Senate Community Affairs Legislation Committee

ADDITIONAL ESTIMATES - 27 FEBRUARY 2014
ANSWER TO QUESTION ON NOTICE

Department of Human Services

Topic: The process for moving from Newstart Allowance to Disability Support Pension.

Question reference number: HS 13

Senator: Cameron
Type of question: Hansard pages 137-138
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Question:

Senator CAMERON: That is fine. Also, you say there has been some commentary about how people want to move from Newstart to DSP, which for obvious financial reasons is understandable. But there seems to be this view out there that you can get on to DSP pretty easily, so therefore it is a 'You're rorting the system, you're a dole bludger' type of approach. Can you just explain to me how difficult it is to move from Newstart to DSP? What is the process?

Ms Campbell: I will ask Mr Tidswell to walk us through that process.

Mr Tidswell: We get a lot of claims every year. There are about seven million Centrelink customers. We have about three million claims a year. So, that gives you some sense of the volume that goes through the system. And there is no doubt about it: there is a percentage of people who are on Newstart, often for some considerable period of time, who test their eligibility for the disability support pension. I do not have the exact figures on number or volume or frequent flyers who do it more often in any given year, but there are a considerable number who test their eligibility, for obvious reasons. But there are—and this is a longstanding bipartisan policy position—checks and balances to go through the various gates. So, there are mechanism there by which we gather information, get information from treating doctors and other health professionals. We then run assessment processes. There are sets of criteria we use to assess and determine, and then we make decisions. And one of those important decisions is that we want people to be able to work. We do not want people to not be able to get a job and work. The tension often comes around the difficult issues of explaining to people that there are things you can do, even though you have some residual disability. Obviously people with manifest disability are dealt with in a much more streamlined way when it is obvious that that disability is not going to improve. But the aim here is to make sure people have a pathway into employment and jobs. So, there are checks and balances in the system.

Senator CAMERON: We are out of time now, but perhaps you could take my question on notice and provide details of the process.

Mr Tidswell: Certainly.

Senator CAMERON: And can you then have a look as to whether there are protocols involved, whether there is a manual involved for the officers who are dealing with this and what the appeals process is?—all of that on DSP, because it is a very important issue and more and more senators and MPs are getting questions about it. So I would like to understand exactly how it works and to be confident that it is a very strict process and it is not open to easily being rorted. Is that a fair statement—that it is not easily rorted?

CHAIR: You might be able to send that to all MPs.

Senator Payne: We will get you some material, Senator Boyce.

Answer:

Please refer to the attached documents for a comprehensive explanation of the process for claiming Disability Support Pension, including the process for those who move from Newstart Allowance:

- Attachment A - Disability Support Pension Eligibility and Claim Process;
- Attachment B - Disability Support Pension Claim Process; and
- Attachment C - Disability Support Pension Claim Process Legend.

DISABILITY SUPPORT PENSION ELIGIBILITY AND CLAIM PROCESS

The Disability Support Pension (DSP) is an income support payment for people whose permanent, intellectual or psychiatric impairment prevents them from working 15 hours or more per week. The payment is subject to the income and assets test unless the person is permanently blind. Customers must also be Australian residents to be eligible.

The assessment for DSP eligibility involves assessing the functional impact of the person's medical condition(s) and the impact on work capacity. Customers have different degrees of disability and a wide range of behaviours and social skills so the assessment results vary according to individual circumstances.

Initiation and Customer Communication

A conversation about DSP can be initiated by either the department or customers. The department may suggest DSP to a customer when a customer contacts the department, via the telephone or face to face channels, to discuss their situation and investigate possible assistance the department may be able to offer. Customers in receipt of Newstart Allowance or other activity tested income support payments may also, often at the suggestion of their employment services provider, test their eligibility for DSP.

Of course, customers may approach the department on their own initiative to inquire about DSP and the eligibility criteria. This may be at the suggestion of health professionals, family members or others in the community. Customers may also use the Payment Finder facility on the department's website to explore possible payments based on their particular situation.

The department's website provides step by step guidance for customers who wish to lodge a claim for DSP. The first step is a series of information videos designed to help customers understand the eligibility criteria, what evidence they need to submit and how the claiming process will work.

Intent to Claim Disability Support Pension

If a customer believes that he or she meets the eligibility criteria they can contact the department to lodge an intent to claim. This is to ensure their claim, if successful, will be paid from the earliest possible date. The intent to claim can be lodged by email, in person at a service centre or by telephone. Customers have 14 days from that date to lodge their claim, although this date can be extended if the customer has difficulty gathering the required evidence, for example, if a customer is not able to obtain a treating doctor's report within 14 days.

Customers can print the claim form on the department's website. If a customer does not have access to a printer, they can pick up a form at a service centre or they can call 132 717 to ask to have a form sent to them.

Customers can submit their completed forms, proof of identity, medical report, and any other documents that may be required (for example, Rent Certificate, Employment Separation Certificate or an authorisation for a person or organisation to act on the customers' behalf) either by post or in person at a local service centre.

Claim Processing

Claims are processed in centralised processing teams located in various cities. Customers must attend a Job Capacity Assessment (JCA) in order to assess their eligibility for DSP. (More detail on JCAs is on page 3.) The department will contact the customer to arrange a convenient time for them to attend an appointment at the nearest service centre. In some instances, the JCA can be conducted by telephone or video conferencing, where that facility is appropriate and available.

The department will advise the customer when a determination has been made. The standard is for a specialist member of the processing team to contact a customer to advise them their claim has either been granted or rejected. If the claim is granted, the customer is told how much their payment will be

and when it will start. If the claim is rejected, the customer is told why their claim was not successful, advised of their right to appeal the decision, and offered alternate payment options where appropriate. Customers are also advised of the outcome of their claim by letter.

Medical Evidence

People claiming DSP are required to provide details about their medical condition(s) and work ability as part of the claim process including, in most cases, a report from their treating doctor. The report can be accessed either online or as a paper form. The treating doctor must be a registered medical practitioner. For mental health conditions, the diagnosis must be from either a psychiatrist or a clinical psychologist.

Doctors may claim the time taken to complete the form under a Medicare item when the form is completed as part of a consultation. In remote areas where customers may have limited access to doctors or medical services, the form may be completed by a community nurse. Forms can either be returned directly to the department or provided to the customer to include with their DSP claim form.

The treating doctor's form has 14 questions in total which query if:

- the patient has one or more conditions that have a significant impact on their ability to function (for example, endurance, walking, sitting, standing, performing daily activities, handling and manipulating objects, bending, self-care, concentration, attention, communication, hearing, vision, continence, consciousness) and the details about each of the conditions listed in order of the greatest degree of impact on function.
- the patient has any condition that is terminal
- the patient has other medical conditions that are generally well managed and cause minimal or limited impact on the ability to function
- there is any other information to provide
- the medical practitioner wishes to provide any medical certificates or would like to discuss any aspects of the report with the department
- consent to release medical information to the individual concerned and to identify any information in the report which might harm either the physical or mental well-being of the patient
- five questions specific to the medical practitioner's contact details, confidentiality and privacy provisions and how long the person has been a patient.

Manifest Eligibility

Based on the evidence provided in the treating doctor's report, a customer may be considered *manifestly* eligible for DSP where it is obvious and clearly evident without further investigation that the customer is sufficiently impaired to be entitled to DSP.

Manifest grants may only be made in very clear-cut cases and in a limited number of clearly defined circumstances where the customer either:

- is permanently blind
- has a terminal illness
- has an intellectual disability
- requires nursing home level care
- has Category 4 HIV/AIDS; or

- is in receipt of a Department of Veterans' Affairs Disability Pension at Special Rate (Totally and Permanently incapacitated).

Claimants of DSP who are *not* manifestly eligible are referred for a Job Capacity Assessment which is conducted by the department's assessors who are health and allied health professionals.

Job Capacity Assessment

The JCA is a comprehensive evaluation of an individual's level of functional impairment and work capacity. Assessors have access to relevant information about the person, including current and past medical and disability details, and prior participation and employment history.

As part of the assessment, assessors must determine if the medical condition(s) is fully diagnosed, treated and stabilised. To determine whether a condition has been fully diagnosed by an appropriately qualified medical practitioner, and whether it has been fully treated, the assessor must consider:

- whether there is corroborating evidence of that condition
- what treatment or rehabilitation has occurred in relation to the condition
- whether treatment is continuing or is planned in the next two years.

A condition is fully stabilised if:

- either the person has undertaken reasonable treatment for the condition and any further treatment is unlikely to result in significant functional improvement to a level enabling the person to undertake work in the next two years; or
- the person has not undertaken reasonable treatment and either significant function improvement to a level enabling the person to work in the next two years is not expected, or there is a medical or other compelling reason for the person not to undertake reasonable treatment.

Job Capacity Assessors must also apply Impairment Tables to assign impairment ratings. The Tables were recently reviewed by the Department of Social Services, the department with policy responsibility for DSP, in consultation with an Advisory Committee made up of medical and allied health professionals and disability stakeholders. The revised Tables, implemented in January 2012, focus on functional ability, concentrating on what a person can do rather than what they cannot do and are consistent with contemporary medical and rehabilitation practice. The Impairment Tables are set out in the *Social Security (Tables for assessment of work-related Impairment for Disability Support Pension) Determination 2011*.

Impairment Tables

There are 15 Tables which cover a range of functions. Assessors use the evidence provided in the treating doctor report, and the customers response during interview to a series of questions designed to help ascertain the functional impact of conditions. For example, an assessor may ask if a customer is able to drive, walk unaided for a certain distance, or shop for basic needs without assistance. Assessors will also observe the behaviour of customers during interview, for example, if the customer is able to understand and communicate, and is aware of social cues. Based on the medical evidence, and the answers provided, the assessors are able to apply a rating using the Impairment Tables for each condition and its functional impact. Numerical ratings are 5, 10 or 20. To be eligible for DSP a customer must have a score of 20 points or more across one or more of the Tables. The Tables are available online at: www.comlaw.gov.au.

Program of Support

A program of support is provided by a designated provider who specifically tailors a program to address the person's level of impairment, individual needs and barriers to employment. Programs of support provide vocational, rehabilitation and employment services, with a particular focus on developing the skills the person requires to improve their capacity to find, gain or remain in employment.

People claiming DSP must have actively participated in a program of support unless they have a severe impairment or are manifestly eligible for the payment. This requirement came into effect in September 2011.

To meet program of support requirements, a person needs to have actively participated in a program for at least 18 months within the three years prior to their claim for DSP, and complied with the requirements of the program. The department can consider evidence from job services providers at any time about a customer's inability to continue participating in a program of support. This is generally where the customer is unable (solely because of their impairment) to improve their capacity to find, gain or remain in employment through continued participation in the program. This evidence needs to be considered by a job capacity assessor.

Appeal Process

If a customer does not agree with a decision about their entitlement, they have the right to ask for a review of the decision. An internal review can be requested by writing to the department, calling or visiting a service centre. An authorised review officer, who has not been involved in the original decision, will review the decision and change the decision if it is wrong.

If a customer believes the decision made by the review officer is incorrect, in most cases the customer can then seek a review by the Social Security Appeals Tribunal (SSAT). The SSAT is an independent tribunal that has the power under the *Social Security Act 1991* to review almost every decision that the department makes on a social security matter. The Tribunal is required by the Act to operate in a manner which is 'fair, just, economical, informal and quick'. SSAT reviews are referred to as 'appeals'. Decisions made by the SSAT are binding on the customer and the department.

Appeals to the SSAT are generally heard by one member, although it is possible to have the appeal heard by two or three members. The SSAT must look beyond whether the decision made by the department contains a mistake or not and actually decide what the correct decision is.

Appeals to the SSAT must be lodged within 13 weeks of receiving an internal review decision to ensure maximum arrears if the appeal is successful. Where a person does not lodge their appeal within 13 weeks they can still appeal, but can only be back-paid to the date they first appealed to the department, in the event their appeal is successful.

A customer or the department may apply to the Administrative Appeals Tribunal (AAT) for a review of a Social Security Tribunal decision. The AAT is not a court, but an independent body that can consider appeals against decisions of Commonwealth departments, tribunals and authorities.

The AAT will review the facts and the law relevant to the case and its decision replaces any decision made by the SSAT. Cases can take up to 12 months to finalise. Appeals must be lodged within 28 days of the day a person receives a written decision from the SSAT.

Appeals to department review officers, the Social Security Appeals Tribunal and the Administrative Appeals Tribunal are free of charge.

Administrative Appeals Tribunal decisions can be appealed to the Federal Court but these appeals must be on a question of law. Court appeals are not free, but lodgement fees can be waived in some circumstances and customers are able to represent themselves.

Department-initiated Reviews

The department conducts reviews of eligibility for Centrelink payments to protect the integrity of the welfare system. Compliance interventions are used where there is an identified risk of incorrect payment.

Interventions are triggered by a range of activities including data-matching, risk profiling and information from the public. The interventions are conducted through a variety of techniques including:

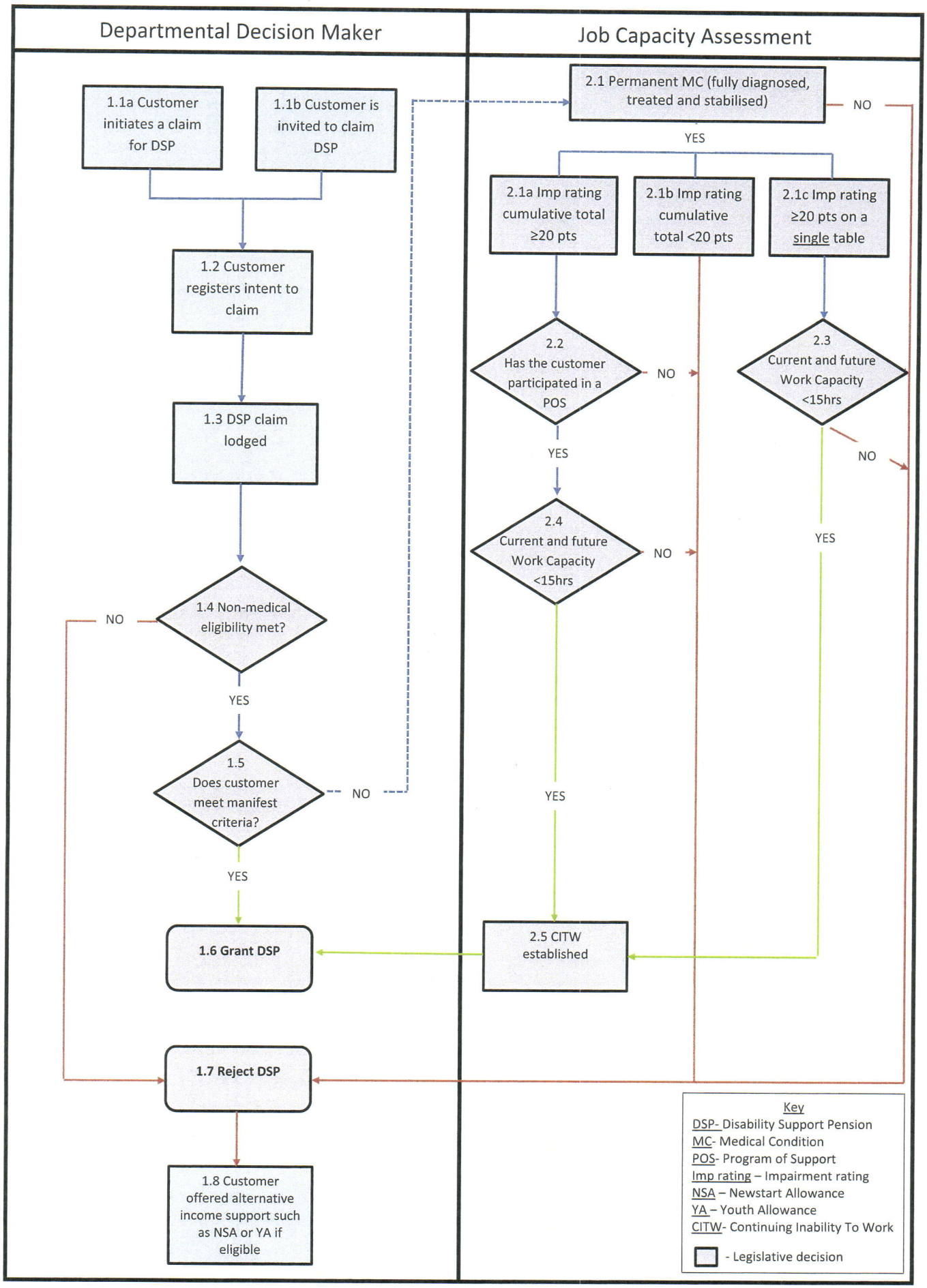
- customer interviews for the more serious matters
- direct interventions involving third party verification of circumstances (for example, data matching the Australian Taxation Office)
- early interventions including outbound customer calls and customer education
- light touch interventions involving education letters and electronic messaging (SMS).

Matters that may involve fraud are referred to the branch within the department responsible for assessment and possible investigation of suspected fraud cases.

Customers for DSP are assessed within the risk based compliance model used by the department.

DSP Medical Qualification reviews are undertaken to review customer's medical condition(s) and their capacity for work.

DISABILITY SUPPORT PENSION CLAIM PROCESS



DISABILITY SUPPORT PENSION CLAIM PROCESS LEGEND

Process	Description
1.1a Customer initiates a claim for DSP	– A customer contacts the department in relation to claiming DSP. This may be either a person: • not currently in receipt of an income support payment, or • receiving an income support payment (such as Newstart Allowance (NSA). – Information is provided to customer in relation to claiming DSP – Customer is referred to disability Videos on Demand
1.1b Customer is invited to claim DSP	– A customer currently receiving NSA is identified as being medically eligible for DSP through a medical Employment Services Assessment. – An Employment Services Assessment is an assessment which assesses the impact of a person's barriers on their capacity to work. – The assessment is undertaken by a health or allied health professional employed by the department who assesses the customer as: • having an impairment rating of 20 points or more on the Impairment Tables, for a condition(s) that is permanent (fully diagnosed, treated and stabilised) • satisfying the Program of Support (POS) requirements (where applicable), and • satisfying work capacity requirements (Continuing Inability to Work (CITW))
1.2 Customer registers intent to claim DSP	- The customer has 14 days from the date the intent to claim is registered to lodge a claim if they want the contact date to be assessed as the start date for payment
1.3 DSP claim lodged	– While awaiting the outcome of their claim, existing NSA customers may be granted an exemption from participation requirements if appropriate, while those not receiving an income support payment will be invited to claim NSA and may seek an exemption from participation requirements if appropriate.
1.4 Non-medical eligibility met?	– Customer circumstances are assessed to determine if they meet the following requirements: • Age • Income and assets • Residency requirements – If the customer does not meet the requirements, their claim for DSP will be rejected.
1.5 Does customer meet manifest criteria?	– A customer is considered 'manifest' where it is obvious and clearly evident without further investigation that the customer is medically eligible (e.g. terminal illness).
1.6 Grant DSP	– The customer is contacted via phone to advise them of the outcome of their claim. – A letter is sent to the customer
1.7 Reject DSP	– The customer is contacted via phone to advise them of the outcome of their claim and rights to review and appeal. – A letter is sent to the customer.
2.1 Permanent medical condition to 2.5 CITW established	– The assessment of medical conditions for DSP occurs during a Job Capacity Assessment (JCA). – JCAs are completed by a health or allied health professional employed by the department. The assessment involves: • assessment of medical condition(s) as temporary or permanent (fully diagnosed, treated and stabilised) • assessment of permanent medical condition(s) against the Impairment Tables • assessment of active participation in Program of Support (where applicable) • assessment of work capacity