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Review of the Tables for the Assessment of Work-related Impairment for Disability Support Pension (DSP Impairment Tables)

Joint submission of:

National Association of People Living with HIV (NAPWA)
Australian Federation of AIDS Organisations (AFAO)

About NAPWA

NAPWA is the peak organisation providing advocacy, policy, education and outreach for people living with HIV. NAPWA membership includes organisations for people living with HIV (PLHIV) in each state and territory and the following affiliate members: Positive Heterosexuals (Pozhets); Positive Women (Victoria); Straight Arrows; and the Positive Aboriginal and Torres Strait Islander Network (PATSIN). NAPWA works across a range of health care and HIV-positive education initiatives to promote the highest quality standards of care and to encourage appropriate clinical and social research into the causes and prevention of HIV. NAPWA is a founding member of the Australian Federation of Disability Organisations (AFDO) and is funded by the Commonwealth to provide advocacy and policy advice to Government and other agencies on national issues affecting people with HIV.

About AFAO

The Australian Federation of AIDS Organisations (AFAO) is the national federation for the HIV community response. AFAO's members are the AIDS Councils in each state and territory; the National Association of People Living with HIV/AIDS (NAPWA); the Australian Injecting and Illicit Drug Users League (AIVL); the Anwernekenhe Aboriginal and Torres Strait Islander HIV/AIDS Alliance (ANA); and Scarlet Alliance, Australian Sex Workers Association. AFAO advocates for its member organisations, promotes medical and social research into HIV and its effects, develops and formulates policy on HIV/AIDS issues, and provides HIV policy advice to Commonwealth, State and Territory Governments.

Scope of this Submission

This submission refers directly to the Inquiry Terms of Reference as they relate to disabling conditions affecting people living with HIV. We stress however, that similar disabling conditions also affect people living with a range of chronic, episodic illnesses. We are concerned to read that somewhere between a third and half of

future Disability Support Pension (DSP) applicants¹ may be affected by changes to the Disability Impairment Tables assessment tool.

Response to the Terms of Reference

NAPWA and AFAO welcome and support the first two items of the Terms of Reference. We recognise that it is some time since the Impairment Tables have been reviewed, and that there have been considerable advances and improvements in medical and rehabilitation practice since the last review. We also recognise that during this time there will be changes in the use of aids and equipment which may be advantageous to some people living with disability.

The impact of HIV is complex and measuring its effects in terms of impairment requires a detailed and nuanced understanding of the nature of HIV disease and a range of potential co-morbid health conditions. We offer here, advice on the impact of HIV disease on individual capacity and ability; and comment on impairment assessments made by Allied Health Professionals and Medical Officers and provide comments on specific impairment tables.

1. update the DSP Impairment Tables to make sure they are consistent with contemporary medical and rehabilitation practice

HIV and rehabilitation

For many people living with HIV, treatment regimens and disease progression is such that illness patterns have become what are commonly described as 'chronically episodic'. For some HIV-positive people this presents a particular set of challenges with intermittent improvements in health and wellness pre-empting a more sustained improvement necessary for a return to ongoing employment. The chronic and episodic nature of illnesses associated with HIV means that the course of rehabilitation is not necessarily a smooth and linear experience. Rather, it may well be beset by setbacks and frustration, including the uncertainties associated with limited income support and the anxiety of needing to satisfy DSP impairment assessment processes.

In the era of antiretroviral therapies (ARV's) the nature of HIV disease progression can also often be exacerbated by the presence of one or more co-morbidities. These co-morbidities and the demands of rigorous treatment regimens may inhibit the ability to function, and can result in a very difficult set of challenges for some HIV-positive people.

NAPWA and AFAO have consistently advocated that if people are to consider re-engagement in community life and re-training, there must be confidence that their efforts will be matched and supported in a productive way. We are also of the view however, that for some people who experience chronic and debilitating impairment, there is little or no possibility of engaging in the workforce; for many people who have lived long-term with HIV, intermittent illness and disability has been a stark

¹ Taylor, Fry Pty Ltd. FaHCSIA: Analysis of the Testing of Draft Impairment Tables

reality. Some of these individuals have been in receipt of DSP for many years, their impairment often having been assessed regularly.

These complicating historical, structural and medical aspects of an HIV diagnosis, serve as an indication of differing education and training requirements within the HIV-positive population and the need for individually tailored rehabilitation programs and services to support a successful return to employment and community re-engagement.

NAPWA and AFAO propose that there should be an increase in rehabilitation program places providing tailored workplace supports for people returning to work after extended periods on income support payments. These programs should include entry level employment opportunities – within local, state and federal government agencies; strategies that reduce workplace stigma and discrimination; and enforceable workplace policies that promote flexible working arrangements which accommodate the needs of people with chronic, episodic conditions.

2. introduce consistent consideration of the use of aids and equipment in the measurement of impairment in the DSP Impairment Tables

HIV and medical technologies

HIV-positive people face high health care costs associated with HIV itself. Many also face the costs of a range of co-morbid conditions requiring as much as eight or more medications a day. As well, some HIV-positive people utilise medical aids, equipment and technologies to assist in a range of co-morbidities which may include:

- cardiovascular disease
- diabetes
- arthritis
- osteoporoses
- neurological impairment (e.g., Alzheimer's, Korsakov's dementia)
- vascular dementia
- mental health issues
- cancers (anal, bowel, breast, cervical and lymphoma).²

For some people living with HIV, the financial burden associated with these essential medical technologies is prohibitive – with many forced to set difficult and often counter-productive priorities in order to accommodate a limited and challenging budget. Successive *HIV Futures* surveys have highlighted the financial difficulties that many HIV-positive people contend with. These difficulties cannot be explained merely in terms of the proportion of HIV-positive people dependent upon social security benefits. There are compounding financial hardships associated with being HIV-positive. Some are structural and result from stigma, disadvantage and reduced employment opportunities; some are associated with the cost of managing the

² K., Law, M.G. (2006). Risk factors and causes of death in the Australian HIV Observational Database. *Sexual Health* 3, 103-112.

negative consequences of treatment; while others are the cumulative effects of living for many years with uncertain or fluctuating health. That research measures of social disadvantage have consistently identified difficulties for HIV-positive people 'suggests that current resources and strategies are inadequate and decisive action must be taken to address this pocket of severe social disadvantage'³.

Many HIV-positive people have additional health costs not covered by Medicare or the Pharmaceutical Benefits Scheme (PBS). It is also of concern that long public hospital waiting lists require many people with chronic, episodic illness to consider costly private health insurance. This is often not as straightforward as it is for other citizens. People with HIV do not enjoy automatic access to private health care and often need to wait for 12 months before being able to draw on such insurance.

Whilst we broadly support recent changes which make it easier for people on DSP to attempt a return to work, we believe that HIV and other chronic, episodic illnesses are not adequately catered for in current welfare to work arrangements. To this end, NAPWA and AFAO have long advocated for the introduction of a *Chronic Illness Concession Card*. We are of the view that such an entitlement would go toward addressing the well-documented cost burden of chronic illness for people with chronic disease who are not entitled to DSP or another pension.

NAPWA and AFAO assert that for many, living with HIV and one or more co-morbidities can be debilitating and disabling and costly technological interventions may be required, including the use of a range of medical aids and equipment which often must be self-funded. We are concerned that HIV-positive DSP applicants who experience a range of co-morbidities, yet fail to qualify for DSP under Impairment Tables eligibility, should have access to income support that is adequate to meet the costs associated with disability and chronic illness. This includes psychological, social and financial support to ensure regular availability of, and access to, essential aids, equipment and medical technologies.

3. reassess the appropriateness of definitions contained in the Introduction to the DSP Impairment Tables, with particular regard to the assessment of people with intermittent psychiatric conditions

HIV and disability

NAPWA and AFAO draw your attention to Article 1 of the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD) which defines persons with disability as including those who have 'long-term physical, mental, intellectual or sensory impairments which, in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others'.⁴ Likewise, in Australia HIV is recognised as a disability for the purposes of the Disability

³ : J Grierson, J Power, M Pitts, S Croy, T Clement, R Thorpe and K McDonald (2009) *HIV Futures 6: Making Positive Lives Count*, monograph series number 74, The Australian Research Centre in Sex, Health and Society, Latrobe University, Melbourne, Australia

⁴ United Nations Convention on the Rights of Persons with Disabilities, available at www.un.org/disabilities/convention/conventionfull.shtml

Discrimination Act (DDA), disability there being defined as including ‘the presence in the body of organisms causing (or capable of causing) disease or illness’.⁵ Accordingly, NAPWA and AFAO assert therefore that it is clear that for some people, HIV (and other chronic, episodic disease and illness) are disabling and present as an impairment to employment that warrants substantive recognition including, equitable access to DSP entitlement.

It is also the case that, as HIV disease progresses it may result in neurological and physical conditions that impair ability whilst ARV’s and other treatments may cause side effects that can be disabling⁶. NAPWA and AFAO assert that some people will experience disability related to HIV and we are concerned, in particular, with the cumulative effects of HIV disease progression and/or the cumulative effects of HIV and co-morbid illness. It is crucial that these aspects of HIV disease be taken into account during impairment assessment.

NAPWA and AFAO are concerned that disability impairment assessment processes do not sufficiently accommodate the episodic, progressive, cumulative and disabling effects of HIV disease. We contend also that definitions of impairment are contextual, for instance, definitions of disability for employment purposes centre on the capacity of work-readiness, whereas in health settings, impairment considerations centre on capacity to perform life functions⁷. We are of the view that these cumulative impairments are not readily separable and assert that the treating doctor’s assessment, representing the longest view of patient history, must be adequately taken into account during the DSP impairment assessment process. We also strongly argue that impairment assessments must take into account the compounding effect of HIV disease and long-term physical, mental, intellectual or sensory impairments which serve to hinder the full and effective participation of some HIV-positive people in the workplace on an equal basis with others.

HIV, psychiatric and mental health conditions

HIV-positive people represent a group at risk for developing neuro-cognitive impairment. Research indicates that the prevalence of depression among HIV-positive people is higher than in the general population; mania, hypomania and psychosis occur more frequently; and HIV-positive people show significantly higher use of mental health services than people in the general population⁸. It is also the case that the risk factors for developing dementia may be exacerbated for some people living with HIV. Not only is HIV infection a risk factor for developing dementia in itself, but co-morbidities such as diabetes can multiply that risk.

⁵ *Disability Discrimination Act 1992*, The Office of Legislative Drafting and Publishing, Attorney-General’s Department, Canberra

⁶ Elliott R, Utyasheva L, Zack E 2009. *HIV, disability and discrimination: making the links in international and domestic human rights law*. *Journal of the International AIDS Society* PP12:29

⁷ O’Brien K, Bayoumi A, Strike C, Young N, Davis A, 2008. *Exploring disability from the perspective of adults living with HIV/AIDS: Development of a conceptual framework*. *Health and Quality of Life Outcomes*, 6:76 www.hqlo.com/content/6/1/76

⁸ M. Carman et al., Trends in the location of the HIV-positive population in Australia: Implications for access to healthcare services and delivery. Australian Research Centre in Sex, Health and Society, LaTrobe University: www.publish.csiro.au/paper/SH09063.htm

Furthermore, the growing number of older individuals with HIV in Australia implies that the prevalence of dementia and additional HIV-associated neurological disorders will increase⁹.

It is our view that some HIV-positive people who have a co-morbid mental illness which attracts an impairment assessment of 'mild but regular symptoms which cause subjective distress' may actually experience a significant impairment when these morbidities are considered cumulatively.

Of particular concern is the difficulty in providing evidence of diagnosis of a psychiatric impairment for people who may be severely mentally ill at the time of claiming DSP. For some of these people being denied access to the DSP and forced to comply instead with the obligations of *Newstart* allowance activity testing during an appeal may impart a further disabling burden on their mental health.

NAPWA and AFAO are of the view that assessment guidelines should allow for maximum flexibility during DSP assessment processes and err on the side of the applicant to avoid unwarranted mental stress and anxiety. Given that regular re-assessment of DSP eligibility is now common practice, we suggest that those people granted DSP who, at a later stage gain increasing ability and capacity will still require assistance through a period of transition with adequate and appropriate support.

4. re-examine the descriptors in the DSP Impairment Tables to ensure that a score of 20 points aligns with an inability to work 15 or more hours per week in the open-labour market at or above award wages without the need for on-going support

HIV, impairment and employment

NAPWA and AFAO recognise that a number of financial government supports exist to assist employers hiring people with disabilities; however, we believe that these financial supports are only part of the solution and require an integrated system of advice and support for them to be of benefit to employers and employees alike. We propose that for HIV-positive people to return to the workplace successfully there needs to be:

- assistance with setting appropriate and achievable goals;
- vocational assessment and guidance;
- career counselling;
- maintenance of medical and other social supports;
- information and support around confidentiality and disclosure; and
- peer support and peer mentoring programs.

The potential for stigmatisation and discrimination in the workplace and the community can act to inhibit some HIV-positive people from full engagement in

⁹ Cysique, L.A., P. Maruff, and B.J. Brew, Prevalence and Pattern of neuropsychological impairment in HIV Epidemiology and Clinical Research, NSW. Australian Institute of Health and Welfare, Canberra, ACT. 2009.

community life. Some long term diagnosed HIV-positive people have not participated in the workplace for a considerable period of time. For instance, among those who stopped work between 1984 and 2005 (median = 2000), a large proportion (19.6%) indicated that their career ended at their time of diagnosis¹⁰.

Returning to work presents many challenges for a number of HIV-positive people. NAPWA and AFAO support the provision of non-punitive mechanisms that enable and support HIV-positive people to re-enter the workplace and to set and achieve appropriate vocational goals. Despite the ongoing challenges of workplace stigma and discrimination which has in the past led to isolation and exclusion, HIV-positive people have made a significant contribution to Australian society. Those able to enter paid employment should be encouraged with incentives and flexible mechanisms of support that best facilitate their re-engagement.

5. redesign the DSP Impairment Tables to focus more on ability

HIV and ability

Whilst NAPWA and AFAO agree that impairment assessments should correctly focus on ability, we stress that the capacity of assessors to fully consider the disabling circumstances for people with chronic, episodic conditions is limited – especially where assessments occur at a time from which circumstances may then change radically.

HIV-positive people can face a range of complex and debilitating health conditions. Despite improvements in HIV medications, people with long-term illness, or less well controlled infection, are subject to fluctuating physical and mental health as well as reduced physical and emotional stamina. A range of co-morbidities is present at a younger age in the HIV-positive population compared to the general population (see above), and they are wider in range and more severe in effect. While the average 75 year old without HIV is on drug treatment for two co-morbidities, the average 55 year old living with HIV is on drug treatment for three co-morbidities¹¹. People who have lived with HIV for many years are thus effectively ageing with increased illness burden and other disease risks.

The mortality rate among Australian people living with HIV due to these co-morbidities is approximately five times higher than among the uninfected general population of a similar age.¹² Deaths directly attributable to AIDS-defining illnesses are now less common than deaths attributed to these co-morbidities, the most significant being liver failure, suicide/drug overdose, cardiovascular disease, lung

¹⁰ : J Grierson, J Power, M Pitts, S Croy, T Clement, R Thorpe and K McDonald (2009) *HIV Futures 6: Making Positive Lives Count*, monograph series number 74, The Australian Research Centre in Sex, Health and Society, Latrobe University, Melbourne, Australia

¹¹ Petoumenos K et al. *Rates of cardiovascular disease following smoking cessation in patients with HIV infection: results from the D:A:D study*. Seventeenth Conference on Retroviruses and Opportunistic Infections, abstract 124, San Francisco, 2010. Available at: <http://www.aidsmap.com/en/news/7CD6E027-9B7D-411B-9D98-A45E587EDCB7.asp>

¹² Petoumenos. K et al, *ibid*

cancer, and non-AIDS cancers¹³. Bone mineral density loss, neuro-cognitive impairment and frailty are also associated with increased risk of morbidity and mortality. Further still, frailty is a recognised clinical syndrome associated with risk of injury and incapacity. Recent studies have found that HIV-positive men were three to eight times more likely to have a combination of conditions that together constitute frailty syndrome. The prevalence of frailty among 55 year old men who had been diagnosed with HIV less than four years previously was similar to that of uninfected men over 65 years.¹⁴

It is important to appreciate that HIV has an impact across the health spectrum. There is no single set of criteria in relation to HIV that fits all cases; dual diagnosis with depression and anxiety, co-infection with hepatitis B or C, liver and kidney disease, cardiovascular disease and treatments-related side effects have ongoing and unpredictable consequences.

Furthermore, although it is accepted that particular antiretroviral drugs affect organ functioning, there is often no alternative to the person continuing treatment with drugs that produce adverse effects. Alternative medications may be less effective and changing ARV combinations can place a person at increased risk of developing further HIV-related co-morbidities if efficacy of HIV disease suppression is diminished.

NAPWA and AFAO are concerned that whilst this narrow assessment criterion, may on the surface appear to be celebrating an individual's ability, it may also ignore the very real effect of cumulative impairments that act to disable and prevent some from gaining employment and deny them access to DSP. We argue that an assessment policy that effectively excludes those with 'a presence in the body of organisms causing (or capable of causing) disease or illness' is inequitable and does not fully recognise the cumulative and debilitating aspects of chronic, episodic illness, including HIV disease.

6. ensure that the DSP Impairment Tables can be used by both Allied Health Professionals and Medical Officers.

HIV and medical opinion

As should be clear, it is important to appreciate that there is no single criterion in relation to HIV that fits all cases; dual diagnosis with mental health conditions, co-infection with hepatitis C, treatments side effects that have had long term consequences, dealing with the effects of cognitive impairments as well as managing other co-morbidities may each contribute to person's disability – and complicate an assessment. For these reasons NAPWA and AFAO have consistently argued that the opinion of a person's treating GP must be recognised in the impairment assessment process and we advocate that assessors should make decisions based on an appropriately informed understanding of the dynamics of living with HIV. We

¹³ Petoumenos. K et al, *ibid*

¹⁴ Desquilbet, L., et al., Frailty in older adults: evidence for a phenotype. *J Gerontol A Biol Sci Med Sci*, 2001. Available at: <http://biomedgerontology.oxfordjournals.org/content/62/11/1279.abstract>

believe that treating doctors should be supported through provision of guidelines and professional training to ensure that they are able to engage in a constructive way with the assessment processes.

The primary function of a review of the Tables should be to ensure that their application for the assessment of new DSP claims and for reviews of ongoing eligibility properly reflects the criteria set out in section 94 of the Social Security Act, as intended by Parliament. If it has been identified that allied health professionals are experiencing difficulties using or applying the Tables and there is considerable disparity from assessor to assessor¹⁵ this may point to issues regarding the appropriateness of allied health professionals from some disciplines playing a part in DSP assessments and/or the need for training in proper use of the Tables.

NAPWA and AFAO are of the view that transparent Impairment assessments must be weighted in favour of the applicant to ensure that those people with complex needs, including some people living with HIV and other episodic and chronic illnesses are not inappropriately precluded from qualifying for DSP and that transparent reporting processes must occur within a framework - similar to the National Compact between the Commonwealth Government and the not-for-profit sector.

Summary of main concerns

The chronic, episodic nature of an HIV diagnosis means that for some people the course of rehabilitation is not a smooth one and may be complicated by the presence of one or more co-morbidities which impair function, challenge rehabilitation efforts and may act to prevent some from participating in the workforce. In the event that sufficient ability exists, such that enables an individual to re-enter the workforce, we are concerned that, at the very least, there should be a tailored transition phase of support that takes into account the difficulties associated with living with chronic, episodic conditions such as HIV.

HIV-positive people face high medical expenses associated with managing the disease and this may include a range of additional health costs not covered by Medicare or the PBS. For many HIV-positive people in receipt of DSP these costs can be prohibitive. NAPWA and AFAO strongly advocate for the introduction of a *Chronic Illness Concession Card* for those people with chronic, episodic illness in receipt of the DSP, those in, or transitioning to the workplace and those on low incomes.

HIV can be a disabling condition and the presence and impact of the virus must be afforded substantive recognition during impairment assessment processes. In particular we are concerned that cumulative impairments, be they induced by HIV directly or by the disabling effect of co-morbidities, should be taken into full account during DSP impairment assessment. Likewise, there should be adequate weight given to the disruptive, episodic nature of HIV disease. We maintain that both an individual's ability and individual's health stability should be considered.

¹⁵ Taylor, Fry Pty Ltd. FaHCSIA: Analysis of the Testing of Draft Impairment Tables

Evidence indicates that HIV-positive people experience a higher incidence of mental health conditions than the general population. In the interests of minimising anxiety and distress on the part of applicants, we are concerned that impairment assessments should err in favour of the applicant. We contend that the current practice of periodic assessment provides a legitimate mechanism for identifying any later change in individual's ability. We are of the view that these mechanisms should be used to provide a buffer against premature refusal of DSP benefits, particularly for HIV-positive applicants experiencing co-morbid mental health conditions.

NAPWA and AFAO are of the view that HIV-positive people have much to contribute to community. We are concerned, however, that any attempt to transition from DSP into the workplace must be matched by providing access to constructive and non-punitive programs under-pinned by flexible policies. We welcome the focus on ability during impairment assessment but we caution that a narrow focus on an individual's ability within a specific impairment table may serve to obscure the impact of cumulative impairments across other impairment tables. Such a narrow focus on ability as has been proposed would be disingenuous and inequitable, and would act to discriminate against people with a range of chronic, episodic illnesses, including those people living with HIV.

Finally, given the significance of DSP assessment outcomes on an applicant's daily life circumstances, we are of the view that interpretation and assessment of the DSP Impairment Tables should only be undertaken by suitably trained Allied Health Professionals and Medical Officers. In particular we are concerned that the professional opinion of the applicant's treating doctor(s) be adequately considered during assessment and be given primacy. It is crucial that a DSP claimant's treating doctor be furnished with information, resources and training regarding impairment assessments so that they may provide relevant, informed opinion that is constructive and supportive of their client and the assessment process alike.

Comments regarding specific Tables

TABLE 5. MENTAL HEALTH FUNCTION

- Despite some useful reference to intermittent symptoms in the introduction to Table 5, the new Tables inadequately address the fact that severe symptoms associated with intermittent psychiatric conditions may 'wax and wane'. A person with episodic psychiatric disability characterised by periods of severe impairment needs certainty of income support, such certainty enhancing work capacity and prospects when they are asymptomatic. DSP is often the ideal form of income support for people in this position, the security offered by suspension policies to cover periods of return to work enhancing employment participation.

- We note that providing evidence of diagnosis and treatment can be difficult or impossible for people who are severely mentally ill at the time of claiming DSP, and who cannot cope with the rigors of *Newstart* Allowance activity testing. Guidelines and resource materials for assessors applying the Tables should allow for as much discretion and flexibility as possible in the DSP assessment process, to ensure that people whose severe psychiatric disability is manifest can be granted DSP. There is some reference to flexibility in the preambles to the Table, but this is of limited use without practical guidance relevant to assessing impairment for people who cannot or will not obtain treating doctor reports, or who refuse treatment due to lack of insight into their condition or fear of treatment.
- We believe that the ratings for this Table are under-weighted. The indicators which produce a **5 point rating** – “mild functional impact” - constitute behaviours/symptoms that may be mild in ordinary daily life but they would make sustained employment, even at 15 hours per week, difficult if not impossible. Casual work for short bursts can be possible for people with such symptoms/behaviours but periods of employment can be short-lived. Expecting sustained, ongoing part-time work at regular hours for people meeting these indicators is unrealistic and counter-productive, placing added stress on people attempting to work while struggling to live with periodic mental illness. Considering that “all or most” of the indicators must apply for 5 points to be assigned, it is difficult to imagine a workplace/employer that could accommodate such a range of behaviours.
- The **10 point rating** criteria are also under-weighted, especially for people whose eligibility for DSP is under review.
- We propose that the **5** and **10** criteria be merged, so that the ratings start at **10**; and that the **20** and **30** ratings be merged also – given that the **20** symptoms clearly produce a total incapacity for work.

TABLE 6. FUNCTIONING RELATED TO ALCOHOL, DRUG AND OTHER SUBSTANCE USE

- We hold similar concerns to those regarding Table 5, in that the ratings for 10 points would make sustained employment impossible.
- We propose that the **5** and **10** criteria be merged, so that the ratings start at **10**; and that the **20** and **30** ratings be merged also – given that the 20 point symptoms clearly produce a total incapacity for work.

TABLE 7. BRAIN FUNCTION/ TABLE 8. COMMUNICATION FUNCTION

- Given the rising prevalence of dementia in the general population and the particular cognitive issues, including HIV-related dementia, that can affect people ageing with HIV, we propose that more guidance should be provided for assessing dementia-related impairment in the introductions to TABLES 7 and 8. We also propose that particular reference be made to early-onset HIV-related dementia (along with reference to additional information in *The Guide to the Tables*.)
- Our comments regarding the under-weighting of symptoms for TABLE 6 also apply in respect of these Tables.

TABLE 10. GASTROINTESTINAL FUNCTION

- We are pleased to note that unlike the previous Tables, the revised Tables include an introductory preamble to the gastrointestinal table.

Previous TABLE 20. MISCELLANEOUS

- We understand that this was the table most commonly applied for people with HIV.
- We are concerned that there is no “MISCELLANEOUS” table in the new Schedule. The Miscellaneous Table was useful for ensuring that proper consideration was given to impairments associated with conditions such as HIV (and for hepatitis C), especially for older people who have a range-of co-morbidities with symptoms of varying severity. Without such a table, a person with general frailty associated with the multiple effects of co-morbidities may not be able to meet the 20 point criteria, despite it being apparent that they live with severe disability by virtue of frailty directly attributable to the combined effect of these co-morbidities.

Previous TABLE 21. INTERMITTENT CONDITIONS

- This defunct TABLE was also highly relevant for DSP assessment for people living with HIV. Long-term HIV infection together with the effects of antiretroviral therapy can cause intermittent problems with severe effects that are not necessarily relatable to a single condition assessable under another Table. We propose that a Table for assessing intermittent conditions be re-introduced.

In conclusion

NAPWA and AFAO are concerned that the revision of the Impairment Tables – and particularly of the removal of tables for miscellaneous and intermittent conditions – will have unintended consequences for DSP claimants and recipients living with HIV or other chronic illnesses.

As discussed above, although HIV is now generally a manageable health condition, people who have lived long-term with HIV can be severely debilitated or generally frail due to the compound effect of managing multiple chronic conditions. Some people in this category are now on DSP, others are still in work but approaching the point where they cannot reasonably sustain ongoing employment.

HIV co-morbidities can be ongoing and degenerative - such as heart disease and HIV-related dementia, with episodic and unpredictable flare-up of symptoms that make sustaining ongoing employment impossible. The former Tables 20 and 21 were a useful component of the previous Impairment Tables for people with multiple chronic conditions, and ensured that adequate points could be attributed for DSP claims/reviews for people whose general frailty is a product of the compound effects of multiple conditions that would not be assessed as producing significant impairment under other Tables.

We have had the opportunity to read National Welfare Rights Network's (NWRN) submission to this Inquiry and note that the NWRN is also concerned that the new Tables will not adequately reflect impairment for people with debilitating chronic health conditions characterised by multiple co-morbidities and/or episodic symptoms. NAPWA and AFAO believe that this consequence of the redesign of the Tables would have been unintended and call for the addition of two new Tables to the revised Tables, replicating former Tables 20 and 21.

Regards



Jo Watson
NAPWA Executive Director

Regards



Rob Lake
AFAO Executive Director