

**Department of Human Services:
Accessibility of Disability Support
Pension for remote Indigenous
Australians**

December 2016

Report by the Commonwealth Ombudsman,
Colin Neave, under the *Ombudsman Act 1976*

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EXECUTIVE SUMMARY

Over the past twelve months the Ombudsman's office has investigated a number of cases in which Indigenous people and their advocates have complained about decisions to refuse Disability Support Pension (DSP) claims. We do not usually investigate where, as in most of those cases, a complainant has a right of review. However, the focus of these complaints was the Department of Human Services' (DHS) assessment process. The complainants argued that their medical impairments were not properly or appropriately assessed. We decided to investigate their circumstances and examine DHS's approach.

Over recent years the qualification criteria for the DSP has been significantly revised and tightened. While it is not the role of the Ombudsman's office to comment on the merits of government policy, it is appropriate that we are alert to situations where the practical application of a policy has unintended consequences. This includes the potential to create inequitable access or outcomes that are inconsistent with legislative intent and do not reflect the principles of good administrative decision making.

We acknowledge that DHS assesses over 100,000 DSP claims per year. The majority of these are processed without significant cause for complaint by claimants. However, the experience of the majority should not necessarily be taken as an indication that the process is working for the most vulnerable in the community. This report focuses on the experiences of one particular vulnerable group—Indigenous people living in remote areas. Remote Indigenous Australians face significant disadvantage and unique cultural barriers in accessing a range of government services, including DSP.

The qualification criteria for DSP set a high bar and the claim process is rigorous. Even those applicants who are familiar with the income support and health systems say they find the DSP claim process complex, lengthy and confusing. Complaints made to our office, along with the anecdotal feedback provided by peak bodies, advocates and community organisations, show that Indigenous people living in rural and remote Australia experience particular difficulty in preparing applications for DSP and meeting the high standard of evidence required by social security law.

This report centres on complaints about the DSP claim process and uses them to illustrate some of the common challenges Indigenous people living in remote areas of Australia face when making DSP claims. The report provides a snapshot of areas where the DSP assessment process has fallen short. Although the number of complaints we receive about DSP is small compared to the total number of DSP claims, the challenges faced by remote Indigenous Australians in navigating the DSP claim process are real and the impact of these challenges can be disproportionately large, given the claimants' particular vulnerabilities.

We acknowledge the initiatives DHS has implemented to improve access to DSP for remote Indigenous Australians. Despite these efforts, we continue to receive similar complaints at the time of publishing this report. The complaints suggest there remains a gap between DHS's service delivery commitments and the reality experienced by Indigenous people in remote areas.

The report makes recommendations about the job capacity and medical assessment processes, including the way the assessments are carried out and the information given to

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and sought from medical professionals providing reports for DSP claims. We have recommended steps to increase awareness of the eligibility requirements for DSP, including the need for some applicants to have participated in a 'program of support'. Given the recent changes to the DSP claim process and the programs of continuous improvement which DHS has outlined in response to our investigation, we have also recommended that the department establishes an implementation, monitoring and evaluation framework to assess the effectiveness of those changes. Our office will continue to work closely with DHS to monitor the implementation of the recommendations in this report.

PART 1—BACKGROUND

1.1 Under social security law, members of the Australian community are able to test their eligibility for a variety of government pensions, allowances and other benefits that provide financial and practical support. Consistent with this, all members of the community are entitled to expect equitable access to payments and services, irrespective of their culture, language or geographic location.

1.2 People with disability, injury or illness who have limited or no capacity to work may be eligible for payments including Newstart Allowance, Youth Allowance, Sickness Allowance and Disability Support Pension (DSP). These payments have differing qualification criteria and income and assets tests. They also have different payment rates and provide access to different support services, such as employment service providers.

1.3 It is generally acknowledged that DSP is the most beneficial payment for a person with a disability as it attracts a higher rate of payment and has minimal (or no) participation or mutual obligation requirements.¹ The qualification criteria and claim assessment processes for DSP are rigorous.

1.4 In our view, remote Indigenous Australians are among the most vulnerable and disadvantaged groups when it comes to accessing government services and payments. This is due to a broad range of limitations and challenges, ranging from language and literacy barriers, geographical remoteness, cultural and confidence barriers, and lack of access to support mechanisms.

1.5 We often receive complaints about DSP claim processes from the general community but, given the particular levels of vulnerability and disadvantage experienced by remote Indigenous Australians, we have chosen to focus on their complaints in this report. Their experience of the DSP claim process is an indicator of whether or not the process is an equitable one to access. The Department of Human Services (DHS)² readily acknowledges the additional barriers that Indigenous DSP claimants face.³

1.6 Over the past twelve months our office has received a small number of complaints from, or on behalf of, remote Indigenous Australians who have experienced particular difficulty with the DSP claim assessment process. This report is centred on seven of those complaints,

¹ 'Mutual Obligation Requirements' replaced the term 'Activity Test and/or participation requirements' from 1 July 2015. Mutual obligation requirements include a range of activities a job seeker may be asked to undertake, such as attending appointments with relevant third party specialist organisations, undertaking job searches and acting on referrals to specific jobs, attending job interviews with prospective employers, accepting and commencing in any offers of suitable work, and participating in any other activity which is relevant to their personal circumstances and that will help the job seeker improve their employment prospects. A job seeker's mutual obligation requirements are specified in their Job Plan.

² For simplicity this report refers to 'DHS' as the department managing DSP unless specifically referring to the medical assessment process, for which DHS's Centrelink program is responsible.

³ In its response to a draft of this report, DHS said it 'acknowledges that people living in remote communities often face particular challenges in accessing appropriate medical care, and understands that people in remote and rural areas are more likely to have difficulty gathering medical evidence to support a claim for DSP'.

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six of which were investigated. Each gives an example of one or more of the steps where people face barriers when claiming DSP, including:

- accessing suitable medical services
- obtaining appropriate evidence to support their claim
- being effectively engaged in job capacity assessment and disability medical assessment interviews.

1.7 We accept the number of complaints we receive about DSP is small compared to the total number of DSP claims processed by DHS. However, the low complaint volume cannot be seen as an indication that the problems the complainants experienced are rare. On the contrary, community stakeholders and advocacy organisations have told us the challenges articulated in the case studies are experienced by many Indigenous people when making claims for DSP. The rate of complaint is indicative of generally low levels of complaint made by Indigenous people, particularly where they are without support from, or representation by, friends, family or advocates.⁴

⁴ See Winangali Indigenous Communication & Research, 'Improving the services of the Commonwealth Ombudsman to Australia's Indigenous peoples', November 2010 available at http://www.ombudsman.gov.au/data/assets/pdf_file/0019/34048/improving_the_services_of_the_commonwealth_ombudsman_to_australias_indigenous_peoples.pdf.

The research was undertaken in two urban and four regional and remote locations across Australia and found that many Indigenous people, particularly those in rural and remote areas, are unlikely to complain and have little awareness of official complaint channels.

PART 2—DSP CLAIMS

Claim process

2.1 The Department of Social Services (DSS) is responsible for the overarching policy in relation to the assessment process for DSP claims. The policy is contained in the *Guide to Social Security Law*.⁵ The claim process itself is not prescribed in legislation,⁶ but DHS has developed guidelines known as ‘Operational Blueprints’ which give effect to DSS policy and detail how DSP claims are assessed.

Initial claim assessment

2.2 When a person claims DSP their claim is first assessed to see whether basic eligibility requirements (such as residence and means testing criteria) are met. If they are not, the claim is rejected and no medical assessment is made. If basic eligibility requirements are met, the medical assessment starts once the person submits their medical evidence.

Qualification

2.3 All qualification criteria for DSP are specified in the *Social Security Act 1991*.⁷ In summary, to qualify for DSP a person’s condition/s must:

- be permanent, in that it is assessed as ‘fully diagnosed, treated and stabilised’ and likely to persist for more than two years
- attract at least 20 points under a rating system known as the ‘Impairment Tables’⁸
- prevent them from working for 15 hours or more per week, or prevent them from being retrained for that level of work, within two years.

If the person does not have a severe impairment, they must also show that they have actively participated in a program of support.

2.4 Under social security law a diagnosed condition can only be assigned an impairment rating if, among other things, it is fully treated and stabilised. A condition is only fully treated and stabilised if:

- The person has undertaken reasonable treatment for the condition and any further reasonable treatment is unlikely to result in significant functional improvement to a level enabling the person to work for 15 hours or more per week in the next 2 years; or
- The person has not undertaken reasonable treatment, but reasonable treatment is not expected to result in significant functional improvement to a level enabling the person to work for 15 hours or more per week in the next 2 years; or

⁵ Published at <http://guides.dss.gov.au/guide-social-security-law> (accessed 22 July 2016).

⁶ It is underpinned by the power to specify the manner in which a claim may be made in s 16 of the *Social Security (Administration) Act 1999* (Cth).

⁷ The main criteria are in s 94.

⁸ Unless the person qualifies for DSP because they are permanently blind under s 95 of the *Social Security Act 1991* (Cth).

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- The person has not undertaken reasonable treatment but has a compelling reason, including a medical reason, for not doing so.⁹

Impairment and work capacity

2.5 Some conditions or circumstances are automatically accepted as qualifying a claimant for DSP because the associated impairment is permanent and sufficiently severe. Qualification on this basis is known as a ‘manifest’ grant.

2.6 If a claimant does not qualify on manifest grounds their condition is assessed to identify whether it is ‘permanent’, that is, likely to persist for more than two years. If a permanent diagnosed condition is also considered, fully treated and stabilised, its functional impacts are assessed with ‘Impairment Tables’. There are 15 tables which group impairments according to the type of functions they impact. The tables provide guidance on how the severity of impairments should be rated using a points system. Impairment ratings range from 0 points (minimal or no functional impact) to 30 points (extreme functional impact) for a single table.

Program of support

2.7 If a claimant’s impairment is assessed as attracting 20 points under a single Impairment Table the impairment is considered ‘severe’. If the impairment results in the claimant being unable to work for 15 hours per week (or being retrained for that level of work) within two years, they are not required to meet any further medical qualification criteria.

2.8 Some claimant’s impairments attract a total of 20 points or more but do not attract at least 20 points on a single table. Those claimants must generally demonstrate they have completed a ‘program of support’ (or that they are unable to complete a program of support as a result of their impairment).

2.9 A program of support is a series of activities¹⁰ designed to help income support recipients prepare for, find and keep work by addressing the barriers to work they experience because of their disability or other circumstances. The required period of participation in a program is normally at least 18 months in the three years prior to the DSP claim.

2.10 Depending on the person’s location and assessed work capacity, activities making up a program of support are generally delivered by:

- Jobactive which is the responsibility of the Department of Employment
- Disability Employment Service (DES), which DSS has policy responsibility for, or
- Community Development Program (CDP) providers. The Department of Prime Minister and Cabinet has responsibility for CDP.

2.11 It is our experience that DSP applicants who have been on income support payments with no mutual obligation requirements or who have been exempt from participation requirements may have no knowledge of the program of support requirement.

⁹ This definition is in s 6 of the legislative instrument containing the Impairment Tables, the *Social Security (Tables for the Assessment of Work-Related Impairment for Disability Support Pension) Determination 2011*.

¹⁰ Usually set and monitored by employment service providers.

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2.12 This view was echoed by the Australian National Audit Office (ANAO) in its recent performance audit report on the DSP. The ANAO found that while DHS’s assessment of DSP claims was in keeping with underpinning legislation, policy and guidance, some aspects of the assessment process and its oversight could be improved. In particular, the ANAO found no evidence that DHS ‘advised unsuccessful claimants of the possible need to participate in a program of support, despite guidance that they should do so’.¹¹

Pre-1 January 2015 claims

2.13 In the past, a medical report form (also known as a ‘treating doctor’s report’ (TDR)) was given to DSP claimants for completion by their own doctor. The TDR questions focused on aspects of the claimant’s medical condition which were most relevant to the DSP eligibility criteria—for example the expected progress of a medical condition over the two year time frame—in contrast with medical records which typically focus on diagnosis, treatment and referral. Claimants were able to supplement the TDR with additional medical evidence in support of their claim, such as other medical reports and hospital records.

Current claims

2.14 From 1 January 2015, in response to changes announced by the Australian Government in 2014, DHS started phasing out the TDR for some new DSP claims¹² and stopped supplying it for all new claims from 1 July 2015.¹³ Claimants are now asked to provide existing written evidence they have about their medical conditions, such as hospital records or specialist reports.¹⁴

2.15 As previously, in some cases, once a person provides written medical evidence in support of their claim, DHS will consider whether they are ‘manifestly’ qualified for DSP on the ground that their conditions meet the eligibility criteria for DSP (for example, certain stages of terminal illness).¹⁵ Their claim is then granted, subject to meeting non-medical eligibility requirements including income and assets.

Job capacity assessments

2.16 Where the criteria for a manifest grant of DSP is not met, DHS refers the claimant for a job capacity assessment (JCA). The JCA is an assessment of the condition’s functional impact, based on the evidence the claimant provides about their medical condition. A Job

¹¹ Australian National Audit Office, ‘Qualifying for the Disability Support Pension’, Report No.18 2015–16, paragraph 2.25 (21 January 2016) at <https://www.anao.gov.au/work/performance-audit/qualifying-disability-support-pension> (accessed 21 September 2016).

¹² Use of the Centrelink TDR medical report was initially phased out for new claimants aged under 35 and living in a capital city.

¹³ For information about this change see Australian Government, Department of Human Services, ‘Medical evidence and assessment’, at <http://www.humanservices.gov.au/customer/enablers/centrelink/disability-support-pension/medical-evidence-and-assessment> (accessed 22 July 2016).

¹⁴ The new claim form includes a medical evidence checklist at p 13 <http://www.humanservices.gov.au/spw/customer/forms/resources/sa466-1510en.pdf> (accessed 22 July 2016) which is echoed in the Guide to Social Security Law. <http://guides.dss.gov.au/guide-social-security-law/3/6/2/10> (accessed 22 July 2016)

¹⁵ There is policy guidance on making manifest grants, including a list of conditions which may lead to a manifest grant. See Department of Social Services, Guide to Social Security Law, ‘Manifest Grants & Rejections for DSP’, 3.6.2.20, at <http://guides.dss.gov.au/guide-social-security-law/3/6/2/20> (accessed 22 July 2016).

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Capacity Assessor is a health or allied health professional employed by DHS. They prepare JCA reports which detail:

- whether the claimant's condition(s) are permanent, fully diagnosed, treated and stabilised and, therefore, can be assigned a rating under the Impairment Tables
- what rating, if any, should be applied to the claimant's impairments under the Impairment Tables
- if required, whether the claimant has actively participated in a program of support
- whether the customer is unable to work, or be retrained for work, of at least 15 hours per week within the next two years because of their impairment.

2.17 Most JCAs are conducted face-to-face but they may also occur by phone, videoconference or be based on medical evidence submitted with the claim (a 'file assessment').

2.18 As part of the JCA, the assessor should consider the circumstances of vulnerable claimants and determine whether the claimant has capacity to provide written medical evidence and whether further specialist assessment (discussed below) is appropriate. The assessor can also consult with other assessors, senior members of staff and the department's Health Professionals Advisory Unit (HPAU) to seek clarification or advice in respect of a medical condition and its functional impacts. The assessor can also contact the claimant's treating health professional to seek further clarification of medical evidence.

2.19 The JCA report may not support the grant of DSP, because the available medical evidence indicates the person's conditions(s) do not meet the legislative requirements for assessment under the Impairment Tables or continuing inability to work. A department delegate considers the JCA report when deciding whether or not to grant a DSP claim and can seek clarification of the JCA report if necessary. In most cases, the delegate accepts the conclusions of the JCA report.¹⁶ If the JCA report concludes that the assessment of functional impairment does not support the grant of DSP, the claim will generally be rejected.

2.20 Alternatively, an assessor can conclude that a claimant's impairment(s) do meet medical eligibility criteria for the grant of DSP and if so, a further 'disability medical assessment' (DMA) will be conducted by a Government-contracted Doctor (GCD).¹⁷ A DMA is not required if the person meets manifest eligibility criteria.

Disability medical assessments

2.20 Since 1 January 2015 claimants who are assessed as being eligible for DSP in a JCA must undergo a second medical assessment called a disability medical assessment. In this assessment, a GCD reviews the medical evidence provided; has an appointment with the claimant; forms a view on whether the claimant's medical condition(s) are permanent and fully diagnosed, treated and stabilised; and whether the impairment rating assigned by the JCA is appropriate. The DMA may vary from the findings of the JCA. The department delegate will consider both reports and generally gives more weight to the DMA report.

¹⁶ The JCA assessment may also be used to determine whether a person should be granted a reduction in their mutual obligations for another payment because of their medical conditions, or what the participation requirements are for activity-tested payments like Newstart Allowance.

¹⁷ Department of Social Services policy in relation to disability medical assessments has been added to the Guide to Social Security Law at <http://guides.dss.gov.au/guide-social-security-law/1/1/d/180> (accessed 22 July 2016).

PART 3—JOB CAPACITY ASSESSMENT ARRANGEMENTS

3.1 This part provides detailed discussion of the current arrangements for conducting JCA interviews and evaluating the available medical information. This background is important in understanding:

- the experience of claimants participating in the claim and assessment processes
- the assessor’s options for tailoring the assessment process and their engagement with claimants.

The Job Capacity Assessment appointment

3.2 In a response to a draft of this report, DHS advised that its existing guidelines state that a face-to-face JCA appointment is preferred unless this is not practicable or possible in the circumstances. For remote customers, DHS considers their location, the available infrastructure in that location and its remote servicing protocols.

3.3 DHS’s current Operational Blueprint states that a triage team chooses the most appropriate mode of JCA assessment that best suits the customer’s needs, using face-to-face (including iPad and video conference), phone and file appointments. The mode of a JCA ‘ensures that customers, irrespective of where they live, receive equal access’.¹⁸ The guidelines do not appear to clearly state that a face-to-face assessment is the preferred mode of assessment.

3.4 The guidelines state that face-to-face assessments are considered appropriate where: the assessor will benefit in seeing the customer, for example, observational data for certain impairments; the customer would benefit in seeing the assessor; a specialist assessment is required; or an interpreter is required.¹⁹

3.5 Phone assessments are appropriate where: it is not suitable for a customer to come in due to medical conditions but it could be beneficial to talk with the customer; there is limited medical information which may lead to a ‘manifest reject’; the customer’s details are not consistent with the medical evidence or there is a previous JCA that was completed face-to-face in the last 14 months.²⁰

3.6 File assessments may be conducted in certain circumstances, including where: clear and definitive conclusions can be made when reviewing the medical evidence provided a relevant specialist report is available, or there is a previous JCA that was completed face-to-face in the last 14 months.²¹

¹⁸ Operational blueprint, ‘People with disability-Assessment Services’, 008-06000000 (accessed 23 September 2016).

¹⁹ Operational blueprint, ‘People with disability-Undertaking a Job Capacity Assessment (JCA)’, 008-06040070 (accessed 23 September 2016).

²⁰ Operational blueprint, ‘People with disability-Undertaking a Job Capacity Assessment (JCA)’, 008-06040070 (accessed 23 September 2016).

²¹ Operational blueprint, ‘People with disability-Undertaking a Job Capacity Assessment (JCA)’, 008-06040070 (accessed 23 September 2016).

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3.7 It is vital the assessor select a method of assessment which allows them to consider all of the relevant information about the claimant's situation. At the appointment the assessor asks the person questions to elicit information relevant to assessing their eligibility for DSP. If the assessment is face-to-face or via videoconference, the assessor is also able to observe the person's manner, movements and physical presentation. The claimant is given the opportunity to discuss their perspective on the impact of their condition and to point to other evidence which can verify those impacts. This further exploration supports an accurate assessment of the DSP claim in circumstances in which the medical evidence available to the claimant and supplied to DHS is lacking or not optimal. This is often the case with remote Indigenous claimants.

3.8 We note with concern that, for the period 1 July 2014 to 31 May 2015, only 33.92% of JCAs for remote Indigenous claimants were face-to-face assessments, including 11.19% conducted via videoconference.²² During the same period 92.18% of JCAs for non-remote applicants were conducted face-to-face, which included 1.9% via videoconference.²³

3.9 We acknowledge the practical challenges of conducting face-to-face assessments in more remote areas; the limited availability of suitably qualified allied health professionals in regional and remote Australia generally; and the need to balance the mode of assessment against timeliness considerations. However, the case studies in this report demonstrate the limitations of other modes and their impact on the assessor's capacity to form accurate views about a claimant's medical conditions and impairments.

Options within the JCA process

3.10 The onus is on a person claiming DSP to supply comprehensive and accurate information about their medical condition(s). However feedback to this office through complaints and stakeholders, is that often the existing medical evidence has been prepared for a purpose other than a DSP claim. Consequently, the evidence does not sufficiently address aspects of the condition which impact on functional impairment. JCA policy and procedures acknowledge that in some situations an assessor should play a more active role in obtaining information. An assessor can:

- refer the case to DHS's HPAU
- contact the person's treating doctor/s or specialist/s to request clarification of evidence
- seek advice from other assessors and senior staff; and/or
- refer the person for further specialist assessment.²⁴

3.11 DHS's HPAU is a team of health professionals in various locations whose role is to provide advice on medical issues in relation to DSP.²⁵ The HPAU may clarify information provided by a claimant or contact treating doctors to clarify existing information or obtain additional information. The HPAU can also provide valuable advice to assessors and administrators on specific medical conditions and their functional impacts. The guidelines

²² DHS advises that for Indigenous customers overall (remote and non-remote), the percentage of face to face JCAs increased from 76% in 2014-15 to 83% in 2015-16.

²³ Information provided by DHS during the investigation of Ms B's complaint.

²⁴ Operational blueprint, 'People with disability-Completing a Job Capacity Assessment', 008-06040080 (accessed 23 September 2016).

²⁵ Created in July 2010 to improve DSP decision-making.

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emphasise this facility is not a substitute for the requirement that a person provide medical evidence when claiming DSP.²⁶

3.12 DHS data shows that the HPAU is accessed rarely. In 2013-2014, there were 115,517 JCAs and in only 3754 cases (about 3.2%) were referrals made to the Unit.²⁷ In 2014–2015, there were 95,028 JCAs with only 3473 cases (about 3.7%) referred to the Unit.²⁸ In 2015–2016, there were 97,698 JCAs and the number of HPAU referrals dropped to 2458 (about 2.5% of cases).²⁹

3.13 DSS policy also permits completion of a JCA based on conversations with doctors and without written medical evidence in limited circumstances. These include where the claimant is unlikely to provide written medical evidence because of a mental health or other serious condition, and/or lives in a remote area and has limited access to medical services. In the second case, DSS policy states:

In the case of people from remote areas who may have limited access to doctors, a community nurse can assist in collating their medical evidence, which should generally be based on clinical notes from a [GP](#) (the diagnosis must be made by a qualified medical practitioner). In these cases it may be possible for the job capacity assessor or the [GCD](#) to form an opinion regarding the person's medical qualification on the basis of available evidence.³⁰

3.14 An assessor may arrange for a claimant to undergo further specialist assessment in certain circumstances where it would inform the assessment. DSS is responsible for monitoring the use of specialist assessments. The guidelines state that a specialist referral should *only* be arranged in relation to new DSP claims where:

- comprehensive evidence has been provided to the assessor...but clarification or additional information is required and cannot be obtained by any other means, or
- the assessor observes or suspects that a person has an intellectual disability, acquired brain injury or psychological/psychiatric disorder and there is no evidence of diagnosis or treatment as the person lacks insight into (or does not acknowledge) the condition or is otherwise incapable of independently engaging in medical services to obtain the required information, or

²⁶ Operational blueprint, 'People with disability-The Health Professional Advisory Unit (HPAU)', 008-03160010-01 (accessed 23 September 2016).

²⁷ Australian Government, Department of Human Services, Annual Report 2013-14, p 36, at <https://www.humanservices.gov.au/sites/default/files/documents/annual-report-2013-14.pdf> (accessed 21 July 2016).

²⁸ Australian Government, Department of Human Services, Annual Report 2014-15, p 28, at <https://www.humanservices.gov.au/sites/default/files/documents/8802-1510-ar2014-15.pdf> (accessed 21 July 2016).

²⁹ Australian Government, Department of Human Services, Annual Report 2015-16, p 41, at <https://www.humanservices.gov.au/sites/default/files/8802-1610-annualreport2015-16.pdf> (accessed 1 November 2016).

³⁰ The guidelines reflect the Department of Social Services' policy in the Guide to Social Security Law, 'Medical and Other Evidence for DSP', 3.6.2.10 <http://guides.dss.gov.au/guide-social-security-law/3/6/2/10> (accessed 21 July 2016).

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- Centrelink Legal Services considers a specialist assessment is required with respect to an appeal to the [AAT](#) (or the Federal or High Court).³¹

3.15 A specialist assessment which focuses on a particular medical condition may be conducted by a DHS assessor if appropriately qualified, or if there is no appropriately qualified assessor available, by an external specialist. The assessment can involve physical assessment (including, for example, a comprehensive assessment to assess the impact of physical conditions) and/or psychological assessment. After considering written medical information supplied by the person, information obtained at the appointment and any additional information obtained from other sources, the specialist assessor produces a report on a range of matters.

3.16 The guidelines state that, in addition to the circumstances listed above an assessor can refer a vulnerable claimant for specialist assessment where the assessor observes or suspects that the claimant:

- has an undiagnosed intellectual/learning disability or acquired brain injury;
or
- an undiagnosed mental health condition and are living in a remote community with little or no access to health services and would need to wait more than 12 months for an appointment; or
- an undiagnosed mental health condition and have little or no insight into their condition or lack capacity to engage with appropriate medical services.³²

³¹ Guide to Social Security Law, 'Specialist Assessments for DSP', 3.6.2.15 at <http://guides.dss.gov.au/guide-social-security-law/3/6/2/15> (accessed 22 July 2016); Operational blueprint, 'Specialist Assessments for disability payment', 008-06050000-01 (accessed 22 June 2015).

³² Guide to Social Security Law, 'Specialist Assessments for DSP', 3.6.2.15 at <http://guides.dss.gov.au/guide-social-security-law/3/6/2/15> (accessed 22 July 2016); Operational blueprint, 'Specialist Assessments for disability payment', 008-06050000-01 (accessed 22 June 2015).

PART 4—CHALLENGES IN EFFECTIVELY ENGAGING REMOTE INDIGENOUS PEOPLE IN THE DSP CLAIM PROCESS

4.1 This part examines the processes discussed above and how remote Indigenous complainants to this office have experienced them in practice.

4.2 DHS states that when assessing claims or potential DSP claims it actively applies special provisions, including the use of specialist assessments and provisional diagnoses, for Indigenous Australians who have limited access to mainstream health services.

4.3 The first five case studies in this report relate to a claim that was assessed prior to the introduction of disability medical assessments and removal of the TDR from the claim process. The cases remain relevant, however, because the fundamental administrative arrangements for conducting JCAs and the approaches to engaging with Indigenous people in remote areas are largely unchanged. Two further case studies relate to claims made after the 1 January 2015 changes.

Clarity of evidence

Engagement with treating doctors

4.4 The Ombudsman's report *Assessment of claims for disability support pension from people with acute or terminal illness*, highlighted the tendency of treating doctors to be encouraging and optimistic in their assessments of patients, leading to a view that many conditions are not 'fully treated' so long as additional treatment options remain. This is so even where those treatments may not improve, or may even slow the deterioration of, the condition. Given that TDRs may be subjective it is important for assessors to engage early with treating doctors early in the process and clarify the medical evidence when it appears to be inconsistent or complete.

4.5 Mr A's case illustrates a situation where the assessor could have engaged with the treating doctor at an earlier stage to clarify the medical evidence or seek additional information. It is set out in some detail to illustrate the severity of Mr A's post-surgery condition in the context of his likely future capacity to work.

Case study 1: Mr A

Mr A is a 64 years old Indigenous man who lives in a very remote community in the Northern Territory. There is a health clinic in the community, but very limited access to specialist medical services.

Mr A's extensive work experience consisted entirely of manual work. He did not attend school and cannot read or write English.

As part of treatment for cancer, Mr A had major surgery including the removal of one eye, lymph nodes, substantial portions of his upper jaw, loss of his nasal cavity and extensive skin grafts from his leg. Following surgery, he also underwent chemotherapy and radiotherapy.

Mr A first claimed DSP shortly after surgery and the medical report listed his operations. It noted that Mr A was predominantly in a wheelchair, could not eat or drink, had severely restricted breathing and severe, generalised weakening. The treating doctor said that Mr A required 24 hour care, including assistance with all activities of daily living.

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The doctor reported that Mr A's condition was expected to last more than 24 months, but the effect of the condition on Mr A's ability to function was uncertain, noting that Mr A's 'outcomes are contingent on the effectiveness of his cancer treatment'.

Because of his remote location the assessor decided to assess Mr A by phone. The JCA noted it was difficult to understand Mr A due to his affected speech. The assessor concluded that 'current and future treatment may significantly improve symptoms of [Mr A's] condition'. The JCA said that Mr A's conditions were not fully treated or stabilised and therefore could not be given an impairment rating. It reported that Mr A's prognosis was contingent on the ongoing treatment and relied on the treating doctor's comment in the DSP medical report to support this conclusion. The assessor did not try to contact Mr A's doctor or seek any additional information regarding his conditions or their impact on his ability to work.

Mr A's DSP claim was rejected. DHS's records show the option of an appeal was discussed with Mr A and his wife, but no request was lodged on Mr A's behalf.

Mr A lodged a second claim for DSP about 6 months after the surgery. The claim again included a DSP medical report completed by a treating doctor from the hospital where the surgery was done. The DSP medical report noted Mr A's continued difficulty in speaking and seeing and that he was fed through a stomach tube. It concluded the impact on Mr A was likely to continue for more than 24 months, with his swallowing difficulty and vision impairment likely to persist. It noted that he 'may experience some improvement in pain'.

This time the JCA was done on the file: the assessor recorded that they had not been able to get to Mr A's community and had not been able to make contact by telephone. He did not try to contact Mr A's treating doctor or seek any additional information. He determined that Mr A's condition was not 'treated and stabilised', relying in part on the same reasons as the first assessor. He identified speech therapy as one possible intervention to assist Mr A. Again, Mr A's DSP claim was refused.

Some months later, a lawyer assisted Mr A to seek a review of the rejection of his DSP claims. Further medical evidence was lodged with the review. A DHS Authorised Review Officer (ARO) granted DSP to Mr A from the date of his first claim. The ARO noted he was satisfied that any further treatment would target Mr A's cancer but would not address the functional impairment he had as a result of the earlier surgery.

The lawyer assisting Mr A lodged a complaint with our office in June 2015. We did not investigate as Mr A's claim had already been granted and investigation was unlikely to provide a better outcome.

4.6 It is concerning that, despite the specific reference in the Operational Blueprint guidelines to the option of seeking further information from a doctor where the person lives in a remote area, the Job Capacity Assessors did not take any steps to clarify the nature or likely outcome of Mr A's ongoing cancer treatment. In our view, the written medical evidence before the assessors should, at a minimum, have raised questions about whether Mr A's functional capacity for work would improve with further treatment of his cancer.

4.7 In this case and in Ms G's case below, clarifying or seeking additional information from treating or other doctors would have been appropriate and may have led to the claim being granted earlier, a cost effective outcome in comparison to the multiple claims and appeal.

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4.8 The Guide to Social Security Law says that “if a report, document or other material contains unclear terminology or lacks clarity, it should also be discussed with its author”.³³ This should be expanded to include situations where evidence is incomplete and the claimant is an Indigenous person in a remote area. The Operational Blueprint states that “if further evidence is required” an assessor may contact the treating health professional, seek advice from the HPAU or request a specialist assessment.³⁴ We believe the guidelines need to be more proactive in helping assessors identify the situations where this may be appropriate. The case examples in this report show that even where there was contradictory medical information, assessors did not seek further or better information.

4.9 DHS states that it is currently delivering retraining and assessors are reminded to confirm or clarify medical evidence they believe is unclear. DHS says that training and operational guidelines are regularly updated and changes to its procedures mean that assessors are now likely to contact treating doctors to clarify evidence. We recommend that guidance and training for assessors should encourage direct contact with treating doctors in a wider range of circumstances, particularly where a face-to-face JCA has not been possible.

4.10 In response to a draft of this report, DHS advised that it has introduced an expert specialised team to support and advise assessors on specific medical conditions, including advice on whether a specialist assessment or additional medical evidence is needed. DHS has also advised that it ‘has a robust quality assurance framework which includes multiple quality control checks for all stages of the DSP assessment process, for example, targeted risk-based and random quality checks on JCA reports’. We recommend the outcomes of these measures should be evaluated and monitored and include quantitative and qualitative information about whether assessors exercise their options to clarify medical information.

Recommendation 1 – contacting treating doctors

(a) DHS review the Operational Blueprint to ensure that it emphasises the need for assessors to obtain the best possible evidence to inform accurate decision making, particularly for remote Indigenous customers. This review should include ensuring that the procedures actively encourage assessors to contact treating doctors to seek additional information, particularly where a remote Indigenous DSP claimant submits incomplete or conflicting information and where a face-to-face JCA is not possible.

(b) As part of its existing quality assurance framework, DHS should monitor and evaluate the cases for remote Indigenous customers in which Job Capacity Assessors do and do not exercise options to gain further clarifying information, including referring to treating doctors, the HPAU, and specialist assessors.

³³ Guide to Social Security Law ‘Medical and Other Evidence for DSP’, 3.6.2.10 <http://guides.dss.gov.au/guide-social-security-law/3/6/2/10> (accessed 27 July 2016).

³⁴ Operational blueprint, ‘Completing an Employment Services Assessment (ESAt) or Job Capacity Assessment (JCA) report’ 008-06040080 (accessed 27 July 2016).

Obtaining additional evidence

4.11 In its response to a draft of this report DHS acknowledged that:

people living in remote communities often face particular challenges in accessing appropriate medical care, [DHS] understands that people in remote and rural areas are more likely to have difficulty gathering medical evidence to support a claim for DSP.

4.12 Ms G's case illustrates the value of specialist assessment and indicates what appears to be a reluctance to make use of this option.

Case study 2: Ms G

Ms G is a 59 year old Indigenous woman who lives in a remote community in the Northern Territory.

Ms G applied for DSP five times between 2013 and 2015 in respect of various conditions including arthritis, gout, kidney disease, diabetes and acquired brain injury. Across the first two applications, the Job Capacity Assessors reached different conclusions regarding whether Ms G's conditions were permanent and attracted an impairment rating. In any event, both applications were rejected on the basis that she did not meet the medical criteria.

In July 2014 an ARO review found 'the medical evidence also indicates that you have a traumatic brain injury but there is insufficient specialist information about the diagnosis, treatment and functional impact of the condition for it to be assessed as permanent. Therefore I am unable to assign an impairment rating for the condition.'

When Ms G claimed DSP for a fifth time in March 2015, the JCA concluded that the combination of her impairments was severe and warranted 20 points under Table 1 (functions requiring physical exertion and stamina). As a result she was granted DSP.

Notwithstanding the grant of DSP, Ms G's lawyer contacted our office concerned that despite all assessors conceding that Ms G has a traumatic brain injury that affects her capacity to work, none of them had taken steps to obtain a specialist assessment so the impact of the condition could be accurately considered in the JCA report.

4.13 In its response to our investigation of Ms G's case, DHS referred to the Operational Blueprint detailing those circumstances in which a referral can be made for specialist assessment at no cost to the claimant. DHS noted that Ms G had not indicated she was having trouble obtaining a specialist assessment and, in any event, she did not meet the requirements for a DHS-supported specialist assessment as she is a 'lifelong patient' of the community health centre, which in DHS's opinion would have been able to arrange a medical assessment for her. While DHS says Job Capacity Assessors will attempt to obtain additional medical evidence on behalf of vulnerable customers, it did not consider Ms G vulnerable.

4.14 We believe this response was inadequate and did not take into account that Ms G lives approximately 750km away from the nearest specialist brain injury assessment provider. We disagree that Ms G, as an Indigenous woman from a remote area with significant disabilities, was not vulnerable. When a vulnerable DSP applicant does not have the requisite specialist reports, it should not be assumed they will inform DHS they are unable to obtain specialist reports. Similarly, the fact that an applicant is a client of a

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community health centre does not necessarily mean they are readily able to access a specialist. DHS should seek information from vulnerable customers such as Ms G about their barriers to obtaining specialist reports and where appropriate, assist them to obtain specialist reports. DHS's approach here has concerning implications for remote Indigenous DSP applicants who experience the evidentiary barriers the department acknowledges.

4.15 DHS has advised that 'specialist assessments are undertaken for customers as required' and it has recently implemented a number of service delivery improvements for remote customers. DHS's existing guidelines and procedures allow for specialist referrals in certain cases, such as where a person has an undiagnosed mental health condition, acquired brain injury or intellectual disability; where the customer would need to wait more than 12 months for a psychological/psychiatric assessment; or where clarification of the medical evidence cannot be obtained by other means. It is not clear whether these procedures were followed for Ms G who had an identified acquired brain injury.

4.16 In our view, the existing guidelines identify a limited range of circumstances where people may have difficulty obtaining specialists reports, such as undiagnosed psychiatric and psychological conditions. They do not specifically address the broader needs of vulnerable claimants who do not necessarily have mental health conditions, or the unique barriers faced by Indigenous people living in remote areas in obtaining specialist reports.

4.17 We recommend that policies and procedures on referrals for a specialist assessment be reviewed to encourage greater use of them for vulnerable claimants. This should especially occur where the person is Indigenous, in a remote location and the medical evidence may not be adequate for the assessor to reach reasonable conclusions on functional impairment. Specialist assessments should be particularly encouraged in cases where DHS has not conducted, or cannot conduct, a face-to-face assessment. The use of these referrals should be monitored and evaluated. DHS should also review and further strengthen training to ensure that assessors consider a referral for a specialist assessment where appropriate and clearly reflect any enhancements to processes in the Operational Blueprint.

Recommendation 2 – specialist medical assessments

(a) DHS amend its Operational Blueprint to allow and encourage Job Capacity Assessors to make referrals to specialist medical assessments where it is apparent that a vulnerable claimant has a reported condition in respect of which they have been unable, or would be unable, to obtain a specialist assessment.

(b) DHS amend its Operational Blueprint to require that, where DHS is not able to conduct a face-to-face JCA, the assessor should consider the vulnerability of and practical barriers experienced by the claimant and, where necessary, facilitate a comprehensive medical assessment, for example by liaising with remote health services which service the applicant's community.

(c) In determining whether a person is unable to obtain a specialist assessment, Job Capacity Assessors should be trained to thoroughly assess all barriers, without placing over reliance on self-reported barriers or making assumptions about the assistance available from third parties. This should include talking to the applicant and any relevant third parties.

Nature and quality of the evidence

Guidance to medical practitioners

4.18 In the Ombudsman's 2009 report regarding DSP for people with acute or terminal illness we made a number of recommendations in relation to the assessment of claims. One recommendation was :

The DSP medical report should be amended to include a guide to answering each of the questions (on the medical report form) including how the various answers might be interpreted by a JCA assessor or Centrelink officer.

4.19 While the DSP medical report (TDR) is no longer used, the issue of the quality of information given to treating doctors about evidence to support claims continues to be relevant. Mr C's case highlights this issue.

Case study 3: Mr C

Mr C is a 64-year-old Indigenous man who lives alone in a short-term hostel in Darwin. His claim for DSP was rejected in September 2014, with the decision affirmed by an Authorised Review Officer (ARO) in November 2014.

After an assessment conducted by phone, the JCA report stated that Mr C was likely to have knee replacement surgery in the next few months.

On review, the ARO concluded that Mr C's osteoarthritis was not fully treated or stabilised and therefore could not be rated under the Impairment Tables. This view appears to have been reached from a phone conversation the ARO had with Mr C and Mr C's reference to an upcoming assessment by an orthopaedic surgeon to discuss treatment options. However, the ARO also had a doctor's report which indicated that, while Mr C may be eligible for knee replacement sometime in the future, surgery was high risk due to other factors (including Mr C's obesity and sleep apnoea) and was likely to be subject to a 2-3 year waiting period. The doctor also said that Mr C's symptoms were likely to persist for more than 24 months, with his ability to function expected to deteriorate within the next two years.

Mr C complained to our office in July 2015. He told us he was upset that he was allocated a phone JCA despite living near a DHS customer service centre and several times requesting a face-to-face assessment. We encouraged Mr C to exercise his review rights.

Mr C lodged an appeal which was decided by the Administrative Appeals Tribunal (AAT) (First Review) in August 2015. A more recent medical report tabled at the AAT echoed previous medical evidence but more clearly stated that 'regarding his outlook over the 2 years, his condition is unlikely to improve. A comment cannot be made on a knee replacement as he may not be a candidate for such surgery'. The AAT consequently found that Mr C's osteoarthritis was permanent for DSP purposes and assigned a rating of 20 impairment points. The AAT also assigned 10 points for his sleep apnoea and restricted lung function. The AAT set aside the DSP rejection and considered that Mr C qualified for DSP.

4.20 The doctors' reports submitted by Mr C contained substantively similar information. Both stated his condition was likely to persist for more than two years, he was an unlikely candidate for surgery, the only treatment available. However, the more recent report available to the AAT used wording reflective of the Impairment Tables: 'unlikely to improve'.

4.21 We suggest there is a strong possibility that had the original medical report made it clear Mr C's condition was 'unlikely to improve', the ARO may have found that his condition was fully treated and stabilised and could be rated under the Impairment Tables. Therefore,

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Mr C would not have had to obtain extra medical and functional assessments, seek legal advice and appeal to the AAT. If it is the case that the use of key terms assists decision makers, it would be preferable if that was made clear to medical practitioners. This is especially so where there is no longer a TDR that specifically addresses DSP eligibility criteria and claimants must rely on existing medical evidence.

4.22 In its response to a draft of this report DHS has advised that it has:

- updated the detailed ‘medical evidence requirements’³⁵ form, which is specifically for claimants and forms part of the DSP claim package. We note however that the form is currently not linked to the more streamlined, simplified information on DSP eligibility on the DHS website.
- reviewed its ‘Consent to disclose medical information’ form to more clearly explain the department’s role in contacting a DSP claimant’s treating health professional to clarify evidence provided
- along with DSS, met with Australian Medical Association (AMA) a number of times since the introduction of the DSP policy changes to discuss information products and included AMA feedback in new editions of information
- liaised with the AMA about including DSP medical eligibility information for treating health professionals on DHS’s health practitioner webpage
- collaborated with the AMA to develop a factsheet to explain the eligibility criteria and information required for DSP. The fact sheet will be distributed by the AMA to its network and will be published on the department’s website.

4.23 We welcome these initiatives and recommend that DHS further develop its publicly available guidance for medical practitioners. For example, we recommend DHS duplicates the medical evidence requirements form on the general DSP information pages on its website. The practitioners’ webpage could be developed further to provide materials on completing reports for DSP purposes and promoted through DSS and DHS’s existing channels of communication with the medical profession. We also recommend that DHS consult more broadly with other key stakeholders, such as rural and Indigenous health peak bodies, when developing and distributing this information.

Recommendation 3 – information for medical practitioners

(a) DHS further develop publicly available guidance to ensure medical practitioners have access to clear information about the qualification criteria, Impairment Tables, and the way in which DHS uses the information provided by medical professionals to assess an applicant’s medical condition for DSP purposes.

(b) DHS consult widely with a range of medical groups, including those that service remote and rural areas, to distribute the information about the qualification criteria, impairment tables, and the way in which DHS uses the information provided by medical professionals to assess an applicant’s medical condition for DSP purposes.

JCAs – Approach to conducting assessment interviews

4.24 We are encouraged by the department’s advice that it has:

³⁵ On DHS’s website at <https://www.humanservices.gov.au/sites/default/files/sa473-1603en.pdf> (accessed 15 July 2016).

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implemented a new approach to triaging all JCA referrals to ensure that assessments have the applicable mode of assessment, are referred to an appropriately qualified assessor taking account of the condition and identify upfront whether a special assessment is required.

4.25 We look forward to receiving more detail on each element of this approach, and encourage DHS to monitor and evaluate its outcomes.

Mode of assessment and visual contact

4.26 In our view, face-to-face assessment is preferable to other forms of assessment. Ms B's and Mr R's complaints illustrate the benefits of face-to-face assessment and the use of interpreters where appropriate.

Case study 4: Ms B

Ms B is an Indigenous woman living in a remote community. English is not her first language. Having lodged unsuccessful DSP claims in 2008 and 2011, Ms B claimed DSP again in mid-2013. Her claim included a treating doctor's report listing a number of medical conditions.

Ms B's JCA was conducted by phone in September 2013 without an interpreter, with her remote location given as the reason. The assessor concluded her diabetes attracted five points under Impairment Table 1, noting that Ms B had advised she was able to walk around her community regularly and needed to stop to rest 'on occasion'. Ms B also reported needing help from family with cooking and cleaning. The assessor did not assign a rating to Ms B's other impairments, mostly due to a lack of information.

Ms B was in receipt of Widow Allowance which is a payment without mutual obligation requirements and therefore does not involve compulsory referral to an employment services provider. Following the JCA, Ms B's lawyer sought referral to a program of support for her. This explicit request was necessary despite assessors for two of Ms B's DSP claims recommending referral to a disability employment services provider, with one citing her 'high and urgent need'.

With the help of a lawyer, Ms B sought review of the DSP refusal in October 2013. By the time her review was considered she had obtained additional medical reports. Among other impairments, Ms B's medical reports referred to 'chronic pulmonary obstructive disease', mentioned severe shortness of breath and said that Ms B became 'easily fatigued'. This was consistent with a JCA conducted for the purpose of her DSP claim two years earlier, where the assessor recorded a presumptive diagnosis of chronic obstructive pulmonary disease associated with shortness of breath, tiredness and a need for rest after 100-200m walking. A second JCA was conducted, on the file, in January 2014. It reached the same conclusions as the first JCA, her claim was rejected, appealed, and an ARO affirmed the original decision in April 2014.

Ms B then appealed to the Social Security Appeals Tribunal (SSAT) in July 2014. The hearing was conducted by phone and Ms B's lawyer provided video footage of Ms B moving around her community. The SSAT increased Ms B's impairment rating to 10 points under Table 10, but this was insufficient to qualify her for DSP.

Ms B lodged a further DSP claim in February 2015. She attended a face-to-face JCA, with an interpreter, in May 2015. Her diabetes, previously assigned 5 points, was assigned 20 points. The assessor also concluded that Ms B's hypoglycaemic episodes (not previously rated) attracted a further 10 points, making a total of 30 points. The assessor's report noted that Ms B tended to overstate her capabilities and understate her disabilities.

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Ms B's claim was granted and backdated to February 2015. Given that she attracted 20 points under a single table and was deemed to have a continuing incapacity to work, there was no requirement for Ms B to have demonstrated completion of a program of support in order to qualify for DSP.

4.27 In Ms B's case, the assessor who conducted a face-to-face assessment noted that she tended to overstate her capabilities and understate her disabilities. This may have been more evident in a face-to-face assessment, compared to a file or phone assessment. In response to a draft of this report, DHS acknowledged that it would have been beneficial to have conducted a face to face assessment for Ms B in 2013. In our view, DHS should actively identify ways to maximise rates of face-to-face JCAs for Indigenous people living in remote locations. This might include expanding the practice of JCAs travelling with remote servicing teams and conducting blocks of assessments on a prearranged day. It might also include increasing the rate of JCAs that are conducted by videoconference, where such facilities can be made available.

Case study 5 – Mr R

Mr R has kidney disease and receives dialysis in Alice Springs for five hours at a time, three times a week. Mr R's claim for DSP lodged in September 2014 was rejected, but he did not understand why. His advocate lodged a complaint to our office on his behalf.

DHS's response indicated that in assessing his claim Mr R 'was not required to attend an appointment' and his JCA was completed on the file. His conditions were listed as end stage renal disease and type two diabetes, both of which were assessed as permanent and fully diagnosed, treated and stabilised. An impairment rating of 10 points was assigned. Mr R requested a review of the decision in December 2014. The ARO determined the additional medical reports Mr R had submitted did not contain any new information relevant to his claim and affirmed the original decision.³⁶

Mr R lodged another DSP claim in April 2015. He had a JCA conducted by video conference in July 2015 and was awarded 20 impairment points and granted DSP. Although the more recent JCA report states the increased impairment rating was a result of more medical information being available, both JCAs concluded that his condition was permanent, fully diagnosed, fully treated and stabilised and a significant improvement in overall functionality was not likely within the next two years and the condition is likely to deteriorate.³⁷

The letter advising Mr R of the grant of DSP did not explain the basis for the different conclusion about Mr R's eligibility. No significant difference in the medical reports was apparent, although the second application was accompanied by supporting letters from a social worker and a Director of Clinical Services.

4.28 Ms B's and Mr R's experiences suggest the value of a face-to-face or video assessment to assess the true impact of a claimant's impairments. Visual assessment is likely to be particularly important in the case of many remote Indigenous Australians who face

³⁶ The rejection letter noted: 'Under Table 1, the appropriate points rating is 10 (for moderate functional impact). To get a 20 point rating under Table 1 (for severe functional impact), the person must be unable to: walk or mobilise around a shopping centre or supermarket without assistance from another person; or be unable to work (or mobilise) from the car park to the shopping centre without assistance from another person. The person must also require assistance from another person to use public transport or be unable to perform light day to day household activities'.

³⁷ JCA 3 October 2014

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well recognised linguistic and cultural barriers, discussed below, when responding to questions such as those posed by Job Capacity Assessors.

4.29 DHS has noted that remote Indigenous customers are more likely to not attend scheduled interviews (a 26% 'did not attend' rate as compared to a 20% rate for other customers), advised that its booking team is trialling a process whereby customers will receive an SMS inviting them to discuss the scheduling of appointments. We also encourage DHS to monitor and evaluate the effectiveness of its trial. We encourage DHS to consider a range of strategies to address the issue as there are a number of challenges, the lack of mobile coverage in remote communities being one of them. Where there is mobile coverage, and subject to privacy considerations, research suggests that personal messaging on Facebook is an effective medium for communicating directly with remote Indigenous Australians. This strategy may overcome some of the limitations of shared mobile phone use.³⁸

4.30 DHS has advised that it has increased its use of videoconferencing for remote customers. While that mode is preferable to telephone or file assessments, it is not a practical option for communities with limited or no internet access.

4.31 DHS acknowledges the benefit of having Job Capacity Assessors visit communities and meet with local health providers to educate and engage them in the medical evidence requirements for DSP. However, we understand that DHS has reduced the frequency of remote servicing team visits to many Indigenous communities from 8 to 12 weekly.³⁹ This is likely to further reduce the opportunities for face-to-face JCAs.⁴⁰

Recommendation 4 – Mode of Job Capacity Assessment

DHS identify strategies to ensure that, wherever possible and practical, all remote Indigenous DSP claimants are offered JCAs where the assessor is able to assess their impairment with the benefit of visual observation, whether in person or via videoconference.

4.32 We are mindful in making this recommendation that increasing the rate of face-to-face or videoconference JCAs may lead to delays in processing claims. However, provided the applicant is given interim support pending the outcome of their claim, we consider this impact justifiable. Particularly as it ensures JCAs are more accessible and more accurate and, in turn, that DSP claim decisions are made on the basis of clear, comprehensive and relevant evidence of a person's impairment. It could also help to avoid the increased cost of multiple appeals and subsequent claims.

Culture and self-reporting

4.33 In Mr A's case, his lawyer noted that he is 'an extremely optimistic man' who 'hopes he is "getting better" and that one day he will go back to work as he "believes in work"', despite the very different conclusions formed by his treating doctors. In both Mr C's and Ms B's cases there was an apparent contradiction between their self-reported accounts of their impairments, their expectations of returning to work or active participation in community, and the medical evidence that described more severe and debilitating conditions, including

³⁸ Professor Peter Radoll, 'Indigenising the Internet', Don Aitkin Lecture, University of Canberra, 31 May 2016.

³⁹ DHS advises that if a remote location has Income Management in that area, Remote Servicing Team visits occur on an eight-week visit cycle. For remote locations only, they occur on a 12-week cycle.

⁴⁰ Verbal advice obtained from Katherine outreach visit undertaken by Ombudsman in August 2015.

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how they presented in visual assessments. This contradiction may arise from a number of factors, including:

- gratuitous concurrence, which can cause Indigenous people to agree with propositions put to them irrespective of whether they actually agree⁴¹
- language barriers that make it challenging to effectively engage claimants in meaningful discussions about the impact of their conditions, noting that for many remote Indigenous Australians English is often their third, fourth or even fifth language
- cultural differences regarding the concept of disability and its interaction with ongoing involvement in employment and community life, in particular the fact there are often no comparable terms for 'disability' in traditional languages, which suggests the experience of 'disability' may be accepted as part of the normal range of human experience.⁴²

4.34 Assessors should be conscious that the way in which they structure their questions to Indigenous people may inadvertently lead to gratuitous concurrence. In all situations assessors should be alert to and carefully assess any discrepancies between the claimant's own assessment of their capacity and that conveyed by medical professionals, and where the two conflict, seek clarification.

Language

4.35 Ms B's initial JCA in 2013 was conducted by phone in English, which is not her first language. Ms B's third JCA, which led to the grant of DSP, was conducted by video conference with a Tiwi language interpreter. Communication with Ms B in her preferred language, combined with a visual assessment of her impairment, appear to have contributed to the job capacity assessor forming a more complete view of Ms B's actual incapacity.

4.36 The importance of using interpreters in engaging with Indigenous Australians as well as people from culturally and linguistically diverse communities has been the subject of two previous Ombudsman's reports.⁴³ The use of interpreters is likely to minimise the risk of gratuitous concurrence.

4.37 In its response to a draft of this report, DHS advised that cultural competency and awareness training is given to departmental staff. Remote servicing assessors working in Northern Australia are trained in cultural awareness and cognitive assessment measures relevant to Indigenous Australians. GCDs and assessors use interpreters when required. DHS also referred to the general training package and selection criteria for GCDs and the training that assessors receive as allied health professionals.

⁴¹ Diana Eades, *Aboriginal English and the Law*, Queensland Law Society (1992)

⁴² Damian Griffis for First People's Disability Network, *First Submission to the Productivity Commission Inquiry into Disability Care and Support* (2010)

⁴³ See Commonwealth Ombudsman, *Talking in Language: Indigenous language interpreters and government communication* Report No 5 (2011) available at http://www.ombudsman.gov.au/files/Talking_in_Language-Indigenous_Interpreters_REPORT-05-2011.pdf and *Use of interpreters* Report No 3 of 2009 available at http://www.ombudsman.gov.au/_data/assets/pdf_file/0013/26221/investigation_2009_03.pdf

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4.38 While we welcome these measures, we consider this response does not fully address the concerns raised in this report. The existing training appears to be mainly targeted at cognitive testing of claimants and the assessment of mental health conditions. It does not fully address training on cultural considerations relevant to disability and self-reporting for Indigenous claimants who may not require these assessments. DHS's training material for GCDs does not give specific guidance on conducting DMAs for remote Indigenous claimants or refer to Indigenous cultural awareness or language. We consider the existing training material could be enhanced and better targeted to address these issues.

Recommendation 5 – Culture and Language

DHS review, and if necessary revise, then monitor and evaluate Indigenous cultural competency and awareness training provided to staff, including JCAs and government doctors conducting Disability Medical Assessments, to ensure it adequately addresses:

- identifying the need for, and use of Indigenous language interpreters
- cultural considerations around disability and self-reporting.

Program of support requirement

4.39 The Ombudsman's office has dealt with several complaints which highlight a lack of awareness about the program of support requirement. In some cases, people have made appeals as far as the tribunal level before being clearly informed that, even if they were assessed as having 20 points in total over several impairment tables, they would be unable to qualify for DSP due to a lack of program of support participation.

4.40 Our engagement on complaints with DHS (as the service delivery agency) and DSS (as the department with policy responsibility for DSP) reflects that neither DHS nor employment service providers are required or even actively encouraged to inform potential or actual DSP applicants of the likelihood they will need to meet the program of support requirement before DSP can be granted. In its response to the draft report, DSS agreed that more could be done to raise awareness with income support recipients about program of support requirements.

4.41 We accept only a small proportion of DSP claims are rejected because the person does not meet program of support requirements.⁴⁴ Despite this, we consider that claimants would benefit from clear information about program of support to help them better understand eligibility and grant decisions, and avoid unnecessary appeals and further DSP claims. This information is particularly important for remote Indigenous Australians who already face significant barriers in accessing information about DSP eligibility criteria and referrals to program of support providers.

4.42 The importance of providing information about program of support requirements was recognised by the ANAO in its 2016 report, *Qualifying for the disability support pension*. The ANAO stated that where rejected claimants are not advised of the requirements, it can have negative consequences on any subsequent claims for DSP. The ANAO considered there was scope for DHS to improve its 'advice about program of support requirements and the

⁴⁴ The ANAO found that in 2013-2014 about 3.9% of rejected claims were due to not meeting program of support requirements: ANAO, 'Qualifying for the Disability Support Pension', Report No.18 2015-16, paragraph 2.15 (21 January 2016) at <https://www.anao.gov.au/work/performance-audit/qualifying-disability-support-pension> (accessed 21 September 2016).

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potential referral of certain claimants to employment or other support services, consistent with current policy'.⁴⁵

4.43 We recommend that DHS, DSS, the Departments of Employment and Prime Minister and Cabinet, along with employment service providers, work together to improve the provision of information about program of support requirements and options, especially to vulnerable people. This should include providing information to remote Indigenous Australians who claim DSP but are not actively participating in a program of support, such as those who are on a non-activity tested payment or have an activity exemption.

Recommendation 6 – Program of Support

(a) DSS, and the Departments of Employment and Prime Minister and Cabinet require contracted providers of employment services (including jobactive, Disability Employment Services and Community Development Program providers) to provide information to remote Indigenous DSP claimants, remote Indigenous customers receiving Newstart Allowance (incapacitated), and remote Indigenous working age income support recipients with longer-term reduced work capacity, of the possible requirement to have completed a program of support if they wish to qualify for DSP into the future.

(b) DHS should provide information to remote Indigenous DSP claimants of the possible requirement to have completed a program of support to be eligible for DSP.

Recent changes to the assessment process

4.44 There is a risk that changes to the assessment process from 1 January 2015 will result in less comprehensive medical information being supplied to assessors. Two recent case studies illustrate the challenges that remote Indigenous DSP claimants continue to face since the new assessment process was introduced, and reinforce the continuing need for monitoring and evaluation of service delivery improvements targeting remote Indigenous DSP claimants.

Case study 6: Ms Y

Ms Y has end stage renal failure and chronic obstructive airway disease. She left her remote community in the Northern Territory and moved to Darwin to receive dialysis for 4-5 hours, 3 days a week.

Ms Y applied for DSP in August 2015. She provided a report from her treating specialist with her claim stating that her kidney condition was fully diagnosed, treated and stabilised and had a severe impact on her functional ability. The specialist recommended she be assigned 20 points under Table 10 for the kidney condition and 10 points under Table 1 for chronic obstructive airway disease.

Ms Y had a face-to-face JCA assessment. The Job Capacity Assessor assigned 10 points for her kidney condition and found that her other conditions were not fully diagnosed, treated and stabilised. The Job Capacity Assessor did not contact Ms Y's treating specialist or the HPAU to clarify the medical information.

⁴⁵ Australian National Audit Office, 'Qualifying for the Disability Support Pension', Report No.18 2015-16, summary (paragraph 9) (21 January 2016) at <https://www.anao.gov.au/work/performance-audit/qualifying-disability-support-pension> (accessed 21 September 2016).

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Ms Y's claim was rejected in November 2015 and she asked for an ARO review. Her advocate complained to our office on her behalf in January 2016 as no review had apparently commenced, and we initiated an investigation.

In January 2016, the ARO contacted Ms Y and spoke to her about her conditions. The ARO is to be commended on their strenuous efforts to contact Ms Y's treating specialist, making at least six attempts over a five week period. Ms Y's original treating specialist advised he could not recall Ms Y without seeing her record and asked the ARO to email it. The ARO also contacted the Aboriginal Liaison Officer at Ms Y's renal unit in an effort to get in touch with her specialists. The ARO eventually spoke to a visiting specialist who had recently reviewed Ms Y. After speaking to the specialist and obtaining further evidence, the ARO assigned Ms Y 20 points for kidney failure and 10 points for chronic obstructive airway disease. In April 2016 Ms Y was granted DSP from the date of her original claim.

During our investigation we asked DHS why the Job Capacity Assessor had not tried to clarify the differences between the treating specialist's views and their own view of Ms Y's impairment. DHS stated that an assessor *may* contact the HPAU, treating health professional or request a specialist assessment as per the Guide to Social Security Law. However, in this case the assessor deemed there was sufficient information for the assessment to be completed.

4.45 In Ms Y's case, the specialist report and the JCA differed significantly as to the functional impact of Ms Y's impairments. Had the Job Capacity Assessor contacted Ms Y's treating specialist in the first instance, he or she could have clarified the discrepancies by obtaining further information, and there may have been no need for an ARO review and investigation by our office. Furthermore, had the Job Capacity Assessor contacted the treating specialist closer to the time the specialist prepared their report, the specialist may have had a better memory of Ms Y's condition than they did when later contacted by the ARO.

4.46 Ms Y's case illustrates that three attempts to contact a treating doctor or specialist over three days (as stated in DHS's guidelines) may not be sufficient, given that doctors are often unavailable, cannot be easily contacted or may have to consult their records before speaking about a customer's condition.

4.47 Despite DHS's Operational Blueprint stating that Job Capacity Assessors may seek further evidence from the HPAU, treating doctor or a specialist assessment, it was not done in this case, nor in four other complaints we have received and investigated since January 2016. In response to a draft of this report, DHS acknowledged that given the nature of Ms Y's condition, it would have been appropriate for the assessor to have sought further advice from the HPAU. DHS advised that it has now reviewed its training for assessors to ensure that assessments of the impacts of renal failure is based on appropriate medical evidence.

The Disability Medical Assessment process

Case study 7: Ms O

Ms O is an Indigenous woman living in a remote regional town over 1,600 km away from a capital city. She applied for DSP in October 2015. She has psychiatric issues which affect her memory. She approached our office as she was concerned about a delay in organising her DMA. Her JCA was conducted at her local Centrelink office using its videoconferencing facilities. The department's contracted service provider, Medibank Health Solutions, known as Disability Medical Assessment Services (DMAS), offered her a DMA by video conference (using Skype or similar technology) due to her remote location.

Ms O asked for the videoconference to take place at her local Centrelink office, as her JCA had been. When she contacted DMAS she was told that she could not use Centrelink's videoconference facilities. If she wished to use videoconferencing facilities she would need to organise and pay for these herself. Ms O eventually had a telephone DMA on 6 June 2016 and was granted DSP on 7 June 2016.

In response to our investigation, DHS advised while preference is given to face-to-face assessments wherever possible, DMAS can also complete assessments by alternative methods, taking into account the customer's individual circumstances. In limited circumstances, a DMA may be done via telephone.

DHS advised that DMAS use their own video conferencing technology for DMAs. The assessments cannot be conducted using the department's video conferencing facility as the two systems are not compatible. DHS advised that a customer will need to have access to the required technology and software to participate in a DMAS video conference assessment. It is the customer's responsibility to have the available technology and hardware, i.e. access to Skype and a video camera. The software must be installed before their DMA appointment. DHS did not consider the incompatibility of the two information technology systems to be a systemic issue which disadvantages customers.

4.48 Ms O's case demonstrates that barriers remain for remote Indigenous people if they wish to have a face-to-face DMA. Ms O was willing to participate in a DMA via videoconference at her local Centrelink office, but was not able to do so. It is concerning that the information technology systems between DHS and its contracted service provider, Medibank Health Solutions, are not compatible to allow DMAs to occur at local Centrelink service centres. It is also concerning that DMAS gave Ms O limited assistance when she tried to contact them for advice about her options.

4.49 We disagree with DHS's view that this is not a systemic issue which disadvantages remote Indigenous customers. While the majority of DMAs are conducted face-to-face⁴⁶, there appear to be limited options for remote Indigenous Australians if they cannot travel to a DMAS clinic to attend their appointment. The DMA process includes observations of the claimant which is not possible by telephone or file assessment and may disadvantage their application, as discussed elsewhere in this report. Many remote Indigenous customers would not have access to the required technology and software, a stable internet connection or the computer literacy skills to participate in a DMA videoconference. We consider that DHS's response to our investigation does not take into account the multiple

⁴⁶ DHS advised this office that in the fourth quarter of the 2015-2016 financial year, 85% of DMAs were conducted face-to-face, 8% were conducted by video conferencing and 7% by telephone: Response provided to Ombudsman's office on 7 September 2016 in response to questions asked under Issue of Interest 2016-200009.

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barriers faced by remote Indigenous Australians and the cultural considerations discussed elsewhere in this report.

4.50 The cases of Mr Y and Ms O highlight the DSP claim process for remote Indigenous Australians has room for further improvement, despite the initiatives DHS has already undertaken. In our view this can only be achieved by ongoing monitoring and evaluation.

Monitoring and evaluation

4.51 Following DHS's advice that it has recently made a range of improvements to improve remote Indigenous claimants' access to and experience of the DSP claim process, we recommend the establishment of a monitoring and evaluation framework.

4.52 This approach was also supported by the ANAO in its recent performance audit on the DSP. The ANAO found that current DSP performance reporting by DSS and DHS was limited, and scope exists for more complete and meaningful performance measures and reporting. This includes improving appeals data to allow DHS and DSS to better understand the reasons for successful appeals and assist in improving the application processes and quality control frameworks. The ANAO found that 'a stronger focus on measuring the quality of decision making for DSP claims would better position DSS [and DHS] to evaluate operational efficiency and identify potential service improvements'.⁴⁷

Recommendation 7 – Monitoring and evaluation

DHS develop a monitoring and evaluation framework for the measures it has identified as addressing Recommendations 1 to 6 of this report.

Reporting on the monitoring and evaluation strategy should include information about:

- specialist assessments conducted for remote Indigenous DSP claimants
- face-to-face and video-conferenced JCAs conducted for remote Indigenous DSP claimants
- face-to-face and video-conferenced DMAs conducted for remote Indigenous DSP claimants
- cultural competency training for JCAs and government-contracted doctors
- JCA contacts with the claimant's doctor and the HPAU in relation to remote Indigenous claimants
- DHS's communication strategy for providing information on DSP to a broad range of health professionals, including those servicing remote Indigenous communities
- grant and rejection rates for DSP claims made by remote Indigenous claimants over the reporting period
- appeal rates and outcomes for ARO and AAT reviews in relation to remote Indigenous claimants over the reporting period.

Recommendation 8 – Reporting

⁴⁷ Australian National Audit Office, 'Qualifying for the Disability Support Pension', Report No.18 2015-16, summary (paragraphs 10, 13) (21 January 2016) at <https://www.anao.gov.au/work/performance-audit/qualifying-disability-support-pension> (accessed 21 September 2016).

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DHS report to the Ombudsman's office on the progress of implementation of the recommendations of this report at the end of the 2016-17 financial year.

PART 5 – RECOMMENDATIONS AND AGENCY RESPONSES

5.1 Indigenous Australians living in remote areas face significant barriers in accessing DSP, including:

- difficulties in accessing appropriate health care
- problems obtaining medical evidence from treating doctors and specialists to support their claims
- being disadvantaged by not having face-to-face JCAs and DMAs
- a differing concept of ‘disability’
- difficulties discussing conditions and their functional impact with health professionals in a meaningful way, due to language and cultural barriers.

5.2 The recommendations made in this report are intended to address some of the most significant challenges we consider remote Indigenous Australians face in:

- collecting evidence
- preparing applications
- accessing, and participating in, JCAs and DMAs
- anticipating the need for and accessing a program of support where required.

5.3 The case studies in this report are a small sample selected to illustrate experiences remote Indigenous customers and their advocates have reported. We are still receiving similar complaints at the time of publishing this report. While the number of complaints is small, relative to total number of DSP claims processed, we nevertheless consider these complaints are important and deserve to be heard.

5.4 Our office provided a draft of this report to the Department of Social Services, the Department of Employment and the Department of Prime Minister and Cabinet. All three agencies agreed to recommendation 6 which concerns providing information about program of support requirements.

5.5 Our office provided several draft versions of this report to DHS for comment and met with DHS to discuss the report and its recommendations. DHS’s final response, including the Departmental Secretary’s letter to the Ombudsman, is reproduced at Appendix A.

5.6 Overall, DHS has welcomed the report and agrees with all of the recommendations to improve service delivery for remote Indigenous Australians. We acknowledge that DHS has already implemented a number of initiatives to address some of the barriers discussed in this report. Nevertheless, we remain concerned that some of DHS’s most vulnerable customers are being left behind and continue to face difficulties in accessing the DSP claims process. We believe that by fully implementing these recommendations and monitoring and evaluating their effectiveness, DHS will better meet its service delivery commitments to remote Indigenous Australians. This office will continue to work closely with DHS to monitor the implementation of the recommendations in this report.

Recommendation 1 – contacting treating doctors

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(a) DHS review the Operational Blueprint to ensure that it emphasises the need for assessors to obtain the best possible evidence to inform accurate decision making, particularly for remote Indigenous customers. This review should include ensuring that the procedures actively encourage assessors to contact treating doctors to seek additional information, particularly where a remote Indigenous DSP claimant submits incomplete or conflicting information and where a face-to-face JCA is not possible.

(b) As part of its existing quality assurance framework, DHS should monitor and evaluate the cases for remote Indigenous customers in which Job Capacity Assessors do and do not exercise options to gain further clarifying information, including referring to treating doctors, the HPAU, and specialist assessors.

Recommendation 2 – specialist medical assessments

(a) DHS amend its Operational Blueprint to allow and encourage Job Capacity Assessors to make referrals to specialist medical assessments where it is apparent that a vulnerable claimant has a reported condition in respect of which they have been unable, or would be unable, to obtain a specialist assessment.

(b) DHS amend its Operational Blueprint to require that, where DHS is not able to conduct a face-to-face JCA, the assessor should consider the vulnerability of and practical barriers experienced by the claimant and, where necessary, facilitate a comprehensive medical assessment, for example by liaising with remote health services which service the applicant's community.

(c) In determining whether a person is unable to obtain a specialist assessment, Job Capacity Assessors should be trained to thoroughly assess all barriers, without placing over reliance on self-reported barriers or making assumptions about the assistance available from third parties. This should include talking to the applicant and any relevant third parties.

Recommendation 3 – information for medical practitioners

(a) DHS further develop publicly available guidance to ensure medical practitioners have access to clear information about the qualification criteria, Impairment Tables, and the way in which DHS uses the information provided by medical professionals to assess an applicant's medical condition for DSP purposes.

(b) DHS consult widely with a range of medical groups, including those that service remote and rural areas, to distribute the information about the qualification criteria, impairment tables, and the way in which DHS uses the information provided by medical professionals to assess an applicant's medical condition for DSP purposes.

Recommendation 4 – Mode of Job Capacity Assessment

DHS identify strategies to ensure that, wherever possible and practical, all remote Indigenous DSP claimants are offered JCAs where the assessor is able to assess their impairment with the benefit of visual observation, whether in person or via videoconference.

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Recommendation 5 – Culture and Language

DHS review, and if necessary revise, then monitor and evaluate Indigenous cultural competency and awareness training provided to staff, including JCAs and government doctors conducting Disability Medical Assessments, to ensure it adequately addresses:

- identifying the need for, and use of Indigenous language interpreters
- cultural considerations around disability and self-reporting.

Recommendation 6 – Program of Support

(a) DSS, and the Departments of Employment and Prime Minister and Cabinet require contracted providers of employment services (including jobactive, Disability Employment Services and Community Development Program providers) to provide information to remote Indigenous DSP claimants, remote Indigenous customers receiving Newstart Allowance (incapacitated), and remote Indigenous working age income support recipients with longer-term reduced work capacity, of the possible requirement to have completed a program of support if they wish to qualify for DSP into the future.

(b) DHS should provide information to remote Indigenous DSP claimants of the possible requirement to have completed a program of support to be eligible for DSP.

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Recommendation 8 – Reporting

DHS report to the Ombudsman's office on the progress of implementation of the recommendations of this report at the end of the 2016-17 financial year.

APPENDIX A – DHS'S RESPONSE



Australian Government
Department of Human Services

Kathryn Campbell CSC
Secretary

Ref: EC16-002307

Mr Colin Neave AM
Commonwealth Ombudsman
GPO Box 442
CANBERRA ACT 2601

Dear Mr Neave

Thank you for your letter dated 6 October 2016 inviting the Department of Human Services (the department) to comment on your draft investigation report *Accessibility of Disability Support Pension for remote Indigenous Australians*.

The department welcomes the Ombudsman's acknowledgement that the department assesses over 100,000 Disability Support Pension (DSP) claims per year without significant cause for complaint and in particular the acknowledgement of initiatives that the department has implemented to improve access to DSP for remote Indigenous Australians.

The department agrees with, and has already implemented, recommendations 1, 2, 3, 4, and 5.

The department agrees with the amended recommendations 6 (b), 7 and 8.

The report states that the number of complaints received by the Ombudsman is small compared to the total number of DSP claims, but nevertheless there can be challenges for remote Indigenous Australians in navigating the claims process. The department is cognisant of these challenges and will use the report's findings and recommendations to continue to improve services for remote Indigenous Australians.

The contact for this matter is [REDACTED], National Manager Ombudsman and Information Release Branch. [REDACTED] can be contacted on [REDACTED].

Yours sincerely

A handwritten signature in black ink, appearing to read 'Kathryn Campbell'.

Kathryn Campbell

30 November 2016