

Fellowship and Standards/Fellowship Services

Telephone: +61 3 9276 7448

Facsimile: +61 3 9276 7432

Email:

14 July 2016

The Hon. Shayne Mallard
Chair, Standing Committee on Law and Justice
Parliament House
6 Macquarie St
Sydney NSW 2000

Dear Mr Mallard,

First review of the compulsory third party insurance scheme – response to questions on notice

Thank you for offering the Royal Australasian College of Surgeons an opportunity to provide evidence as part of the NSW Standing Committee on Law and Justice's review of the compulsory third party (CTP) insurance scheme on Friday 17 June 2016.

We note that the NSW Government has released a CTP reform position paper which may preclude any further input from stakeholders on the scheme's reform, however please find below our responses to questions taken on notice at the Committee's hearing. Thank you for this further opportunity to provide comment.

We would like to acknowledge and thank the NSW/ACT branch of the Australasian Faculty of Rehabilitation Medicine, which has provided input on this response.

Do people delay necessary treatment or not access the full suite of rehabilitation services available on the basis of exhausting their funds too early? Please provide figures and/or evidence of the percentage of motor vehicle trauma victims affected in this way.

People do not delay rehabilitation due to lack of funds. They have equal access to public rehabilitation facilities and this access is based on need. In an unpublished study of 3,257 road trauma admissions between 2009 and 2012 in NSW, only 0.5% of survivors were discharged directly to a residential aged care facility. This demonstrates that almost all survivors who cannot be sent home following acute care treatment are accessing inpatient rehabilitation.

The more relevant issue is how slowly claims are processed. Many patients who are ready for rehabilitation have no access to private rehabilitation even though they will be eventually assessed as compensable. This puts more pressure on the public rehabilitation system which is already overloaded.

Our rehabilitation colleagues have confirmed that there is a sizeable group of road trauma patients whose referrals to private specialist rehabilitation centres are delayed while paperwork and approvals are obtained. We do not have details on the exact size of this cohort.

Delays to claim settlement impact the patient, may increase acute length of stay and also increase the total cost of care delivered to the patient. Decisions about rehabilitation need to be streamlined and made as soon as possible, preferably within 24 hours. In New Zealand decisions about cover are finalised within an average of 1.2 days.

What is the cost of brain injury in Australia?

An Access Economics report commissioned by the Victorian Neurotrauma Initiative estimates the total financial

cost of Traumatic Brain Injury (TBI) in Australia to be \$8.6 billion per year.¹ The lifetime costs per incident case of TBI were estimated to be \$2.5 million and \$4.8 million for moderate and severe TBI respectively, across Australia.

In NSW patients with severe TBI stay in acute care for a median of 40 days, followed by sub-acute inpatient brain injury rehabilitation for a median of 47 days. These figures can be used to calculate hospital costs per case of severe TBI in NSW.

A joint research project led by La Trobe University, Melbourne calculates that after discharge, the mean annual costs of care for a severe TBI (needing constant care at time of discharge) is \$170,721 per annum (95% CI \$45,672 to \$294,336), or \$208,399 per annum (95% CI \$52,512 to \$295,081) including equipment/home modification costs.²

Please provide further details of the score systems used to assess rehabilitation requirements, including the short form health survey.

The Injury Severity Score system used in acute trauma care does not give sufficient predicative information about rehabilitation outcomes. Different outcome measures are used by rehabilitation physicians to monitor the different stages of a patient's rehabilitation journey.

Scoring systems vary depending upon the stage of recovery/rehabilitation. Inpatient management collects data using the Functional Independence Measure (FIM) scale and the Post-traumatic Amnesia (PTA) scale. In the community area of the Brain Injury Rehabilitation Program in NSW, the Mayo-Portland Adaptability Index (MPAI-4) is used to capture function across three domains (Ability; Adjustment; Participation).

The FIM is the most commonly used scale to assess rehabilitation requirements, and can predict costs of care in the home. It assesses physical and cognitive disability, and focuses on the level of physical and/or cognitive disability indicative of the burden of caring for an individual. The FIM was developed for use in the inpatient rehabilitation setting to measure function on admission and discharge for patients with all diagnoses. Its items relate to basic function and some activities of daily living. It does not measure participation elements such as social interaction, return to work or study, or recreational activities.

FIM items are scored based on the level of assistance required for an individual to perform each function or activity. The scale includes 18 items, of which 13 items are physical domains based on the Barthel Index, and five items are cognition items. Each item is scored from one to seven based on level of independence, where one represents total dependence and seven indicates complete independence. The scale can be administered by a physician, nurse, therapist or layperson. Possible scores range from 18 to 126, with higher scores indicating more independence. Alternatively, 13 physical items could be scored separately from five cognitive items, to generate separate physical and cognitive sub-scores.

The FIM is commonly used in a number of countries, including the USA, Canada, Australia, France, Japan, Sweden and Germany, to measure the patient's progress and assess rehabilitation outcomes. Scores are responsive to change and have also been shown to reflect the patient's discharge destination. The FIM scores on admission and discharge to inpatient rehabilitation are routinely collected and stored in the largest clinical registry of rehabilitation data, managed by the Australasian Rehabilitation Outcomes Centre (AROC).

The Short Form Health Survey (SF-36) is a measure of quality of life and does not measure rehabilitation outcomes specifically. It should be noted that measures of psychological outcomes and pain are not collected as a routine part of the FIM but do represent common outcomes of motor vehicle accidents that affect rehabilitation outcomes.

SF-36 was developed as a multi-purpose survey of general health status, and is one of the most widely utilised measures of health-related quality of life. The SF-36 assesses physical and mental health across eight core domains: vitality; physical functioning; bodily pain; general health problems; physical role functioning; emotional role functioning; social role functioning; and mental health. The SF-36 has been validated as being responsive to changes in health status over time among unintentionally injured adults. To improve speed and ease of administration, a 12 item short form of the SF-36 - the SF-12 - has since been developed, and is also widely used.

What are the limitations of the AMA 4 score?

The NSW Motor Accidents Compensation Act 1999 requires that damages for non-economic loss only be awarded where the permanent impairment of the injured person caused by the motor accident is greater than 10%. The AMA 4 Guides are widely used as an authoritative source for the assessment of permanent impairment. However, the Motor Accidents Authority (MAA) Permanent Impairment Guidelines³ make significant changes to the AMA 4 Guides to align them with Australian clinical practice, and to better suit them to the purposes of the Act. The MAA Guidelines score impairment but has no way of scoring activity limitation or participation in the community. It will score for the range of movement of the joint but not for the inability to run or the lack of participation in community sports, such as activities with the patient's children.

The AMA 5 Guides are more appropriate as they measure for chronic pain and pain interference with participation and activity. The AMA 5 is not used due to a perception that it favours the injured, is too complex to use, and challenges entrenched notions regarding the adequacy of the AMA 4.

The problems/limitations of the AMA 4 include:

- The injury must be stabilised before the AMA 4 is applied, however this may take years.
- Impairment ratings are often erroneously elevated.
- Errors in clinical and causation analysis are common - these include inappropriate diagnosis, rating prior to being at maximal medical improvement, using unreliable examination findings, not considering what is normal for the individual, and inaccurate causation assessment.
- The AMA 4 is misapplied to allow double dipping or duplicative ratings.

RACS is happy to provide further assistance, for example through the reference panel or working groups assisting the design of the new scheme.

Yours sincerely,

John A Crozier AM CSM, FRACS
Chair, Trauma Committee
Royal Australasian College of Surgeons

cc Dr Raffi Qasabian, Chair, NSW Committee, RACS
Assoc Prof David Hillis, CEO, RACS
Mr John Biviano, Director, Fellowship & Standards, RACS
Mrs Deborah Jenkins, Director, Relationships & Advocacy, RACS

¹ Access Economics Ltd. The economic cost of spinal cord injury and traumatic brain injury in Australia. Melbourne: Victorian Neurotrauma Initiative; 2009. Available from: <https://www.tac.vic.gov.au/about-the-tac/our-organisation/research/tac-neurotrauma-research/vni/the20economic20cost20of20spinal20cord20injury20and20traumatic20brain20injury20in20australia.pdf>

² Lannin N, Ratcliffe J, Chen G, Cameron I, Tate R, McCluskey A, Callaway L, Winkler D, Roberts K. Community living after catastrophic brain injury in Victoria: preparedness, outcome and cost. Melbourne, Victoria: Institute of Safety, Compensation and Recovery Research; 2014. Research report#: 0914-57R6, N-E-12-057 Severe Acquired Brain Injury Slow Stream Rehabilitation Research Framework.

³ Motor Accidents Authority of NSW. Permanent impairment guidelines for the assessment of permanent impairment of a person injured as a result of a motor vehicle accident. Sydney: NSW Government; 1 Oct 2007. Available from: <http://www.maa.nsw.gov.au/>.