

## **Disability Support Pension (DSP) Project: A snapshot of DSP client experiences of claims and assessments since the 2015 changes**

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Joni Gear  
Legal Project Officer  
**National Social Security Rights Network**  
T: +61 448 007 428  
E: [rpo@nssrn.org.au](mailto:rpo@nssrn.org.au)  
W: [www.nssrn.org.au](http://www.nssrn.org.au)

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## 1. About the National Social Security Rights Network

The National Social Security Rights Network (NSSRN) is a peak community organisation in the area of income support law, policy and administration. Our members are community legal centres across the country who provide free and independent legal assistance to current and former social security and family assistance claimants and recipients.

The NSSRN's research and policy positions are informed by our members' unique access to client-related experience. This allows us to make meaningful contributions to a range of policy and administration areas.

## 2. Executive Summary

Disability Support Pension (DSP) is a social security payment available to some people living with a disability and who have limited capacity to work.

This paper examines the impact of key changes made to the DSP medical assessment process in 2015. The findings are based on the analysis of a snapshot of DSP client experiences of claims and assessments from one of the NSSRN's member centres, Basic Rights Queensland Inc (BRQ) (the "DSP Project"). The snapshot included 22 clients who appealed the Department of Human Services' decision to reject their DSP claim to the Administrative Appeals Tribunal (AAT).

Over the past decade, DSP has undergone significant reforms and been subject to public inquiry. This paper is a continuation of the work that the NSSRN has done during this period, making recommendations aimed at improving the administration and delivery of DSP policy to the Department of Human Services (DHS) and the Department of Social Services (DSS) in an effort to minimise any negative impact on people claiming DSP.

The analysis of the data obtained by the DSP Project is consistent with the concerns previously raised by the NSSRN regarding two key changes which were made to the medical assessment process in 2015<sup>1</sup>:

1. Removal of the Treating Doctor's Report (TDR) (which elicited specific medical information from treating doctors relevant to DSP eligibility):
  - That the removal of the TDR would make it more difficult for claimants and doctors to understand what information to provide to support their claim; and
  - That worthy claimants may not be successful due to the greater reliance on raw medical evidence which may not specifically address the complex and unique legislative requirements for the DSP, such as addressing key legislative questions.
2. Introduction of the Disability Medical Assessment (DMA) process (a second medical assessment by a Government-Contracted Doctor):
  - That the introduction of DMA would negatively impact the efficiency of processing DSP claims.

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<sup>1</sup> National Welfare Rights Network, Submission No 27 to Joint Committee of Public Accounts and Audit, *Commonwealth Risk Management - Inquiry based on Auditor-General's report 18 (2015-16)*, 7 November 2016.

## **Impact of removal of TDR**

Of the 22 casework files included in this snapshot, 17 clients were successful in their appeal to the AAT by providing information that a TDR would likely have covered.

These clients were deemed to have been eligible for DSP at the time of their initial claim. Most of these claimants who were successful on appeal were able to persuade the AAT of their DSP medical eligibility on the basis of additional evidence obtained after the decision of the Authorised Review Officer (ARO) and after the claimant sought legal advice. Typically BRQ elicited this evidence from the Treating Health Professional (THP) by requesting responses to a questionnaire. This questionnaire was tailored to DSP eligibility requirements and the impairment table guidelines – in effect, it acted as a replacement TDR.

In most of our case studies, the raw medical evidence was not enough to address DSP eligibility, particularly questions regarding functional capacity. Additional medical evidence was required to satisfy the assessment criteria and this was typically provided in the form of a targeted THP report. In our view, the removal of the TDR resulted in worthy claimants being denied DSP payments, a decision they were only able to successfully appeal with legal assistance.

The data also highlighted the under-utilisation of the safeguards in the assessment process in cases where the Job Capacity Assessor (JCA) made findings inconsistent with the THP's written medical evidence. In almost all cases, the JCA had not contacted the THP to clarify medical or treatment issues, and had not sought advice from the DHS's Health Professional Advisory Unit.

## **Impact of DMA process**

The NSSRN's key concern at the introduction of the DMA process was that it would increase delays in processing of claims and potentially increase the rate of appeals. Only 4 of the 22 cases in our snapshot were referred for DMA and while the DMA process naturally extends the claim assessment time, these generally occurred within two months of the JCA.

In only one of the four cases did the Government Contracted Doctor (GCD) contact the THP. That occurred despite advice from the Department of Human Services that GCDs are instructed to contact THPs in a variety of situations, including where medical evidence is incomplete or does not fully address the extent of functional capacity, or where the person has a number of vulnerabilities. Contacting the THP in these circumstances may have improved the DMA process by ensuring that all relevant medical evidence was considered.

## **Other issues**

Our snapshot demonstrated that many worthy DSP claimants experience significant delays in being granted the Disability Support Pension. In circumstances where a claimant appeals the Department of Human Services' decision, the Tribunal commonly makes a determination 10 months after the initial DSP claim was lodged.

The data also highlighted a lack of understanding of the Program of Support (POS) requirements. The POS is an employment support program which must be completed by some claimants to be eligible for DSP. The snapshot data establishes that POS requirements remain a critical issue for many DSP claimants, despite the fact that DSS data shows that POS

requirements are only a relevant factor in determining a small number of DSP claims. In 10 of our 22 cases, the claim for DSP was rejected on the basis that the POS requirements were not met. On appeal the Tribunal found that 9 of these cases medically qualified for DSP: 1 case satisfied the POS requirements, and 8 cases had their points increased resulting in a finding of a severe impairment (and therefore no requirement to complete a POS).

### **3. Recommendations**

#### **Recent changes to medical assessment process**

Our casework snapshot considered the experience of people claiming DSP between 2015 and mid-2017, prior to the recent introduction of changes to the medical assessment process, and the pilot of a new streamlined process.

The NSSRN has been consulted on the new streamlined process, which include:

- Changes to information for claimants and their THPs, including new questionnaires which aim to provide a guide on the type of evidence required to support a claim; and
- Early assessment of medical eligibility, where cases which clearly do not meet medical eligibility are identified early and rejected, prior to an assessment of other qualification criteria. Meritorious claims advance in the assessment process and are referred for a Job Capacity Assessment.

We support these efforts to improve the claims and assessment processes and appreciate being consulted on this process. The new guide and questionnaire for claimants and THPs goes some way to addressing our concerns.

However, the issues raised by our casework data remain relevant to the newly introduced processes. This data will act as a baseline moving forward, and we look forward to examining the impact of the streamlined process on our member centre clients in the future.

#### **Recommendations**

Based on the analysis of data obtained through the DSP Project, the NSSRN makes the following recommendations to improve the operation of the claims and assessments process for DSP:

##### **1. Improvements in communication with DSP claimants, including:**

- 1.1. The production of a hard copy and online flow-chart guide covering the steps required to satisfy medical eligibility for DSP, including plain English definitions of legal terms such as “permanent”, and “fully, diagnosed, treated and stabilised”. This must include an explanation of the Impairment Tables and points system, and the option for a person to step into the role of the decision maker and ‘test their eligibility’.
- 1.2. The production of a comprehensive hard copy and online guide for THPs that explains the threshold of DSP eligibility and the Impairment Tables.

## **2. Improvements in medical assessments, including:**

- 2.1. A requirement of Job Capacity Assessors to contact the THPs in instances where:
  - the assessment is conducted via telephone or video link; or
  - the assessment is for a vulnerable client; or
  - the Job Capacity Assessor is going to make a determination contrary to medical evidence from the THP.
- 2.2 If a Job Capacity Assessor makes a determination which is contrary to medical evidence from the THP, they must refer to the matter to Centrelink's Health Professional Advisory Unit.
- 2.3 If a Job Capacity Assessor finds that the medical evidence does not address some of the DSP eligibility requirements, then they must inform the claimant of the gaps.
- 2.4 A copy of the Job Capacity Assessment report must be provided to all claimants.
- 2.5 THPs be compensated for providing reports to support DSP claims.
- 2.6 GCDs who conduct Disability Medical Assessments must be provided with an assessment checklist designed for the claimant to ensure they assess each aspect of the claim.
- 2.7 GCDs must contact the THP if the Disability Medical Assessment is conducted via telephone or video conference.
- 2.8 The Disability Medical Assessment process should focus on assisting vulnerable and disadvantaged claimants whose claims are denied following a JCA, rather than limiting the process to double checking favourable assessments.
- 2.9 The efficiency and effectiveness of the Disability Medical Assessment process must be publicly evaluated by an independent body.

## **3. Adopting changes to legislation and policy to allow for individuals, who appeal the decision to reject their DSP claim, to be deemed eligible for DSP on any date between the time of claim and a review determination.**

This will fast track claimants who:

- i. request an internal review of the decision to reject their DSP claim, or pursue an appeal to the Administrative Appeals Tribunal;
- ii. deteriorate in their condition while their review/appeal is on foot;
- iii. are unsuccessful in their appeal because they were not medically eligible at the time of claim; and
- iv. submit medical evidence which proves that they became medically eligible for DSP after the time of claim but before the appeal is determined.

**4. Improvements to the Program of Support, including:**

4.1 Information about the POS must be communicated to all claimants, particularly to unemployment payment recipients who are likely to be potential DSP claimants. At the very least, information should be targeted to reach those on unemployment payments who are regularly exempted from mutual obligation requirements due to ongoing medical issues.

4.2 Any claimant who is found ineligible for DSP on the basis that they have not commenced a POS, must be assessed as to their capacity to participate in the program. If medical evidence indicates that they cannot participate in the program, they should be found to be eligible for DSP.

4.3 A no-cost POS must be available to any claimant who satisfies the DSP income and assets test, is not currently in receipt of an income support payment, and who is required to complete a POS to become eligible for DSP.

**5. A requirement for DSS and DHS to regularly publish comprehensive data about the DSP program, including:**

- i. consistent, regularly published data about claim processing timeframes, including data broken down by reference to the two current stages (JCA and DMA);
- ii. consistent, regularly published data about the DMA process, including proportion of claims referred for a DMA, outcomes of the DMA process and proportion of DMA determinations which differ from the JCA process; and
- iii. information about the use of interpreters, face to face assessment versus assessment by phone, video link or on the papers, and other measures of service delivery relevant to assessing the process' quality for particularly groups such as residents of remote communities, non-English speaking claimants and so forth.



## 4. Background and Objectives

### 4.1 Eligibility for the Disability Support Pension

- 4.1.1 The focus of this paper is on the medical eligibility requirements for DSP. To qualify for DSP, a person must also meet income and assets tests, as well as age and residency requirements. A person who is above the age pension age (currently 65) is not eligible for DSP payments.
- 4.1.2 The eligibility criteria for Disability Support Pension is set out in Division 1, Part 2.3 of the *Social Security Act 1991* ("the Act"), which provides the legislative basis for the Disability Support Pension. The Department of Social Services and the Department of Human Services are responsible for the delivery of the pension.<sup>2</sup>
- 4.1.3 Under the medical eligibility requirements, a person will qualify for DSP if a number of conditions are satisfied.

i. **The claimant must have a physical, intellectual or psychiatric impairment and their impairment rating is of 20 points or more under the Impairment Tables.**

Some impairments automatically qualify for DSP, such as permanent blindness. For others, the impairment must be permanent, meaning that it must be a fully diagnosed, treated and stabilised condition as defined in the Act, and likely to persist for more than two years.

The *Social Security (Tables for the Assessment of Work-related Impairment for Disability Support Pension) Determination 2011* sets out the Impairment Tables. There are 15 tables that assess "the level of functional impact of a person's impairment and [assign] an impairment rating corresponding to the identified level of impact."<sup>3</sup>

ii. **A person will qualify for DSP if they have a severe impairment and a Continuing Inability to Work (CITW).**

A person has a severe impairment if they have 20 points under one Impairment Table. A person has a CITW if at the time of their claim they have a work capacity of less than 15 hours a week.

iii. **A person without a severe impairment will qualify for DSP if they have at least 20 points or more across the impairment tables, a CITW, and have actively participated in a Program of Support (POS) for at least 18 months in the 3 years before claiming for DSP (subject to limited exceptions).**

The POS attempts to assist people living with a disability obtain work. A person is exempt from parts of the POS if their condition makes it unfeasible for them to complete the program. A person will qualify for DSP if they meet the POS and CITW requirements.

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<sup>2</sup> The Department of Social Services (DSS) is responsible for payment policy. They also manage the financial outlay of social security payments and maintain the Guide to Social Security Law. The Department of Human Services (DHS) is responsible for implementing the legislation and policy and administering the system.

<sup>3</sup> Guide to Social Security Law, Part 3.6.3.05 Guidelines to the Rules for Applying the Impairment Tables.

## 4.2 Recent evaluations of the DSP medical assessment process

- 4.2.1 Since 2015, the Disability Support Pension has been subject to public audit and inquiry. This paper builds on those reviews of the pension scheme.
- 4.2.2 In 2015, the Australian National Audit Office's (ANAO) published their audit report on *Qualifying for the Disability Support Pension*.<sup>4</sup> The ANAO conducted their fieldwork between December 2014 and April 2015.<sup>5</sup> Their audit examined the impact of changes to the eligibility criteria for DSP in late 2011 and 2012. In September 2011, the Program of Support requirements were introduced for new DSP claimants.<sup>6</sup> In January 2012, the Impairment Tables were revised.<sup>7</sup> These changes resulted in a noticeable decline in the grant rate of DSP claims.<sup>8</sup> The ANAO also considered issues arising from targeted reviews of DSP recipients.
- 4.2.3 The ANAO audit prompted a public inquiry by the Commonwealth Parliament's Joint Committee of Public Accounts and Audit ("the Joint Committee"). The Joint Committee's inquiry focused on the Commonwealth's risk management of the Disability Support Pension program. The inquiry was open to public submissions. It considered the balance of the administrative efficiency of the DSP program and budget pressures, against "the burdens placed on individual claimants and recipients."<sup>9</sup>
- 4.2.4 The Joint Committee's inquiry considered two changes made to the DSP claims and assessment processes in 2015. These changes were implemented after the ANAO had completed their audit. As noted, they were:
- the removal of the Treating Doctor's Report, and
  - the introduction of the Disability Medical Assessment.

## 4.3 Overview of the 2015 changes to the DSP medical assessment process

- 4.3.1 The two key changes to the DSP claims and assessment processes in 2015 were:

- **Removal of the Treating Doctor's Report**

Prior to 2015, all new claimants of DSP were issued with a Centrelink medical report form for their treating health professional ("treating doctor's report" or "TDR"). The form asked a range of questions about the diagnosis, treatment, clinical history and functional impact of a person's medical conditions. The report was designed to elicit information relevant to assessing medical qualification for the disability support pension.

When a person claimed the DSP, DHS would issue this report to them to take to their Treating Health Professional (THP), often the general practitioner

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<sup>4</sup> Australian National Audit Office, *Qualifying for the Disability Support Pension*, Report No 18 (2015–16).

<sup>5</sup> Ibid 20.

<sup>6</sup> Introduced by the *Family Assistance and Other Legislation Amendment Act 2011 (Cth)*.

<sup>7</sup> Revised due to the *Social Security (Tables for the Assessment of Work-related Impairment for Disability Support Pension) Determination 2011 (Cth)*.

<sup>8</sup> The grant rate for 2011 was 59.8%, dropping to 48.5% in 2012 and 43.3% in 2013. See Department of Social Services, Submission No 28 to Joint Committee of Public Accounts and Audit, *Inquiry based on Auditor-General's Report 18 (2015-16)*, May 2017, 6.

<sup>9</sup> Joint Committee of Public Accounts and Audit, Parliament of the Commonwealth of Australia, *Commonwealth Risk Management - Inquiry based on Auditor-General's report 18 (2015-16)* (2017) 1 [1.3].

responsible for co-ordinating and managing their overall care and treatment. The THP was also able to include or attach other medical evidence they considered relevant to the claim. Medical practitioners were able to claim the time taken to complete the form as a Medicare item, when the form was completed as part of a consultation.

The TDR usually was the key medical evidence considered by DHS when determining whether the person met the DSP medical requirements.

On 1 January 2015, the TDR was abolished for all new DSP claimants under 35 and living in metropolitan areas. From 1 July 2015, this policy was extended to all new DSP claimants.

From 1 July 2015, new DSP claimants were given an information checklist identifying types of primary medical evidence (such as hospital records or x-rays) that they may wish to supply with their claim.

DSP claims were then assessed against this primary medical evidence.

- **Introduction of Disability Medical Assessment (DMA)**

Prior to 2015, all DSP medical assessments were conducted by Department of Human Services' staff employed as Job Capacity Assessors (JCA). JCA's are health or allied health professionals. The medical assessment is typically conducted in person. The JCA determines whether the claimant's medical condition(s) has been fully diagnosed, treated and stabilised, and assesses the appropriate impairment rating.

Prior to 2015, the JCA was followed by final determination of the claim. In practice, the JCA's opinion about a person's medical eligibility for the DSP was usually accepted by the final decision-maker.

On 1 January 2015, a second medical review was introduced to new DSP claimants under 35 and living in metropolitan areas. This second review, called a Disability Medical Assessment (DMA), was conducted by a Government-Contracted Doctor (GCD). It occurred only if the JCA determined that a person was medically eligible for the DSP.

From 1 July 2015, all new DSP claimants were referred for a DMA if the JCA determined they were medically eligible for DSP.

#### **4.4 Joint Committee's May 2017 report on the 2015 assessment changes**

- 4.4.1 The NSSRN made a submission to the Joint Committee's inquiry.<sup>10</sup> We anticipated a number of adverse and unintended consequences arising from the above outlined changes. The NSSRN viewed these changes as "undermining the quality of the DHS assessment process."<sup>11</sup>

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<sup>10</sup> National Welfare Rights Network, above n 1.

<sup>11</sup> National Welfare Rights Network, above n 1, 3.

- 4.4.2 The Joint Committee’s final report was published in May 2017. The report recommended improvements to DSP claims and assessment which aligned with our concerns. The Joint Committee concluded that there was “further scope for administrative and risk management improvements to the DSP program.”<sup>12</sup> The Joint Committee’s report also found that due to a lack of publicly available material it was “difficult to externally analyse the efficiency or effectiveness of the assessment and review processes.”<sup>13</sup>
- 4.4.3 The Joint Committee’s inquiry report made several observations on the impact of these changes. The Joint Committee found that “the time to complete assessments and reviews had increased, despite the new processes.”<sup>14</sup> The Joint Committee emphasised the need to improve the “quality of communication”, noting that this could lead to improvements in “both decision-making and timeliness of assessments and reviews whilst also potentially lowering the number of appeals.”<sup>15</sup>
- 4.4.4 Following the Joint Committee’s published report of May 2017, the NSSRN collated and analysed data from one of our member centres to further assess the impact of the 2015 changes on DSP claimants. The focus of this research was to identify improvements which could be made to the DSP medical assessment processes.

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<sup>12</sup> Joint Committee of Public Accounts and Audit, Parliament of the Commonwealth of Australia, *Commonwealth Risk Management: Inquiry based on Auditor-General's report 18 (2015-16)* (2017) 2 [1.7].

<sup>13</sup> Ibid 5 [1.21].

<sup>14</sup> Ibid 3 [1.15].

<sup>15</sup> Ibid 4 [1.16].

## 5. Project Methodology

### 5.1 Project scope

- 5.1.1 In collaboration with BRQ, the NSSRN identified casework files for clients who:
- i. lodged a DSP claim after the 2015 changes to the medical assessment process were implemented;
  - ii. received notification from the Department of Human Services that their claim was denied; and
  - iii. were assisted by BRQ to appeal the rejection of their DSP claim to the Administrative Appeals Tribunal.
- 5.1.2 NSSRN engaged an external research consultant to review the 22 case files which fell within this project criteria.
- 5.1.3 Due to the small sample size, we are careful not to draw conclusions about the experience of claiming for DSP. These cases represent a particular client set of BRQ: people who had DSP rejected, who appealed to the Administrative Appeals Tribunal, who were deemed by BRQ to have cases with legal merit, who were not financially able to pay for legal representation, and who would have been disadvantaged in pursuing appeal unrepresented. The casework snapshot does not reflect the experience of all DSP rejected claimants.

### 5.2 Case Study Criteria

- 5.2.1 The cases selected for this snapshot were chosen in consideration of the two major changes to the DSP medical assessment process in 2015: the introduction of the Disability Medical Assessment and the removal of the Treating Doctor's Report. The cases chosen only involved clients affected by these new processes.
- 5.2.2 The case studies were selected via a search of the BRQ client database (CLISIS), using the following search terms:
- *DSP*
  - *Closed*
  - *6+ case hours*
  - *Represented at court/tribunal.*
  - *Case opened between 01/07/2015 and 03/04/2017.*<sup>16</sup>

This search provided 58 files, however only 22 of these files met the specific project criteria (i.e. where the client's DSP claim was made after the policy changes in 2015). We did not include appeals against review decisions which cancelled an earlier grant of DSP.

- 5.2.3 The 22 clients included in the snapshot were provided similar legal assistance. Not all clients approached BRQ at the same stage of their matter, however each client:
- had their initial DSP claim rejected,
  - had unsuccessfully had this decision to reject their claim internally reviewed by a Centrelink Authorised Review Officer, and

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<sup>16</sup> The casework review search was conducted on 3 April 2017.

- appealed the outcome of this internal review to the Social Services & Child Support Division of the Administrative Appeals Tribunal (otherwise known as tier 1 review).

5.2.4 A short overview of the client demographics are included in the Appendix of this paper.

## 6. Project observations

### 6.1 Summary of case outcomes

6.1.1 Of the 22 casework files included in this snapshot, 17 clients were successful in their appeal to the AAT. They were deemed to have been eligible for DSP at time of their initial claim.

6.1.2 The following table outlines the appeal decisions for the 17 successful clients:

Reason for DSP rejection	AAT decision on appeal	Cases
Program of Support requirements not met	Severe impairment (No POS required)	8
	POS met	1
Under 20 points	20 points awarded	5
Not fully diagnosed treated or stabilised	Fully Diagnosed Treated & Stabilised	3

6.1.3 There were 5 clients who the AAT determined were ineligible for DSP. The reasons were that their medical condition was not deemed fully diagnosed treated and stabilised (1), their condition attracted less than 20 points on the impairment tables (1), and the Program of Support requirements were not met (3).

### 6.2 Impact of removal of Treating Doctor's Report

6.2.1 The NSSRN did not support the removal of the Treating Doctor's Report (TDR) in 2015. We considered the TDR to be a necessary guide for claimants and their Treating Health Professional (THP) to understand what information was required to support a DSP claim.<sup>17</sup> We did not agree with DHS's view that the reliance on raw medical data would "add an additional level of assurance to the DSP claim process."<sup>18</sup>

6.2.2 We anticipated that the removal of the TDR would cause additional hardship to claimants. We were concerned that claimants who initially failed to provide sufficient medical evidence with their claim would later struggle to obtain further evidence of their condition at the time of claim. Similarly, we anticipated that a number of meritorious claimants would miss out on DSP payments for some time if they did not provide enough detailed evidence addressing their medical eligibility at the time of claim.

6.2.3 The ANAO audit found that the main reason for delays in assessing claims was because the claimant failed to provide all the information needed to assess their claim. In consideration of this, the Joint Committee's inquiry report concluded that improvements could be made to the quality of communication with claimants.<sup>19</sup> The inquiry particularly noted a "lack of clarity in outlining what information people

<sup>17</sup> National Welfare Rights Network, above n 1, 5.

<sup>18</sup> DHS, *Question on Notice number 11*, received 30 January 2017 as quoted in Joint Committee of Public Accounts and Audit, Parliament of Australia, *Commonwealth Risk Management - Inquiry based on Auditor-General's report 18 (2015-16)* (2017) 3 [1.14].

<sup>19</sup> Joint Committee of Public Accounts and Audit, above n 9, 24 [3.7].

should include in their claim or review responses; program of support requirements, and clearer use of the terms ‘fully diagnosed, treated and stabilised’.”<sup>20</sup>

- 6.2.4 In our case snapshot, most claimants who were successful on appeal were able to persuade the AAT of their DSP medical eligibility on the basis of new medical evidence. In each of these successful appeals, the new evidence was obtained after the decision of the ARO and after the claimant had sought legal advice. Typically, Basic Rights Queensland (BRQ) elicited this evidence from the THP by requesting responses to a questionnaire. This questionnaire was tailored to DSP eligibility requirements and the impairment table guidelines – in effect, it acted as a replacement TDR.
- 6.2.5 By their very nature, appeals against rejected DSP claims are undertaken as a merits review. The Administrative Appeals Tribunal, a merits review body, will assess the facts, law and policy related to the matter and arrive at their own decision. The provision of additional evidence commonly leads to successful outcomes at the administrative appellate level.<sup>21</sup> In the 2016-17 financial year, the percentage of tier 1 AAT appeals resulting in a decision to set aside the original DHS decision was almost 20%.<sup>22</sup>
- 6.2.6 It is not possible to discern how these claims would have been initially assessed had the TDR remained in use. However, in most of our case studies, the raw medical evidence was not enough to address DSP eligibility, particularly questions regarding functional capacity. Additional medical evidence was required to satisfy the assessment criteria and this was typically provided in the form of a targeted THP report. In our view, the removal of the TDR resulted in worthy claimants being denied DSP payments.
- 6.2.7 The Joint Committee’s inquiry report also recommended improved communication about DSP medical eligibility requirements and the assessment process.<sup>23</sup> Informed claimants are more likely to provide evidence which adequately addresses the eligibility requirements. In turn, this is likely to lead to fewer appeals of unmeritorious claims.

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<sup>20</sup> Ibid 2 [3.7].

<sup>21</sup> See Department of Social Services, Submission No 28 to Joint Committee of Public Accounts and Audit, *Inquiry based on Auditor-General’s Report 18 (2015-16)*, May 2017, 6.

<sup>22</sup> Department of Human Services, Submission No 42.2 to Joint Committee of Public Accounts and Audit, *Inquiry based on Auditor-General’s report 18 (2015-16)*, May 2017, 2.

<sup>23</sup> Joint Committee of Public Accounts and Audit, above n 9, 32 [3.41].



**Recommendation 1.**

*DHS improve their communication with DSP claimants through:*

- i. The production of a hard copy and online flow-chart guide covering the steps required to satisfy medical eligibility for DSP, including plain English definitions of legal terms such as “permanent”, and “fully, diagnosed, treated and stabilised”. This must include an explanation of the Impairment Tables and points system, and the option for a person to step into the role of the decision maker and ‘test their eligibility’.*
- ii. The production of a hard copy and online guide for Treating Health Professionals (THPs) that explains the threshold of DSP eligibility and the Impairment Tables.*

(We note that in mid-2017, improvements were made to the DSP claims and assessment processes. DHS introduced a new guide and questionnaire for claimants and their THPs. These changes addressed a number of our concerns with the removal of the TDR. Since June 2017, all new DSP claims are assessed in a streamlined process: claims which are clearly not going to satisfy the medical eligibility criteria are filtered out within a few days of the date of claim. Claimants have 13 weeks to provide additional evidence which would reopen their claim. This process also can assist in guiding claimants to the gaps in their medical evidence.)

6.2.8 There are two safeguards in the assessment process which may be used to address any deficiencies in the medical evidence provided. Every DSP claimant must undergo a Job Capacity Assessment (JCA). This is conducted by a Job Capacity Assessor who is a qualified health or allied health professional employed by DHS. If the Job Capacity Assessor’s expertise does not cover every aspect of the claimant’s condition, a secondary Assessor will be present. JCA Assessors have the discretion to:

- contact the THP to clarify any medical or treatment issues; and
- seek assistance and advice from DHS’ Health Professional Advisory Unit (HPAU). The HPAU are “a team of health professionals, including medical practitioners, in Centrelink who are available to provide medical advice and opinions to assist in determining a person’s eligibility for DSP for new claims... The HPAU is only asked for advice following completion of all usual assessment processes.”<sup>24</sup> The HPAU can also contact the THP and provide payment where additional evidence from the THP is sought.

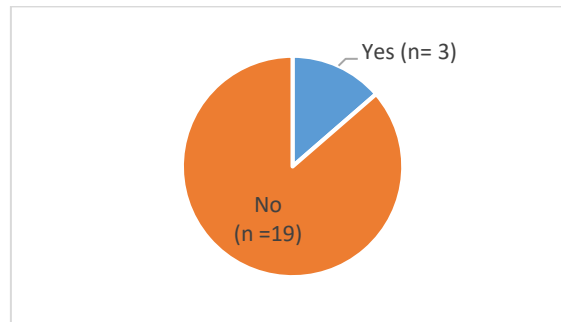
6.2.9 In our snapshot of the 22 cases, these two options were under-utilised:

- The majority of JCA Assessors did not contact the THP:

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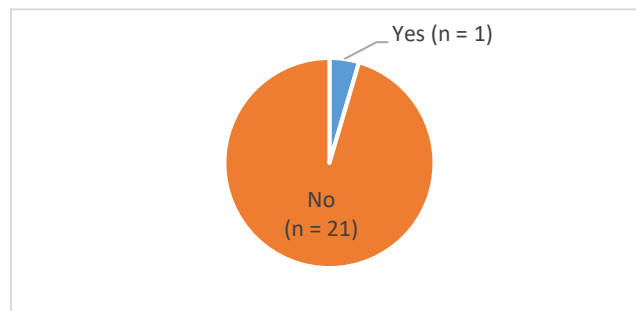
<sup>24</sup> Guide to Social Security Law, 1.1.H.60 Health Professional Advisory Unit (HPAU), <<http://guides.dss.gov.au/guide-social-security-law/1/1/h/60>>, accessed 30 October 2017.

### Did the JCA Assessors contact the THP?



- The majority of JCA Assessors did not refer the claim to the HPAU:

### Did the JCA Assessors refer the claim to the HPAU?



- 6.2.10 In the following case example of DA, the JCA Assessor did not contact any THP. However, the JCA Assessor made findings inconsistent with the THP's written medical evidence. In our view, it is likely that any errors arising from the JCA's findings would have been corrected by contacting the THP directly to discuss their opinion.

*DA is an Indigenous man with a number of complex mental health issues. His Centrelink file had vulnerability indicators of homelessness, mental health and childhood trauma history. He applied for DSP in early 2016. He had a diagnosis of complex Post-Traumatic Stress Disorder, Major Depressive Disorder, Substance Dependency, and Bi-polar disorder. His claim was assessed against Table 5 – Mental Health. He provided medical evidence from his GP and Psychiatrist. The medical evidence indicated that he had no capacity to work. The JCA was conducted by telephone. The JCA Assessor determined that DA had a baseline work capacity of 8-14 hours that may increase to 15-22 hours, contrary to the THPs opinions. This was affirmed by the ARO. On appeal to the AAT, the tribunal accepted the opinion of the THPs that DA had a continued incapacity to work. (We note that DA's original DSP claim was rejected on the basis that his mental health conditions were not FDT&S at the time of claim. However, on appeal the AAT found otherwise.)*

It is unclear why the JCA Assessor, who conducted the assessment via telephone, made a finding contrary to the opinions of DA's THPs. The error in assessing DA's work capacity (and the stability of his condition) may well have been avoided had the JCA Assessor taken the opportunity to contact DA's GP or psychiatrist. In our view, given DA's complex mental health issues and disadvantage, it should have been obligatory for the JCA Assessor to have contacted the THP prior to making an adverse decision.

- 6.2.11 The ANAO audit report encouraged DHS to provide more comprehensive reasons for rejecting a claim.<sup>25</sup> The NSSRN supports this recommendation. Our member centres frequently provide advice or information to clients who have been rejected for DSP. In our experience, many of these clients do not understand why their claim was rejected. We recommend that claim rejection letters provide clear reasons why a claim was rejected. All claimants should also receive a copy of their JCA report. This information will provide claimants with the opportunity to identify the gaps in their medical evidence, or choose not to pursue appeals without merits.

#### **Recommendations 2.1-2.4**

*2.1 A requirement of Job Capacity Assessors to contact the THPs in instances where:*

- *the assessment is conducted via telephone or video link; or*
- *the assessment is for a vulnerable client; or*
- *the Job Capacity Assessor is going to make a determination contrary to medical evidence from the THP.*

*2.2 If a Job Capacity Assessor makes a determination which is contrary to medical evidence from the THP, they must refer to the matter to Centrelink's Health Professional Advisory Unit.*

*2.3 If a Job Capacity Assessor finds that the medical evidence does not address some of the DSP eligibility requirements, then they must inform the claimant of the gaps.*

*2.4 A copy of the Job Capacity Assessment report must be provided to all claimants.*

- 6.2.12 The removal of the TDR created barriers for claimants seeking to obtain other medical evidence, in addition to their raw medical evidence, in support of their claim. Previously, a THP could claim the completion of the form as a Medicare item or part of a consultation. Since the TDR was removed, our member centres found that many THPs requested that their patients pay for medical reports to support a DSP claim. Usually this request occurred after the claim was rejected by the Original Decision Maker (ODM) and the claimant sought further evidence to support and explain their raw medical evidence. This evidence was easier to obtain once the client had obtained legal assistance, and their lawyer was able to directly negotiate with the THP to provide the report at no cost or for an affordable amount. However, some member centres continue to report that they struggled to negotiate with the THP to reduce the expense of these medical reports. Only a small number of our member centres have a limited disbursement fund. This means claimants, who are of limited financial capacity, often have to bear the cost of the reports.

<sup>25</sup> Australian National Audit Office, above n 4, 9.

### **Recommendation 2.5**

*THPs be compensated for providing reports to support DSP claims.*

(We note that the mid-2017 improvements to the DSP claims and assessment process reintroduced a Medicare claim item for DSP medical reports.)

## **6.3 Impact of Disability Medical Assessments process**

- 6.3.1 In our client snapshot, only 4 of the 22 cases were referred for a Disability Medical Assessment (DMA). As noted above, a referral for a DMA occurs only after a Job Capacity Assessor finds that the DSP claim meets medical eligibility requirements. The DMA is conducted by a government-contracted doctor (GCD).
- 6.3.2 The NSSRN previously expressed a view that the majority of referrals to a DMA would make no difference to the ultimate decision of medical eligibility.<sup>26</sup> We argued that DHS already had sufficient internal processes in place to ensure that the JCA was making accurate assessment decisions.
- 6.3.3 As our casework snapshot only includes clients who appealed their DSP claim rejection to the AAT, all 4 of the claims accessed as medically eligible by the JCA were overturned by the DMA. However, in each of these 4 cases, the AAT decided in favour of the claimant and considered them to be eligible for DSP at their time of claim.
- 6.3.4 Recent figures show 11,717 DMA's were conducted for the period 1 July to 31 December 2016. During this period, 15.8% of claims that went to a DMA were rejected.<sup>27</sup> The majority resulted in claims granted.
- 6.3.5 Our key concerns with the introduction of the DMAs were that they would increase delays in the processing of claims and potentially increase the rate of appeals.<sup>28</sup> The Joint Committee's inquiry found that the average time to complete a DSP assessment increased from 50 days during ANAO audit to 52 days in 2015-2016 when DMAs were introduced.<sup>29</sup> In our submission to the Joint Committee's inquiry, we identified one claimant who waited 6 months for their DMA following their JCA assessment.<sup>30</sup>
- 6.3.6 For the 4 cases in our snapshot, the DMA occurred generally within 2 months of the JCA. Although the figures are not as startling as 6 months, the DMA process naturally extends the claim assessment time. The following table outlines the additional time required for the completion of the medical assessment.

<sup>26</sup> National Welfare Rights Network, above n 1, 6.

<sup>27</sup> Department of Human Services, Submission No 42.2 to Joint Committee of Public Accounts and Audit, *Inquiry based on Auditor-General's report 18 (2015-16)*, May 2017, 3.

<sup>28</sup> Joint Committee of Public Accounts and Audit, above n 9, 28 [3.24].

<sup>29</sup> Ibid 32 [3.38].

<sup>30</sup> National Welfare Rights Network, above n 1, 6.

#### Time between JCA and DMA:

Client	JCA	DMA	Days between JCA & DMA
BA	20-May-16	07-Jul-16	48
FA	14-Mar-16	28-Apr-16	45
IA	05-Jan-16	09-Mar-16	64
KB	21-Aug-15	17-Sep-15	27

- 6.3.7 The NSSRN has been advised by the Department of Human Services that GCD's are instructed to contact treating health professionals (THP) in a variety of situations, including where medical evidence is incomplete or does not fully address the extent of functional capacity, or where a person has a number of vulnerabilities. GCD's could recommend payment of \$80 to a THP who provided relevant information. Despite these instructions, the GCD contacted the THP in just 1 of our 4 cases.
- 6.3.8 Some cases illustrated issues with the DMA process. For example, some cases describe cursory assessments. The GCD must be guided to undertake a thorough review of all impairments experienced by the claimant. In the case of FA:

*FA described her experience of the DMA to her lawyer and the AAT. She stated that the GCD conducting the DMA asked yes/no questions which only related to Table 1 - Stamina/Exertion & Table 2 – Upper Limb, despite FA's claim also being for a communication impairment. The GCD informed FA that she had sufficient points (30) across multiple tables and did not ask any questions about these communication issues. Although the GCD found 20+ points across the impairment tables, FA had not satisfied the Program of Support requirements and was therefore rejected for DSP. On appeal to the AAT, the tribunal member observed the extent of FA's communication impairments at the tribunal hearing and found that her evidence of these issues compelled 20 points under Table 8 – Communication. She was therefore eligible for DSP.*

#### **Recommendation 2.6**

*Government Contracted Doctors (GCD) who conduct Disability Medical Assessments must be provided with an assessment checklist designed for the claimant to ensure they assess each aspect of the claim.*

- 6.3.9 The NSSRN has expressed concerns about the use of video conferencing and telephone medical assessments, particularly as these mostly occur for claimants who live in rural or remote locations.
- 6.3.10 The case of BA, as detailed below, illustrates the issues arising from short consultations and the use of video conferencing equipment.

**BA** claimed for DSP in early 2016 on the basis of physical impairments to his spine and respiratory systems. BA did not speak English well and required an interpreter. He had several vulnerabilities, including a trauma background. The JCA found that BA satisfied medical eligibility for DSP, assigning him 20 points under Table 4 – Spinal Function. BA was then referred for a DMA. The DMA was conducted via video conference. The GCD conducting the DMA found that the JCA had erroneously used Table 4 for both spinal and respiratory impairments. In addition to this error, the GCD found that neither condition was FDT&S. BA was found ineligible for DSP. BA appealed to the AAT and subsequently obtained legal representation from BRQ. BRQ developed a clarifying questionnaire for BA's THPs, which aligned with the impairment ratings. The AAT found that the GCD conducting the DMA made a quick decision based on a short amount of consultation time and did not conduct a proper examination due, in part, to the video-conferencing facilities. Based on the additional THP medical reports, the AAT found BA had 20 points under Table 4 and therefore eligible for DSP.

- 6.3.11 As of October 2017, DSS reported that there were “32 Government-contracted Doctors in regional and remote areas of Australia with a high Indigenous population, including Karratha, Toowoomba and Carrajong.”<sup>31</sup> We advocate for more GCDs in rural and remote areas to ensure that more claimants have the opportunity to have face-to-face assessments.

#### **Recommendation 2.7**

*To ensure thorough assessments, GCDs must contact the THP if the Disability Medical Assessment is conducted via telephone or video conference.*

- 6.3.12 One case in our snapshot involved a GCD who did not clearly understand the DSP eligibility requirements.

*In the case of KB, documents obtained under freedom of information revealed that Centrelink had to clarify contradictory and inaccurate statements in the DMA report. In their report, the GCD made contradictory statements regarding their understanding of the definition of permanency of a condition. The GCD also did not make sufficient reference to the impairment table descriptors. Prior to this DMA, a JCA had awarded 20 points in one table on the basis of medical reports, a telephone call with the THP and a face-to-face assessment with KB. Despite strong medical evidence from the THP and relevant guiding impairment table descriptors, the GCD reduced the number of points to 10. We note that the DMA was conducted by video conference. On appeal, the AAT found that the original JCA decision was correct, based on the advice given by the THP on the telephone and in written reports. KB was medically eligible for DSP.*

<sup>31</sup> DHS, Answer to Question on Notice (Question reference number 6), to Senate Finance and Public Administration References Committee, Parliament of Commonwealth, Inquiry into The Appropriateness And Effectiveness Of The Objectives, Design, Implementation And Evaluation Of The Community Development Program (CDP), received 16 October 2017.

- 6.3.13 Despite some of our concerns with the DMA process, the NSSRN has previously advocated for its expanded use for vulnerable or disadvantaged claimants whose claim has been rejected following a JCA. A DMA may have benefitted the following client:

*RA is a man in his early 40s who applied for DSP in September 2015. He was not able to work due to his diagnosis of Paranoid Schizophrenia and an Acquired Brain Injury. He was diagnosed with chronic schizophrenia in mid-2013 during an inpatient admission to a psychiatric unit. Whilst in receipt of Newstart Allowance, he claimed DSP. The JCA and ODM determined that he was not eligible as his mental illness was not Fully Diagnosed, Treated and Stabilised (FDT&S). Three days prior to the decision to reject his DSP claim, his Newstart Allowance was cancelled. This was on the basis that he was not considered to be unemployed by Centrelink – he was an inpatient at that time and therefore did not have “a present intention to be part of the labour market.” RA appealed both his DSP claim rejection and the cancellation of his Newstart Allowance. He had not worked for several years and was reliant on his social security payment to meet basic living costs. Two separate ARO’s affirmed the decisions of both ODM in respect to his DSP claim and Newstart Allowance. RA appealed his DSP claim rejection to the AAT. The tribunal member found that his mental illness was FDT&S from the inpatient clinical report of mid-2013. This evidence had been available to both the JCA and ARO. RA was found by the AAT to be medically eligible for DSP at the time of his claim.*

RA was a particularly vulnerable client. He was admitted to a psychiatric unit for some time during the course of his claim and appeal. He also experienced financial hardship as a result of the cancellation of his Newstart Allowance. A DMA may have identified the JCA’s oversight of the 2013 medical report, and corrected the original decision to reject RA’s claim.

**Recommendation 2.8**

*The DMA process must be extended to assist in assessing claims by vulnerable and disadvantaged claimants, which are rejected at the JCA stage. This is instead of limiting the DMA process to double checking favourable DHS assessments.*

**Recommendation 2.9**

*The efficiency and effectiveness of the DMA process must be publicly evaluated by an independent body.*

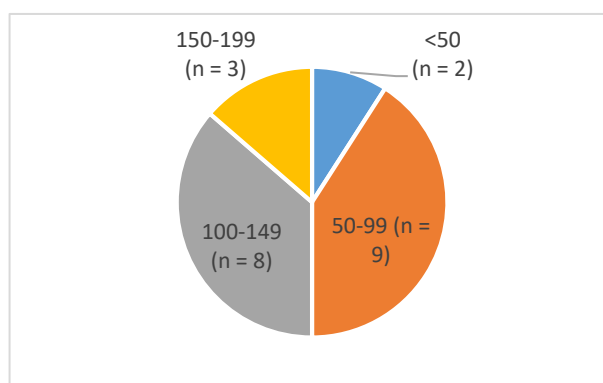
## 6.4 Other issues

While our research primarily focused on impact of the removal of the TDR and the DMA process, we have outlined other issues of significance below.

### Significant delays experienced by worthy claimants

- 6.4.1 The Joint Committee’s inquiry report found that “the time to complete assessments and reviews had increased, despite the new processes [introduced in 2015].”<sup>32</sup> In Part 6.2 of this paper, we discussed how claims were delayed due to insufficient medical evidence.
- 6.4.2 The 22 cases included in the snapshot indicate that the time involved in a DSP claim assessment could vary from less than 2 months to almost 6 months. In our snapshot, a period of 2 to 4 months was common for the claim assessment.

**Days between claim & DSP rejection:**



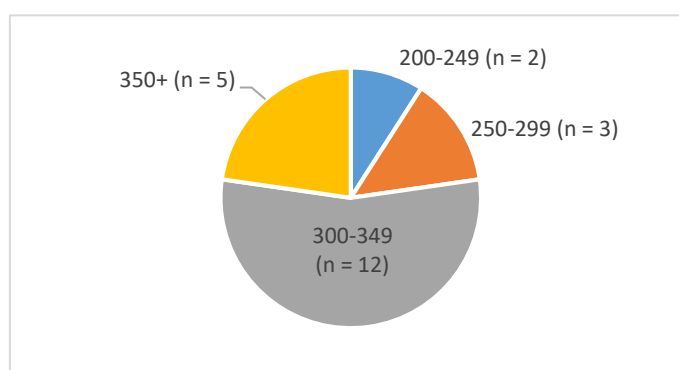
- 6.4.3 Each matter in our casework snapshot involved an appeal to the first tier of the AAT. Recent figures show that the Tribunal finds in favour of between 20 to 25 per cent of appeals against rejected claims. The decisions were primarily overturned due to additional information being provided to support a claim.<sup>33</sup> As previously noted, 17 of the 22 cases were successful on appeal. The following chart illustrates that many worthy DSP claimants experience significant delays in their pursuit of pension payment. In the majority of our snapshot cases, the appeal judgement came more than 10 months after the initial DSP claim.

<sup>32</sup> Joint Committee of Public Accounts and Audit, above n 9, 24 [3.5].

<sup>33</sup> Ibid 33 [3.41] quoting Ms Serena Wilson, Deputy Secretary, DSS *Committee Hansard*, 30 November 2017, 21.



#### Days between claim & determination of AAT appeal:



- 6.4.4 In 2013-2014, claims were often denied on the basis that the claimants medical condition was not fully diagnosed, treated and stabilised (FDT&S).<sup>34</sup> In our experience, many unsuccessful claimants do not understand the legal definition of these terms but believe they medically qualify for DSP payments. For example, a claimant may have debilitating injuries caused by a stroke but they must undergo many months of rehabilitation, and pursue all treatment options, before they will be fully treated and stabilised (rendering them eligible for DSP).
- 6.4.5 Many of our member centres advise appellant clients to make new claims for DSP, while they await their appeal hearing. This is because many clients' conditions deteriorate over time, rendering them more likely to satisfy the thresholds of DSP medical eligibility on a later date. However, not all appellants with deteriorating conditions make new claims, despite new evidence suggesting they are now eligible for DSP. This causes significant delays for some people, such as in the following case:

***OA** is a woman in her mid-50s with a degenerative lower back disease. She applied for DSP approximately 14 months after the onset of her condition. Her medical evidence indicated that she was on the wait list to see a pain specialist. The ODM rejected her claim on the grounds that she had not undergone a review with a pain specialist. OA applied for an internal review. She submitted an extra medical report from a spine surgeon. The spine surgeon recommended further investigation of her condition (x-rays and an MRI). An ARO affirmed the decision to reject her claim. OA appealed this decision to the AAT. The tribunal member agreed that OA's condition was not fully treated at the time of claim, but concluded that her condition was now FDT&S. The tribunal member recommended that OA make a new claim for DSP.*

<sup>34</sup> This reason represented 35.8% of rejections. See Commonwealth of Australia 2014, *Official Committee Hansard*, Senate Community Affairs Legislation Committee, Supplementary Estimates, Budget Estimates 11 December 2014, Question reference number: ES14-000542.

### **Recommendation 3**

*That legislation and policy be amended to allow for individuals, who appeal the decision to reject their DSP claim, to be deemed eligible for DSP on any date between the time of claim and the review determination. This will fast track claimants who:*

- i. request an internal review of the decision to reject their DSP claim, or pursue an appeal to the Administrative Appeals Tribunal;*
- ii. deteriorate in their condition while their review/appeal is on foot;*
- iii. are unsuccessful in their appeal because they were not medically eligible at the time of claim; and*
- iv. submit medical evidence which proves that they became medically eligible for DSP after the time of claim but before the review application is determined.*

### **Lack of understanding of Program of Support**

6.4.6 In September 2011, the Program of Support (POS) Rules were introduced to DSP eligibility requirements. The NSSRN member centres assist a number of DSP claimants who are deemed ineligible because they have not completed a POS. Despite our regular interaction with this cohort of claimants, DSS data shows that POS requirements are only a relevant factor in determining a small number of DSP claims. For instance, in 2015-2016, POS requirements were relevant to only 3.8% of DSP claims. The overwhelming majority of DSP claims which are granted involve claimants who are assessed as having a severe impairment and therefore exempt from POS (94%).<sup>35</sup>

6.4.7 However, the POS requirements remain a critical issue for many DSP claimants. A key concern is the lack of information and communication about who will be required to complete the program. Additionally, there is limited information available to claimants on whether they have met the program's requirements. At the time of publication of the Joint Committee's inquiry report, it was noted that there was limited information available online explaining the POS.<sup>36</sup> The Commonwealth Ombudsman has also noted the lack of understanding of the POS requirements, particularly by Indigenous DSP claimants living in remote areas.<sup>37</sup> In our experience, many claimants who have their claim rejected on the basis of not completing a POS will pursue an appeal to the AAT. Improved communication about the POS requirements is necessary to ensure that claimants can better anticipate their eligibility status. The following case in our snapshot illustrates this issue:

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<sup>35</sup> Australian National Audit Office, above n 4, 26.

<sup>36</sup> We note that the DHS web page on POS was updated between early 2017 and April 2017 to include general information. For Joint Committee commentary see: Joint Committee of Public Accounts and Audit, above n 9, 35 [3.50].

<sup>37</sup> Commonwealth Ombudsman, *Department of Human Services: Accessibility of Disability Support Pension for remote Indigenous Australians*, Report No 6 (2016) 7 [2.11] & 25 [4.39].

*UA had been employed in the same job for 7 years prior to making her claim for DSP. Her claim was assessed across 4 impairment tables. Both the JCA and ARO found a total of 25 points across the tables. UA had not completed a POS and was deemed ineligible for DSP. UA made a complaint to Centrelink stating that she was not aware that they had to complete a POS to be eligible for DSP. UA stated that if she had known this was required, then she would have commenced the POS at the earliest opportunity. Centrelink stated that they did not know UA required a POS until after the JCA assessed her DSP claim. Ultimately, on appeal, UA was found to have a severe impairment and was not required to complete a POS.*

#### **Recommendation 4.1**

*Information about the POS must be communicated to all claimants, particularly to unemployment payment recipients who are likely to be potential DSP claimants. At the very least, information should be targeted to reach those on unemployment payments who are regularly exempted from mutual obligation requirements due to ongoing medical issues.*

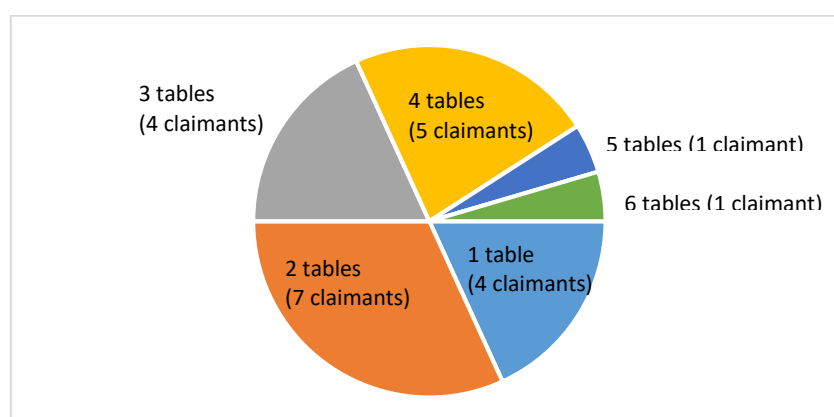
- 6.4.8 In addition to the lack of information, the POS requirements raise a number of concerns. The N SSRN has argued that there is no rational basis for differentiating a person with a single severe impairment from someone with multiple impairments that, in combination, are equally severe.<sup>38</sup> In our experience, many claimants with multiple impairments are less likely to satisfy work requirements. Many struggle managing multiple conditions and several, often conflicting, forms of medical treatment.
- 6.4.9 The Joint Committee's inquiry report also noted that the definition of severe disability may exclude claimants with significant disability but whose impairments fall across multiple categories.<sup>39</sup> The Joint Committee's inquiry report recommended that DSS and DHS undertake a post-implementation review of the POS requirements.
- 6.4.10 Our client snapshots illustrate how common it is to claim for DSP on the basis of multiple impairments. In our snapshot, only 4 claimants were assessed against one impairment table. The remaining 18 were assessed against multiple tables.

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<sup>38</sup> National Welfare Rights Network, above n 1, 11

<sup>39</sup> Joint Committee of Public Accounts and Audit, above n 9, 4 [1.19].

### Claims involving multiple impairment tables (initial claims):



- 6.4.11 In 10 of our 22 cases, the claim for DSP was rejected on the basis of the POS requirements not being met. On appeal, the tribunal found that 9 of these cases were eligible for DSP: 1 case satisfied the POS requirements, and 8 cases had their points increased resulting in a finding of a severe impairment (i.e. 20 points under a single impairment table).
- 6.4.12 Participation in POS is difficult for some claimants. Many participants are exempted from POS because their medical condition prohibits them from participation.

**AA** claimed for DSP on the basis of psychological and neurological conditions. Both the JCA and ARO determined that AA had a total of 20 points across 3 impairment tables. As AA did not satisfy the definition of having a severe impairment, he was required to satisfy the POS requirements. Although AA had been enrolled in a POS, his Employment Service Provider (ESP) advised that the POS was suspended due to temporary work incapacity. The POS was suspended at the time AA lodged his DSP claim. On appeal, it was submitted on AA's behalf that the POS requirements had been satisfied in line with the AAT Tier 2 decision of O'Cass and Secretary 2016 AATA 876, which held that a claimant was not required to "actively participate" in POS. They would be deemed to be participating if their POS continues, but they were exempted for some reason. AA was successful in his appeal and DSP was granted.

- 6.4.13 The NSSRN is concerned that many claimants are unable to actively participate in a POS due to their medical conditions. Many claimants, particularly those who were working up until the time of the onset of their impairment, may have to wait 18 months until they can access DSP, despite their inability to meaningfully benefit from the POS. The following case study illustrates this point:

***MA** is an Aboriginal man in his mid-30s who claimed for DSP on the basis of 7 interrelated medical conditions. His claim was assessed against 4 of the impairment tables. Both the JCA and ARO found that he had a total of 25 points across the tables. MA had not completed a POS and his claim was rejected. On appeal, the AAT agreed with the assessments of the JCA and ARO and found MA to be ineligible for DSP. However, the tribunal member commented that MA's impairments would likely impede him from participating in a POS. With no other alternative, the tribunal member suggested that MA follow the legislative requirements and then lodge a new claim.*

#### **Recommendation 4.2**

*Any claimant who is found ineligible for DSP on the basis that they have not commenced a Program of Support, must be assessed as to their capacity to participate in the program. If medical evidence indicates that they cannot participate in the program, they should be found to be eligible for DSP.*

- 6.4.14 Another case illustrates the financial barriers of completing POS when not in receipt of any social security payment.

***EA** had been employed in a farm processing and packing role for 15 continuous years. In 2014, she developed a spinal injury after moving a box of vegetables at work. Her worker's compensation claim was rejected. She claimed for DSP approximately 18 months after the onset of her injury. Her partner's income precluded her from claiming for Newstart Allowance while her DSP claim was under assessment. EA was assessed as having 20 points across two tables, and therefore did not meet the definition of having a severe impairment. Her Employment Service Provider noted that she may find it difficult to enrol in a Program of Support because she was not receiving any social security payments and may have to pay a fee to enrol in one. On appeal, EA was found to have a severe impairment and was medically eligible for DSP at the time of her claim.*

### **Recommendation 4.3**

*A no-cost POS must be available to any claimant who is not currently in receipt of an income support payment, who satisfies the DSP income and assets test, and who is required to complete a POS to become eligible for DSP.*

### **Impact of changes on grant rate of DSP**

6.4.15 DSS provided data on DSP claims and population figures to the Joint Committee's inquiry. These figures illustrate a substantial drop in the grant rate of DSP in 2016:

#### **DSP claims and population data up to June 2016<sup>40</sup>:**

	Number of claims determined (Over financial year ending June)	Grant rate (Over financial year ending June)	Number of Recipients (as at June)	Annual Change in population Number
2010	142,709	63.9%	792,581	35,463
2011	151,815	59.8%	818,850	26,269
2012	134,157	48.5%	827,460	8,610
2013	127,173	43.3%	821,738	-5,722
2014	142,096	40.7%	830,454	8,716
2015	113,443	36.9%	814,391	-15,523
2016	102,600	25.7%	782,891	-31,500

Although the grant rate of DSP has continued to decline since the narrowing of the impairment tables in 2012, the 2016 grant rate is significantly lower than previous years. The figure of 23.7% represents the lowest grant rate in recent history.<sup>41</sup>

6.4.16 These figures may be affected by a range of factors, however in our assessment, the decline can be reasonably attributed to the 2015 changes to the DSP medical assessment process. In our view, these changes had a profound effect on the claims and assessment experience of many claimants and made it more difficult to meet DSP medical eligibility.

### **Lack of available data on DSP**

6.4.17 It is difficult to evaluate the DSP program as data is not readily available. In our submission to the Joint Committee's inquiry, the NSSRN argued for improved collection and publication of data about the DSP program. We supported the recommendations made in the ANAO report that DSS and DHS develop comprehensive external and internal performance measures. We reiterate these endorsements here, as comprehensive data may address misunderstandings about the DSP program. It will also equip organisations, such as the NSSRN, to make informed assessments and comments about the mechanisms of the program and any unintended consequences.

<sup>40</sup> Department of Social Services, Submission No 28 to Joint Committee of Public Accounts and Audit, *Inquiry based on Auditor-General's report 18 (2015-16)*, May 2017, 6.

<sup>41</sup> Ibid.

**Recommendation 5**

*That DSS and DHS be required to regularly publish comprehensive data about the DSP program, including:*

- i. consistent, regularly published data about claim processing timeframes, including data broken down by reference to the two current stages (JCA and DMA);*
- ii. consistent, regularly published data about the DMA process, including proportion of claims referred for a DMA, outcomes of the DMA process and proportion of DMA determinations which differ from the JCA process; and*
- iii. information about the use of interpreters, face to face assessment versus assessment by phone, video link or on the papers, and other measures of service delivery relevant to assessing the process' quality for particularly groups such as residents of remote communities, no-English speaking claimants and so forth.*

## 7. References

Australian National Audit Office, *Qualifying for the Disability Support Pension*, Report No 18 (2015–16).

Commonwealth of Australia 2014, Official Committee Hansard, Senate Community Affairs Legislation Committee, Supplementary Estimates, Budget Estimates 11 December 2014, Question reference number: ES14-000542.

Commonwealth Ombudsman, *Department of Human Services: Accessibility of Disability Support Pension for remote Indigenous Australians*, Report No 6 (2016).

Department of Human Services, *Answer to Question on Notice (Question reference number 6)*, to Senate Finance and Public Administration References Committee, Parliament of Commonwealth, Inquiry into The Appropriateness And Effectiveness Of The Objectives, Design, Implementation And Evaluation Of The Community Development Program (CDP), received 16 October 2017.

Department of Human Services, Submission No 42.2 to Joint Committee of Public Accounts and Audit, *Inquiry based on Auditor-General's report 18 (2015-16)*, May 2017.

Department of Social Services, Annual Report 2016-2017.

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Department of Social Services, Submission No 28 to Joint Committee of Public Accounts and Audit, *Inquiry based on Auditor-General's report 18 (2015-16)*, May 2017.

Joint Committee of Public Accounts and Audit, Parliament of Australia, *Commonwealth Risk Management - Inquiry based on Auditor-General's report 18 (2015-16)* (2017).

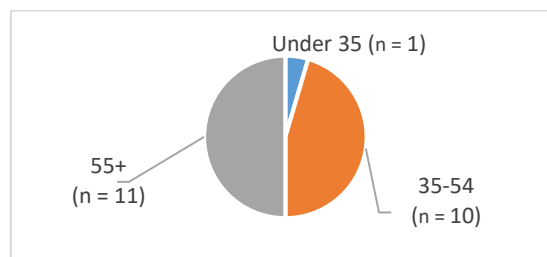
National Welfare Rights Network, Submission No 27 to Joint Committee of Public Accounts and Audit, *Commonwealth Risk Management - Inquiry based on Auditor-General's report 18 (2015-16)*, 7 November 2016.



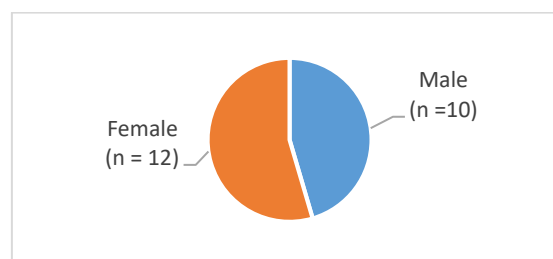
## 8. Appendices

### 8.1 Client demographics

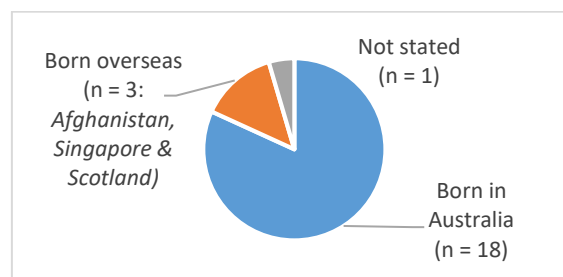
#### Age distribution:



#### Gender distribution:

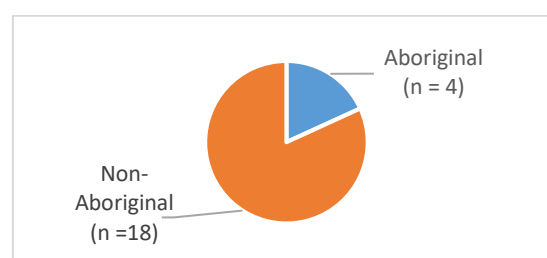


#### Country of birth:



#### Indigenous indicator:

*(No client identified as Torres Strait Islander, or both Aboriginal and Torres Strait Islander)*



## 8.2 Summary of 22 DSP files in research project

ID	Date of claim	Condition(s)	Impairment table(s)	Reason for rejection at ARO	JCA spoke to THP	JCA included contributing assessor	Referral to HPAU	DMA occurred	DMA spoke to THP	Successful AAT outcome
AA	21/06/2016 (previous 10/12/2015)	Parkinson's Disease, left wrist injury, depression	2,3,7	POS not met	✓ 1 <sup>st</sup> JCA 11/02/2016 ✗ 2 <sup>nd</sup> JCA 18/08/2016	✓ 1 <sup>st</sup> JCA ✗ 2 <sup>nd</sup> JCA	✓ 1 <sup>st</sup> JCA ✗ 2 <sup>nd</sup> JCA	N/A rejected by ODM & ARO	N/A	✓
BA	25/02/2016 (previous 18/03/2015)	Kyphoscoliosis thoracic spine, COAD, Latent TB	4	Not FDT&S, 0 points	✗ 1 <sup>st</sup> JCA 15/06/2015 ✓ 2 <sup>nd</sup> JCA 20/05/2016	✗ 1 <sup>st</sup> JCA ✓ 2 <sup>nd</sup> JCA	✗	✓	✓	✓
DA	03/03/2016	PTSD, MDD, Alcohol dependence/withdrawal, bi-polar	5	Not FS&T, 0 points	✗	✗	✗	N/A rejected by ODM & ARO	N/A	✓
EA	23/11/2015	Spinal Injury	2,4	POS not met, no CITW	✗	✗	✗	N/A rejected by ODM & ARO	N/A	✓
FA	13/11/2015	Larynx cancer, headaches	1, 2, 8	POS not met	✗	✗ 1 <sup>st</sup> JCA ✓ 2 <sup>nd</sup> JCA	✗	✓	✗	✓
IA	15/10/2015	Crohn's disease	1, 4, 10, 13	POS not met	✗	✓ 1st, 2 <sup>nd</sup> & 3 <sup>rd</sup>	✗	✓	✗	✓
KA	10/12/2015	Degenerative disc disease (DDD), osteoarthritis of knee, depression, morbid obesity	3,4,5	15 points only	✗	✗ 1 <sup>st</sup> JCA ✓ 2 <sup>nd</sup> JCA	✗	N/A rejected by ODM & ARO	N/A	✓
MA	28/08/2015	Respiratory disorder, sagittal sinus thrombosis, leg amputation, spinal condition, brain tumour	1,3,4,7	POS not met, no CITW	✗		✗	N/A rejected by ODM & ARO	N/A	✗
OA	30/12/2015	Degenerative back disease	3,4	Not FDT&S as not FT&S.	✗	✗	✗	N/A rejected by ODM & ARO	N/A	✗
QA	16/11/2015	Leukaemia, neuropathy	2,3,11	0 points not permanent as not FT&S	✗	✗	✗	N/A rejected by ODM & ARO	N/A	✗
RA	29/09/2015	Schizophrenia	5	Not FT&S, 0 points	✗	✓	✗	N/A rejected by ODM & ARO Scheduled for new 03/2016 DSP claim.	N/A	✓
SA	29/10/2015	Cerebellar atrophy	3,8	POS not met, no CITW	✗	✓ x 2	✗	N/A rejected by ODM & ARO	N/A	✓
TA	24/09/2015	Arthritis, diabetes	1,2,3,4, 15	10 points only.	✗	✓ 1 <sup>st</sup> JCA ✓ x2 2 <sup>nd</sup> JCA	✗	N/A rejected by ODM & ARO	N/A	✓
UA	09/12/2015	Vestibular dysfunction, IBS	10, 11, 12, 14	POS not met.	✗	✓	✗	N/A rejected by ODM & ARO	N/A	✓
WA	30/09/2015	Migrainous vertigo, knee condition, neck DDD	1, 3, 4, 11	POS not met.	✗	✓	✗	N/A rejected by ODM & ARO	N/A	✓
XA	18/08/2015	Dystonia, osteoarthritis, depression	1,2,3,4,5,8	POS not met.	✗	✓ 1 <sup>st</sup> JCA ✓ 2 <sup>nd</sup> JCA	✗	N/A rejected by ODM & ARO	N/A	✓
YA	17/08/2015	ischaemic heart disease, Shoulder & upper arm disorder, diabetes, hypertension, hypercholesterolaemia, adenocarcinoma of the colon, lower back pain & disc degeneration, depression	1,2,4,5	POS not met	✗	✓	✗	N/A rejected by ODM & ARO	N/A	✓
AB	30/09/2015	Schizophrenia, hypertension, diabetes	1,5	10 points only	✗	✓	✗	N/A rejected by ODM & ARO	N/A	✓
BB	21/12/2015	ASD, heart palpitations, CAPD	7	10 points only	✗	✗	✗	N/A rejected by ODM & ARO	N/A	✗
EB	30/10/2015	Neck disorder, PTSD, depression	4,5	10 points only	✗	✓ 1 <sup>st</sup> JCA ✓ 2 <sup>nd</sup> JCA	✗	N/A rejected by ODM & ARO	N/A	✓
IB	20/07/2015	Degenerative spine disease, depression	4,5	0 points, not FT&S.	✓	✓ 1 <sup>st</sup> JCA ✓ x2 2 <sup>nd</sup> JCA	✗	N/A rejected by ODM & ARO	N/A	✗
KB	08/07/2015	Spinal disorder, immunodeficiency	1,4	10 points only.	✓	✗	✗	✓	✗	✓

### 8.3 Glossary of Technical Terms

AAT	Administrations Appeal Tribunal
ADL	Activities of daily living
ARO	Centrelink Authorised Review Officer
ASD	Autism Spectrum Disorder
ATSI	Aboriginal or/and Torres Strait Islander
BRQ	Basic Rights Queensland
CBT	Cognitive Behavioural Therapy
CAPD	Central Auditory Processing Disorder
CITW	Continuing inability/incapacity to work (for at least 15 hours per week)
CLINK	Centrelink
COAD	Chronic Obstructive Airways Disease
DDD	Degenerative Disc Disease
DES – ESS	Disability Employment Service – Employment Support Service
DMA	Disability Medical Assessor (completed by GCD)
DMS	Disability Management Service
DSP	Disability Support Pension
Dx	Diagnosis
ESAt	Employment Services Assessment
ESP	Employment Service Provider
FDT&S	Fully diagnosed, treated and stabilised
FT&S	Fully treated and stabilised
GCD	Government Contracted Doctor
GP	General Practitioner
HPAU	Health Professional Advisory Unit (within CLINK)
IBS	Irritable Bowel Syndrome
JC Assessor	Job Capacity Assessor
JCA	Job Capacity Assessment
MDD	Major Depressive Disorder
MH	Mental health
ODM	Centrelink Original Decision Maker
OT	Occupational Therapist
PIR	Partners in Recovery
POS	Program of Support
PTSD	Post-Traumatic Stress Disorder
Px	Prognosis
RTW	Return to Work
SC	Special circumstances
SME	Subject Matter Expert (internal at CLINK prior to ARO)
SR	Self-reported (always means the client is reporting, has not been used in other contexts)
TAS	Telephone advice service
TB	Tuberculosis
TDR	Treating Doctors Report (standardised form used prior to 2015)
THP	Treating Health Professional
TOC	Time of Claim