Submission No 8

INQUIRY INTO FIRST REVIEW OF THE LIFETIME CARE AND SUPPORT SCHEME

Organisation: NSW Bar Association

Date received: 9 May 2017

SUBMISSIONS BY THE NEW SOUTH WALES BAR ASSOCIATION

STANDING COMMITTEE ON LAW AND JUSTICE REVIEW OF THE LIFETIME CARE AND SUPPORT SCHEME

INTRODUCTION

1. As always, the New South Wales Bar Association appreciates the opportunity to provide submissions to the Standing Committee on Law and Justice with regard to the operation of compensation schemes.

2. The Lifetime Care and Support scheme remains an invaluable resource to those people who are catastrophically injured on the roads in NSW. The Bar Association's concerns with regards the operation of the scheme include:

   (a) Ensuring that the Scheme remains viable;

   (b) Ensuring that the very substantial monies collected to care for the catastrophically injured are being spent on the catastrophically injured (rather than administration);

   (c) Ensuring that the scheme operates fairly and efficiently; and

   (d) Ensuring that the scheme has structures (including Guidelines) that will provide lasting, fair and timely access to benefits.

3. Issues which the Bar Association wishes to draw to the attention of the Standing Committee on Law and Justice are set out below, along with questions for the Committee to consider providing to the Lifetime Care and Support Authority for a response.

A. The Guidelines Review

4. The LTCS Authority (or icare as it is now known) is currently undertaking a review of its guidelines. The Bar Association has provided submissions in relation to that review. Copies of those submissions dated 3 December 2015 and 7 October 2016 are attached for the information of the Committee.

5. The Bar Association has had a number of meetings with icare staff to address the concerns raised in the submissions. A revised copy of the guidelines has not yet been circulated. It is hoped that the significant issues raised by the Association will be taken into account in revision of the guidelines.

6. One of the most problematic areas of service delivery within the scheme is the provision of services to the family and children of the injured person, where the injured person either needs assistance or is no longer capable of performing that service themselves.

7. To give an example, a single parent may have the responsibility to prepare a young child's school lunch, transport them to and from school, supervise their homework and so forth. For a participant with a moderate brain injury or a spinal cord injury such as paraplegia, it may still be possible to modify a home, modify a vehicle and provide assistance to the scheme participant, such that the parental responsibilities can still be discharged.

8. However, some traumatic brain injuries and some spinal injuries will be so severe that it becomes unsafe or impractical for the scheme participant to continue to provide all of those services to the child.

9. The Bar Association has expressed its concern about proposed amendments to the guidelines that would exclude treatment where "*the treatment or service is for the participant's family members*". The Association submissions on this issue are set out in the attached letter of 3 December 2015 at page 6.

10. Similarly, the Association has expressed similar concerns in its attached submission of 7 October 2016 at pages 4 to 9. The Bar Association remains concerned that icare has not yet truly come to grips with its responsibilities to assist the catastrophically injured in discharging parental responsibility where the accident removes the capacity to exercise that responsibility.

11. A further concern is that the draft guidelines provide that icare will not assist with exercising parental responsibility for those who choose to have children post-accident. This is an unduly harsh provision. Exclusion from parenthood should not be one of the effective conditions imposed by icare for those who have suffered mild traumatic brain injury or less severe spinal cord injury.

12. The Bar Association is also greatly concerned about the removal of general discretionary provisions from within the guidelines that allow icare the capacity to waive application of the guidelines in a case where it be unreasonable in the circumstances to adhere to the guidelines. The retention of a general discretion to avoid unjust outcomes is important.

13. Discussions with icare about the guidelines will hopefully continue.

B. Streamlining participation disputes

14. A small number of cases have seen protracted disputes over scheme eligibility. In some instances, these disputes have been driven by the claimant, but a larger number appear to have been driven by insurers.

15. There is a financial incentive for insurers to place claimants in the LTCS scheme. Although the individual insurer effectively pays a share of the LTCS levy at the time the premium is collected, an insurer wishing to reduce its current liabilities has an incentive to place as many claimants as possible in the LTCS scheme. This has resulted in some unnecessarily protected disputation through the court system, with a three level dispute mechanism.

16. The Association has made representations to icare with regard to simplifying this process and removing the right for insurers to engage in the third round of disputation.

17. The Committee is invited to ask icare what is being done to address the considerable expense and delay being created by this small group of cases. Has the Authority spoken to or co-ordinated with SIRA (which regulates CTP insurer conduct) in relation to these cases?

C. Quality Standards

18. The Association repeats the following questions it submitted to the last SCLJ inquiry into the operation of the LTCS scheme.

    (a) What are the KPIs that measure the quality of care services being provided by retained nursing and care provision agencies?

    (b) What minimum training or qualification standards are applied to the staff at LTCS care providers? Is there a competency standard? Is it mandatory? What are the minimum training requirements for a carer sent out to an individual's home?

    (c) What is the incidence of staff from care agencies failing to show for regular shifts? How well are the agencies performing in sourcing alternate staff when that occurs? What are the delays and inconvenience for scheme members?

D. Independence of scheme participants

19. The Lifetime Care and Support Guidelines make provision for payment of an annual lump sum to scheme participants capable of managing their own care and treatment needs. There are a group within the scheme who are highly intelligent and functional and should be capable of managing their own annual budget (for example, a mature, tertiary-qualified paraplegic).

20. Scheme participants in this category should not be required to apply to icare for each minor item of expenditure, but should be provided with an annual budget. The LTCS Authority has previously advised that it is trying to move towards an appropriate system of annualised expenditure for such participants. The NDIS is based on such an approach. This gives rise to the following questions:

    (a) How many scheme members are currently receiving an annual (or other periodic) payment such as to permit them to enjoy a degree of independence in choosing their own priorities and spending funds?;

    (b) What goal or target has icare set over the next twelve to twenty-four months in terms of increasing this number?

E. Utilisation

21. The LTCS Legislation was amended in 2012 to make it extraordinarily difficult for any family member to be paid for voluntary services provided to a scheme participant.

22. There continue to be many scheme participants whose family prefers to provide domestic and care services, rather than have a stranger in their home providing such services or for other reasons (such as a sense of cultural obligation).

23. The Bar Association believes it is important that the utilisation of benefits under the scheme be measured. The Care Plans issued by icare should cover the claimant's full needs. If there is significant under-utilisation it is important for icare and ultimately the Parliament to understand why. Thus, the Parliament is encouraged to ask – what are the measurements made by icare as to the extent to which there is under-utilisation of allocated scheme services and benefits?

24. Questions that would produce these answers include:

    (a) Over a twelve month period, what was the total amount allocated under Care Plans for the costs of care and treatment? [It is assumed this data is kept for budgeting purposes.];

    (b) Having measured the total amount allocated under Care Plans, what percentage was actually spent? In simple terms, how much of the budget set for treatment and care (through Care Plans) was used? The answer should reveal the under-utilisation rate; and

    (c) What are the reasons for under-utilisation and what is icare doing to address them?

F. Employment

25. icare has previously advised that vocational rehabilitation is one of the scheme's goals. To measure the success of performance in this field, it is necessary to have data:

    (a) How many of the current scheme participants are capable of some form of employment?;

    (b) How many are actually in jobs? Of those in jobs, how many have received assistance from icare to find or maintain employment?;

    (c) How many scheme participants are currently unemployed and capable of and looking for employment? What success has icare had in rehabilitating them into the workplace?; and

(d) What has been icare's goal for vocational rehabilitation over the last two years? What has been its success in achieving that goal? What is the goal for the next twelve months to two years? What measurements will be made of its success in achieving that goal?

G. Advice Services

26. Participants within the scheme have the right to challenge their Care Plan and to dispute the care and services that they are allocated if they believe their needs are not properly or fully met. However, this right is of minimal value or use if the scheme participant does not have the intellectual capacity or tenacity to pursue the relevant dispute resolution mechanisms.

27. The Committee is invited to ask icare about the utilisation of dispute mechanisms and the level of information and other services available to scheme participants to dispute their Care Plans:

(a) What is icare doing to ensure that scheme participants and their families are properly advised about their right to challenge and dispute Care Plans?; and

(b) What is icare's knowledge as to the degree of dissatisfaction with issued Care Plans where no challenge is being raised? Has icare investigated and addressed what resources are available to scheme participants to assist them with fully understanding, exercising and pursuing their rights.

H. Expansion of the icare role

28. Under the new Motor Accidents scheme, icare will take over the role of handling all treatment and care needs for all motor accident claims from five years post-accident. This will represent a dramatic expansion of the role of icare. What plans are being made as to how icare will facilitate this new and expanded role?

I. What isn't working?

29. It is appreciated that the SCLJ relies upon scheme stakeholders to identify issues of concern within the operation of the scheme. However, it should not be unrealistic to expect that those responsible for administering the scheme should be independently capable of providing frank and fearless advice to the Parliament identifying shortcomings and areas for improvement.

30. The SCLJ is encouraged to ask those responsible for administering the LTCS scheme:

(a) What isn't working well within the scheme?;

(b) What could work better?;

(c) What legislative or structural changes does the scheme need?;

(d) What improvements do those responsible for administering the scheme suggest should be made to improve its fairness, efficiency and performance?; and

(e) Is the scheme working efficiently in terms of transferring premium collected to the injured? How could the scheme be more efficient?

9 May 2017

Submission No 8, Attachment No 1

INQUIRY INTO FIRST REVIEW OF THE LIFETIME CARE AND SUPPORT SCHEME

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15/16

3 December 2015

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Administration Support Officer
Lifetime Care and Support Authority
Level 24, 580 George St
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Dear Ms

Review of Lifetime Care and Support Guidelines

Thank you for your email dated 3 November 2015 seeking the comments of the New South Wales Bar Association regarding the new draft Lifetime Care and Support Guidelines.

The Association appreciates the opportunity to provide submissions in relation to the proposed changes to Parts 1, 5 and 6 of the LTCS Guidelines. The Association appreciates that the structure of the Guidelines is critical to the fair administration of the scheme, consistency of the decision making and providing clarity to claimants, insurers and their lawyers as to issues surrounding scheme eligibility and benefits.

The Association strongly supports a number of the proposed changes including:

(i) Requiring insurers to serve an application for scheme membership on the injured person (and their legal representative);

(ii) Amending the eligibility criteria so that for an adult with a pre-existing injury or disability, the Functional Independence Measure (FIM) is appropriately utilised to measure the degree of accident related impairment;

(iii) Making clear within the Guidelines that a determination on permanent scheme eligibility can be brought forward in an appropriate case;

(iv) Taking steps to provide greater opportunity for participants to be more involved in how their treatment and care needs are delivered;

(v) Setting a ten working day timeframe for the Authority to process requests for treatment (excluding prosthesis and home modifications);

(vi) Being specific as to the occasional obligation for scheme participants to undergo medical examination or assessment to determine reasonable and necessary needs; and

(vii) Amending the reasonable and necessary treatment criteria to allow the pursuit of treatment where there is risk of adverse consequences (provided the potential rewards outweigh such risk).

The Association does however have concerns about some of the proposed amendments and some of the drafting. Those concerns are set out below. The Association would be pleased to meet with the Lifetime Care and Support Authority and discuss these concerns in the course of the review of the Guidelines.

Part 1, Paragraph 2.7 – An Incomplete Application

It is noted that the Authority is specifying that an application is not complete unless it consists of:

(i) A signed application form;

(ii) A medical certificate completed by a treating specialist; and

(iii) A FIM or WeeFIM score sheet (for brain injury or burns).

It is noted that Paragraph 2.8 gives the Authority a discretion to treat an application as complete, even if it is missing relevant annexures.

The reality is that an injured person in a spinal unit or brain injury unit does not necessarily have immediate access to a specialist who is FIM or WeeFIM trained. If it is the Authority making the application or an insurer making the application then there is no issue with applying the criteria in Paragraph 2.7.

However, the Association submits that all that should ever be required from an injured person is (i) and (ii). The Authority can always organise the FIM testing. It is appreciated that there is a waiver provision in Paragraph 2.8, but the concern is that no injured person should ever be delayed in lodging an application (which in turn triggers the entitlement to recover payments) by the need to obtain a FIM score from an accredited specialist.

It is recommended that Paragraph 2.7 be amended so that it is only applications from insurers and the Authority that require a FIM score to be annexed.

Part 1, Paragraph 2.13 – Application made by Insurer

The Association recommends that Paragraph 2.13(b) be expanded or modified so that an insurer sending a copy of their application to the injured person (at the same time it sends the application to the Authority) can meet its obligation by sending a copy of the application to the injured person's legal representative. Indeed, if there is legal representation, all communications should be with that representative.

Part 1, Paragraph 5.8 – Brain Injury

The criteria for brain injury eligibility remain substantially the same. These criteria deal with what might be termed *"frank"* injuries arising during the course of a motor vehicle accident and include circumstances where a blow to the head causes post traumatic amnesia (PTA) of greater than one week, or there is a coma of longer than one hour or a significant brain imaging abnormality.

What this paragraph does not deal with clearly or well is acquired brain injury arising subsequent to an accident. For example, an elderly person suffers a fractured knee or hip in a motor vehicle accident and undergoes surgery. During the course of surgery, there is a rapid acceleration of dementia due to oxygen flow deprivation, minor myocardial infarcts or the stress of surgery brings on a stroke.

The level of impairment arising may well meet FIM criteria. Injury may have occurred to the brain. Nonetheless, there may not be PTA for one week (although there may arguably be impairment for life). There has not been a significant impact to the head, but there has been trauma occasioned to the brain during the surgical procedure. There may or may not be brain imaging abnormality.

There are only a small number of cases each year that would fall within this category, but it is the Association's view that such persons should be eligible for membership of the scheme.

It is noted this issue has been raised by the Association's representative with the Authority previously. The Association urges the Authority to give this issue further consideration.

Part 1, Paragraph 6 – The Authority's Determination

It is noted that the Authority, upon making a determination as to eligibility, will notify the applicant and the injured person if the injured person is not the applicant.

This means that if the insurer is the applicant, then the insurer gets to find out the result of the application. It seems unfair that if it is the injured person who applies (or if the Authority applies on behalf of the injured person), then the injured person will be told the result, but the insurer won't be told the outcome of the application.

The insurer has a financial interest in the outcome. It is recommended that Paragraph 6 be amended so that an insurer is advised of a claimant being accepted or rejected for scheme membership in all cases, just like the injured person.

Claimants would prefer that insurers be told – if the insurer is going to exercise some sort of review or appeal right, then the claimant wants the Authority's decision to come to the attention of the insurer promptly so that that any review process occurs expeditiously.

Part 1, Paragraph 7 – Interim and Lifetime Participation

The Association very much supports the Authority giving itself the power to bring forward a decision on permanent membership. In spinal injury cases, there is absolutely no need to wait two years to make a permanent membership decision.

However, it is noted that Paragraph 7.4 limits the application of this discretion by reference to Paragraph 7.1.

Paragraph 7.3 provides that a child will not be assessed for lifetime participation before the age of 5 years and that a child who becomes an interim participant under the age of 3 years may spend longer than two years as an interim participant. It is unclear why a severe spinal injury in a child under 5 would still necessitate waiting until age 5 before a decision would be made about permanent membership.

The Association recommends that the new Paragraph 7.4 be amended to refer to Paragraph 7.1 and Paragraph 7.3 rather than to Paragraph 7.1 alone.

Part 5, Paragraph 6.6 – Principles for Service Delivery

It is noted that the third of the identified principles (c) says that participants have the right to refuse services, even where others may consider their choice to be unwise. As a generalised statement in relation to capable and informed adults, this general principle may hold true.

However, many scheme members have brain injury, some of them severe. Some scheme participants are children. It just is not accurate to say that every scheme participant has a "*right*" to refuse services (which includes treatment). There may be some circumstances involving lack of capacity where such refusal can and should be the subject of challenge and, in extreme cases, potentially even court orders to compel lifesaving treatment that is in the participant's best interests.

It is appreciated that the statement of general principle is well intentioned, but it is not of universal application.

Part 6, Paragraph 2.6(j) – Treatment and Care Criteria

The Association has no issue with the Guidelines setting out the circumstances under which the Authority will consider new or innovative services where there is sufficient basis for doing so. There is a list provided of factors the Authority will take into account, comprising (i) through (iv).

It is assumed that the Authority is not intending that a new or innovative treatment would need to "*tick all boxes*". It is accepted the Authority might want two or three criteria to be fulfilled in relation to any given treatment depending upon how strongly any of the boxes were ticked.

To avoid confusion and inconsistency, it is recommended that there be minor re-drafting to indicate that (i) through (v) are factors that the Authority will consider and take into account, without the need for all of them to be satisfied. The use of the word "*or*" at the end of items (i) through (v) and some re-wording of the preamble is recommended.

Part 6, Paragraph 4.1(a) – Considering Risk in Treatment

It is noted that the Authority says a treatment or care need will not be reasonable or necessary if "*it is likely to cause harm to the participant*". The Association strongly objects to this definitive and inaccurate statement.

Stepping outside the motor vehicle sphere, on any view of it, chemotherapy causes harm to a cancer patient, although it holds out the prospect of ultimately providing a "*cure*". No one would argue that chemotherapy is not a reasonable and necessary treatment for a cancer sufferer.

Similarly, there may well be treatments that either risk or definitively will cause harm to an LTCS member, but nonetheless, that harm is worth enduring for a potentially greater benefit or to avoid an even greater harm occurring. To give another example, an infected leg may need to be amputated (an undoubted "*harm*" to the participant) in order to save the rest of the body.

This clause requires re-consideration and redrafting (if it needs to be stated at all).

PART 6, PARAGRAPH 5 – EXCLUDED TREATMENT AND CARE

It is noted that reasonable and necessary treatment expenses are defined **not** to include where (b) "*the treatment or service is for the participant's family members*".

Again, this is an inaccurate statement of the Authority's obligations under the Act and the Guidelines.

Take for example, a scheme member with children who, due to left-sided hemiplegia, is unable to make a child's school lunch, iron their school uniform or drive the child to various activities.

Currently, the Authority pays for the provision of assistance to the injured person, such that the participant's family member still receives the services which the injured person would otherwise have provided.

On one view, the service is being provided for the scheme participant (to allow them to continue to discharge their parental obligations), but on another view, the service is for the benefit of the family member.

The Association is very concerned that at some future point in time, currently provided services may be cut off because of a misunderstanding or misapplication of Paragraph 5(b).

The Association strongly recommends that this section be clarified or re-written or eliminated altogether. The scheme can, does and should pay for services to family members that the participant is no longer able to provide.

ADDITIONAL ISSUES

The Association raises the following additional issues for the consideration of the Authority in its Guideline revision process. It is noted that these issues have been raised with KPMG as part of their review of scheme dispute resolution processes. They have also been informally raised with the Authority by an Association representative.

(a) Currently the dispute process over medical eligibility runs to three stages (assessment, assessment panel, review panel). This process can take upwards of two years from start to finish, leading to significant delays in resolution of compensable claims. Insurers with deep pockets and a financial incentive to put claimants in the scheme have even lodged Supreme Court proceedings seeking administrative review of LTCS decisions at various levels.

The whole point of setting a three level decision-making process was to ensure that claimants who deserve a place in the scheme, get in. The point was not to help insurers off-load a liability in any individual case.

Insurers' administrative rights cannot be cut down – the High Court has said so. However, whether insurers should be able to generate a review panel determination and whether insurers driving protracted disputes should be obliged to meet the claimant's costs are issues worthy of consideration.

(b) Some medical eligibility issues and treatment issues are not purely medical questions. Causation can be a mix of medical and legal issues. What is "*reasonable and necessary*" can be in part a medical judgment, but also in part, a value judgment. Where it is a value judgment, the decision needs to be made on a proper legal basis rather than medical basis.

To give one hypothetical example, what constitutes a "*reasonable*" size of yard which falls within the scope of reasonable domestic maintenance is not a medical judgment – it is a legal/value judgment. When modifying a bathroom, what constitutes a "*reasonable*" standard of bathroom fittings is not a medical question.

It would improve both the quality of reasoning and decision making if there was capacity in the Guidelines (in appropriate cases) to have a lawyer (such as a CARS assessor) added as a member of an assessment or a review panel to assist in cases where there are tricky questions of interpretation of the Guidelines or where there is a mix of medical and legal questions to be resolved.

(c) Section 11(b)(2) of the Act provides that the Lifetime Care and Support Authority may waive the operation of Section 11(b)(1) which contains prohibitions on the Authority funding certain types of care (voluntarily provided by family members). The power to waive the operation of the Act can presumably only be exercised by the Authority and not by an assessor, assessment panel or review panel.

However, there are no Guidelines as to how to apply to the Authority to have it exercise this power. There are no guidelines addressing the circumstances in which the Authority will exercise the power. It is not made clear that the power is that of the Authority, rather than an individual assessor to exercise. There is no guidance as to how to ask the Authority or how long they will take to answer or whether they have to give reasons.

Similarly, various parts of the Guidelines have permitted the waiver of various prohibitions within the Guidelines. In short, there are discretions.

Again, it is not clear who could exercise such a discretion. Is an assessor, an assessment panel or a review panel able to exercise the power to waive the operation of the Act or the Guidelines or can such waiver only be exercised by the Authority? If the power is limited to the Authority, then under what circumstances will the Authority exercise such power?

The Association appreciates the great virtue of flexibility. However, having a power to exercise a discretion and providing no guidance as to who can exercise such power only leads to confusion and under-utilisation of the discretionary relief.

The Association again expresses its thanks for the opportunity to be able to make submissions in relation to the proposed amendments to Chapters 1, 5 and 6.

The Association looks forward to the opportunity to make submissions on the balance of the proposed Guideline revisions in due course.

Yours sincerely

P A Selth
Executive Director

Submission No 8, Attachment No 2

INQUIRY INTO FIRST REVIEW OF THE LIFETIME CARE AND SUPPORT SCHEME

Organisation: NSW Bar Association

Date received: 9 May 2017

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Our ref: 06/293-2

7 October 2016

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By Email:

Dear

Review of the Lifetime Care and Support Guidelines

The New South Wales Bar Association (the Association) appreciates the opportunity to comment on Stage 2 of the Lifetime Care and Support Guidelines (the Guidelines) review. We also appreciate the extension of time granted to provide our submission.

It is noted that this stage of the review addresses Parts 8, 9, 10, 12, 16, 18 and 19 of the Guidelines. The Association takes a continuing keen interest in the Guidelines. Valuable common law rights were removed from innocent accident victims consequent upon the introduction of the Life Time Care and Support (LTCS) scheme. The Association believes it is critically important that over time, the replacement of those common law rights with LTCS membership not be de-valued by unnecessarily restrictive Guidelines on benefits under the scheme.

At the heart of the LTCS scheme is the commitment to provide for the "*reasonable and necessary*" care and treatment needs of scheme members. Attempts to prescribe or limit what is "*reasonable and necessary*" through restrictive Guidelines has the potential to undermine the intent of the Act.

The Association understands the necessity for consistent decision making and to give both scheme administrators and participants as clear as understanding as possible of what the scheme provides. Nonetheless, the scheme caters to a variety of individuals with variety in the effects of their injuries and the full variability of their personal circumstances.

The flexibility to ensure that "*reasonable and necessary*" needs are met allowing for individual circumstances should not be compromised for overly onerous regulations.

In commenting upon the Guidelines, the Association has not limited its comments to its "*new*" or "*revised*" elements. The Association has considered the Guidelines as a whole and considered any current provisions that should be clarified or re-visited.

Particular Concerns

In summary, the Association has particularly strong concerns about the following aspects of the proposed revisions to the Guidelines:

- Removal of the general discretion to vary the Guidelines;
- The failure to clarify the application of the scheme to expenses prior to scheme admission or whilst permanent membership is under review;
- The incorporation of external standards into the Guidelines;
- The lack of clarity over gardening or carer assistance and household maintenance provisions;
- The clarity of the statement regarding assistance to be provided to address childcare obligations for those no longer physically or psychologically capable of discharging parental responsibilities; and
- Possible repercussions from the provisions in relation to the capital costs of a motor vehicle.

Removing the Waiver Provision

Currently the Guidelines provide:

> *"To avoid requirements that might be unreasonable in the circumstances on any injured person, the Authority may waive an observance of any part or part of these Guidelines."*

It is proposed that this provision be removed. The Association does not support this proposal. This provision provides the Authority with the flexibility to consider what is "*reasonable and necessary*" in individual circumstances and to modify the effect of the Guidelines in an individual case to "*avoid*

requirements that might be unreasonable".

The Association proposes that rather than removing this provision it should be retained and expanded upon. The provision should clarify who has the power to waive observance of any part or part of the Guidelines. The Association accepts that it would be inappropriate for individual assessors to be waiving the Guidelines and submits that there should be a process that allows an application to be made to the General Manager of the Authority (or an appropriate delegate) for waiver of a Guideline where it might be unreasonable in the particular circumstances of the injured person. A decision should be given by the Authority in writing as to why or why not the provision is or is not to be waived.

The Association views this provision as a critical safety net that sits beneath the Guidelines to avoid unjust and unreasonable outcomes. The Association considers that removal of this provision is a significant step towards the potential diminution of rights within the scheme.

PART 8 – ATTENDANT CARE SERVICES

The Introduction

It is noted that the new Guidelines take effect from the date of gazettal and are said to apply to all applicants for participation in the LTCS scheme, whether for interim or lifetime participants and "*whether determined or otherwise.....*"

There is no issue with applying the new Guidelines to all scheme participants with immediate effect. However, the ambiguity in the Guidelines that has not been addressed is in relation to circumstances where expenses are incurred prior to an application for scheme membership or whilst an application for scheme membership is being determined.

It is understood that, at present, there is an informal practice that the scheme will pay treatment expenses from the date of accident if an application for scheme membership is made shortly after the accident and determined relatively shortly thereafter. However, at present, there is no proper basis - statutory or regulation - for payments of initial ambulance and hospital expenses until the Authority actually makes the decision to admit somebody as an interim or lifetime participant.

This informal practice apparently does not extend to where there is a twelve or eighteen month delay in determining whether somebody should be a scheme member. The basis for covering expenses for a few days whilst not a scheme member, but not a few weeks, months or years is unclear.

It is also unclear what happens in relation to expenses where somebody is accepted as an interim participant, not accepted as a lifetime participant and after six months of dispute, it is finally determined that lifetime membership is appropriate. At present there is no clarity within the Guidelines to cover the six month period where lifetime membership was disputed.

It may be that the Authority prefers to leave the payment of initial expenses prior to scheme membership

and treatment expenses during dispute periods to be dealt with on a case by case basis outside legislative and regulational power. However, this discretionary approach appears remarkably inconsistent with the proscriptive approach otherwise being adopted throughout the Guidelines.

1. Reasonable and Necessary Attendant Care Services

In relation to Clause 1.1, the Association has no issue with subparagraphs (a) through (e). However, we recommend that an additional criteria be added at the outset (i.e. as (a)) that the primary criteria as to what the Authority should consider reasonable and necessary treatment or care needs in connection with attendant care services is that they be "*required as a consequence of the injury*". The over-arching principle should be that Lifetime Care will pay reasonable and necessary treatment and attendant care needs caused by an accident, even if they don't maximise independence, facilitate a return to a former role, eliminate a risk of harm or otherwise.

Nursing

At Clause 1.7 it is proposed that the Guidelines incorporate independent standards set by the Attendant Care Industry Association (ACIA). Doing so would remove would transparency and accountability and would allow the imposition of rules or standards set by a third party that can be amended without reference to the LTCS Authority or Parliament.

Home Maintenance

The Association recommends modification of Clause 1.8(a). The clause currently provides for "*routine home maintenance for the purpose of upkeep and to ensure safe and easy access*". The "*and*" should be removed and replaced with *"or"*. For example, cleaning windows is for the purposes of upkeep, but has nothing to do with safe and easy access.

Domestic Services

It is noted that Clause 1.10 now limits gardening services that it will provide to those necessary "*to ensure safe and easy access*" and that Clause 1.13 now seeks to exclude domestic services on a variety of grounds.

Restricting gardening to "*ensure safe and easy access*" under Clause 1.10 provides a standard which is unclear. Such wording does not provide a medical or legal basis that would permit analysis. The following circumstances below illustrate the challenge presented,

(a) Does weeding a garden bed fall within gardening "*to ensure safe and easy access*"?

(b) Is pruning a tree that would otherwise extend over a neighbour's yard required "*to ensure safe and easy access*"?

(c) Is pruning a hedge that would otherwise be unsightly, but that has no garden path running next to it necessary "*to ensure safe and easy access*"?

As you will note from the examples, the standard to *"to ensure safe and easy access"* may be difficult to understand and therefore appropriately apply.

When it comes to Clause 1.13, the Association has similar concerns about the exclusion of upkeep of "*an entire acreage*". The Association submits that this language is unclear. For example, will the Authority maintain a garden, provided the block size is less than one acre. Further, in the same clause, is the exclusion on upkeep "*beyond what is required for safe and easy access to the house and immediate garden/land area*" intended to apply only to a farm or also to be applied to the ordinary domestic home. It may be clearer if Clause 1.13(a) was divided into two parts to reflect property sizes greater than one acre and farms separately.

It is noted that Clause 1.13(e) says that the LTCS Authority will not pay for domestic services where the service "*frequency is to a level exceeding acceptable community standards*". The Association accepts that what is reasonable and necessary should be judged by community standards. However, the Association's concern is with who is judging what "*acceptable or community standards"* are and the clarity of reasons or factors articulating those standards are derived.

The Association would welcome further discussions with the Authority regarding who and what factors may be considered in the constitution of "*acceptable community standards*".

Clause 1.13(f) provides that the Authority will not pay for "*internal or external home decoration or renovation"*. The Association submits that this clause is unclear and requests the Authority to further consider the application of this provision. The Association would welcome further discussions in this regard.

Childcare

The Association is concerned about the Guidelines not adequately addressing replacement childcare services. Clause 1.12 is a clear example of why this concern arises. It states:

> *"However, domestic services to assist with childcare should not replace parental responsibilities. For example, where a child participant is required to attend a medical appointment related to the motor accident injury, Lifetime Care expects that the parent will accompany the child and will not pay expenses for an attendant care worker or domestic service provider to do so."*

This provision shifts the Authority's obligations under the Act and the Guidelines. As the clause is currently presented, it requires a parent or guardian to take time off work and therefore incurring an expense to accompany the child to medical appointments in connection with the accident. The Association submits that the parent should be provided with the option of either being reimbursed for

having to take time off work to accompany the child to medical appointments or requesting the Authority to provide a carer to take the child to appointments.

Home maintenance and domestic services when the participant is away from home

It is strongly recommended that the preamble to this clause be redrafted to remove the implied presumption against assistance. If the claimant is hospitalised for four months, then their lawn still needs to be mowed. The Association is of the view that the criteria listed at (a) through (d) need not be amended. However, the Association does suggest that the opening sentence of Clause 1.15 be amended as follows:

> *"If the participant is away from home for an extended period of time, whether domestic services, gardening and home maintenance services are considered reasonable and necessary will be determined on a case by case basis having regard to the following criteria."*

It appears that Clauses 1.16 and 1.17 apply generally in relation to attendant care services rather than just home maintenance and domestic services when the participant is away from home.

Moreover, the present wording of Clauses 1.16 and 1.17 excludes circumstances which may be reasonable and necessary and therefore does not accurately outline the Authority's obligations. For example, in relation to 1.16(a) it is said that what is reasonable and necessary does not include circumstances where the service is for an injury, condition or circumstances that existed before a motor accident or that are not as a result of the motor accident. However, there may be circumstances where there is a pre-existing condition that was not incapacitating that is rendered incapacitating as a result of the motor accident. The Association considers that in those circumstances the Authority should cover reasonable and necessary treatment and care needs as a consequence.

Furthermore, Clause 1.16(c) provides it is not reasonable and necessary to cover services for "*other members of the participant's family or household*". The Association considers that the Authority does and should continue to provide services to a participant's family or household where the participant previously provided those services and, as a consequence of physical or intellectual disability, is no longer capable of doing so. For example, if a quadriplegic cannot transport a child to a medical appointment (or to school, or to extracurricular activities), then the Authority can, currently does and should continue doing so.

Similarly, with Clause 1.16(d) and the replacement of parental responsibility, if a single parent is no longer able to supervise a child due to physical or intellectual impairment, then the Authority's obligation is to provide the reasonable and necessary services as a consequence of the injury.

With regards to Clause 1.17(a), it is noted it is said that the Authority will not pay travel expenses except where it is to and from medical treatment. If as a consequence of physical or intellectual injury the claimant occurs additional travel expenses (i.e. now requires a taxi because they cannot drive), then that is

an expense generated by the injury. The Authority currently does meet such expenses and the Association considers that it should continue to do so. If there is a change of policy, it should be explained. If the Authority is not in a position to fund this expense, the right to claim these expenses in damages from a Compulsory Third Party (CTP) insurer should be restored.

2. Attendant care services for participants who are children

The Association notes and accepts that the LTCS Authority will not provide for the replacement of the usual care and supervision provided by a parent (Clause 2.1) and does not generally provide attendant care services for the participant's siblings. However, as the Authority may be aware, a child with injuries that qualify for scheme membership (physical or intellectual) can place considerably greater demands upon a parent.

For example, the uninjured 17 year old can be left alone at home while a parent takes the 11 year old sibling to soccer practice. However, a 17 year old with a severe traumatic brain injury cannot necessarily be left alone at home. In those circumstances, the Authority should be replacing the usual care and supervision (which would have been nil) so that the parent may accompany the 11 year old to soccer. An alternative may be that if the parent is to stay home with the 17 year old to provide the necessary attendant care, then the Authority should be prepared to provide the carer to take the 11 year old to soccer practice.

Clauses 2.1 and 2.2 do not accurately reflect what the Authority will and should pay for in terms of the *"extra"* care and supervision needs of an injured child and the issues that arise when the demands of a scheme participant who is a child mean that a parent can no longer meet their usual care and supervision duties in relation to other children in the household.

3. Attendant care for participants who have caring responsibilities

The Association is of the view that Clause 3.1 is inaccurate. At this time, Lifetime Care currently pays for reasonable and necessary expenses for attendant care for participants who have care and responsibility *"to assist them to perform their role"*. We consider that Lifetime Care should continue to do so. Where necessary, LTCS does and should continue to *"replace"* the performance of the role if the participant cannot be *"assisted"* to perform the task. For example, a single parent who is a quadriplegic cannot drive a child to school and cannot be assisted to do so. Their services need to be replaced. We submit that the word *"replace"* should appear in the Guidelines alongside the word *"assist"*.

We submit that this wording should be adopted in Clause 3.2 where it is declared that an attendant care worker may assist a participant to travel with their children to and from school, but would not be solely responsible for taking the children to and from school.

In relation to Clause 3.3, it is noted that the LTCS Authority will only pay the reasonable and necessary expenses to discharge childcare obligations for a dependent child under age 18 and where that child was born or conceived prior to the motor accident injury. This appears to sugest that the LTCS Authority will

not provide assistance to for example, a person with an injury who chooses to become a parent after the accident.

Further, where the dependent child is intellectually or physically disabled, there will be the occasional case where parental responsibility will extend well beyond age 18. Based on the current wording, it appears that the Authority will not provide assistance to the scheme member in circumstances where the intellectually disabled child, despite requiring care, is over 18 years of age.

With regards Clause 3.4 and the declaration that Lifetime Care is "*unable*" to fund the costs of care for a child conceived after a motor accident if the parent is unable to perform a parenting role, reconsideration is invited. A consequence of a traumatic brain injury is that it can lead to poor decision making and poor impulse control. There may be circumstances where the person makes what may be considered poor decisions with serious long term consequences for example a situation where an a vulnerable young adult with a traumatic brain injury falls pregnant. Clause 3.4 assumes a rational choice and decision to proceed to parenthood on the part of a scheme participant who may not be capable of such rational choice.

5. Attendant care services when the participant is away from home

It is noted that the LTCS Authority will provide attendant care services whilst the participant is away from home. It is worth pointing out that not all trips away from home include a holiday. It is noted that Clause 5.7 says that Lifetime Care considers "*a reasonable notice period*" for domestic travel to be two months and for overseas travel to be three months, although this is seemingly limited to when there is a requirement for "*additional care holiday support*".

There may be circumstances where two or three months' notice prior to travel may not be possible. For example, travel interstate or overseas for a family member's funeral. Additional attendant care may be required to travel to attend such a funeral. Provided this is not classified as a "*holiday*" then Clause 5.7 presents no problem. However, if Clause 5.7 is intended to have general application to all trips away from home by the participant, then the restrictions in terms of notice become unreasonable. The Association submits that emergency circumstances should be accommodated and we invite clarification on the Clause.

PART 9 – EDUCATION SUPPORT SERVICES

Clause 2.3 Reasonable and Necessary Exclusions

The Bar Association is concerned with the wording in Clause 2.3(e). It is said that reasonable and necessary treatment does not include *"assistance with tasks that are the responsibility of a parent or guardian, such as supervising homework and helping to access the local library, other resources or project materials"*. We submit that this wording is overly broad and potentially an inaccurate reflection of what will and will not be paid for.

For example, a 17 year old HSC student when uninjured may need no assistance from a parent or guardian in terms of supervision of homework or help to access a local library. A brain injured 17 year

old may need such assistance. Where the need for assistance is not an issue of parental responsibility, but rather is as a consequence of accident related injury, then parents should not be forced to cease work or reduce the time spent assisting other children to undertake a supervisory task that, but for the accident, would not have been required. The Association recommends that the Authority redraft Clause 2.3(e) to more clearly delineate between parental responsibilities that would have existed irrespective of the injury and supervisory responsibilities created by injury.

PART 12 – TRANSPORT MODIFICATION (MODIFICATIONS TO A MOTOR VEHICLE)

The Association has no issue with the proposed amendments to the Guidelines subject to drafting issues to ensure preservation of current compensable rights.

At present, the Act and Guidelines make clear that the Authority will not pay for the capital costs of acquiring a suitable vehicle to modify. On this basis, there has been at least one instance where a CTP insurer has funded the capital costs of acquisition of a suitable vehicle (albeit only after a complaint to State Insurance Regulatory Authority (SIRA) – the insurer initially denied liability to pay on the basis that the LTCS Authority should be funding the capital costs).

The Association is concerned to ensure that nothing in the amendments to this portion of the Guidelines act to remove a CTP insurer's potential liability to pay such capital costs unless that liability is fully assumed by the Authority.

Section 141A of the *Motor Accidents Compensation Act* (MAC Act) provides that no damages may be awarded to a person who is a participant in the scheme "*in respect of any of the treatment and care needs of the participant, or any excluded treatment and care needs.*"

Section 141A(2) provides that section 141 applies whether or not the treatment and care needs are assessed treatment and care needs, whether or not the LTCS Authority is required to make a payment in respect of the treatment and care need concerned and whether or not the treatment, care or support is provided on a gratuitous basis.

A "*treatment and care need*" and "*excluded treatment and care need*" are said to have the same meaning as they have in the Lifetime Care legislation.

In the *Motor Accidents (Lifetime Care and Support) Act 2006*, treatment and care needs are defined in section 5A and refer to "*home and transport modification*" at (j). There is power to declare an excluded treatment and care need by regulation (such as the Guidelines).

At present, the capital costs of acquisition of a suitable vehicle are not a treatment and care need (because they are a capital cost rather than a modification) and have not been excluded by regulation. Accordingly, there is liability for the CTP insurer to pay for the capital costs of a suitable vehicle in appropriate compensable cases.

The Association is concerned that the proposed drafting of the revised Guidelines opens up an argument that capital costs may now be covered (at least potentially and in part) by the LTCS scheme or may otherwise be an excluded need. Either interpretation would be enough to remove the capacity for a scheme participant to recover the capital costs from a CTP insurer. This is presumably not the intent of the LTCS Authority in revising the Guidelines.

The inclusion in the Guidelines at Clause 2.3(b) that the purchase of a vehicle is "*not considered reasonable*" appears to bring the purchase of the vehicle within the purview of the scheme. It would be far better to have the declarative statement at the outset of this section that capital costs of the acquisition of a suitable vehicle are not covered by the scheme (consistent with the definition in section 5A of the Ac). On this basis, the Association recommends that section 2.3(b) should be removed.

Clauses 9 and 10 then become problematic in terms of the LTCS Authority assisting the participant to purchase a vehicle by making a contribution. By offering to put in a small amount the Authority may be having the effect of denying the scheme participant the opportunity to recover the vast majority of the cost from a CTP insurer.

If the LTCS Authority is actually intending to take over the field, in terms of always and fully funding the capital costs of acquisition of suitable vehicles where required, then that is supported. On the other hand, if the Authority's intent is only to make a small partial contribution in rare and unusual cases, then there may be the unintended consequence of removing compensable rights in all cases.

Further consideration and discussion in this regard is requested.

The Bar Association appreciates the opportunity to make submissions addressing concerns about the proposed Guidelines and seeks a meeting with the LTCS Authority to discuss the concerns set out above.

Should you have any queries regarding this letter please contact the Deputy Executive Director,

P.A. Selth
Executive Director