Submission No 16

INQUIRY INTO THE EXERCISE OF THE FUNCTIONS OF THE LIFETIME CARE AND SUPPORT AUTHORITY AND THE LIFETIME CARE AND SUPPORT ADVISORY COUNCIL - FOURTH REVIEW

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The Director
Standing Committee on Law and Justice
Legislative Council
Parliament House
Macquarie Street
Sydney NSW 2000

By email: lawandjustice@parliament.nsw.gov.au

Dear Director,

The Eleventh review of the exercise of the functions of the Motor Accidents Authority and the Motor Accidents Council and the Fourth review of the Lifetime Care and Support Authority and the Lifetime Care and Support Advisory Council

The Law Society's Injury Compensation Committee ('the Committee') is pleased to make submissions to the Standing Committee on Law and Justice's Eleventh review of the exercise of the functions of the Motor Accidents Authority and the Motor Accidents Council ('the Eleventh MAA Review') and the Fourth review of the Lifetime Care and Support Authority and the Lifetime Care and Support Advisory Council ('the Fourth Lifetime Care Review').

The Committee understands that the Standing Committee is holding these reviews concurrently. The Committee therefore provides this submission in response to both reviews.

The Eleventh MAA Review

Insurer Profits

The Committee refers to the Standing Committee's Tenth Report which followed the Tenth Review of the functions of the Motor Accidents Authority and the Motor Accidents Council. The Committee refers to Recommendation 4 in the Tenth Report which proposed:

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That the independent competition review commissioned by the Motor Accidents Authority and the work being undertaken by the Authority to improve the profit assessment methodology involve extensive stakeholder consultation, including with the Motor Accidents Council and the stakeholders who have contributed to the Committee's Review in relation to insurer profits. That the Motor Accidents Authority make publicly available the results of this Review and any other subsequent proposals to change the profit assessment methodology used by the Motor Accidents Authority, as soon as possible.

The Committee strongly endorses this recommendation. No consultation has yet taken place with the Law Society as a stakeholder. As far as the Committee is aware, the result of any review which may have taken place has not been made publicly available.

The Committee proposes that the recommended review take place as soon as possible. Should the review find excessive insurer profits, then in the future such profits should be directed to improving the benefits to the injured in the scheme in an affordable, effective, fair and efficient manner.

The Whole Person Impairment Threshold

The Committee refers to Recommendation 12 in the Tenth Report which proposed that the next review "include a focus on the issue of the 10% whole person impairment threshold for non-economic loss".

The Committee strongly endorses this recommendation. Further, the Committee proposes that the 10% whole person impairment threshold be abolished together with the Medical Assessment Service (MAS) and be replaced by the threshold set by section 16 of the *Civil Liability Act 2002*. The section 16 threshold for accessing an entitlement to non-economic loss is 15% of "a most extreme case" coupled with a sliding scale of damages until the severity of the non-economic loss reaches 33% of "a most extreme case". Such an assessment would be made by the Claims Assessment and Resolution Service (CARS) Assessors in any event.

The abolition of the 10% whole person impairment threshold and MAS would represent a significant cost saving and remove the current inefficiencies in its administration. Its replacement by a 15% of "a most extreme case" threshold would make the scheme fairer for the injured as more claimants would be entitled to damages for non-economic loss. CARS assessors are well experienced and more than capable of making assessments under the proposed 15% of "a most extreme case" threshold. Overall, such a threshold would render the scheme more effective, fair and efficient whilst maintaining its affordability through the dismantling of MAS and the associated administrative costs.

The Committee's proposal is by no means novel. In December 2005, the Legislative Council General Purpose Standing Committee No. 1 in its *Personal Injury Compensation Legislation Report 28* proposed in Recommendation 7 that the *Motor Accidents Compensation Act 1999* be amended:

to replace the existing WPI threshold for the recovery of non-economic loss damages under s. 131 of the Act with the same threshold as is used for claims for non- economic loss damages under the Civil Liability Act - namely 15% of 'a most extreme case', coupled with a sliding scale of damages until the severity of the non-economic loss reaches 33% of 'a most extreme case'.

The 10% whole person impairment threshold is harsh and arbitrary in nature. It excludes many seriously injured claimants from accessing damages for non-economic loss. Eligibility for compensation for non-economic loss should be based upon subjective indicia such as pain, depression, changes in lifestyle and future deterioration, and not just deterioration.

The use of the relevant AMA guide (4th Edition), as modified by the Motor Accidents Authority's Permanent Impairment Guidelines, has not delivered the greater consistency and objectivity of assessment foreshadowed by the Government at the time of its introduction. This lack of consistency and objectivity has led to a regular flow of expensive judicial review applications in the Supreme Court of NSW.

In the alternative, if a whole person impairment assessment is to be retained as a method for determining a threshold for non-economic loss, then it ought to be carefully reviewed for the purpose of setting a new and appropriate lower threshold which is affordable, effective, fair and efficient.

The Role of the MAS Assessor

The Committee believes that MAS Assessors are not the appropriate persons to determine any issue of causation. In the Workers Compensation Commission, Arbitrators ordinarily make findings on causation and injury before an issue of impairment is referred to the relevant Approved Medical Specialist ('AMS'). The Committee is of the view that CARS Assessors are the best persons to make an assessment of causation given that the test of causation is largely a legal one and requires legal training and extensive knowledge of case law which has developed in this area over the years.

The Committee is of the view that a MAS Assessor should not make any binding determinations on causation in any wider context then in respect of the Claimant's non-economic loss entitlement. In particular, the Committee believes that MAS Assessors should not be empowered to make binding determinations on any care dispute as is presently the case because of the interplay between section 58(1)(a) and the definition of "treatment expenses" in section 46 of the *Motor Accidents Compensation Act 1999* (MACA).

The Committee believes that the only person who should be able to determine a care dispute is a CARS Assessor who has been provided with all of the evidence in support of the CARS Application. This should include the statements of all care witnesses, and oral evidence of both the Claimant and of any care witnesses who are questioned at the Assessment Conference. The Committee opines that the best way to fix this problem is to amend the definition of "treatment" in section 46 so as to remove any mention of "attendant care services".

The difficulties MAS Assessors have experienced wrestling with complex issues of causation are illustrated in the recent Supreme Court decisions of *Nguyen v Motor Accidents Authority of New South Wales & Anor (2011)* NSWSC 351 (3 May 2011) and *GIO General Limited v Smith & Ors (2011)* NSWSC 802 (5 August 2011).

In *Nguyen* the relevant MAS Assessor was faced with the task of assessing impairment arising from a direct injury to the Claimant's neck which also caused some secondary loss of movement in the left and right shoulders. The MAS Assessor determined that any restriction in movement of the shoulders could not be taken into account in assessing the Claimant's whole person impairment because there was no direct injury to each of the shoulders but only to the neck. In this respect, His Honour Justice Hall found that the MAS Assessor had fallen into error as he was required to

assess the degree of permanent impairment of the injured person "as a result of the injury" pursuant to section 58(1)(d) without being constrained by any additional requirement that there must have been a specific injury directly to the person's affected body party which had been injured in the accident.

In His Honour's view, the dismissal by the MAS Assessor of the shoulder impairments as relevant to his assessment of the Claimant's overall whole person impairment was not warranted by the use of the phrase "as a result of" in section 58(1)(d) nor by any common law principles of causation (see paragraph 119 of His Honour's Judgment).

In the Committee's view, the Supreme Court judgment of Hoeben J in *GIO General Limited v Smith & Ors* reveals an equally unsatisfactory approach by a number of MAS Assessors to the issue of causation. This was a case in which a psychiatric injury was alleged to have been caused by two successive accidents in 2007 which were some eight months apart. The MAS Review Panel assessed the Claimant at a total of 17% whole person impairment but attributed this full impairment to each of the two motor accidents without attempting to conduct any apportionment. This determination appears to have been made chiefly because of a misguided construction of the MAA Permanent Impairment Guidelines which govern assessments of impairment.

His Honour Justice Hoeben expressed his view in no uncertain terms at paragraph 43 of his judgment as follows:

> *I agree with the fundamental submission by GIO and NRMA that the issuing of two certificates by the Review Panel, each of which asserted in relation to the respective motor accident that the Major Depressive Disorder gave rise to a Whole Person Impairment which is greater than 10%, verges on the absurd.*

His Honour went on to say at paragraph 59:

> *The two certificates issued, to the extent that they assert in the case of each motor accident, that the major depressive disorder caused by it is greater than 10% WPI are inconsistent with the Review Panel's assessment of the total WPI caused by both motor accidents.*

His Honour Justice Hoeben quashed the Review Panel's certificates in both cases and remitted the question of impairment to be reconsidered by the Review Panel.

In the Committee's view, these two decisions show the inadequacy of some of the provisions of the MAA Permanent Impairment Guidelines. In particular, it is noted that paragraph 1.19 of these Guidelines requires an Assessor to be satisfied that there "was an injury to the part being assessed caused by the accident" before assessing an impairment arising from the affected body part. *Nguyen* makes it quite clear that this provision is inconsistent with section 58(1)(d) of the Act and it is also inconsistent with any common law test of causation.

The Committee submits that these Guidelines should be immediately amended to reflect the correct state of the law as expounded by Hall J by deleting paragraph 1.19(i) of the Permanent Impairment Guidelines. Similarly, the Committee believes that a close review should be conducted of paragraphs 1.33 to 1.36 of the Guidelines dealing with pre-existing impairment and subsequent injuries. The Committee is of the view that these provisions do not accord with any common law test of causation nor with common sense. In this respect, the Committee endorses the Bar

Association's comments at paragraphs 65 to 72 of its submission as an example where the arbitrary nature of 1.33 to 1.35 can work a clear injustice.

Delays with MAS

The Committee endorses the Bar Association submissions at paragraphs 95 to 104. The Committee believes that the MAS review and further medical assessment process envisaged in sections 62 and 63 of the MACA derogates in practice from at least one of the objectives of the MACA set out at section 5(1)(b) which is to "encourage the early resolution of compensation claims".

It is the experience of many solicitors that there is minimal finality associated with the MAS process with many instances of multiple reviews and further medical assessments by MAS which can sometimes delay the finalisation of claims by a period of years. The Committee submits that it would be an infinitely more efficient and simpler process to allow a CARS Assessor to make a determination as to whether the Claimant reaches the required threshold to recover damages for non-economic loss, care or treatment expenses.

It must also be borne in mind that the MAS review and further medical assessment process is not adequately compensated in terms of party/party legal costs by the existing Schedule 1 of the Regulations. This only makes allowance for legal costs payable to a Claimant in the maximum sum of $1,600 regardless of the number of MAS disputes which may have arisen. The Committee considers this to be grossly unfair, as the Claimant has no control over whether the insurer lodges multiple reviews or further medical assessments yet he or she is required to provide detailed legal submissions responding to each of the insurer's further Applications.

The allowance of $1,600 is manifestly inadequate to cover anything other than lodging or replying to the initial MAS Applications. The Committee submits that there should be additional allowances for responding to any of the insurer's multiple subsequent Applications. Again, this is a matter where the Claimant is suffering by reason of the ongoing dilatory conduct of the Motor Accidents Authority with regard to amendment of the *Motor Accidents Compensation Regulation 2005*. The gap between recoverable party/party legal costs and the total solicitor/client legal costs is invariably funded by the Claimant out of any settlement or judgment money he or she may receive. In other words, it is the Claimant who is suffering from the delays associated with the amendment of the Regulation.

Pre-Filing Requirements in Part 4.4 Division 1A of MACA

Sections 89A to 89E and section 91(1) of the MACA contain problematic provisions relating to pre-filing requirements. These provisions apply to claims lodged after 1 October 2008 regardless of the date of the accident. Given that the three year limitation period under section 109 of the MACA is rapidly approaching for claims lodged after 1 October 2008 the Committee believes there is need for urgent legislative reform in this area. Indeed there are already a number of cases where the pre-filing requirements have proved to be problematic in respect of late claims where the accident took place, for example, in early to mid-2008 but the claim was not lodged until after 1 October 2008.

The difficulties associated with the new pre-filing requirements can be summarised in the following steps which are now required to be taken before any CARS Application for General Assessment can be lodged by the Claimant to suspend the limitation period in section 109:

(i) The Claimant first has to wait for his or her injuries to have stabilised and then is required to provide all relevant particulars of the claim as required by section 85A sufficient to enable the insurer to make a "proper assessment" of the Claimant's full entitlement to damages;

(ii) Section 89B then requires the parties to exchange all documents before attending a mandatory settlement conference. This requirement to lodge all documents would include, for example, all statements and submissions on which the Claimant relies, along with all necessary medical and economic loss evidence;

(iii) After the insurer has made a settlement offer as contemplated pursuant to section 82, both parties are required to attend a mandatory settlement conference within the meaning of section 89A;

(iv) If the claim is unable to be settled at the section 89A settlement conference then each of the parties is required to exchange offers within 14 days and this offer must include a schedule of damages as contemplated by section 89C;

(v) After each party has exchanged offers following the section 89A conference a Claimant must wait a further 28 days under section 91(1) before any CARS application can be lodged.

In addition to the provisions in sections 89A to 89E, parties must also remember that before any Application for General Assessment can be lodged with CARS, clause 9.3.4 of the Claims Assessment Guidelines requires that any non-economic loss dispute has been lodged with MAS at least three calendar months prior to the lodging of the CARS Application.

The Committee would like to raise the issue of why Division 1A is required at all. There is already a requirement pursuant to section 85A for all relevant particulars of the claim to be lodged before the CARS Application is filed. Additionally, the Committee submits that the regime in Division 1A assumes that there is a point in time in a motor accident claim where the entirety of the claim becomes very clear and no further amendments to the claim are required. The reality is far different. A standard personal injury claim is a movable feast. For instance the Claimant may suffer deterioration in his or her medical condition, have surgery, obtain a new job, lose his or her current job, or additional medical reports may need to be obtained from doctors in new specialties. Further, it is invariably necessary for the Claimant to respond to any fresh material exchanged by the insurer which the Claimant has not previously seen. There is minimal flexibility permitted under the scheme in Division 1A for these late documents except in the circumstances outlined in section 89B(2) and (3). The Committee is concerned as to what happens if a party obtains fresh documentation after the settlement conference but still wishes to rely on these fresh documents at the Assessment Conference. Does this mean that the Claimant has to convene another formal settlement conference to comply with section 89A? In this respect the legislation is silent. A number of Committee members have had recent experiences of insurers disputing that a settlement conference is one which complies with section 89A and, hence, satisfies the pre-filing requirements. It is the Committee's submission that this adds unnecessary uncertainty and complexity to the CARS process.

The other difficulty with these provisions is that there are a number of claims where even the most diligent solicitor cannot comply with the pre-filing requirements. For instance section 89E(e) relieves the Claimant of the requirement of having to comply with sections 89A to 89D in circumstances where the Claimant's injury has not

sufficiently recovered within three years after the accident. The question must be asked what happens if the condition stabilises at, for example, two years and eight months after the accident? Pure mathematics suggests that it would simply be impossible to comply with all of the requirements in section 89A to 89D during this four month period. An impossible situation would also arise where the solicitor is only briefed by the Claimant during the last four to six months before the limitation period expires. Again the solicitor would be placed in a near impossible position to comply with the Division 1A requirements.

In view of all of the above, the Committee suggests that urgent amendment be made to the MACA as follows:

(i) By deleting Division 1A in its entirety along with section 91(1);

(ii) If these amendments are unpalatable to the Government, then section 89E(e) should be amended so that the following types of claims are excluded from the pre filing requirements:

(e) The claim is in respect of an injury that has not sufficiently recovered within 30 months after the motor accident to enable the claim to be quantified.

The Committee also recommends the addition of a further subparagraph as follows:

(f) The claim is in respect of an injury where exceptional circumstances exist to justify non-compliance with sections 89A to 89D.

Regulated Costs

The Committee continues to be very concerned by the lack of progress regarding the amendment of the party/party costs regime set out in the *Motor Accidents Compensation Regulation 2005* (the Regulations). The Committee reiterates that there has been no meaningful increase in the costs scale since the commencement of the MACA in 1999, other than modest CPI increases. The Committee notes that the FMRC report which was commissioned by the Authority in 2008 suggested that roughly 40% of total solicitor/client costs were ordinarily covered by the party/party allowance which is available under the Regulations. It is not the legal practitioner but the injured person who feels the brunt of the substantial discrepancy between the paltry party/party legal costs which are on offer and the real solicitor/client legal costs.

Anomaly with sections 82(1) and 91 of the MACA

The Committee has identified the following legislative anomaly in sections 82(1) and 91 of the MACA:

Under section 91(1), claims made before 1 October 2008 cannot be referred to CARS for general assessment unless one of the following has occurred:

(i) Two months have elapsed since the insurer made an offer of settlement.

(ii) The period in which the insurer was duty bound to make an offer has expired and the insurer has not done so.

(iii) One of the exceptions to the time limited requirements in section 91(2) has been satisfied.

If the Claimant is forced to reply on the second of these circumstances outlined above, then the Claimant needs first to satisfy the superseded section 82(1)(a), that applies to claims made before 1 October 2008, which prevents a Claimant from providing all relevant particulars about the claim to the insurer until "one month after the injury has stabilised, as agreed by the parties or as determined by a medical assessor".

Section 58(1)(c) has been repealed so a MAS Assessor no longer has the power to determine whether the Claimant's injury has stabilised for the purposes of section 82(1)(a), which applies to claims made before 1 October 2008. Accordingly, the only available avenue for a Claimant in such circumstances is to file a CARS Application and to try and reach agreement with the insurer that his or her injuries have stabilised within the meaning of section 82(1)(a). In the absence of an agreement being reached with the insurer, the Claimant has no way of determining this issue, so there is every possibility that the claim may remain 'in limbo' permanently and can never be referred to CARS for general assessment.

This is a very live problem which has led to the Principal Claims Assessor dismissing numerous claims for failure to comply with sections 82(1) and 91(1)(b). The Committee notes that the dismissal of the claim does not prevent the Claimant from re-lodging the CARS application if the procedural requirements outlined above can be met. However, the Claimant is then likely to face difficulties in complying with the three year time limitation set out on section 109 of the MACA, if he or she subsequently wishes to commence District Court proceedings.

The Committee submits that urgent steps should be taken to amend section 58(1) so that the repealed section 58(1)(c) still applies to claims lodged before 1 October 2008.

The Fourth Lifetime Care Review

Summary

The Committee's recommendations in relation to this review focus on the right of the participants or prospective participants ('Participants') in the Lifetime Care and Support Scheme ('the Scheme') to make fully informed decisions as well as ensuring that the Authority's decisions are of the highest standard. Participants' choice should be respected and encouraged.

Underpinning these recommendations are:

1. The right of Participants to paid legal representation.

2. Ensuring that there is an appropriate review process for decisions made by the Authority.

3. That the consent of injured person be required before they becomeParticipants in the Scheme.

4. The ability of Participants to exit the Scheme.

Access to Independent Legal Advice

Section 18 of the *Motor Accidents (Lifetime Care & Support) Act 2006* ('the Lifetime Care Act') makes it clear that legal costs are not payable by the Authority in respect of legal services provided to an injured person in connection with the referral of a matter for the making of a determination, or review of a determination, in relation to the resolution of disputes under Part 3 of the Lifetime Care Act.

Further, section 29 makes it clear that no legal costs are payable by the Authority for or in respect of legal services provided to Participants in the Scheme in connection with an assessment under Part 4 of the Act, with respect to the treatment and care needs of Participants or the determination or review of a determination in that regard.

The Committee finds it is extraordinary that not only are legal costs not payable, but that the Scheme goes out of its way to steer Participants away from obtaining legal advice and representation.

The Lifetime Care Act contains some 68 sections, including three Schedules, and is the subject of a range of Guidelines relevant to decisions made in accordance with the Lifetime Care Act. Rights and obligations arising under the Lifetime Care Act must also be interpreted and applied in a manner consistent with the MACA. Thorough knowledge of both Acts, associated Regulations and Guidelines is required in order to make informed choices and exercise rights under the Lifetime Care Act. Participants cannot possibly possess such knowledge.

If ever there was a 'vulnerable group that required access to legal advice and representation, it is those who have suffered injuries that are so catastrophic that they qualify as Participants in the Scheme.

To enable Participants to make fully informed decisions, to ensure that they are able to prosecute their rights in the most difficult of circumstances, and to ensure that their rights are not compromised as a result of incorrect decisions, Participants should be allowed legal costs under the Lifetime Care Act.

Access by Participants to legal advice becomes of greater significance because the Scheme does not provide for external, independent, review of decisions. As it currently stands, the Authority has put in place a system specifically aimed at eliminating scrutiny of its decisions other than by way of internal review. Not allowing the payment of Participant legal costs reinforces this position.

The Third Review conducted by the Standing Committee on Law and Justice recorded the Lifetime Care and Support Authority's statement that costs were not recoverable with respect to eligibility and treatment and care needs disputes "... because the Act stipulates so and that these decisions concern medical or clinical issues, not legal issues" (paragraph 4.113).

The Lifetime Care and Support Authority also informed the Standing Committee that, whilst Participants are able to instruct lawyers to assist with disputes, it generally did not consider it necessary for Participants to seek legal assistance for disputes about treatment and care on account of the dispute's complexity (paragraph 4.115).

With the greatest of respect, the Lifetime Care and Support Authority's opinion in this regard is not relevant. What it believes Participants may or may not need is simply not an answer to the substantive question. Further, to state that the Lifetime Care Act stipulates that no costs are payable does not address the substance of the issue. The statement that the disputes do not involve "legal issues" is extraordinary given

that the rights and obligations established by the Act, and the exercise and review of those rights, are by their very nature "legal issues" and complex ones at that.

The Committee recommends that the Lifetime Care Act be amended so as to allow for the payment of legal costs for representation and advice sought by Participants with respect to disputes under Part 3 and assessments under Part 4.

In the absence of legal advice, catastrophically injured Participants are unable to give voice to their disagreement with decisions made about their treatment and care needs and to make choices.

Review of Decisions and Dispute Resolution

Participants who disagree with the Lifetime Care and Support Authority over decisions about their treatment, rehabilitation and care needs can ask the Lifetime Care and Support Authority to reconsider its decision by having it reviewed by another member of staff. If the issue is not resolved, Participants may lodge a formal dispute which is referred to a "single independent dispute assessor". There is no avenue for external review.

The Lifetime Care and Support Authority appears to have set up a Scheme that minimises its accountability by not only the denial of legal representation to Participants but also by denying Participants the right to external review of its decisions.

As part of the Third Review, a representative of the Australian Lawyers Alliance argued that:

> *... Participants who have legal rights under the Act should be given the means to enforce those rights and that, for Participants, this means not having to rely on those, who in effect, are in the employ of the Authority.*

The reality is that there is no meaningful and transparent review process in place. The independent tribunal established by the Lifetime Care and Support Authority is not truly independent. It is supported and renumerated by the Authority.

Given the propensity of the Lifetime Care and Support Authority to issue guidelines with respect to how the Lifetime Care Act is to be applied and how decisions are to be made, the absence of external, independent review means that there is no check on the Authority's exercise of powers or failure to exercise its powers. In short, there is no safeguard to ensure that the Lifetime Care and Support Authority does not err in its decision making by either act or omission. This is of particular concern given the level of vulnerability of the Participants in the Scheme.

The Committee submits that a system of external review needs to be incorporated into the Lifetime Care Act.

Entry into the Scheme

The consent of injured persons is not required for them to become Participants in the Scheme. An application can be made unilaterally by the Insurer.

In their submissions with respect to the Third Review, the Australian Lawyers Alliance argued that subsection 8(2) of the Act ought be repealed. The Committee agrees with this recommendation.

Having regard to the manner in which the rights of Participants are impacted by their entry into the Scheme, the Committee believes that their consent must be obtained before they are forced into a Scheme from which they may never be able to exit.

Exit from the Scheme

The Third Report issued by the Standing Committee noted that this issue had been raised by stakeholders but took the view that allowing Participants to opt out of the Scheme was contrary to the purpose of the Scheme, and that opting out may not be in the best interests of Participants. The Standing Committee, however, observed that where possible, Participants' choice should be respected and encouraged.

The Committee submits that there ought be opt out provisions, particularly given that catastrophically injured Participants are forced into the system without their consent.

There seems to be a prevailing view that Participants need a paternalistic approach taken to the exercise of their rights under the Lifetime Care Act, in particular their treatment and care needs. Whilst lip service is given to "choice", the reality is that Participants simply do not have any choice in a meaningful sense. They are bound by the decisions of the Lifetime Care and Support Authority with no external mechanism for review of those decisions and no right to receive legal advice under the Lifetime Care Act with respect to these rights.

The Third Report cited a number of examples of Participants who said that they ought to be able to opt out of the Scheme whilst others said that they were happy to remain in the Scheme. These examples are addressed in 4.15 to 4.45 of the Third Report. The Committee submits that some Participants continue to take the view that they are better off opting out of the Scheme, rather than have a bureaucrat making decisions for them.

The Committee strongly supports a provision that would allow Participants to "opt out" of the Scheme, subject to appropriate safeguards being put into place, including the provision of legal advice to Participants.

Participants' choice needs to be respected and under the current provisions it is not. The Committee recognises that for some people participation in the Scheme does work, and for those people the right choice is to remain within it.

The evidence of Mark Harris, contained in the Committee's Third Report, illustrates some of the problems with the Scheme and why some people may not wish to remain Participants in it. Indeed, Mr Harris put it well when he said (paragraph 4.24) that:

> *The opportunity to exit the Scheme would be nothing more than allowing a mentally able person control of their own life without the frustrations and delays incurred with requests to the Authority.*

Further, the Third Report made reference to a study conducted in the United Kingdom which found that those with a disability, given the support and finances to source their own treatment and care services, not only led to lower long term costs, but better personal experiences moving forward:

> *... a study was conducted in the United Kingdom a few years ago involving two separate groups of disabled people.One was empowered with enough money to source services, equipment or anything else they needed. The other group was bras' dash, that is, kept on bread and water.*

Those on the bread and water system ended up costing the State far more than those who had been empowered with funds.

The Committee recommends that an opt out mechanism be built into the Scheme.

Should you have any inquires concerning the content of these submissions, please do not hesitate to contact the Committee's Policy Lawyer, Patrick McCarthy on 9926 0323 or email: patrick.mccarthy@lawsociety.com.au .

Yours sincerely,

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President