

**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 with HIV/AIDS
and
Australian Federation of AIDS Organisations***

About NAPWA

NAPWA is the national 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 (PAT SIN). 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 peak body for Australia's community sector response to the HIV/AIDS epidemic. AFAO is charged with representing the views of our members: the AIDS Councils in each state and territory, the National Association of People Living with HIV/AIDS, the Australian

Illicit and Injecting Drug Users' League, 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/AIDS 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 Review

Our comments below relate directly to the 4 June 2010 Background Paper prepared for the Review Advisory Committee. We have concentrated on issues that are particularly relevant for people living with HIV (PLHIV). Given the broad array of debilitating co-morbidities that can affect HIV-positive people, particularly given the combined effects of HIV and ageing, these issues are necessarily wide-ranging.

Regarding term of reference no. 6, we understand the importance of ensuring that the Impairment Tables 'can be used' by allied health professionals as well as doctors, but this should not skew the review. 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 entitlement 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, 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. It is perfectly understandable that, e.g., a physiotherapist may have difficulty applying the multiple tables that are potentially relevant for a 50 year old DSP claimant with multiple chronic conditions associated with HIV, including dementia. The issue here is whether allied health professionals should be involved in such a case at all where their professional qualifications and experience are clearly of limited or no relevance.

We have had the opportunity to read the submission to this Review prepared the Legal Aid Commission of NSW. We concur with the points made by Legal Aid regarding this issue - under the heading 'Lack of relevant experience of JCAs' - particularly its support of the Commonwealth Ombudsman's recommendation that JCA Assessor allocation should where possible align with the DSP claimant's primary medical condition. We also note the Legal Aid Commission's comments regarding the 'serious lack of knowledge of the Impairment Tables amongst treating doctors and treating specialists ... this is one of the major reasons that claims for DSP are often inadequately assessed' (p. 9).

In addition we note comments made by the Legal Aid Commission and the National Welfare Rights Network in their submissions to the 2008 DEEWR Job Capacity Assessment Review (<http://www.deewr.gov.au/Employment/Programs/JCA/Review/Pages/attachmentB.aspx>). These organisations' perspective has been informed by in-depth analysis of issues identified in their casework - from original decision maker reviews, to SSAT, AAT and Federal Court appeals. This nuts and bolts understanding of issues central to DSP

assessment processes and appeal decisions, is invaluable. We believe that close consideration of these organisations' submissions should be a central part of this Review.

The Introduction Section of the Impairment tables

Our fundamental concern regarding the Introduction to the Tables relates to interpretation of 'diagnosed', 'treated' and 'stabilised' in the assessment process. In explaining what constitutes a 'permanent condition', the Background Paper states that:

'A permanent condition is defined as a condition that has been diagnosed, treated and stabilised ...'.

We note that the concept of 'diagnosed, treated and stabilised' is drawn from section 4. of the Introduction to the Tables, where it is stated that:

"For (an impairment) rating to be assigned the condition must be a fully documented, diagnosed condition which has been investigated, treated and stabilised. ...'

Especially for new claims from people with psychiatric and cognitive impairments caused by trauma or by recent onset/exacerbation of medical conditions, these determinations require subtle considerations. Assessing the impact of psychiatric and cognitive impairments is of particular concern to NAPWA and AFAO because of the prevalence of depression and anxiety conditions among people with HIV, and the rising incidence of HIV-related dementia among the cohort of people ageing with HIV (please refer to the NAPWA/AFAO joint submission to the Productivity Commission *Inquiry into Caring for Older Australians* for further background information, attached). Managing such conditions can be especially problematic for PLHIV, who must often also manage a range of other co-morbidities associated with HIV and the effects of antiretroviral therapy, as well.

We fully concur with Legal Aid's submission to this review regarding the problems of interpretation associated with the definition of 'permanent' in Introduction to the Tables, and also in respect of references to 'diagnosed, treated and stabilised'.

In addition to endorsing Legal Aid's submission to the Review, we provide the following comments of particular relevance regarding impairments related to HIV, and regarding common co-morbidities and frailty experienced by many older people who have lived long-term with HIV. Further background information regarding: the stigma faced by PLHIV; barriers to workforce engagement; and inadequate knowledge among many health professionals of medical and psycho-social issues faced by PLHIV is provided in NAPWA's submission to the the 2008 DEEWR JCA Review - (<http://www.deewr.gov.au/Employment/Programs/JCA/Review/Pages/attachmentB.aspx>).

Comments regarding specific Tables

TABLE 6. PSYCHIATRIC IMPAIRMENT

- 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 during an appeal. Guidelines 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.
- We believe that the rating for this Table is under-weighted. The symptoms which produce a NIL rating - those producing ‘Mild but regular symptoms which cause subjective distress’ – may be insignificant where the person has no other impairment but become significant when experienced in conjunction with other impairments, for example for a person with HIV-related cognitive impairment and/or other chronic conditions. Giving this range of symptoms a TEN rating would mean that people with multiple conditions would have mild but regular psychiatric symptoms taken into account, as is appropriate.
- We propose that the TEN rating criteria are also under-weighted, especially for people whose eligibility for DSP is under review.
- We propose that the NIL and TEN criteria should be merged, so that the ratings start at TEN; and that the TWENTY, THIRTY and FORTY ratings be merged also – given that the TWENTY symptoms clearly produce a total incapacity for work.
- We agree with Legal Aid’s comments regarding the need for the Tables to continue to take into account the fact that severe symptoms associated with intermittent psychiatric conditions may ‘wax and wane’ (p.7 of Legal Aid’s submission). 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.

TABLE 8. NEUROLOGICAL FUNCTION

- Given the rising prevalence of dementia in the general population and particular cognitive issues that can affect people ageing with HIV (attached submission refers), we propose that specific reference should be made to dementia in the introduction to TABLE 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 this Table.

TABLE 11.1. GASTROINTESTINAL

- There is no introduction to this TABLE. We propose that given the fact that these debilitating symptoms can be associated with a wide range of co-morbidities to which other Tables may seem more immediately relevant, applying this TABLE may be overlooked or inadequately considered – with the result that these particularly difficult symptoms are not given sufficient consideration.

TABLE 20. MISCELLANEOUS

- We understand that this is the TABLE most commonly applied for people with HIV, and revisions over the years mean that the TABLE is now well developed. However, we propose that the introduction to the TABLE should be revised, so as to provide more guidance in using system-specific TABLES in addition to this one. This guidance would be particularly useful for assessment of eligibility for older PLHIV who have range-of co-morbidities with symptoms of varying severity. Without such guidance, the last sentence warning against double-counting unduly dominates.

TABLE 21. INTERMITTENT CONDITIONS

- This TABLE is also potentially relevant for DSP assessment for PLHIV but the ‘attack’ terminology is, we propose, inappropriate. For PLHIV, long-term infection together with the effects of antiretroviral therapy can cause intermittent problems with severe effects that could not be termed as an ‘attack’, given the complex causes of these symptom ‘flare-ups’. We propose that references to ‘attack’ be replaced with references to ‘attack or flare-up’, or other terminology that would take into account symptom flare-up.