detail in chapter 10). In particular, a longitudinal database that collects information on individuals, including their functional support needs, health conditions and formal and informal supports would assist in costing the NDIS.

The 2003 ABS SDAC was approximately a one in 400 household sample. When compared to the 2003 survey, the 2009 SDAC sample was almost doubled to improve the quality of the estimates at both national and state levels. The 2009 ABS SDAC is the most up-to-date information on the level of disability within the Australian population. Specifically, the SDAC includes:

- demographic and socioeconomic wellbeing information on people with disabilities and their carers
- detailed information on activity limitations (for example, self-care, mobility and communication)
- information on health conditions and the functional support need associated with these health conditions.

Despite the increase in sample size, considerable uncertainty remains due to the small number of people with some less common disabilities. For example, it may be that an estimate of 2000 people in a particular category is based on responses of only a very small number of people (meaning that random sampling error would have a considerable proportional impact on the estimated population). Accordingly, the uncertainty around some of our prevalence estimates is high. Where relevant, the relative standard errors of estimates are included.

The 2003 ABS SDAC (adjusted for population to 2009 numbers) and underlying information from the burden of disease data on the prevalence of certain health conditions were used to further understand the possible range of people likely to be included in tier 3 of the NDIS (section 14.3).

There is no single comprehensive data source that can be used to estimate the likely cost of formal support required by people in tier 3. Hence, a variety of sources were analysed to estimate unit costs for different types of supports and severity levels, including:

- information on the unit costs of disability supports provided under the National Disability Agreement (NDA) — specifically, accommodation support, community support, community access and respite
- information on the annual cost of attendant care, equipment, home modifications and transport of people in the:
  - NSW Lifetime Care and Support Scheme
  - the serious injury division of the New Zealand Accident Compensation Corporation (ACC)
  - the major injury division of the Victorian Transport Accident Corporation (TAC)

- the Multiple Sclerosis (MS) Longitudinal Study
- taxi subsidy schemes in NSW and Victoria for people with disabilities.

The estimated unit costs are documented in section 14.4.

14.3 Estimated number of people in tier 3

Numbers of people in tier 3 by age group and criterion

As outlined in chapter 3, a person eligible for tier 3 support would have a permanent disability, (or if not permanent, would be expected to require very costly disability supports) and would meet at least one of the following criteria:

- have significant limitations with communication, mobility or self-care (the three core activities of daily living)
- have an intellectual disability
- be in one of two early intervention groups. The first group would be those for whom there was a reasonable potential for cost-effective early interventions that would improve their level of functioning (as in autism, acquired brain injury, cerebral palsy and sensory impairments). The second group would be those with newly diagnosed degenerative diseases, such as Multiple Sclerosis and Parkinson’s disease, for whom early preparation would enhance their lives
- have large identifiable benefits from support that would otherwise not be realised. This group (expected to be relatively small) takes account of the difficulties in slotting everyone into the specific groups above.

The interaction of the NDIS with other government support schemes is also discussed in chapter 3. It is recommended that memoranda of understanding be established with different systems (including the aged care, health, mental health, education, housing and palliative care systems) so people access the most suitable supports and expertise. Further, the Commission is proposing that upon reaching the pension age (and at any time thereafter), the person with the disability could elect to stay with the NDIS or move to the aged care system (but would be funded by the aged care budget). For the purpose of costings, the cost of people aged less than 65 years were included in the analysis.

A combination of functional support need and health condition was used to estimate the number of people (table 14.1). A more detailed breakdown is provided in appendix H.

Different levels of functional support need were used for different criteria:

- People requiring at least daily assistance with core activities (self-care, mobility and communication) was used to estimate people with significant limitations with core activities.
- The ABS functional definition of people with a disability[1] was used to assist in proxying the number of people with an intellectual disability. This is because people with intellectual disability may not necessarily be restricted in core activities but may still require assistance with non-core activities, such as catching public transport, planning a day and paying a bill.
- The early intervention group includes people who are likely to require ongoing low-level support, as well as people who need episodic support. For example, an early intervention for behavioural support may be time-limited, whereas an early intervention for a person with Multiple Sclerosis may be ongoing. In the latter case, the person with Multiple Sclerosis may not be at a stage where they require daily support. However, low-level support will assist with managing the condition in the immediate future. Hence, the ABS functional definition of people with a disability was used to estimate the number of people who may require early intervention.

A person's main health condition was also used as a proxy in all of the criteria, as different support systems are more suited to assisting people with different health conditions. For example, a person with end-stage cancer may require daily assistance with core activities. However, the health and palliative care systems are better suited to assist these people.

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[1] Specifically, people with a disability who are not restricted in core activities but have schooling/ employment restrictions and people with either a profound, severe, moderate or mild core activity limitation was used in the modelling.

Table 14.1 **Parameters used to proxy the number of people in tier 3**

Criterion	*Functional support need*	*Health conditions included*	*Health conditions excluded*
People who have significant limitations with a core activity (self-care, mobility, communication)	A person needs assistance with at least one core activity (self-care, mobility, and/or communication) at least once a day	Intellectual disability, congenital malformations, deformations and chromosomal abnormalities Nervous system disorders (including multiple sclerosis, cerebral palsy and Parkinson’s disease) Sensory conditions (including hearing, vision and speech) Musculoskeletal disorders (including arthritis and back problems) Injury (including head injury and amputations) Autism and autism related disorders (including Rett's syndrome and Asperger's syndrome) Dementia and Alzheimer’s Disease Stroke Schizophrenia and psychosis	Respiratory conditions (including asthma and emphysema) Diseases of the digestive system Diseases of the skin and subcutaneous tissue Diseases of the genitourinary system Neoplasms (including breast cancer and prostate cancer) Diseases of the blood and blood forming organs (including haemophilia) Diabetes Obesity Mental health conditions not involving psychosis (including depression and eating disorders) Diseases of the circulatory system

(Continued next page)

Table 14.1 **(continued)**

Criterion	*Functional support need*	*Health conditions included*	*Health conditions excluded*
Early intervention (not already captured in ‘significant limitations with a core activity’)	People with a profound, severe, moderate or mild core activity limitation People with a disability who are not restricted in core activities but have schooling/ employment restrictions	Nervous system disorders (including multiple sclerosis, cerebral palsy and Parkinson’s disease) Autism and autism related disorders (including Rett's syndrome and Asperger's syndrome) Acquired Brain Injury Stroke Paralysis Dementia and Alzheimer’s Disease	All in ‘significant limitations with a core activity’ Schizophrenia and psychosis Musculoskeletal disorders
Intellectual disability (not already captured in ‘significant limitations with a core activity’)	People with a profound, severe, moderate or mild core activity limitation People with a disability who are not restricted in core activities but have schooling/ employment restrictions	Intellectual disability, congenital malformations, deformations and chromosomal abnormalities	All in ‘significant limitations with a core activity’ and early intervention Nervous system disorders Autism and autism related disorders

The fourth criterion for tier 3 supports (large identifiable benefits from support that would otherwise not be realised) has not been explicitly costed. It is assumed that the number of people in this group would be modest and would cover rare cases. An example would be someone with significant disfigurement who may not require assistance with core activities on a daily basis, but nonetheless requires some care and support to assist in participating in society. However, not all people with a significant disfigurement would require care and support. Accordingly, this group was not explicitly counted in costings. People eligible for tier 3 supports under criterion four would be assessed on a case-by-case basis.

It is estimated that 358 850 people (or 1.9 per cent of the population under the age of 65 years) would be in tier 3 of the NDIS in 2009 (table 14.2). Of these, 226 790 people require daily assistance with core activities, a further 81 740 would receive early intervention support and a further 50 320 would receive support due to their intellectual disability. The estimate of intellectual disability appears low compared with epidemiological estimates of intellectual disability (and the relative standard errors are also high for this group as the numbers are small, implying relatively large uncertainty about the estimate). Some of this is due to people with intellectual disability being counted among the daily assistance group. However, even after accounting for this, the number still appears low. This is discussed in more detail later in this section. Section 14.6 includes a scenario that assumes a higher number of people with intellectual disability.

Table 14.2 **Estimated number of people in tier 3**[a]
2009

Criteria	*0–14 years*	*14–49 years*	*50–64 years*	*Total under 65 years*
People who require daily assistance with core activities	77 320 (8.21%)	84 970 (6.72%)	64 500 (6.82%)	226 790 (4.33%)
Early intervention	19 790 (17.51%)	38 480 (13.10%)	23 470 (13.60%)	81 740 (8.02%)
Intellectual disability	23 850 (16.75%)	20 900 (19.83%)	5 570 (27.78%)	50 320 (12.06%)
Total tier 3	**120 960**	**144 350**	**93 540**	**358 850**
Total population	4 145 000	10 838 000	3 883 000	18 866 000
% of total population	**2.9**	**1.3**	**2.4**	**1.9**

[a] Relative standard errors of estimate in brackets.

Source: Commission estimates based on ABS (2009a).

As a means of cross-checking the above numbers, the same criteria were applied to the 2003 ABS SDAC CURF (to the extent possible given data limitations). The estimates were adjusted to reflect changes in the population and demographic profile of Australians between 2003 and 2009 using ABS population estimates (ABS 2008d). The aggregate estimates of the number of people eligible for tier 3 in the proposed NDIS are very similar (349 020 in the 2003 SDAC compared to 358 850 in the 2009 SDAC). However, there are differences in the estimates by different criteria and ages. In particular, the estimates based on the two datasets diverge in terms of intellectual disability and for the 50–64 year age group. This may reflect overlapping classifications and co-morbidity. Nevertheless, the similarity of the aggregates suggest reasonable reliability of the overall estimate of the number of people in tier 3.

Table 14.3 **Estimated number of people in tier 3**

2003 SDAC estimates inflated to 2009 values

Criteria	*0–14 years*	*14–49 years*	*50–64 years*	*Total under 65 years*
People who require daily assistance with core activities	82 520	73 500	57 670	213 690
Early intervention	11 740	31 630	19 150	62 520
Intellectual disability	27 220	39 460	6 130	72 810
Total tier 3	**121 480**	**144 590**	**82 950**	**349 020**
Total population	4 145 000	10 838 000	3 883 000	18 866 000
% of total population	**2.9%**	**1.3%**	**2.1%**	**1.8%**

Source: Commission estimates based on ABS (2003) and ABS (2008d).

Severity hierarchy within the daily need for assistance group

People needing daily assistance with core activities have varying levels of need. For example, some people indicate that they need assistance with a core activity more than six times a day while others once a day. Hence, a further ‘severity’ hierarchy was derived, based on information in the 2009 SDAC. The hierarchy is as follows. People who need assistance with any core activity:

- more than six times a day are counted in the first category
- between three to five times a day are counted in the second category
- twice a day are counted in the third category
- once a day are counted in the fourth category.

Generally speaking, people are reasonably evenly distributed across the categories, with slightly more people falling in the fourth category (needing assistance once a day) than the other categories (table 14.4). For example, in the 0–14 year age group, 28 per cent of people (or 21 430 people) need assistance at least six times a day with a least one core activity; 25 per cent of people (or 19 670 people) need assistance with at least one core activity between three and five times a day; 18 per cent of people (14 040 people) need assistance twice a day with at least one core activity; and 29 per cent of people (22 180 people) need assistance once a day with at least one core activity.

Table 14.4 Severity distribution of people in the daily assistance category

	0–14 years	*14–49 years*	*50–64 years*	*Total under 65 years*
Share of daily assistance population				
people who need assistance more than six times a day with at least one core activity	28	27	20	25
people who need assistance three to five times a day with at least one core activity	25	25	21	24
people who need assistance twice a day with at least one core activity	18	16	20	18
people who need assistance once a day with at least one core activity	29	32	39	33
Number of people who require daily assistance				
people who need assistance more than six times a day with at least one core activity	21 430	22 980	13 000	57 410
people who need assistance three to five times a day with at least one core activity	19 670	21 510	13 370	54 550
people who need assistance twice a day with at least one core activity	14 040	13 330	12 690	40 060
people who need assistance once a day with at least one core activity	22 180	27 150	25 430	74 760
Total number of people who require daily assistance with core activities	77 320	84 970	64 490	226 780

Source: Commission estimates based on ABS (2009a).

Epidemiological data compared to SDAC data

Standard errors around the estimates of each of the tier 3 criteria are high, suggesting significant uncertainty about their accuracy (table 14.2). For this reason, the results were crossed checked against the 2003 Australian Burden of Disease (BoD) data (AIHW 2007b), which includes estimates of the prevalence of health conditions.

The BoD study analyses levels of death and disability from a comprehensive set of diseases, injuries and risks, which are combined to form an estimate of the total health 'burden'. The classification of diseases is based on the International Classification of Disease – Version 10. The BoD study includes an extensive review of available data and literature. This has information on the incidence, prevalence, duration and relative risk of mortality for major diseases by age and sex.

However, while these data may present a more accurate estimate of the number of people with each health condition than the 2009 SDAC, they do not include any information on functional limitations for each condition, or on co-morbidity. This means that while useful as a cross-check, the BoD data cannot itself be used to cost the NDIS.

In order to make a consistent comparison between the BoD and SDAC data, some alterations to 2009 SDAC estimates were necessary (hence the reported numbers in table 14.5 will differ from those presented in table 14.2).[2]

Table 14.5 **Comparison of 2009 SDAC and BoD data**[a]

Condition	*2009 SDAC*	*Burden of Disease (inflated to 2009 population)*	*Ratio of BoD estimate to 2009 SDAC estimate (%)*
Intellectual disability	107 340	249 100	232
Schizophrenia	42 020	82 030	195
Multiple sclerosis	21 600	12 570	85
Dementia	2 570	9 570	372
Epilepsy	52 310	46 430	89
Parkinson’s disease	3 730	5 780	155
Huntington’s disease	970	1 140	118
Cerebral palsy	15 660	40 080	256
Stroke	30 020	71 380	223
Autism/Asperger’s	53 530	75 260	141

[a] Totals are not comparable because BoD counts multiple health conditions for individuals.

Source: ABS (2009a); 2003 Burden of Disease (unpublished); ABS (2008d).

Generally speaking, there are large differences between the BoD data and the 2009 SDAC data, with the latter providing a lower estimate. There are several potential reasons for this:

- The 2009 SDAC presents a count of the number of people who list the condition as their main condition. If all conditions listed by each person were considered the number would be higher.[3]
- As noted above, random variations are likely to be high in the 2009 ABS SDAC due to small sample size issues. This may contribute to differences between the estimates.

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[2] The estimates are for people under the age of 65 years. They include all people who reported the condition in the 2009 SDAC, regardless of the level of functional support need. Functional support need is also used in estimating the number of people in tier 3 and so the numbers presented in table 14.5 will not reconcile to numbers presented in table 14.2.

[3] Further analysis will be undertaken for the final report when the 2009 ABS SDAC CURF is made available.

- There is no information on support need in the BoD data, which therefore is likely to include people with mild levels of disability, who would not require assistance from the NDIS. This is likely to be a key driver in the large difference in the estimate of people with a disability.

For example, the literature review undertaken for the BoD study indicates that the incidence of intellectual disability is approximately 16.3 per 1000 live births. This is based on data from the Western Australia IDEA (Intellectual Disability Exploring Answers) database 1983–1996. However, not everyone with intellectual disability is likely to require assistance with activities of daily living. Hence, the 249 100 presented in the table is likely to be the upper bound of people with intellectual disability accessing tier 3 supports.

Of the 107 340 people with intellectual disability in the 2009 ABS SDAC, 48 per cent are captured in the daily need for assistance group and a further 47 per cent are captured in the intellectual disability group (that is, people with intellectual disability who do not have a daily need for assistance with core activities but have a disability and are restricted in schooling/employment). The scenario analysis in section 14.6 assumes that the number of people in the intellectual disability group is 197 640 people (people with intellectual disability, less those with daily needs with core activities) rather than the 50 320 people captured in the 2009 SDAC.[4] As mentioned previously, this is likely to be the upper bound of the intellectual disability group and overall the impact on cost is not significant reflecting the relatively low level of supports required.

14.4 Costs

This section presents the annual costs of different supports for people in tier 3. Four categories are discussed below in detail — care and support, aids and appliances, home modifications and transport. For each group in tier 3, the number of people accessing the different services is calculated and an annual cost is assigned to each support (figure 14.1). A range of annual costs is presented for each support type due to the high uncertainty in the costings. As mentioned previously, no specific data source provided the information required to cost the NDIS accurately. A variety of different sources were used to estimate annual costs (these data sources are listed in section 14.2).

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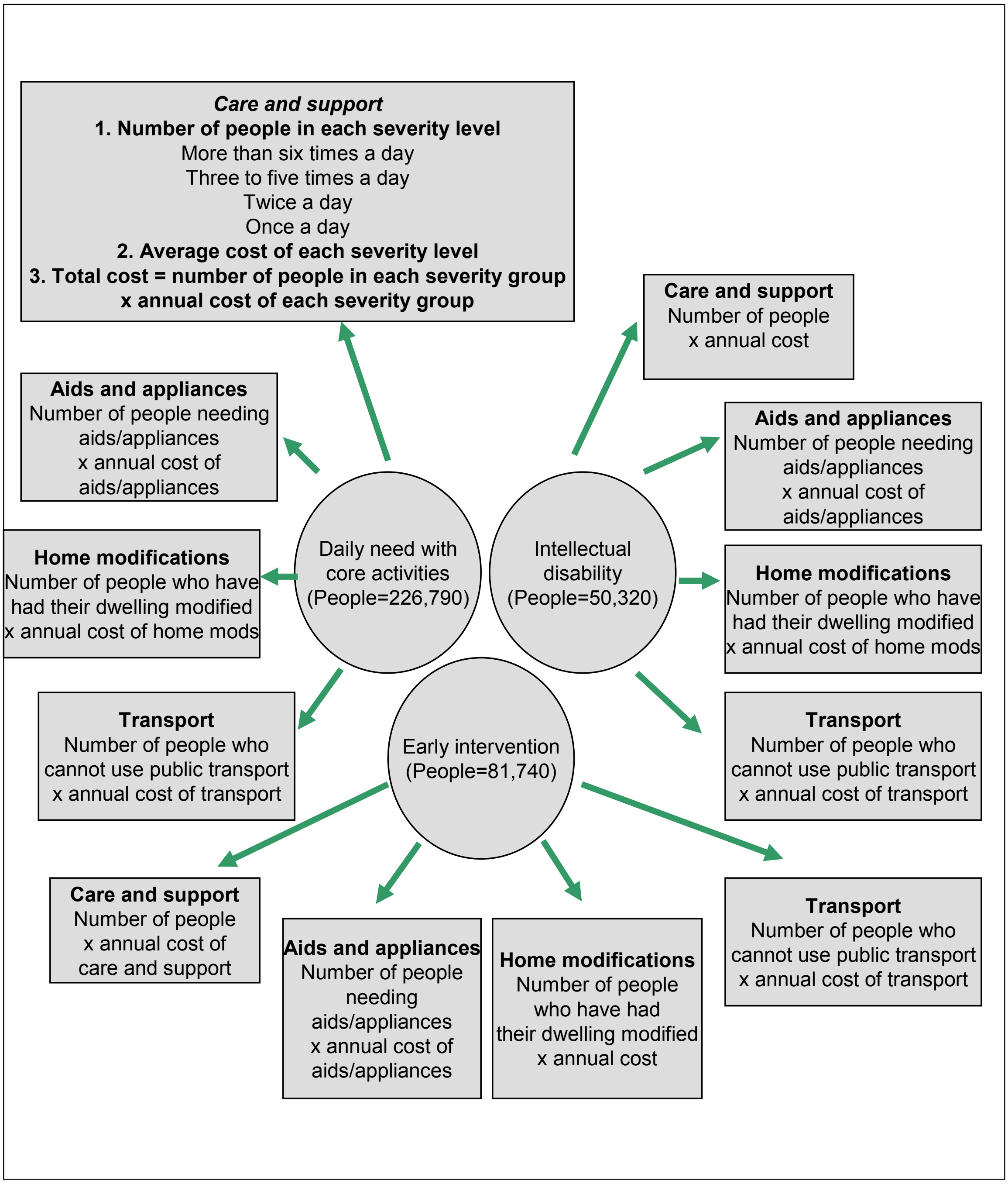
[4] The estimate of the number of people with intellectual disability in the BoD study is 249 100. The estimate of the number of people in intellectual disability group using the 2009 SDAC is 50 320. However, 51 460 people with an intellectual disability group were captured in the ‘daily need for assistance with core activity group’. Hence, the 249 100 BoD estimate was reduced by 51 460 (to 197 640) so there was no double-counting.

Figure 14.1 **Costing methodology**



Care and support

Care and support covers a range of formal services, including attendant care, accommodation support, nursing care, day programs, therapy, domestic assistance and meal preparation. These supports are not costed separately. Rather, different average annual costs are assigned to different severity levels, from which a package of care and support would be developed for the individual.

Within tier 3 a severity distribution of need was developed based on SDAC respondents on the frequency of need for assistance with core activities (discussed in section 14.3). Unfortunately there is no direct mapping from these responses to hours of care and support appropriately needed per day. The estimated annual costs for each severity group are derived from the estimated hourly cost of care and support and the assumed number of hours per day of care and support needed (table 14.6). This annual cost was cross-checked against current disability support packages for reasonableness (for example, the annual cost of people who require assistance more than six times a day is reflective of the cost of people in group homes). It is important to note that all annual costs in this chapter represent an average cost for the group. Some people will receive more than this average cost and others less, depending on their assessed need. Further, attendant care accounts for about 80 per cent of the total cost of comparable schemes. Hence wage rates are the principal driver of total cost. The range identified in our estimates overwhelmingly reflects the uncertainty about future wage rates.

Table 14.6 **Care and support annual unit costs**

	Hours	*Hourly cost*			*Annual cost*		
		0–14 years	*14–49 years*	*50–64 years*	*0–14 years*	*14–49 years*	*50–64 years*
	Hours	$	$	$	$	$	$
Daily need with core activities							
more than six times a day	8	39–49	39–49	39–49	34 100–42 600	113 500–141 900	113 500–141 900
three to five times a day	4	36–45	36–45	36–45	15 800–19 700	52 600–65 700	52 600–65 700
twice a day	2	36–45	36–45	36–45	7 900–9 900	26 300–32 900	26 300–32 900
once a day	1	36–45	36–45	36–45	3 900–4 900	13 100–16 400	13 100–16 400
Intellectual disability					2 300–3 000	7 500–10 000	7 500–10 000
Early intervention					7 500–10 000	7 500–10 000	7 500–10 000

Source: Unpublished data from the NSW LTCSA and SCRGSP (2011) — average cost per person receiving supports.

The following should be noted with regard to the annual unit costs:

- The annual costs per person presented are consistent with the average per person costs of current disability supports. The average cost per person in Australia for accommodation support is $61 000, for community support is $5 500, for community access is $10 500 and for respite is $8 700.[5] Accommodation support includes a range of supports, including group homes and attendant care in the person's home. Accordingly, there is a range of costs for this group. The $61 000 is close to the upper bound of the second highest severity ('three to five times a day'). This seems reasonable, given that group homes cost substantially more (in NSW, the cost is around $140 000 per client per year, excluding capital costs). The care and support costs for people requiring assistance one to two times a day are higher than the current average per person costs of respite and community access, reflecting a likely under-met need in these categories.

- The hourly rate, ranging from $36 to $45, is consistent with data from accident compensation schemes. The $45 allows for the proposed wage increase currently being heard by the Fair Work Australia Tribunal. Hence, the $36 per hour is closer to the current hourly cost.
- Hourly costs for people in the 'more than six times a day category' were increased by 8 per cent to reflect a user cost of capital. This 8 per cent is based on the average user cost of capital across social services, and is consistent with unpublished data on the capital costs of group homes in NSW. It is likely that people in this category are particularly likely to require accommodation support, and hence the hourly rate was increased to include a cost of capital.
- For people aged 0–14 years, 30 per cent of the annual unit cost was assumed to be met by the NDIS. The assumption here is that families provide most care to children between the ages of 0–14 years, regardless of disability, and that care should be provided predominantly to support parents in their role of caring for a child with a disability. It is also assumed that the education system is responsible for providing some supports to children with disabilities. It is assumed that the scheme will meet the full cost of the early intervention category for the 0-14 year age group. Early interventions in this age group are likely to be as costly as for other age groups.
- It is assumed that the support system strikes a balance between formal (paid) individual supports and the unpaid supports provided by family members and the community. That is, the scheme does not seek to totally replace informal care — to do so would critically undermine its financial viability and is unlikely to reflect the wishes of people with a disability or their carers. In the extreme case, were the NDIS to provide paid care for each individual for the full extent of their expressed need (that is, no care was provided at all by family and friends), the scheme would potentially cost between $30–$40 billion per annum in care and support alone.

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[5] SCRGSP (2010) and AIHW (2009b).

- An annual cost per person of between $7 500 and $10 000 was assigned to people with intellectual disability and in the early intervention category. Current average national community support and community access places under the NDA average between $5 500 and $10 500. The upper ranges were chosen due to anecdotal evidence of under-met need. It is also worth noting that that the early intervention group contains a range of people with different health conditions, and consequently, the annual unit costs represent only an average. Some intensive behavioural therapy may be relatively more expensive, whereas educating a person about their newly diagnosed condition may be far less costly. There is also no necessary time limit on the early intervention. The estimate assumes that approximately 82 000 people are receiving early intervention at a point in time — people can enter and exit.

Combining the estimated unit costs (table 14.7) and the number of people eligible for tier 3 (tables 14.2 and 14.3) generates an estimated total cost of between $9.40 billion and $11.82 billion per annum. The vast majority of this cost (90 per cent) is for people with daily need for care and support.

Table 14.7 **Cost of care and support**

Dollars ($m)

Daily needs	*0–14 years*	*14–49 years*	*50–64 years*	*Total under 65 years*
More than six times a day	730–910	2 610–3 260	1 480–1 840	4 820–6 010
Three to five times a day	310–390	1 130–1 410	700–880	2 140–2 680
Twice a day	110–140	350–440	330–420	790–1 000
Once a day	90–110	360–450	330–420	780–980
Total	1 240–1 550	4 450–5 560	2 840–3 560	8 530–10 670
Intellectual disability	50–70	160–210	40–60	250–340
Early intervention	150–200	290–380	180–230	620–810
Total	**1 250–1 560**	**4 900–6 150**	**2 980–3 740**	**9 400–11 820**

Source: Commission estimates using data contained in tables 14.4 and 14.6.

The cost of care and support was estimated to be $9.5 billion in the Disability Investment Group (DIG) report, which is at the lower estimated end of the range presented here (box 14.1). Whilst the DIG report included a greater number of people in the target population, more than 50 per cent of people in this group were assigned an annual unit cost of $1 000. Further, the unit costs for the higher-severity groups were lower than the unit costs used in the current analysis. The current analysis uses data from accident compensation schemes on hourly costs of care, and also includes annual costs for early intervention strategies and for people with intellectual disabilities. (The DIG report only included people with an intellectual disability who had a severe or profound core activity limitation.)

Box 14.1 **Key findings from the Disability Investment Group report**

- The target group for the DIG estimates was people with a severe or profound core activity limitation regardless of health condition. This constituted approximately 578 000 people in 2009 under the age of 65 years. The 578 000 was comprised of:
  - constant support need (40 000 or 6.9 per cent)
  - frequent support needs (104 000 or 18.0 per cent)
  - regular support needs (32 000 or 5.5 per cent)
  - grade B lower support need (86 000 or 14.9 per cent)
  - grade C lower support need (316 000 or 54.7 per cent)
- The annual costs of care and support were $100 000 for constant support needs, $50 000 for frequent support needs, $25 000 for regular support needs, $10 000 for grade B support needs and $1 000 for grade C support needs.
- The proportion of people in the target group using aids and appliances was 58 per cent and the annual cost per person was $240 per annum.
- The proportion of people in the target group who had their dwelling modified was 15 per cent and the annual cost per person was $2 000 per annum.
- The proportion of people in the target group who needed assistance with transport was 44 per cent and the annual cost per person was $320 per annum.
- The annual cost of the scheme in 2009 was estimated to be $10.8 billion comprising:
  - $9.5 billion in care and support
  - $129 million for aids and appliances
  - $159 million for home modifications
  - $90 million for transport
  - A 10 per cent administration fee.
- Excluding chronic diseases (cancer, diabetes, circulatory (except stroke), respiratory, inflammatory bowel disease and genitourinary diseases) reduced the annual estimate from $10.8 billion to $8.2 billion.

Source: DIG (2009a).

Aids and appliances

In order to estimate the cost of aids and appliances, the proportion of people in tier 3 of the NDIS needing aids and appliances (regardless of use) was estimated using the 2009 ABS SDAC (table 14.8), and annual costs (table 14.9) were assigned to each category using accident compensation scheme information and the MS longitudinal database.

As expected, a higher proportion of people who require daily assistance with core activities require aids and appliances than people with intellectual disability and people in the early intervention group. The percentages presented below are broadly consistent at the aggregate level with the 2003 ABS SDAC information.

Table 14.8 **Proportion of people needing aids and appliances in tier 3**

Percentages

Tier 3 categories of the NDIS	*0–14 years*	*14–49 years*	*50–64 years*
People who require daily assistance with core activities	42	65	78
Early intervention	4	38	33
Intellectual disability	14	27	5

Source: ABS (2009a).

Applying the proportion of those needing aids and appliances (table 14.8) to the estimate of the total number of people in tier 3 (table 14.2), suggests that there are approximately 170 330 people who need aids and appliances (table 14.9).

Table 14.9 **Number of people needing aids and appliances in tier 3**

Tier 3 categories of the NDIS	*0–14 years*	*14–49 years*	*50–64 years*	*Total*
People who require daily assistance with core activities	32 380	54 850	50 540	137 770
Early intervention	800	14 560	7 830	23 190
Intellectual disability	3 410	5 680	280	9 370
Total people	**36 590**	**75 090**	**58 650**	**170 330**

Source: Commission estimates based using data contained in tables 14.7 and 14.2.

Several data sources were used to generate a range of annual unit costs of aids and appliances (table 14.10). A lower annual cost was selected for people with intellectual disability. It was thought that people with intellectual disability would not require the same level of assistance with aids and appliances as other conditions, such as multiple sclerosis and stroke (bearing in mind that people with intellectual disability who have daily needs are counted in the first category).

Aids and appliances cover a range of items which vary substantially in cost (for example, wheelchairs, continence aids, prostheses, communication items and lifters). A wheelchair can cost between $1 000 and $30 000, and continence aids can cost between $1 and $400.[6] Aids and appliances also have varying lives. For example, a continence aid may only be used once, whereas a wheelchair can last several years. It is important to note that these costs represent an annual average, taking into account that some items are more expensive, but last several years, and other items are less costly, and may only be used once.

Table 14.10 **Annual unit costs of aids and appliances**

Dollars

Tier 3 categories of the NDIS	*0–14 years*	*14–49 years*	*50–64 years*
People who require daily assistance with core activities	2 000–5 000	2 000–5 000	2 000–5 000
Early intervention	2 000–5 000	2 000–5 000	2 000–5 000
Intellectual disability	1 000–2 000	1 000–2 000	1 000–2 000

Source: Private correspondence with NZ ACC, NSW LTCSA and the MS Society of Australia.

Combining unit costs (table 14.10) with the total number of people in each category (table 14.9) generates an estimated cost of aids and appliances that ranges between $331 million and $824 million (table 14.11). This figure is significantly higher than the estimate of $240 million presented in the DIG report. The DIG estimate was based on information from a review of the NSW Program of Appliances for Disabled People (PADP) (PWC, 2006). However, the annual costs derived in the current analysis is based on more comprehensive information from accident compensation schemes and the MS longitudinal database, and is likely to be more robust. That said, the estimates appear high compared with the NSW PADP scheme. Accordingly, the $331 million (the lower bound) is likely to be more realistic.

Table 14.11 **Annual cost of aids and appliances**

Dollars ($m)

Tier 3 categories of the NDIS	*0–14 years*	*14–49 years*	*50–64 years*	*Total*
People who require daily assistance with core activities	65–162	110–274	101–253	276–689
Early intervention	2–4	29–73	16–39	46–116
Intellectual disability	3–7	6–11	0–1	9–19
Total (annual cost $m)	**70–173**	**144–358**	**117–292**	**331–824**

Source: Commission estimates using data contained in tables 14.9 and 14.10.

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[6] Private correspondence, Review of NSW Health PADP program.

Home modifications

The cost of home modifications was estimated by using the 2009 ABS SDAC to calculate the number of people in tier 3 of the NDIS who had ever had their dwelling modified (table 14.12 and table 14.13), and multiplying this by the relevant annual costs (table 14.14 and based on information from accident compensation schemes and the MS Longitudinal database).

People who require daily assistance with core activities in the 50–64 year age group are more likely to have had their house modified (table 14.12). The percentages presented below are broadly consistent at the aggregate level with the 2003 ABS SDAC information.

Table 14.12 Proportion of people in tier 3 who have had their dwelling modified

Percentage

Tier 3 categories of the NDIS	*0–14 years*	*14–49 years*	*50–64 years*
People who require daily assistance with core activities	12	24	32
Early intervention	0	7	24
Intellectual disability	0	0	0

Source: Commission estimates based on ABS (2009a).

Applying the above proportions to the total number of people in tier 3 (table 14.2), provides an estimate of the number of people in tier 3 who have had their dwelling modified. Overall, it is estimated that approximately 58 930 people in tier 3 have their dwelling modified (table 14.13).

Table 14.13 Number of people who have had their dwelling modified in tier 3

Number

Tier 3 categories of the NDIS	*0–14 years*	*14–49 years*	*50–64 years*	*Total*
People who require daily assistance with core activities	9 460	20 580	20 540	50 580
Early intervention	0	2 700	5 650	8 350
Intellectual disability	0	0	0	0
Total people	**9 460**	**23 280**	**26 190**	**58 930**

Source: Commission estimates using data contained in tables 14.12 and 14.2.

As with aids and appliances, annual unit costs of home modification were based on a number of different data sources. In the year that people have their homes modified, the actual cost is high — on average between $10 000 and $30 000 (table 14.14). However, this does not occur on an annual basis. We assumed that the investments have a ten year economic life, so that the unit cost varies between $1 000 and $3 000.

Table 14.14 **Annual unit costs of home modifications in tier 3**

Dollars

Tier 3 categories of the NDIS	*0–14 years*	*14–49 years*	*50–64 years*
People who require daily assistance with core activities	1 000–3 000	1 000–3 000	1 000–3 000
Early intervention	1 000–3 000	1 000–3 000	1 000–3 000
Intellectual disability	1 000–3 000	1 000–3 000	1 000–3 000

Source: Private correspondence with NZ ACC, NSW LTCSA and the MS Society of Australia.

Combining unit costs (table 14.14) with the total number of people in each category (table 14.13) generates an annual cost between $59 million and $177 million. The DIG report estimated an annual cost of $159 million for home modifications, which falls towards the upper bound of this range. The DIG report used an annual unit cost estimate similar to that in this report, but assumed that a higher number of people had their dwelling modified.

Table 14.15 **Annual cost of home modifications**

Dollars ($m)

Tier 3 categories of the NDIS	*0–14 years*	*14–49 years*	*50–64 years*	*Total*
People who require daily assistance with core activities	9–28	21–62	21–62	51–152
Early intervention	0	3–8	6–17	8–25
Intellectual disability	0	0	0	0
Total (annual cost)	**9–28**	**23–70**	**26–79**	**59–177**

Source: Commission estimates using data contained in tables 14.13 and 14.14.

Transport

In order to estimate the annual cost of transport, the proportion of people in tier 3 of the NDIS who need assistance with transport was estimated using the 2009 ABS SDAC (table 14.16 and table 14.17) and annual costs (table 14.18) were assigned to each category, using accident compensation scheme information and the MS longitudinal database.

Overall, approximately 23 per cent of people who require daily assistance with core activities cannot use public transport at all, compared to 10 per cent in the early intervention group and 17 per cent in the intellectual disability group.

Table 14.16 **Proportion of people who cannot use public transport at all in tier 3**

Percentage

Tier 3 categories of the NDIS	*0–14 years*	*14–49 years*	*50–64 years*
People who require daily assistance with core activities	23	29	17
Early intervention	23	4	12
Intellectual disability	13	16	45

Source: Commission estimates based on 2003 ABS SDAC CURF. Note: these data will be updated with 2009 ABS SDAC information for the final report. This information was not available for the draft report.

Given the above proportions and the overall tier 3 population (table 14.2), it is estimated that 70 630 people in tier 3 cannot use public transport (table 14.17). In comparison, the NSW Taxi Transport Subsidy Scheme has 76 000 eligible participants at 30 June 2010 (Transport NSW, 2010) and the Victorian Multi Purpose Taxi Program had 155 000 eligible participants at 30 June 2010 (VIC Department of Transport, 2010). These numbers include people aged over 65 years. Approximately 25 per cent of participants in NSW are under 65 years old[7] which makes the 70 630 estimate look reasonable.

Table 14.17 **Number of people who cannot use public transport in tier 3**

Number

Tier 3 categories of the NDIS	*0–14 years*	*14–49 years*	*50–64 years*	*Total*
People who require daily assistance with core activities	17 480	24 700	10 830	53 010
Early intervention	4 470	1 430	2 820	8 720
Intellectual disability	3 140	3 280	2 480	8 900
Total people	25 090	29 410	16 130	70 630

Source: Commission estimates using data contained in tables 14.14 and 14.2.

The annual unit costs of transport used in the modelling are based on accident compensation scheme data and annual per person costs in taxi subsidy schemes in NSW and Victoria (table 14.18). The average per person cost in the NSW scheme is approximately $320, and the average per person cost in the Victorian scheme is approximately $290. These numbers are low when compared to accident

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[7] Private correspondence with the NSW Transport Taxi Subsidy Scheme.

compensation data, and hence the numbers presented in table 14.18 are higher than these average costs. Constant unit costs are assumed across age groups and categories within tier 3. A cost of $750 per annum equates to roughly one trip a fortnight at an average cost of $30 per trip, and $1500 per annum roughly equates to approximately one trip per week at an average cost of $30.

Table 14.18 **Annual unit costs of transport in tier 3**

Dollars

Tier 3 categories of the NDIS	*0–14 years*	*14–49 years*	*50–64 years*
People who require daily assistance with core activities	750–1 500	750–1 500	750-1 500
Early intervention	750–1 500	750–1 500	750-1 500
Intellectual disability	750–1 500	750–1 500	750-1 500

Source: Private correspondence with NZ ACC and NSW LTCSA and unit costs of taxi subsidy schemes in NSW and Victoria.

Combining unit costs (table 14.18) with the total number of people in each category (table 14.17) generates an estimate of the total annual cost of transport that ranges between $52 million and $106 million. The overall figures are similar to the DIG estimate of $90 million (although the numbers used to arrive at this varied).[8] The annual costs in this analysis used more data sources and hence should be more robust than the DIG report.

Table 14.19 **Annual cost of transport**

Dollars ($m)

Tier 3 categories of the NDIS	*0–14 years*	*14–49 years*	*50–64 years*	*Total*
People who require daily assistance with core activities	13–26	14–37	11–16	38–80
Early intervention	2–5	2–5	2–4	7–13
Intellectual disability	3–7	1–2	2–4	7–13
Total (annual cost)	**19–38**	**18–44**	**15–24**	**52–106**

Source: Commission estimates using data contained in tables 14.17 and 14.18.

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[8] The DIG analysed the number of people who need assistance with transport compared to the number of people who cannot use transport at all, resulting in a larger number of people accessing transport support. Also, the annual cost used in the DIG report was based on the average annual cost of the NSW taxi subsidy scheme only, and hence was lower than the estimates used in this analysis. The overall figures are similar, as the higher number of people (in the DIG report), but lower cost, balance out.

Summary of costs

It is recommended that the scheme be funded on a pay-as-you-go basis (discussed in chapter 12) and hence this section presents a summary of the annual cost of the scheme in 2009 (the year of primary data collection).

It is estimated that the annual cost of the scheme (which covers around 360 000 people) would be between $9.8 billion and $12.9 billion, with care and support being the largest component of costs. In addition to the costs of formal supports, a 10 per cent administration loading is included. This administration loading is based on the claims handling expenses associated with accident compensation schemes. This brings the annual cost to between $10.8 billion and $14.2 billion. Hence, the *gross* cost of the NDIS is estimated to be $12.5 billion, which is the mid-point of this range. It should be noted that the administration loading of 10 per cent is considered to be the minimum requirement for administration. There will be high start-up costs associated with the scheme, including establishing regional offices of the NDIA, recruiting and training staff (including assessors) and establishing IT systems. There will also be higher initial capital costs associated with building appropriate accommodation. Further analysis of these start-up costs will be included in the final report.

It is further recommended that a risk margin (or buffer) be included in the costings due to the high uncertainty around the estimates. This buffer has yet to be determined and will be included in the final report.

14.5 Offsets

This section discusses the current offsets to the gross cost of the NDIS. In summary:

- the National Disability Agreement (excluding Australian Government employment services) includes expenditure of $5.21 billion in 2009-10 (SCRGSP 2011)
- it is estimated that approximately 30 per cent of Home and Community Care expenditure is provided to people under the age of 65 years. In 2009-10 this represented $583 million
- approximately 6500 people under the age of 65 years are in residential aged care (AIHW 2010b). This represents approximately $270 million in expenditure[9]

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[9] The average per person Australian Government cost of young people in nursing homes was based on private correspondence with NSW ADHC.

- a further 2 130 people under the age of 65 years are in community aged care (AIHW 2010c) representing approximately $36 million[10]
- $130 million is spent on aids and appliances across Australia. Half of this is attributed to people under the age of 65 years ($65 million)
- $24.3 million is spent on the NSW Taxi Transport Subsidy Scheme and $49.4 million is spent on the Victoria Multi Purpose Taxi Scheme. Taking into account the proportion of people under the age of 65 years (approximately 25 per cent) and extrapolating these values to all of Australia results in an approximate offset of $36 million.

Overall, the *direct* offset based on the above calculations is approximately $6.2 billion (table 14.20).

Table 14.20 **Summary of direct offsets**

Dollars ($m)

Direct offsets	*$m*
National Disability Agreement	5 210
Home and Community Care	583
Residential aged care	270
Community aged care	36
Aids and appliances	65
Taxi subsidy schemes	36
Total	**6 200**

Source: SCRGSP (2011), Department of Health and Ageing (2009); AIHW (2010b); AIHW (2010c); private correspondence with NSW ADHC; DIG (2009a); and the NSW Government Transport Annual report 2009-10.

Given these direct offsets and the estimated gross costs of the NDIS, the *net* cost of the scheme lies between $4.6 billion and $8.0 billion, with a midpoint of $6.3 billion (table 14.21).

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[10] The average per person Australian Government cost of people under the age of 65 years receiving community aged care packages was based on private correspondence with NSW ADHC.

Table 14.21 **Summary of gross and net cost**

Dollars ($m)

Summary of costs	*$m*
Care and support	9 400-11 820
Aids and appliances	331-824
Home modifications	59-177
Transport	52-106
Total annual cost	9 842-12 926
Administration	10%
Total annual cost including administration	10 826-14 219
Direct offsets	6 200
Total net cost of the scheme including administration	**4 626-8 019**

Source: Commission estimates using data contained in table 14.7, table 14.11, table 14.15, table 14.19 and table 14.20.

In addition to the direct offsets, other indirect offsets are likely. These have not been included in any estimated offset. For instance:

- there is significant potential for the NDIS to improve employment outcomes for people with disabilities and their carers. That would reduce the costs of the Disability Support Pension (along the lines discussed in chapter 4) and support and allowances paid to carers, while also contributing to taxation revenue and productivity
- expanding the available community support may reduce unnecessary costly hospitalisations
- people with intellectual disability, acquired brain injury and mental illness are over-represented among the homeless, imprisoned and among drug and alcohol service users. There is significant scope to reduce the numbers in this position through the community support funded by the NDIS
- there are offsets to the Carer Payment and the Carer Allowance. There could be offsets in Carer Payment of $1.14 billion and Carer Allowance of $0.72 billion (taking into account the proportion of carers under the age of 65 years and the proportion of carers with health conditions likely to be covered by tier 3)
- efficiency gains from rolling many small programs (such as aids and appliances programs) into one scheme
- long-term gains from investing in early intervention programs. Early intervention programs are aimed as reducing high-cost crisis situations which are evident in the current state-based disability schemes. This is discussed in more detail in chapter 2.

The gross cost of the NDIS is estimated to be 3.68 per cent of existing tax revenue for all levels of government, while the net cost (the real resource requirements for the NDIS) represents 1.86 per cent of total Australian tax revenue (table 14.22). The net cost of the scheme would amount to around an annual $280 premium per Australian for comprehensive insurance coverage of a person's long-term care and support needs if he or she acquired a significant disability.

Table 14.22 **Summary of gross and net costs** [a]

Gross cost	$ billion	12.5
as a % of total tax revenue	%	3.68
Net cost	$ billion	6.3
as a % of total tax revenue	%	1.86

[a] Total tax revenue includes Australian Government and local and state taxes, but excludes taxes on public corporations or taxes imposed on other levels of government.

Source: ABS Cat. No. 55060DO001_200809 Taxation Revenue, Australia, 2008-09, published 2010 and Commission calculations.

Are these reasonable estimates of the costs?

The above analysis indicates that the current system is between 50 per cent and 100 per cent under-funded (that is, at the upper-end, expenditure would need to double).These cost estimates are highly uncertain because the data underlying them were not designed to cost a disability scheme.

An international comparison of expenditure (to the extent that this is possible) indicates that, compared with other countries, Australia and New Zealand have a lower level of spending as a share of GDP on long term care for people under the age of 65 years. Expenditure is more than double in the Scandinavian countries of Denmark, Sweden and Norway, and slightly less than double in the United Kingdom when compared to Australia (figure 14.2).[11]

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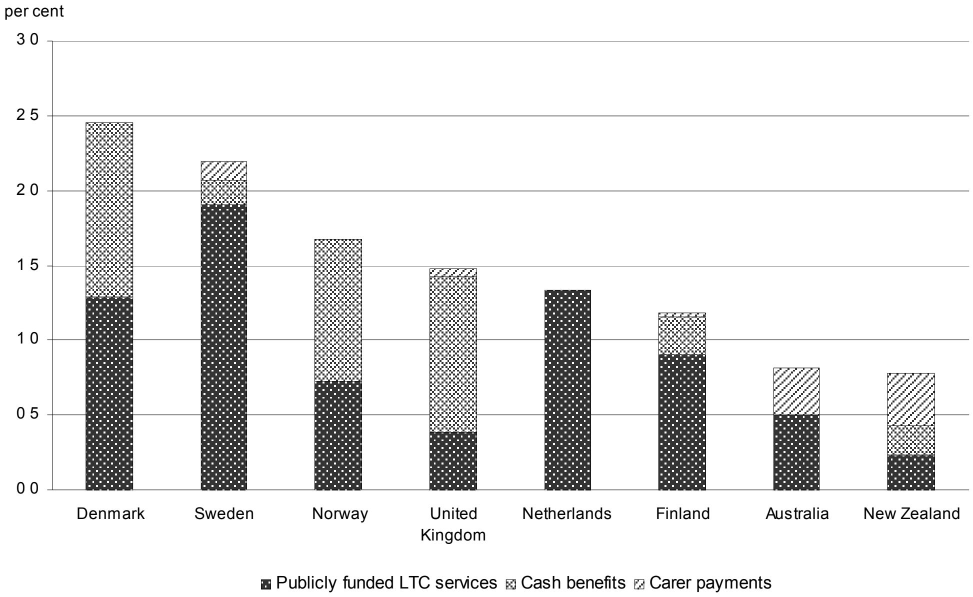
[11] Income support payments are not included with the exception of carer payments as cash benefits in some countries are used to pay informal carers and hence is was comparable to include carer payments in Australia and New Zealand.

Figure 14.2 **Expenditures on long-term care, 2007**[a,b,c]

For people under 65, percentage of GDP



[a] Except for Australia, the Netherlands and NZ, the data is from Eurostat (table C2.2, Detailed Breakdown of Social Benefits for the Function: Disability). [b] The Australian figures are from the Report on Government Services and are for 2007-08. [c] The Netherlands figures are primarily AWBZ and WMO long term care expenditures for people with disabilities (AWBZ expenditures reported in Mot (2010), other expenditures are from Eurostat). [d] The NZ data is from the Ministry of Health's Annual Report for 2008, From the ACC's 2008 Annual Report, from the Ministry of Social Development's 2008-09 Annual report, from a personal communication from the ACC giving the number of long-term care claimants — used to pro-rate carer payments (received October 2010) and from figures on carers payments from the Ministry of Social Development.

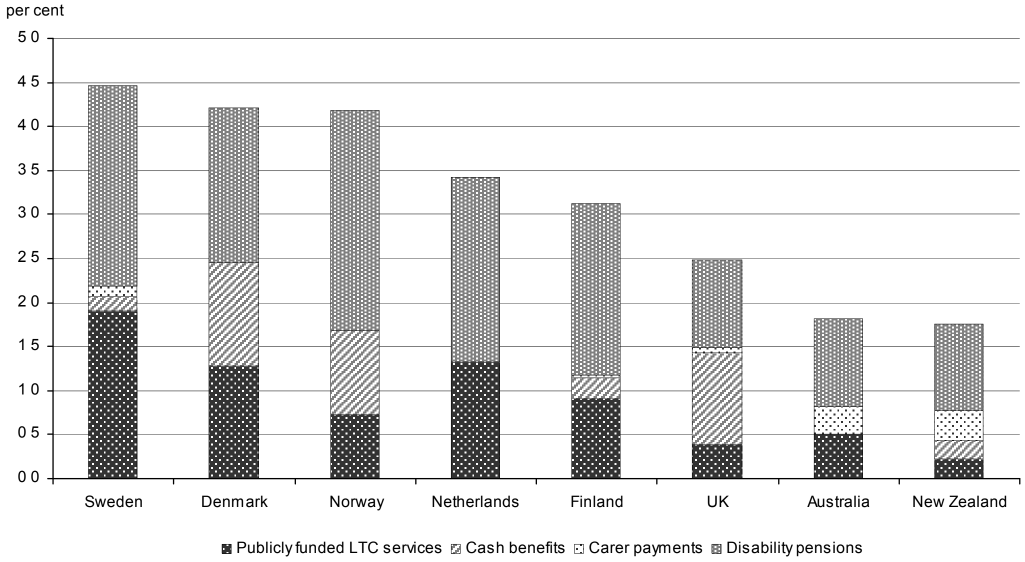
Data sources: Eurostat (2010); SCRGSP (2010); Mot (2010), NZ Ministry of Health (2008); ACC (2008), NZ Ministry of Social Development (2009); NZ Ministry of Social Development (2010); ACC, Special request concerning the number of long-term care claimants, received October 2010.

Even when disability income payments are included, it appears that Australia spends relatively less than other countries (figure 14.3).

This analysis indicates that doubling the spending (the upper-range of the estimate) is not unreasonable based on overseas benchmarks.

Figure 14.3 **Payments for people with disabilities, carers payments and disability pensions**

For people under 65, percentage of GDP



Data sources: Eurostat (2010); SCRGSP (2010); Mot (2010), NZ Ministry of Health (2008); ACC (2008), NZ Ministry of Social Development (2009); NZ Ministry of Social Development (2010); ACC, Special request concerning the number of long-term care claimants, received October 2010.

That said, chapter 2 presents information on the extent of unmet needs of people who require daily assistance with core activities. Thirty-seven per cent of people in this group indicated that their core activity needs were not met or only partly met. And 43 per cent indicated that their non-core activity needs were not met or only partly met with. This information suggests that the 50 per cent increase in annual expenditure (the lower bound of the estimate) would be more reasonable.

More analysis on the reasonableness of the costings will be undertaken for the final report.

14.6 Scenarios

This section presents alternative scenarios to the base case estimates above. The key impacts on the headline numbers for each scenario are discussed and compared to the main option. In almost all instances the scenarios indicate higher scheme costs. The scenarios discussed are:

- Scenario 1 — a higher number of people with intellectual disability accessing tier 3 supports (this scenario is based on information from section 14.3).

- Scenario 2 — relaxing the criterion on 'health condition' for people eligible for tier 3 supports, so that anyone with a daily need for assistance with at least one of the core activities is included. The base case assumed that some people who have daily core activity support needs would find more appropriate support in other systems such as the health and palliative care systems.
- Scenario 3 — this also includes people with at least one core activity limitation who get support at least once a week
- Scenario 4 – assuming that people only utilise 80 per cent of their entitlement to supports. Analysis of accident compensation scheme data indicates that utilisation of supports is usually less than 100 per cent in a needs-based system.

Scenario 1 – a higher number of people with intellectual disability accessing supports

This scenario assumes that the number of people with an intellectual disability accessing tier 3 supports is more in line with epidemiological data. Overall, the number of people in the intellectual disability group will increase by just less than 200 000 people. The annual cost of including these additional people is between $990 million and $1310 million in care and support costs alone. Overall it is estimated that the annual cost (including 10 per cent administration) would be between $11.98 billion and $15.80 billion. This represents an increase of approximately 11 per cent.

Scenario 2 – all people requiring daily assistance with at least one core activity regardless of health condition

Scenario 2 assumes that all people requiring daily assistance with at least one core activity receive tier 3 support regardless of their health condition. The base case assumes people with some health conditions would be better supported by the health and palliative care systems and hence are excluded from costings. The health conditions included in the criterion are listed in appendix H.

Approximately 309 900 people require daily assistance with at least one core activity. The base case includes 226 790 people in this category (or 73 per cent). The overall number of people in tier 3 increases to 441 960 people (an increase of 23 per cent). The severity hierarchy within the 309 900 people is slightly more on the severe side (that is, more people require assistance at least six times and a day and less people require assistance only once a day) for the 309 900 people compared to the 226 790 people.

The cost of care and support increases by between \$5.49 billion and \$6.58 billion. Overall it is estimated that the annual cost (including 10 per cent administration) would be between \$16.99 billion and \$22.00 billion. This represents an increase of approximately 55 per cent.

Scenario 3 – including people who need assistance with at least one core activity at least weekly

Scenario 3 includes people who need assistance with at least one core activity at least weekly rather than daily. The same health conditions listed in table 14.1 are used in this scenario. The number of people who need assistance with at least one core activity two to six times a week is 72 340 and the number of people who need assistance weekly with at least one core activity is 46 900. This increases the total number of people estimated to be in tier 3 to 452 500. The annual cost for people who need assistance two to six times a week (half an hour of care per day) is assumed to be between \$6570 and \$8200 per person and the annual cost for people who need assistance once a week (one hour per week) is assumed to be between \$1880 and \$2350 per person.

The cost of care and support increases by between \$280 million and \$330 million. Overall it is estimated that the annual cost (including 10 per cent administration) would be between \$11.13 billion and \$14.12 billion. This represents an increase of approximately 3 per cent.

Scenario 4 – assuming utilisation of supports is 80 per cent of the full entitlement

This scenario assumes only 80 per cent of the full entitlement is utilised in paid formal support. The cost of the NDIS is estimated to be between \$8.66 billion and \$11.38 billion, or a 20 per cent decrease in the costs of the scheme.

Summary of scenarios

The first three scenarios indicate higher scheme costs than the base case. The increase in costs range from 3 per cent to 55 per cent. Scenario 5 indicates a reduction in unit costs of 20 per cent.

Overall, including people in the scheme with relatively lower care and support needs increases the number of people in the scheme by 26 per cent, but only increases the overall cost by 3 per cent. In practice, the costs would be slightly higher, as these smaller claims would be likely to have a higher relative administrative costs associated with them. That said, the cost impact would still be minor.

Allowing for a higher estimate of the number of people with intellectual disability is likely to produce the maximum estimate of people accessing supports. This increases the number of people in the scheme by 55 per cent, but only increases the costs by 11 per cent. This is because the annual costs associated with these people are, on average, lower than other people in the scheme. Extending the scheme to include all people with a daily need for assistance with at least one core activity regardless of health condition increases the number of people in the scheme by 23 per cent and the costs by 55 per cent (the bulk of which is in care and support costs).

Accident compensation scheme experience suggests that people do not utilise their full need for supports from the formal system. Assuming an 80 per cent utilisation rate effectively assumes a 20 per cent decreases in the cost of the scheme.

This scenario analysis further indicates the significant level of uncertainty in the costings and the sensitivity of scheme costs to key assumptions. The central core estimate is reasonable and further work will be undertaken to validate this number. That said, there is no ideal data source that will become available before the final report, and so there will always be a significant degree of uncertainty in the numbers.

15 Insurance arrangements for injury

Key points

- There are a range of state and territory arrangements for insuring people for catastrophic injury, with coverage varying depending on the type of accident, its location and exact circumstances. There is little rationale for the striking differences across schemes.
  - Only about half of people injured catastrophically will have access to some form of insurance — usually compulsory third party motor vehicle cover.
  - The other half rely on generally inadequate taxpayer-funded health and disability services — in most cases, for the rest of their life.
- Existing fault-based insurance arrangements for catastrophic injury do not meet people's care costs efficiently. Legal costs can be substantial, only a fraction of claims succeed and monies recovered often fall well short of meeting people's lifetime needs. Fault-based systems are also problematic because:
  - court outcomes are uncertain, people's future needs are unpredictable and poorly captured by a once-and-for-all lump sum, compensation is often delayed, and there is a risk that lump sums are mismanaged
  - adversarial processes and delay may hamper effective recovery and health outcomes
  - in the presence of insurance, especially with little focus on risk-rating for some causes of injury, the common law does not provide incentives for prudent behaviour by motorists, medical practitioners and other parties.
- No-fault arrangements are likely to produce generally superior outcomes compared with fault-based common law systems. They:
  - provide consistent coverage across injured parties according to injury related needs
  - provide much more predictable and coordinated care and support over a person's lifetime
  - do not adversely affect people's incentives to improve their functioning following an injury
  - are likely to be more efficient
  - reduce people's freedom to the extent that (some) common law rights are removed
  - currently perform no worse at deterring excessively risky behaviour, as despite the appearance of the common law, it is the insurer that pays. And although no-fault arrangements would probably not meet all people's desire for 'punishment' of an at-fault party, there is no clear evidence that the common law achieves this either.

15.1 Introduction

There are many accidents resulting in injury each year in Australia, with over 50 000 for transport accidents alone (Henley and Harrison 2009, p. 2). Some of these accidents are 'catastrophic', resulting in substantial and permanent disability. For example, this could include delayed diagnosis of meningitis resulting in severe brain damage, quadriplegia from falling off a ladder, and an acquired brain injury from a motor vehicle accident or criminal assault.

Various inconsistent and ostensibly arbitrarily different arrangements have evolved in each state and territory to provide insurance cover for people catastrophically injured. Systems broadly align with the cause of injury and include:

- workers' compensation schemes throughout Australia
- no-fault third-party motor vehicle insurance arrangements in the Northern Territory, Victoria, Tasmania and New South Wales and fault-based arrangements in other states[1] and the ACT
- limited provision for people suffering disability because of violent crime (a rising source of catastrophic injury)
- fault-based medical indemnity and public liability insurance.

There is little rationale for the striking differences between schemes. The practical consequence for people acquiring disability is that the amount, nature and timeliness of support depends on the type of accident, its exact circumstances and location. This can have very lasting impacts for people with catastrophic injury.

- In many cases, people rely on the common law to claim compensation, which will only succeed if they can identify a negligent and solvent first party as the cause of the accident ('fault-based' arrangements). How much compensation they get depends on the presence of insurance, the circumstances of the accident, the quality and cost of their legal representation, judicial interpretation of liability and the process for assessing damages. If a person is unable to pursue a common law claim, they must rely on publicly-funded health and disability services, which are often comparatively inadequate.
- However, in some instances, no-fault insurance is available to cover at least their lifetime care and support needs, regardless of whether they can identify an at-fault first party (defendant) as responsible for causing the accident and, hence, liable to pay. Table 15.1 sets out the key characteristics of fault versus no-fault arrangements.

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[1] Tasmania's MAIB provides no-fault benefits alongside access to common law damages.

- Sometimes there are hybrid systems, in which people obtain the benefits of no-fault insurance for one type of claim (long-term care costs), but can pursue other types of claims (income loss and compensation for 'pain and suffering') through the common law where an at-fault first party is involved.

Table 15.1 **No-fault versus fault schemes**

Fault based systems (common law)	*No-fault systems*
Eligibility	
Based on the tort law of negligence, determines whether or not the defendant first party is liable to pay. This requires that the defendant owed the injured party (plaintiff) a duty of care, that the injury arose from a breach of the duty of care and that the injury is sufficiently proximate to the breach. Contributory negligence by the plaintiff will reduce the amount of damages awarded.	100 per cent coverage of catastrophically injured parties within causes of injury covered by a scheme (eg motor vehicle accidents, workers' compensation, potentially expanding out to all causes of injury) Achieve broader coverage by restricting the ability of an injured person to engage civil court action. This limits legal process costs.
How is the level of need determined?	
Claims are assessed against heads of damage in an adversarial setting. Medico-legal reports and expert opinion help to inform the reasonableness of claims, but there is no structured process or consistency across individuals. Settlements amounts take into account of the probability of success, hence reducing the likelihood of full compensation.	Administrative processes implemented through an objective and consistent assessment tool to identify functional needs and supports.
What is the form or nature of compensation?	
Fixed lump sum payment or the option of a structured settlement, though structured settlements are almost never taken-up voluntarily. In some instances, a court appoints a trustee to administer funds. This occurs for children beneficiaries or those with a 'legal' disability such that decisions about the use of funds are subject to oversight to ensure use of funds is reasonable and affordable.	Legislation and policy guidelines determine: ▪ service needs as they arise (medical, social and vocational rehabilitation; personal care; assistive technologies and early interventions) ▪ periodical payment of income benefits (usually based on a percentage of pre-accident earnings subject to caps) ▪ statutory lump sum for permanent impairment.
Who bears the risk of future uncertainty?	
The injured party bears the risk that a once-and-for-all (discounted) lump sum will meet injury-related needs for their lifetime. If funds are insufficient or mismanaged, social welfare and health and disability services are relied on.	The scheme bears the risk, taking responsibility to meet all injury-related needs (subject to legislated conditions) for the life of the injured person, which is held as a contingent liability.

As an illustration of the inconsistencies across the state schemes, a person catastrophically injured in a car accident on the southern side of Boundary Street in Tweed Heads (NSW) would be guaranteed high quality lifetime support, regardless of whether there was an at-fault first party. Had the accident occurred on the same road just a few metres to the north (Queensland) then, in the absence of an at-fault first party, the person would have to rely on often inadequate publicly-funded services. The difference reflects that NSW has a no-fault motor vehicle accident scheme and Queensland a fault-based arrangement.

This chapter considers the strengths and weaknesses of common law versus no-fault insurance arrangements, particularly in relation to catastrophic injuries. Chapter 16 looks at the actual design and implementation of more coherent insurance arrangements for people catastrophically injured in accidents.

This chapter does not address the policy responses to injuries or other harms from product failure (product liability). The body of law in this area is different from accidents covered in this chapter, in that strict liability is the usual standard for liability, claims are infrequent, actions often take the form of class actions, there are often very complex facts that need to be contested, and the defendant parties are typically corporations (sometimes domiciled abroad).

Options for scheme design are plentiful

In designing injury insurance schemes, governments can choose between mixtures of:

- fault-based arrangements, no-fault insurance and public provision of supports (and whether these operate exclusively or allow hybrids)
- coverage across the various 'heads of damage', predominantly long term care and support needs, income support, and pain and suffering
- coverage of catastrophic versus less severe injuries.

Existing schemes involve varying combinations of the above features. For example, in NSW, third-party motor vehicle insurance covers lifetime care and support for catastrophic injuries, replacing common law claims for damages covering these costs, but retains the right for people with catastrophic injuries to pursue other heads of damage (for income and pain and suffering). In contrast, in Victoria, insurance arrangements cover all severities of motor vehicle injuries (not just catastrophic ones) providing no-fault lifetime care and support, income support and a statutory lump sum based on the level of permanent impairment; but also permits people to pursue the possibility of extra compensation through common law avenues.[2]

While injury insurance arrangements are of policy relevance in their own right, they can also provide lessons for the NDIS more broadly — and most particularly about governance. Those lessons are mainly addressed in chapter 7.

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[2] The preservation of common law rights was not the intention of the original proposal, but a result of compromise amendments made to the Act in the Victorian upper house (Field 2008, p. 92)

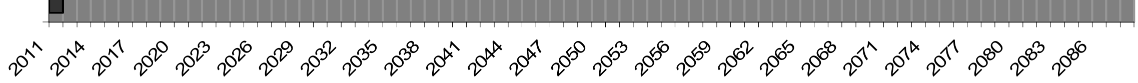
15.2 What is catastrophic injury?

A key focus of insurance for personal injury is on people who face particularly high and enduring costs from an accident. There are over twenty thousand people with a 'catastrophic-level' injury in Australia, with an additional seven to eight hundred catastrophically injured each year (Walsh et al. 2005). This level of injury is mostly experienced by young men aged less than 30 years old,[3] and usually entails a period of initial acute care and intensive medical and social rehabilitation to return to some level of independence. In most cases, the consequences of the injury will have a broader and permanent impact on a person's life and functioning, and typically affect their family.

The fullness of recovery and scope for effective medical treatments varies across individuals, injury types and over time as more advanced treatments develop. While there is a concentration of costs and an emphasis on hospital and rehabilitation services during the initial recovery period, the principal ongoing service need is for lifetime care and support, mainly personal care services (figure 15.1).

Figure 15.1 **How do lifetime care and support costs accrue?**

Projected community support payments for major injury TAC clients, 2011 accident year, $ million



Data source: TAC estimates.

Around half of all catastrophic injuries are the result of motor vehicle accidents, 8 per cent are work related, 11 per cent arise from medical incidents, with the remaining 32 per cent classed as general injuries, typically associated with sport and recreation activities, criminal assault and catastrophic falls (Walsh et al. 2005). While falls, sport and recreation activities account for a significant number of injury

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[3] For example, around 44 per cent of participants in the NSW LTCS scheme were injured between age 16 and 30 years, and 72 per cent of adult participants are male (NSW LTCSA 2009, pp. 12,14).

statistics, these do not usually cause major trauma.[4] Criminal injuries are an increasing source of catastrophic injury in Australia.

There are complex boundaries in the classification and definition of catastrophic injury, as compared with disease. While 'disease' is generally differentiated from injury (Langley and Brenner 2004), workcover schemes will include some occupational diseases, such as malignant mesothelioma related to workplace contact with asbestos. For the purposes of this chapter, a 'catastrophic' injury refers to a level of personal injury broadly consistent with existing definitions and assessments used by the Victorian Transport Accident Commission (TAC) major injury unit, the NSW Lifetime Care and Support Authority (LTCSA) and the New Zealand Accident Compensation Corporation's (ACC) National Serious Injury Service.[5]

Severe brain injury and spinal cord injury are the most common forms of serious or catastrophic injury, but multiple amputations, severe burns and permanent blindness can also give rise to a similar need for treatment, rehabilitation and lifetime care and support.

On average, a successful award under the common law for the lifetime care associated with a catastrophic level injury is around $1 to $2 million. Amounts tend to vary across claim types — averaging $1.1 million for a successful motor vehicle claim, $1.67 million for a medical negligence claim and $1.4 million for a general injury claim (Walsh et al. 2005). (To reflect current values, and adjusting for wage inflation in awards and superimposed inflation, it would be realistic to inflate these awards by around 30 per cent.) These common law awards are upper estimates of the funds that actually go to injured parties, as certain legal charges not recoverable from the defendant party are taken out of the final award. As discussed in section 15.10, these can be significant.

Average participant lifetime care and support expenses (including attendant care, hospital, medical and social rehabilitation, home and vehicle modifications and equipment) under the no-fault Lifetime Care and Support scheme covering catastrophic transport accidents in NSW is projected to be around $1.41 million

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[4] Exceptions are falls by old people, which sometimes involve serious disability. These would typically be covered by the aged care system since the risks of such falls often reflect the natural process of ageing.

[5] The Tasmanian Motor Accidents Insurance Board (MAIB) distinguishes catastrophic injury based on a 'requirement for daily care', in which case, disability and medical benefits are not subject to a limit of $400,000, but should not exceed expenses for attendant care and other services otherwise incurred within purpose-built group accommodation (Schedule 1, Motor Accidents (Liabilities and Compensation) Regulations 2010). Catastrophic injuries with daily care liabilities account for around two-thirds of total claim provisions (MAIB 2009).

(LTCSA 2009). Under the Victorian TAC scheme, the average lifetime care cost for major injury clients (equivalent to catastrophic) is around $1 million.

The value of benefits provided will be significantly higher than this in many cases, principally reflecting the costs of personal care projected over a lifetime. Some of the more expensive common law claims occur for severe birth injury, with liability estimates of such cases as high as $20 million under a no-fault system (including payments for income and level of permanent impairment; ACC 2009, p. 32). For high level quadriplegia, the average lifetime care cost of TAC clients is around $5.6 million, whereas the equivalent cost for paraplegia is $870,000.

15.3 Criteria to assess injury insurance arrangements

There are many possible criteria against which to judge no-fault versus fault-based insurance arrangements for addressing catastrophic injury across Australia:

i. the certainty, timeliness and quality of care and support throughout a person's life (section 15.4)

ii. coverage of people acquiring a disability through a catastrophic injury (section 15.5)

iii. recovery and health outcomes (section 15.6)

iv. the freedom of parties to choose whether they want to litigate and, if successful, how to spend the proceeds (section 15.7)

v. people's desire to achieve justice when someone caused them a loss (section 15.8)

vi. the impact on people's incentives to take care to avoid injuring others (section 15.9)

vii. costs and the efficiency of achieving objectives (section 15.10)

viii. the desire by people to get compensation for loss of earnings and pain and suffering (chapter 16; appendix I).

There are inevitably tradeoffs between these criteria. Consequently, no insurance arrangement is perfect, and choosing the 'best' requires some judgment. In addition, as a practical reality, litigation arrangements for compensation are often subject to statutory limits and other rules (with such constraints growing after 2002 to secure the affordability of insurance systems — see box 15.1). Unless governments were to wind back these constraints, the comparison between alternatives is therefore between no-fault regimes and constrained common law arrangements. As Field (2008, p. 97) observed, the common law is 'a pale imitation of its former self', and hence, the goals of affordability and cost effectiveness apply to common law regimes as equally as they do to no-fault systems.

The subsequent sections weigh up how various insurance options fare against the above criteria. The particular issue of insurance benefits for loss of earnings and pain and suffering is addressed in chapter 16 (and appendix I).

Box 15.1 **2002 reforms to tort liability insurance laws in Australia**

Since early 2002, Australian state and territory governments undertook a process of reform to instil greater predictability, manage cost increases and secure the availability of various classes of insurance. The context for these reforms was influenced by:

- a hardening (increase in the price) of premiums
- the collapse of HIH (from insufficient attention to pricing risk and the full and relative costs of capital), and the near collapse of Australia's largest medical defence organisation (UMP/AMIL)
- a range of international and domestic factors affecting returns to investment and the cost of re-insurance
- an increase in compensation payments for personal injury (awards for personal injury had increased at an average rate of 10 per cent per annum, well outstripping inflation which averaged 2.5 per cent over the same period)
- changes in the courts willingness to extent liability for negligence
- increasingly litigious community attitudes

Insurance products affected included public liability insurance and professional and medical indemnity insurance.

Complementary tort law reforms were enacted by state, territory and Australian governments to reflect constitutional division of powers. State and territory governments hold constitutional power over the law of negligence, administration of the courts system, and for insurance that does not cross state boundaries. The Australian Government has powers to protect consumers and give effect to prudential standards.

Tort law reforms broadly included those relating to:

- establishing liability, contributory negligence, foreseeability, causation and remoteness of damage, standard of care for professionals, and mental harm (must be a recognised psychiatric illness and harm must be foreseeable to a normal person)
- thresholds and caps on damages, to remove smaller claims (mainly for general damages) from the legal system and set limits on particular heads of damages on larger claims. There were also concerns in some states and territories about the proportion of payouts absorbed in legal costs, and some measures were applied to improve disclosure and ensure a larger portion of recovered damages went to the injured parties
- claim procedures, through time limits, methods for making and resolving claims (including pre-litigation procedures, advertising, court procedures and legal costs).

Source: Australian Government (2004).

15.4 Certainty, timeliness and quality of lifetime care and support

As noted earlier, most catastrophic injuries involve lifelong disability, and hence, the need for lifelong care and support. In some cases, the common law can deliver adequate payouts that cover all of these costs. However, compensation outcomes from litigation typically fall well short of meeting people's lifetime needs. This reflects that:

- court outcomes are uncertain
- people's future needs are unpredictable, so that damages awarded at a given time may underestimate or overestimate people's future needs
- compensation is often delayed
- assumptions about discount rates play an important role in determining lump sum compensation, especially for payouts intended to last many decades, and while it is generally agreed rates applied are too high, agreement is lacking about the 'right' discount rate
- lump sums may not be managed appropriately to meet long term needs.

Court outcomes are uncertain

Judicial interpretation of liability, particularly judicial assessment and application of the principles of contributory negligence, proximity, causality and foreseeable risk, is unpredictable. Many see the 'lottery' nature of the common law as one of its key weaknesses, generating dissatisfaction among both claimants and defendants. The high rate of out-of-court settlements, in part, indicates an aversion of both sides to the inherent risks of going to trial, with settlement amounts broadly reflecting the expected risks and benefits of a court hearing.

Inconsistencies in judicial reasoning and interpretation of the individual circumstances of a case are frequently made evident through appeal processes, in which decisions are overturned between different levels of the judicial hierarchy based on different reasoning and interpretations of how legal precedent should be applied (box 15.2). Though, in part, variations in judicial reasoning, especially by judges at different levels, can reflect test cases or areas where the common law is not settled. This is an important feature of the common law, adding to its value and flexibility to remain relevant over time. Moreover, there is the similar argument that legislation is not always certain, with the design of statutes subject to change in parliament and administrative decisions applying the legislation subject to appeal.

Box 15.2 **A case of inconsistent judicial reasoning**

Nagle v Rottnest Island Authority [1993]

In 1977, a man became a quadriplegic after diving from a partially submerged ledge striking his head against a fully submerged rock. He sought damages from the Authority on the basis that it should have warned people not to dive from what seemed an obvious diving platform. In this case, the judicial reasoning behind the decisions of the trial judge, full court appeal judges and high court judges was inconsistent. In particular:

- There was inconsistent opinion about whether or not a duty of care was owed by the defendant, including whether or not the submerged rocks were a hidden or obvious risk
- There were inconsistent views about the scope of the duty of care, and hence, whether or not there was a breach. In particular, the various views about the standard of care expected reflected different interpretations about the foreseeability of the accident and its circumstances and the proximity of the relationship between the defendant and the plaintiff.
- There was disagreement as to what extent the defendant failed to warn of the danger. (Would a general sign, a more specific sign or a fence have met the standard of care expected? To what extent did no history of accidents shape the standard of care expected?)
- Following the different interpretations of the expected standard of care, there were also inconsistent views about whether the defendant's failure to provide a suitable standard of care (e.g. warning signs or a fence) constituted causation, and hence whether the existence of such precautions would have prevented the injury. While the plaintiff was aware of the presence of rocks, there was a difference of opinion between judges about whether a warning would have added to his state of knowledge and prevented the plaintiff's actions.

Ultimately, the High Court determined that a warning sign should have been erected and found in favour of the plaintiff (some 16 years after the accident).

Source: http://www.austlii.edu.au/au/cases/cth/high_ct/1993/76.html.

The calculation of damages also lacks clarity in some areas, such as accounting for gratuitous care, with the law in Australia not settled about the way particular heads of damages are quantified, with different case histories and methodological approaches holding precedent across jurisdictions.

These judicial risks are a key motivation behind the use of mediation between the injured party and insurers to reach settlement prior to a court hearing.

Assessing damages is an exercise in predicting the future

Common law damages for personal injury are based on an estimate of incurred and predicted future costs directly related to the injury. Damages are assessed at a single point in time and, with few exceptions, the amount awarded is unable to be altered regardless of how wrong a prediction may prove to be. Even the best efforts of legal practitioners and the use of experts will involve errors due to the inherent uncertainties in predicting future outcomes and losses related to an injury. As a result, it is likely that damages based on 'sophisticated guesses' by the courts and negotiating parties will prove inadequate to cover the full costs of injury. Alternatively, it might transpire that the damages awarded are surplus to actual injury related expenses and losses. Either way, such inaccuracies incur a cost.

As critiqued in the influential High Court decision of *Todorovic v Waller [1981]*, in cases where:

> … the medical prognosis is that the full manifestations of a plaintiff's injury will not be apparent for some years after trial. The once-and-for-all lump sum award is in those situations a seemingly inadequate form of compensation, because the task of translating the assumptions as to the future into the money figure to be awarded to a plaintiff as a single sum, is incapable of being performed with accuracy. (Aicken J, 150 CLR 403 at 457, in NSW Law Reform Commission 1992)

In particular, reflecting that damages are only recoverable for the additional costs associated with an injury, various assumptions are required about the situation of a person had they not been injured, compared with the situation of the person following the injury. This involves considerable speculation and potential inaccuracy about:

- the extent of recovery and resulting disability after the injury has stabilised
- life expectancy
- the availability of gratuitous care
- formal care needs and associated cost over the lifetime of the injured party
- the impact of the disability on the person's lifetime earning capacity
- the future risk of a complication related to the injury (for example, the risk of epilepsy following brain damage)
- future advancements in medical science, surgeries and assistive technologies.

To take account of these risks and uncertainties, in practice, damages are calculated by weighting the sum of money payable in the event that a risk materialises by the probability of that risk occurring — an expected value. For some general risks there is an adjustment (usually a reduction) for ‘contingencies’, such as to account for the possibility of future unemployment, sickness or death.

To some extent, postponing the trial, settlement or final assessment of damages until more facts emerge, increases the capacity to predict future outcomes and reduces potential errors. However, delaying legal proceedings is one of the primary sources of dissatisfaction from the public and professionals with the tort system (and a major source of legal costs). It can hamper incentives to rehabilitate and can limit early access to treatment, care and a transition to independence. (Although, arrangements such as signed agreements with government departments responsible for disability services or disbursement funding through law firms or the first party’s insurer, can mitigate some of the delays in access to rehabilitation and other disability-related services, with costs reimbursed once settlement is reached or a judgment made).

Some scope to vary damages awarded after trial can occur in a very small proportion of cases through appeal mechanisms. However, the facts covered at the date of the appeal must be relevant to the appeal, and the legal costs of revisiting a case can be high, hence eroding the potential gains from correcting damages.

In addition, there are instances where the uncertainties associated with the calculation of damages can be reduced through the subsequent adjustment of damages years after liability and an initial determination was awarded. This can occur only under restricted circumstances and these provisions are rarely used in practice. As an illustration, under section 30B of the *South Australian Supreme Court Act 1935*, a court has the power to make an interim assessment of damages (excluding non-economic loss, unless the plaintiff’s contributory negligence prevents recovery of the full amount of their economic loss) and adjourn the final assessment until the medical condition of a plaintiff has stabilized, or four years has expired since declaratory judgment was entered. The interim order may be varied on the application of either party.

In summary, common law regimes are not always effective at addressing the care and support needs of people with catastrophic injury and needs spanning many years or even decades into the future.

Delays

Early resolution of successful claims and rejection of those lacking merit has been a central focus of reforms to legal processes and claims management. Avoiding reliance on courts (as a generally acknowledged slow, complex and costly way of dealing with disputes (box 15.3)) has seen a policy focus on ‘pre-action protocols’.

Specific reforms have led to requirements for pre-litigation disclosure, case conferencing prior to the commencement of proceedings, exchange of offers, active use of cost orders to encourage early acceptance of reasonable offers and use of scale or fixed cost models for charging. The most obvious benefits of early resolution and reduced delays include:

- increased efficiency through a reduction in legal transactions costs
- shorter and less stressful litigation process for claimants and earlier attempts to mitigate permanent injury and other injury-related losses.
- early investigation of the facts (mutual evidence disclosure and third-party subpoenas), before recollections become ‘murky’.

The main mechanism for early resolution of claims is out-of-court settlement. While not disputing the range of benefits listed above, several problems remain with settlement processes. In particular, faults in negotiation processes and the lack of a structured process for systematically assessing liability and damages mean that full compensation is unlikely to be achieved in most circumstances.

It has been suggested by some participants that removing the common law cause of action associated with future care, and instead providing benefits in a statutory no-fault setting, would have the important benefit of reducing litigation delays. The basis for this argument is that although liability is determined relatively quickly in a proportion of cases, assessing the quantum of damages is held-up because of uncertainties associated with calculating a person’s future care needs. Medical and rehabilitation costs already incurred, lost income and future capacity for paid employment are all suggested to be more readily identifiable at an early stage. For example, Avant Mutual Group, Australia’s largest medical indemnity insurer, suggested that in their experience of litigating major civil claims:

> … the most significant head of damage is future care costs. By eliminating this head of damage we would expect major civil claims litigation to be resolved more quickly, less expensively and with less stress for those involved. (sub. 550, p. 2)

On average, over the four year period from 2006-07 to 2010-11, the time between a motor vehicle accident occurring to the resolution of a common law claim for compensation under section 93 of the Victorian Transport Accident Compensation Act was fifty two months. Many TAC claims take significantly longer to resolve, with the top 10 percentile of claims averaging around 7.5 years following the date of the accident. Based on beneficiaries whose funds are administered by Victoria’s Senior Masters’ Office, the time between the accident and resolution of the claims was 6 years on average, and nearly 9 years for medical negligence claims.

Box 15.3 **Some examples of litigation delay**

- A plaintiff was injured in a motor vehicle accident while on a working holiday in South Australia and suffered severe brain damage. He received a 30 per cent reduction in damages due to contributory negligence. The court assessed damages at $761 022, 14 years after the accident. A subsequent appeal led to an increase in damages to $856 922, though representation of the plaintiff by the Public Trustee was taxed at $361 000. Disputes continued through the courts regarding these costs and interest awarded. Twenty three years after the accident, the case was still not resolved, with collective costs most likely far exceeding the damages (Luntz 2007).
- *Agar v Hyde [2000]*: Two men were injured playing rugby in 1986 and 1987, aged 19 and 18 respectively. The judgement was handed down against the plaintiffs 13 and 14 years after the date of their injuries.
- *Vairy v Wyong Shire Council [2005]*: Over 12 years elapsed between the accident in 1993 and a final decision being made against the plaintiff on appeal to the High Court of Australia in 2005. The quantum of damages was agreed between the parties prior to 2002 when the case was first heard in the NSW Supreme Court, but resolution of the case required the courts to assess liability.
- Medical indemnity claims can be particularly difficult to resolve, with nearly 60 percent of claims not finalised 2 years from the date of claim commencement, and 15 per cent of claims still not finalised more than 5 years after the claim was initiated (ACCC 2009). These delays are in addition to the time that elapses between the date of the medical incident and when a claim is commenced — frequently over a decade. The Commission has heard many examples of protracted claims, especially for birth related injuries, such as a claim not being commenced until 20 years after the birth and the case then continuing for several years on issues including the life expectancy and future care needs of the now adult concerned.

A significant period of time generally elapses between the date of the accident to when the application to commence a common law claim is received — on average, around 2.5 years for TAC claims. This initial delay, at least in part, reflects the unavoidable problem of medical stabilisation, particularly in cases of brain injury where a person's injuries and extent of recovery can take years to become apparent. But, in some instances, the length of time before a writ is issued may also reflect a departure between a medical practitioner's and solicitor's opinion about how long it takes for an injury to stabilise. As stated by plaintiff lawyer, Burt:

> Some lawyers adopt a wait and see approach by advising new clients that "nothing can be done until the eighteen month anniversary". …in cases involving relatively minor injuries or injuries that you recognise as being unlikely to produce any significant disability, this may be an appropriate course to adopt. However, over the years in my own practice, I have acted for numerous people with "winning cases" who have come to me after receiving this type of advice. (2002, p. 1.1)

If it is true that many solicitors overestimate the time taken for the seriousness of an injury to be established (Luntz 2002, p. 23), to the extent that this prolongs the time before compensation is received, this could be of concern. Medical reports can help to crystallise knowledge about the state of an injured person's condition, but these are also attributed as a source of delay, with a general reluctance of medical practitioners to participate, hence giving rise to a specific medico-legal industry with links to insurers and law firms. Moreover, there may be reasons why lawyers deliberately delay obtaining advice from medical experts:

> It is important that medical experts not be retained until all of the information has been gathered for the simple reason that the history provided by your client to that doctor would appear in the medical report. If the history is inaccurate then this will in itself be sufficient to raise credit as an issue at trial. … supporting documents given to the doctor might have to be provided to TAC. (Burt 2001, p. 1.6)

To reduce the delay between when an accident occurs and when legal proceedings are initiated, many schemes variously impose statutory limitation periods, after which a common law claim is ineligible except in a small range of circumstances. A statutory limitation period is not applied under the Victorian TAC scheme, which may account for the significant time period before a common law claim is commenced following an accident.

The Claims Assessment and Resolution Service (CARS) in NSW seeks to address legal delays by providing a structured, early opportunity for resolution. Other than in special circumstances, there is no access to courts until the matter has first been to CARS — a process which some lawyer groups have criticised as being 'extremely cumbersome, bureaucratic and slow' (Goudkamp 2005). In general, frustrations with such pre-litigation requirements are confined to complex cases that are unlikely to reach early settlement through procedures lacking the full force of a court's authority.

Even so, the introduction of CARS and a range of other changes (including removal of damages for pain and suffering for whiplash injury and implementation of clinical practice guidelines for injury management), has reduced NSW legal and investigation costs as a proportion of claims. In particular, the Cabinet Office of NSW claimed that following the reforms:

- legal costs fell by around two-thirds
- investigations costs approximately halved
- the proportion of total payments actually paid to claimants increased from 80 to 86 per cent, though return to the claimant is only 61 per cent of total premiums. (2005, p. 32).

The outcomes from CARS highlights some of the deficits of standard common law processes, which are relevant to alternative measures for redress and care and support of injured people.

Application of a discount rate

Injured people often need care and support over many subsequent years (and in cases of catastrophic injury, for the rest of a person's life). The typical practice of courts awarding damages is to do so by providing a once-only lump sum. This includes damages for a range of losses, including losses expected to accrue into the future, such as the costs of care for the rest of a person's life. To account for the financial return a lump sum can yield to a beneficiary from receiving the money in advance of when many expenses are actually incurred, courts apply a 'discount' rate to the stream of expected future costs. Apart from an assumed rate of investment return, the discount rate applied also takes account of expected inflation and tax provisions.

The discount rate is a key driver of the adequacy of a lump sum, and indeed, whether or not the principle of indemnity — the payment of a benefit not greater or less than, but equivalent to the value of the losses actually suffered — is achieved. In the event that the discount rate applied is based on incorrect assumptions and set too high, the practical consequences for the ability of a beneficiary to fund even just their lifetime care costs depends on:

- the amount of damages awarded for other heads of damages (income and pain and suffering) and whether there is scope to 'redirect' these damages towards meeting future care costs
- whether there is a reduction for contributory negligence, such that the total amount of the lump sum may not be sufficient to meet lifetime care costs, and especially if the reduction for contributory negligence is high
- the period over which the discount rate is applied, with a discount rate applied over a large number of years having a marked effect on the amount the lump sum is reduced (box I.1 and table I.2). Catastrophic injuries are generally permanent and care and support needs long lived, hence people with these injuries are generally most affected.

Not surprisingly, significant contention surrounds what rate is appropriate, and some prominent High Court decisions have influenced the rate applied and basis for application. The High Court established a discount rate of three per cent in *Todorovic v Waller [1981]*, arguing that such a rate allows for inflation, wages, prices and taxes on the invested sum awarded. Despite this decision, there is considerable variability in the discount rate applied to lump sum damages, both across jurisdictions and individual schemes (table 15.2). The fact that real discount rates vary so markedly, both by jurisdiction and the cause of accident, means that an equivalent future stream of care and support costs will generate quite different lump sum compensation amounts (appendix I).

The issue of a discount rate that is set 'too high', and how this can affect the prospects of a person being able to finance their lifetime care costs, is not a feature of no-fault systems as such investment risks are borne by the scheme itself.

Table 15.2 **Statutory discount rates**

Before and after reforms to civil liability insurance laws in each jurisdiction

Jurisdiction	*Professional and public liability under civil liability laws*		*Workers' compensation*	*Transport accidents*
	before	*after*		
New South Wales	3	5	5	5
Victoria	3	5	6	6
Queensland	3	5	5	5
Western Australia	6	6	6	6
South Australia	3	5	3	5
Tasmania	7	7	3	7
Australian Capital Territory	3	3	3	3[a]
Northern Territory	5	5	n.a	6

n.a NT does not have common law settlement for workers' compensation [a] a rate of 5 per cent is under consideration by parliament, as proposed in the Road Transport (Third Party Insurance) Amendment Bill 2011.

Source: Australian Government (2004, p. 93); Cumpston Sarjeant (2008); Plover and Sarjeant (2010. p. 3).

Management of fixed lump sums by beneficiaries

Lump sum payments have the advantage that a recipient can make their own choices about investment strategies and the desired liquidity of the funds. Beneficiaries taking responsibility for managing their lump sums themselves can also avoid some of the difficulties in getting cost-effective annuities (Cameron 2007).

More importantly, a recipient has the flexibility to consume their money in a way that best meets their preferences. Arguments underpinning this principle align with the value of self-directed funding (chapter 6). However, there are some important differences, including:

- the difficulty that many people may have in managing large amounts of money. Most recipients of lump sum damages lack experience in managing such large sums of money, and while financial advice can assist decisions, it is not a requirement. As stated by Luntz (2002), the dissipation of awards is not always because the recipient chooses to spend it unwisely, but because they are inadequately equipped to invest it safely, or they are unlucky, often due to the financial climate and especially in the early years if capital growth is minimal (pp. 25–6)

- exposure by vulnerable people to fraud by others, which may completely exhaust their lifetime disability funding. Cumpston (2002) describes the case of Tomislav Papic, who lost $5 million of a $6 million settlement to theft
- people may face pressures to give money to relatives or make short-sighted decisions, such as gambling the money away. For example:
  - In *Cockburn & ORS v GIO Finance Ltd*, the father took control of his quadriplegic son's settlement of $1.49 million and dissipated it in his own failed business ventures ([2001] NSWCA 177)
  - Decisions of the Administrative Appeals Tribunal of Australia relating to the enforcement of a preclusion period for access to social security pensions benefits and allowances, found that misuse of lump sum compensation for personal injury was frequently linked to gambling and drinking problems and illicit drug use, taking extensive holidays; and payments and repayments to friends and family (O'Neill, AATA 619, 21 August 2009; Page, AATA 370, 21 May 2009)
  - Previous surveys of how plaintiffs spend their money have revealed that lump sums are commonly spent quickly, discharging debts that have accumulated between the accident and the resolution of the claim on purchases of motor vehicles and household appliances, and occasionally paying the mortgage on a house (NSWLRC 1984). While not all are necessarily inappropriate expenditures, it does mean that the capital sum remaining to generate a return and draw-on for ongoing expenses is less likely to be sufficient.
- in the same way that assessing damages under the common law is an exercise in predicting the future, so is an injured person's predicament in choosing how to responsibly spend their lump sum for the duration of their remaining life. Even trustees of people with disability, who must scrutinise expenditures not knowing exactly how long the money must last or what a person's future health status might be, struggle with this predicament
- the concern that people have weakened incentives for prudent financial management given a capacity for recourse to publicly-funded care and support.

The consequence of these problems (compounded by the difficulties in predicting the costs of lifetime care, and statutory limits on damages and discount rates) mean that lump sum amounts are often not adequate to meet long-term care and support costs. The NSW report by the NSW Law Reform Commission found that:

> … in some cases the compensation was dissipated within three years of the award. These studies also found inaccuracy in the lump sum award where inadequate allowance was made for the effects of inflation on the cost of items and services including wheelchairs, pharmaceuticals and home nursing. Other inaccuracies were found in the failure to assess accurately the physical capabilities of the victim and his or her likely lifestyle and employment prospects. (1992, chapter 2.6)

Some participants have similarly recognised problems with the management of lump sums. For instance, the Tasmanian Government said:

> There is also justified concern that large lump sum settlements are often misused or are grossly inadequate for long term support. (sub. 600, p. 6)

Similarly, the Australian Orthotic Prosthetic Association observed:

> This lump sum settlement in many instances is used not for ongoing lifetime prosthetic care. Often amputees mismanage these funds and then become reliant upon the government community programs for their long-term care. Victoria and NT have systems by which settlements do not include major lump sum payments for lifetime care, but instead provide ongoing lifetime care, support and funding. This model appears to make a great deal of sense. (sub. 237, p. 3)

In many ways, lump sums are a peculiarity of history (Veitch 1982). One of the major historical motivations for their existence was a concern that the defendant might become insolvent. But this is now unlikely given that regulated insurers are typically the source of the financing, and lifetime care schemes are typically government guaranteed.

Structured settlements have not been taken up

While structured settlements suffer many of the same problems associated with lump sums, they have the important benefit of reducing:

- mismanagement of lump sum amounts
- risks to the injured party from uncertainty over life expectancy (Life insurance companies are better able to handle this risk).

Since legislative amendments to remove tax impediments and facilitate court-ordered structured settlements, there appears to be only one instance of these tax-exempted, CPI-indexed lifetime annuities being taken up in Australia.[6] The main difficulty

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[6] While structured settlements primarily provide periodical payments for life, they can also provide a small upfront lump sum, such as to enable career and lifestyle changes. The Commission understands that there has previously been an instance of the NSW government offering structured settlements, though this only operated from the mid-1980's and ceased for any new participants in 1992. In particular, for people catastrophically injured through no-fault

appears to be that the prices of annuities are unattractive for insurance companies to purchase on behalf of beneficiaries, especially in the context of the currently high discount rates used to determine lump sums (Cameron 2007).

Although accepting a greater risk, people holding lump sums could usually get a better financial return in the absence of structured payments. Cameron (2007) gives an example where despite the tax exemption available for structured settlements, a stream of annuity payments was estimated to total $2.9 million, while a conventional investment (with a 7.3 per cent return and annual withdrawals equal to the annuity and indexed at 3 per cent) was estimated to reach a capital value of $4.8 million. The difference between the two sources of income reflects the sensitivity to the investment rate of return, as the guaranteed (risk-free) stream of income provided through the purchased annuity generally assumes a lower average return than may be achievable in practice through conventional investments.

Many of the issues around structured settlements would be resolved by no-fault arrangements.

How do no-fault systems fare?

Whether or not no-fault systems meet a person's lifetime needs better than common law damages depends on their generosity, the assessment arrangements used and case management of injured people.

Under Australasian no-fault systems for compensation, rehabilitation and lifetime care and support, an insurer holds a 'claim' to ongoing care and support and other benefits as a contingent liability. This means that a catastrophically-injured person will generally have lifelong contact with the scheme and, to the extent possible, a particular person or group of people coordinating a variety of support needs. In addition, the risks associated with unforeseen costs that arise into the future in relation to an injury is managed by the scheme, rather than being borne by the individual (that is, no-fault insurance schemes provide intertemporal insurance).

The schemes manage the provision of supports through an objective assessment process, in accordance with the relevant legislation and policy guidelines governing access to benefits and the levels of support available. Even if the actual function is contracted out, the scheme will generally oversee claims management and various assessment-related functions; determination of claims for medical treatment

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of their own, this scheme provided an advance lump sum payment and a guarantee to pay lifetime care and support expenses upon receipt of invoices (including for domestic and nursing care, reasonable hospital and medical costs and necessary equipment).

rehabilitation services (including social and vocational rehabilitation services) lifetime care and support; home modifications; aids and appliances; and any other supports enabled under the legislation. Overlaying this is an appeals process for reviewing the way in which a scheme meets the care and support needs of individuals with catastrophic injuries.

In theory, the problem of managing a lump sum under fault-based insurance arrangements is replicated in a fully-funded lifetime scheme. That is, a person's annual support needs must be sustainably financed from returns on a portfolio of assets — the pool of funds put aside to meet each participant's estimated (net present value of) lifetime liabilities. However, the problems besetting unregulated management of lump sums under fault-based systems are addressed through pooled funding, a strong governance and prudential framework, including full funding of liabilities, supervision of investments and (bounded) discretion to set levies. Such no-fault systems are also normally government underwritten, so there are effectively no genuine insolvency risks.

In addition, lifetime care schemes can encourage the development of a service network, including systems to provide best practice models of rehabilitation. For catastrophic injury, initial acute and sub-acute care is not significantly different across compensated and non-compensated clients. However, the difference can be pronounced for the transition to rehabilitation, access to specialist rehabilitation units and transitioning back into the community. When the Victorian TAC commenced operation in 1987, the TAC responded to the severe shortage of rehabilitation facilities by building and operating their own facility for many years. This is no longer required, as sufficient capacity now exists due to the increased number of clients and attached funds (TAC funds 80 per cent of clients using the main brain injury rehabilitation unit in Victoria).

Despite the range of advantages associated with no-fault systems discussed above, some participants have criticised the financial sustainability of no-fault systems, including the associated consequences for guaranteeing participants' continuing care needs (subs. 375, 392 and 409). In particular, the previous unsustainable growth in liabilities of the New Zealand accident compensation scheme is sometimes held up as a characteristic of no-fault systems more generally. As stated by Mark Blumer:

> The most significant feature of the ACC's situation at the end of 2008-09 is that its financial position has become unsustainable … If this is allowed to continue the Scheme's very existence could be under threat. … Those who depend on the scheme may find the supply of their care needs cut back, or whoever is funding the scheme may have to put in extra money. I would not trade a right to care for that situation. (2010)

Similarly, Maurice Blackburn, Slater and Gordon and Shine Lawyers cite the affordability of no-fault approaches as a concern, drawing on the New Zealand scheme as an example of:

> … a system that is perceived to be equitable at conception, but comes at a high cost, [and hence] may quickly develop inequities through reductions in rights and benefits aimed at mitigating costs … (sub. 392, p. i).

The financial predicament of the New Zealand scheme, as made public following the change of Government in 2008, illustrates a potential vulnerability of no-fault systems. But above all, the unfunded growth in liabilities affirms the need for a sound governance framework, and does not necessarily demonstrate financial sustainability as a specific weakness of no-fault systems. While mainly in relation to the NDIS but also relevant to no-fault systems for accidental injury, chapter 7 presents a framework for good scheme governance, including the need for appropriate and clear:

- limits on political interference that might otherwise jeopardise a scheme's integrity
- legislation defining scheme boundaries, reducing any unfunded creep in scheme coverage or inconsistent decisions about the reasonableness of benefits
- performance metrics to provide a discipline on costs, administration expenses and drive efficiencies in delivery of care and support
- effective monitoring by a government department concerned about the financial sustainability of the scheme.

Associated with these potential, albeit avoidable, concerns about the desirability of no-fault systems is the tension that governments have been seen to impose legislative restrictions on the ability to access and obtain compensation through the common law, and yet might soon seek to take legal rights away more completely. On the one hand, limitations on the common law have been motivated to ensure that compensation remains comprehensive and prioritised to those most in need, particularly those with catastrophic injuries and lifelong needs for care and support. On the other hand, people whose injuries fall below the set thresholds have undoubtedly lost.

The removal of, at least some, common law rights within a no-fault system is offset to the extent that injured people are instead promised access to lifetime care and support (and perhaps other forms of assistance also, depending on the scope of the scheme and the extent that common law rights are removed). An important distinction, however, is that a statutory no-fault system manages access to benefits through a statutory authority rather than judicial processes. The Commission has heard two main concerns about the role of a statutory body and the administration of statutory benefit rules in no-fault systems:

- while a no-fault system overcomes the 'lottery' nature of the common law damages, a proportion of those successful in obtaining compensation under the fault based compensation system would fare worse under a no-fault system
- more so than under a fault-based system that has fewer levers available to governments to intervene in the way benefits are allocated, administrators of a no-fault system may be perceived as susceptible to direction from government to either restrict benefits or alter scheme coverage.

Another concern raised by some participants about no-fault systems is the failure of such regimes to consider the individual situation of the person with a disability. For example, Maurice Blackburn, Slater and Gordon and Shine Lawyers said that an important function of the common law is that it:

> … provides flexibility in delivering alternative compensation levels to people with different impacts from the same disability, and can therefore address heterogeneous needs and preferences. (sub. 392, p. ii)

They went on to cite the specific example of dealing with cases of disfigurement, suggesting that statutory benefits under no-fault regimes are too inflexible to adequately deal with instances where the type of impairment and the associated loss experienced, does not necessarily align with functional impairment loss (as is typically used to determine the amount of compensation under a no-fault fault system) (sub. 392, p. 16).

The Commission agrees that addressing individual circumstances is important to achieving good outcomes for people with disability; indeed, a statutory scheme that is too rigid could result in perverse outcomes. For example, a person whose face is disfigured might benefit from plastic surgery, especially if the absence of such an intervention would prevent them from having the confidence to leave their home and participate in the community, including in gainful employment. Similarly, the psychological effects of a physical injury, which can be devastating to a person's life and identity, should be addressed in complement to other treatments and interventions. To this end, existing no-fault systems attempt to take account of an individual's situation through:

- needs assessment, which can be undertaken as individual circumstances change (chapter 5)
- identifying features central to the person's pre-accident lifestyle, including by tailoring supports to former participation goals. As occurs under the Victorian TAC, this might include, for example, the provision of a more highly specialised wheelchair to enable sport to be played by a former athlete who had experienced a spinal injury

- the establishment and enhancement of mechanisms to enable greater control by individuals as to how resources could best meet their participation goals, health and wellbeing, including through self-directed funding approaches, client satisfaction surveys and monitoring of client outcomes.

The Commission has been careful in this draft report to design an NDIS that supports the practical realisation of self-directed funding approaches (chapter 6). In coordination with the experiences of the NDIS, there is also a role for self-directed funding models in lifetime care schemes for accidental injury, as has been a central theme of many participants' advice. For example, as stated by Maurice and Blackburn, Slater and Gordon and Shine Lawyers who emphasised the importance of choice:

> People with a disability should have the option to receive care through a consumer directed care model *and* the option to relinquish care responsibility to a designated case manager. (sub. 392, p. ii)

The practical task to allay concerns about removing common law rights among some groups within the community should not be underestimated. Despite numerable past official inquiries and reviews investigating the issue and broadly reaching similar conclusions about a no-fault system of statutory benefits as the best way to proceed[7], governments have resisted implementing such changes on most occasions. Incremental change may address this to some extent, and may also be appropriate to ensure that any new system is up and running before taking on functions broader than the important task of ensuring comprehensive lifetime care and support for the most severely injured. These issues are explored in chapter 16.

15.5 Coverage of people acquiring a disability through a catastrophic injury

By definition, full common law compensation for the losses associated with catastrophic injury only applies where an at-fault (provably negligent) first party (defendant) can be identified, damages are assessed accurately and there is no contributory negligence to reduce the amount of compensation the defendant is liable to pay.[8]

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[7] Official inquiries include: the 1967 New Zealand Royal Commission of Inquiry into Compensation for Personal Injury; the 1974 Australian National Rehabilitation and Compensation Committee of Inquiry; the 1981 New South Wales Law Reform Commission Inquiry into Compensation for Personal Injury and Death from Motor Vehicle Accidents; the 1986 Victorian Government Statement on Transport Accident Reform; and the 2004 Productivity Commission report on National Workers' Compensation and Occupational Health and Safety Frameworks.

[8] Contributory negligence is the failure of the injured person to take reasonable care for their own safety, with a per cent reduction based on the relative contribution the plaintiff made to their own injury.

A person acquiring a catastrophic injury but unable to establish another solvent party's legal liability for the injury would generally[9] not gain access to compensation under a fault-based common law system. This includes cases where:

- the accident was purely a matter of chance without any other party's involvement. For example, a driver, their passengers or a pedestrian might sustain motor vehicle injuries from chance or blameless events outside the control of the driver — a car tyre blowing out, the driver suffering a heart attack or stroke, an oil slick on the road, an unexplained mechanical failure or an unavoidable collision with an animal darting across the vehicle's path. In accidents more generally, a person may fall off a ladder after a strong unexpected gust of wind, or a swimmer may acquire a brain injury when submerged by a freak wave. Bad luck is common
- a person may make a mistake that anyone might make, but which results in their own catastrophic injury
- another person causes the accident but has nevertheless taken 'reasonable' care. For example, someone causing an accident that was blameless or inevitable (such as because they sneezed, had a heart attack or were bitten by an insect whilst driving) would be unlikely to be found negligent[10]
- the injury arose out of a single vehicle accident and the injured driver was themself at fault, or alternatively, an accident took place in a person's own home or private property, such as from falling off a ladder, falling from a horse, or rolling a four-wheel motor bike on a rural property.[11]

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[9] There are some statutory exceptions, which provide access to common law damages in some circumstances where a legally not at-fault first party is defined as at-fault for the purposes of ensuring insurance cover for the injured third party. For example, in NSW, the *Motor Accidents Compensation Amendment Act 2006* extended no-fault cover to pedestrians and passengers who were injured as a result of 'blameless or inevitable' accidents. Such accidents seeking common law damages are now processed in the same way as fault-based claims, although the driver of the vehicle (still technically defined as at-fault) will remain ineligible to claim. No-fault cover for children's medical expenses and rehabilitation costs was also provided for under the legislative amendment, and since April 2010, at fault motor vehicle injuries are entitled to a maximum of $5,000 for reasonable and necessary medical expenses and/or lost earnings.

[10] A recent case decided by the High Court epitomises the limits to negligence. *Sydney Water Corporation v Maria Turano & Anor* [2009] HCA 42 concerned a claim against Sydney Water for the death of a driver and injury of other occupants of a car that was hit by a tree during a storm. The plaintiff's case rested on the argument that Sydney Water was negligent because a leaking water main (laid in 1981, ten years prior to the accident) had damaged the tree's roots, making it susceptible to collapse. The High Court dismissed any liability because Sydney Water could not have reasonably foreseen the risk of an accident.

[11] The Victorian TAC covers accidents involving off-road vehicles on a no-fault basis, which are also required to purchase insurance.

Consequently, the scope of cases that are non-compensable under the common law is very wide. Australia-wide, only about half of catastrophic injuries are compensated through insurance, with the supports required for the remainder covered through (generally inadequate) taxpayer-funded health and disability services. The proportion varies significantly across jurisdictions and depends crucially on whether a fault or no-fault insurance system is in place.

Motor vehicle accidents

Across Australia, compulsory third party (CTP) insurance arrangements cover around two-thirds of motor vehicle accidents resulting in a catastrophic injury (Walsh et al. 2005). No-fault cover (which extends to 100 per cent of these injuries) is available in NSW, Victoria, Tasmania, and to a more limited extent in the Northern Territory. Coverage is patchy in other jurisdictions, due to fault-based access to benefits and the potential for damages to be reduced through contributory negligence. Limited cover for at-fault drivers (in the form of a lump sum payment) can be purchased from some insurers as an additional feature of CTP cover, but these are subject to caps and various other restrictions and exclude cover for motor bikes.

Workplace accidents

Workers compensation arrangements provide no-fault cover in all Australian jurisdictions, and hence, extend at least some no-fault benefits to 100 per cent of injured parties, but in some jurisdictions, care and support costs are not adequately provided for catastrophic injuries (chapter 16). Residual common law rights for some heads of damage are available in all jurisdictions, except South Australia and the Northern Territory.

Medical accidents

Estimates show that catastrophic medical incidents attract some form of compensation in about 50 per cent of cases across Australia (based on a comparison with New Zealand that operates a no-fault system for covering these injures) (Walsh et al. 2005). Access to benefits is managed entirely through litigation, though most claims are settled out of court. Cases are often not finalised for many years following the incident, or the initial discovery, that gave rise to the initiation of a claim.

General accidents in the community or at home

Cover for general injury, through either public liability insurance or private legal liability insurance (as tends to be included in home and contents general insurance policies), provides access to compensation for about 20 per cent of general injury claims. These claims are managed through the adversarial system, though recent tort law changes have limited the extent that people with less serious injuries can claim and the level of damages available.

Criminal injuries

Each jurisdiction has a taxpayer-funded criminal injury compensation scheme, recognising that the offender may not always be (sufficiently) solvent to pay damages, such as can be accessed under the crimes act in various jurisdictions.[12] These are usually last resort schemes however, and albeit that they ensure broad coverage across affected individuals, they do not provide adequate levels of compensation for severe physical injury, including permanent disfigurement and loss of function experienced from violent crime. Rather, as stated by the Victorian Victims of Crime Assistance Act 1996, for example, the purpose of providing financial assistance to victims of crime is:

> … as a symbolic expression by the State of the community's sympathy and condolence for, and recognition of, significant adverse effects experienced or suffered by them as victims of crime … (section 1.2. b)

Across jurisdictions, caps on the total amount of compensation are applied between $25 000 to $75 000, though the availability of this level of financial assistance would require evidence of significant costs incurred related to the injury.[13] This means that for catastrophic injury, victims of crime are not covered for their future (most likely lifelong) care needs. This can negatively affect the extent of rehabilitation and recovery and long term prosects for community participation. As recounted by one participant whose daughter was brutally injured in 2002:

> … when she was bashed by her then ex boy friend. She was left with a severe brain injury, and we were told that she would not improve and the only option offered to us, which we believe was due to the fact that Anj was a victim of crime with no compensation, was an aged nursing home in Benalla. The physios in intensive care said she needed botox and plastering, this was not done. The lack of these procedures has had a enormous effect on her wellbeing and rehabilitation, If these things had been done early Anj would not have had to suffer years of pain and suffering as she has had to due to the fact she didn't have the funding. (sub. 535, p.1)

Similarly, the Commission has heard of an instance of a person now in their twenties residing in a nursing home having been physically abused and severely brain damaged by their parents as a 6-week-old child. But apart from a trivial

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[12] Or in some instances from a government department if it is proven the department breached their duty of care.

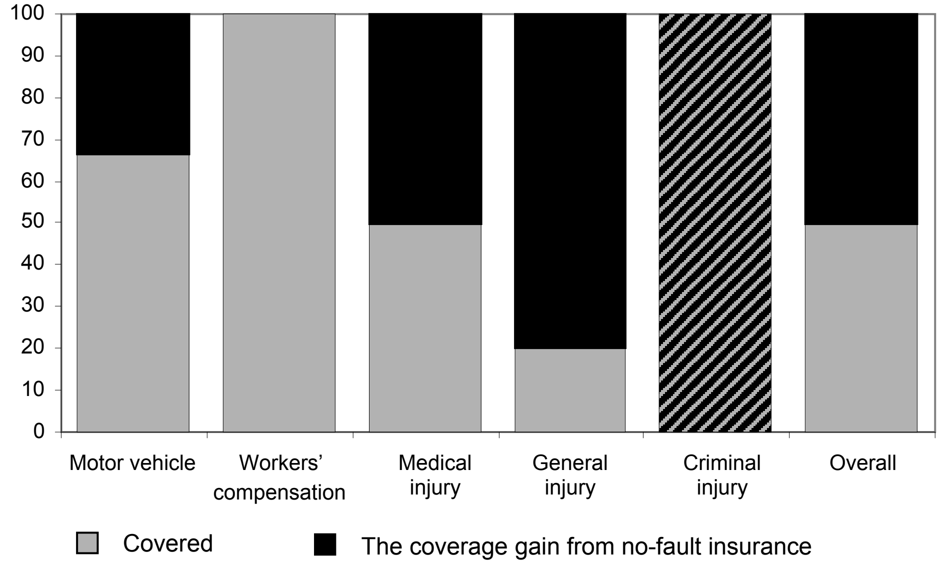
[13] Within these limits, benefits claimable span across medical expenses, loss of amenities and expectation of life, physical injury, mental and nervous shock, and loss of income.

amount of compensation awarded through victims of crime assistance, this person relies on evidently inadequate support from the disability and health systems.

The introduction of universal no-fault arrangements for catastrophic injury, by definition, would provide complete coverage, with the minimum gains shown in figure 15.2. (They are a minimum because some schemes offering 100 per cent coverage provide significantly capped benefits, such as for criminal injury.)

Figure 15.2 **The coverage gap by source of injury**[a]

Per cent of people whose lifetime care and support needs are (not) covered



[a] Although a 'symbolic' level of cover extends to 100 per cent of catastrophic criminal injuries, cover for this category is represented differently to show the potential for significantly improved depth of cover under a new no-fault arrangement.

Data source: Walsh et al. (2005).

15.6 Impacts on recovery and health outcomes

A key goal of all insurance systems (common law, no-fault or social insurance) is to improve a person's health and functioning following an injury.

There are several conceptual grounds where adversarial fault-based systems could reduce the scope for such improvements (and might sometimes exacerbate problems):

- the size of a person's award for compensation (and that of his or her lawyer) under the common law is dependent on the severity of the injury. The usual strong incentives for people to maximise recovery is undermined by an awareness that the greater the recovery, the lower the potential level of compensation. In effect, the prospect of injury-related compensation is like a tax on recovery. It would not be surprising for such a tax to have an effect. This interpretation does not require the person to 'manufacture' their disability (though that will sometimes happen)

- litigation processes take time, are stressful, and accentuate a person's preoccupation with the disabling aspects of an injury (Psychosocial factors play a significant role in recovery.)
- no-fault insurance schemes directly seek to achieve better health and functioning by explicitly managing cases and consumption of services and supports to get better outcomes as fast as possible. At a broader level, no-fault schemes regularly survey their clients, are developing tools to measure and better understand how to improve client outcomes and progress. These are not the priority concerns of fault-based systems.

Generally, these theoretical concerns are supported by empirical evidence. A recent review undertaken for the Australian Centre for Military and Veteran's Health (Pietrzak et al. 2009) concluded that:

> The search of literature showed that evidence associating compensation with a worse disability outcome appears irrefutable. Hundreds of papers included in three meta-analyses and all the individual papers from the updated search showed adverse effect of compensation on health and RTW outcomes. (p. 6)

The Australasian Faculty of Occupational Medicine and The Royal Australasian College of Physicians (2001) also concluded:

> Although most people who have compensable injuries recover well, a greater percentage of these people have poorer health outcomes than do those with similar but non-compensable injuries. There is sufficient good quality evidence to show this to be true, and significant agreement among practitioners in all relevant fields (medical, legal, insurance, government oversight bodies) to support the evidence and to suggest that a complex interaction of factors is responsible for this.

Professor Richard Madden suggests that common law processes for medical injury has the perverse effect of preventing disclosure of errors and risks in the health system, hindering efforts to improve safety and quality (sub. 466, p. 2). Similarly, a key objective of the 2005 legislation establishing a no-fault system for medical injury in New Zealand was to move away from reporting medical error decisions to foster instead improved quality, safety and learning initiatives, including through:

> … sharing information on issues where there is a risk of harm to the public. … disclosure of harm as a first step in facilitating claims, strategies to reduce barriers to claims… [and] addressing competence and performance issues as internal organisational responsibilities. (Malcolm and Barnett 2004, p. 21)

Not all agree about the potential for common law processes to lead to adverse health outcomes. In particular, one up-to-date 'review of reviews' does not support the above contentions (Spearing and Connelly 2010). This study was also raised by the Law Council of Australia as the basis for their claim that:

> … arguments that litigation impedes recovery are not supported by any conclusive evidence. (sub. 375, p. 12)

Given the apparent meticulous approach of the Spearing and Connelly study, it should be considered carefully in the debate. The authors sifted through the various systematic reviews in the compensation literature. Many reviews were eliminated from consideration on the grounds of their coverage.[14] Of the remaining 11 systematic reviews, 9 of them concluded that access to compensation had negative impacts on health outcomes (compared to the counterfactual). One study made no judgment either way because of the nature of the studies it considered. The remaining study (Scholten-Peeters et al. 2003 referred to as SP from now on) found no robust negative effect of litigation on health outcomes (following whiplash injuries). Spearing and Connelly eliminated all bar the latter study because of various defects in the quality of the other reviews, and on the basis of that study, concluded that:

> Until consistent, high quality evidence is available, calls to change scheme design or to otherwise alter the balance between the cost and availability of injury compensation on the basis that compensation is 'bad for health', should be viewed with caution. (p. 9)

However:

- it is not clear why the penalty for a defect in quality is a weight of zero when making judgments about impacts. Therefore the other reviews arguably also have *some* relevance to judgments about the impacts of compensation
- a more recent study into whiplash (Centre for Automotive Safety Research CASR 2006, p. 10) considered that SP had not given credence to an important study finding a robust link between litigation and adverse outcomes. Moreover CASR's own research on South Australian whiplash injuries did find such a link (p. 74)

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[14] Spearing and Connelly did not include in their meta study reviews examining compensation effects for some groups relevant to the Commission's analysis, including reviews that considered effects on children, professional negligence or where the injury was from an unknown cause. Reviews not in the English language were also omitted.

- the burden of proof used by SP (and also adopted by Spearing and Connelly) was a requirement to prove beyond reasonable doubt that litigation arrangements were bad for health. For example, using SP's criteria, a study suggesting that litigation had 1.9 times the likelihood of retarding recovery, but which was not statistically significant at the 0.05 level would be seen as strong evidence of no impact. However, in many other contexts where a risk of harm is present on conceptual grounds, the onus of proof is reversed. In that case, the requirement would be to demonstrate that litigation had no adverse effect, especially in the light of the subjective concerns raised by many clinicians. The heart of the issue is that the *policy* interpretation of impacts and their statistical significance should be against the background of the implications of false positives and negatives, rather than focusing alone on reducing the likelihood of false positives (McCloskey 1985; McCloskey and Ziliak 1996).

As discussed in appendix J, the evidence on the impacts of litigation on health and wellbeing outcomes of those experiencing major injury is weakened by methodological limitations. However, the weight of the evidence suggests adverse impacts of litigation. Certainly, there is no evidence that litigation produces *better* health and functioning outcomes than no-fault schemes, despite being more expensive on a case-by-case basis (as discussed below).

As an addendum, a related question is the net wellbeing impacts of common law versus no-fault systems for people other than the injured parties. There is little evidence on this score, but if litigation is stressful for the person with an injury, it is likely also to be so for their support network. Equally, in some cases, the defendant may also suffer significantly from an adversarial approach — even if ultimately found not to have been at fault (for example, as shown by the testimony of a general practitioner facing a writ for case of cerebral palsy for a birth that occurred 20 years previously — Kerr 2004).

15.7 People's freedom

No-fault systems usually extinguish people's common law rights for at least one head of damage (predominantly lifetime care and support). In Australasia, New Zealand is unique in extinguishing virtually all common law rights for all accidents. Where a scheme extinguishes common law rights, it means that third party insurers (such as the NSW LTCS Authority or the Victorian TAC) determine the amounts and nature of supports. In contrast, access to the (unconstrained) common law allows people to:

- attempt to get larger compensation payouts

- obtain a lump sum payment, which they can choose to spend as they wish. Lump sum payments are the ultimate form of 'self-directed funding' (see chapter 6). However, it should be noted that lump sums settlements and court awards may be held by a third party in trust (for children and some adults with diminished decision making abilities).

Accordingly, extinguishing common law claims diminishes freedom of choice, which is often highly valued by people and can enable them to allocate resources to the spending areas that match their preferences and heterogeneous needs (Maurice Blackburn, Slater and Gordon and Shine lawyers, sub. 392, p. ii). The Law Council of Australia was very concerned by any move to constrain common law rights:

> It is also not appropriate to deprive disabled people of choice, by compulsorily requiring them to enter into a prescriptive scheme for life, where all decisions are subject to the approval of the scheme's managing authority (as is the case under the NSW Lifetime Care and Support Scheme …). (sub. 375, p. 5)

Similarly, personal injury lawyer, Mark Blumer, recently commented in a public presentation about the proposal for an NDIS that because no-fault compensation systems take away people's enforceable (common law) rights, they must include a review mechanism that maintains practically enforceable rights regarding whether or not a particular treatment, rehabilitation or type of care is needed. Similarly, the Australian Lawyers Alliance suggested that the review mechanism under the NSW LTCS scheme suffered a 'natural justice problem' and that:

> Any scheme introduced as a result of this [Productivity Commission] inquiry should allow for an appropriate and properly funded way for decisions of the care-funding authority to be tested in a transparent way. (sub. 305, p. 10)

The tendency of individuals to object to what may be viewed as paternalistic features of no-fault systems will vary, often depending on the particular event that gave rise to their injuries. For example, the psychological trauma (pain and suffering) faced by victims of criminal violence or assault may call for an appropriate balance between:

- a victim spending their compensation in a way that is meaningful and enables them to 'feel' compensated and empowered. As summarised in Hull's reading speech about the purpose of special financial assistance to Victorian victims of crime as to:

  > …acknowledge a victim's suffering — not dictate to victims how they should spend their award. The victim is in the best position to decide for themselves how best to use their money. If they see fit to spend it on paying off their mortgage or gas and electricity bills, going on a family holiday, buying a red coat, or even setting up a fund to assist in the search for an alleged offender, then it is a matter for them and not government. (Victorian Hansard, 26 May 2000, p. 1912)

- allocating it in a way that encourages it to last over time (which could continue to remind them of the traumatic event) or be put towards more sensible, albeit less meaningful, uses. (This issue is taken up in chapter 16 and appendix I.)

There are a number of counterarguments to the issues raised about the reduced freedom implied by the removal of common law rights. First, while freedom of choice has value, it has to be weighed up against any costs of fault-based systems and any advantages for the wellbeing of people through alternative insurance arrangements.[15] Freedom of choice per se, is not a sufficient basis for maintaining all common law rights.

Second, the Commission envisages a greater role for self-directed funding in the proposed new arrangements for the disability system and injury schemes, so the capacity to choose among supports need not be missing in a no-fault system.

Finally, it is not practical to remove a person's right to taxpayer-funded supports if a person has exhausted their lump sum secured through litigation. In that case, successful litigants can free-ride on taxpayer-funded supports. Taxes are coercive mechanisms — people cannot choose to be taxed or not. So the freedom of choice exercised through the common law can entail loss of freedom for other people forced to subsidise it.

Consequently, from a practical perspective, it is difficult to support the notion that fault-based systems provide people with very much widened choices compared with no-fault systems.

15.8 The value of 'justice'

Is it 'just' to compensate victims only?

Many in the community might regard the common law as appropriately one-sided in its compensation arrangements, with justice being served by no compensation for the at-fault driver.

However, consider the most negligent of cases, say a highly intoxicated young man, driving an unregistered vehicle at speed who severely injures both himself and the

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[15] Notably, compulsory third party insurance (which underpins both fault and no-fault systems) also reduces freedom, as people cannot elect to self-insure. That reduction in freedom is justified by the fact that many people negligently harmed by a self-insured party would not get adequate compensation because the defendant's liability would be limited through bankruptcy provisions.

innocent party. Most people would regard it as repugnant to leave the at-fault young man without any support (surgery, rehabilitation, a wheelchair), accepting the legitimacy of meeting some basic level of need for services. Under current fault based arrangements, a generally inadequate level of support would be provided through the general disability system and the social welfare system, with the gap in injury-related needs filled by family, charity and other informal arrangements. So ultimately, the at-fault party would 'get by', albeit mainly relying on taxpayer-funded health and disability services and transferring a proportion of their injury-related costs to other parties providing informal supports.[16]

If determined appropriate, a no-fault arrangement could have provision to differentiate between people's access to scheme benefits in a way that could incorporate some common law attributes (if judged appropriate). For example:

- on the one hand, access to a particular scheme benefit could be limited to only those people whose injury was caused by the clear culpability or egregious actions of another person
- on the other hand, access to some benefits could be denied if there is evidence of deliberate recklessness in causing your own injury.

That said, it is reasonable to expect the community would have limited appetite to restrict access to benefits for many instances of catastrophic injury — perhaps, only to restrict benefits made available in lieu of a person's 'pain and suffering'. Nevertheless, the relevant point is that the common law would not be the only way of achieving such an end, *if* it were regarded as desirable.

The principle of collective responsibility for the costs of injury has a long pedigree in attempts to integrate personal injury law with social welfare principles, and was strongly advocated in the Woodhouse Report (1967). This report continues to guide the remit and operating principles of the Accident Compensation Corporation in New Zealand, and recognised that injuries caused by accidents are often the result of a complex series of events, involving multiple causes and agents, and that personal choices are socially embedded. In particular, Woodhouse argued a parallel responsibility for accidents is shared between:

> … groups, networks, organisations, corporations and government agencies ... Their success depends on social coordination, not just assertions of personal choices. (Report of the royal Commission of Inquiry [Woodhouse report] 1967)

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[16] No-fault motor vehicle accident schemes variously exclude or reduce payments (for impairment and income benefits) and restrict access to some services to drivers who are convicted of culpable driving under the relevant legislation, were driving under the influence of alcohol or other drugs, were uninsured, or not in possession of a licence.

This recognises, for example, that a person may make a small ‘mistake’ that anyone might make (say a momentary slip in attention), but which results in the injury of another party. International empirical evidence suggests that it is common for ‘good’ drivers to make such mistakes, with the most common cause of accidents being carelessness and lack of attention, rather than reckless or deliberately aggressive driving (Pearson Royal Commission Report). And such accidents are common, with nearly one in five individuals reporting having been involved in a road crash in some capacity over the last three years (DITR 2010, p. 81).

Accordingly, looked at more closely, the common law does not appear to generally achieve a just discrimination between an at-fault and innocent party, in many cases because ‘fault’ lacks a moral dimension. That is, many injuries caused by a person deemed to be negligent (under the common law) are not always easily categorised into the ‘victim/perpetrator’ model.

The ‘retributive’ function of the common law

People suffering negligent injury from another party often want to punish that party through financial penalties — ‘making them pay’. In *theory*, the common law provides one avenue to do that by imposing a financial penalty on that party. As stated by the Australian Lawyers Alliance:

> If tort law becomes incapable of recognising important wrongs, and hence incapable of righting them, victims will be left with a sense of grievance and the public will be left with a feeling that justice is not what it should be.’ (sub. 305, p. 16)

In practice, however, the capacity of the common law to ‘right wrongs’ is limited because of the role of the insurer. Indeed, the factors that generally reduce the capacity of the common law to create incentives for care also undermine the capacity of the common law to provide an avenue for retribution. And, the mechanisms that could effectively be used for retribution — criminal charges, de-registration of professionals, loss of licence — are available whether or not a common law fault–based system is in place. Moreover, as noted above, many cases involving common law negligence are the result of everyday common mistakes that anyone can make.

On the other side of the coin, however, some cases of negligence cross criminal boundaries, and this is where victims’ and society’s desire for compensation as a form of retributive justice are likely to be greatest. To address this, some no-fault systems retain exemplary damages — intended to punish the defendant by requiring them to pay compensation to the plaintiff over and above the amount of compensation necessary. For example, these are available alongside New Zealand’s no-fault accident scheme. However, exemplary and aggravated damages (collectively termed punitive damages) are no longer universally available in Australia following the suite of reforms commenced in 2002 to abolish these damages in personal injury cases (Australian Government 2004, p. 97).

In summary, neither fault-based or no-fault systems address people's desire for retributive justice, and so this cannot be used as a criterion for weighing up alternative insurance arrangements.

15.9 Providing incentives for people to avoid injuries

While many injuries are the result of pure accident, many could be prevented if people changed their behaviours. Poor occupational and health standards, substance abuse, dangerous driving, weak adherence to professional standards, faulty products and generally engaging in risky behaviours can cause injury to a person and to others. To the extent that a risk is observable and able to be changed, the goal of policy is to reduce the costs of people's risky behaviours. For instance, although age and gender are statistical risk factors in causing road accidents, people cannot alter these specific characteristics. Even still, it may be possible to modify behaviour, such as decisions about vehicle type, including by discouraging the use of high powered motorbikes and heavily modified performance vehicles, having zero tolerance of alcohol consumption and requiring appropriate training.

People are less likely to take account of the full costs of their risky behaviour when they are unaware or misinformed about the capacity to cause injury, and especially if the costs of injury are borne by others. Policy attempts to correct people's incentives to take care, avoid risks and hence reduce injury. What level of policy intervention is appropriate however, depends on how direct costs and benefits accrue from incremental changes in levels of safety, vis-à-vis the costs and benefits of some risk taking. (Achieving zero risk would be very costly and undesirable.)

There are many policy approaches to increasing safety and reducing the likelihood of accidents, such as regulation; guidelines, protocols and standards; raising awareness; changing technologies; 'naming and shaming'; fines, criminal prosecutions for breaches of laws and — relevant to this chapter — the deterrent effects of civil litigation. In that vein, the Law Council of Australia has emphasised the importance of civil litigation as a deterrent:

> … common law compensation systems perform an important regulatory role, deterring or discouraging negligent behaviour by requiring responsibility and restitution. (sub. 375, p. 11)

The deterrent effects of litigation may arise in several ways.

The direct monetary effect

People causing injury to others may have to pay compensation — creating direct monetary incentives to avoid negligence. However, this argument has little relevance to common law cases involving serious injuries, since in most instances the party at fault is covered by insurance.

In theory, strong monetary deterrence against negligence would apply to cases in which an at-fault party is not insured. In that instance, the person would be liable to pay compensation personally. For example, this would arise in cases involving criminal injury or a negligent party driving an unregistered vehicle. (In the latter case, such people have significantly higher odds of being in an accident resulting in injury). However, in most instances of injury caused by a person (as compared with a corporation), such people have no capacity to pay compensation anyway (‘judgment proof’), and so the apparent deterrence effect is absent.[17]

The reality is that the effective capacity to seek common law damages in personal injury goes hand in hand with the existence of insurance (Justice Kirby 2000), which in turn, blunts the deterrence effects claimed for the common law (especially when there is limited application of experience rating — see below (Harris 1991).

The insured still have some incentives to be careful

Even where people insure against the majority of the monetary risks of civil litigation, insurers structure their policies to address moral hazard and ensure parties still have (at least some) incentives to take due care. In particular, insurers have strong fiscal incentives to manage moral hazard to protect their financial viability from growth in claims and costs.

In the event of an accident in which a policyholder is at-fault and a common law claim against them is successful, they:

- may have to do certain things such as put in place risk mitigation strategies before being able to get insurance cover (for instance, workers’ compensation insurance goes hand-in-hand with compliance with OHS standards; and medical indemnity insurers finance clinical risk management programs).
- will still have to pay a front-end deductible to their insurer

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[17] As an illustration, the Queensland Nominal Defendant provides personal injury insurance to people injured by uninsured (or unidentified) drivers. In 2009–10, the value of such claims and associated settlement costs were nearly $30 million, of which it recovered around $650,000 from the uninsured parties, or around 2 per cent of the total costs (Motor Accident Insurance Commission 2010, pp. 6, 59).

- may face higher risk-rated premiums in the future if they fall into a higher risk category (experience rating). In some cases, no insurer will cover them, and where insurance is mandatory (workers compensation, CTP and in some jurisdictions medical indemnity), this will often disqualify them from legally undertaking the activity that leads to the risks. For instance, a high-risk medical practitioner may not be covered to perform certain procedures, usually triggered by an unusually high number of claims against a practitioner.

Of these, experience rating, and risk rating more generally, has the potential to have a significant effect on excessively risk-taking behaviours.

Some have criticised no-fault systems for paying weak attention to moral hazard. For example, Howell et al. (2002) argued that New Zealand's no-fault accident compensation scheme has resulted in higher than optimal levels of workplace accidents than in systems where common law rights persist. The evidence for that contention is not strong, but either way, their argument primarily rests on the deficiencies of risk rating of the workers compensation fund, and not an intrinsic deficiency in no-fault schemes. No-fault schemes can apply risk rating, and they typically do so to some extent, or at least equivalently to fault based regimes.

A *potentially* important difference relevant to experience rating between common law and no-fault systems is the nature of the information insurers are able to access about the inherent riskiness of a particular driver (or class of drivers). Under fault-based systems, court judgments or settlements reveal the extent of negligence and its costs for the injured party. No-fault arrangements make no judgment about culpability for the purpose of meeting people's care and support needs, but nothing would prevent them from doing so in setting CTP premiums. In that instance, they would need to rely on information from police reports about the extent of fault, and the number and severity of past accident claims. Dionne 2001 describes how experience rating has successfully been applied in Quebec's no-fault motor vehicle accident scheme.

If fault based systems were better able to determine accurately the relative riskiness of drivers than any process that a no-fault system *could* use, then risk rating would be more effective at deterrence under a common law than a no-fault system. However, as discussed above, courts and settlements (which reflect the expected probability of success in the negotiated lump sum) are not a reliable basis for determining the appropriate level of compensation and the extent of fault, and so it is doubtful, even in this theoretical world, that the common law would possess superior information for setting risk rated premiums.

In any case, there are several practical reasons, some of them regulatory, why the impact of risk rating on moral hazard should not be exaggerated, regardless of whether a common law or no-fault system is present.

- In many instances, risk rating reflects the higher probabilities of accidents for broad groups of people with characteristics that they cannot change (like their age or gender). Deterrence primarily only works if it relates to a risky trait that people can change, although it may work to the extent that it eliminates supply or consumption of a target group. For example, if a fully risk rated premium were applied to young male drivers, it is possible this group would defer the purchase of a vehicle or switch to a safer, lower performance vehicle to the extent that this would lower their CTP premium.
- There are transactions costs of setting risk-rated premiums that limit their effectiveness in reducing negligent behaviours. Many individual characteristics that might be highly relevant to risk are often not observable ex ante (such as drink or aggressive driving, or passive adherence to OHS standards in a workplace).
- Government often place statutory limits on the potential for premiums to vary in accordance with efficient risk-rating — especially if there is a negative impact on low income groups or the supply of certain activities (box 15.4). In the case of medical indemnity, the Australian Government subsidises the insurance system to ensure premiums are not too high for clinicians. Given these regulatory and budget measures, insurers do not set fully risk-rated premiums.[18] In particular, the capacity for an insurer to deter reckless driving through a bonus/malus[19] is typically bounded.
- In the motor vehicle area, the price effects of risk-rating and the imperfect monitoring of unregistered vehicles encourages the riskiest people with the most limited resources to (illegally) opt out of compulsory third party insurance.

This does not mean that risk rating is unworkable. There may well be advantages in some forms of experience rating (such as higher premiums and larger excesses for drivers with past costly claims for which they were at fault), and relaxation of some of the government rules that limit the potential to vary premiums accordingly.

However, as already alluded, experience rating need not be the exclusive domain of common law insurance systems (administrative processes already in place mean that no-fault insurance systems have a similar capacity to apply experience rating if sought).

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[18] In New Zealand, the situation is even more striking than in Australia. Even after partial adjustments for risk, premiums for the highest engine capacity motorcycles are only around one tenth of the actuarially fair amount (Office of the Minister for the ACC 2010).

[19] A bonus is a reduction in the premium otherwise payable to reflect good driving behaviour and claims history, whereas a malus imposes a penalty, or higher premium, for evidence of bad behaviour.

Potentially, this is a useful feature of no-fault systems, especially given the significant costs of establishing a person's culpability for causing an accident under the common law.

Box 15.4 **Risk rating in compulsory third party insurance**

Reviews of CTP premiums and compensation schemes frequently state the importance of capacity to pay when setting premiums. As a result, the flexibility of insurers offering CTP motor insurance is tightly controlled. Insurers' discretion to adjust premiums by offering a bonus or imposing a malus is limited in some jurisdictions according to specific regulations creating a maximum premium, or by prohibiting zone or age differentiation, such as in Queensland.[20]

Although the compensation models adopted across jurisdictions range across modified common law schemes to government monopoly no-fault cover, premium charges are quite similar across jurisdictions when expressed as a percentage of AWE. If annual premiums start to track above 40 to 50 per cent of average weekly earnings, governments typically respond by placing additional restrictions on judicial access (through civil liability laws or other statutory provisions) or reducing entitlements (Cutter 2007). As stated in a comparison of CTP schemes across Australia:

> Clearly the compensation model in each jurisdiction is tailored to achieve an affordable CTP premium. In some cases clear interventions (eg. MACA 1999) have been introduced in order to achieve this. (Cutter 2007)

The main implication of governments seeking to create affordable and stable premiums is that insurers are unable to charge an actuarially-based 'fully funded' premium. Despite insurers' attempts to sort risk types according to a number of categories (age, experience, driving and accident record and vehicle type), this is only partially successful at sorting drivers into homogenous groups. Consequently, insurers take care to market strategically and price relative to their competitors in such a way that reduces bad risks and attracts good risks:

> The bonus/malus limitations mean that insurers are not able to charge 'sound' rates for every risk. Better risks are written via a mixture of pricing and marketing strategies, and ensuring that prices relative to competitors are where they need to be, i.e. higher than competitors for the worst risks and lower than competitors for the best risks. … The interaction with competitors is more important than technical rating …(Konstantinidis et al. 2007).

The key underwriting risk factor used by CTP motor insurers is age, and in particular, drivers under 25 years, who on average, generate a loss in excess of 100 per cent, even at the maximum allowable malus (Konstantinidis et al. 2007). Hence, CTP insurers seek to avoid such risks by charging a price for young drivers that is higher than competitors. In a non-market situation, where there is a monopoly provider (such as the government), there is no discretion to sort risks and deter less profitable drivers, but this is overcome to the extent that the single provider can deliver better risk-returns on other drivers.

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[20] For example, in NSW, if an insurer's filed base premium is set close to the reference base rate, there is greater scope to impose a penalty for malus. A premium discount is limited to 15 per cent, or 25 per cent for over 55 year olds (the MAA Premiums Determination Guidelines, Section 24 of the *Motor Accidents Compensation Act 1999).*

Given the above arguments, it is unlikely that fault-based systems address ex ante moral hazard better than no-fault systems. In some ways fault-based systems may even perform worse, such as in the presence of the high discount rates in some jurisdictions, which systematically reduces the likelihood of full compensation and efficient risk-rating by insurers. Moreover, given the lump sum nature of compensation paid out to injured people under the common law, it is possible that there is a higher risk that people seeking common law compensation exaggerate the severity of their injuries, with the costs that imposes (a form of 'ex post moral hazard').

Other measures are more likely to provide effective deterrence

In summary, there are three main reasons why fault-based systems are unlikely to strongly deter negligence compared with no-fault systems:

- people at fault who are not covered by insurance rarely have a capacity to pay compensation, significantly weakening any deterrent effects of the common law in personal injury for such people (who often tend to have the highest risks)
- by pooling risks, insurance reduces the extent to which an at-fault party bears the financial consequences of his or her action
- risk-rated insurance (including the use of experience rating) could theoretically provide incentives for care, but risk rating tends to be blunt and could, in any case, be applied in no-fault systems.

Moreover, as noted earlier, the common law is only one tool in the armoury of policy measures that can encourage better injury mitigation, with the other tools being generally more efficient (as the Commission noted in its review of workers' compensation and occupational health and safety arrangements in Australia — PC 2004).

Recognising the muted capacity of common law deterrence in the context of compulsory third party insurance, some have suggested that the common law is not well equipped to deal with the broader concept of 'accident prevention', which requires:

> …careful attention to environmental design, public education, group interaction, organisational cultures and political coordination. Any modern policy of accident prevention that does not consider these strategies will miss the important health and safety challenges of the coming century. (Gaskins 2000)

That said, the common law is likely to have some deterrence effects in some cases. As Justice Kirby (2000) has noted in respect of medical malpractice suits:

> The allegation of professional negligence is not only potentially costly. It is also personally insulting. It is emotionally hurtful. It tends to attract media coverage. It gets known around the profession. It is damaging to one's ego and practice. Defending it is distracting and time-consuming.

The question is whether the size of that effect is sufficient to outweigh the costs of the common law fault-based systems. Given the costs described later (section 15.10), and the prospect of relatively weak deterrent effects, the answer is probably no. This was also the conclusion of Professor Cane (who, among other things, is prominent for subsequent editions of Atiyah's *Accidents, Compensation and the Law*):

> There is a significant body of empirical research about the deterrent efficacy of the tort system, which can perhaps be summarised by saying that tort law has more deterrent effect in some contexts than others, but in no context does it deter as effectively as economic theory of tort law would suggest. … because there is considerable doubt about the deterrent efficacy of tort law, and given the availability of much cheaper compensation mechanisms, the conclusion that tort law is not worth what it costs is an attractive one … (2007, pp. 55–56, 69)

Given such doubts about the deterrent effect of fault-based compensation systems, the Australian Medical Association (sub. 568, p. 10) argues against the use of high premiums and claim costs as a discipline on practitioners. They cite a range of professional safeguards (including the national registration mandatory reporting regime and the health complaints system) as superior alternatives.

In any case, the policy choice is not only between two options — common law rights on the one hand, and a no-fault system with no common law rights on the other. In the Australasian context, only New Zealand has completely barred the gate to common law rights in injury cases. Most Australian insurance systems are hybrids.

15.10 Efficiency and costs

All insurance systems entail costs beyond those of providing care and support and other forms of compensation to the injured party. In no-fault systems, claim numbers are higher because people at fault also make claims, and staff also perform roles, such as coordinating care and support, not usually undertaken by insurers in (pure) fault-based systems. On the other hand, in fault-based systems, the insurers must meet the usual costs of any insurance business (claims management, financial management and so on), but also face costs associated with their own legal expenses (and any obligations to pay external legal costs).

Such costs are not necessarily wasteful, as at least some administrative 'inputs' are required to secure care and support for an injured person. However, an important policy question is the competing cost-effectiveness of fault-based versus no-fault systems. If one system can deliver equal or better services at lower costs, then the increment in costs in the other scheme *can* be seen as 'waste' in the sense that it diverts resources that could be used to help injured parties better (or to lower insurance imposts on people).

These issues are discussed below. Appendix I provides a more detailed analysis on the important matter of legal process costs.

Administrative costs

The available evidence from no-fault systems suggests relatively low administrative costs. For example, the ratio of administrative costs to premium income in NSW Lifetime Care and Support scheme was around 2 per cent in 2008-09 (LCSA 2009, p. 20).[21] It was significantly higher for the Victorian TAC scheme, which covers all types of motor vehicle accidents and some residual common law rights, at 14.1 per cent of TAC premium income in 2007-08 (TAC 2009 p. 45).[22] Administrative costs were 9.9 per cent of premium income in the New Zealand scheme (ACC 2010, pp. 18, 47). In the Tasmanian CTP scheme, general and administrative expenses were around 4 per cent of net premium income (MAIB 2010, p. 22, p. 26).[23]

The various components of administration expense items should be interpreted carefully, however, as higher 'costs' may not necessarily represent wastage depending on what the expense is incurred for and whether the outcome is achieved. For example, while no-fault systems administering long-term weekly payments face an additional administrative burden above fault-based systems that mainly pay lump sums, weekly payment of benefits has the advantage of preventing mismanagement of lump sums. Similarly, sometimes injury management and return to work research is included in scheme administration expenses.

There is some evidence that fault-based systems have somewhat higher ratios of administrative costs to premiums, *before* counting any costs associated with explicit and implicit claims for legal and other litigation costs (Cutter 2007; WRMC 2009, p. 33). That raises the question of the size of those litigation costs since they are instrumental in determining the relative cost-effectiveness of the competing schemes.

A further cost pressure on fault-based systems are reinsurance costs. Under (pure) no-fault systems, there are more claims, but these are more predictable than the

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[21] Administrative costs include all personnel costs, operating expenses, consultancy, depreciation and various other costs. The low proportion of administration expenses in premium income reflects the immaturity of the scheme, with many participants not yet living in the community and requiring coordination services.

[22] The ratio is higher in 2008-09, but affected by the one-off costs of the re-location of the TAC, and therefore not representative.

[23] additional costs were associated with accident prevention, but these are not intrinsic to the normal insurance function of the Board.

fewer but sometimes larger claims under common law fault-based arrangements, hence increasing reinsurance costs (for example, see Walsh et al. 2005, p. 39).

What affects the size of litigation costs?

The magnitude of litigation costs reflects many influences, including:

- the role of mediation, which reduces costs compared to a court hearing, since the major influence on total costs is the stage of settlement
- the duration of litigation. Some cases take several decades to resolve. Given that billable hour is the dominant billing method, each additional six months a case takes to resolve is estimated to raise costs by 7 per cent (Williams and Williams 1994)
- the complexity, novelty or difficulty of cases, which often need expert testimony); facts and expert evidence are often relied upon heavily to establish the circumstances of an accident and the legal liability of another party
- statutory limits on litigation (or its costs). Civil liability laws were changed in each jurisdiction in 2002, which among other changes, limited access to damages and the amount of damages awarded (Chu 2007). These changes are likely to have increased the costs of navigating a successful case through the now tighter legal structure:

  > … what the statistics [on the number and value of claims] do not show is whether the costs of each litigated claim has increased through more rigorous preparation — my sense is legal costs have increased. (Chambers 2007)

- the negotiating muscle of the consumer, and in particular, differences between the plaintiff who consumes personal injury legal services at most once in their life, compared with the insurer (defendant), who repeatedly consumes these services and usually maintains in-house expertise.
  - Plaintiff law firms often engage a cost consultant with specialist expertise in providing costing advice and preparing an itemised bill of costs for the law firm. Estimates available to the Commission indicate that the use of cost consultants is highest for medical negligence claims (80 per cent of claims) versus only about 50 per cent for non-medical negligence claims.
  - The Senior Masters' Office in Victoria negotiates solicitor-client costs to achieve sizable savings for their client beneficiaries in most instances. Estimates show a 15.5 per saving on these costs is achieved on average, which reflects the extensive experience of the Senior Masters' Office in dealing with plaintiff lawyers on behalf of their trustees and a detailed understanding of what constitutes reasonable fees and charges.

Some estimates of legal costs

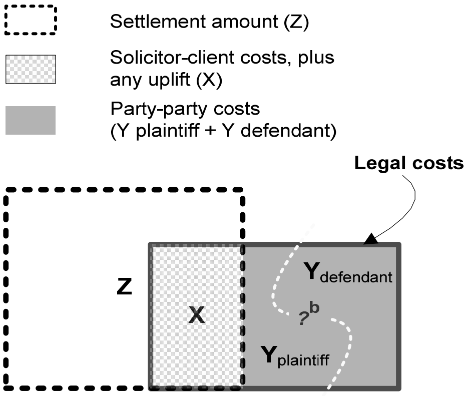
While it is straightforward to identify the factors influencing litigation costs (including fees, disbursements and charges), enumeration of them is hamstrung by a paucity of systematic, publicly available information on legal fees and charges.

Given the distribution of who ultimately bears legal costs — between plaintiffs and their solicitors, insurers (defendants) and, in turn, premium payers — the visibility of legal process costs varies but is generally poor.

Figure 15.3 is a stylised representation of how common law insurance allocates resources between the settlement awarded to a successful plaintiff ('Z') and legal processes including:

- party-party costs 'Y' (box 15.5), which are incurred separately by the defendant's insurer and the plaintiff
  - If a plaintiff is successful, they do not generally bear any party-party costs, with these costs ultimately borne by premium payers (which, if lower, could otherwise enable reduced premiums or increased benefits to injured parties)
  - If a plaintiff is not successful, they may be liable to pay the defendant's costs *and* some of their own disbursements.
- solicitor-client costs 'X' (box 15.6), including any uplift. These costs are taken directly from the plaintiff's settlement.[24]

Figure 15.3 **How do 'legal costs' relate to the settlement amount?[a]**



[a] This is a stylised representation informed by personal communication with the Victorian Senior Masters' Office. [b] The split between plaintiff:defendant party-party costs varies. For motor vehicle cases, estimates of the average ratio range from 80:20 to 60:40. For medical negligence, it is understood a defendant's party-party costs often exceed those of the plaintiff.

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[24] Although it is understood by the Commission that if a matter reaches court or if a request to have costs assessed by the court, the plaintiff may be able to recover uplift fees from the other side. This relies on the presence of a contractual agreement about uplift between a plaintiff and their legal representation.

Box 15.5 **Party-party costs**

Party-party costs are the costs of litigation that a court can order to be paid by one party to the other party. Party-party costs are sometimes calculated on the basis of the Supreme Court Scale, or a fixed costs model and may be subject to scrutiny if reviewed by a taxing officer of the District Court or a Supreme Court Cost Assessor.

Whether legal fees and charges are claimable as party-party costs generally depends on the cost item being assessed as 'necessary' and 'proper' to attain justice — reasonable charges for work reasonably undertaken. This will vary depending on the circumstances of the proceeding, and a cost may be dismissed if the legal practitioner has not used the most economic alternative (not necessarily the most convenient) to attain justice under the circumstances. As the stage of litigation proceeds, costs allowable generally increase.

In the event that a plaintiff is not successful, or an Offer of Compromise is refused and at the resolution of the case it transpires that such an offer was reasonable, there is the prospect that the plaintiff (or in some instances, the plaintiff lawyer) may have to pay (at least a portion of) the defendant's costs. Similarly, if compensation is not awarded to the injured party, it is likely the plaintiff lawyer will be 'out-of-pocket' by a significant portion of their fees otherwise be payable in the event of a successful resolution. In the long term, such losses are recouped through the profits from litigating successful cases.

In attempting to evaluate the size and nature of solicitor-client fees and charges, the Commission was presented with numerous informed judgements but, in general, estimates were not substantiated by rigorous evidence. Overseas estimates can be informative, but are not necessarily detailed to inform policy judgements in an Australian setting (box 15.7). The Commission was able to source some detailed estimates drawn from around 130 cases settled over the period 2009 to 2010 (see table 15.3).

While not necessarily providing numerical estimates, some participants argued that the costs of litigation were very significant. For example, commenting on the inefficiency of the common law in managing access to benefits, the Medical Indemnity Protection Society suggests that the requirement to find legal negligence involves:

> … an inefficient and time consuming process that dissipates resources which in our view could be better applied to outcomes rather than process. (sub. 282, p. 3)

While this view is intuitively reasonable, it is important to assess the actual evidence about the magnitude of the inefficiency. There is some evidence on the issue, but estimates of litigation costs are generally partial in nature. For instance:

- Avant Mutual (sub no. 550) suggested that the party-party legal costs in a cerebral palsy claim would lie between $625 000 and $800 000 out of compensation package lying between $8.9 and $12.3 million, depending on the circumstances of the case. This is around 7 per cent of the compensation amount but this ignores solicitor-client costs (including any uplift fees).

- In Queensland, legal and investigation costs of plaintiffs and defendants for CTP insurance amounted to between 15 and 18 per cent of the claim payments on finalised claims on motor vehicle accidents from 2002—2010 (Motor Accident Insurance Commission, 2010, p. 28).[25] In the ACT, legal costs are slightly higher than Queensland, and equivalent to 19 per cent of premium revenues.
- The ABS estimated that legal fees for personal injuries in Australia were around $1.2 billion in 2007-08, comprising around $410 million for motor vehicle injuries, $350 million for workers' compensation and $450 million for other injury claims (ABS 2009). Fees associated with 'no-win, no-fee' arrangements accounted for about 50 per cent of the total personal injury fees (assuming that 'no-win, no-fee' arrangements predominantly relate to personal injury litigation). These estimates relate only to legal fees from businesses whose activity is mainly legal services. It would ignore legal costs in insurers or other businesses whose major function was not legal.

Box 15.6 **Solicitor-client costs and uplift fees**

Solicitor-client costs are payed to the plaintiff lawyer out the award or settlement amount. Overall, there is almost no up-to-date and systematic knowledge in the public domain about these fees and charges. This is because in Australia, cost agreements (which also outline 'no-win no-fee' arrangements and 'uplift' amounts) are generally not disclosed outside of the confidential client-lawyers relationship, except if they are assessed by the court, or in the event of a dispute about costs, such to the Office of the Legal Services Commissioner.

It is common in personal injury matters for the plaintiff to retain a lawyer on a no-win, no-fee basis, which in the event of a loss, waives considerable fees. A written 'conditional cost agreement' outlines how costs are to be re-paid, which may or may not include 'uplift' — success-based fee arrangements charged as a percentage of the total legal costs (see appendix I).

Based on anecdotal information, the Commission understands that around 30 to 70 per cent of personal injury claims have a no-win, no-fee agreement associated with the claim, which are believed to generate between 15 and 50 per cent of the legal costs associated with a case. From the more comprehensive information the Commission was able to access however, it appears that around 70 per cent of cases have an 'uplift' applied, and given that not all conditional fee agreements will include an uplift, this suggests the prevalence of no-win, no-fee exceeds the upper end of most participant's expectations. In addition, the Commission found that, on average, across all claims (including those with and without an uplift applied), around 28 per cent of solicitor-client costs are accounted for by uplift fees.

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[25] Finalised claims covered a range of heads of damage (economic loss, general damages, and care and support). Claims for care, aids and appliances, and home and vehicle modifications were about 9 per cent of the total costs — or 40 to 50 per cent less than total litigation costs.

As mentioned, the Commission was able to obtain comprehensive detail on average solicitor-client and (the plaintiffs) party-party legal costs from the Victorian Senior Masters' Office (SMO). This source of evidence covered all common law systems for securing compensation in Victoria — TAC motor accident claims, workers' compensation claims, medical negligence claims and public liability (other) cases. The client group of the Senior Masters' Office that legal cost information were drawn from (table 15.3) predominantly have catastrophic-level injuries[26], and while the estimates appear broadly consistent with a-priori assumptions, it is important to note that these estimates do not include party-party costs incurred by the defendant. This means that total legal costs are underestimates.[27]

Table 15.3 **Estimates of legal costs[a]**

Based on 2009 and 2010 settlements

	Solicitor-client costs (X)	Party-party costs (plaintiff only) (Y_p)	Settlement amount awarded (Z)	X/Y_p[b]	$(X+Y_p)/(Z-X)$[c]	$(X+Y_p)/(Z+Y_p)$[d]	$X/(Z-X)$[e]
Compensation	*$ average*	*$ average*	*$ average*	*ratio*	*per cent*	*per cent*	*per cent*
0-250k	24020	34939	145023	0.69	48.7	32.8	19.9
>250k-500k	41656	44643	380357	0.93	25.5	20.3	12.3
>500k-750k	32048	36938	610682	0.87	11.9	10.7	5.5
>750k-1m	73989	96159	918418	0.77	20.1	16.8	8.8
>1m	151705	184384	3035502	0.82	11.7	10.4	5.3
Cause of injury							
Med. negligence	142224	177348	2614805	0.80	12.9	11.4	5.8
Motor vehicle	32664	40317	424465	0.81	18.6	15.7	8.3
Work	56961	46264	359445	1.23	34.1	25.4	18.8
General	52688	83454	568312	0.63	26.4	20.9	10.2
TOTAL	56916	70718	839325	0.80	16.3	14.0	7.3

[a] party-party costs are also incurred by the defendant, but the dataset did not include information on these. [b] ratio of solicitor-client costs to party-party costs incurred on behalf of plaintiff. [c] total legal costs incurred on behalf of the plaintiff as a per cent of 'in-the-hand' compensation available to the plaintiff to meet injury related losses [d] total legal costs incurred on behalf of the plaintiff as a per cent of the 'claim costs' drawn from insurance premium revenue [e] solicitor-client costs (directly paid from the settlement amount) as a per cent of a plaintiff's 'in-the-hand' compensation.

Source: Senior Masters' Office of Victoria.

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[26] Even though some settlements may appear low (less than $250 thousand), this is likely to reflect a person's age rather than a less serious injury. The data were de-identified and provided to the Commission as totals and averages for different groups of clients.

[27] If making the rough assumption that party-party costs of the plaintiff (Y_p) are equivalent to that of the defendant (Y_d), then the estimate of total legal costs provided in table 15.3, ($X+Y_p$), is 36 per cent lower than total legal costs ($X+Y_p+Y_d$) might otherwise be.

However, perhaps a more salient finding underlying the estimates provided above is:

- the extent to which legal costs comprise a larger proportion of the compensation amount when compensation is relatively low or, alternatively, the extent to which legal process costs are less significant for above average settlement amounts
- the very wide distribution in how plaintiffs fare, as measured by the spread in solicitor fees and charges paid by individuals in obtaining compensation.

In particular, looking at the proportion of solicitor-client costs taken out of each beneficiary's award, the coefficient of variation — or degree of dispersion from the average — is very large. The large spread in individual outcomes is observed even when calculated within different bands of compensation, and further supports the notion that common law compensation processes can be something of a ‘lottery’. However, it is just one uncertainty at the end of a line of uncertainties (including the initial uncertainty about whether or not another party can be liable, and hence, whether compensation is payable at all) that individuals face when the risk of acquiring a catastrophic injury is realised.

Box 15.7 **Some overseas estimates of legal costs**

Overseas studies provide some evidence about the magnitude of litigation costs. These are potentially relevant to the Australian context, though estimates can be sensitive to the nature of the tort system in a country.

- In the United Kingdom, the Jackson review of civil litigation costs found that medico-legal costs represent a very high share of total costs in some classes of personal injury. For example, data provided by the Medical Protection Society (MPS) indicated that the ratio of legal and medical costs to overall costs (which includes payouts to plaintiffs) varied from around 50-66 per cent depending on the size of the claims (appendix 22 of the review). Notably claims dealt with by the MPS outside the UK showed a nearly identical cost structure, suggesting these data may be relevant to Australia.
- In the United States, there is (dated) evidence that only 50 percent of total malpractice costs go to patients (Thorpe 2004) and that average litigation expenses associated with aircraft accidents were just under 30 per cent of total payouts (Luu 1995).
- Data from the United States suggests tort costs in 2008 were US$255 billion or 1.8 per cent of GDP (Towers Perrin 2009). Of this, personal tort cases (mainly motor vehicle injuries) represented US $94 billion. Medical malpractice was a major component of the remaining tort costs. These tort costs included legal costs, administrative expenditures of insurers, and benefits paid to plaintiffs. Administrative costs are features of any insurance system, not just ones relating to the liabilities of common law actions. Moreover, benefits paid to plaintiffs are not litigation costs, but transfers from one party to another. In past studies, these benefits accounted for about 45 per cent of the total costs (Chimerine and Eisenbrey 2005). In that case, litigation costs would be around 30 per cent of the total tort ‘costs’ identified by Towers Perrin.

The implications of costs

Putting aside other heads of damage, insurance premiums to finance claims for lifetime care and support must cover four basic costs:

(i) the costs of lifetime supports for an injured person. Two influences affect the relative size of these costs in a fault versus no-fault system. The most important is coverage. For any given insured population, the total value of these costs is lower in a fault-based system than a no-fault one, simply because far fewer people are able to make claims in the former. A second influence is the average claim, which will depend on the distribution of injury costs for at-fault and 'innocent' injured parties, and the extent of scheme generosity for a person with a given injury rating

(ii) any costs associated with coordination of care and support. These costs will typically be zero for a fault-based system, but may partly be picked up as costs in the health care and disability sector more generally

(iii) the standard administrative costs of any insurer (including reinsurance, claims management, depreciation and so on). These costs are similar for both fault and no-fault systems.

(iv) any litigation costs (whether explicit in party-party form or implicit as a share of the compensation payouts). These are zero in pure no-fault systems and significant in fault-based systems.

Table 15.4 sets out the implications for efficiency of a fault-based system that has low coverage, some legal process costs, but no care coordination costs compared with a no-fault system that covers all claims and has some coordination costs, but that has no litigation costs.

The table is illustrative, but the parameters underlying it are consistent with some of the estimates of costs provided to the Commission. There are several ways of conceptualising the inefficiency in this illustration:

- The first is the total cost per claimant associated with providing identical lifetime supports (item 14/item 2). Using this metric, the no-fault system can provide the same support and care services for 19 per cent lower costs than a fault system (item 19). This is an underestimate of the real cost differential between the two systems since the impact of the same value of support and care expenses on the quality of life of the injured person is likely to be greater under the no-fault option given that it allocates resources to coordination (item 10).

- The second is the reduction in support and care services under a fault-based system (item 20) that would lead to a cost per claimant identical to the no-fault system. The no-fault system can deliver nearly 33 per cent more services than the fault-based system for the same price (item 21). (And for the same reasons given above, this will underestimate the real service advantage of the no-fault system.)

While table 15.4 uses indicative numbers, even significant departures from the key underlying assumptions still suggest that a no-fault system is likely to be more efficient than a common law fault-based system.

Table 15.4 **Illustration of the impacts of legal process costs on efficiency**

N	*Cost category*		*At fault*	*No-fault*
(1)	Costs of lifetime care and supports per injured person ($m)[a]		2.0	2.0
(2)	People claiming (number)		200.0	400.0
(3)	Total lifetime support costs ($m)		400.0	800.0
(4)	Solicitor-client fees as a share of settlement/judgment amount (%)	(5-17)	11.0	-
(5)	Solicitor-client fees, including any uplift ($m)		49.4	-
(6)	Total value of settlement/damages award ($m)		449.4	800.0
(7)	Ratio of party-party costs to value of awards		0.17	-
(8)	Party-party costs $m		76.4	-
(9)	Ratio of care coordination costs to support costs		-	0.05
(10)	Care coordination ($m)		-	40.0
(11)	Ratio of administrative/operating costs to value of claims		0.12	0.12
(12)	Administration and operating costs ($m)		53.9	96.0
(13)	Total legal process costs ($m)		125.8	-
(14)	Total costs ($m)		579.8	936.0
(15)	Legal/medico costs as a share of total costs (%)		21.7	-
(16)	Insurance policies (million)		14.0	14.0
(17)	Premium needed to recover costs ($)		41.4	66.9
(18)	Total costs per claimant ($m)		2.90	2.34
(19)	Premium cost advantage (%)		..	19.3
(20)	Support provision associated with same premiums ($m)		1.51	2.0
(21)	Service level gain (%)		..	32.7

[a] In order to make ‘like for like’ comparisons, it has been assumed that the average injury costs of a person that cannot ascribe fault to a third party are identical to the average for a person that can identify an at-fault party.

Source: Commission calculations.

15.11 The performance of common law systems of fault-based compensation

The Commission identified a range of criteria against which to judge the performance of fault-based versus no-fault systems. Information about some aspects of the two systems is incomplete (especially in relation to costs). However, a no-fault system:

- provides much more predictable care and support over a person's lifetime, especially for people needing such supports over the longer run. In particular, no-fault insurance schemes explicitly focus on the health, functioning and participation outcomes of their clients on a life-time basis, including through care coordination, ongoing case management and monitoring client outcomes through systematic information management
- provides consistent coverage of all parties acquiring a disability through an injury, regardless of the circumstances of how the accident occurred, and recognises that most apparently at-fault parties have merely made commonplace miscalculations, rather than acted maliciously. In the event of clear recklessness, a series of disciplinary mechanisms exist, or could be augmented, to punish perpetrators, potentially extending to punitive court actions or even criminal sanctions
- does not adversely affect people's incentives to improve their functioning following an injury
- does entail reduced capacity for choice to the extent that the right to common law actions are extinguished, though it would be possible for some common law rights to co-exist with a no-fault system
- will probably not meet all people's desire for 'punishment' of an at-fault party. However, the common law does not achieve a different outcome because at-fault parties are insured, and as noted above, much apparent negligence has no moral aspect. And there are still other avenues, including police charges, loss of licence, complaints about professionals and registering of professions, such as occurs for health practitioners
- probably has an equivalent capacity to deter excessive risk by using risk (and experience) rating in providing insurance cover (and neither system is a particularly powerful force for reducing injury rates against a background of insurance, other policies addressing excessive risk taking and people's own desire to avoid injury to others)
- is likely to be more efficient (that is, more care and support for each premium dollar).

Overall, no-fault systems are likely to produce generally superior outcomes compared with fault-based systems. That said, there are many questions about how to design a no-fault injury scheme and to determine its exact boundaries and pathway to implementation. Those are the concern of the next chapter.

16 A national injury insurance scheme

Key points

- A priority for reform is the establishment of no-fault lifetime care and support for *all* catastrophic injuries. The scheme established for this purpose, the National Injury Insurance Scheme (NIIS), should:
  - provide an all encompassing system for managing the care and support needs of all people experiencing catastrophic injury
  - primarily be funded from insurance premiums and, where appropriate, include experience and risk-rating to help prevent injury
  - be structured as a federation of separate, state-based schemes.
- To coordinate the federation of individual schemes, jurisdictions will need to establish a small full-time secretariat that:
  - ensures consistency in eligibility, definitions and assessment
  - reports on services relative to the minimum benchmark of care and support services
  - manages a comprehensive database, facilitates sharing of data and ensures consistent monitoring of performance, including actuarial valuations and client outcomes
  - works to eliminate any unwarranted variations in scheme design.
- There would be merit in state and territory governments contracting out the above secretariat functions. The National Disability Insurance Agency could play an important role in this respect (noting the NDIA itself is a federated institution). It could act as a host for cooperation, assist in, and publish, benchmarking information and encourage diffusion of best practice.
- An independent review of the NIIS should occur in 2020. Apart from evaluating ways the performance of the NIIS might be improved, it should consider the case to expand the NIIS. This might include widening NIIS coverage to include other heads of damages and significant, but non-catastrophic, injuries.

16.1 Introduction

The past chapter identified many flaws in the current, predominantly common law (or fault-based) arrangements for providing care, support and other assistance to people injured in accidents. It identified the general superiority of no-fault insurance arrangements. However, that leaves many choices about the exact scope and design of a new National Injury Insurance Scheme (NIIS), involving questions about:

- the severity of injuries covered (all, serious, catastrophic?)
- the various heads of damage that might be covered (care, economic loss, pain and suffering?)
- whether common law arrangements might coexist with a no-fault scheme
- whether some payments for heads of damage in what is generally a 'no-fault' scheme might take account of fault in determining the scale of the payments.

In the Commission's assessment, the priority for reform is the establishment of no-fault lifetime care and support for *all* catastrophic injuries. This is the key focus of the policy changes proposed by this chapter, which are given effect through the staged implementation of a NIIS. By removing much of the focus on litigation as the current mechanism for seeking compensation, and extending cover to people catastrophically injured but unable to obtain any compensation to fund their lifetime care and support needs, the NIIS will:

- provide greater fairness and more certain outcomes for all people newly affected by such life-changing injuries
- enable meaningful change to the continuity and coordination of care and support, facilitating better health and participation outcomes over the course of an injured person's life
- reduce reliance on social welfare services and supports that, given the complex and specific care needs of people with catastrophic injuries, are more likely to result in inadequate care and support arrangements and lost opportunities for forward-looking injury management.

Beyond the significant undertaking of universal lifetime care and support for people with catastrophic injury, there are numerous options to extend the scope of cover provided by the NIIS. These are important considerations that frequently balance a range of complex issues and options. The Commission has not made specific recommendations in this inquiry about the exact direction of further reforms, mainly to ensure that the NIIS is up and running and its performance better known before additional changes take place. That said, the merits of various policy options to extend the scope and functions of the NIIS are summarised within this chapter and detailed more comprehensively in appendix I. To facilitate improvements to the NIIS over time, and within that context, evaluate the case for extending its coverage, an independent review of the NIIS is proposed for 2020 (draft recommendation 16.5).

16.2 Implementing a no-fault approach for lifetime care and support of all catastrophic injuries

Given the findings of chapter 15, probably the least contentious issue is in relation to lifetime care and support for people experiencing catastrophic injury. (Care and support includes long-term care and any medical/hospital expenses, home modifications and vocational rehabilitation.) This is the area where many of the flaws in common law, fault-based arrangements are experienced most acutely — inequity, delay, uncertainty, and poorer outcomes. Catastrophic injuries largely affect young people, with around 70 per cent of those affected under 30 years old, so the effects of the injuries on the life of the people concerned are prolonged, as well as extreme in any instance (Walsh et al. 2005, p. 2). The average duration of a major injury claimant in the Victorian Transport Accident Commission (TAC) is around 30 years.

To avoid many of the deficiencies of common law compensation systems, and improve outcomes for people with catastrophic injuries, there are strong grounds for governments to create a no-fault system of nationally consistent care and support arrangements for catastrophic injuries (the NIIS). The financing of claims would be jurisdictionally based, as would scheme management and operation, though a federated approach would ensure that the level of benefits and the standard of care provided by individual schemes are subject to minimum reasonable benchmarks.

State-based schemes should draw on the best arrangements already in place around Australia, and extend their scope so that all catastrophic injuries are insured. This would include motor vehicle accidents, medical treatment, criminal injury and general accidents occurring within the community or at home. A person could acquire an identical disability from an accident in any of these contexts, and as such, there is a good rationale for equal insurance and access to care and supports.

Existing institutions like the Victorian TAC and NSW Lifetime Care and Support Authority (LTCSA) should expand to include the management of other catastrophic injuries in those jurisdictions, including medical treatment injury, general injuries arising in the home or community and criminal injury. Tasmania and the Northern Territory could also build on their existing no-fault structures for motor vehicle accidents. As a small jurisdiction — with few catastrophic injuries — the Australian Capital Territory could consider contracting out the management of catastrophic injuries to another serious injury scheme, using premium income as the funding source. Queensland, Western Australia and South Australia would need to either establish a new body to administer their scheme or significantly expand the role and functions of an existing structure, such as the Motor Accidents Insurance Commission in Queensland.

While it is proposed that existing workcover schemes would stay in place, state and territory governments could transfer the management of the small number of people experiencing catastrophic injury to their NIIS scheme — in effect, contracting these cases to the NIIS. Existing workcover schemes have performed well at preventing such injuries but are not well geared to provide coordinated lifetime care and support for catastrophic cases.

No-fault insurance for catastrophic injury would mean that common law actions for damages associated with lifetime care and support would be extinguished. The premise for this is that the goal of a no-fault scheme is to provide high quality care and supports, making redundant the uncertain and costly process of accessing any additional supports through the common law. This is separate to whether or not the right to sue for economic losses, such as income, and non-economic losses, such as pain and suffering, should be retained — a matter taken up in section 16.2 and appendix I.

Structuring no-fault catastrophic schemes under an NIIS

The creation of an NIIS should provide an all encompassing system for managing and bringing together the care and support needs of all people experiencing catastrophic injury. The structure of the NIIS, and in turn, the way it operates and interacts with its participants, is especially significant in the context that care and support needs of people with catastrophic injury are typically lifelong. Well-built relationships and strong governance will be decisive factors in the realisation of scheme objectives over the long term. In particular, no-fault catastrophic injury schemes under the NIIS should use a governance structure and case management system that:

- provides coordinated services to people and creates specialist centres of excellence that are otherwise lacking (for example, trauma centres)
- focuses on the long-term liabilities of care and support, rather than costs or payments applying to any given period (with the latter typical in the broader disability and health system). That focus has the advantage that scheme managers are likely to be less tolerant of unwarranted cost pressures. A cost shock might seem to be small at the instant they appear, but a long-term actuarial model can reveal the high cumulative effects on liabilities.[1]

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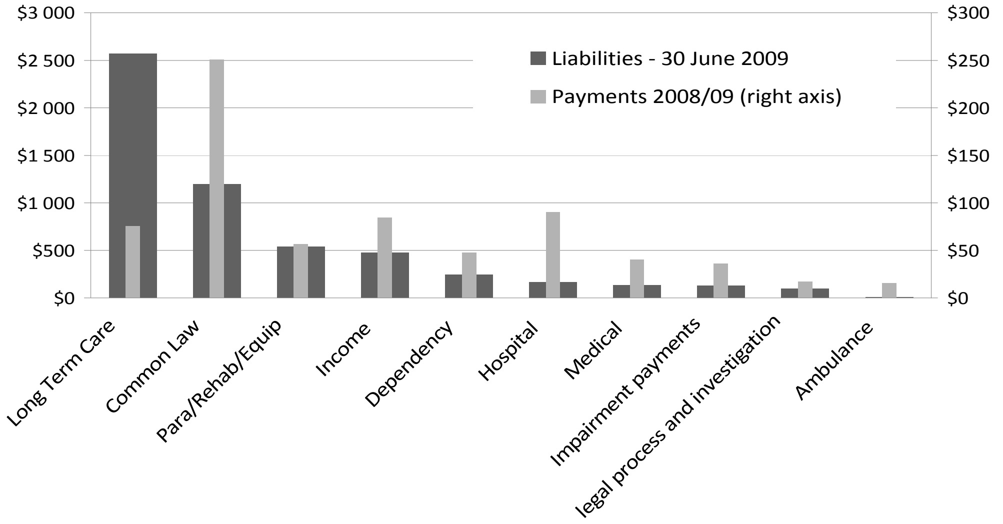
[1] Suppose that a cost of a scheme is around $500 million each year, and that costs are expected to grow by 6 per cent in nominal terms each year forever. Suppose that the discount rate is

Figure 16.1 shows how the relative contribution to a scheme's future liabilities differs from the spending on such benefits in a given year. Long term care is the main source of Victorian TAC future liabilities, even though other benefit types are more 'expensive' in the short term, such as one-off common law damages

- is data-rich, allowing more evidence-based judgments about the best way of improving services to, and outcomes for, participants; and in discovering opportunities for early intervention and injury prevention. Since data are continually collected, monitoring of cost pressures and outcomes can be done in real time. Similarly, no-fault schemes acquire expertise in proactively managing care and support needs, including by predicting the potential seriousness of the injury within days of an accident and promoting early interventions where appropriate.

Figure 16.1 **Liabilities are mostly long term care**

$ million



Data source: TAC estimates.

These features of a NIIS go beyond addressing the various deficiencies of common law approaches to meeting people's long term care and support costs. In addition, a no-fault lifetime care approach should take into account people's individual circumstances, and include a greater role for self-directed funding

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7 per cent. In that case the present value of the liabilities can be shown to be 107×500 = $53.5 billion. Now suppose that a small (but permanent) cost pressure of 1 per cent occurs in year 1. In the year in which it occurs, it costs $5 million — not a lot relative to the overall scheme cost in that year, and easily overlooked by a manager with an eye on current performance. However, a permanent shock of this magnitude means that the present value of the stream of future costs is now $535 million more. So the present value of that 'small' cost pressure is equivalent to more than the entire cost in the year in which it first occurred.

and self determination of care and support. The Commission proposes that the NIIS (and NDIS) would incorporate these features, though the extent to which, and pace of adopting self-directed funding in accident schemes should be based on the experiences from their earlier introduction in the NDIS (chapter 6). Chapters 7 and 10 address the governance and data issues in more detail.

Moreover, there are significant advantages in having fully-funded accident insurance schemes. In fully-funded schemes, an amount equal to the present value of the expected future liabilities of a newly injured person would be transferred to the scheme fund. This issue is discussed more fully in the section on how NIIS claims should be financed.

What might the costs be?

The annual costs of reform in this area have been estimated at around $500 million in 2004-05 (Walsh et al. 2005, table 16.1). These are costs that would need to be reflected in premiums. The real costs would be less because there would be savings to the Australian Government from reduced use of publicly-funded Medicare and other services, with estimated savings of $70–$80 million (Walsh et al. 2005, p. 25). Further savings could also be expected as a coordinated lifetime care scheme would produce better health and wellbeing outcomes, reducing long-run usage of services, including of income support.

The estimates in table 16.1 are for 2004-05 and so only provide a guide to the likely current costs. Costs are determined by many factors, including the wage costs of attendant care, population growth, income effects that drive increased motor vehicle ownership and increased usage of health services, and catastrophic injury rates. Over the shorter run, changes in the cost of capital and reinsurance, and competition in the insurance industry also affect premium rates. Given these multiple effects, the Commission has not sought to re-estimate the costs with any great precision. However, a very rough indicator might be the growth in (absolute) nominal GDP since 2004-05. That would suggest net annual costs of a comprehensive scheme of around $685 million or around $31 per Australian. It should be emphasised that this is a ball park figure in the absence of more detailed evidence. It is notable, for example, that average CTP premiums for Queensland actually *fell* from 2003-04 to 2008-09 (MAIC 2009, p. 22).

Assumptions about the quality and adequacy of care also underlie estimates of costs, and differences on this count equally affect comparisons of the cost effectiveness of fault-based vis-à-vis no-fault schemes, including increments in costs required to reach a minimum benchmark in service quality under the NIIS.

Coverage of all catastrophic injuries would lead to significantly higher costs in some jurisdictions. In particular, Western Australia and the Northern Territory would be expected to experience significant percentage increases in CTP premiums. In the case of Western Australia, the resulting premiums would still be lower than many other jurisdictions.

Table 16.1 **Estimates of the Australia-wide additional costs of a lifetime care and support scheme for catastrophic injuries**

$million per annum, 2004-05[a]

			Medical treatment injury			
	Workplace injury	*Motor vehicles*	*Medical indemnity*	*Medical misadventure*	*General injury*[b]	*All*
NSW	0	0	-3	25	101	123
VIC	0	0	-1	16	66	81
QLD	4.5	45	1	13	53	112
SA	0	32	1	5	20	58
WA	2.6	56	1	6	26	89
Tas	0.4	0	0	2	7	9
ACT	0	4	0	1	3	8
NT	0	8	0	1	5	14
Australia	8.5	145	-1	69	281	494

[a] The costs for a no-fault motor vehicle scheme for NSW in 2004-05 is shown as zero. In fact, the costs of establishing a scheme were estimated as $68 million. However, since then a no-fault scheme has been introduced. Since the purpose of the table is to indicate the rough incremental costs of introducing a comprehensive lifetime care and support system in the near future, the fact that NSW has already established a lifetime system for motor vehicles must be netted out of the calculations. [b] includes criminal injury.

Source: Walsh et al. (2005).

For the Northern Territory, premiums would be around 40 per cent higher than the average Australian CTP premium (Walsh et al. 2005, p. 53). This reflects the special circumstances of the Northern Territory, with a high serious injury accident rate (box 16.2), and also that current rates of non-claiming by Indigenous people are high, who are also disproportionately involved in accidents. Indigenous Territorians would often find it hard to contribute premiums of this level, and large increases might have the perverse impact of increasing rates of non-insurance among this group. Meanwhile, non-Indigenous Territorians would bear premium charges that included large cross-subsidies to Indigenous people.

As recognised more generally in Commonwealth Grants Commission processes, there are grounds for Australians as-a-whole to contribute more to those jurisdictions facing special disadvantages. Such involvement would be against the background of the Australian Government's already strong involvement in coordinated policies to address Indigenous disadvantage. In that context, there are grounds for the Australian Government to provide a subsidy to the Northern Territory to reduce the costs of a comprehensive catastrophic injury scheme.

Box 16.1 **The challenge of reducing serious road injuries in the NT**

Tackling the rate of serious injury and fatal motor vehicle accidents in the Northern Territory is a complex challenge. The apparent causes are multiple and often overlapping, involving alcohol and drug use, excessive speed and driver fatigue

Overlying these factors is the difficulty that the Northern Territory is a large geographic area and has a sparse population. This makes monitoring and enforcement of road safety difficult and more costly. Attitudes among NT drivers towards responsible road use and safety are suggested to be poor, with the severity of injuries increased by the non-wearing of seatbelts and the driving of over crowded and unsafe (and unregistered) vehicles. Indigenous Territorians are over represented in serious injury statistics.

It is estimated that the annual cost of serious injuries caused by motor vehicle accidents in the Northern Territory is $145 million, with 9 people seriously injured on average each week. This cost would be even higher if more Indigenous people sustaining serious injuries were to access services and supports appropriate to their needs.

Official strategies of the Northern Territory police to address the problem include:

- intelligence-led traffic policing capacity, and increased monitoring and reporting, including building capacity within NT police and partnerships with other agencies
- targeted education of vulnerable road users
- increased drink and drug driving enforcement
- increased enforcement of speeding, not using seatbelts/restraints, using handheld mobile phones, driving unsafe motor vehicles and other unsafe practices.

Source: NT Police Road Safety Strategy 2008–2013.

While addressing the consequences of catastrophic injuries for Indigenous people — who are often in remote locations with limited services and who tend not to make claims — is inextricably tied to the dilemmas in providing other services (chapter 9), reducing the rate of serious injury motor vehicle accidents should be a central focus of the Northern Territory Government. Further speed limit reductions could be an effective first step to reduce serious injury road accidents. Figures of the Northern Territory Police, Fire and Emergency Services show, in the two years following the introduction of 130km/hr speed limits in 2007, there was a 25 per cent reduction in fatal accidents, 44 per cent fewer 'hospitalised' accidents and 77 per cent fewer 'minor injury' accidents (NTPFES, Media Release, August 2009).

How should NIIS claims be financed?

The NIIS should be funded from a variety of sources, but mainly from existing insurance premium income sources. The appropriate funding source would broadly depend on the jurisdiction and the cause of accident and, if appropriate, to enable risk rating of the insurance premium and provide efficient incentives for safety and injury prevention. As discussed in chapter 15, in principle, a risk-rated premium makes adjustments for the different risk profiles of individuals to reflect their expected contribution to the costs of injury. Full upfront funding from insurance premiums also has the advantage of providing a sustainable and targeted funding source, while supporting sound scheme decisions to minimise future liabilities.

Apart from financing of NIIS claims through the insurance pool, funding of residual claims, not specifically covered by insurance would rely on new sources of income. While this would entail additional contributions from state and territory governments, including for scheme establishment, this sits within the broader context of the Australian Government's role in funding the significant additional resources required for disability services under the NDIS. To this end, the additional funds required for injuries are a relatively lesser burden on state and territory budgets. For all causes of injury, a significant source of revenue would be savings in legal costs (which account for a significant component of premiums in fault-based systems — chapter 15).

As individual jurisdictions would be responsible for underwriting their scheme under the NIIS, it would be a matter for each state and territory to choose between alternative sources of financing NIIS claims, including any other specific sources appropriate within their jurisdiction.[2] Nevertheless, this chapter suggests a range of financing options for each cause of catastrophic injury — transport, medical treatment, occupational and general injuries (including criminal injury).

Transport accidents

Motor vehicle claims under the NIIS should be funded from existing insurance products made mandatory for owners of motor vehicles (namely compulsory third party motor vehicle insurance). Jurisdictions would select their preferred mechanism for funding. For example, in NSW a levy is imposed on the CTP premium collected by the seven private insurers operating in the market, whereas in Victoria, the entire premium is levied by the TAC as the single statutory insurer. (The potential to phase in greater risk and experience rating of premiums is discussed later).

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[2] For medical injuries, however, the Australian Government is a key stakeholder.

The Commission envisages that rather than just motor vehicle accidents, catastrophic transport accidents more generally should be covered under the NIIS. At this stage, an exact source of funding has not been detailed however, as the various subtleties of different forms of non-road transport would need to be evaluated more thoroughly — including, for example, aircraft accidents that interface with international pooling arrangements. The Commission will examine this issue more closely after the draft report.

The Commission seeks feedback on a workable funding arrangement for catastrophic injuries resulting from water, air and railway modes of transport.

The administrative efficiency of alternative approaches to secure funding for these other sources of transport accidents is an important consideration. For example, tracing a source of funding on an individual accident basis (within the context of current fault-based liability insurance products) would be complex and costly to administer. Imposing a flat levy on insurance premiums upfront, on the other hand, is likely to be more achievable, but more information about the level of the levy required to cover catastrophic injuries on a no-fault basis, and impacts on premiums and underwriting, is required.

Medical accidents

Most participants to this inquiry support the principle of no-fault provision of lifetime care for people injured through medical accidents. For example, the Medical Indemnity Protection Society (MIPS) criticised the current common law negligence ‘trigger’ for access to care and support funding of health care incidents, stating that it:

> … generally requires an arguably inefficient and time consuming process that dissipates resources which in our view could be better applied to outcomes rather than process. … MIPS' view is that a clearer and more cost and time efficient trigger than "negligence" is needed to determine access to obtaining benefits under any disability long-term care and support scheme. … It is our view that there is considerable scope within existing funding for appropriate long-term care costs of patients who become significantly disabled if more efficient processes for determining access to resources and funding of those resources are implemented. (sub. 282, pp. 3, 5).

The introduction of no-fault lifetime care of catastrophic medical accidents under the NIIS (and the associated removal of the head of damage for future care costs), will remove a proportion of the frictional costs associated with determining the quantum of damages in medical negligence claims. The extent of such savings is not certain, but it is reasonable to assume that the litigation process should be significantly more straight forward, requiring less reliance on predicting life expectancy[3] and a person's ongoing health status and care requirements.

Even so, moving to no-fault cover for catastrophic medical accidents is unlikely to come at zero cost, as the savings in legal process and disputes may not be sufficient to *fully* meet the increase in coverage. This may place some pressure on medical indemnity premiums if arrangements for funding the larger number of claims were drawn solely from such insurance.

But the impact on premiums is not straight forward, and especially not in the context of various elaborately-designed taxpayer-funded schemes specifically directed at supporting the affordability of practitioners' medical indemnity premiums (box 16.2). It may be possible to redirect a proportion of these government subsidies, while still retaining some measures, such as a version of the Australian Government's Premium Support Scheme, to provide an assurance that premiums paid by practitioners would not increase too substantially. Another option raised by the medical sector was a contribution to funding by taxpayers.

That measures to support the affordability of medical indemnity premiums already exist is proof that any additional pressures on premiums would give rise to concerns within the medical sector. This message was corroborated by comments from health practitioner groups and medical indemnity insurers. For example, MDA National cautions that any new scheme:

> … should not result in an increase in medical indemnity insurance premiums for doctors. Depending on the interaction of the NDC&SS [national disability care and support scheme] with medical indemnity insurance, there is a risk that the NDC&SS will increase medical indemnity insurance premiums for our doctor members. The cost of premiums will need to be passed on to patients and the community. Following the introduction of tort reform in 2002/2003, the medical indemnity insurance industry has stabilised and the premiums for our doctor members have become more affordable. This has encouraged the provision of medical services, and minimised the withdrawal of services in certain areas of clinical practice, to the benefit of patients and the community. (sub. 445, p. 1)

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[3] Damages for loss of earning capacity are calculated over the length of a person's projected 'working life'. Hence, unlike care costs, this head of damage does not rely as acutely on estimates of life expectancy.

A number of participants have specifically cautioned against the removal of taxpayer-funded subsidies. For example, the AMA stated that:

> …insurance support arrangements should be maintained, particularly if the right to pursue legal compensation is preserved. It is possible to argue for a redirection of Commonwealth and State monies which currently are dissipated via the transactional costs of current compensation systems toward supporting the cost of a no fault National Disability Scheme, especially if there is an overall reduction in costs for Medical Indemnity Insurance. However, the extent to which a new no fault scheme will impact on indemnity insurance premiums for classes of medical professionals is unpredictable, and it will be necessary to ensure that the affordability of medical indemnity insurance is maintained. At the very least, the Premium Support Scheme should be kept in place to ensure affordability of indemnity insurance for all doctors. (sub. 568, pp. 9–10)

Box 16.2 **Existing Australian Government subsidies for medical negligence claims**

Exceptional Claims Scheme — covers the cost of a doctor's private practice claims above the limit of their medical indemnity insurance cover (generally $20 million). No claims have been submitted against this scheme.

High Cost Claims Scheme — reimburses medical indemnity insurers 50 per cent of the insurance payout associated with each claim exceeding $300,000 (up to the limit of the practitioner's cover, at which point the exceptional claims scheme applies). This is a direct measure to ensure premium affordability and predictability, which also reduces medical indemnity insurers' reinsurance costs associated with funding large claims. In 2009-10, Medicare Australia administered payments of $21.4 million for the 98 claims received, with the slightly fewer 82 claims in 2008-09 costing $19.5 million.

Premium Support Scheme — ensures doctors pay only 20 cents for each dollar of premium beyond that equivalent to 7.5 per cent of their gross income from private billings. Government payments are then made to medical indemnity insurers to cover the gap. In 2009-10, 2439 practitioners were eligible under the scheme, receiving $17.2 million in payments towards their insurance costs, and with administration expenses of $2.4 million.

Run-off cover scheme — requires medical indemnity insurers to provide free run-off cover for eligible doctors (mostly those retired, with permanent disability, or through death or maternity), with the cost of associated claims funded by government from a levy imposed on insurers' medical indemnity insurance income. Run-off cover occurs because professional indemnity insurance is provided on a 'claims-made' basis, so there is a need for insurance cover, even if a practitioner is no longer working in private practise. In 2009-10, there were 28 claims received, with a total benefit of $2.1 million paid.

Source: www.health.gov.au; Medicare Australia, Annual Report 2009-10.

Similarly, MDA National cited the importance of government assistance, estimating that the Exceptional Claims Scheme (ECS) and the High Cost Claims Scheme (HCCS) result in an overall reduction in medical indemnity premiums for their members of around 10 to 15 per cent. It suggested that:

> … the decision to remove or modify any of the existing Government support schemes should only occur once the impact of the NDC&SS [national disability care and support scheme] is actually understood. We submit that in the transition phase the existing schemes should be maintained and should apply after the NDC&SS. In particular, we submit that the HCCS should be maintained although it may be possible to increase the threshold at which the HCCS applies from $300,000. (sub. 445, p. 2)

Some participants have outlined specific preferences about the particular financing mechanism used to fund NIIS claims. For example, MDA National submitted that it would be inappropriate and impractical to fund the scheme through a levy on medical indemnity insurance premiums. In particular, they believe such a levy would be approximate in nature and lead to doctors having to fund the cost of care for cases which they did not cause:

> Even if at an overall level a levy on medical indemnity premiums did not increase insurance costs then it is highly likely that it will do so at a specialty group level with premiums for some groups increasing while premiums for other groups decrease. This is likely to have medical workforce implications and may result in the withdrawal of medical services in certain areas of practice, such as obstetrics. (sub. 445, p. 3)

MIPS suggested that the Australian Government should take full responsibility for funding medical incident cases under the NIIS, including from savings associated with government support measures:

> Future care and medical costs relating to significant adverse medical events should be funded 100 per cent by the Commonwealth noting:
>
> - There can be significant savings from the current High Cost Claims Scheme from process savings and from reduced (from otherwise) premium support scheme payments (because of the reduction in premium required due to reduced risk required to be funded).
> - The Commonwealth through its Medicare payments is contributing to health care practitioners' funding of their indemnity arrangements.
> - In the absence of direct Commonwealth funding any increased costs of indemnity arrangements are likely to be passed on by health professionals and will therefore lead to pressure on Medicare payments, health insurance and increased direct patient contributions.
> - The Commonwealth is intending to take over responsibility for public hospitals.
> - Such a funding approach will be more efficient and transparent than the current process
> - The Commonwealth through Medicare, Carers' Allowances, Pensions, etc. already underwrites the majority of care and support for non-compensable matters. (sub. 282, p. 6).

However, while the proposal by MIPS above would reduce reliance on government supports, this stems from a reduction in practitioners' premiums from the assumed full government funding of care and support costs for catastrophic claims covered under the NIIS. It is not clear how full taxpayer funding, the continued availability of measures to support the affordability of premiums (even if less use is made of them) and reduced premiums for practitioners represents an equitable outcome.

This raises the question of what mix of sources for financing medical injury claims under the NIIS is most appropriate?

Funding from medical indemnity premiums

To the extent that a medical injury results from a health practitioner's error, there are sound reasons why medical indemnity insurance funds should contribute to at least some of the costs of claims under the NIIS, particularly in the context of risk rating. While some medical injuries are an unavoidable consequence of supplying such services, there may be valid reasons why the cost of such injuries should be reflected in practitioner's costs of supplying services. Equally, however, this would have to be balanced by any impact on the supply of medical services.

While ultimately consumers of health services pay for at least some of the cost of higher premiums; there are benefits from the distribution of financial responsibility resting with indemnity insurers (and healthcare providers through the pricing of insurance policies) in a way that can encourage risk management and efficient precautionary behaviour. While this would be in addition to the robust framework for registering and disciplining health professionals that already operates, it can provide a useful additional mechanism to reinforce the high value of patient safety. (The process of adverse event notifications in New Zealand provides an example of how a no-fault scheme can assist with fostering public safety and reporting of risks — box 16.4.)

That said, links to patient safety and the ability to risk rate premiums does not necessarily mean *all* costs should be borne by health practitioners — reflecting the broader benefits to the public associated with the anticipated increase in coverage and reduced reliance on social welfare services and the NDIS.[4]

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[4] Based on the criteria and experiences of the New Zealand scheme, a no-fault insurance scheme could increase cover to around 5 times that which it is currently.

Funding by taxpayers

Hence, there are reasons for some funds, including establishment costs, to be contributed by government. Although the extent of any taxpayer money contributed by government should reflect that:

- no-fault coverage of medical incidents would include cases where medical error was not necessarily the cause of injury, but where the particular injury resulting from that treatment is not a *usual* or *expected* consequence of that treatment
- significant taxpayer revenues are already used by the Australian Government to subsidise medical indemnity premiums and the cost of medical negligence claims. Although the extent of subsidisation, such as through the high cost claim scheme, could be expected to fall in light of the reduced rate of larger claims, which would instead be covered under the NIIS, it may be appropriate to restructure access to subsidies once the scheme is fully established. For example, increase the threshold to access PSS payments and over time reduce the rate of the subsidy, whilst still ensuring overall affordability for practitioners. This should be the subject of review
- state and territory governments implicitly contribute taxpayer money through self-insurance arrangements for public hospitals
- taxpayers solely bear the costs of the NDIS. To the extent that more targeted sources of funding are available and appropriate to fund NIIS claims, these should be used to reduce any additional direct burden on taxpayers.

Box 16.3 **Medical indemnity premiums**

For claims notified in 2007-08, the ultimate claims cost was over $200 million, averaging $81 690 per claim and with just over 3 per cent of claims exceeding $0.5 million. Total premium revenue in the 2007-08 underwriting year was around $306 million, or on average $5392 per premium, which has gradually declined since it peaked at $7500 per premium in 2002-03 (especially if adjusting for real prices).

There is significant variation in the average cost of premiums across specialty groups however, in 2008-09 ranging from $2667 for a non-procedural general practitioner to $48 910 for an obstetrician. Similarly, there is significant variation in the average written premium across jurisdictions — highest in NSW at 24 per cent higher than the national average, but less in the Northern Territory, South Australia and Tasmania. Differences among jurisdictions mainly reflect the different common law regimes operating within each state and territory.

Reflecting the complete removal of common law rights to sue for personal injury in New Zealand, the cost of medical protection insurance is far less than in Australia — selling for around AUD$1270 for general practitioners or AUD$270 for nurses in 2010.

Source: ACCC (2009b); Medical Protection Indemnity Society (2010).

Re-direct government subsidies?

As already alluded, the third possibility for funding NIIS cover of catastrophic medical incidents would be to modify aspects of how existing government subsidies operate. For example, as indicated by MDA National (sub. 445, p.2), once the scheme is fully established, it may be possible to increase the threshold at which the HCCS applies. In effect, this would increase the cost of claims that insurers cover themselves up to the attachment point of their reinsurance. Similarly, it may be possible to increase the threshold at which PSS payments are available, and reduce the proportion of the premium costs above that threshold which is contributed by taxpayers. Of course, any changes to the complex set of arrangements supporting the affordability of medical indemnity insurance would need to be thoroughly evaluated in a review.

In summary

There are a variety of funding options for funding catastrophic medical accidents covered under the NIIS, all of which involve significant complexities. Nevertheless, at least in the interim, a funding source must exist to make progress in this area.

The Commission seeks feedback on practical interim funding arrangements for funding catastrophic medical accidents covered under the NIIS.

Once the scheme is fully established, Australian governments should examine the scope to finance NIIS claims for catastrophic medical accidents from re-weighting government subsidies and premium contributions.

What 'medical injuries' should be covered by the NIIS?

The Commission expects that at least some concerns from participants about the affordability of medical indemnity insurance premiums in the context of financing NIIS claims reflect uncertainty about the number and nature of claims that would be covered under the NIIS. That is, to what extent would the NIIS provide:

- truly no-fault cover for sufficiently unexpected and unusual injuries resulting from a practitioner's advice, treatment or diagnosis; or instead
- observe some notion of a practitioner's standard of care to the patient and whether that may have caused a severe adverse outcome for the patient?

The New Zealand Accident Compensation Scheme previously used a criteria for covering medical incidents that took account of a health practitioner's adherence to a standard of care (fault), but this was changed in 2005 following an interagency review commissioned by government in 2002. The review found that the medical misadventure criteria (established under the 1992 legislation):

- were arbitrary, slow and confusing
- did not align with the Woodhouse principles, given the incorporation of fault and levelling blame on the health practitioner, which was out of kilter with the ethos of a no-fault scheme
- created unfairness, with poor and inconsistent coverage resulting from the focus on how an injury occurred rather than the impact of the injury on the claimant.

While it is not possible to definitively attribute New Zealand's introduction of the new criteria in 2005 to *all* of the change observed in claims for treatment injury, it is reasonable to conclude that coverage substantially increased under the new legislation.

- From 1992 to 2005, an average of 3 000 claims were received by the ACC each year, with around 40 per cent accepted (around 1200 claims); although from 2001 to 2004, the rate of acceptance was even lower than this. Around 15 per cent of claims accepted were because of medical error and 85 per cent were for medical mishap.[5]
- Following the new legislation in 2005, the average number of claims has increased three fold to around 9,000 per year, and the acceptance rate is around 65 per cent (around 5850 claims per year or in the order of 4–5 times as many claims as pre 2005).
- The Commission understands that most of the growth in claims was for non-catastrophic injury, with catastrophic treatment injuries apparently not markedly changed and remaining stable (ACC 2011, personal communication).

The new criteria for treatment injury, which replaces the previous criteria for medical misadventure, does not investigate a health practitioner's clinical practice other than to evaluate whether there is a physical injury and whether that arose out of treatment (box 16.4). A central motivation for this is to foster a culture of safety, including

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[5] Medical error is when the practitioner failed to provide a standards of care reasonably expected under the circumstances. Medical mishap is when, as a result of appropriate and timely medical treatment, a severe and rare injury is sustained. These terms were defined in section 5 of the NZ Accident Rehabilitation and Compensation Insurance Act 1992, but are no longer current.

early, open disclosure of patient injury. As stated by the Malcolm Report (2004) in relation to reform of medical misadventure in New Zealand, there is a need to:

> … move from 'medical error' to a culture of safety rather than blame in what is an otherwise no-fault insurance system. (Malcolm and Barnett, p. 10)

In a similar vein, the move away from the punitive system of finding medical error towards a true no-fault system for treatment injury in New Zealand was motivated so as to shift the focus from an individual practitioner's failure and more to the need to create safe, supportive systems of care at the organisational level — a process widely called 'clinical governance'. This aligns with evidence that a significant proportion of claims against public hospitals in New Zealand were organisational in character (Malcolm and Barnett 2004, p. 16).

Reflecting these considerations, the Commission envisages the NIIS would:

- cover the lifetime care and support needs of medical injury claims regardless of whether or not the practitioner was 'at fault', but based on the injury being catastrophic in severity and a sufficiently unexpected or unusual outcome from medical treatment (with some possible exclusions relating to discretionary consumption of medical services, such as some plastic surgery procedures or consumption of health services abroad). Common law rights to sue for damages relating to future care costs should be removed
- not cover some catastrophic disabilities in the event that an administratively applied criteria determines the treatment or care provided was delivered in a timely and appropriate manner and there is no clear reason for the condition, other than a genetic factor or underlying health condition. Any claims falling within this category, but still in need of services and supports, would be appropriately covered under the NDIS.

The Commission seeks feedback on an appropriate criterion for determining coverage of medical accidents under the NIIS.

The capacity of an administrative, expert panel to make timely and efficient decisions is also relevant, particularly to identify injuries that are:

- an 'unexpected' or 'unusual' outcome of treatment
- either wholly or substantially the result of an underlying health condition, rather than the medical treatment itself.

One of the most complex areas for deciding cover for treatment injury is birth cases, particularly cases of cerebral palsy where it can be difficult to identify whether an aspect of the ante natal or intra partum medical care caused the cerebral palsy. In addition, emerging research continues to shift medical opinion in this area. In New Zealand, if paediatric advice does not identify an apparent cause, cover for treatment injury is denied, and the disability is instead attributed to an underlying condition of the child or the birth process itself, such as underlying prematurity that could not have been avoid from any treatment intervention.[6]

The advice the Commission has received from New Zealand's Treatment Injury Centre suggests that although some cases are more complex than others, it is usually possible to identify whether or not a birth injury has occurred with adequate certainty and timeliness. Nevertheless, any potential for errors in this process should be monitored and reviewed over time and, in any event, would be tempered by the availability of the NDIS as a comprehensive system for providing care and support for disability.

Box 16.4 **Treatment injury in New Zealand**

Under the New Zealand's Accident Compensation Corporation Scheme, a treatment injury is any injury resulting from treatment by a registered health professional, including from disease prevention, delays or failure to diagnose, a delay to follow-up or refer, or the failure of equipment used in treatment.

The treatment has to give rise to a physical injury, and is not covered if the injury either wholly or substantially relates to an underlying health condition or other genetic factor. The fact that the treatment did not achieve the desired result does not itself constitute a treatment injury.

In house clinical advisors (registered health professionals with clinical experience) make decisions about coverage. Generally, claims involving allegations of delay or failure to treat or diagnose will require external advice.

The ACC (as the statutory insurer in New Zealand) has a role to notify the Director General of Health of a risk of harm to the public based on claims information, with a capacity for urgent notifications to be made within 72 hours.

- Prior to 2005, when the requirement for cover was still based on a practitioner's fault (medical misadventure), there were on average 12 notifications per month.
- In 2010, there were 24 adverse event notifications per month. (These do not constitute an allegation of error or blame and are usually about systems or patterns of events at the organisational level.)

The ACC also publishes professionally reviewed case studies to educate practitioners on the risks of various treatment injuries and help prevent avoidable incidents.

Source: www.acc.co.nz; Personal Communication with ACC.

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[6] The birth process itself is not considered 'treatment'. The ACC does not accept cover for birth injury unless a treatment intervention, or a delay in treatment, caused the injury (ACC 2010, p. 6).

Workplace accidents

The preventative gains from occupational health and safety measures means that catastrophic-level injuries are increasingly a less prevalent feature of workers' compensation schemes, with soft-tissue, muscular skeletal and work-related stress the major types of injury. It is estimated that fewer than 60 cases of catastrophic injury arise from workplace accidents across Australia each year (Walsh et al. 2005).

But the low prevalence of catastrophic workplace injury also means that current workers' compensation schemes are generally not adequately equipped to support the lifelong needs of people with catastrophic injury. Some jurisdictions address this by transferring relevant cases to their no-fault motor vehicle accident scheme (in effect, catastrophic claims are contracted out to a different scheme, with funding attached). Such an arrangement exists between Victoria's Workcover and the TAC. The Commission proposes that this type of arrangement be adopted in all jurisdictions to cover catastrophic workplace injuries under the NIIS. Importantly, claims would be financed from workcover premiums, maintaining efficient incentives for injury prevention in workplaces.

In some jurisdictions, including Western Australia, Queensland and Tasmania, adequate funding of catastrophic-level workplace injuries would require legislative change. This is because present arrangements:

- do not source adequate funds for lifetime care and support for those unable to prove the fault of their employer
- provide generally inadequate funding relative to what would otherwise be needed to fund claims in a NIIS setting (mainly due to limitations on statutory benefits, reductions for contributory negligence and high discount rates).

In particular, to align with a no-fault approach, the specific head of damage associated with compensation for future care needs would need to be removed and additional premium revenue sought to fully meet the lifetime care costs of additional no-fault catastrophic claims under the NIIS. In the three jurisdictions requiring additional funding:

- it is estimated that approximately double the current allocation of premium revenue (paid as common law lump sum damages) would be necessary to provide no-fault lifetime care and support
- overall, the additional impost would be very modest — estimated in 2005 at around 0.5 per cent of total premiums currently collected (Walsh et al. 2005, p. 56).

Acknowledging the inadequacies of Tasmania's present arrangements for dealing with catastrophic workplace injuries, the Tasmanian Government has indicated:

> Coverage of catastrophic injury under a national scheme would seem to offer a more equitable outcome for the very few cases of catastrophic injury (around one per year in Tasmania). (sub. 600, p. 6)

In summary, some jurisdictions will need to slightly increase their funding of catastrophic workplace injuries to cover these claims on a no-fault basis under the NIIS. This has the benefit of improving injury management and removing uncertainty that the lump sum payment may not be sufficient (including due to uncontrollable factors such as life expectancy and the discount rate). In addition, with the availability of comprehensive care and support through the NDIS, it is eminently sensible for governments to move away from lump sum payments for lifetime care and support (thereby managing the potential for 'double dipping' into the NDIS in the not uncommon circumstance that a financial lump sum is mismanaged).

To this end, existing workcover schemes would continue to source premium revenue to cover catastrophic workplace injuries and manage non-catastrophic claims. However, the care and support of catastrophic claims would occur through the NIIS under a contractual arrangement with the relevant workcover scheme.

General injuries arising from accidents in the community and at home

While a levy on public liability insurance would be one obvious method for financing no-fault coverage of catastrophic 'general injuries' to third parties, the personal injury component of cover would need to be made compulsory and enforced.[7] Moreover, the KPMG-Econtech review (for the Henry Tax Review (Treasury 2009a)) of the efficiency of state and territory taxes, found taxes on insurance to be relatively inefficient. (The marginal excess burden of insurance taxes was 67 per cent, which was the most inefficient of tax alternatives (table 12.2)). This suggests financing NIIS claims through an extension of (and levy on) existing public liability insurance could have unintended outcomes[8] and it is likely that more efficient mechanisms are available.

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[7] Public liability policies generally include cover for personal injury, death and property damage caused to a third party. In some instances, public liability and product liability are sold as a package.

[8] Including increased rates of non-insurance and higher monitoring and enforcement costs.

If, indeed, public liability premiums were no longer required to cover catastrophic claims, the cost of these premiums would be expected to fall. This would occur not only from the direct effect of a reduction in large claim costs (the top 1 per cent of claims account for almost a quarter of claim costs (ACCC 2005, p.14)), but also because of lower reinsurance costs. (Fewer large and unpredictable claims increase the capacity for insurers to take on risks before having to purchase reinsurance cover.)

Sporting bodies and public authorities (including public and private schools, local government, government departments and the Crown) are mainly affected by public liability insurance claims, given the prevalence of leisure and recreation activities as a source of injury. In particular, local governments have most exposure to personal injury claims under their public liability cover, including through their provision and management of beach amenities, swimming pools, sporting grounds, playgrounds, community centres and maintenance of roads and footpaths. (Box 16.5 provides some examples of personal injury liability involving local councils.) Therefore, public liability premiums of local governments would generally be expected to fall most significantly from catastrophic claims instead being covered under the NIIS.

But apart from accidents occurring within the community (as presently covered on a fault-basis by public liability insurance), general accidents also arise from activities on private residences and from violent crime, both in a domestic and non-domestic setting. This raises the additional question of how best to finance NIIS claims for these catastrophic accidents like:

- falling off a ladder or being severely burnt at home
- injuries resulting from criminal violence (mainly assault) and self-harm (box 16.6).

While a households' home and contents insurance policy generally includes some cover for personal injury, such protection against legal liability usually extends only to non-householders or visitors to a home or residence, it does not cover a householder themself. Plus, legal liability cover for personal injury is not universally included within home and contents insurance policies and not all households are insured. For the same reasons discussed above for public liability insurance, it is not recommended that this product be mandated and a levy imposed. Nor is it suggested that a special household insurance product be established to cover injuries to a first party (householders themselves) and made compulsory (compulsory first party insurance). (Not only are insurance taxes generally inefficient, especially if the levy does not relate to accident risk or people's risk taking behaviour, making a particular form of insurance compulsory imposes an administrative burden, particularly to control evasion of insurance.)

Box 16.5 **Local governments' duty of care to prevent injury**

So called 'trip and fall' accidents are the main source of legal action against local councils. Local governments hold a position of authority that requires them to identify whether or not a potential hazard is obvious to an ordinary user, and hence, have a duty to provide appropriate warning of any non-obvious risks. It is often not clear whether or not councils adequately carry out their duty of care to the community:

- Newcastle City Council v Lindsay [2004] NSWCA 198 — This decision found that the defect in the walking path caused by raised tree roots was obvious, but that the council not warning pedestrians had not raised the risk of injury, emphasising that pedestrians also have a duty to lookout for obvious and common risks.
- Timbs v Shoalhaven city Council [2004] NSWCA 81 — permission was sought from the council to remove a large gumtree near a residence. Following inspection, the council did not provide permission for the tree's removal and suggested the tree was safe, but in a later storm the tree fell on the house and caused the death of Mr Timbs. The tree's roots were found to be decaying, and while the council could have advised Mr Timbs to seek independent advice about the condition of the tree, the council's opinion that the tree did not pose a risk in the absence of any further investigation was determined negligent. The council was found liable.
- Swain v Waverley Council [2005] HCA 4 — this case clarified the extent of local councils' duty of care to safeguard beach swimmers and surfers, including through the placement of flags and warning signs, with the injured surfer obtaining damages of $3.75 million (even after a reduction for contributory negligence).

Source: NSW Legal information Access Centre, Hot Topics: Legal issues in plain language, no. 51, p. 19.

Even with the NIIS covering catastrophic level injuries on a no-fault basis, existing cover for personal injury liability (as typically provided under a household's house and contents insurance policy) would continue to be relevant. By far, the majority of claims under such policies are for non-catastrophic (mostly minor and moderate) injuries.

Alternative funding mechanisms are likely to be more efficient, less costly to administer and could be better targeted to changing local risk factors in a way that prevents injury, rather than simply charging a flat price to cover the cost of accidents. The Insurance Council of Australia has frequently commented about the inefficient and inequitable effects of statutory contributions drawn from insurance products, such as levies for fire services. Also citing the Henry Tax Review and the Victorian Government's own State Tax Review, they instead suggest that:

> … a funding system built around a base of land/property offers the most efficient and equitable arrangement. (ICA 2010, p.2)

Box 16.6 **How common are serious falls and assaults?**

The main sources of serious but non-fatal general (or community) injuries are falls and assaults. Fires, burns and self-harm also give rise to a significant number of serious injury cases. Drowning and poisonings tend to be less common.

Falls are most represented in the statistics, with a total of around 32,000 classed as a high threat to the person's life (consistent with a serious non-fatal injury) in 2004-05. Around two-thirds of these were by females, who had a mean length of stay in hospital of 1-week, which is significantly longer than all other sources of serious but non-fatal injuries. Unlike other sources of serious injury in the community, falls are by far most commonly experienced by people aged over 65 years.

- rates of falls for people under 65 years is generally around 500 cases per 100,000 population. These are mostly from sport or recreation related activities at younger ages, or home-related tasks and activities for people aged over 45.
- rates almost double for each 5-year increment in age up to age 80, and 10 per cent of all females aged over 90 years experience serious injury from a fall. These are mostly attributed to slipping, tripping or stumbling and consistent with a loss of agility, movement and balance associated with ageing — in fact, 10 per cent of all hospitalised falls occurred in aged care facilities.

In 2008, there were over 170,000 assaults recorded in Australia. Previous estimates indicate that around 2 per cent of total recorded assaults require hospitalisation (Mayhew 2003). Other statistics show that in 2004-05, there were 4,246 serious but non-fatal assaults (about 2.5 per cent of all recorded assaults).

Around three-quarters of all hospitalised cases of assault involve males, and mostly from a bodily force rather than an object or implement. For cases where the injured person was is 0-4 years, the cause of assault in around 50 per cent of hospitalised cases is classified as maltreatment syndromes, neglect and abandonment. In most cases of assault the injury is to the person's head, with about 10 per cent of cases involving an intracranial injury. Rates of assault are substantially higher in the Northern Territory than any other Australian jurisdiction.

Source: AIHW 2008, Hospital separations due to injury and poisoning Australia 2004-05; Mayhew (2003).

To this end, alternatives to a levy on public liability insurance or the establishment of a new mandatory household accident insurance product to fund catastrophic criminal and general injuries include:

- a levy on land taxes or local government rates[9]

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[9] Local government are not explicitly mentioned in the Constitution, and hence, their authority is a 'residual power' of State governments. The jurisdiction of local government is usually enacted through specific local government legislation, but also as mentioned within other legislation, such as bushfire and domestic animal control legislation. Apart from collecting local government taxes, local governments rely on grants from State and Australian governments.

- general state and territory taxation revenues.

While it would be a choice for individual jurisdictions, on balance, the Commission favours local government sources of revenue for reasons that:

- this could be collected reasonably efficiently given it would be a surcharge on existing local council rates
- land taxes and other property based taxes have relatively fewer distortionary effects than other transaction-based taxes (reflecting the low responsiveness of demand and supply to price changes created by the 'tax wedge'), and hence impact relatively less on welfare
- local councils would be relieved of some of the costs of their public liability premiums, as the lifetime care costs of high costs claims would now be covered under the NIIS. As such, some of the proposed NIIS levy on rate payers is already factored into rates charges to cover the costs of a local council's public liability premiums and, hence, a proportion of the new levy is simply a transfer within local government
- a council would have incentives to either encourage or discourage certain activities, taking account of the full social and economic costs and benefits within their local area.[10] Local governments would also have incentives to address some sources of violent crime, such as through alcohol free zones, community outreach centres and women's refuges, as gains in crime prevention and other characteristics of local government policies would affect the premium for an area. Notably the National Committee on Violence noted that:

  > …local governments, which are the level of government closest to the everyday lives of most Australians, are in an important position to contribute to the prevention and control of violence within their respective communities. (Chappell 2004, p. 158)

- to the extent that NIIS cover for general injuries reduces individual incentives to privately insure for the costs of disability arising from injury, there are merits in looking at new ways of individuals contributing.

Nevertheless, there may be special circumstances in some local areas, such as from higher rates of social and economic disadvantage, which may warrant a contribution from state and territory general revenues. Indeed, apart from local

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[10] Any change in a local council's contribution to risk (including based on claims experience) should factor into the levy for their local government area. Interventions should be cost effective and deliver a net return on investment. For example, while a program to reduce rates of old aged falls in New Zealand was successful at reducing the incidence of falls by nearly 50 per cent (based on a randomised control trial by Wolf et al. (1996)); it was not found to yield a positive return.

government rates, grants from state governments provide an important source of revenue for local governments, and state and territory finances are already the source of funding for victims of crime compensation. This would be relatively simple to administer and it would further increase the incentives of state governments to engage strategies to reduce violent crime and rates of self-harm, including for example by:

- reducing alcohol fuelled violence associated with the availability of alcohol at venues, restricting opening hours, crowd management, policing and public education
- early intervention strategies in health, education and community services.

While there is a paucity of reliable estimates of the additional costs associated with no-fault cover of lifetime care for general injuries (including catastrophic criminal injuries), rough estimates in 2005 (Walsh et al., p. 52) indicate that based on a triangulation of information sources and New Zealand experience:

  - a total annual cost in the order of \$300 to \$350 million, of which only \$70 million is currently spent on compensation for lifetime care through fault-based public liability insurance arrangements
  - around 220 to 250 catastrophic-level general injuries can be expected each year, of which only 40 to 50 currently receive public liability compensation.

Given the significant broadening of coverage required, and the impost of financing general injury claims, it is possible that liabilities could be partially upfront funded. The issue of full or partial upfront funding of future liabilities is discussed below.

Should liabilities be fully funded?

A fully funded NIIS would allocate upfront the estimated lifetime cost of care and support associated with each entrant into the scheme. This provides certainty about the capacity of the fund to meet a person’s future liabilities, and it also provides a buffer for year-to-year variations in costs, in effect, smoothing premiums over time and reducing reinsurance costs. Funds would be invested to generate a capital return and drawn down against as actual costs are incurred to meet participants’ care and support needs. A fully funded scheme has the highest solvency and presents a lower risk for future tax payers, premium payers and scheme participants. However, a strong governance framework protects a less than fully funded scheme against these risks, including the potential for blowouts in unfunded liabilities, as was the experience in New Zealand (chapter 7).

Realistically, fully funding can only apply to the new incidence of catastrophic injuries. People who acquired a catastrophic injury in the past would continue to be supported by the existing disability and health system and the NDIS.

But because the NIIS would be government underwritten, it is also possible to put aside only a proportion of the estimated lifetime liability, and instead draw on future taxpayer revenues to meet any unfunded gap in scheme expenses (obligations to meet lifetime care and support costs) as they are incurred. Partial pre-funding of futures liabilities is a common feature of government guaranteed social insurance systems, and may be desirable to the extent that a sound governance structure ensures the scheme remains affordable and also depending on the competing priorities for government expenditure and the existing and future tax burden on the community. In particular, under a partial upfront funding arrangement, scheme expenses are funded more proximate to when they are actually incurred, and while returns from a scheme's capital assets are foregone, funds are instead available for other potentially high yielding and welfare enhancing uses, such as investing in the NDIS.

Given the well functioning insurance systems already in place to fund injuries, the Commission proposes the NIIS operates on a fully funded basis, with one possible exception. Future liabilities associated with general injuries, including criminal injuries, could be only partially pre-funded. Consideration of this alternative would take account of:

- expectations about intergenerational equity
- the desire to smooth financial commitments associated with a new scheme, until such time that it matures and liabilities start to stabilise
- the ease of merging the NIIS and NDIS if contemplated at some point in the future.

Risk rating

Risk rating is an important aspect of insurance products, including for mandatory products. By reflecting higher risk in higher premiums the consumer receives an important price signal that may affect their purchasing choices and their behaviours (Dionne 2001, Henry Tax Review (Treasury 2010a)).

Existing motor accident schemes apply risk ratings to the determination of premiums, although for some classes of risk this is muted, in part, by the need to address social and economic impacts. For example pure risk rated premiums that would apply to young male drivers would be so high as to be prohibitive for many (affecting employment and imposing wider social and economic costs).

Similarly, pure risk rating in some jurisdictions is not applied to car owners in rural areas, as this would require premiums to be significantly higher, reflecting in part the greater time spent in the car and the greater risk of serious accidents. The benefits of risk rating have to be sensibly weighed against other objectives.

However, at the margins there may be opportunities for higher risks to be reflected in higher premiums, for example with high powered motorcycles. In New Zealand, the ACC recently increased some classes of motorcycle premiums a little more than two fold.[11] This reflected a desire to send a strong market signal to owners and would-be purchasers about the higher risks of driving high powered motor bikes. In fact, if premiums were fully risk rated, they would have increased 8 times.

Clearly there are limits on the capacity of risk rating because of the social and economic costs and because some drivers would avoid paying premiums by driving uninsured vehicles without altering their risk status. On the latter point technologies are changing to allow easier detection of uninsured vehicles (such as automatic number plate recognition systems (ANPR)). For example, Victoria and ACT police use mobile ANPR systems, with the ACT RAPID technology leading to the issuing of over 1800 infringements during a six-month trial, and prompting the Government to invest around $4 million in the new technology over four years, including two additional cars and six dedicated police officers. Such new technologies can also work in tandem with other road safety measures to enable more effective monitoring and enforcement and help prevent accidents.

The optimal design of risk rating for the purpose of reducing catastrophic injury is both an empirical issue and one requiring fine judgments about the wider impacts. In the NIIS this would be a matter for the individual schemes and state governments.

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[11] On average, the ACC receives 3.4 times more motorcycle claims per 10 000 vehicles than for cars, and the cost of an average claim is 2.6 times more expensive. The relativity factor of a 601+cc motorcycle (compared to passenger vehicles) is 1205 per cent, but was previously set at 150 per cent, giving rise to significant cross-subsidisation between vehicle types. Even with the significant increases proposed to the rates payable on 601+cc motorcycles (from $252.69 to $623.91 proposed by the ACC), all other car drivers would continue to subsidise motorcycle drivers and pillion passengers, adding an estimated $77 to each premium for the 2010-11 year (www.acc.co.nz/news/PRD_CTRB118214). For this class of motor cycles, a premium of $426.92 was subsequently approved by the Minister and, though significantly less than that proposed by the ACC, unsurprisingly, there was a hostile response from riders.

Why not just use the NDIS?

The Commission recommends the creation of a new national disability scheme that would provide high quality care and support for all people with significant disability. That invites the question of why an NIIS is needed at all. In theory, all compulsory insurance products providing third party cover could be removed, with all people's needs funded and met through the NDIS. The South Australian Government did not go this far, but it saw the NDIS as the residual funder of any expanded injury scheme:

> … if the Commission recommends a scheme with comprehensive coverage including all severe injuries the South Australian Government would be opposed to any additional costs being imposed through CTP premiums which are already relatively high in this State. Enhancements to coverage and services to victims of motor accidents should be funded through the National Scheme's own funding mechanism(s). (sub. 496, p. 3)

However, there are several reasons why a separate funding stream is appropriate.

- As noted above, amendments to risk rating provides the opportunity for deterring accidents, whereas there would be no easy mechanism to address moral hazard through prices in an NDIS.
- Third party premiums reflect the external costs of consuming a product — that is, the likely costs of an individual causing an injury. In effect, if premiums force a driver to take account of the costs associated with their unsafe driving, choice of vehicle type, or other aspects of transport use within an individual's control, such costs imposed on others are partly internalised and injuries reduced (Edlin and Mandic 2006).
- At the margin, some people will not consume the product because its value does not exceed its costs, such that efficient pricing of preferences and 'externalities' from consumption that increase the costs of accidents aligns with targeted (premium) funding.
- Premiums for the NIIS would be collected at the geographic level where governments have the greatest capacity to reduce risks. Accordingly, state governments have the capacity to improve policing and the justice system, to improve transport safety through laws, regulation, social marketing, training, and infrastructure (reducing CTP premiums); and with local government, reducing the risks of general accidents (as already discussed).
- The NIIS would primarily be 'a fully funded' scheme, drawing on its revenue sources to cover the expected lifetime liabilities of new cases, hence, providing strong incentives to manage costs over time and certainty about the

capacity of the fund to meet a person's future liabilities, but a buffer from year-to-year variations in costs and premiums.

A federated approach

One way of realising an NIIS would be for each jurisdiction to set up a scheme that provides equivalent lifetime care and support for catastrophic injury as is currently available through the Victorian TAC, the NSW LTCS scheme or Tasmania's MAIB, but to otherwise go it alone. That would produce large gains, but it would also miss out on some benefits from cooperation.

The Victorian Government suggested that an effective step forward would be to increase the coverage of no-fault insurance arrangements across jurisdictions, and the consistency of support provided under existing schemes. It considered that a new national partnership, possibly under the National Disability Agreement, could be the best way to encourage this:

> [It] would reward the establishment of consistent no-fault insurance schemes for transport related injuries (including for jurisdictions that already have some schemes in place, in line with the current policy approach). … Over time, this will build expertise and service capacity, in turn increasing benefits for the wider population of people with a disability. (sub. 537, p. 29)

The Commission proposes that the NIIS should be structured as a federation of separate, state-based no-fault schemes. Schemes would be separate to the extent that they control the implementation and development of their own scheme, including, for example:

- funding options
- pricing of premiums, including risk rating
- investment of scheme assets
- set up of legislative infrastructure
- the level of support provided above the minimum benchmark
- oversight of service delivery, assessment and dispute management
- the balance between internal or external care coordination and case management services.

The purpose of federation membership, and the establishment of a small full-time NIIS secretariat as a national coordinating capability, would be to:

- provide an independent advisory and monitoring capability

- ensure consistency in eligibility, definitions and assessment. The fact that an accident occurs in one jurisdiction or another should not reveal gaps in coverage and other problems symptomatic of the current arrangements, particularly evident for motor vehicle injuries
- provide certainty around a minimum benchmark of services, care and supports, though benchmarking would need to be transparent and agreed
- share data (and maintain a central database), undertake cooperative trials, research studies, reporting (including actuarial valuations) and benchmarking of performance (including measures of client outcomes)
- reap economies by pooling risks where appropriate
- eliminate other unwarranted variations in scheme design.

In the latter vein, the Victorian Government acknowledged that under a national approach to injury insurance, existing no-fault schemes would 'also require refinement to achieve more consistency' (sub. 537, pp. 28–29).

This implies some mechanism for cooperation — such as a memorandum of understanding or even statutory provisions that provide a framework for cooperation and joint activities. Over time, separate state and territory schemes could coalesce, with the ultimate goal being the creation of a single Australian system. However, while there are strong arguments for a 'federated' approach, agreements about the extent and nature of cooperation should not jeopardise a timely transition to no-fault schemes at the state and territory level. Indeed, implementation may well need to occur in a staged fashion, jurisdiction-by-jurisdiction.

There would be merit in the states and territories contracting out the secretariat functions listed above. The National Disability Insurance Agency (NDIA) (as proposed by draft recommendation 7.1 for the NDIS) could play an important role in this respect (noting the NDIA itself is a federated institution). It could act as a host for cooperation, assist in and publish benchmarking information (for both the NIIS and NDIA) and encourage diffusion of best practice.

As already mentioned, to reduce the fixed costs of operating their own schemes, smaller jurisdictions could choose to sub-contract scheme management to another state. (It may also be possible to contract NIIS cases to a private sector insurer operating across jurisdictions or to the NDIS.)

The Australian Government's role

The Australian Government would be a less important party in the NIIS than state and territory governments (that is, beyond its involvement in subsidising medical indemnity insurance, its role as a stakeholder in the NDIA, and as already flagged, its role to contribute towards premiums in the Northern Territory where the injury risks are higher).

Its capacity to intervene in state insurance matters is expressly prohibited under the Australian Constitution (s. 51 (xiv)), except where state insurance crosses borders. This is a general restriction, that is, the Commonwealth cannot regulate state insurance under any power.[12] For example the corporations power could not be used even if state insurance companies were corporations.

Moreover, there does not appear to be any power under which the Commonwealth could legislate to extinguish the common law right to sue under negligence, contract or statute to recover damages for accidental injury.

- The corporations power would not permit it, because a car accident, for example, is generally between individuals.
- The external affairs power seems, at first inspection, too remote, unless Australia were to sign a treaty about no-fault accident insurance (akin to the UN Convention on the rights of people with disability). That said, the Commission notes previous 'remote uses' of this power to give effect to conventions and provide a basis for the Australian Government legislating in areas of state control, including management of the Murray-Darling basin under the Federal Water Act.
- Accidents are not usually 'in trade and commerce'.
- The welfare power could be used to provide benefits to injured parties but not to stop them from suing, because it is a power to make laws with respect to the provision of allowances, not the power to make laws about claims in negligence.

The Australian Government could use the referral power,[13] but this would require all states to agree. For example the states agreed in 2003-04 to create a consistent public liability insurance regime, which included changes to the common law suit of negligence.

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[12] For example, *Victorian WorkCover Authority v Andrews [2005]* FCA 94, at 53.

[13] S. 51 (xxxvii), along with the territories power, s. 122.

As a consequence, the Australian Government role would be to encourage a cooperative solution, and to assist in the creation of an NIIS that included data sharing and other common features (while not eliminating the scope for some experimental variation).

The Australian Government could also make an agreement with the states and territories that the creation of the NIIS would be the quid pro quo for the Australian Government's substantial injection of funds into the general disability system through the NDIS.

Implementation could be rapid

Implementation of a NIIS should be faster than the full rollout of the NDIS. As noted above, this is because there are existing well-established schemes in place that could form the blueprint for the design of schemes in other jurisdictions. Moreover, while the severity of the injuries means that the costs are significant, the numbers of people affected are relatively small (around 1000 a year). Accordingly, the organisations that coordinate services would not need to be very large — and would not be likely to place excessive pressures on an already strained labour market in disability services.

The priority for jurisdictions without a lifetime care and support scheme already in place would be to initially establish no-fault arrangements for (new cases of) catastrophic motor vehicle and medical accidents, and expand coverage to other sources of injury within two years. Existing schemes would provide a template to make a rapid pace of implementation to be realistic. The Commission suggests a timeline for implementation whereby:

- state and territory governments set up catastrophic injury schemes for motor vehicle and medical accidents by the end of 2013. This would be the starting point for an NIIS that ultimately covers all sources of catastrophic injury
- schemes expand to cover all causes of catastrophic injuries by the end of 2015.

The Commission has also outlined a case for broader changes to the common law and the coverage of the NIIS (see below and appendix I). Realistically, such reforms are more radical and would take a longer time to implement. Moreover, they should not divert attention from the core task of establishing no-fault lifetime care and support for all people catastrophically injured. In the Commission's view the practicability for implementing wider reforms and expanding the remit of the NIIS should be carefully tested in the independent review proposed for 2020 (draft recommendation 16.5).

In the longer run, there would be logic in bringing the NIIS into the NDIS, so that there would be one Australia-wide scheme addressing the consequences of disability and major injury. (Existing funding sources would remain, recognising the value of a broad range of financing approaches and of risk rating.) However, beyond the in-principle attractions to merging schemes, the practical case for making such a change would be a matter for an independent review to comprehensively assess the associated risks and deliverable gains. Consideration should be given to:

- the transactions costs of merging schemes and potentially disrupting the continuity and quality of participants' care and support
- the distinct and complex care and support needs of catastrophic injuries and the performance of the NIIS in meeting these specific needs. The NIIS would be focused on a relatively small group of people subject to very particular and individualised intensive management; it would also have a much greater interaction with the health system
- the extent that the benefit structure and standard of benefits might change under any merged arrangement, especially when the NIIS would have a separate source of funding (premiums), which would cover the expected lifetime liabilities of new cases (it would be 'a fully funded' scheme)
- the competitive discipline and potential for benchmarking that jurisdiction-based implementation and financing of the NIIS creates. This has a capacity to generate efficiencies and innovation in scheme operation, service delivery, cost management and participant outcomes that are not necessarily built into an NDIS model.

While there might be some sense in eventually merging the NIIS and the NDIS, there are large differences in the schemes that affect whether that would be worthwhile. The gains from a merger might not be worth the costs of bringing quite different arrangements together. That question should be put off until the Commission's proposed review of the NIIS in 2020.

Nevertheless, even as separate schemes, and regardless of whether or not a merge takes place, there are reasons for schemes to coordinate and work towards consistency across scheme features including:

- many aspects of scheme governance
- data collection, and measurement and evaluation of outcomes
- sharing of capital infrastructure
- assessment tools.

16.3 The scope of the NIIS beyond 2020

What about the other heads of damage?

It is likely that the biggest welfare gains from reform of injury insurance would arise from covering catastrophically injured people for their lifetime care and support, regardless of whether an at-fault first party can be identified. This would be the main priority for reform over the next few years.

However, there may still be significant gains from extending no-fault insurance arrangements to the other heads of damage ('economic losses' and 'pain and suffering') and, on the other side of the coin, to limit the use of the common law in these areas.

There are many variations in how 'no-fault' schemes limit the ability to engage in civil actions. Some no-fault schemes prohibit court action entirely; other 'hybrid' schemes permit people to maintain their common law rights for other heads of damage.

- In New Zealand, the *Accident Compensation Act 2001* prohibits access to common law damages, excluding exemplary damages for injury caused by an intentional or reckless act of another party.
- In NSW, the LTCS scheme prevents a claim for common law damages for 'future care' damages only, but enables other heads of damage under the common law. Finity Consulting (2010) recently processed historical NSW claims data and estimated that the average size of 'residual' damages for hypothetical LTCS scheme claims (in 2009 values with LTCS scheme related future care heads of damages removed) was $860 000.
- In Victoria, the TAC scheme for motor vehicle accidents provides lifetime care and support services and statutory income payments on a no-fault basis, but also enables common law access for economic loss (above no-fault income entitlements) and pain and suffering.
- In Tasmania, the MAIB provides no-fault lifetime care and support, but allows full access to common law damages. Retaining access to common law damages alongside no-fault benefits has, however, been attributed to the 'relatively scant schedule of benefits on a no-fault basis' (Mackey 2006, p, 26).
- In the Northern Territory, the Territory Insurance Office provides only no-fault statutory benefits for residents and modified common law damages for non-residents.

However, any residual fault-based arrangements still use many legal resources, and based on the TAC experience, hybrid arrangements continue to divert a significant proportion of premium revenue away from actual compensation. A hybrid system may also continue to have adverse effects on health and other outcomes for those seeking compensation for these other heads of damage.

The Commission has analysed various options for including cover of these other heads of damage in a no-fault scheme.

Overall, the Commission sees merit in compensation for pain and suffering being limited to cases where a party suffers serious injury from the gross negligence of others. In particular, if compensation for pain and suffering were provided through the NIIS, it would cover cases where a party suffers serious injury from the gross negligence of others, with:

- payments based on an impairment formula with determination of the amount using an objective assessment tool applied soon after the occurrence of the injury
- a nominal defendant seeking to recover the costs of claims from the at-fault party when their fault was vindicated and where an income source was available.

The Commission similarly sees merit in removing access to sue for lump sum damages for income losses under the common law, with people injured as a result of an at-fault first party instead covered through the NIIS. An administrative process, not the common law, could determine whether or not there was an at-fault first party, and payments should be made periodically and not on a lump sum basis. There are also in principal reasons why NIIS should extend coverage of income loss from injury beyond cases involving an at-fault first party.

Despite reasons to proceed down this path, the Commission envisages several obstacles to reform of kind above succeeding, especially given uncertainty about the magnitude of legal process costs (and hence the transactions costs savings from the removal of the legal right to sue). It is expected over time, however, that obstacles of this kind would diminish, especially as the NIIS becomes operational and evidence accumulates on outcomes for participants to ease any concerns among the community and governments.

There is also the risk that a too ambitious agenda for reform, could prove dismantling to the scheme’s main priority — the establishment of comprehensive, no-fault lifetime care and support. Hence, the Commission’s interim position is that common law rights for individuals to sue for pain and suffering and loss of income from personal injury be retained. However, these matters would be the subject of the review of the NIIS in 2020 (draft recommendation 16.5), which should determine whether such losses should instead be covered under the statutory scheme and associated common law rights removed.

What about non-catastrophic injuries?

There is a persuasive case for a no-fault insurance system to cover the care and rehabilitation costs of significant but non catastrophic injuries. This reflects:

- that the flaws of the common law still apply to this head of damage whether a catastrophic or less severe injury is experienced
- the high proportion of legal costs associated with a lesser common law lump sum associated with less severe injuries — likely to be around 50 per cent (chapter 15) — means that dealing with this group under the NIIS could generate significant efficiencies. Moreover, the costs and delays associated with obtaining common law damages would also be substantially avoided in most cases
- the potential for savings in future liabilities and social welfare costs by providing interim support for cases that are at the boundaries of catastrophic injury. Providing an appropriate length of access to services and supports would prevent a situation of delayed or partial recovery, reducing the risk of further injury, or exacerbation of the original injury, associated with sub-optimal treatment or inadequate rehabilitation. In some instances, relatively minor injuries can trigger a spiral into reduced social and economic participation that can become difficult and costly to reverse.

As implementation of the NIIS will only include catastrophic-level injuries, at least until the 2020 review, the Commission sees merit in the use of a two-staged assessment to distinguish between a participant’s interim (say up to two years post accident) and long-term participation in the NIIS. This has a range of practical advantages, including the points raise above, but in particular, it would:

- limit the potential adverse consequences from any classification errors in determining a catastrophic injury, especially for suspected moderate to severe brain injury where the extent of injury and scope for recovery is initially uncertain
- align with the approach either explicitly or implicitly adopted in existing no-fault motor accident schemes, including
  - the NSW LTCSA, which manages a person’s interim (up to 2 years) and lifetime participation

  - the Victorian TAC, which separately manages a group of ‘long hospital’ clients, which despite having initially high levels of care and support needs, is typically only required for a relatively short duration compared to the duration of a catastrophic injury. Nevertheless, a proportion of these clients (up to around 8–10 per cent) continue to access services more permanently.

Appendix I looks at how a process of interim and permanent participation in the NIIS could operate. It draws on the experiences of current schemes to show that the costs of covering participants at the margin need not raise a schemes’ liabilities significantly.

That said, it is not proposed that the NIIS expand to cover all severities of accidental injury, rather just those with significant care and support needs, and health care costs should generally be excluded. An exception would be specific injuries where the coordination of acute care, and potentially the creation of specialist facilities, would reduce the future liabilities of the insurer. This separation of functions recognises the appropriate roles of the health system and the NIIS. Similarly, because existing workcover schemes offer no-fault care and support for all non-catastrophic injuries, the NIIS should not expand to cover these.

Where does this leave the common law? Ultimately, the Commission sees a strong argument for common law fault-based systems to no longer be the avenue for seeking redress for injuries from accidents. It would continue to be an important area of redress in many other areas — such as product liability. Any move towards this objective would take time, however, and should be phased in, with the costs and benefits of expanding the coverage and functions of the NIIS carefully evaluated at critical points.

The first priority is establishing no-fault lifetime care and support for all catastrophic injuries. Whether or not reform occurs beyond this should be the subject of an independent review in 2020, which should also evaluate the performance of the NIIS in achieving its objectives.

DRAFT RECOMMENDATION 16.1

State and territory governments should establish a national framework in which state and territory schemes would operate — the National Injury Insurance Scheme. The NIIS would provide fully-funded care and support for all catastrophic injuries on a no-fault basis. The scheme would cover catastrophic injuries from motor vehicle, medical, criminal and general accidents. Common law rights to sue for long-term care and support should be removed.

DRAFT RECOMMENDATION 16.2

State and territory governments should fund catastrophic injury schemes from a variety of sources:

- ***compulsory third party premiums for transport accidents***
- ***municipal rates and land tax for catastrophic injuries arising for victims of crime and from other accidents (excluding catastrophic medical accidents)***

Once the NIIS is fully established, the Australian Government should examine the scope to finance catastrophic medical accidents from re-weighting government subsidies and doctors' premium contributions.

[The Commission is seeking feedback on interim financing arrangements for catastrophic medical accidents — see 'Information Requests' at the end of the recommendations section.]

DRAFT RECOMMENDATION 16.3

The NIIS should be structured as a federation of separate state catastrophic injury schemes, which would include:

- ***consistent eligibility criteria and assessment tools, and a minimum benchmarked level of support***
- ***consistent scheme reporting, including actuarial valuations and other benchmarks of scheme performance***
- ***shared data, cooperative trials and research studies***
- ***elimination of any unwarranted variations in existing no-fault schemes.***

State and territory governments should agree to a small full-time secretariat to further the objectives outlined above. The NIIS and the NDIA should work closely together.

DRAFT RECOMMENDATION 16.4

State and territory governments should consider transferring the care and support of catastrophic workplace claims to the NIIS through a contractual arrangement with their respective workers' compensation schemes, drawing on the successful experiences of Victoria's Worksafe arrangements with the Transport Accident Commission.

DRAFT RECOMMENDATION 16.5

The initial priority for the NIIS should be the creation of no-fault accident insurance schemes covering catastrophic injuries arising from motor vehicle and medical accidents in all jurisdictions, with schemes in place by 2013. Other forms of catastrophic injury should be covered by at least 2015.

An independent review in 2020 should examine the advantages and disadvantages of:

- ***widening coverage to replace other heads of damage for personal injury compensation, including for pecuniary and economic loss, and general damages***
- ***widening coverage to the care and support needs of non-catastrophic, but still significant, accidental injuries, except where:***
  - ***the only care needed can be provided by the health sector***
  - ***the injuries arose in workplaces covered by existing workplace insurance arrangements***
- ***merging the NIIS and the NDIS.***

16.4 Some other matters

There is scant evidence on the size of legal fees and charges

… but is mandating transparency practical and necessary?

Chapter 15 assessed the issue of legal fees and charges and, in particular, identified significant difficulties in ascertaining the nature and size of these costs. While the Commission was able to secure a detailed source of systematic evidence and draw some useful insights, it was difficult to come by. The unmatched paucity of such systematic evidence limits the prospect for informed public commentary and constrains policy judgments.

There are good grounds to pursue increased transparency, especially to the extent that the paucity of accurate and comparable data to analyse the frictional costs of existing common law arrangements acts as an additional obstacle to policy reform that might otherwise direct resources more efficiently. Similarly, it is undesirable that consumers have little idea of the real fee they pay in compensation cases, with no way of comparing their experiences with the average, making informed judgments about how their experience is likely to play out, or whether there might be a basis for negotiating or disputing costs, such as through an independent cost assessment. Nevertheless, it may not be appropriate that strong steps be taken to ensure greater transparency at this stage, especially if inevitable opposition from lawyer groups might divert attention from the more urgent priorities of implementing the NIIS and NDIS.

The Commission seeks feedback on the benefits and risks of requiring nationally consistent disclosure to an appropriately charged body responsible for monitoring and publicly reporting trends in legal fees and charges paid by plaintiffs in personal injury cases.

For example, could the Office of the Legal Services Commissioner (or equivalent) in each jurisdiction (or the proposed National Legal Services Commissioner under the COAG draft Legal Profession National Laws) take a greater role in this regard? What level of transparency would be sufficient? For example, should the Legal Services Commissioner be required to annually publish information on the average legal costs of settlements and court awards, categorised by:

- range or bracket of compensation
- the cause of injury (motor vehicle, workplace, medical, general injury)
- the proportion of party-party costs and disbursements
- the proportion of solicitor-client fees and disbursements?

A key motivation for improved transparency of legal fees and charges would be to inform sound policy judgments in the proposed 2020 review, which would examine the widening of NIIS coverage to replace other heads of damage for personal injury compensation, including for pecuniary loss and general damages, and non-catastrophic level injuries (draft recommendation 16.5).

Interactions between the NDIS and NIIS

The NDIS would provide services and supports to people with a demonstrated need for services and supports within the scope of the NDIS, but not otherwise covered under the catastrophic criteria of the NIIS. This would include people with a common law claim for compensation in progress who would benefit from early treatments and other interventions.

- At the successful resolution of a common law claim, the costs of services, programs and supports consumed would be recoverable from the damages awarded. Beyond services already provided in the acute care setting, these might include vocational assistance, post acute social and medical rehabilitation, home and vehicle modifications, and home and personal assistance.

- Importantly, this would help to address the potential for sub optimal outcomes for people pursuing common law claims but without structured access to services and supports.
- Incidentally, if would also allow benchmarking of outcomes for people pursuing common law claims against those not involved in litigation proceedings. People with injuries accessing the NDIS would, of course, gain access to services and supports on the same basis as anyone else satisfying the entry requirements and assessment (chapters 3 and 5).

The NDIS would also provide benefits to people with injuries arising from accidents prior to the start date of the NIIS, including those who have received lump sum compensation. If such compensation is still available, the NDIS would recover from the lump sum the cost of services and supports provided.

Interaction of the NIIS with the aged care sector

For people over the pension age who have catastrophic accident-related injuries, as distinct from other forms of disability, the Commission's view is that:

- the NIIS would fully fund people's support needs attributable to the injury
- the aged care system would still meet any ageing-related costs as they grew older — as in the arrangements under the Victorian Transport Accident Commission and in the New Zealand Accident Compensation Corporation.

It is understood by the Commission that it is generally feasible, albeit sometimes difficult, to identify care and support needs that are substantially the result of injury, as distinct from those wholly or substantially related to ageing. This is unlike the case for dividing care needs between disability and ageing, because:

- the time and event associated with acquiring an injury is more clearly traceable, as there is usually a clearly identifiable cause — for example, a motor vehicle accident, a fall or a physical assault
- no-fault accident schemes manage the care and support needs of a targeted group of clients. They develop familiarity and experience with knowing and, indeed, planning for needs specifically associated with spinal chord injury, traumatic brain injury, severe burns and blindness. While there are variations in needs across individuals, the source of such variation is mostly identifiable.

Perhaps the greatest impediment to well-functioning arrangements would be poor processes and protocols for agreeing to share funding between areas of government. This has been the experience of New Zealand's ACC, which since realising the impact of additional costs on its liabilities, has recently sought to improve arrangements between agencies about shared funding including by establishing:

- a stream within its National Serious Injury Unit to specifically manage the claims of clients aged over 60, including ensuring that funding for non-injury related needs are sourced from the appropriate government agency based on joint funding agreements
- inter-agency protocols and shared assessment arrangements.

Some estimates of the cost of covering older-aged falls (the major source of injury for this age group) are outlined for new Zealand's accident scheme in box 16.7.

Box 16.7 **Falls by people aged over 65 years in New Zealand**

Each year around 100 000 people aged over 65 years fall and make a new claim under New Zealand's injury scheme. Of those requiring non-acute rehabilitation:

- nearly 60 per cent are discharged home, mostly with some form of support services
- around one quarter are discharged to an assisted living or residential facility
- around 10 per cent rely only on health sector funding following rehabilitation

Averaged over the last 5 years, less than 0.02 per cent of claims for falls by people over 65 years old are catastrophic level — severe traumatic brain injury or spinal chord injury. In 2009-10, the average spend on catastrophic level falls by people aged over 65 years was around NZD$74 000, with 88 claims covered. Between 50 and 60 per cent of claims receive attendant care, around 10 percent receive residential care and nearly all access at least some other form of social rehabilitation.

As a proportion of all spending on attendant care, residential care and social rehabilitation for catastrophic injuries, old aged falls account for about 2 per cent of expenditures.

Source: Personal Communication NZ Accident Compensation Corporation.

17 Implementation

17.1 Implementation in outline

In this draft report, the Commission has laid out a blueprint for a coherent response to the significant problems that bedevil the provision of disability support services. But while many people need help urgently, implementation cannot occur overnight. The Commission's proposals concern arrangements for the long run:

- They involve two major new national programs on a scale much larger than the sum of all the current state-based disability and accident arrangements, so careful and detailed preparatory work will be needed.
- Different pathways and contingencies are possible and need to be planned for.
- No matter how careful the planning, the introduction of the NDIS, a wholly new and very complex scheme, will inevitably encounter some early difficulties. These would be more manageable and less likely to be serious if the scheme started on a relatively small scale.

Moreover, implementation will confront the difficulties of a major reform being undertaken within a system that has multiple jurisdictions with established systems, overlapping responsibilities and a long-standing shortfall in funding. For such reasons, existing state and territory disability services will have to remain as they are for a while and, even after the introduction of the new arrangements, coexist for some time. During this period, the Australian Government should supplement funding under the National Disability Agreement to reduce some of the worst rationing of support services. This would also help to alleviate pressures on the state schemes during the transition to the NIIS and the NDIS.

This chapter is about the various phases in the implementation of the NIIS and NDIS. The proposed timetable is discussed below and summarised in tables 17.1 and 17.2.

17.2 Implementation of the NIIS

Chapter 16 has laid out a detailed implementation plan for the NIIS, noting several reasons why its overall implementation could be rapid. This would be helped by the strong knowledge base that already exists. Some jurisdictions have already made a successful transition from fault-based to no-fault motor vehicle accident schemes (the Lifetime Care and Support scheme in New South Wales, for example), and a number of others have undertaken detailed work on the possible implementation of a no-fault system. The Heads of Treasuries Insurance Issues Working Group had earlier looked at possible national arrangements for the sharing of information through a central database, benchmarking, and consistent actuarial valuations. Senior state insurance executives meet regularly, and working groups such as the Heads of Compulsory Third Party Authorities and Heads of Workers' Compensation Authorities are well versed in many of the issues.

To facilitate implementation, the Commission proposes that a full-time high level taskforce comprising representatives from all jurisdictions should be established. The initial priority should be the creation of no-fault motor vehicle and medical accident insurance schemes in all jurisdictions by October 2013, with other forms of catastrophic injury to be covered by 2015 (table 17.1).

Table 17.1 **Implementation of the NIIS**

Date	*Milestone*
Second half of 2011, or early 2012	COAG would: • agree to the establishment of the NIIS, whereby states would implement no-fault accident insurance schemes for long-term care of new cases of catastrophic injury • agree to have these arrangements in place in all jurisdictions for motor vehicle and medical accidents by October 2013 • establish a full-time high level taskforce to help implement this the taskforce would report back regularly to Heads of Treasuries meetings and COAG on milestones reached
Oct 2013	NIIS to cover catastrophic injuries from motor vehicle and medical accidents in all jurisdictions on a no-fault basis
2015	people suffering catastrophic injuries from other causes should be covered by at least 2015
2020	independent review of the NIIS

This would require a memorandum of understanding between jurisdictions, or other provisions that provide a framework for cooperation and joint activities. (Some existing cooperative agreements between the states in relation to disability services are noted in box 17.1.)

The key stakeholders in the NIIS will be the state and territory governments. But the Australian Government would play a facilitation role, and perhaps contribute to the premium pool in those jurisdictions where the injury risks are higher (chapter 16). More broadly, it could encourage the states and territories to establish an NIIS as a quid pro quo of the very large additional revenue contributions it would make to the NDIS.

Box 17.1 **Existing cooperative agreements between the states**

Memorandum of Understanding (MOU) between Victoria and NSW

The aim of the MOU is to assist ADHC and the Victorian Department of Human Services to engage in a collaborative approach to the delivery of specialist disability services in cross-border regions of NSW and Victoria:

- To establish arrangements for the better coordination of service delivery of cross-border specialist disability services
- To enable eligible individuals living in cross-border community to access specialist disability services funded by the State other than their State of residence, where it is considered appropriate to do so
- To establish an ongoing forum in which cross-border issues can be discussed and resolved
- To facilitate a better understanding of each department’s policies and services as it affects day to day regional business.

The Tri-State Agreement

The Western Australia, South Australia and the Northern Territory Governments in 2004 formed the Tri-State Disability Services Group to develop a framework agreement to ensure a coordinated approach to providing disability services to the Ngaanyatjarra, Pitjantjatjara and Yankunytjatjara lands covering 350 000km^2 across the three jurisdictions.

The framework agreement has guided the operations of the three jurisdictions in delivering services to the people of the region over the past five years.

The Interstate Portability Protocol

In 2000, the Disability Services Ministers endorsed a national policy framework regarding the interstate transfer of people with a disability. This framework or Protocol establishes a mechanism to assist people with a disability transferring between jurisdictions to negotiate programs and services to achieve a comparable level of support. Work is currently underway to improve the implementation of the Protocol across jurisdictions.

Source: NSW Government (sub. 536, pp. 49–50).

When established, the NDIA (itself a federated institution) would act as a facilitator, to ensure clear linkages between the various state and territory government schemes. It would:

- host regular meetings of the CEOs of the accident scheme agencies
- act as a forum to address issues such as greater consistency in eligibility, definitions and assessment; the appropriate benchmark standard of care; reporting standards; and benchmarking of performance
- be the central repository for data and its analysis
- assist in undertaking cooperative trials across jurisdictions, combined research studies, and diffusions of any lessons from innovations undertaken by a given jurisdiction.

17.3 Implementation of the NDIS

Early negotiation between all governments

The Australian Government and the state and territory governments should negotiate early on the NDIA and the NDIS.

The initial objective should be to get agreement to allow detailed work to begin immediately on creation of the NDIS, irrespective of how the pathway to a new system unfolds. Examples of such detailed work are given below.

For other matters, such as the structural aspects of the NDIA and the NDIS, early work may need to wait until sufficient jurisdictions have given in-principle support and the broad shape of the scheme has been settled. The Australian Government should be responsible for drafting legislation to establish and underpin the NDIS, but in consultation with state and territory governments.

A taskforce should oversee preparatory work

To oversee an early start on essential preparations, all governments, through the Council of Australian Governments (COAG), should establish a high level taskforce comprising senior officials from all jurisdictions. In view of the commercial, corporate model of governance proposed for the scheme (chapter 7), the taskforce should be headed by a person with insurance or disability experience who has driven change successfully in a large organisation, appointed with the agreement of all jurisdictions. The taskforce should operate on a full-time basis, and report back regularly to Heads of Treasuries meetings and to COAG on agreed milestones in the planning for the commencement of the NDIS.

A key task will be to develop the details and drafts of the proposed intergovernmental agreements and the associated revenue arrangements, including setting out the financing obligations of the Australian Government and the reciprocal introduction of tax reform by state and territory governments. This will involve close liaison between Heads of Treasuries and the taskforce.

Governments should seek to achieve in-principle agreement on these matters at an early meeting of COAG in 2012, and final agreement in early 2013. This should allow the scheme to commence at the beginning of 2014.

There are many 'nuts and bolts' issues that will need to be resolved early in order to successfully implement the NDIS. Work could commence immediately on many of these, in many cases through parties contracted to the taskforce. Examples include the following:

- *Data and the systems that underpin it* will be critical. These will act like navigation systems, providing continual feedback and informing small ongoing adjustments that will help keep the NDIS on track. Without this feature, the scheme would not be able to effectively monitor outcomes nor keep costs under control. For example, under a constrained budget it would mean the re-emergence of rationing and under a flexible budget it would risk the financial sustainability of the scheme. In either case, it would imply less than ideal outcomes for people with a disability and their families. To avoid this, there is a need for high quality, real-time data to be produced and incorporated into day-to-day decision-making. Work should begin on:
  - processes for achieving agreement on data standards and content, assessment standards and protocols and standards for services, electronic patient records and so on
  - devising the administrative and IT arrangements to allow communication and reporting between the NDIA and the many assessors, suppliers, and others that will have a role to play (and for whom regular communication and reporting will be important for the smooth running of the NDIS). One possibility would be to start with fairly standard and relatively flexible commercial software packages that are already used in some jurisdictions, but simpler approaches may also work just as well for some parties providing services in the NDIS, as effective communication need not require common or highly sophisticated IT systems. (These matters are discussed in chapter 10.)

- Development would start on *the assessment toolbox* so that a reasonable measure would be available at the commencement of the scheme. The Australian Government would fund its development and it would be tested in pilot form in some states for selected groups of existing clients.
- The detailed elements of how *self-directed funding* would work and what rules should apply would need to be agreed to.
- The fine details on the role of *non-government intermediaries (DSOs)* would need to be determined, arrangements put in place to encourage their formation, and people with disabilities would need to be made aware of their potential role in the new scheme.
- Work would be needed with interested support and advocacy groups to plan how to build confidence so that people with disabilities will exercise choice in the new arrangements. People with disabilities and their carers will be looking for information and guidance about the assessment procedures, case management, self-directed funding and complaints mechanisms. Existing disability organisations and advocacy groups should play a key role in disseminating this information.
- Arrangements would also be set in train to encourage capacity building for service providers, who would face a considerably altered client base and client expectations and would require encouragement and guidance to develop appropriate skills and to support their workforce (including training for staff in new service offerings and in dealing with consumers with much greater autonomy to make their own decisions).
- Quality monitoring of *service providers* would be required to protect the interests of clients. The taskforce would oversee the development of the precise procedures and arrangements for implementing the arrangements spelt out in chapter 8, including standards, reporting requirements and other quality controls (chapter 8).
- Planning should also commence:
  - for a *regional presence* for the scheme. Medicare or Centrelink offices would be appropriate in remote areas such as Weipa or the Tiwi Islands.
  - on *workforce development*, in view of expected large increase in demand
  - to build an evidence base for possible *early intervention* programs
  - to develop an *Indigenous strategy*
  - to develop *information dissemination* strategies (for example, web design) and to prepare for a future *research* role.

The costs of setting up the NDIS, while significant, would be reduced by using the NSW LTCS scheme, TAC, ACC or MAIB schemes as sources for well-tested procedures, guidelines and operating systems. And while there are many details to be sorted out, there are many people within the current state and territory disability services sectors with experience and expertise in the provision of disability support. There are also long-standing working groups of state officials who are well versed in many of the issues confronting the sector, and who are already seeking to make beneficial changes.

The taskforce should also start work on the structural elements of the NDIS, once its agreed form is clear. As noted in chapter 7, Commonwealth legislation would be needed to establish the NDIS and the NDIA, and to set in train processes for the creation of the appointment panel for the board, appointment of the board, appointment of the advisory council, the appropriation of funds (and the formula relating to these) and funds management. Such legislation can be sequenced as needed, starting with an early establishment Act, which can be followed later by a financing Act, and the main Act for the scheme.

Targeted consultation will be needed

This preparatory work would draw on the skills and knowledge of practitioners in the field, and would seek to build upon the best features of the current state schemes. The taskforce would need to consult with key groups to reach a position on many of the matters listed above. For example, discussions would need to be held with:

- disability professionals and insurance experts, about terminology, data definitions, assessment standards and protocols
- people with disabilities, about how the proposed scheme should work and how it would interact with them
- service providers, about administrative procedures, the proposed arrangements for self-directed funding and quality control measures.

However, these consultations should be about implementation, and it is important that they be well-targeted and not prolonged. Their primary purpose would be to obtain particular information and to test the practicality and appropriateness of the proposed building blocks of the scheme.

The important thing is to start early on areas where progress would lead to more effective building blocks for better future provision of disability support services, almost irrespective of the final shape of the scheme, and not wait for the structural and legal aspects of the scheme to be agreed upon. The latter approach would lead to completely unnecessary delays in implementing better support programs for people with disabilities.

The Commission sees its proposed timetable (table 17.2) as realistic and achievable. Other large public policy changes have also been introduced to tight timeframes in the past. The Job Network — a sweeping change in employment services across Australia — took two years to implement. The Higher Education Contribution Scheme was also introduced over a very short period, as was Medibank (box 17.2).

Box 17.2 **Implementing Medibank**

Medibank started on schedule, on 1 July 1975. In nine months, the Health Insurance Commission had increased its staff from 22 to 3500, opened 81 offices, installed 31 minicomputers, 633 terminals and 10 medium-sized computers linked by land-lines to the central computer, and registered and issued health insurance cards to 90% of the Australian population. Its information technology was, for its day, state of the art, but the enormous burden of processing around 150 000 claims a day caused severe problems for some months. It was December before the processing delays had been overcome …

Source: Scotton (2000, pp. 9–11).

Implement the NDIS slowly and build it up over time

Even with successful completion of the preparatory work discussed above, the proposed NDIS would be too large and complex to implement fully at a single start date. It would need to be rolled out in a carefully staged way. Consequently, many people who would be entitled to support services under the guiding legislation would not be able to receive them until the scheme was fully operational, which will take several years (five years, in the Commission's view). The drafting of the legislation should include a timetable for the transition to a full scheme. But once fully operational, the scheme would provide support services to all who are entitled, as specified in the legislation.

As noted in chapter 3, the Commission is recommending that the NDIS provide three tiers of support (and therefore, three somewhat different populations of customers):

- tier 1: promoting opportunities for people with disabilities, and creating community awareness of the issues that affect people with disabilities; and minimising the impact of disability
- tier 2: information, referral and web-based services

- tier 3: the provision of funded individualised supports.

When the NDIA first begins operation, it would need to be able to begin delivering tier 1 and tier 2 services, at least initially at a basic level. Delivery of these services should improve quickly, as the NDIA refines its processes and learns more. The feasible number able to be brought into the scheme each year will depend in part on the success of the implementation taskforce in settling some of the preparatory matters discussed above.

For the all-important tier 3 services, the Commission proposes that the scheme would begin with a group of clients that is sufficiently large, but not unmanageably so. While all people with disabilities entitled to support from the NDIS have high needs, there are too many for the scheme to incorporate all of them in the proposed first year of operation (2014). The scheme needs to begin slowly to allow the NDIA to test its procedures, learn about what elements of the scheme work best and determine what adjustments need to be made. The administrative arrangements will need to be bedded down, links with external assessors and support providers made functional, regional offices opened and staffed, and so on. The capacity of the available workforce of experienced assessors and case managers to handle a sizeable intake load, and the effectiveness of internal processes to equilibrate their decisions, would also be an important constraint.

Gradual implementation would allow the NDIA to refine the scheme's processes with a client base that is not overwhelming; build robust and well-functioning assessment, funding and case management processes; fine tune administrative arrangements; and allow for a measured recruitment process that would encourage good staffing selection (rather than a rush to select a large number of people in a short time period).

Moreover, given the inevitable uncertainties about the exact costing of the scheme before its commencement (chapter 14), the early phase would be used to provide a much more precise estimate of the longer-run size of the Australian Government's premium contributions to the NDIS premium fund. It is difficult to predict such matters as how many people with disabilities will apply to the NDIA for services and support, what their assessments will reveal in the way of reasonable and necessary support, what mix of needs they will have, how much informal care they can reasonably be expected to rely upon themselves, and so on.

The phased introduction of the scheme would reduce the risks of costly, abrupt changes to the services market, as funding shifts from block to individualised funding. It would give service providers time to adapt their administrative systems, and to train and recruit new staff. Moreover, the transition period would allow people employed in state government disability departments to make a decision about whether to stay in the state government services field, shift into the NDIA or choose other roles. The NDIA and service providers could be expected to employ many of these people.

Which people to start with?

Our proposal would be to select a particular region that contained a modest number of likely clients (say, around 10 000) and implement the scheme there in 2014 (stage 1). This would be the 'test bed' for the scheme, where early problems could be identified and ironed out, the efficacy of the toolbox tested and refined, and more precise estimates of likely scheme costs arrived at.

In the second year, the scheme would expand Australia-wide, and should be fully operational by 2018. In the intervening years, more people with disabilities would be brought into the scheme. Groups that might be considered for the early rollout stages might include:

- people with newly-acquired disability who would meet the criteria for support under the scheme; this would allow the NDIA to learn about helping clients from the onset of disability, allow for the optimal use of early intervention measures, and might limit the scheme's exposure to cost escalations, were these clients to be brought in at a later date
- children aged under five years who have substantial core activity limitations, as early investments have the potential to have high long-run payoffs
- select groups for whom involvement in pilot early intervention programs looks promising; this would inform future therapies and approaches to disability
- people who are now cared for by ageing carers, thus benefiting both the person with a disability and the aged carer
- people who have been inappropriately placed in nursing homes, thereby also freeing up nursing home resources for elderly people.

The practicality of particular levels of intakes each year should be a matter for the NDIA to manage this as it sees fit. As it built up its internal capacity and refined its procedures to reflect what it had learned while supporting stage 1 clients, it would be well-placed to decide such matters. For example, it might choose to take on much larger numbers of clients in the second and subsequent years, as its systems, procedures and workforce were more established and the NDIA had become a more experienced agency.

Table 17.2 **Implementation of the NDIS**

Date	*Milestone*
Second half of 2011, or early 2012	COAG would: • agree to an MOU that sets out in-principle agreement that the NDIS should commence in stages from Jan 2014 • create a high level taskforce from all jurisdictions, to be headed by a person with insurance or disability experience who has driven change successfully in a large organisation (appointed with the agreement of all jurisdictions) the taskforce would: • work full time on planning the details of the scheme • develop a draft intergovernmental agreement for final signing in 12 months • report back regularly to Heads of Treasuries meetings and COAG on milestones reached in the planning for the commencement of NDIS by Jan 2014
Feb 2013 COAG meeting	final consideration and agreement by COAG to the intergovernmental agreement, including an agreement on funding arrangements announcement of the NDIS Board taskforce executive to act as interim staff
March to May 2013	Commonwealth to introduce legislation to create NDIS and NDIA, with an initial appropriation • state legislation and further Commonwealth legislation to follow board to commence formally • board to appoint a CEO • staff to be recruited
July 2013	appoint NDIA case managers • intensive training over 2 months test information systems between those who want to be service providers and the NDIS
Sep to Dec 2013	establish local and regional offices for NDIA intensive training of allied health professionals as NDIS assessors commencement of public information campaign; outreach by local case managers to local disability organisations, people with disabilities, existing and potential service providers, local community service groups and local media information sessions across Australia for people with disabilities, their families and carers, service providers and the general community • what the NDIS will do for people • the assessment process • people's rights and responsibilities disability organisations also to undertake group information sessions call for interest and pre-registration of stage 1 clients

(Continued next page)

Table 17.2 **(continued)**

Date	*Milestone*
Jan 2014	NDIS commences with a full-scale rollout in a region with around 10 000 clients. That would allow fine-tuning of the scheme, while providing high quality services to many thousands of people.
2015	in Jan 2015, rollout would extend nationally to cover all of Australia • progressively it would be expanded to cover all relevant people with a disability, commencing with all new cases of significant disability and some of the groups most disadvantaged by the current arrangements.
2017	NDIA evaluation of effectiveness of self-directed funding
2018	all current and new clients to be receiving NDIS services
2020	independent review of NDIA and NDIS

However, many people have been waiting a long time for better services, so the process for recruitment into the scheme must not be open-ended. The Commission proposes that the NDIA's legislation should give the NDIA some flexibility, but should specify that all those who met the criteria for entitlement must be receiving services by 2018.

17.4 Interaction between the two schemes

There are likely to be some economies of scope between NDIS and NIIS (for example, some local case managers, assessors and support providers may undertake the same function for clients in both schemes). In such cases, it would be important to streamline compliance burdens, for example, in relation to reporting and performance monitoring, to avoid a 'doubling-up' of such requirements.

In time, there may be some logic in bringing the NIIS into the NDIS. However, as discussed in chapter 16, this is not clearcut, as there are some differences between the two schemes, and the gains from a merger might not be worth incurring the costs. The Commission consider it much more important that governments address the undoubted problems of the present arrangements through the NDIS and NIIS, rather than wait many more years in an attempt to achieve a consensus on a single all-encompassing scheme.

The Commission recommends that, in 2020, governments should institute an independent and public inquiry into the appropriateness of a merger. After this period of operation, sufficient experience and information would be available then to better establish the costs and benefits of this.

DRAFT RECOMMENDATION 17.1

In the second half of 2011 or early 2012, the Australian Government and the state and territory governments should, under the auspices of COAG, agree to a memorandum of understanding that sets out an in-principle agreement:

- ***that the NDIS should commence in stages from January 2014, be rolled out nationally in 2015 and be fully operational by 2018***
- ***to follow the reform timetable for the NIIS specified in draft recommendation 16.5.***

DRAFT RECOMMENDATION 17.2

The Australian Government and the state and territory governments, under the auspices of COAG, should create:

- ***a full-time high level taskforce from all jurisdictions to commence work on the detailed implementation of the NDIS***
  - ***to be headed by a person with insurance or disability experience who has driven change successfully in a large organisation, appointed with the agreement of all jurisdictions***
  - ***with a draft intergovernmental agreement to be prepared for final consideration and agreement by COAG in February 2013***
- ***a full-time high level taskforce from all jurisdictions to commence work on the implementation of the NIIS by the states and territories.***

DRAFT RECOMMENDATION 17.3

In the period leading up until the full introduction of the NDIS, the Australian Government should supplement funding under the National Disability Agreement to reduce some of the worst rationing of support services.

DRAFT RECOMMENDATION 17.4

In 2020, there should be an independent public inquiry into the operation of the NDIS and its effectiveness in meeting the needs of people with disabilities. The review should also encompass the review of the NIIS as set out in draft recommendation 16.5.

APPENDICES

A Consultations

A.1 Conduct of the inquiry

Following receipt of the terms of reference, the Commission placed notices on the inquiry website, advertised in national and metropolitan newspapers and sent a circular to a wide range of individuals and organisations, inviting participation in the inquiry. The Commission then embarked on an extensive round of informal consultations to help it understand the key issues and to become aware of the most appropriate ways of engaging with people with different disabilities.

Discussions also commenced with the Independent Panel established by the Government to advise the Commission during the course of the inquiry (FaHCSIA 2010). The panel comprises people with extensive expertise and knowledge of disability issues, and the Commission has continued to meet with the panel at frequent intervals during the course of the inquiry.

In May 2010, the Commission released several documents in different formats, and an online Auslan presentation, to help people and organisations provide their views to the Commission:

- A full Issues Paper covering the issues in detail, indicated some particular matters on which it sought information, and invited formal public submissions.
- A short set of questions addressing the main issues for people wanting to provide a personal response based on their personal experiences (perhaps made in confidence).
- A short Auslan presentation of the key questions and a text version of the Auslan presentation was placed on the inquiry website.
- An Easy English version of the key issues was also made available. It was prepared in a questionnaire format that allowed people with disabilities or their support worker/s to write answers on the printed document, to be returned to the Commission.

Accompanying this material was a second circular that advised participants about the different means by which they could make their views known to the

Commission, explained how the Commission intended to publish material so as to reach most people and provided information as to how the public hearings would be organised to facilitate their involvement.

There has been considerable public interest in this inquiry. At the time of release of this draft report, over 600 public submissions have been received and placed on the inquiry website. Many were from people with disabilities or those who care for them. Also well-represented are the large and small organisations that support them.

A full list of public submissions is contained in section A.2. It includes 45 personal submissions where the author was willing to make the submission public on a ‘name withheld’ basis. In addition, the Commission received a handful of confidential submissions and over 100 personal responses (generally, short emails) and completed Easy English questionnaires.

During the course of the inquiry, the Commission also consulted with a range of interested parties in Australia and New Zealand to obtain an overview of the key issues. A list of individuals and organisations that the Commission held discussions with is contained in section A.3.

During June and July 2010, an initial round of public hearings was held in most state and territory capital cities. A list of the 119 participants who took part is contained in section A.4. A full transcript of the proceedings at all hearings is available on the inquiry website.

In conducting this inquiry, the Commission has been assisted by the participation of a large number of individuals and organisations. The Commission thanks all those who have contributed thus far.

A.2 Submissions received

Participants	*Submission no.*
Able Community Care	16
Access Innovation Media	257
ACE National Network Inc	366
ACH Group	293
ACT Community Living Project Inc	196
Action for Community Living	508
Action for Tasmanian Autistic Children	24
ACTU	417
Advocacy Tasmania Inc	483
Agency for Clinical Innovation (NSW)	93
Alcorn, Ian and Heather	57
Allen, Lyn	81
Allowance Incorporated	130
Allsop, Gary	39
Alzheimer’s Australia NSW	289
Alzheimer's Australia	478
AMPARO Advocacy Inc	501
Anderson-Porter, Fiona	154
Anglicare Australia	270, 594
Annecto - the people network	367
APC Prosthetics Pty Ltd	241
Arthritis Victoria	231
Asher, Anthony	435
Association for Children with a Disability	297
Association for Children with a Disability (Vic)	509
Association of Doctors in Developmental Disability (ADIDD)	377
Attendant Care Industry Association	268
Australasian Society for the Study of Intellectual Disability (ASSID Victoria)	323
Australian Advisory Board on Autism Spectrum Disorders	467
Australian Association of Developmental Disability Medicine and the National and NSW Councils for Intellectual Disability	29
Australian Blindness Forum	438
Australian Catholic Bishops Conference	332
Australian Catholic University	356
Australian Centre for Financial Studies	531
Australian Communications Consumer Action Network	565
Australian DeafBlind Council	35, 121

Australian Dental Association Inc	552
Australian Dual Diagnosis Recovery Network Inc	31
Australian Federation of Disability Organisations	495
Australian Human Rights Commission	72
Australian Institute of Health and Welfare	415
Australian Lawyers Alliance	305
Australian Leukodystrophy Support Group	564
Australian Medical Association	568
Australian Nursing Federation (ANF)	335
Australian Orthotic Prosthetic Association	237, 387
Australian Physiotherapy Association	503
Australian Rehabilitation and Assistive Technology Association	400
Australian Rehabilitation Providers Association Inc	523
Australian RehabWorks	451
Australians Mad As Hell	153
Autism Asperger ACT Inc	298
Autism Aspergers Advocacy Australia	516
Autism Behavioural Intervention NSW	331
Autism Early Intervention Outcomes Unit (AEIOU)	408
Autism SA	462
Autism Spectrum Australia (Aspect)	443
Autism Victoria	468
Avant Mutual Group Limited	550
Baird, Brigette	51
Baker, Lesley J	188
Bankstown LGA	32
Baptiscare	441
Barker, Helen	535
Barnes, Elena	89
Barnes, Les	139
Barnett, Rev. Dr Glenn	99
Becker, Bruce	452
Bedford	287
Bellchambers, Joyce	58
Bellis, Clare	555
Bennett-Roberts, Alison	319
Bergin, Faye and Michael	234
Best, Maria	164
Bigby, Christine	384

Bishop, J and M	173
Black, Cr Judith M	95
Blind Citizens Australia	327
Blue Mountains Interagency Working Party	142
Blue Skies	307
Booth, William Sabin	175
Bosotti, Max	372
Brady, Philip	36
Brain Injury Australia	371
Brain Injury Network SA (BINSA)	274
Branson, Jenavene	85
Brightwater Care Group	398
Broughton, Brian L	66
Brown, Prudence	548
Browning, Trevor and Trish	50
Buck, Wayne, Ann and Michael	250
Buckley, Bob	111
Burge, Gary Nicholas	2
Burke, Margaret Ann	197
Caelli, Maureen	79
Cairns Community Legal Centre Inc	439
Callaway, Libby; Sloan, Sue and Winkler, Di	526
Calvary Health Care Bethlehem	436
Campbelltown City Council	469
CAN (Mental Health) Inc	71
Cancer Council Australia	558
Capricorn Community Development Association Inc	599
Care Connect Ltd	407
Carers Australia	406
Carers NSW	244
Carers Victoria	475
Carers WA	345
Carroll, Lorna	106
Carroll, Terri	403
CASA (Committed About Securing Accommodation for People with Disabilities)	54
Cassidy, Ann	245
Catholic Health Australia	295
Catholic Social Services Victoria	453
Centacare Townsville	485

Central Sydney GP Network Ltd	18
Centre for Developmental Disability Health Victoria	185
The Centre for Cerebral Palsy	290
Cerebral Palsy Alliance (formerly The Spastic Centre)	527
Cerebral Palsy Australia	574
Cerebral Palsy League	505
Charlie Rook OAM	75
Children with Disabilities Australia	532
Chronic Illness Alliance	215
City of Botany Bay	213
City of Kingston	177
City of Playford	308, 603
City of Port Adelaide	64
City of Salisbury	343
Clark, Mia	123
Clarke, Mark W	309
Clayton, Phil	421
Coffs Coast Regional Disability Committee	223
Colby, James	280
Community and Public Sector Union	353
Community Living Project Inc	354
Completefeet.com.au	134
Condren, James	258
Connolly, Peter	143
Councils of Social Service in Australia	369
Country Women's Association of NSW	97
CPSU / SPSF	116
Croft, Krystyna	447
Culpitt, Jocelyn	428
Cynthia Pereira	425
Dagostino, Bruno and O’Hanlon, Terry	602
Dalling, Jacqueline	141
Darch, Peter	456
Darebin City Council	497
De Josselin, Kathleen	90
Deaf Australia Inc	374
Deaf Children Australia	522
Deaf Society of NSW	373
DeafBlind Association (NSW) Inc	300

Deafness Forum	363
Debra Australia	554
Dell, Amanda	465
Demmery, Peter	92
Dennison, Cyril	76
Department of Broadband, Communications and the Digital Economy	598
Deschamp, Dr Philip	136
Dewar, Meredith	317
Dexter, Matthew	94
Dieticians Association of Australia	294
Dignity for Disability	360
Disability & Positive Ageing Planner	395
Disability Advocacy and Complaints Service of South Australia	267
Disability Advocacy Network Australia (DANA) Ltd	490
DisAbility Connections Victoria	246
Disability Council of NSW	489
Disability Discrimination Legal Centre Inc	152
Disability Discrimination Legal Service Incorporated	73
Disability Information Advocacy Service Inc	208
Disability Knowledge Network	256
Disability Professionals Association - SA Chapter	316
The Disability Trust	230
Disability Services Commission Victoria	388
Disabled Access Consultancy Pty Ltd	44
Donovan, Joylene	40
Down Syndrome Victoria	492
Dunstan, Dr Edwin	120
Durrant, Suzanne	165
E W Tipping Foundation	397
Early Childhood Intervention Australia	450
EARtrak Pty Ltd	404
Ellis, Elizabeth	584
Endeavour Foundation	472
Epilepsy Council of Australia & Epilepsy Australia	272
Ethnic Disability Advocacy Centre	339
Evans, Jess	585
Evans, Kate	278
Family Advocacy Inc	160
Feenstra, Peter	172

Field (furthering inclusive learning & development)	577
Fighting Chance Australia	131
Filmer, Ewan and Joanne	312
Financial Services Council	576
Findlay, Sandi	193
First Peoples Disability Network (Australia)	542
Fisher, Helen	538
Foreman, Dr Noela	240
Forrester, Dr Mike	119
Foster, Alan	476
Foster, John	218
Friedreich Ataxia Clinic	423
Fyffe, Dr Chris	385
Gains, Reece	582
Geelong Parent Network	219
Genetic Support Network Vic	593
Getting A Life	370
Gippsland Carers Association Inc	133
Good, Pam	271
Gowell, Kylie	138
Greco, Peter	351
Grujic, Claire	159
GTK Rehab	265
Guiding Light Services	459
Gunn, Catriona	566
Gunnis, Korey and Strathdee Laurie	132
Haggarty, Katherine	107
Hanna, Amanda	563
Harris, Susan	190
HC Harrison Consultants Pty Ltd	431
The Hawkevale Trust	105
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A.3 Visits and discussions

Australia

Aboriginal Disability Network

ACT Government departments

Australian Bureau of Statistics

Australian Federation of Disability Organisations

Australian ICF[1] Disability and Rehabilitation Research Program, University of Sydney

Australian Social Inclusion Board

Graham Bashford

Brightwater Care Group

Café 64, Walgett

Carers Australia (national meeting of all branches)

Centrelink

Chris Cuff

Comcare

CRS Australia

Department of Education, Employment and Workplace Relations

Department of Families, Housing, Community Services and Indigenous Affairs

Department of Health and Ageing

Department of the Prime Minister and Cabinet

Disability ACT

forum hosted by the Disability Coalition of Western Australia (attendees included National Disability Services WA, the Developmental Disability Council of WA, People with Disabilities WA, Headwest, Advocacy Southwest, CASA (Committed About Securing Accommodation for People with Disabilities, the Ethnic Disability Advocacy Centre and Carers WA)

Disability Services Expo

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[1] ICF refers to the International Classification of Functioning, Disability and Health (see http://sydney.edu.au/health_sciences/aidarrp/about_us.shtml).

Dorothy Sales Cottages

Dyson Consulting Group (Maree Dyson)

First Peoples Disability Network

Heads of Workers’ Compensation Authorities and Heads of Compulsory Third Party Authorities (National, and Long Term Support Working Group)

Insurance Council of Australia

Koomarri Employment Services

Law Council of Australia

Moree — disability service providers roundtable; Newell Advocacy

Motor Accident Insurance Board, Tasmania

National Council on Intellectual Disability

National Disability Alliance

National Disability Services

National People with Disabilities and Carer Council

New South Wales Council for Intellectual Disability

New South Wales Government departments

New South Wales Lifetime Care and Support Authority

Northern Territory Government departments

Physical Disabilities Australia

Queanbeyan Hospital

Queensland Government departments

Professor Dinah Reddihough, Director of Developmental Medicine, Royal Children’s Hospital, Melbourne

Social Inclusion Board of South Australia

South Australian Government departments and agencies

St Giles Society

Tasmanian Government departments

Dr Jane Tracy, Centre for Developmental Disability Health, Monash University

Transport Accident Commission

Treasury

Victorian Government departments

Western Australian Government

Worksafe Victoria

New Zealand

Accident Compensation Corporation

New Zealand Government departments

Kaleidoscope Consulting International

United Kingdom

HM Treasury

A.4 Public hearings

Hobart — 7 June 2010

Action for Tasmania’s Autistic Children
Speak Out
Advocacy Tasmania
Young People in Nursing Homes Tasmania
Ann MacArthur

Melbourne — 8 and 9 June 2010

Chris Monteagle
Lifestyle in Supported Accommodation Group
Valarie Johnstone
Action for Community Living
Advocacy Disability Ethnicity Community
Raelene West
Youth Disability Advocacy Service
National Federation of Families, Parents and Carers
Victorian Coalition of ABI Service Providers
Michael Merrett
Lorina Nervenga
Leslie Cope, Adam Cope
David Hayter
Matthew Potocnik
Summer Foundation
Shaunagh and Wayne Stevens
UnitingCare Community Options
George Vassiliou
Joseph Toscano
Irene Kwong
Scope
Bernadette Roberts

Adelaide — 16 June 2010

Julia Farr Association
Intellectual Disability Association of SA
Harold Rush
South Australian Council of Social Service
South Australian Council on Intellectual Disability
Erin McKenzie-Christensen and Jeff Christensen
Helen Keene
Steve Nirta
Melissa Leckie

Julie Sutherland
Margie Charlesworth and Elisia Farrukh
Stefan Slucki
Joan Hay
Maurice Corcoran
Jody Holdback
Brain Injury Australia

Canberra — 12 and 13 July 2010

Deafness Forum Australia
Women With Disabilities Australia
Richard Cumpston
Bob Buckley
Sally Richards
Hazel Moir
Carers Australia
UnitingCare Australia

Brisbane — 15 and 16 July 2010

Henk Horchner
Mamre Association/Pave the Way
Ian Alcorn
Cyril Dennison
Youngcare
Amparo Advocacy
Rosemund Harrington
Ben Lawson
Paul Hamilton
Kyabra Community Association
National Ethnic Disability Alliance
Mary Walsh
Parent to Parent Association Queensland
Henk Horchner
Anne Vetter
Health Consumers Network
Speaking Up For You
Capricorn Community Development Association
Australians Mad As Hell
Susan Freeme
Mary Walsh
Cerebral Palsy League
Endeavour Foundation
Blue Skies Group

Queensland Advocacy Inc
Queenslanders with Disability Network
Queensland Parents For People With A Disability

Sydney — 19, 20 and 21 July 2010

Slater and Gordon
Spinal Cord Injuries Australia
Carers Alliance
Sunnyfield
Carers Victoria
Ron Singh
Carmelita Bongco
Korey Gunnis and Laurie Strathdee
Margaret Anne Reynolds
Kathy Breen
Family Advocacy
Autism Behavioural Intervention New South Wales
Fortitude Parents Group
Australian Council of Social Service
People with Disability Australia Inc
National Disability and Carer Alliance
New South Wales Disability Discrimination Legal Centre
Adam Johnston
Disability Council of New South Wales
Muscular Dystrophy Foundation
Brainlink Services
Motor Neurone Disease Association of Australia
Young People in Nursing Homes Alliance
Deborah Fullwood
Access Innovation Media
Michael Herdman
Australian Federation of Disability
Australian DeafBlind Council
Ability Options Ltd
Allowance Inc
Dianne
Limbs 4 Life Inc
Multicultural Disability Advocacy Association of New South Wales
Fighting Chance
Stewart MacLennan

Perth — 22 July 2010

LHMU (Liquor, Hospitality and Miscellaneous Union) WA Branch
Ethnic Disability Advocacy Centre
Muscular Dystrophy Association of Western Australia
William Booth
Brian O’Hart
National Ethnic Disability Alliance
Headwest Brain Injury Association of Western Australia
Developmental Disability Council
People with Disabilities (Western Australia)
Carers Western Australia
Samantha Jenkinson
Samantha Connor
Erik Leipoldt
Blind Citizens Western Australia

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