

Attachment : Case study in Pearls and Irritations, John Menadue blog

Government and the medicalisation of disabilities

Each year two thirds of applications for a *Disability Support Pension* are rejected; a rejection rate which has doubled in 8 years (Christopher Knaus, *Guardian*, 8 June 2018).

- At the Exodus Foundation, in the waiting area, a woman clutches her bags. One is stuffed with tattered papers; the medical story she tries to present. Forms and letters from Centrelink, Newstart, applications for disability support, appeal tribunal letters, housing and photocopies of Emergency Department visits, blood tests and hospital discharge summaries.

No one has described her predicament. She holds it together in a plastic shopping bag. It is all she has about herself. She lives in emergency accommodation, 'doss houses' and sometimes the street; always at risk. There are fifteen medical diagnoses listed, some potentially and immediately life-threatening.

She is trapped in a kind of medicalised poverty.

This scenario recurs in NGOs, homeless shelters and agencies.

- At the Matthew Talbot Hostel a soft-faced youth was referred in a state of bewilderment. With his mother, he had immigrated from South America to Melbourne. He had had difficulties at school and couldn't find work. His mother said he might find work in Sydney. He was now on the street and homeless.

The papers he clutched listed the interviews he must attend to receive JobStart payments. Something he could not do. He was distressed and anxious - every interview was a confrontation, which he failed. A psychiatrist considered he was developmentally delayed.

- At the bedside in Liverpool Hospital, I arrived to find the patient in tears. He handed me a Centrelink letter. His *Disability Support Pension* had been cancelled. He was seriously ill and had not presented for a scheduled interview. I phoned Centrelink only to be put in a queue, "your call is important to us". It was lunchtime so I went directly to the Centrelink office in Liverpool CBD. That didn't work. A flummoxed officer handed me a form to fill in.

The *Disability Support Pension* (DSP) discriminates against some of our most powerless citizens through the medicalisation of their disability. This hard-line approach started in the mid-70s.

During the Whitlam Government, Senator Grimes, Minister for Social Security, asked me to review decisions by the Administrative Appeals Tribunal (AAT) which had overturned previously rejected claims for an *Invalid Pension*. The procedures were extremely tortuous – files to different sections and backwards and forwards between major government departments, all acting independently of each other. There were more decision points than a heart transplant operation. It was grossly inefficient.

In April 1978, there was a watershed in social welfare, when 181 members of Sydney's Greek community were charged by the Federal Police with defrauding the Department of

Social Security by making false claims for *Sickness Benefits* and *Invalid Pensions*; “the Greek Conspiracy”. The subsequent court cases dismissed the charges and damages were awarded to the victims.

These events provoked the Liberal Government of that time to commission a review by a Melbourne QC into the legal implications of the *Invalid Pension* in the *Social Security Act*. His report said, that to take into account social and personal circumstances for an *Invalid Pension* was an “unnecessary gloss on the law”!

The review recommended narrowing of the criteria for an *Invalid Pension* to medical impairments only. Some 30,000 people, who might otherwise have qualified for an *Invalid Pension*, had their applications rejected in the next twelve months. A public outcry ensued, spearheaded by the Australian Council of Social Services. The Sydney Morning Herald ran articles on the “crackdown on invalid pensioners”. The deepest sadness was the eagerness with which administrators fastened onto the hard-line criteria, and, for me, it was distressing to see the alacrity with which doctors willingly complied with the new directions.

Senator Dame Guilfoyle, Minister for Social Security, followed by Senator Chaney, tried to quell the disquiet by saying there had been no change. But within the department, officers had been instructed to use physical incapacity as the sole criterion for an *Invalid Pension*. With views of this kind permeating the social bureaucracy, it is no wonder that years later, in 2012, the National Mental Health Commission opposed the initial concepts of the National Disability Insurance Scheme which neglected people with mental health problems.

Under the Keating Government, there was further ‘medicalisation’. A new criterion was introduced; the claimant had to have a 30% (medical) impairment to be eligible for a disability payment. There were, again, protests about a “crack-down” and inappropriate criteria. And, as if to show how arbitrary these assessments can be, the Government decided that a 10% (medical) impairment could be deemed to be a 30% impairment!

To the credit of the social security bureaucracy, there were attempts to better connect medical conditions to a person’s function and social disadvantage. The medical forms were restructured to lead doctors through a logical pathway – linking degree of impairment, to functional capacity and to social disadvantage. These steps were in line with WHO’s efforts to explain and define these concepts for the global community.

Problems in the assessment for disability payments, through the *Disability Support Pension*, continue to today, as the Government searches for testable and verifiable medical criteria.

Yet, despite the increasing medicalisation, the doctors in the best position to assess a patient’s disability are excluded – family doctors. As Shane Lawlor, at Goulston Legal in Queensland, says, “applicants lose their best opportunity to submit DSP-specific documentation from a supportive treating doctor.” This runs counter to the Social Security Act, which states, “The [impairment] Tables may only be applied to a person’s impairment after the person’s medical history, in relation to the condition causing the impairment, has been considered.”

Of all medical practitioners, the GP is in the best position to assess a person’s disability and impairment for work. The GP knows the range of medical problems experienced by the patient and is familiar with the social and work environments in the areas in which the patient lives. All highly relevant information for a fair and just assessment of a person’s ability to

work. It is absurd to pretend there are no differences between rural and remote areas and regional centres, which in turn differ from outer and inner metropolitan areas - in the way medical conditions can impede a person's ability to earn a living.

The role of GPs, and other treating doctors, has been replaced by the Job Capacity Assessment. An 'assessment' made by staff, who never see or hear from the patient, and who have no knowledge of the environments in which disability is manifest. If a doctor is to be involved, at all, in the decision process, this will be a government contracted doctor who, again, does not see or speak to the claimant.

Medical specialist advice might be sought, but the claimant is responsible to obtain a report. This is especially difficult for disadvantaged people. Moreover, specialists focus on organ systems and rarely practice in the environments in which people live and work.

More fundamental, there are intrinsic problems with the assessment criteria for the DSP. The criteria are daunting and confusing, and for claimants bamboozling and intimidating.

The WHO definition of disability is an umbrella term. It encompasses body structure and function, impairments, activities, participation, limitation of activity and environmental factors. The DSP, on the other hand, despite it being a disability payment, focusses on impairments – albeit work-related, and excludes all the other factors.

There are two *impairment tables* for use in the assessment, one, generic, in the Social Security Act, and the other, a detailed departmental guide for the assessment of work - related impairment. They are based on a point score with a threshold for granting a payment. The rationale underpinning the scores fits poorly to many disabling conditions. Fluctuating or episodic conditions, such as recurrent hypoglycaemic episodes or the exacerbations of a psychotic illness, and chronic pain syndromes cannot be scored with any validity. For some medical conditions, e.g. chronic lung disease, the point score is tied directly to lung physiology and not to real-world functioning.

The compounding interactions of common multiple conditions are poorly assessed in the scoring system. A person with impaired vision and a neurological problem affecting balance and gait will have an interactive, not separate, impacts on day-to-day function - let alone their ability to work.

To my mind, the assessment tools and processes for a DSP are a 'dog's breakfast' driven by a desire to harden-up access to income support rather than aiming to assist with a disabled person's real needs for support.

What needs to be done?

Apart from starting all over again and going back to the social principles that introduced income support for disabled people in 1908, there are immediate steps to be taken:

1. Put the primary health care provider, the GP, back as a central part of the assessment process (appropriately reimbursed).
2. Reduce the reliance on departmental officers - health professional and others - in the final determination for a DSP.
3. Provide a broadly-based procedure for assessing the impact of a person's disablement on their capacity to earn a living, to include – medical and social workers with relevant experience and community representatives.

It will be an uphill battle, as governments of both persuasions abhor the welfare budget; they see it as an unreasonable drain on the community rather than as a resource to enable citizens to live more productive lives.

Ian W Webster AO

Physician
