REPORT ON PROCEEDINGS BEFORE

STANDING COMMITTEE ON LAW AND JUSTICE

FIRST REVIEW OF THE DUST DISEASES SCHEME

At Jubilee Room, Parliament House, Sydney on Friday, 2 June 2017

The Committee met at 9:00 am

PRESENT

The Hon. S. Mallard (Chair)

The Hon. D. Clarke
The Hon. T. Khan
The Hon. D. Mookhey
Mr D. Shoebridge
The Hon. L. Voltz (Deputy Chair)

The CHAIR: Welcome to the first review of the Dust Disease and Lifetime Care and Support schemes. The Committee examined both schemes separately in 2014. However, this is the Committee's first review of the schemes since the Government introduced a suite of legislative reforms to the State's insurance and compensation schemes in 2015. Before we commence I acknowledge the Gadigal people, who are the traditional custodians of the land on which we meet. I pay respect to elders past and present, and I extend that respect to other Aboriginal people present. Today is the first of two hearings that we plan to hold in this inquiry. We will hear today from the New South Wales Bar Association, Australian Lawyers Alliance, Attendant Care Industry Association, Suncorp, NSW Agency for Clinical Innovation, Hunter Brain Injury Service, and Insurance and Care NSW [icare].

I will now make some brief comments about the procedures for today's hearing. Today's hearing is open to the public and is being broadcast live via the parliamentary website. A transcript of today's hearing will be placed on the Committee's website when it becomes available. In accordance with the Legislative Council's *Guidelines for the Broadcast of Proceedings*, while members of the media may film or record Committee members and witnesses, people in the public gallery should not be the primary focus of any filming or photography. I also remind media representatives that they must take responsibility for what they publish about the Committee's proceedings. It is important to remember that parliamentary privilege does not apply to what witnesses may say outside their evidence at the hearing. I urge all witnesses to be careful about any comments they may make to the media or to others after they complete their evidence as such comments would not be protected by parliamentary privilege if another person decided to take action for defamation. The guidelines are available from the secretariat.

There may be some questions that a witness could only answer if they had more time with certain documents to hand. In those circumstances witnesses are advised that they can take questions on notice and provide answers within 21 days. I remind everyone that Committee hearings are not intended to provide a forum for people to make adverse reflections about others under the protection of parliamentary privilege. I therefore request that witnesses focus on the issues raised by the inquiry's terms of reference and avoid, where possible, naming individuals unnecessarily. Witnesses are advised that any message should be delivered to Committee members through Committee staff. To aid the audibility of this hearing, I remind both Committee members and witnesses to speak directly into the microphones. In addition, several seats have been reserved near the loud speakers for persons in the public gallery who may have hearing difficulties. I welcome our first witnesses this morning from the New South Wales Bar Association and the Australian Lawyers Alliance.

ANDREW STONE, New South Wales Bar Association, affirmed and examined

GENEVIEVE HENDERSON, Australian Lawyers Alliance, affirmed and examined

The CHAIR: Would either or both of you like to make a brief opening statement?

Mr STONE: Each of us will say something, if we may. The New South Wales Bar Association very much appreciates the opportunity to address the Standing Committee on Law and Justice. We are reasonably regular visitors here. It is always a pleasure to be here and to share our thoughts about the way these compensation schemes are operating. The Lifetime Care and Support [LTCS] Scheme is very important to our members for a number of reasons. The first is that we care about our clients. The clients for whom we are pursuing compensable rights also have lifetime care and support rights and at times they seek our assistance in terms of whether or not they enter into the scheme, applications are brought by insurers to put them into the scheme, and also their interactions with the scheme. So we advise and act for them in a variety of ways.

Secondly, our clients have in many instances surrendered valuable common law rights in exchange for scheme membership—I am not complaining about that outcome, simply observing it—but the consequence is knowing what they have given up, I and we care about what they are getting back in exchange. In other words, we want to make sure that what they are getting is what they were promised when they gave up those common law rights in exchange for the benefits of this scheme. Thirdly—and this is looking a little bit forward—move five years into the future and every motor accident victim in New South Wales will be a member of the scheme because what is proposed under the Motor Accident Injuries Act is that after five years of an insurer meeting your treatment and care needs, provided you have more than a minor injury and provided you were at fault, these are the people who will then take over and administer your rights for life. Over time it is about to become a much bigger scheme and its efficient operation will remain of relevance to a much broader number of motor accident victims.

Mr DAVID SHOEBRIDGE: Provided you are not at fault.

Mr STONE: Provided you are not at fault. So everybody catastrophically injured is picked up and taken care of, those who can prove fault and have more than a minor injury will go into this scheme. That could be 4,000 or 5,000 people a year, rather than the current 200 year. It is a massive expansion over the horizon. I would like to acknowledge that those we interact with at the Lifetime Care and Support Scheme, their senior management, are open, approachable, consultative and clearly demonstrate that they care about those within their responsibility.

They are a pleasant group of people to deal with and I think it is important that we acknowledge that. But they have the limitation that they are bureaucrats and they have certain bureaucratic ways. You cannot blame them for that because they have a bureaucracy to administer and to run. This does at times mean that the process still is very paperwork intensive. It also means that they are not as strong as we think they could be in identifying weaknesses because Ministers do not let them put out annual reports that are critical, open and honest about what goes on—they are public relations jobs. By and large I repeat the adjectives that I used: open, approachable and consultative; they are a good group to deal with.

Having said that, our approach in particular to the guidelines under the Act is to not imagine this group of people in charge of them. These guidelines will affect people coming into the scheme long after I have ceased to hold a practising certificate and long after this group of people are running it. As I have said before, I view these guidelines as if they are being administered by the meanest, laziest and most incompetent person on secondment from the Department of Agriculture, because that is where the public service space happens to be that shuffles them into this scheme—I have just probably been remarkably unfair to those lovely people who work in the Department of Agriculture but I am trying to paint a picture.

The guidelines are what protect people in terms of their benefits and their rights. That is why the guidelines are so critically important to us. Those were pretty much the opening comments I wanted to make, save to suggest that there are four topics that we would encourage the Committee to talk to us about today should they sufficiently garner the Committee's interest. I thought I would throw it over to the Committee to choose, rather than me talk for the next 20 minutes. The first is that we still think there are improvements in scheme efficiency that can be made. Secondly, there can still be better monitoring and analysis of the underutilisation in the scheme.

Thirdly, that there are guidelines being proposed—they are nowhere near finalised but we have some very significant concerns about what those guideline changes may involve. Fourthly, both Suncorp and the Insurance Council of Australia had a dig at the legal profession in their submissions about lawyers trying to stop people getting into this scheme and the evil that that is, and I would briefly like the opportunity to respond to that, if you care enough to ask. Subject to the suggestion that they might be four topics we could usefully look at, I will hand over to Ms Henderson.

Ms HENDERSON: I am Genevieve Henderson, I am the representative of the Australian Lawyers Alliance [ALA]. We are a national association of lawyers, academics and other professionals dedicated to protecting and promoting justice, freedom and rights of the individual. So we are not a legal professional body to that extent; our remit is to look after an individual. The ALA has put a brief submission before the committee. We had the benefit of reading the Bar's submission before we did that and we are very much in agreement with what the Bar has put forward. I have had the opportunity to speak with Andrew before today and we agree—I agree and the ALA agrees—with the proposals that he has put forward. I think my role today will be to support Andrew mostly and to provide whatever information I can provide that he is unable to do so. But I expect the primary evidence will come from Mr Stone from the Bar.

The CHAIR: Thank you for those statements. I propose to have a free-flowing discussion, if that is all right with members. Mr Mookhey?

The Hon. DANIEL MOOKHEY: Are you responsible for people not getting into the scheme, as are the allegations that have been made against you by Suncorp?

Mr STONE: I cannot speak for every lawyer and the advice they give their clients about scheme membership, remembering that at any stage an insurer can apply to put somebody into the scheme and it is then up to the scheme to decide. They do an initial assessment, beyond that it can be reviewed by a panel of three, and beyond that it can be reviewed by a further panel of three. We have submitted that is an overly elaborate mechanism with too many review steps in it, in particular for the insurer. I can say that at a personal level I have been responsible for persuading a number of people to come into the scheme who had not been picked up as potential scheme members; two of them, one involved an accident in Wentworth and they had immediately been carted to hospital in Mildura and they did not get picked up across the border; another one involved an accident in Broken Hill where they were immediately flown to Adelaide, and they were not picked up.

New South Wales hospitals are reasonably good at picking up people to come into the scheme. When they are immediately taken out of the State they sometimes slip through the cracks. At a personal level I can say I have worked very hard to persuade some people, "No, this is a good scheme—join up for it". Others will occasionally instruct us they do not want to be in the scheme, and often they have had two years as an interim member, they are borderline on whether they will get into the scheme or not on a brain injury, and they would prefer to be out of it. In some instances, you can understand that because the scheme is intrusive, it involves going to somebody for permission for every item of expenditure for the rest of your life, and if you are marginal as to whether you belong in or out and you are capable of managing your own affairs that might be something you do not want.

Perhaps the best example of that—and I am here going to name a name only because it is a reported NSW Supreme Court decision, so I am not breaching any confidentiality—and that is the case of Mr Milton. Mr Milton was an Olympic skier; he represented the country as a paralympian in Sochi. He had been a member of the Lifetime Care and Support Scheme, he had a mild traumatic brain injury and an amputated leg—it was the amputated leg, I believe, that was the basis for his Olympic participation in the Paralympics. After two years he did not want to be in the scheme. The scheme assessed him and said, "That's fine. On your way". The insurer spent the next four years pushing through the review panel of three, the next review panel of three, a trip to a Supreme Court judge, and beyond that to the Court of Appeal, losing at every single stage, trying to get Mr Milton into the LTCS scheme in order that they not have to pay his ongoing treatment and care needs and in order that they be met by the LTCS scheme.

That sort of thing will hopefully disappear in five years because that financial incentive to avoid paying the future treatment costs of Mr Milton will go away because it will only be a five-year liability, not a lifetime liability. The argument in Mr Milton's case was whether he was just over the threshold for intellectual impairment or not, and there were suggestions that he had learnt how to use the Functional Independence Measure test and was manipulating the outcome to try and keep himself out of the scheme. To me, the better question is: why did Mr Milton so desperately want to be out of the scheme? My understanding is because he spent six months of the year travelling the world, engaged in his skiing pursuits, and he did not want to have the bureaucratic ball and chain, he wanted out and to be running his own life. But there are some people at the bottom edge who have that desire. I know that is a long way of answering your question but I have tried to do some education with it, but there are some people at the margins for whom this is not really suited to them.

Mr DAVID SHOEBRIDGE: And by not entering the scheme he retains his ability to recover a lump sum for the future medicals, which he can then deal with in his own way?

Mr STONE: And he gets his independence, yes.

Ms HENDERSON: Could I add something from the Australian Lawyers Alliance's position? I agree with what Mr Stone has said. From the lawyers' position, our role is to provide advice as to the options that are before somebody, and we outline the pros and cons of both schemes. I agree with Mr Stone, in some instances the pros and cons weigh one way or another, but the decision is always the client's, it is never the lawyer's. This scheme has been around for a little while and I probably acknowledge that at the beginning lawyers were afraid of it and thought it was terrible. But I am sure that has gone—certainly from the Australian Lawyers Alliance point of view. Our role is to provide the best advice to the clients and for them to make the decision.

There are people who do not wish to be in this scheme and it is true that this decision is made after two years. So I have had the experience of the scheme. It is not true that a lawyer can prevent someone from going into the scheme, and Mr Stone has outlined one way an insurer can make sure that someone does go into the scheme, and that is through Lifetime Care and Support making a decision and then going through the internal review processes. But there is another way, and this is one of the Australian Lawyers Alliance's positions in our paper. There seems to be a gap in the legislation that repeat applications can be made for people to go into the scheme.

I have a client, I will call him Mr Brown, he had his accident five years ago, he was entered into the scheme as an interim participant. At the two-year mark his eligibility for lifetime participation was assessed to be no, he had sufficient capacity—it was a brain injury—to come out of the scheme. The review period is six months within the scheme, and no application was made to review that decision. Mr Brown did not wish to be in the scheme. He was an intelligent person who lived in the eastern suburbs, he had capacity, he had good support, so he thought he could deal with it himself so he would know the decision from him was not to go in. Two years after the review period had expired, the insurer made a further application to put him into the scheme. They did it in what I do not think is a very upfront way because they did not disclose the reason for the medical assessment in the correct way—sorry, I withdraw that. What they did was they said, "We would like to make an assessment for him to go into the scheme".

At that time the law said you could not force someone to go through that assessment. The law changed; they went through with the medical assessment, made an application and now he is back in the scheme. So the effect of that is only that that has delayed resolution of his claim, because with common law benefits that decision must be determined one way or the other, and he has expended legal costs and time preparing a case which included his future care needs, and now they have gone. That is something that the insurer has done and is always available to them. So Mr Milton probably does not have to go through that process; they will just go, "We are not going to the Court of Appeal anymore, we are just going to put a new application in".

Mr DAVID SHOEBRIDGE: To work out the practicality of that, if you have a modified common law damages claim on foot including future medical expenses and the insurer then puts on a late application to go into the scheme, does that prevent the final resolution of the common law claim?

Ms HENDERSON: No, it does not prevent the final resolution.

Mr STONE: It delays it, yes. I have had a case where it was delayed two years while an insurer fought endlessly to try and get my client into the scheme.

Mr DAVID SHOEBRIDGE: Was that delayed by operation of the Act or delayed because a submission is made to the court to say, "We do not want you to do this because we have this outstanding application". Is it a kind of court case management thing?

Mr STONE: Delayed because he cannot finalise his rights until you know whether he is in or out of the scheme.

Ms HENDERSON: Exactly.

The Hon. TREVOR KHAN: Sorry, at least for me that is non-responsive. Is that because of the Act?

Mr DAVID SHOEBRIDGE: Or it simply because the insurer says, "Look, we have got the application. We want this other application resolved before we get a trial date?" Could a Supreme Court judge say, "This is the third time you have done this. Bugger it. We are going to set a trial date"?

Mr STONE: Yes, a court could force it on while the application is pending.

Ms HENDERSON: Yes, except this one is a Claims Assessment and Resolution Service [CARS] matter, the one I am dealing with. We are not in the court system.

Mr DAVID SHOEBRIDGE: But CARS could force it on but there is a compelling argument against them if they say, "Well, we may not be liable for these future costs?

Ms HENDERSON: Absolutely, quite so.

Mr STONE: Correct, and the moment a CARS assessor said, "No, I am going to force it on", you would expect the insurer to be hauling it up to the Supreme Court to stay it pending the outstanding application to Lifetime Care. There are a couple of simple things that could be done to improve the efficiency. First, there could be better coordination between Lifetime Care and the State Insurance Regulatory Authority [SIRA] because they are now separate agencies over the regulation of insurer conduct in this area because you have one agency that cops the brunt of, namely, Lifetime Care processing people in and out but SIRA regulates the conduct of the insurer driving the challenges to put people in.

I think there is a shortfall in coordination. Second, Suncorp have made what is a very sensible suggestion, namely, where there are delayed applications do not wait then the two-year interim period. The two-year interim period was designed to allow maximum recovery from brain injury before you made a decision about permanent membership. But it basically means that any application after two years should not go through that interim membership; it should be considerably shorter, and indeed on occasions where there has been a belated application—my chap in Broken Hill was a flail arm; it was the equivalent of an amputation at the shoulder and when I picked it up and persuaded him to make the application, that was three to four years after the accident and they then made a decision on making him permanent within a month or two after that.

That is the way it should operate all the time once you get beyond two years. That is a suggestion in the Suncorp paper and I would support it. The other thing is you could look at removing the right for the insurer to make repeated applications to put people in. That really is meant to be a safety net for a claimant who takes a turn for the worst. It is not meant to be an out clause for an insurer whose lawyers can scramble around trying to find any grounds to get the individual insurer out of the liability by offloading it on the scheme. They are some practical suggestions of how you could improve efficiency and resolve those sorts of disputes.

The Hon. TREVOR KHAN: Or could you limit it to one further?

Mr STONE: I have no difficulty in doing that to an insurer. I am a little more reluctant to do that against an injured person who is trying to get into the scheme.

The Hon. TREVOR KHAN: I think we have had these sorts of discussions before.

Mr STONE: Yes.

Ms HENDERSON: I agree with Mr Stone on that last because not everyone is legally represented and is aware of their rights. They might have some late access, so I think that would be better.

Mr DAVID SHOEBRIDGE: You could say ordinarily a maximum of two and then say a claimant could make an additional one where there was a significant change of circumstances or that sort of rationale?

Mr STONE: Yes, but some heat will go out of this in five years time because there will not be that advantage to the insurer to put people into the scheme; all they will be doing is avoiding their first five year liability not their lifetime liability.

The Hon. DANIEL MOOKHEY: Some people have suggested that the transfer after five years creates an incentive to delay the medical treatment in the first five years on behalf of insurers on top of that to otherwise try to minimise expenditure without any visibility to the scheme at the point of transfer or to SIRA of any oversight at all. Do you think they are valid concerns?

Mr STONE: A good and genuine concern. It is a concern that exists in other places within the new Act as well. For example, everybody gets six months of no fault benefits and then you move on to proving fault. If you are a motorcyclist who has lost a leg in a single vehicle at-fault accident, I do not know that you are going to be getting many prosthetic expenses approved at five months and two weeks when the tap turns off at six months.

The Hon. TREVOR KHAN: I do not think if you had lost a leg—I suspect there would not be too many at six months.

Mr DAVID SHOEBRIDGE: They would be fitting you a prosthesis but it is an extreme analogy.

The Hon. TREVOR KHAN: I get the drift.

Mr STONE: That is a separate issue but there are two of those changeover points in the Act is my point, rather than just the one at five years. There is also exactly the same problem at six months.

The Hon. DANIEL MOOKHEY: Do you think, therefore, that there ought to be an aspect of transparency around the care provided in the first five years and for the purposes of assessing liability for the Lifetime scheme is there a role for SIRA to have any oversight of that? As I understand it, it is pretty hard for an actuarial estimate of what your liabilities are for the scheme if you have no idea what is happening to a person's treatment in the first five years?

Mr STONE: I do not think it is impossible because they have some modelling from Victoria. Whether that will be replicated in New South Wales, we just do not know. I have my submission that they are underestimating what will be the utilisation rate post-five years and its cost but that is probably a discussion for a different Act and a different day.

Mr DAVID SHOEBRIDGE: And almost certainly there will be some complicated negotiations between icare and the insurers which may take into account an underservicing premium that will be paid on top if a claimant is transferring, but that is another Act?

Mr STONE: Yes, but the final model of the bill was an improvement over the initial model that did not necessarily have a bulk bill rate where it was individual cases being costed and sold versus selling the entire class of liability. It is obviously much easier to sell a class of liability than it is to try to pick through individual cases, so that is a significant improvement in it.

The Hon. DANIEL MOOKHEY: I accept that; that is interesting, but what does that mean for a person's care in the first five years when prospects of recovery to make decisive medical impact is statistically much higher—

Mr STONE: Absolutely.

The Hon. DANIEL MOOKHEY: —if their treatment pathways are being subject to essentially perverse and financial incentives, what does that mean for their care?

The Hon. TREVOR KHAN: Sorry, I do not want to be rude but does this fall within our terms?

Mr STONE: I think I said that I suspect that is not this Committee but that requires SIRA to be a good regulator.

Mr DAVID SHOEBRIDGE: It is a different scheme.

The Hon. DANIEL MOOKHEY: I accept that but it is a state of a person's care at the point of entry to this scheme is why I am asking this.

Mr STONE: And it is important that they have been well looked after before the transition, although again that is five years and six months away from being this scheme's problem.

Mr DAVID SHOEBRIDGE: It is technically not this scheme; it is technically a different scheme but is done by the same authority?

Mr STONE: No, two different authorities—SIRA and icare; what one is selling to the other.

Mr DAVID SHOEBRIDGE: Going back to this resistance to enter the scheme, it comes down to how the scheme is responding in the interim and when it is made a permanent determination. One of the issues you raised is the independence of scheme participants and the concept of being handed a budget rather than having individual expenditure items. Can you talk about that?

Mr STONE: Certainly the National Disability Insurance Scheme [NDIS], remembering that Lifetime Care was the forerunner to the NDIS—and a number of people who helped develop Lifetime Care went on to help develop the NDIS—is very much based around participant choice and independence; in other words, give people a budget and trust them to spend it. I know that has been something that Lifetime Care has been working on. I think the bar asked the question last time round at this inquiry exactly how many people have moved on to such a budget in terms of having an annual expenditure and I am testing my memory but there were not many, if any.

A good question for them this afternoon might be: How many have you succeeded in getting onto a budget rather than having line item approval of individual expenditure and what is your target in two years time when we have you back and report on how well you are doing on the target when you come back. That is a really important aspect for people. I have been told anecdotally in one instance overseas where they said, because it is very hard to monitor, "Here's your cheque for the budget. Tell us at the end how you have spent it. If it has been sensible, we will do it again next time." I would like to think that amongst the capable there will be more and more of that occurring over time because that is very much the independence goal rather than the cap-in-hand-for-everything goal.

Mr DAVID SHOEBRIDGE: Ms Henderson, are you in private practice?

Ms HENDERSON: Yes. I am in private practice.

Mr DAVID SHOEBRIDGE: Do you have examples from your private practice or your colleagues where you have heard of difficulties in terms of individual expenditure approvals? Is it going well? Are there instances where it is not working?

Ms HENDERSON: The answer is that it is variable and depends on the individuals within the Lifetime Care and Support Authority that are dealing with it. So, the quality of the people who are making the decisions is important. They are generally very good, but some care plans are much better than others. They are overly bureaucratic. I do have some examples where the experience is quite poor and the participants are being "put through the ringer", their words, to get individual line items approved where it seems to be unnecessary. One example was within the first two years, the person had quite high care needs at that point. They were catastrophically injured. They felt the boxes they had to tick to get what was an obvious piece of equipment was too much. This person that I am thinking of had quite severe psychiatric injuries arising from the catastrophic injuries from the car accident. In that instance a little bit less bureaucracy and more heart would have been better. I am hoping that things have moved on with Lifetime Care, that they are being less bureaucratic. That example led to some adverse outcomes.

The CHAIR: There would be some people that have been in the scheme for a long time.

Ms HENDERSON: This person was in the interim period and did not wish to become a lifetime participant, even though it was quite clear they would have to because of the extent of their injuries.

The CHAIR: People who have been in the scheme for a lifetime may have adapted to the bureaucratic model versus independent model.

Mr STONE: Some people tell you it has been the best thing that has ever happened to them and they have had a Rolls Royce run through it. Other people, in particular young men with brain injuries, they have an outreach problem getting to them and getting them to engage. Some people turn fighting Lifetime Care into their lifetime goal and they are going to be difficult throughout. It is a real mix. As Ms Henderson has said, that depends on the quality of the case manager, their degree of advocacy and if you are a case manager with 80 files it is human nature to have favourite clients and some that sit in the too-hard basket. It is a challenge for any bureaucracy when you are monitoring the individuals to work out which ones are in the too-hard basket and how to help get them out of the too-hard basket and do something about it.

The Hon. TREVOR KHAN: In practice you have the same problem?

Ms HENDERSON: Absolutely.

Mr STONE: I am not pretending I am any different. I am human. They also have a couple of bureaucrat shibboleths. They cannot get over the idea that any family member might ever receive reimbursement for anything. They would rather spend vast amounts of money than cut a cheque to a member of a family. I will give you an example. A solicitor rang me and said, "I have a brain-injured client who lives in Cootamundra. He needs to go to Wagga for a medical appointment once a month". There is no public transport between the two. "Currently his sister is taking a day off work a month and driving him to Wagga and back. It is helpful that she is there to explain what happens at the appointment, but she is missing a day a month. She has asked Lifetime Care can they make up her wage for the day and they have said, 'No'. What can we do?" I said, "You will not get anywhere with that."

The Hon. TREVOR KHAN: So you pay a taxi and three times as much?

Mr STONE: You will not get a taxi between the two. The sister said, "I am not doing it". Next week Lifetime Care will supply a car. There are no cars in Cootamundra, so it will have to come from Wagga, and if need be an attendant carer in the car, will come from Wagga to Cootamundra, pick him up, drive him back to Wagga, wait to the end of his appointment and take him back to Cootamundra again. They would rather write a $3,000 cheque a month for that than write a $250 cheque to his sister because one of their ironclad rules is "we will not pay family members".

Mr DAVID SHOEBRIDGE: Putting to one side the expense, for the participant going with your sister would be preferable to going with a stranger?

Mr STONE: Plus, she is an asset at the medical appointment in saying what he has been like. That is one of the hang-ups, they have a real issue with the family member being compensated for doing anything.

Mr DAVID SHOEBRIDGE: You have raised this with icare since December 2015?

Mr STONE: Longer than that.

Mr DAVID SHOEBRIDGE: There is the outstanding process about the guidelines. Where have you got to on this issue with the guidelines?

Mr STONE: We really do not know. They are updating their guidelines. We have no issue with that. There have been a number of positive improvements. We have supplied the Committee with the Bar Association submissions, the two lengthy feedback documents we have given them. The changes to the guidelines raised a number of specific concerns for us. We have had productive meetings. We have told them about the concerns. The extent to which they have listened, taken it on board and changed we have no idea because we have not yet seen the next round. They have told us that they will come back to us with the entirety of the guidelines before they bring them up here for final approval.

The one that worried me most and at the broadest level: The Act used to provide that every participant was entitled to their reasonable and necessary expenses. Following a Court of Appeal decision in case of Thiering the Act was amended under then Minister Pearce and it basically gave Lifetime Care the regulatory capacity to define what reasonable and necessary meant. They gave them the regulatory power to call black white. I had been comforted by the protection in the Act that whatever the guidelines said they could not take away the provision in the Act that said if it was reasonable and necessary for you the Act gives it to you. The sop was that within the guidelines there was a clause that still protected people. It was, "reasonable in the circumstances".

There was a discretion to waive the guidelines in an individual case if it was reasonable to do it. They are looking at removing that clause, which is the final discretionary protection against an unjust outcome in the guidelines. I would be particularly disappointed if that final protection for people was removed. It is rarely utilised, if ever, but it is knowing that there is long stop provision, that there is someone you can tell, "This set of rules does not work for me". Here is why it is fair in the circumstances. "Can someone exercise a discretion or power to help me out?" I am concerned about the removal of that.

The Hon. DANIEL MOOKHEY: What reasons have they given you for its removal?

Mr STONE: Crown Solicitor's advice, which I have not seen and do not understand.

The Hon. DAVID CLARKE: The Cootamundra situation, where they will not pay the sister $250 but they will pay $2,000. How long has that situation been going on for?

Mr STONE: The resistance to paying family members to do anything has been foundational bedrock of the scheme. It comes from the good point of view that we do not want family members to be carers, we want them to be family members, we will provide paid care where it is required. If you do not want paid care and instead you want to stay home and look after your child or you do not want strangers in the house, in some instance they are good at finding other flexible ways in which to help you. In some cases they are not. It, in turn, means that there are a number of people do not use the amount of care they are provided in the care plan because family choose to do it themselves. That is their right. I am not saying in every circumstance they should be paid. But the Cootamundra example is one where it just makes sense.

The Hon. DAVID CLARKE: Getting to the core of it, who would make that decision that, no, we are not going to pay the sister? Where is that decision being made? Who is making that decision?

Mr STONE: The case manager would make the recommendation that it occur to whoever the coordinator is at Lifetime Care and the coordinator would make a decision and that would be subject to review.

The Hon. DAVID CLARKE: Is it not a policy decision, not just a carer making an individual decision?

Mr STONE: It would require an exception under the guidelines because the guidelines provide we do not pay family members. It is institutionally ingrained. There are some legitimate reasons for it, but there is a lack of flexibility in some circumstances.

Mr DAVID SHOEBRIDGE: There is another aspect about the concern of payment for family members. It is a blanket prohibition on paying for services that are deemed as parental responsibility. Are you aware of this?

Ms HENDERSON: Yes, I am. If I am a parent and it is my job to make breakfast for my child, that is my job to make breakfast for my child, whether I can do it or not. That is not something that I can get a benefit from under the scheme.

Mr DAVID SHOEBRIDGE: It has been explained to me that one example when they do not pay is if you have a child with a significant disability who is a member of the scheme and they need to go to a doctor as a result of the injury, or a medical service as a result of the injury, they are saying, "We are not going to pay for the parent to take a day off work because they are parent and they have to do that anyway"?

Ms HENDERSON: Exactly. That is exactly the example Mr Stone has just outlined. It is not just Cootamundra, it is any medical appointment.

Mr DAVID SHOEBRIDGE: There are two things. One is the blanket issue about family members, but the other is that they seem to have an issue about parental responsibility as a separate class of exemption for payment?

Mr STONE: That is a little bit separate. Their view is that parents ought to discharge parental responsibility. I do not have an issue with that approach. They say, "We will assist the parent so they can discharge their parental responsibility. Sometimes people are so badly injured that they just cannot discharge it. For example, I am a single parent, I have a child, the child has to get to and from ballet practice at the end of school.

Mr DAVID SHOEBRIDGE: Tell me about it.

Mr STONE: They will assist me to get the child to and from ballet practice. But the question is: If I cannot be assisted, if I am a quadriplegic and on this particular day I am not up to it, do they then provide the carer who will take the child to and from ballet class, or is it only if they can get me up, get me out of the house and get me into the van so I can be in the van as the child goes to and from the class? That qualifies as assisting me, but they will not do it on the day that I cannot do it.

The reality is that they fudge that line an awful lot, but if you ask them to make a decision around that line, they get a little prickly in some cases. For example, the proposed new guidelines, and I am hoping they back down on some of these, say they will not meet the cost of assisting you with a child that you choose to have after the accident. I have a real issue about the authority telling people, in particular a young couple or a young paraplegic father, "Your wife desperately wants children as part of her relationship with you, but if you go ahead and have a child, we will not help you be a paraplegic dad."

Mr DAVID SHOEBRIDGE: Do they have a one-child policy, or a no-child policy?

Mr STONE: It could be a no-child policy. They have a no-more-children policy, or at least it is not their responsibility if you choose to do it. But I think they could be a little more flexible on that, and I am hoping they back down on that.

The Hon. DANIEL MOOKHEY: Would this issue resolve if this scheme were to be refigured and redesigned around the annual NDIS expenditure that you propose?

Mr STONE: Not necessarily, because it would still depend on what they built into the budget, because if they do not build the child into the budget, then that does not change it if it is a lump sum.

The Hon. TREVOR KHAN: You are spreading the money thinner.

Mr STONE: Yes.

Mr DAVID SHOEBRIDGE: I have not taken your submissions to be "we need to wipe the slate clear and start again".

Mr STONE: No.

Mr DAVID SHOEBRIDGE: I have taken your submissions to be that, by and large, this scheme provides enormously valuable services in an effective way, and we have got to make it better. Is that your submission?

Mr STONE: And keep an eye on these regulations. If they have listened to us and all of these rough edges that have somehow appeared in the proposed regulations get sanded back because of the submissions we have made, then there is no issue. On the other hand, if in 12 months time they still contain all of the prickly parts that have caused us so many concerns, you will be hearing from us: Can somebody please inquire into a regulation before it is passed, because this is an incredibly important package for seriously injured people and it has got some ugly and overly prescriptive bits in it, which is not the deal that everybody signed up to—in short form.

The Hon. TREVOR KHAN: If there was a change in the guidelines, what is the impact on people who are already in the scheme?

Mr STONE: It is retrospective.

Ms HENDERSON: It applies, yes.

Mr STONE: It applies to everybody in the scheme. There is no grandfathering of on old regulation and a new regulation.

Ms HENDERSON: I have been part of some of these meetings with Lifetime Care about the regulations and, as I understand, they are becoming more and more prescriptive of the guidelines. They say the purpose of that is to give certainty to the participant about what they can and cannot apply for. As you become more prescriptive, you become proscriptive, and if they remove the reasonable and necessary overlay, then it becomes quite draconian and the examples we are raising become obvious. They are becoming more and more detailed in what they will and will not allow you to apply for, but the effect is they are cutting things out and there have been unintended consequences.

The Hon. DAVID CLARKE: Let us take one of those prescriptive examples. You spoke about the wife who wanted to have a child and used the term one-child policy. In fact, after the accident, it is indeed a no-child policy.

The CHAIR: They will not support the child.

The Hon. DAVID CLARKE: That is right.

Mr STONE: I could be beating up on something and they have already made an internal decision, having heard from us; that is a really bad idea, did not realise it—whoops—it is gone.

Mr DAVID SHOEBRIDGE: That was their proposal.

Mr STONE: In fairness, it is a proposal. We have spoken against it and we do not know if they have abandoned it or not, but it sufficiently concerned me that I wanted to ventilate it here in terms of this is the sort of stuff to watch out for if it is still in there, because these are things that concern us.

The Hon. DAVID CLARKE: It certainly existed at some stage?

Mr STONE: No, it has not been their current policy; it is their proposed change of policy that we have spoken to them about, not making their change of policy and we do not yet know what they are going to do.

The Hon. TREVOR KHAN: The other problem is that it assumes that conception is a choice.

Mr STONE: You might have noticed that we mentioned that in our submission. There are some brain-injured young people who make some poor choices as a consequence of their brain injury.

Mr DAVID SHOEBRIDGE: It does not require a brain injury.

Mr STONE: No.

The Hon. TREVOR KHAN: Seeing as we have been through the abortion debate, the level of failure of contraception is frighteningly high. How I got through, I have no idea. It leads to this problem: The child is conceived, not because you were looking to have a child, you were simply looking to have sex.

Mr DAVID SHOEBRIDGE: You put the broader philosophical point that you should not be constraining somebody's choice about having a family, simply because they have had a severe motor accident?

Mr STONE: To give you an example of the prescriptive, the new guidelines say they have an obligation to assist with household maintenance but they will not attend to internal or external home decoration or renovation, which is fine, except if you are a paraplegic who wants to hang up the odd picture and that is a little hard if you are in a wheelchair, unless all your pictures are down at ankle level. It is that degree of flexibility that is concerning.

The Hon. TREVOR KHAN: What were they looking to address?

Mr STONE: I think it is a case that I argued with them over somebody who lived on more than a quarter acre block at Camden, had bigger than average garden. It might have been described as a show garden. We argued with them that it is a bigger garden; some people live in flats, some people have bigger gardens, they take them as they find them. It gives them pleasure to have the garden, can we have a bit more than the usual amount of garden? That then brings about the bureaucratic response of "rein it in", otherwise ask them.

The CHAIR: It goes to the underlying philosophy, but what is the philosophy of the approach to caring for people in the scheme? Is it quality of life and a holistic enjoyment of life, or is it the basic medical and physical needs that you have to meet?

Mr STONE: They pay for gardening services, but they do not want to cut it back to beyond what is required for safe and easy access to the house and immediate garden/land area. Again, if you are the paraplegic and enjoy looking at your garden, well you do not need to access it. Can it be an overgrown jungle, or are you entitled to have someone weed your garden beds?

Mr DAVID SHOEBRIDGE: They mow a path to the compost out the back but the rest of it goes to ruin.

The Hon. LYNDA VOLTZ: That is not necessarily true, from what you are saying, because they are saying "the immediate precinct". The guy at Campbelltown had a quarter-acre block?

Mr STONE: It was bigger than a quarter acre. I think it was an acre or so.

The Hon. LYNDA VOLTZ: I assume when you talk about farmland, there are greater difficulties?

Mr STONE: I certainly do not think they have the duty to maintain a hobby farm. You have to strike some balance. One thing they want to build in is that the service is "frequency to a level not exceeding acceptable community standards". That is okay, except who exactly is judging community standards and where are they articulated? Particularly if they put that to some of the doctors who run this scheme, they may or may not be—

Mr DAVID SHOEBRIDGE: I do not think doctors are good judges of community standards.

Mr STONE: Otherwise it goes to the occupational therapists and the OTs become the judges of community standards.

The Hon. DANIEL MOOKHEY: Is there an alternative to such a prescriptive approach?

Mr STONE: Yes, take each person as you find them and work it out.

The CHAIR: The independent budget approach you were talking about before.

The Hon. DANIEL MOOKHEY: But your point about the independent budget approach is that you still have to determine what is recoverable?

Mr STONE: You still have to work out the basis for calculating the budget.

Mr DAVID SHOEBRIDGE: There is not perfection in either model.

Mr STONE: No.

Mr DAVID SHOEBRIDGE: Completely removing guidelines would make it an utterly discretionary outcome, which would produce other unfairness. You are saying that there needs to be some pressure valves, some flexibility in the guidelines, because the world is infinitely complex and guidelines will always be prescriptive.

Mr STONE: Yes.

Ms HENDERSON: Yes.

The CHAIR: These things arise, particularly from bureaucrats, because at some point in time there has been an abuse. Some one has exploited, not necessarily a person, a scheme member, but someone associated with the scheme has exploited a benefit, and they put in these prescriptive rules all the time. We do it all the time as parliamentarians.

Mr STONE: I think abuse might be unfair. I think asking for my client to have the garden that she had maintained for 40 years and loved still maintained does not necessarily fall within abuse.

The CHAIR: I agree, and I am not suggesting the lawyers are doing it.

Mr STONE: Perceived excess might be a better phrase, if I could suggest that.

The Hon. LYNDA VOLTZ: Sometimes you need guidelines to ensure they are not whittled away; that gardening is not a reasonable expectation you should receive when you under the lifetime care. It is also important to have guidelines.

Mr DAVID SHOEBRIDGE: Most people get their needs without fuss, but some people go beyond it and are being cut off.

Mr STONE: Or some people who sit fit outside the regular box. That is why I come back to discretion is so important as being the power to say "You don't fit the cookie cutter model so we need to look at you more as an individual" and what can we do? I have got to say in some cases they are very good at doing it.

The Hon. DANIEL MOOKHEY: I do not necessarily share this view but the contrary view is if you enable discretion in a scheme that has such a long-term effect, it is very difficult to calculate liability. Is there a compromise between the two views that is not being reflected in the current scheme?

Mr STONE: This scheme is certainly not short of money. It is over funded rather than underfunded and the under-utilisation rate keeps it in very healthy surpluses—by under-utilisation rate I mean the people who have plans written, for which premium is being collected, and who choose not to use it.

The Hon. DAVID CLARKE: There are rules and there has to be discretion. What is the solution?

Mr STONE: We say that the current drafting within the guidelines that retains the discretion where it would cause undue hardship, you can ask the authority to waive the guidelines. That removes some of the pricklier, overly prescriptive stuff they are looking to put in now.

Mr DAVID SHOEBRIDGE: We are having a discussion in some ways about there are parts of the status quo you want to retain, which is the discretionary element—

Mr STONE: Yes.

Mr DAVID SHOEBRIDGE: But there are other parts of the status quo that are producing unfairness and unnecessary bureaucracy. The problem is that there is an outstanding proposal from icare but we do not know whether it has landed yet?

Mr STONE: Yes.

The Hon. DANIEL MOOKHEY: I refer to the line item "budget control". Are there any compelling reasons for its retention for people who are able to make their own decisions?

Mr STONE: No.

Ms HENDERSON: The only one I can think of is the choice of the participant. They may prefer it. They might not want to take over control but that would be the only one; the choice of the participant.

Mr STONE: And you are dealing with a cohort, many of whom are not necessarily up to the task, but a good number of whom still are. This includes people with a very severe brain injury where there needs to be a relatively hands on approach. But equally intelligent people in a wheelchair who have got nothing wrong with what is between their ears ought to be being encouraged in independence. I think good steps have been taken to try to work out what is the annual budget that the average paraplegic spends. They may be able to tell you that they have made great strides in that department in terms of approving pharmacy accounts and budgets. It might be there is a success story there that they can tell you about, but that should certainly be the goal.

The Hon. DANIEL MOOKHEY: Assuming we have made decisions about what is recoverable and what is not for the annual budget, is there a need for a scheme akin to the NDIS authorised provider scheme that is a barrier for entry to people who wish to provider services?

Mr STONE: There currently is. They have authorised providers.

The Hon. DANIEL MOOKHEY: Are the fees paid to authorised providers essentially centralised? Please excuse my ignorance but is it akin to Medicare where the Government aggregates the buying power and uses it to leverage prices down for everybody?

Mr STONE: Yes. There is a competitive tender that, in turn, causes me some occasional concerns about quality.

The Hon. DANIEL MOOKHEY: In your view should we shift to an NDIS style budget, it would have no implications for the effect of the collective buying power of the scheme?

Mr STONE: I think you need a mix. You are always going to need some people who need hands on intervention to get the best out of the scheme. There will be others who ought to be being encouraged to be independent, and it is about getting the right mix.

Mr DAVID SHOEBRIDGE: It is a false dichotomy because you can have your own budget but you can actually then go and get your services from a provider who has been—

The Hon. DANIEL MOOKHEY: No, I am not suggesting that I agree with any of these arguments but I would like your views so we can put them to icare if it were to say that this would result in higher buying costs.

Mr STONE: You would have to ask them that.

The CHAIR: Our secretariat have suggested some questions which I think we owe a duty to ask because they have done the research with us.

The Hon. TREVOR KHAN: We are not, actually.

Mr DAVID SHOEBRIDGE: Can we put them on notice?

The CHAIR: I would like to hear the answer because it is to inform me for questions later on. In your submission you note that participants do not have the intellectual capacity to suit their care plan. Do you have any suggestions that would ensure that these participants are being heard and represented?

Mr STONE: We have frequently said over the years that a right to challenge is only as good as your capacity to exercise it. I understand from discussions with them last month or the month before that the authority is in the process of having a number of the representative associations to be more engaged in providing advocacy services for scheme participants. We view that as a very important development. We are not sure if those agencies will have the technical skills, once you get into formal dispute processes because there is no legal fees in any of this so we tend not to have any involvement unless it happens to be I do it as a labour of love for people who are with me for compensation claims, and I have done that on a number of instances, as indeed has Genevieve and others engaged with lifetime care on our clients' behalf. So I think that is a really important question to ask them about what are they doing to ensure people have access to adequate resources to raise queries and challenges to their plans.

Mr DAVID SHOEBRIDGE: Ms Henderson, will you step us through the process? For example, someone has severe burns and they may think that they need a particular kind of burns suit to wear, and there is a dispute about the provision of that, that is, whether it is a full body or partial body one. It might be a $3,000 item. Lifetime Care and Support want to provide a $1,000 item but they want a $3,000 item. What happens?

Ms HENDERSON: That creates a dispute. The plan is drawn up and it has to be justified. If it cannot be justified then it creates an internal review which is generated by the participant and they go through a three-steps review process that Mr Stone has described.

Mr DAVID SHOEBRIDGE: The first stage?

Ms HENDERSON: An internal review.

Mr DAVID SHOEBRIDGE: The second stage?

Mr STONE: A single assessor.

Mr DAVID SHOEBRIDGE: Then you go to a panel?

Ms HENDERSON: Yes.

Mr DAVID SHOEBRIDGE: Number three, also internal?

Ms HENDERSON: Also internal.

Mr STONE: Semi-internal. They are independent doctors and occupational therapists off a panel that the authority puts together.

Mr DAVID SHOEBRIDGE: If you disagree with that panel?

Ms HENDERSON: It ends.

Mr STONE: It ends. It is only the scheme eligibility that has got three layers. It is two layers within the scheme. The scheme writes a plan. If you are dissatisfied with the plan it can go to an assessor and it goes beyond that assessor to a panel of three, if you can show an error in the original assessor's decision.

Mr DAVID SHOEBRIDGE: Eligibility has two semi-internal icare formulated—

The Hon. TREVOR KHAN: Just before you continue, if you can show an error in the original decision of the assessor, who makes the assessment of whether there has been an error in the original assessor's decision? Is that a gateway before you get to the panel of three?

Mr STONE: Yes.

The Hon. TREVOR KHAN: Who assessors that there is a mistake?

Mr STONE: There is a proper officer in the Motor Accidents Scheme. I do not think it is as clearly specified in this scheme—I have not had to look at it for a while—but there is a bureaucratic review of whether you have identified an error in the original assessment. The last time I had to do this was the Camden show garden. We asked for the gardening beyond, they said no. We then went to the single assessor. The single assessor said you can within six metres of the house. We said, "That's nuts." Does that include the gazebo? Does it include the garage? Why six metres? Are you going to stake out the lawn for where the mower man can and can't go? We said that is not a good legal decision. We went to the proper officer. We went to the panel of three. The panel of three came up with a different decision. We then actually sat down an negotiated an outcome with them. That all took more than six months.

Mr DAVID SHOEBRIDGE: This Committee carried out a compensation review. The way workers compensation decision-making operates is a dog's breakfast. This Committee suggested there should be a single jurisdiction to deal with those kind of disputes, hopefully separate from icare or SafeWork. Is there some merit in looking at a jurisdiction if you are going to establish that kind of jurisdiction to also give it an independent review of some of these issues? Personal injury raises common issues across the different schemes.

Mr STONE: You would hope that there could be a simple system that would deal with 95 per cent of these sorts of disputes internally, quietly, quickly and fairly. I am not wanting to build a large edifice for dispute resolution.

Mr DAVID SHOEBRIDGE: We are all on the same page there. It is those tricky ones that bounce out the high-cost ones, the principal disputes.

Mr STONE: Especially if you are going to start introducing community standards as one of the primary reasons to say no. That does not necessarily go to three rehabilitation positions that may or may not be at the forefront of determining what our community standards for whether something should be done. That is the area where you might look at: Can you improve the current dispute system?

Mr DAVID SHOEBRIDGE: If you are going to establish a decent personal injury specialist tribunal to deal with, say, workers compensation, then that would potentially be a convenient spot to put some of these intractable disputes from these schemes.

Mr STONE: A bigger conversation for another day.

The Hon. DANIEL MOOKHEY: How many intractable disputes are there? How common is it?

Mr STONE: Not many. Fifty per cent-plus are enormously satisfied with the service they are getting. There is then the next percentage who I suspect a little bit grumbly but live with it. Then you have got a very small percentage grumbly about it and are actually prepared to do something about it.

The Hon. DANIEL MOOKHEY: That is not unusual with other schemes.

Mr STONE: Yes.

The Hon. TREVOR KHAN: If you spend some time in a hospital with 20 patients, some of them are going to grumble about precisely the same service they receive. You just wonder what some people are complaining about sometimes.

Ms HENDERSON: May I just say something about Mr Mallard's question?

The CHAIR: Yes.

Ms HENDERSON: We were talking about the capacity of participants to participate in the scheme. One of the issues that was raised by the Australian Lawyers Alliance is when the Lifetime Care and Support Authority becomes aware that a person clearly lacks capacity at all and there is no other person to make appropriate orders. What can they do about? What are they willing to do about it? So they are engaging with someone who has not got appropriate guardianship orders. That is a question I would like to raise. I have brought it up with them directly and they have told me that they feel it is a conflict of interests for them to make an application for someone to have a guardian appointed. I think it is a real gap in the scheme. These might be the only people that some participants are dealing with on a regular basis. I would appreciate it if you would ask them what will they do with those people who are clearly not engaging because they do not have the intellectual capacity to do so.

The Hon. DANIEL MOOKHEY: What should they do?

Ms HENDERSON: If they feel it is within their power they should gather the information and make an application to the guardianship tribunal for the NSW Trustee and Guardian to be appointed as the guardian for that person.

The CHAIR: You feel icare should do that?

Ms HENDERSON: Yes, make the application.

The Hon. TREVOR KHAN: But that could be a nightmare in itself, could it not?

Mr STONE: Absolutely.

Ms HENDERSON: But someone needs to do it. If there is nobody else in the person's life and they are drawing up a plan which a person is not engaging with because they cannot, then where is that person left?

Mr DAVID SHOEBRIDGE: You can see that in some cases that could cause fracture between icare and the individual if they are resistant.

Ms HENDERSON: Quite so.

Mr DAVID SHOEBRIDGE: Maybe icare is not the authority to do it?

Ms HENDERSON: It might be some other authority to do it, but if they could identify—

The CHAIR: You have referred to advocacy groups being brought into the process more.

Ms HENDERSON: Yes. We lawyers face this problem quite regularly ourselves. I appreciate there could be a conflict but they are the people engaging. If there is a way that can be improved then that should be addressed.

Mr DAVID SHOEBRIDGE: What you are saying is that avoiding the issue, does not resolve the issue?

Ms HENDERSON: Correct.

Mr STONE: I very much appreciate the complexity of the task they face because those in this scheme include those from disadvantaged backgrounds who live in difficult circumstances. At the extreme it is very hard to safely meet your occupational health and safety standards to send somebody into care for the paraplegic in the front room if their brother is dealing crack out in the back room. There are complexities to this that are difficult and I am not necessarily making that up.

Mr DAVID SHOEBRIDGE: And young men with acquired brain injuries can be difficult to deal with as well.

Ms HENDERSON: And paraplegia, both.

Mr STONE: For a variety of reasons. They have an enormously complex and difficult task but it is in part making sure that they are reaching out. One of the questions I invite the Committee to have a look at is in particular amongst the lower brain injury group who are marginal as to whether they belong or not in the scheme. Perhaps look at the bottom 10 per cent in terms of expenditure. Are they there because they in fact have higher plans and we are just not spending the money on them, and if not why? Or are they there because they have no needs and therefore do not ask us for anything?

I do not think it would hurt 10 years into this scheme to have a look at whether we are meeting the needs of perhaps the top 10 per cent and the bottom 10 per cent, to look at them as classes in terms of a review as to whether the scheme is working at the two ends. I think the top 10 per cent is probably pretty good, it is the bottom 10 per cent that I have some real questions about what goes on within it. If you identified that set of files by annual expenditure and either why are they in the scheme or why are they getting little out of the scheme? I think that would be a good group to have a look at as to what is going on.

Ms HENDERSON: I agree. I think that would be a very useful exercise.

The Hon. TREVOR KHAN: But what you are feeling is that they are not actually getting—

Mr STONE: I think they would be a mix of the two hard basket and should they have been there to begin with?

The Hon. DANIEL MOOKHEY: Are you aware of any inquiry into the reason for this underutilisation?

Mr STONE: At a formal level, no. At an information level they understand that there are some people who just do not want the carers in the house, somebody chooses to stay home or for a variety of reasons. Some people just choose not to engage or some people are difficult to reach out to, they do not answer their mobile phone and they do not turn up to appointments.

Mr DAVID SHOEBRIDGE: Some people have deep chronic depression and other mental illnesses that make them become quite exclusionary and seclusionary.

Mr STONE: Some people reach the point where it is not safe for them to engage with them, in that they have got to send workers meeting occupational health and safety obligations.

The Hon. DANIEL MOOKHEY: But you say there is utility in such an inquiry?

Mr STONE: I would like to think that they would want to do an internal review after 10 years and have a look at their bottom 10 per cent to say: What can we improve across this cohort? I think that is a really good group to look at.

The CHAIR: We are out of time. Thank you both for taking the time to give evidence to this inquiry. Any questions taken on notice should be responded to within 21 days. The secretariat will be in touch with you.

(**The witnesses withdrew**)

DANIELLE BENNETT, President, Attendant Care Industry Association, affirmed and examined

NATASHA CEBALO, General Manager, Attendant Care Industry Association, affirmed and examined

BARBARA MERRAN, Founding President and Advisor, Attendant Care Industry Association, affirmed and examined

Ms MERRAN: Could I just mention before we start that I have just had an accident two days ago and have a broken leg and a broken rib, so I may gasp occasionally, but I am more than competent to manage.

The CHAIR: Thank you for coming in. We are sorry for your accident.

Mr DAVID SHOEBRIDGE: We are even more grateful for you coming in, Ms Merran.

Ms MERRAN: I think it is important.

The CHAIR: Would each of you like to make a statement or a combined statement?

Ms BENNETT: Ms Merran would like to.

Ms MERRAN: I have got quite a number of things to say and certainly in reference to examples given by the previous people speaking—for example, the Cootamundra one. The area of family members being paid are things that we are deeply involved in. I think the most important thing that I can offer, other than the experience of delivering the really complex services on the ground, is that I also have experience in medico-legal work. I have worked, prior to Lifetime Care and icare existing, where there has been a lot of legal intervention, and since. Certainly from a participant point of view and a provider point of view, I see it as a much easier and more comfortable system for all players. It is extremely noticeable, you have not got one side pushing for more, another side pushing for less, and spending enormous time in court cases determining what someone needs, when it is always in the middle.

For me, the scheme has really demonstrated that it has been positive for the participants, and I think for our society, I really have not had one problem, nor has the Attendant Care Industry Association [ACIA], with the Lifetime Care Authority at all, and our participants, I think, have the best service delivery of any other scheme anywhere that I have ever seen. I also might mention that Ms Bennett and I are on the project team and have been involved in writing the quality safeguards for the NDIS and have written the quality standards. So we are very comfortable with where the quality lies and have probably a greater understanding of the NDIS than most people. I think a lot of things that are said are assumptions rather than reality. So that is about it in a nutshell, from an overview.

The Hon. DANIEL MOOKHEY: I just want to start with your last comment around the NDIS design. What are the features of the NDIS design that are admirable and not present in the Lifetime Care and Support Scheme that should be?

Ms MERRAN: None. NDIS needs to par back to where Lifetime Care is to make it be effective, and that is in the works with the Department of Social Services. There are a number of participants of the Lifetime Care scheme who are managing their own funds and buying services from the providers, and that has been a very interesting thing. The ones who have taken over the management of their service delivery with the funds are still using the same providers they were using under the scheme. We have also had a number where the family have taken on the management and then found it too difficult and given it back to Lifetime Care and said, "Look, we thought we could do this but we can't, it's too complicated, it's too hard and it takes up too much time".

The Hon. DANIEL MOOKHEY: You would have heard the earlier discussion around line item budgeting and line item approval. Do you have views on that?

Ms MERRAN: Yes. I have absolutely strong views on all of this.

The Hon. DANIEL MOOKHEY: Tell us.

Ms MERRAN: One of the great advantages with Lifetime Care in comparison to the system before, and, in fact, all other systems, is that there are line items that are automatic and they are already set up. So that if someone needs a wheelchair, they are already there—it is already ticked off, it is just a formality.

Mr DAVID SHOEBRIDGE: They have looked at the course of an injury and they have said, "Well, after three months we can expect you will want your first wheelchair, in 12 months you will want an improved wheelchair", and those are pre-approved?

Ms MERRAN: They are pre-approved. Like with ventilation, they only have one ventilator-dependent person at the moment, but that number does not actually correlate to statistics, so it will change. It was all pre-approved prior to the scheme starting and it involved specialist rehab doctors and providers and the authority to determine, look, if someone is ventilated they automatically are going to get two ventilators, two suction devices, portable things. So it is just a tick and flick. Unfortunately, one of the speakers earlier made it sound as though you have to beg to get these things, and I have never found that to be the case, ever.

Mr DAVID SHOEBRIDGE: I do not think that was their presentation. I think their presentation was there are instances which fall outside of obvious approval under the guidelines and that is where the friction is.

The Hon. TREVOR KHAN: I think that is a conclusion we might now draw. I am not being unfair to either, but I think the suggestion was that depending upon whoever is looking after you, you potentially get a different result. That is what I took the evidence to be.

The Hon. DANIEL MOOKHEY: But that category of expenditure that you have just described is essentially being pre-approved, or at least there are systems for it to be recovered quickly or approved quickly.

Ms MERRAN: Yes.

The Hon. DANIEL MOOKHEY: Does that account for the majority of a person's claims?

Ms MERRAN: From my experience yes.

Ms BENNETT: And from mine. I would agree.

The Hon. DANIEL MOOKHEY: Are there instances that you are aware of of claims that were made that did not fall within that system that did create avoidable friction?

Ms MERRAN: We were involved in the very beginning in assuring that all the equipment needs that were obvious were signed off. So yes, there are exceptions to that rule, but I have never seen an exception rejected, nor have I ever seen where the person has needed more service or more support that it is said "We have been told no". That has never happened.

The Hon. LYNDA VOLTZ: I guess the question is around those lifestyle kind of—

The Hon. DANIEL MOOKHEY: The non-equipment category.

Ms MERRAN: And certainly about the babies—talking about lifestyle. We have had three babies born this year and with fantastic support from the scheme in very difficult situations.

Mr DAVID SHOEBRIDGE: So changing the guidelines to exclude that support would be deeply, deeply problematic?

Ms MERRAN: I think there are a lot of things written in the guidelines that are generalist and written to protect the authority and the taxpayer from financial abuse of the situation, and when you are thinking that a number of people within the scheme come from difficult psychosocial backgrounds, by virtue of the fact the scheme addresses those who are not insured necessarily or are driving without licences and they are in unregistered vehicles, then you are going to have those extremely difficult people who will push you to the nth degree. Both Ms Bennett and I have been involved in a particular case where the person bashes up the workers, punches taxi drivers in the face, trying to sue the scheme for something that is imagined. Lifetime Care are still there supporting him and still supporting the provider to try and make it work, and they have been fantastic—they will get in a guard to protect the worker; they have done everything that you can possibly do. And that is not a one-off situation.

We have a lot of people—and this is where it comes to families being paid—if we use the Cootamundra as an example, I will give you examples of things we have found, that the sister may not have had a drivers licence but the sister may be a junkie. There are all sorts of things behind what you see, and particularly from a legal point of view, from what the lawyers see; the on-the-ground stuff is very different to the lawyer giving advice. I think you will find that from the rehabilitation doctors you speak to. They are very aware of that. They have to have these guidelines in place to protect against that particular thing.

The Hon. DAVID CLARKE: You are saying that in that situation there must have been something like that in the way?

Ms MERRAN: Not there must have been but it is quite likely that there would have been.

The Hon. DAVID CLARKE: Except that Mr Stone was assuming in this case he was aware of that there was not something like that would obviously not allow for that to be paid.

Ms MERRAN: We all know what assumptions are, don't we?

The Hon. LYNDA VOLTZ: The point he was making was that family members do not get paid under the scheme. It was the principle that family members do not get paid under the scheme.

Mr DAVID SHOEBRIDGE: And it is not on the assumption that they are all junkies; it is a philosophical approach.

Ms MERRAN: No, it is not; it is a risk approach. It is mitigation of risk for the scheme. There are cases when they will pay someone and they have.

The Hon. LYNDA VOLTZ: Can you outline cases where you know family members have been paid?

Ms MERRAN: In a remote situation. What they have done where there have been family members paid—and I am not saying there are many but there have been—it has been with involvement of the treating doctor, the treating team and the family member has worked through a provider organisation. As a family member you cannot get workers compensation and things like that; professional indemnity and public liability. They get them to draw in a provider organisation that provides them with all those insurances, education and support.

The Hon. TREVOR KHAN: I come from Tamworth and it is common for people to come Sydney on a plane who are injured or disabled, clearly coming down for appointments or assessments or frighteningly to see us lawyers. They may be accompanied by someone and supposing it is a family member on that fun trip to Sydney, hanging around airports. I hate the term paid because it might be that that family member has taken the day off to accompany the person but is it reasonable that the middle or older accompanying family member is compensated for the lost day's wage?

Mr DAVID SHOEBRIDGE: And effort?

Ms MERRAN: There are lots of complexities within that and that is where you have to look at whether the person wants to be involved.

The Hon. TREVOR KHAN: Let us assume it is a family member. It might be a sibling who knows that the person going to Sydney may not be terribly good at negotiating their way through Sydney?

Ms MERRAN: Lifetime Care would pay for a support worker or even a senior person from a provider like a registered nurse to travel with them.

Mr DAVID SHOEBRIDGE: Let us assume it is the partner, who is very stressed and anxious about it who wants to go and help them?

The Hon. TREVOR KHAN: I have been trying to avoid the partner because there are obligations that arise out of spousal commitments and many people do not have those.

Mr DAVID SHOEBRIDGE: They have mobility difficulties, they are super anxious about it and can be there to calm them. Why would you not send that package down and that package is best delivered by the spouse?

Ms MERRAN: And it may well be and I am sure there are exceptions to the rule where they do pay family members to do things but they want the family members to be protected with all the insurances.

The Hon. DAVID CLARKE: Instead of it being the exception to the rule that is allowed, why is there not a rule for which there are exceptions and it is in the reverse? Why would you assume that the relative would be the obvious one in certain circumstances?

The CHAIR: That is a question for icare.

Mr DAVID SHOEBRIDGE: The question is possibly against you but you are here representing community care and support providers including private not-for-profit and charitable organisations?

Ms MERRAN: Yes.

Mr DAVID SHOEBRIDGE: And what might be said against you in this is that you have an interest in it. The less support that is being provided by family members, the bigger your market. Can any of you answer that?

Ms MERRAN: I can answer that by saying, yes, you could say we have an interest in it but we also have a passion and belief in what we do and we would not be around if we did not.

Mr DAVID SHOEBRIDGE: I am not denying that but do you acknowledge the self-interest element?

Ms MERRAN: I personally do not acknowledge it because it goes against the grain of every philosophy of my organisation but I am sure that can be the case.

Ms CEBALO: But I think you are also correct in that our interest is in supporting service providers. We are not advocates and we do not speak for family members, while we do support them.

Mr DAVID SHOEBRIDGE: I am not denying your bona fides and your concerns but that conflict is there at some point?

The CHAIR: But you would welcome active family member participation?

Ms MERRAN: Absolutely.

Ms CEBALO: Absolutely.

Ms BENNETT: Absolutely.

Ms MERRAN: And as I said they do occasionally pay family members when it is the most appropriate thing to do but if they make a blanket guideline around that, then you do have problems.

The CHAIR: Are you involved in respite care?

Ms MERRAN: Yes.

The CHAIR: When family members provide primary support at home and need a break, you do that as well and that comes through the scheme?

Ms MERRAN: Yes. Most of the people my organisation looks after and those of Ms Cebalo through the scheme are 27 or 28 hours a day (sic); they do not fit into the same category and the family are very involved but the services are complex.

The CHAIR: How do the Federal carer allowances work. The person can get a Federal benefit and be a full-time carer for someone?

Ms MERRAN: Yes, but that is a minimal amount of money. It works very well in the aged care market where someone can manage with two or three hours support a day. I am not as confident in commenting on that. In the catastrophic area it would have no impact.

Ms CEBALO: I make a comment on the earlier point around the differences with the NDIS. A lot of our members really value some of the components of the lifetime care scheme that are not present in the National Disability Insurance Agency [NDIA].

The Hon. TREVOR KHAN: What are they?

Ms CEBALO: Things like the role of the Lifetime Care coordinator, which we have mentioned in our submission, makes the role of the service provider organisation a lot easier because they have a dedicated person that they can call up when there are specific needs that a participant has. An equivalent role does not exist within the NDIS.

Mr DAVID SHOEBRIDGE: And do these Lifetime Care coordinators stay around or are they like in some insurance companies where they get churned every three months?

Ms CEBALO: No.

Ms MERRAN: No. They have been very stable in their employment.

Ms BENNETT: Despite the growth, yes.

Ms MERRAN: The other thing is they have the attendant care unit team, which is something we have not seen in any other scheme.

Mr DAVID SHOEBRIDGE: Ms Bennett was going to speak about that?

Ms BENNETT: I was going to talk about how great the attendant care unit is and the dedication that they do give, not only to the attendant care industry but to providers. When there are escalation of issues within a program, you need extra support or the coordinator has changed, you can always go to the attendant care unit and they are a dedicated team of five now, I think. They are specifically in the interest of the service providers, and managing the contracts and performance of those providers.

Ms CEBALO: The difference with the NDIS is you just need to get on the phone; it is the NDIA helpdesk and you never know who you will get.

Ms BENNETT: You never get the same person.

The Hon. DANIEL MOOKHEY: They are two features. Are they any other features that are present?

Ms CEBALO: They are the key ones. The one we may be pointing out is individualised training that is provided to support workers to help them understand the specific needs of a participant's plan, which might be things to do with their equipment or particular behaviours.

Ms BENNETT: Particular behaviours of concern or support that they need. That is certainly what we are finding is lacking with the NDIS rollout.

Mr DAVID SHOEBRIDGE: So on the whole you are saying that the NDIS should be learning from Lifetime Care as opposed to the other way around?

Ms BENNETT: Absolutely.

Ms MERRAN: And it is.

Ms BENNETT: Particularly in the complex market, so for that small market of the NDIS we believe it should be modelled with more alignment than the greater NDIS market.

The CHAIR: That is something we will take up with the NDIS. We are not doing an inquiry into the NDIS but it is very helpful.

Ms BENNETT: Every conversation we have with Lifetime Care ends up about the NDIS.

Ms CEBALO: It is easy to think that the NDIS is the new shiny scheme and that is the one that should be the model and maybe in some that is the case, but perhaps not always.

Ms BENNETT: And it is new.

Ms MERRAN: It is too soon.

The CHAIR: It is a brand-new thing.

Ms MERRAN: It is far too soon and it has been pushed to be rolled before it is ready.

The Hon. DANIEL MOOKHEY: I return to a question arising from earlier discussion around family member participation in the care of a person. You described a category of insurance that your members have that a family member would not have. Is that the only point of difference between the care? Incidentally, what insurance do you have that they do not?

Ms MERRAN: Workers compensation, for a start. An individual cannot get workers comp insurance. That is the most important one. There is professional indemnity and public liability but the most important is the training relevant to meet the needs. So you are not only protecting and helping the participant you are protecting and helping the person delivering the service, be it a family member. That does not mean that there are not family members being paid and not with a provider. They are following that on from the Transport Accident Commission in Victoria where they found it was an issue. They have been doing it the longest. They found that works the best.

The Hon. LYNDA VOLTZ: Are not the guidelines for attendant care that you have to go through an approved attendant care provider?

Ms MERRAN: I do not think it is in the guidelines.

The Hon. LYNDA VOLTZ: It is on the sheet provided.

Ms BENNETT: For Lifetime Care?

The Hon. LYNDA VOLTZ: Yes.

Ms BENNETT: There is an exception where they will go off panel if the workforce is not there.

The Hon. LYNDA VOLTZ: The example you used was remote areas. So, in remote areas that would be the scenario?

Ms BENNETT: It can be an issue.

The Hon. DANIEL MOOKHEY: Are there reasons why the scheme could not mass purchase a policy on behalf of family members to provide the same levels of indemnity and insurances?

Ms MERRAN: I think it is again about risk mitigation and, like the NDIS, how many steps can we go back from the reality of where things can go wrong.

The Hon. DANIEL MOOKHEY: You would agree the purchase is essentially a form of insurance and would mitigate the risk?

Ms MERRAN: Yes, but the Government will not do it. They would not touch it with a barge pole.

Ms CEBALO: Another key difference between the National Disability Insurance Scheme, where family care is possible, are the needs of the majority of the participants within Lifetime Care. They are at the higher end. As Ms Merran said, there is a large amount of training that is given to the majority of service providers.

The Hon. DANIEL MOOKHEY: What is that training?

Ms MERRAN: Training is relevant to the need of the individual. If one somebody is on a ventilator and has percutaneous endoscopic gastrostomy feeds and a suprapubic catheter or severe brain injury there are training packages that workers have to complete and be signed off. Discharging hospitals are heavily involved in the initial training and it is designed by the rehab doctors and their teams around the specific things a person will require. You have to be signed off as competent to deliver those things. I wanted to say, do not think for one moment that I do not support family members being involved, because I do. Whether they get paid or not is another matter, I do not know the answer to that.

The Hon. DANIEL MOOKHEY: You were describing the design of the care plan in the early parts of your evidence. Are people in the scheme having meaningful input into the design of those plans and are there improvements possible around that?

Ms BENNETT: Are they having much input?

The Hon. DANIEL MOOKHEY: In the design of care plans, is that working?

Ms BENNETT: In my experience, the participants we provide support to, absolutely. When that plan is reviewed it is reviewed with the participant, the provider, and the treating team to ensure that everybody's needs, the participant's needs, are met.

The Hon. DANIEL MOOKHEY: Are the original plans reflecting the treatment pathways that a person ends up needing?

Ms BENNETT: Not always. Sometimes they are discharged from hospital with a lot more services than is required in the community. They may be discharged needing two workers and once they get home and have settled into their environment and a provider comes in, workers are trained, it often reduces. We often see the reduction in a plan.

The Hon. DANIEL MOOKHEY: I am asking because, given the estimates about the financial liability turn on the first plan, I am wondering whether it is generally falling within the ball park? Is it going over or under? Are excessive levels of premiums being recovered for the risk? Do you know?

Ms MERRAN: The catastrophic end is the area we see the most. It takes someone with a catastrophic injury about six months to settle back into the community and for anyone to see what they need.

The Hon. DANIEL MOOKHEY: That is reflected in the design?

Ms BENNETT: Yes.

Ms MERRAN: Absolutely.

Mr DAVID SHOEBRIDGE: Could I ask you to return to where some of this started, which is the independence of scheme participants. There are the approved schedule of services, which is partly an answer to that, but what about the overall philosophy of saying, you may have a significant injury but you want to and can manage your life, we will give you an annual budget. How do you respond to that as a philosophy?

Ms CEBALO: That is the philosophy of the NDIS, to an extent.

Mr DAVID SHOEBRIDGE: We are talking about Lifetime Care and Support, how do you respond to that as a philosophy?

Ms CEBALO: For the NDIS the philosophy comes from assessing the individual's capacity to make those decisions.

Mr DAVID SHOEBRIDGE: I have put it to you in the terms of a person has the capacity. They may have a catastrophic spinal injury but are fully able to make decisions about themselves?

Ms CEBALO: In the quality and safeguards framework for the NDIS it looks at the person's capacity to make the decisions but also the risk of the supports that are being provided. I put that at the high end of spinal injury, some of the supports that would be provided would be at a high level of risk.

The Hon. TREVOR KHAN: Can you explain why? I am not doubting what you say.

Ms CEBALO: I will let Ms Merran talk to the clinical needs. If a person is unable to support themselves to go to the bathroom, if they had a catheter or some other clinical needs, do I have the right to decide I am going to let my family member change the catheter using public funds, even though my family member might not be trained in how to do that?

Mr DAVID SHOEBRIDGE: I asked you about the philosophy. They have the capacity, they know how to run their lives, giving them an annual budget?

Ms BENNETT: I would support the philosophy behind that, no issue.

Ms CEBALO: Proportional to risk.

Mr DAVID SHOEBRIDGE: Which is what the Hon. Trevor Khan was exploring.

The Hon. TREVOR KHAN: You have unpacked parts of the potential problem.

Ms CEBALO: That is the difference between the NDIS participants and the Lifetime Care, for the majority of Lifetime Care we are up in the high level of risk, particularly for the attendant care industry providers. The NDIS has a broader grouping and obviously a larger number of participants.

The Hon. DANIEL MOOKHEY: When we are talking about a person who is a paraplegic, in NDIS terms it is high care high risk, but in Lifetime Care and Support terms, it is not.

Ms MERRAN: It is not.

The Hon. DANIEL MOOKHEY: I understand your point of proportionality to risk. What are the risks of a paraplegic who is fully competent mentally from having an annual budget?

Ms MERRAN: There is not.

The Hon. TREVOR KHAN: But there are so many others under the Lifetime Care and Support Scheme who are not paraplegic.

Ms BENNETT: The majority have brain injury. That is what we are dealing with. They do not have the capacity to make those decisions.

The Hon. TREVOR KHAN: Do I take it that some people with closed head injuries will exhibit as being quite functional—that might not be an appropriate term—but the nature of their injury is such that their level of capacity of coping will vary over time with stress and other matters?

Ms BENNETT: And different triggers that create different behaviours.

The Hon. DANIEL MOOKHEY: Can we conclude from that, because the majority have head injuries, as opposed to physical incapacity, it is not worth creating two systems? It is undue complexity.

Ms MERRAN: The Attendant Care Industry Association is of the opinion that all community services, be they aged or disability, should be under the same umbrella. It is about the participant having the right to direct their care and to manage their services if they are able to. From ACIA's point of view there is no difference between aged care, disability services, children, adults, whatever it is, even nursing homes—they say it is your home, but it is not. If they were empowered with that ability to make decisions then we would have a fair and just system in our society.

Mr DAVID SHOEBRIDGE: The Hunter Brain Injury Service particularly talk about the friction points for people who have got interim acceptance into Lifetime Care and Support for two years but then are determined not to be eligible. They exit Lifetime Care and Support and they talk about having a six- to nine-month delay between leaving Lifetime Care and Support with all the good service that they provide and then there is nothing until their eligibility is determined under NDIS.

Ms MERRAN: The interesting thing is that that is not the end of the market that we see. Those people who are not going to be long-term in the scheme, the services they may well be receiving may be occupational therapy, physiotherapy. We are unlikely, other than to have a lawn mowed, to have any involvement in that group, so it would be difficult to comment.

Mr DAVID SHOEBRIDGE: None of you have noticed this in the work that you do?

Ms BENNETT: I have not come across it, no.

Ms CEBALO: No.

Ms MERRAN: No.

The Hon. DANIEL MOOKHEY: Did you hear the earlier discussion around guardianship?

Ms MERRAN: Yes.

The Hon. DANIEL MOOKHEY: Do you have a view that you would like to add?

Ms MERRAN: It already works. It is the case manager's responsibility, or the local doctor's responsibility. Guardianship is a major issue. Nobody wants to make it because it is a very difficult area. At the same time, because Lifetime Care has case managers who are external to them, there is also the service providers. It would be considered the case manager's role, or the treating team's role, or the provider.

Mr DAVID SHOEBRIDGE: A case manager within Lifetime Care and Support?

Ms MERRAN: Case managers are on a panel. They are not part of Lifetime Care. There are no case managers in Lifetime Care.

Mr DAVID SHOEBRIDGE: Who is the case manager and what is the entity?

Ms MERRAN: It is a panel of providers. We are service providers, they are case management providers.

Mr DAVID SHOEBRIDGE: Paid for by Lifetime Care?

Ms BENNETT: Yes, and they do the needs care assessments.

Mr DAVID SHOEBRIDGE: Do your organisations regularly make guardianship applications?

Ms MERRAN: Mine does.

Ms BENNETT: No, we have never made an application.

The Hon. TREVOR KHAN: What is your standing to make the application?

Ms MERRAN: Well, just to—

The Hon. TREVOR KHAN: I am not being rude. How do you rock up to the guardianship board and say, "I know Fred Bloggs. We provide him with some services. We reckon he is unable to cope and we should make a guardianship order"?

Ms MERRAN: We would first go to the case manager to see if they would do it and then we would go to a social worker to get an intervention and assessment there, or a psychologist, but if no-one wants to touch it—and that is often the case because it is very difficult—we will just write to the guardianship board and say, "We have concerns for this person. They have no other supports."

Mr DAVID SHOEBRIDGE: You say the guardianship board then self-refers and commences their own assessment and application?

Ms MERRAN: Yes.

The Hon. TREVOR KHAN: We had issues with my now deceased father-in-law. The hospital was suggesting that we make a guardianship application, I was saying, "Keep me out of this." I was wondering what the essential benefit was because he was refusing a whole range of services,

Ms MERRAN: But that is his right.

The Hon. TREVOR KHAN: Whether we had an order or not was not going to make any difference to the practical situation on the ground. If a guardianship order is made, what will it do?

Ms MERRAN: We have some interesting ones, perhaps not in New South Wales, but, nevertheless, when there is just medical guardianship given to a particular person. That can be extremely interesting, or it can be financial, so it is how it is split up and for what purpose.

Mr DAVID SHOEBRIDGE: When you say "interesting", often it does not resolve the issue if you have a completely resistant individual. Saying, "We now have a guardianship order and we are telling you to have this medical treatment", does not resolve that?

Ms MERRAN: Absolutely. We are not saying that we want to—

The Hon. TREVOR KHAN: It is not a panacea.

Ms MERRAN: There are some people who just do not have anyone, and they are open to abuse.

The Hon. DANIEL MOOKHEY: Is there clarity on how the system is interacting with these people who are discharging that responsibility, or is it more haphazard?

Ms MERRAN: I would say it is more haphazard.

Ms BENNETT: Yes, I would agree, with the experience we have had.

The Hon. DANIEL MOOKHEY: In your view, is there a need for the regulator or someone else to provide clarity as to how such circumstances should be handled and by whom?

Ms MERRAN: It would help if there are guidelines. Wherever ACIA sees a gap that affects service providers, we develop guidelines, and people start to use them and something settles down, but guardianship is such a tricky area.

The Hon. DANIEL MOOKHEY: I am not suggesting that it is easy. I am suggesting that the absence of clarity makes it harder.

Ms MERRAN: Absolutely.

Mr DAVID SHOEBRIDGE: I doubt that you are desperately keen for a guideline that says it is the obligation of your members to make guardianship applications, because that could be extremely destructive of the relationship you have with your clients. Is that the case?

Ms MERRAN: Yes, and it is not our area of expertise.

Ms BENNETT: No, it is not.

Ms MERRAN: We would prefer not to do.

Mr DAVID SHOEBRIDGE: Who should?

Ms MERRAN: Somebody should.

The Hon. TREVOR KHAN: Well said.

Mr DAVID SHOEBRIDGE: Ms Bennett, do you have a view about this?

Ms BENNETT: It would either have to be the case manager or the Lifetime Care coordinator who has the direct contact.

Mr DAVID SHOEBRIDGE: Is it right for the Lifetime Care and Support Authority to be put in that position to have to make that decision if they are going to have a lifetime relationship with someone and they may poison it with that application?

Ms BENNETT: It is difficult. It is a challenge

Ms MERRAN: Do not forget that making a recommendation for guardianship does not necessarily mean it will happen.

Mr DAVID SHOEBRIDGE: Tell that to the person who has been resisting it.

Ms MERRAN: I know.

The Hon. TREVOR KHAN: That is assuming that the person who is resisting is aware of who made the application.

Ms MERRAN: It is not usually the person who needs the guardianship application that—

Mr DAVID SHOEBRIDGE: It is surrounding family.

Ms MERRAN: It is the family and disputes within families.

Mr DAVID SHOEBRIDGE: I do not think we will solve this in the next 30 seconds. I want to ask you about two potentially different accreditation standards. Ms Cebalo?

Ms CEBALO: We manage the Attendant Care Industry Standard [ACIS] quality standard at the moment. Danielle might want to answer this as well. Danielle and Barbara are involved in the accreditation standard that will be used for the NDIS when it is rolled out. At the moment, until there is clarity on how that standard is going to be managed, we believe that Lifetime Care should continue to maintain their own standard.

Mr DAVID SHOEBRIDGE: Ms Bennett?

Ms BENNETT: Yes, we would support that.

Mr DAVID SHOEBRIDGE: Is there move afoot from Lifetime Care and Support to say, "Problem solved; we have the NDIS standard", or are they happy to maintain their standard?

Ms BENNETT: I think they are still concerned about the governance of the NDIS standard and how that might impact if there is a change with that standard, how that would impact on their participants. So with the direct engagement with ACIA and managing the attendant care industry standard, they have much more influence and say how it is scoped.

The CHAIR: Thank you for coming in this morning. Your evidence has been very helpful. Ms Merran, thank you for coming in with your injury.

Ms MERRAN: That is okay. I could not come in without it.

The CHAIR: You have coped well; I hope you have good carer. There are questions on notice. Members may have more questions. You will have 21 days to respond to those questions. The secretariat will be in touch with you. Thank you very much for coming in this morning.

Ms MERRAN: Thank you.

Ms CEBALO: Thank you.

Ms BENNETT: Thank you for the opportunity.

(The witnesses withdrew)

(Short adjournment)

MATTHEW KAYROOZ, Head of Accident and Trauma, Personal Insurance Portfolio and Products, Suncorp, affirmed and examined

The CHAIR: Do you want to make an opening statement?

Mr KAYROOZ: I speak on behalf of Suncorp. The Suncorp group offers compulsory third party [CTP] and workers compensation insurance across Australia in various underwritten schemes. In New South Wales CTP we underwrite under the brands GIO and AAMI. Thanks for the opportunity to discuss the Lifetime Care and Support Scheme. We have put forward our submission to the standing committee. Suncorp has taken a very active role in the past six years in talking about the design of the statutory schemes across Australia. We have actually put out several papers over the past four or five years regarding no-fault insurance and the benefits of a no-fault catastrophic scheme and I am happy to table those two reports into the scheme.

Our policy development has really been underpinned by the belief that the focus of these schemes should be on health and a return to life outcomes rather than just a compensation payment which has been the traditional basis of the development of these schemes through tort law. We have been public supporters of both the introduction of the Lifetime Care Scheme when it came in and also the National Disability Insurance Scheme. I think we are one of the only insurers that has publicly advocated for it. We believe that in the future these insurance schemes for catastrophic injuries remain best run under a public government underwritten scheme.

The New South Wales Lifetime Care and Support Scheme is a great scheme. It has made a huge difference not only to the lives of those people involved in a motor accident that actually, for some reason, cannot find someone to blame for the accident and received no cover, but also to those people who formerly had to go through a long adversarial process to actually gain certainty for their future because the scheme has removed that. Don Ferguson, the chief executive officer of Lifetime Care and his team continue to develop the scheme to a more customer centric approach as well as adhering to basic insurance principles that actually has ensured that this scheme is well funded and is actually sustainable into the future, whilst meeting those customer needs as well into the future.

In a nutshell, we think the scheme is running really well and our submission has actually pointed out some areas where we think there is improvement, particularly around the point of view of where someone can transfer in or out of the scheme between insurers and non-insurers. In particular this refers to, I think, the main type of injury that occurs which is the mild to moderate brain injury. To that extent we look at those injuries and it is one of those mysteries where you can have what appears to be a minor brain injury and then all of a sudden, over many years of treatment, that person can no longer function and it is a severe injury and go into scheme. Conversely for some people, particularly younger children, a brain injury that seems reasonably serious, after a period of months they have very, very good recoveries and I think it relates to our medical knowledge of the brain and how it impacts people. We are still working through those things.

In summary, you have our recommendations and I think the key one is consideration being given to extending the liability of the Lifetime Care and Support to actually start from the date of the accident, instead of when it is actually transferred into the actual scheme maybe in two years' time. Consideration be given to commencement of the two-year date from the actual date of the accident rather than when it actually goes into the scheme. I think our other recommendations are really about maintaining the ongoing education amongst the health community and the providers about lifetime care and brain injuries, and the facility and ability to put in a motor claim accident through that period, particularly in regional areas where quite often there are multiple injuries to someone.

For those multiple injuries basically the focus is on the orthopaedic and the obvious ones but all of a sudden, someone is at home and three months later we find out they have a brain injury that has not really been picked up addressed, or the claim work has not gone and that early treatment has not gone through. There is a whole process of forms that need to be filled in to get that going.

The Hon. LYNDA VOLTZ: Essentially your problem is that when an accident happens it can take three months for a determination of the eligibility of the scheme and that is those three months the costs are not being picked up by the insurer?

Mr KAYROOZ: There is one issue which is in regional areas we do not even know there is a brain injury. It is not that the scheme picks it up but the focus is on the orthopaedic and the obvious injuries and quite often you do not know they have had a knock to their head. It is just that education in particularly regional areas where they do not have the full metropolitan facilities that we do not realise there is a brain injury. It is actually starting the whole process whether it is an insurer of lifetime care of getting that recovery there, and then the forms to be filled in. At the moment we pick up a claim, we work it through and it is not an obvious lifetime care claim that can be transferred in a month or two, our treatment over the first 1½ years—if we think it is going to go into lifetime care, if there is a major interventions we need to make, and we think it is obviously lifetime care, there is a financial incentive there for an insurer to say, "We will not put that in place because we know its lifetime care. We are not going to get paid back for it. So we'll wait until it goes into lifetime care and they can pay for it". But there is a gap for 12 months missing there. I put my hand up, insurers do say, "Yes, it is our cost base." There are not many claims here, we are not talking about a large amount of money. What we are talking about are the incentives—any incentives that prevent the early intervention in health care for people with brain injuries should be removed. I suppose it is not a major issue, there are not a lot of these claims, but we are talking about how to get focus to make it smooth for people to focus on recovery.

Mr DAVID SHOEBRIDGE: I am sure that you have raised this with icare. What is their position back at you?

Mr KAYROOZ: I think we can work through the issue. I think people are stuck on the finances at the moment. When you cut down underneath it I do not think there is a lot of quibbling or, as I said, we have a good relationship with lifetime care but I think in the working of things I do not think we work long enough and often enough. It is the responsibility of insurers and lifetime care to actually take a breath every six or 12 months to see where it is going. That is something that reflects on both of us. We have everyday workings that go okay but long term we have not come up with these issues and said how it does because the finances look at it first of all. As I said, where does it sit? We are just putting it up there and saying now the focus is on getting people better quicker. We think that just removes any potential financial incentive for anyone to sit there and go, "Why not invest in this straight away upfront and take away this whole issue about who pays and not pays."

The Hon. DANIEL MOOKHEY: Returning to your earlier evidence about regional general practitioners and other types of medical providers in the detection of orthopaedic injuries over other injuries. Is that happening because they are not looking to detect any injuries to the brain or is it because the brain injuries are not presenting at that point in time?

Mr KAYROOZ: It is a bit of both. It is also a bit of scale. I know that lifetime care has actually done some really good regional educational processes, we are saying that has got to be ongoing. I think it is just a realisation that in regional hospitals I do not think they have the access to the resources that we do in the metropolitan areas. When someone comes into those areas—again we are not talking large numbers, we are talking very small numbers. We have got two or three examples of where this has occurred.

The Hon. TREVOR KHAN: Are you able to provide us with those? Someone with a relatively major orthopaedic injury would be transferred to one of the referral hospitals in regional New South Wales.

Mr KAYROOZ: Yes.

The Hon. TREVOR KHAN: They would not be in a small hospital. If you have examples I would be very interested to see the statistics.

Mr KAYROOZ: There are not a lot, just one or two. As I said, the scheme is working really well. We are picking up now saying, "How can we get a good scheme running even better?" It is just coming up in those regional areas. Some of these are not major orthopaedic ones but when someone presents at a regional hospital the first thing they look at is—there is the head test but after two or three weeks of being released from the hospital, down the track the person is back at home and then all of a sudden we have had one or two notifications where there is a bit of a head knock and there is some functional disability that is starting to show itself. I will take that on notice and see if we can pull those out.

The Hon. TREVOR KHAN: You will obviously have to depersonalise it in a way but I would be very interested in that. If possible, will you also include location?

Mr KAYROOZ: Okay.

Mr DAVID SHOEBRIDGE: Statistics show that every year 60 interim Lifetime Care and Support Scheme members exit the scheme when they are found to not enter the permanent scheme. Every year I think about 180 go in and then about 120 are held within the scheme. What is Suncorp's experience with the proportion of the 60 that bounce back into your responsibility? How does that work?

Mr KAYROOZ: I can only talk from Suncorp's perspective. It is a good news story because most of those people who come out have actually had recovery, they come back into the scheme and it is a good sign.

Mr DAVID SHOEBRIDGE: Is there a formalised arrangement where you get handed over the care plans and the casework and the like? Does that work?

Mr KAYROOZ: There is a reasonable transfer of that over. We find that transfer works reasonably well from our point of view at the moment. In one or two cases every now and then it is a bit lumpy. As I said, that transfer roughness usually occurs—from them transferring to us it works usually reasonably well.

Mr DAVID SHOEBRIDGE: Does the friction come from the claimant? Where is the friction?

Mr KAYROOZ: What we find difficult sometimes is if we have a claimant who is saying they do not want to enter into lifetime care. They are in our scheme and we are saying to them, "It is obvious that you are entitled to lifetime care." They are saying, "I don't want to go into that system." There is a process that we need to go through but then it needs various forms filled in to get assessments and some people do not want to get assessments. It is a small number there where people are saying, "I don't want to go in." Then we are saying, "There is a process here and your needs are best met by lifetime care." Now with the recent change to the CTP legislation the medical care and support that is provided is on an ongoing basis and I think that issue is starting to move into the background. Formerly, in the development of someone not wanting to go into the scheme under the old process they then built up a case to have medical and care into the future pulled into a lump sum.

Mr DAVID SHOEBRIDGE: That is now off the table.

Mr KAYROOZ: Yes, which is a great thing. Again that is what I referred to earlier on, where, particularly with brain, you drag someone through an adversarial process where they make recovery but then all of a sudden you have to prove—there is this perverse adversarial system we have where you are getting told by an insurer, "You have really recovered well. You are as good as possible." Then you have the other person with advisors saying. "You have got to show that your recovery is terrible and maximise your lump sum". So there is a profit interest for the insurers and there is a profit interest for the advisors, the poor person in the middle is going, "I just want to get better and back."

I think this new scheme removing the lump sum for medical care and support on an ongoing reasonable and necessary basis into the future actually takes that whole incentive away. It just gets insurers, advisors and people better rather than, "How do I drive the system to get the best result?" That works too, so long as there is a very good dispute resolution process, and I know over the last year or two the lifetime care and support system has introduced several initiatives in improving the dispute process for those candidates in there, with access to a panel of lawyers et cetera. That is very important as well.

Mr DAVID SHOEBRIDGE: Are you satisfied with the way the current dispute resolution system works? Say, for example, if you think a claimant should be covered by the scheme and the scheme does not accept it, obviously you have a financial interest to have a claimant into the scheme. Are you satisfied with the way the dispute resolution system currently works?

Mr KAYROOZ: We think the dispute process works reasonably well, so long as there are independent medical assessments made. We think, as I mentioned before, that moving forward with the removal of the ability to get a lump sum for medical care and support into the future, takes away a whole incentive for that argument of the adviser saying "If you want a lump sum get out of the scheme", and the insurers pushing them in. That friction has gone. The dispute process works well. I suppose the issue that we notice is trying to get some of the medical certificates signed up. We will go to hospitals asking for the appropriate documents and appropriate tests to get done, and as an insurer—and I know there are reasons for it—there is a reluctance of people, because of the workload, it is just an insurer asking for another medical report, so it is parked. We would like to work closer with Lifetime Care to work with them to get them to ask for some of those forms where hospitals respond to that a lot quicker than to insurers.

The Hon. TREVOR KHAN: Recommendation 4 is extending the liability of the Lifetime Care and Support Authority from the date of the accident instead of the date of determination. Does that go to your issue about, and I am not trying to put words in your mouth, the potential reluctance of insurers to spend money on people who they think might end up in the scheme?

Mr KAYROOZ: It adds the incentive for them to do it, because someone can actually be out of the scheme for four years and we find in most cases, after two years from the date of the accident there are reasonable tests and knowledge that people should know whether they are in or out.

Mr DAVID SHOEBRIDGE: Ideally, you would regulate consistent with self-interest if it is not going to cause problems, and what you are saying is having the liability start from the date of the accident is consistent with regulating in accordance with self-interest because you are not going to be saying, "Well, do we really want to provide this?" You can just be simply saying, "Well, it is needed, I will pay for it", and it will get picked up by Lifetime Care and Support?

Mr KAYROOZ: Yes.

The Hon. TREVOR KHAN: It removes the disincentives.

Mr KAYROOZ: Yes. You can look at it as an insurer saying what we are talking about with this recommendation is purely saying it is our profits. I would like to think that Suncorp operates in a different way.

The Hon. TREVOR KHAN: We do not have to worry about it being Suncorp. You are making an assessment that is talking about a whole industry.

Mr KAYROOZ: Yes, and we are talking about the dynamics of the scheme, which you can see in our papers later on is about a higher level, and it is exactly what you said.

The CHAIR: What quantum are we talking about?

Mr KAYROOZ: We are talking small numbers of claims, and, as I said, this is mainly in the area of those claims that fall into that area of mild to moderate brain injury. There are a lot of cases going in there that I would say 60 per cent, you look at them and there are spinal injuries or severe brain injury where everyone knows it is that, as you said, 40 per cent.

Mr DAVID SHOEBRIDGE: But even in those really severe ones, it takes a couple of months, does it, to—

Mr KAYROOZ: Yes, or it could through the hospital period. But with those I think we have a really good working relationship. But I agree. Even with those serious ones I would have to put up that in looking at it theoretically there is still that financial incentive.

Mr DAVID SHOEBRIDGE: But it is not really those because they are normally being driven by the hospital determinations and you are not making decisions.

Mr KAYROOZ: Yes.

Mr DAVID SHOEBRIDGE: It is those more marginal ones.

Mr KAYROOZ: Yes.

The Hon. DANIEL MOOKHEY: And these are people who are coming to you to claim through their CTP policies?

Mr KAYROOZ: Yes, they have had a motor vehicle accident and we get them notified first up.

The Hon. DANIEL MOOKHEY: So your point is that because you know that they will eventually end up there, they should be absolutely clear about it from day one?

Mr KAYROOZ: We have a first estimate of it that we believe these people should end up in Lifetime Care. Yes, we have a belief that will end up in Lifetime Care; what I am saying is there is a self-interest at the moment, or an incentive, that says if we think there are some major treatments that we know Lifetime Care will provide, why would we pay for it now when we know if we waited a couple of months and do the assessments that will then go—

The Hon. DANIEL MOOKHEY: Do you not have a legal liability under existing CTP policy to cover them?

Mr KAYROOZ: We do, and what I am saying is that I would like to think that we would do it. What I am talking about is why have incentives in the scheme to drive some behaviours? I just wanted to make it very clear that, as I said before—

The Hon. TREVOR KHAN: You are doing this on a no-admission basis.

Mr KAYROOZ: I can turn around and say I think we do a really good job at Suncorp, and as an insurance industry, that there will be occasions where you could pull out examples where it has pulled back.

The Hon. DANIEL MOOKHEY: I appreciate the candour and the honesty, and you are right, we ought to be designing schemes around the way people behave in self-interest.

Mr DAVID SHOEBRIDGE: Always bet on self-interest.

The Hon. DANIEL MOOKHEY: Of course. But there is an argument to suggest that given people pay CTP—because, by definition, they are not uninsured people if they are coming to you and they are presenting first and they have already paid for this policy—why is it not being covered anyway?

Mr KAYROOZ: I think any reasonable treatment is covered; it is just the questionable ones where you look at it and go, "Well, we can delay that a couple of months". I am happy for anyone to come in and see our claims office and look at these claims and the way we treat it and I think we would stand up to scrutiny.

The Hon. TREVOR KHAN: I do not think we take your evidence as talking about any practices that go on in Suncorp. So remove that concern.

Mr KAYROOZ: You are right, we pay the obvious treatments, insurers pay the obvious treatments; we are talking about a design of the model that, as you nicely put, is an incentive for behaviours that we do not want to occur.

Mr DAVID SHOEBRIDGE: It is the expensive house modification or those sorts of things that you can put off for six, eight or 12 months, arguing the toss about it, and then "I'll sell you in Lifetime Care and Support". You do not want to have those kinds of pressures in the system.

The Hon. DANIEL MOOKHEY: The additional issue about the mechanisms of transfer from CTP to Lifetime Care for five years, which is intended—you are aware of that change?

Mr KAYROOZ: In the CTP legislation, yes.

The Hon. DANIEL MOOKHEY: It has been presented to me that that also creates the same incentive that you just described, that care in that five-year period that you are providing is provided knowing full well that after five years the liability transfers and therefore that creates the same incentive to understand in the first five years. Is that valid?

Mr KAYROOZ: It depends what other incentives you put in there. I would like to put in there saying there is incentive for those injuries that over a five-year period the incentive to get that person better and quickly off your book in two years will see most of those people get full treatment and care. That five-year period for those claims prevents that happening.

The Hon. TREVOR KHAN: I am going to take the same point that I took before, Chair. It is not for this inquiry.

The Hon. DANIEL MOOKHEY: I am not trying to steer the issues. The reason I am asking is because I do intend to ask icare about how they are modelling the levy to recover the costs, which is valid for the purpose of this inquiry. So that is the motivation, it is because icare is required to impose a levy on CTP premiums for the purposes of recovering all of these costs, which is the reason I am asking in the context of this inquiry.

The Hon. TREVOR KHAN: I still question whether that falls within the context of this inquiry.

Mr DAVID SHOEBRIDGE: Could I ask a question on a different tangent, if the Hon. Daniel Mookhey is going to take that up with icare?

The Hon. DANIEL MOOKHEY: I will.

Mr DAVID SHOEBRIDGE: This committee, when it was dealing with workers compensation, looked at the dispute resolution system there and thought it was a bit of a dog's breakfast, which is kind of an underestimation, and then suggested that there be a single competent jurisdiction to deal with disputes, at least in that area. If the Government was to go down the path of establishing that kind of jurisdiction, a specialised personal injury jurisdiction, do you think some of the disputes that arise in Lifetime Care and Support might readily be determined in an independent jurisdiction like that rather than just bouncing back and forth between you and the authority?

Mr KAYROOZ: The first point is Suncorp Insurance's position on that personal injury dispute process, we would agree with that. We think personal injury on a statutory basis across the States should have a very fundamental, similar process that meets the Australian complaints standards and dispute standards. The catastrophic claims, again, there has to be a process that meets those needs, but the volume of these and the sensitivity of dealing with people—the Lifetime Care dispute process at the moment works pretty well.

Mr DAVID SHOEBRIDGE: You would not establish a jurisdiction to deal with the disputes in Lifetime Care. But those pressure points, do you think there might be some utility at least in keeping a weather eye on it and maybe putting those difficult things in that same dispute area?

Mr KAYROOZ: There are possibilities for it but again I would not relate the disputes process and Lifetime Care with WorkCover. The workers compensation one at the moment, the Lifetime Care one, seems to be working really well for clients and it is a different set-up. Down the track at the end of the day, where someone has very few complaints there should be that external independent process that handles it and where that sits—

Mr DAVID SHOEBRIDGE: With all these different statutory schemes we should be trying to get to that point?

Mr KAYROOZ: Yes. There should be a point at the end.

The Hon. TREVOR KHAN: As I am told, under the current scheme if you wish somebody to go into the scheme who is on your books, an assessment is done by an assessor. If you disagree, they may say, "No, that person does not fall within the scheme", and you can then appeal to a panel of three? Is that right?

Mr KAYROOZ: Yes, there is an independent panel. There is a dispute process.

The Hon. TREVOR KHAN: If you are not satisfied with their determination you can appeal again to a further panel?

Mr KAYROOZ: I would have to take that off line. I know there is a second appeal but the third appeal I would have to double check.

The Hon. TREVOR KHAN: I think Mr Stone or the Bar Association have put this proposition to us and again you can take it off line and think about it. What is the rationale for you getting two bites of the cherry by two independent panels? You do not have to answer it now but can take it away as homework. Tell me why that is reasonable?

Mr KAYROOZ: I would like to clarify that the disputes appeal is at a certain point in time because part of this process is that if that appeal is one or two bites of the cherry and it finishes, and then after treatment over the next 1½ years that person deteriorates in the next 12 months and it is actually more confirmed that this person needs to go into Lifetime Care and meets that criteria, there should be a process to go back and do the appeal there.

The Hon. TREVOR KHAN: I am not arguing that.

Mr KAYROOZ: Okay. I just wanted to clarify that.

The Hon. TREVOR KHAN: It is the question about what is the determination mechanism, including the appeal process, and whether it is appropriate that the insurer essentially can have two bites of the cherry whereas I understand on other styles of matters the appeal process is assessor then panel of three, full stop?

Mr KAYROOZ: I need to take that question and confirm it back to you.

Mr DAVID SHOEBRIDGE: But there are things like significant change in circumstances, as you point out?

The Hon. TREVOR KHAN: But you understand my question is not directed to that.

Mr DAVID SHOEBRIDGE: Yes, that is right, so we are not including that, nor is the question including circumstances where, say, initially being treated as an orthopaedic injury and then becoming aware that there is some kind of brain damage or acquired brain injury that was not included in the initial assessment. We are talking about having repeated goes on basically the same—

Mr KAYROOZ: Yes, on the same-point-in-time assessment, because as I said what we opened up with is that mainly we are dealing moderate to serious brain injury and yet how they pan out over years—with appropriate treatment some work out wonderfully and other people deteriorate as time goes on. The rhyme and reason for that quite often is not understood properly and that is where over a period of time we need to look at different entry points.

The Hon. TREVOR KHAN: Sure. As to the summary of recommendations, could you consider running the two-year interim period from the date of accident rather than from the date of determination of eligibility, so that it is different from your recommendation 4? If it took three to six months to determine that this person should go into the scheme, it would mean then, under recommendation 4, that you would be running the eligibility period for maybe 21 to 18 months. What is a rationale for shortening up the interim eligibility period?

Mr KAYROOZ: I suppose in some cases where we see someone should be eligible at about 18 or 19 months and it ends up being three or four years down the track where we have someone on board; to go in there we have been treating them for four years in that long period of delay before we get into the eligibility period, so that is why we are trying to be consistent with the other one that there is a period of time where the eligibility starts from.

The Hon. TREVOR KHAN: I therefore have misunderstood. I have taken the two-year interim period as being a period of time where actually the cost is picked up by the Lifetime Care and Support Scheme. Am I wrong?

Mr KAYROOZ: It has been there in the Lifetime Care and Support, yes.

Mr DAVID SHOEBRIDGE: But I think there are two different things. One is you want liability for everybody running from the date of the accident?

Mr KAYROOZ: Yes.

The Hon. TREVOR KHAN: I get that.

Mr DAVID SHOEBRIDGE: But the second point is that there is like a two-year interim period, which is designed for a number of reasons. The first is that you can actually have a greater number of people getting access to this service but the other thing is that it allows Lifetime Care and Support to spend time with somebody and to fully understand their needs to determine whether or not they should be permanently in the scheme or not.

Mr KAYROOZ: Sure.

Mr DAVID SHOEBRIDGE: But if they are on your books until a claim is made and you determine 18 months down the track that they should have been in Lifetime Care and Support, how does the interim period work then because they may only be with Lifetime Care and Support for a matter of months?

The Hon. TREVOR KHAN: Yes, that is right. It is recommendation 5. If there is a delay in putting the person into the scheme, perhaps my friend's suggestion of 18 months is not but with a closed head injury it may take six months in order to crystallise so you then have the person in the scheme for only 18 months, if my maths is correct. What is efficacious about reducing that two-year period down?

Mr KAYROOZ: I will take that on board and I will get back to you with a case.

Mr DAVID SHOEBRIDGE: The most extreme case would be if there is an acquired brain injury that deteriorates over time and it is three years after the accident that you actually make the application.

The Hon. TREVOR KHAN: That is right and then you have lost your whole interim period under that criteria.

The Hon. DANIEL MOOKHEY: Should we adopt the suggestion about changing the date to the date of the accident? Do you foresee any consequences on the premium level?

Mr KAYROOZ: Not on the overall level. Again it looks as though there is a large incentive. The overarching CTP premium and the Lifetime Care levy combined—if there is a shift either way, it has to reflect that shift.

The Hon. TREVOR KHAN: It depends on the cost profile, does it not?

Mr KAYROOZ: Yes.

The Hon. TREVOR KHAN: Somebody who has had a catastrophic motor vehicle is whipped off to the Royal Prince Alfred Hospital. I assume there would be a very high upfront cost in the first month in dealing with the injured patient, with tubes and machines. If you move it back to the date of the accident, all that high upfront intense care of the patient would then get transferred to Lifetime Care and Support?

Mr KAYROOZ: Yes, and a lot of that is transferred through the Medicare rebate system that we have that is paid by the hospital system and then that goes into a levy that we pay through there.

Mr DAVID SHOEBRIDGE: Could you explain to the Committee how those costs are dealt with under the current scheme. For example, there is a terrible accident, the patient is taken by ambulance, four weeks in intensive care, then two months in hospital rehabilitating and then exiting. Who under the current scheme meets those hospital costs?

Mr KAYROOZ: Can I take that on notice and get back to you. I think I have a good idea of how it is worked through; an estimation of the health insurance as to what the hospitals pay. Then that is estimated every year and put on as a levy.

Mr DAVID SHOEBRIDGE: It is not straightforward, that is all?

Mr KAYROOZ: It is not just an individual's bill for the hospital that is given to them. It is actually a levy that we put back; they estimate the overarching costs for motor vehicle claims over a year and as part of the CTP premiums.

The Hon. TREVOR KHAN: Is that how it is done? So they do not just send you a bill?

The Hon. LYNDA VOLTZ: No.

Mr DAVID SHOEBRIDGE: It is complicated.

The Hon. LYNDA VOLTZ: While you are getting those figures, because it is now no fault; it has shifted?

Mr KAYROOZ: Only for a six-month period.

The Hon. LYNDA VOLTZ: But that will still impact on them; that will still change?

Mr KAYROOZ: For the first six months, yes, which is a great news story.

The Hon. LYNDA VOLTZ: But it also changes Lifetime Care and Support and a whole range of things, does it not, if you shift it back to that date?

Mr KAYROOZ: Yes. My understanding is they estimate the hospital costs overarching for motor vehicle accidents over a year. They estimate that and it is given to Lifetime Care and whatever that number is becomes part of the levies or premiums we charge. It is estimated every year. It is actuarially reviewed.

The Hon. LYNDA VOLTZ: There have been significant changes to compulsory third party insurance. For a start, journey claims coming off workers comp going on to CTP, and then you have no fault. If we could get some idea of those changes?

Mr KAYROOZ: I can take that on notice.

The Hon. DANIEL MOOKHEY: Is the thrust of your evidence that adoption of your proposal to shift liability to the point of the accident, as opposed to eligibility, is that going to simplify a transfer that already happens or is it creating a new opportunity to transfer liability onto the lifetime care scheme?

Mr DAVID SHOEBRIDGE: Or both?

Mr KAYROOZ: The aim of it I talked about before is purely from a principle point of view. We are not talking large amounts of money. We are talking about 180 claims that come into the scheme each year. We are talking about 180 claims each year. It is the every day operation. It is not talking huge amounts of money. As a percentage of the total scheme it is a small amount of money. It takes away the potential incentive for people to have an incentive to act in different ways.

The Hon. DANIEL MOOKHEY: Should we adopt the proposal you would be able to recover the costs from the scheme?

Mr KAYROOZ: Yes, Lifetime Care would pick up the costs above the hospital costs.

The CHAIR: They would recalculate your levy?

Mr KAYROOZ: The levy would have a small impact on the cost of Lifetime Care and on what the initial cost of insurers are.

The CHAIR: Hospitals do not hold back treatment?

Mr KAYROOZ: There is no difference there.

The CHAIR: It is the interim you are speaking of?

Mr KAYROOZ: Where this comes into play is where they come out of hospital. It is mild to moderate. They then go into treatment facilities. There may be modifications needed at home and determination saying we are going through the application for Lifetime Care, there is a possibility over the next three months while we go through that process that Lifetime Care will get it, but the insurer will say, "Should we pay for this or not?".

The Hon. TREVOR KHAN: Instead of proposal four where it is from the date of the accident, could it not be two or three months after the date of accident or the date of determination, whichever is earlier?

Mr KAYROOZ: Yes.

Mr DAVID SHOEBRIDGE: Or date of application would be a significant improvement. That is the point at which you are potentially recognising the internal conflict.

The Hon. TREVOR KHAN: Yes. That gives it greater flexibility.

The Hon. DANIEL MOOKHEY: From the perspective of the premium payer your point would be, if the liability was to transfer as a new liability into Lifetime Care some of the additional cost to the NDIS levy would be offset by a lowering of green slip premiums?

Mr KAYROOZ: Yes. The percentages would be—

Mr DAVID SHOEBRIDGE: A fraction of a fraction.

Mr KAYROOZ: Yes.

The Hon. TREVOR KHAN: For the individual involved it might be impacted by negative behaviour. It is worthwhile fixing it for one person?

Mr KAYROOZ: Yes. We are saying the scheme is working really well. This is, "How can we make it better?"

Mr DAVID SHOEBRIDGE: From a common approach angle, having the liability from the date of the application makes a lot of sense. In other schemes it is from the date of application and you are not dealing with retrospective issues and it is a known point in time.

Mr KAYROOZ: We are happy to work with you in Lifetime Care to get a suggestion that works better. Again, the focus is on the injured person. These people are seriously badly injured.

The Hon. DANIEL MOOKHEY: What has been the response from icare and others to this proposal?

Mr KAYROOZ: We have had initial talks with icare. We have not gone into detail. We have waited for this Committee to go through it.

The Hon. DANIEL MOOKHEY: Would you expect to attract the support of other insurers? I accept that is a hard question.

Mr KAYROOZ: How other insurers view it, I do not know. I would think they would agree that they would be happy to have the liability shifted. It is the minor one. We have put in a submission and I am happy to talk on behalf of Suncorp.

Mr DAVID SHOEBRIDGE: We had the Bar Association here earlier and Mr Stone, SC, gave three examples where injuries had happened at Broken Hill or near the Victorian border and the claimant was taken to Adelaide or across into a Victorian hospital.

The Hon. TREVOR KHAN: Mildura.

Mr DAVID SHOEBRIDGE: Neither Adelaide nor the Victorian hospital picked up the eligibility for Lifetime Care and Support. Is there a noticeable issue about the cross-border facilities? Is there a need for Lifetime Care and Support to get to those obvious injury points across the border?

Mr KAYROOZ: Yes. It goes to the ongoing education in the regional areas. It builds on that.

Mr DAVID SHOEBRIDGE: And, probably south-east Queensland?

Mr KAYROOZ: Yes.

Mr DAVID SHOEBRIDGE: Those obvious points?

Mr KAYROOZ: Yes, the obvious points. Lifetime Care has done some really good work in the regional areas. We are saying it cannot be a one-off, it has to be ongoing.

The Hon. TREVOR KHAN: A patient is transferred to Mildura from an accident in New South Wales. What happens in terms of the cost of that patient being treated in Mildura? How does Suncorp, I assume, paying that cost?

Mr KAYROOZ: It depends when they put the claim form in and we work through what are hospital costs or not. I will have to take that on notice.

The Hon. TREVOR KHAN: There is an admission process in every hospital and you get somebody who rolls up, if you come through accident and emergency, and asks a range of questions.

Mr KAYROOZ: Yes.

The Hon. TREVOR KHAN: I am sure it is not that much different in the other States. I understand why people do not find out about Lifetime Care and Support because the care of the patient is different from the administrative process. I am interested as to how the cross-border cases are dealt with. Is it the insurer, rather than the hospital, that should be the trigger in terms of notifying of Lifetime Care and Support issues?

Mr KAYROOZ: The notification we get in claims depends on the injured party and their advisors. In some States police immediately report to insurers. At the moment we are at the beck and call of when the injured party contacts us and the hospitals and health system are under no obligation to report to an insurer.

Mr DAVID SHOEBRIDGE: If there has been an accident and someone is injured and taken away is there nothing in the current system that has that information getting to insurers?

Mr KAYROOZ: Under the new system the State Insurance Regulatory Authority will be notified, they have access to the police and for the major ones there is a chain reaction of notifying the insurer and this is your insured and you are involved.

Mr DAVID SHOEBRIDGE: Going forward, yes, hopefully?

Mr KAYROOZ: That has developed over the last couple of years.

The Hon. TREVOR KHAN: Developed over the last couple of years?

Mr KAYROOZ: Yes.

The Hon. TREVOR KHAN: Driving motor vehicles for compulsory third party.

The CHAIR: We will have to conclude the discussion about cross-border relations. Thank you for giving evidence today. You have taken quite a few questions on notice and the secretariat will advise in relation to questions on notice. We ask you to supply the answers within 21 days.

(The witness withdrew)

ADELINE ELIZABETH HODGKINSON, Co-Chair, NSW Agency for Clinical Innovation Brain Injury Rehabilitation Directorate, sworn and examined

RACHEL MORRIS, Occupational Therapist, Hunter Brain Injury Service, sworn and examined

The CHAIR: Dr Hodgkinson, would you like to make an opening statement?

Dr HODGKINSON: Yes. I have tabled a brief submission which refers to Rachel's submission. Although we have appeared at previous hearings, the issues currently facing us this year are the introduction of the National Disability Insurance Scheme and the decision by Lifetime Care and the NDIS to not operate on the same participants, so that if someone is a disabled person eligible for the National Disability Insurance Scheme, the agreement is if they have an injury that makes them eligible for the Lifetime Care and Support Scheme, that only one scheme is involved, and that they transfer to the Lifetime Care and Support Scheme. This decision is generally a sensible one, but there have been some issues and inequities arising from that transfer. Rachel has one or two particular incidents to discuss. I have attempted to summarise the issues into categories.

There are the eligibility issues. A disabled person who incurs a severe traumatic brain injury will move to Lifetime Care and Support, and that is the subject of Rachel's submission. An individual covered by Lifetime Care and Support for an injury sustained in a motor vehicle accident who then develops a second significant disability unrelated to the motor vehicle accident would not be covered for that injury by Lifetime Care and Support. I have not had any clear decision as to how Lifetime Care and Support or the NDIS would fund the future care of that person. An example is that a lady I have had involvement with sustained a head injury from a motor vehicle accident. She required a certain amount of care, but not a lot of care.

Then some yeas later she fell and sustained another severe injury, but that fall was unrelated to a motor vehicle accident and not really attributable to the original accident, so there was no link; it is a second unrelated accident. Now she has 24-hour care costs. The difficulty is how will Lifetime Care continue to provide care for that person? Their argument is that her care costs are not injury-related and they did not pay for her medical care costs in hospital. They are struggling with some care support, but certainly not her entire needs. That is a second instance.

The third instance that Rachel also mentions is that a person may enter the scheme and not be in the NDIS, but they then exit the scheme at the interim mark. So at the two-year mark they then exit the scheme. That decision to exit the scheme is assessed in the last month or two and, sometimes due to other factors, they may enter a period when they are unfunded, so they may have a care component that is unfunded. Then they need to apply to the NDIS, be accepted by the NDIS, have a plan or whatever, which may take six months. So for six months or more they will be uncovered, and there is no handover of care from Lifetime Care to the NDIS. Maybe that needs to be looked at.

In respect of the differences in services that are provided, the NDIS has a different structure and a different focus. A lot of it is choice and control for the disabled in the community. They do not take over any medical costs; they are all assumed to be met by Medicare, whereas Lifetime Care will pay for necessary medical and rehabilitation costs. That is a benefit that Lifetime Care has over the NDIS. Lifetime Care have been very clear that it does not pay for recreational activities. It will pay for a carer for someone to attend the movies or to attend church, but it will not pay for transport to get to church or transport to get to a recreational venue, or membership of an organisation which would be for recreation, whereas the NDIS would pay for those things. That would be part of the flexible funding arrangement and they would be eligible to use their transport allowance how they wished and there would be no restrictions on it.

In respect of oversight, I like the Lifetime Care and Support's processes, which are ensuring quality. There is an accreditation process for care services. That is not the case in the National Disability Insurance Scheme, but that is not what this is about. There are differences in the funding arrangements, so there is more of a push for self-management in the NDIS and much less self-management and certainly no flexibility in Lifetime Care. If you are paid for transport from X to Y, that is where you have to pay, you cannot manage your—

Mr DAVID SHOEBRIDGE: They are a remarkably different cohort. The severity of injury that you see in Lifetime Care and Support is almost all at the upper end, which partly explains that?

Dr HODGKINSON: No. The are differences in the schemes from our perspective—Rachel and I both work with brain injury. So the current numbers of people with severe brain injury in the NDIS is 3 per cent of the scheme. Really whatever the scheme is designed for, brain injury forms only a very small component of it. So a lot of what is seen with NDIS from our point of view only relates to that 3 per cent of the scheme. Lifetime care and support can be any severity as can NDIS. I do not think there is a difference in severity. I think really there is a need to ensure that there are no gaps in service provision.

Ms MORRIS: I am really pleased that I am here from the perspective of the clients, those people really interfacing at ground level, and just some of those challenges the clinicians and I experience on a daily or weekly basis. I am grateful for the opportunity to be able to give the Committee some feedback how that hopefully may influence or change some of the decisions with regard to the legislation that is around the lifetime care scheme. I want to comment on my submission. The two points with my recommendations that I made at the end is really something I would welcome your input and experience and opportunity to discuss.

The CHAIR: Would you like to outline your recommendations?

Ms MORRIS: The recommendations are that for NDIS participants with approved plans that are narrative and support some of the lifetime care scheme who do not meet lifetime care scheme lifetime eligibility criteria of two years to have funding available and for supports to be ongoing from Lifetime Care and Support until the NDIS scheme funding is available for them.

Mr DAVID SHOEBRIDGE: We might break them down into three. That is your first one. Do you have examples of how that has created problems.

Ms MORRIS: Yes, the current case example that I discussed, and has been de-identified, he has got the potential not to meet the lifetime care scheme. His NDIS supports have stoped now. They have been absorbed into the Lifetime Care scheme and he had chronic mental health problems prior to his motor vehicle accident. He is actually much better now because he has had regular care and support and structure. So in terms of lifetime care it is doing a great job, he is in such a good shape now. But potentially when lifetime care ends, he is longer eligible for that two years, the NDIS application process is so laborious that he could end up with no care potentially for six to 12 months.

Mr DAVID SHOEBRIDGE: And fall right back into the hole he was in at the beginning?

Ms MORRIS: Yes.

Mr DAVID SHOEBRIDGE: Is six to nine months the normal period to get accepted through NDIS?

Ms MORRIS: Absolutely. The NDIS will not even enter into discussions with us if they are having active rehabilitation treatment in care. Currently for our clients that we know "potentially" are not going to get into the scheme that would be eligible, whether it is a chronic alcohol problem pre-injury or something that they would be eligible for Disability Support Pension [DSP] and the NDIS scheme, they will not even give them a number. They will not give them a NDIS number which can begin that process.

The Hon. TREVOR KHAN: I do not want to be rude, and I am not being dismissive when I say that, that seems to be a deficiency in the operation of the NDIS but that is not to say that we should not do anything. Really at the heart of it is that they will not even undertake the assessment and they are out on the street, in essence?

Ms MORRIS: Yes.

The Hon. TREVOR KHAN: That is remarkable.

Mr DAVID SHOEBRIDGE: This is how I would have assumed it would operate without having read your submission. I would have assumed that a rational scheme would work with two years in lifetime care and support. If you become permanent then you stay in lifetime care and support but if you have been determined not to meet the criteria at the end of two years, I would have assumed that there would be a case conference where the Lifetime Care and Support case manager would meet with, if there is CTP insurer involved, and the NDIS and sort it out between them.

Ms MORRIS: That sounds wonderful.

Mr DAVID SHOEBRIDGE: But that does not happen?

Ms MORRIS: No, not as far as I am aware.

Mr DAVID SHOEBRIDGE: Should that be how it happens?

Ms MORRIS: It would be ideal because it is all about transfer of care, and that is what I do as a case manager all the time, co-ordinating that pathway and the transfer—

The CHAIR: Earlier the Committee heard there are no NDIS case managers?

Mr DAVID SHOEBRIDGE: At the end of two years Lifetime Care and Support will know so much about this person that you think they could just sit down with whoever is making decisions in the NDIS and download the information and almost have it automatically.

Ms MORRIS: There is a bit of an assumption there as well. The people who you are handing over to are going to be as experienced as Lifetime Care. I love the Lifetime Care scheme because the clinicians and the co-ordinators really understand exactly what they are doing. But what they are then doing is potentially handing over the CTP or the NDIS to a coordinator who tend to be not as skilful and they do not have as good an understanding.

Mr DAVID SHOEBRIDGE: They drop off a cliff in some cases?

Dr HODGKINSON: I think what happens is Lifetime Care funding ends and it ends when the scheme ends. So there is not any opportunity to transition.

The Hon. TREVOR KHAN: Is that right? There is an opportunity. If you are working on the basis that a person is likely to go out of the scheme that does not happen overnight, I take it?

Ms MORRIS: No, we have had discussions locally up in the Hunter region. We have got a great relationship with the Lifetime Care scheme office there. We have bounced around ideas with how we can support participants so that they do not fall off the cliff, as you are suggesting. They have thought, maybe we need to be doing team assessments which is the functional independence measure assessment which determines eligibility for that lifetime participation at six months. So then you are only giving somebody 18 months of active treatment we have in care before you are then determining their eligibility for lifetime participation. So you are not actually having the full extent of that.

The Hon. DANIEL MOOKHEY: Are the deficiencies in the transfer processes to NDIS—put aside CTP—reflective of engendered cultural practise on the part of the NDIS or is that reflective of the fact that the NDIS is new and still evolving its systems?

Dr HODGKINSON: The NDIS is new and evolving so its processes are slow and it would be hoped that six months could shorten. In terms of the process of leaving Lifetime Care and Support that is something that has a variable approach sometimes. For a lot of patients it is an easy decision about whether they are in or whether they are out but there is that group of patients where they are on the borderline and then there are drivers for getting out of the scheme. That might be if they have a third party compensation claim. They may wish to be out of the scheme in order to be able to have a lump sum payment. So that is one driver. The participant and their legal adviser may wish them to be out of the scheme. This is where there would be some appeals of the decision and it would drag on past the end date for Lifetime Care and Support.

Mr DAVID SHOEBRIDGE: There are some cases where the insurers keep reviewing and say they should be in the scheme as well.

Dr HODGKINSON: Yes..

The Hon. TREVOR KHAN: Yes, but that is not the problem that we are facing here.

The Hon. DANIEL MOOKHEY: But accepting that there are reasons people wish to be out of the scheme, is the transitional assistance good, bad, indifferent, could be improved—

Dr HODGKINSON: There is no transitional financial assistance really once you reach the point. If in the six months prior to that a decision is made that they are going to exit the scheme then applications could be made—

The Hon. TREVOR KHAN: To whom?

Dr HODGKINSON: To NDIS or to community support services for a transitional package. Yes, you could try and line that up but the National Disability Insurance Scheme is not going to consider someone unless they are out of lifetime care.

Mr DAVID SHOEBRIDGE: Do you think one useful thing to do, depending on how much it costs, would be to say if someone is exiting the scheme after the two-year interim period has ended then maybe consideration of a six-month transitional package so that lifetime care and support that has all this knowledge, and has often done a great job, can also help by being there while the NDIS gets started and while the transfer happens? Would that be helpful?

Ms MORRIS: They really are the experts. The lifetime care coordinators really go out and meet the clients. They really absorb themselves in the clients world, which is fabulous. If they can work with the health team and whoever to drive that transfer that would be fantastic.

The Hon. DANIEL MOOKHEY: Did you say earlier that the NDIS will not consider a person if they have any connection to this scheme?

Ms MORRIS: Yes.

Mr DAVID SHOEBRIDGE: The question was any connection but did you not say while they were a participant?

Ms MORRIS: Or whilst they are having general active rehab as well.

The Hon. DANIEL MOOKHEY: If Mr Shoebridge's quite sensible suggestion were to be adopted, would that require the NDIS to change its approach from participant to connection?

Dr HODGKINSON: If the decision has been made that they will leave the scheme then transition package funding to ensure that they are not just left high and dry is reasonable.

Mr DAVID SHOEBRIDGE: And it would not be a barrier to making application to the NDIS?

Dr HODGKINSON: It would not be a barrier, no.

Mr DAVID SHOEBRIDGE: You said that, but I took the evidence as being that you might be able to put in an application but they will not consider the application until you are out of the Lifetime Care and Support Scheme.

The Hon. DANIEL MOOKHEY: That is what I am asking. Will the NDIS simply just wait for your transitional assistance that lifetime care has provided you to end and we have just delayed everything by six months?

Ms MORRIS: I guess that is a discussion that has happened with lifetime—

Dr HODGKINSON: I think if a decision had been made that they were exiting lifetime care and support and all that was occurring was some transitional support, then they would have to consider an application, whereas if they were an active participant they would not.

The Hon. DANIEL MOOKHEY: When you say "they would have to consider" is that a resolved policy on the part of the NDIS or is more that you would expect them to?

Mr DAVID SHOEBRIDGE: Well the—

The Hon. TREVOR KHAN: Do not cut across. That question is on point, at least as far as my brain is concerned.

Ms MORRIS: Can you repeat the question?

The Hon. TREVOR KHAN: Is NDIS in a sense being bloody-minded and saying, "We will not look at this person until they are out of lifetime care and support?" Is that what they are doing?

Dr HODGKINSON: Yes.

The Hon. TREVOR KHAN: In providing a further interim package of six months we still run into the problem of the bloody-mindedness of NDIS saying, "We will not consider the application until they are out of lifetime care and support." If we go and say, "Add an extra six months." That is not changing what the essential problem is, which is NDIS.

Dr HODGKINSON: I think lifetime care would be in a position to negotiate with NDIS over that.

Ms MORRIS: And I think potentially the second recommendation of a dedicated team under the lifetime care umbrella to have training to develop knowledge and expertise to link in with the NDIA and lifetime care scheme might potentially be some resolution. So for these clients who you know are NDIA eligible who are in the lifetime care scheme, perhaps then there is a task force within lifetime care that will then drive that NDIA application with obviously the health support as well. So it is identifying these clients because there are going to be more. I currently case manage nine people and three of those I think are eligible for NDIA but at the moment they are lifetime care.

The Hon. TREVOR KHAN: I am not being unsympathetic, I am just working out who is essentially the problem.

Ms MORRIS: The problem is for the client, is it not, really? So whatever outcome.

The Hon. TREVOR KHAN: I accept that the problem is for the client, but which is the client organisation that is the problem? If lifetime care and support has a scheme—

Ms MORRIS: Lifetime care have actually changed the rules, I have got to be honest. Up until recently this one client that I mentioned, he had NDIA funding for his mental health condition and he had lifetime care for his motor vehicle accident. Things were travelling along quite well. As a case manager I was able to clearly delineate between the two different conditions and make requests that were relevant for the motor vehicle accident and allow the mental health sector and the NDIS to deal with the mental health issues. But we were given this notification locally that NDIS would no longer be relevant for anybody who is in the lifetime scheme and that was all going to be absorbed. So I guess this situation we are in is because of a decision that has been made locally by lifetime care.

The Hon. DANIEL MOOKHEY: But that is for a person with two conditions?

Ms MORRIS: Dual diagnosis, yes.

Mr DAVID SHOEBRIDGE: But you are saying that is not wholly unusual.

Dr HODGKINSON: It is not uncommon, no.

Ms MORRIS: No, it is not unusual at all.

The CHAIR: But that is different to what we have been talking about in terms of the transfer across totally from lifetime care and support to NDIS.

Mr DAVID SHOEBRIDGE: Just to go back to that transfer—

The Hon. DANIEL MOOKHEY: Could we have a response to that question because it was a good one?

The CHAIR: Just to clarify. We are not talking about the current situation you have just outlined, but the transfer from lifetime care and support to NDIS at the two-year point?

Ms MORRIS: The two separations.

The CHAIR: That is a black-and-white transfer?

Ms MORRIS: Yes.

The CHAIR: Even though lifetime care and support has made an assessment and has been treating this patient, NDIS will make a new set of clinical assessments as to whether or not accept the patient.

Ms MORRIS: Yes.

The CHAIR: I assume that is the gap.

Ms MORRIS: Yes.

The CHAIR: Do the medical people have identical criteria?

Dr HODGKINSON: They are not identical, they are similar. The lifetime care assessments relate all the disability to the injury, whereas the National Disability Insurance Scheme simply looks at disability—whatever the cause and however many causes you may have.

The Hon. TREVOR KHAN: I still struggle as to why the answer to this problem is not that the NDIS needs to be undertaking its assessment during the two-year period. Why is that not the answer?

Dr HODGKINSON: They would not be involved if the person stayed within lifetime care and support. That would be an unnecessary assessment and involvement.

The Hon. TREVOR KHAN: Perhaps I have got this entirely wrong, but if a person is assessed and found within the two-year period to be ineligible to remain within the scheme then at that point in time a person could lodge an application and begin the assessment process, accepting it is not allowed? Is that right?

Ms MORRIS: No. The proposal that has been discussed locally, which I think I mentioned, was the six months prior to the end of that interim—

The Hon. TREVOR KHAN: I accept that. I am simply asking that if a person is told before the two-year period that they are not going to remain in the scheme, then why is not the answer that at that point in time the person can lodge their application with the NDIS and the NDIS commence its assessment process? That would overcome the problem.

Ms MORRIS: Yes, at 18 months.

Dr HODGKINSON: That would. At the moment that has not been agreed to by NDIS or between lifetime care and NDIS, which could have a joint agreement.

The Hon. DANIEL MOOKHEY: Is not the solution here that before we contemplate the design of transitional assistance packages that we should be telling lifetime care to do a deal with the NDIS to provide clarity as to how to treat these scenarios?

Dr HODGKINSON: As long as they do not leave people in a black hole, yes.

Ms MORRIS: In the lurch, yes.

The CHAIR: At the end of the day everyone is focused on their budgets.

Ms MORRIS: Nobody wants to waste their time essentially, do they?

The CHAIR: Could NDIS be second-guessing this?

Mr DAVID SHOEBRIDGE: It would only be once a decision had been made. Basically, once a decision is made by Lifetime Care and Support that somebody is going to be exiting, that is when there should be an immediate trigger with NDIS to come in, sit down and work out what is going to happen.

The Hon. TREVOR KHAN: I will just answer the Chair's point. People are provided with aged care packages all the time, but you are given, I think, 60 days in which to take up the care package. It is not a yes or no, because there are a variety of circumstances where the aged-care packages will become available and, frankly, dealing with old people who have a whole range of issues themselves, sometimes you just cannot get them to cooperate in operating under the aged-care package. I hear what you say, but it does not reflect the reality, at least in dealing with people in aged care.

Mr DAVID SHOEBRIDGE: Could we just go on to something else? One is the transition, and that does not seem to be working particularly well and we should pay attention to it. The other one is where you have got the parallel entitlements—significant injuries being dealt with under Lifetime Care and Support and then either a pre-existing or post facto condition that should be then picked up by NDIS, but because of, you said, a local decision with Lifetime Care and Support that is not happening.

Dr HODGKINSON: It is not local, it is between Lifetime Care and Support and the NDIS.

Mr DAVID SHOEBRIDGE: Can you explain that in more detail?

Dr HODGKINSON: We received a notification that there had been an agreement between Lifetime Care and Support and the National Disability Insurance Scheme that only one scheme would be involved.

Mr DAVID SHOEBRIDGE: When did you get the notification and who did it come from? Did it come from both agencies or just Lifetime Care and Support?

Dr HODGKINSON: It only came from Lifetime Care and Support and it came from—

Ms MORRIS: Deborah Hoffman worked in the NDIS and she is now working at icare. She had met with us up in the Hunter and that is why I say locally, probably, because she was trying to work out some issues that we were experiencing locally. I have got a letter here that Synapse wrote to Deborah Hoffman personally, just outlining some of their concerns about the interface of NDIS and the Lifetime Care scheme. Would you like me to table this?

The CHAIR: Yes. If there are any issues about privacy we will deal with that.

Ms MORRIS: I am just looking at it to see if it had a date on it when the decision was made.

Mr DAVID SHOEBRIDGE: Are we talking the last few months or—

Dr HODGKINSON: This year or late last year.

Document tabled.

Mr DAVID SHOEBRIDGE: You gave that example, Ms Morris, about your client whose needs were being met under Lifetime Care and Support but then the pre-existing mental condition. I had understood that you said that was all working very well now.

Ms MORRIS: It was working very well.

Mr DAVID SHOEBRIDGE: It was working well when both systems were working together.

Ms MORRIS: When two schemes were working in parallel.

Mr DAVID SHOEBRIDGE: Now this decision has happened, what has been the effect?

Ms MORRIS: The client is potentially made disadvantaged because the way the NDIS supports are delivered is very flexible. For example, he gets allocated so much money for transport, which is something that Dr Hodgkinson referred to. He can use that money flexibly to put petrol in his car so that he can drive for his mental health. That is as much reasoning and justification that is required for the NDIS plan supporter, whereas when I approached that locally in the Hunter with Ms Hoffman, Lifetime Care are not open to doing that because you are more heavily regulated with regards to what you can do and how you can provide the client with transport. So he will have to complete a personal expense claim form, which is going to be difficult where there is a brain injury, and he will not get that petrol money for his car, and he lives on a disability support pension. So in terms of his general wellbeing, it has been significantly impacted for him with the merging of the two schemes.

Mr DAVID SHOEBRIDGE: But how does NDIS just simply say "We are not paying"? If someone would have an entitlement under NDIS how can they just simply say "We are not paying anymore"? I do not understand how that works.

Dr HODGKINSON: Ask Lifetime Care about the agreement. We were told the effect.

The Hon. TREVOR KHAN: You were told the effect. Were you told the rationale? I can think of one.

Ms MORRIS: To simplify it, I guess. As a clinician, that is what I am thinking the rationale may have been: to simplify it for the participant.

The Hon. TREVOR KHAN: Or is the rationale that because of the different ways the schemes operate there is the potentiality of, perish the thought, gaming the schemes—that is, you get a package from one and then you make claims on the other so that the potential for duplication—

Ms MORRIS: No, I do not agree with that. That is not my experience. I like to think that people do the right thing.

The Hon. TREVOR KHAN: That is admirable. I was a criminal lawyer.

Mr DAVID SHOEBRIDGE: He acted for criminals, he means.

Ms MORRIS: But the Lifetime Care coordinators are fabulous. You explain things, it is reasonable and necessary, you have got all those criteria, you have discussions. There is no double-dipping, from my experience.

Dr HODGKINSON: I would take your point that of course human beings being what they are, where there is opportunity to game the system there will be gaming. Sometimes the gaming is between State and Federal organisations.

The Hon. TREVOR KHAN: I agree with that too.

Dr HODGKINSON: And sometimes it is individuals.

The CHAIR: And the bureaucrats, particularly the State ones—

Dr HODGKINSON: The bureaucrats always assume honesty.

The CHAIR: They try to also game-proof the systems as much as they can.

Dr HODGKINSON: I think Lifetime Care is very regulated, so it tries to make decisions according to their legislation and their Act.

Mr DAVID SHOEBRIDGE: It sounds to me like we need to explore with Lifetime Care or SIRA what the nature of this agreement is. It may be that it comes with certain funding from NDIS so as these services can be extended; we do not know. I suppose we need to explore that in detail. But you would like us to, I assume?

Dr HODGKINSON: Yes.

Ms MORRIS: Absolutely.

Mr DAVID SHOEBRIDGE: Maybe get it publicly tabled.

The Hon. DANIEL MOOKHEY: In terms of the level of knowledge that you have described of case managers which gives you the confidence to assume that there is not the level of gaming that might be present in other schemes, is that a function of the fact that this is a pretty small scheme and that there are only 1,200 people and it is not too hard to be able to facilitate over a long period of time decent knowledge as to their relationships? I am asking that because should the scheme expand dramatically, which is intended, are the systems robust enough that you would have the same level of assurance if it was to go from 1,200 to, say, 6,000 or 10,000 or 12,000?

Ms MORRIS: That is a difficult question to answer because I think one of the benefits of the scheme is that to be a case manager you have to have a certain amount of experience of working with the client group to be working within the Lifetime Care offices.

The Hon. DANIEL MOOKHEY: What is the ratio of case managers to clients?

Ms MORRIS: I have got nine at the moment—complex, new brain-injured clients—and I work full-time, and I struggle sometimes to get through what I need to do for clients. So I am very busy. Other people might be able to manage more, but I think that is a good number.

Dr HODGKINSON: I think, in general, most newly injured Lifetime Care participants have a case manager appointed and over time the need for intense case management is much less.

The Hon. DANIEL MOOKHEY: But that is a relatively low ratio. In your experience, is that a mitigation device against fraud abuse, misclaims, dual claims—the type of practices which are common in other schemes?

Dr HODGKINSON: A case manager cannot mitigate against fraud.

The Hon. DANIEL MOOKHEY: Of course. Putting that one aside, in terms of—

Ms MORRIS: There are always discussions with clients when they have had an injury generally because people are on compensation or whatever—that happens in the background. As clinicians working with a team, I think that is the essential thing: you are not on your own; you work as a team. You might work as a small team, a therapy team, you might work on a greater clinical team with the doctors, and even out there with the Lifetime Care coordinators—it is a team, and I think that is the key message. I think if you worked on your own then that area in terms of being able to get to know someone is going to be a lot greater.

Mr DAVID SHOEBRIDGE: Who pays for your services, Ms Morris? Where does your funding come from? Which bucket of money or stream of money does your funding come from?

Ms MORRIS: I am Hunter New England Health. We are quite unusual at the Hunter Brain Injury Service in the fact that we do take on compensable clients as well as non-compensable clients. We offer an equitable service. Whether they go in or out of the scheme does not matter because they just come through. They have the same service across-the-board and then those decisions about eligibility and things just happen without us.

Mr DAVID SHOEBRIDGE: So your funding comes from the NSW Health budget?

Dr HODGKINSON: Yes.

The Hon. DANIEL MOOKHEY: Is that for the non-compensable part of it or the compensable part?

Dr HODGKINSON: Just to explain: the brain injury program in New South Wales has been established as a part self-funding organisation so Health pays our wages. We are Health employees. There is an expectation that revenue that we are part of raising is held by the local health districts but fed back to the brain injuries services to support that. We are not operating as private individuals or earning a revenue but there is an expectation that we provide service to the private sector.

Mr DAVID SHOEBRIDGE: You are operating at a critical place in the State as well because you are noticing these things in advance of other parts of the State?

Ms MORRIS: Yes.

Mr DAVID SHOEBRIDGE: So getting this scheme designed to right now, based on your experience, is really important?

Ms MORRIS: I think so. As it rolls out throughout the State, I think it would be really good to know what is going to happen for these people who are eligible for the NDIS who may not go into the Lifetime scheme.

The CHAIR: Thank you for coming into with your expertise. It was helpful for us to explore the interface with NDIS, which is a new thing for us to be looking at. You have taken a few questions on notice.

The secretariat will advise you of those and we ask that you reply to those questions in writing within 21 days. Thank you for your attendance and for the work you are doing in the community.

(The witnesses withdrew)

(Short adjournment)

VIVEK BHATIA, Chief Executive Officer and Managing Director, icare, affirmed and examined

NICK ALLSOP, Chief Actuary, icare, affirmed and examined

DON FERGUSON, Group Executive, Integrated Care, icare, sworn and examined

CHRIS KOUTOULAS, General Manager Operations, Dust Diseases Care, icare, sworn and examined

The CHAIR: Good afternoon and welcome to the first review of the Dust Diseases and Lifetime Care and Support schemes. Would any of you like to make an opening statement?

Mr BHATIA: Thank you very much for the opportunity. At the outset, let me thank the Committee for taking the opportunity to perform its oversight responsibilities over these two very important schemes that icare has a responsibility to administer on behalf of the New South Wales Government. We formed icare in 2015 with the core mission of protecting children in care, which included the full realm of responsibilities right from the prevention through to the caring of individuals when injuries do occur. There are two or three things I would like to highlight in this opportunity to open the session today. First, we have taken the opportunity to look at the various schemes within icare to see whether there are opportunities to cross-pollinate and leverage pockets of excellence within each of the schemes for the betterment of the whole.

A great example of that, in my opinion, is the workers care program, where we have looked at our functionalities of looking after catastrophically injured people in the Lifetime care scheme and examined it with the workers compensation scheme. We have known in the past that that role has not been discharged in a more effective manner by scheme agents and we believe that there is a different way of looking at people who are catastrophically injured, which we have got in house. We have more than 300 people now who have been brought in house and are receiving a very different level of service than they have in the past. The other thing I would like to emphasise is that we have taken the opportunity with the two schemes we are here to talk about today collectively which have a life of about 100 years—90 years for Dust Diseases this year and 10 years last year for Lifetime Care; to look at them and understand that while they are working well, what are the things that we need to improve upon?

As the schemes work well and we deliver services we also have different expectations: our expectations and expectations customers have of us. In a similar manner 10 years ago when the first iPhone was released it was a novelty value for everybody but if you gave someone that phone today it would be a big disappointment. As expectations change of us we want to make sure we are ahead of the curve and understand where the challenges are to constantly improve. We must embrace technological advances that surround us in the ecosystem to provide a better service to our participants.

To that extent we have embraced a human centred design approach where we bring in participants of the schemes, their families and their carers to help us iron out the wrinkles in our processes: whether we have become bureaucratic over a period of time; are things too prescriptive; or are we looking at things in a black and white manner, as opposed to the needs of an individual? We try to take that out of the picture to provide a service they need and expect of us. That has been an important process. We are investing in the training of our people and carers and technology. I believe that will help to provide the holy grail for customer experience, which is choice. For them to interact with us through a channel of choice, not one forced on them. We will offer interaction through phone, face-to-face or internet—it will be across all channels.

One more point is contribution to community. One of the biggest things is to look at opportunities where we can contribute to the community at large. That is through our research and grants function. The responsibility for that lies with the Dust Diseases Board. It is an important responsibility. We are one of the largest funders in the country of research and grants with dust diseases. That responsibility is discharged by a multi-partisan board that oversees these important research grants. Through the icare foundation we are looking at opportunities for us to do more around accessibility of services in the regional areas. In partnership with Spinal Cord Injuries Australia we recently opened the first NeuroMoves program in Lismore. Previously people had to go to Sydney or Brisbane to access the program. If that pilot works as well as we expect we will expand that across the regions in New South Wales.

The Carers NSW program we partner with is important because when an accident happens it effects family as well as the individual. It effects the people around them, their loved ones. We need a mechanism to provide support to them along with an adjustment factor that their life has changed. We have a family care program and young carers program for children or siblings of people injured in these accidents. While we are looking at these different things we are constantly ensuring that we do not get into the area of unconscious competence—these schemes work well, let us not think about that. We want to critically challenge ourselves.

This process works wonders because the Committee shines a light on areas we need to focus on. The review three years ago gave us many areas to focus on and we have taken the opportunity to look at those things and improve them. We hope during this process we will learn more through submissions and from the Committee about areas of focus for us.

The Hon. DANIEL MOOKHEY: I have some preliminary questions. What is the funding ratio of each of the schemes and what is the scheme efficiency?

Dr ALLSOP: In terms of the Lifetime Care scheme, its current funding ratio is 150 per cent. That needs to be considered in light of the probability of adequacy of the liabilities. The liabilities, through the accounting standard which it sits under, are booked at a central estimate level. There is roughly a 50:50 chance of those liabilities being either too high or too low.

The Hon. DANIEL MOOKHEY: It is 150 with a P50 either way?

Dr ALLSOP: Exactly. If we were to move that to a 75 per cent probability that the liabilities would ultimately prove to be adequate the funding ratio would drop to 130 per cent.

The Hon. DANIEL MOOKHEY: That is Lifetime Care?

Dr ALLSOP: That is Lifetime Care.

The Hon. DANIEL MOOKHEY: What about dust diseases?

Dr ALLSOP: Dust diseases, in theory, does not have a funding ratio because it is a pay-as-you-go scheme. We do have assets that have accumulated and if compared to the liabilities they are about 68 per cent of the liabilities at the central estimate level. If we add a risk margin to take those liabilities to roughly the 75 per cent probability of adequacy that would drop to 55 per cent.

The Hon. DANIEL MOOKHEY: What is the scheme efficiency on Lifetime Care?

Dr ALLSOP: How are you defining scheme efficiency?

The Hon. DANIEL MOOKHEY: Percentage of incomes returned to clients.

Dr ALLSOP: In our pricing basis for Lifetime Care it is about 92 per cent of the levy we collect goes back and benefits the participants of the scheme.

Mr BHATIA: For dust diseases it is in the mid eighties.

The Hon. DANIEL MOOKHEY: Upward trend, downward trend?

Dr ALLSOP: Relatively stable.

Mr BHATIA: It pays to point out that there is a big difference, as the Committee members know, between the compulsory third party scheme versus the Lifetime Care scheme in terms of the efficiency of the schemes.

The Hon. DANIEL MOOKHEY: On dust diseases, what is the average time for completion of assessment of liability for a claimant?

Mr KOUTOULAS: It depends on the nature of the claimant. If it is a worker, the average timeframe from the date of application to the actual determination of the claim is sitting around 62 days. And, for a dependent it is much less, from the date of application to determination it is 29 days.

The Hon. DANIEL MOOKHEY: Why the discrepancy?

Mr KOUTOULAS: There is not a lot of medical information and diagnosis required for a number of dependants given their partners are already in the scheme.

Mr DAVID SHOEBRIDGE: The complex investigative work is done?

Mr KOUTOULAS: On the majority of cases, yes.

Mr BHATIA: Over the last 18 months both these time horizons have dropped dramatically.

The Hon. DANIEL MOOKHEY: I was going to ask for your trend analysis?

Mr KOUTOULAS: More than 50 per cent in each case.

The CHAIR: How many people are currently in the scheme?

Mr KOUTOULAS: We roughly have 4,200.

The CHAIR: That is going down, or stable?

Mr KOUTOULAS: It is stable.

Mr BHATIA: What we see is that there is a 55 per cent improvement in the turnaround times from application to determination.

Mr DAVID SHOEBRIDGE: That is largely driven by making decisions on a continual basis instead of waiting for board meetings?

Mr BHATIA: There are a number of factors. That is one factor that contributes. It is the two day determination. Once we have done the medical examination we determine the claim in two days. That was a commitment that was made as per an Act of Parliament. We are continually looking at how to make things easier, from the industrial history assessment to the medical assessment. We are streamlining those processes at the same time, including simplification of the form. We had an eight-page form. It is now a two-page form now. These are the things that for some time have not been looked at from a streamline perspective. We are also trying to make sure we can call people and take the application on the phone. Some people are not in a position to sit down and apply for the benefits.

Mr DAVID SHOEBRIDGE: Could you give us the ratio of approvals to rejections over the last three years?

Mr KOUTOULAS: Since the icare reforms the ratios have not changed. The ratio of approval is a 97.8 per cent pre and post icare?

Mr BHATIA: It has been quite stable.

Mr KOUTOULAS: It has been stable.

The CHAIR: The cohort of clients, is it a late-in-life asbestos exposure?

Mr KOUTOULAS: Mostly.

The CHAIR: That is late life that the asbestos has materialised as a disease?

Mr BHATIA: Typically in their seventies.

Dr ALLSOP: The average age of claimants entering the scheme is about 75 at the moment.

The CHAIR: Are you doing any work that indicates this will move through and we will not need the scheme in the future, as there are no new disease entries?

Dr ALLSOP: There still will be a degree of workplace exposure and that will persist until we have removed all of the asbestos from our environment.

The Hon. TREVOR KHAN: The second part of the answer does not flow from the first. There is workplace exposure and then there is all that asbestos that still lingers in our environment in a variety of ways.

The Hon. DANIEL MOOKHEY: That is what I was going to ask about, the secondary exposure and any actuarial assessments that you have created or otherwise provided as to assess the likely claim size?

Dr ALLSOP: We are not liable for non-work related exposures, so we have not done the assessments on how big that would potentially be. In fact, the reason we believe we are past the peak of asbestos-related claims reporting is that the majority of our exposure is pre-1987, and combined with the age of the participants who enter the scheme at the moment, we believe we are going to see a tapering off over the next—admittedly 20 or 30 years, but it is past the peak.

The Hon. TREVOR KHAN: You do not expect many exposures to arise from builders who are involved in renovations of all those homes?

Dr ALLSOP: There absolutely will be some exposure that arises. Mitigating that is the better understanding of the risk and the better safety measures that are in place to protect people who encounter asbestos in the workplace.

Mr BHATIA: Also the numbers of people are much lower because there is only one particular group of people who are exposed to those things. Also, as Dr Allsop has said, we are a lot more aware, as a society, in terms of PPs, et cetera, and a lot more safety precautions are in place.

Mr DAVID SHOEBRIDGE: Before we go off dust diseases, I do not know if any of you had the opportunity to read the submission from Maurice Blackburn Lawyers? Their particular concern is that there is a much more limited class of dust diseases under the Dust Diseases Act than are picked up in common law. They detail, for example, types of pneumoconiosis. There seems to be an arbitrary line; some are in the Act, some are not in the Act. Do you notice in practice that there is this arbitrary line?

Mr KOUTOULAS: We have that defined list of dust diseases in our legislation and we receive applications relating to those diagnoses. The vast majority of our claims are related to asbestos exposure, and that accounts for roughly 95 per cent of our total cases. From the perspective of other types of diseases that might not be covered, the workers compensation legislation does generally allow other diseases of gradual onset to be covered under that legislation, so I guess the dust diseases has its mandated schedule of diseases, but there is availability of support under the workers compensation generally.

Mr DAVID SHOEBRIDGE: Looking at the kind of conditions they say are in, for example, schedule 1 has coal workers' pneumoconiosis but does not include carborundum pneumoconiosis. It includes hard metal pneumoconiosis but not bauxite fibrosis. These seem to be subjected to luck as to whether you fall on one side or the other of this is completely arbitrary line.

The Hon. TREVOR KHAN: Is it that some are more, dare I say, fatal in respect of their consequences? Is that the reasoning that has been applied? You do not know?

The CHAIR: Or more prevalent?

Mr KOUTOULAS: I do not know from a medical perspective. In respect of prevalence, we would need to do more studies to understand what is the incidence, what are the exposure rates, what are the types of latency periods associated with these types of diseases, what are the workplace patterns. It requires quite a lot of investigation and research to help us understand what is the actual impact from a financial perspective.

The Hon. TREVOR KHAN: Black lung?

The Hon. DANIEL MOOKHEY: Is black lung covered by your scheme?

Mr KOUTOULAS: It is covered under the dust diseases scheme, but there has not been any claims for that in New South Wales.

The Hon. DANIEL MOOKHEY: Queensland has got quite a few.

Mr KOUTOULAS: Queensland has got one, yes.

Mr BHATIA: Queensland, yes.

The Hon. TREVOR KHAN: Sorry, got one?

The Hon. DANIEL MOOKHEY: Queensland has more than one.

Mr KOUTOULAS: More than one, sorry.

Mr BHATIA: We have not had one as yet in New South Wales.

The CHAIR: It is a late-emerging disease after exposure. Going back to your in-house expertise, can we take on notice why some are excluded and some are not?

Mr DAVID SHOEBRIDGE: Farmer's lung is in, grain worker's lung is not.

Mr BHATIA: Some of them are probably a decision from a long time ago. As Chris has said, we need to make sure that we take this on notice and come back to you and say what the prevalence is, but one of the things that may come out of it is that we need to do a lot more research to understand the incident rates, the prevalence, the mortality rates, et cetera.

The Hon. DANIEL MOOKHEY: Is this within your authority to decide, as you understand it?

Mr DAVID SHOEBRIDGE: No.

The CHAIR: No.

Mr DAVID SHOEBRIDGE: You are covered by the Act.

The Hon. DANIEL MOOKHEY: Is it the Parliament?

Mr BHATIA: It is the Parliament.

Mr DAVID SHOEBRIDGE: You have the knowledge, because are you dealing with it and you have the best access to the research.

Mr BHATIA: Absolutely.

The CHAIR: The Act is probably quite old.

Mr BHATIA: It is a 90-year-old Act.

The Hon. TREVOR KHAN: The Act is old.

The CHAIR: Yes, the medical knowledge and prevalence of diseases and the issues of the day would not reflect those today. It would be good to give us feedback on that.

The Hon. DAVID CLARKE: If you came across people who were affected by these dust diseases, what would you do with that information? Would you pass it on to anybody?

Mr BHATIA: As Chris said, we do not typically get too many applications that are not in that region. We have a 98 per cent acceptance rate, which means that we hardly get any applications of numbers of such infections that fall outside the Act, and maybe we do not see them because they already look at it and say it is not—

Mr DAVID SHOEBRIDGE: You have a schedule.

Mr BHATIA: There is a schedule, there is no point applying for it. It works both ways. We do not see it, so we do not really know what the incident rates are.

The Hon. TREVOR KHAN: You have a 97.5 per cent acceptance rate of claims. Is the basis for rejection on the basis of no symptoms or no—

Mr BHATIA: Lack of workplace exposures, sometimes.

Mr KOUTOULAS: Sometimes, yes.

The Hon. DANIEL MOOKHEY: Returning to the question of the financial stability, should the Parliament decide to act to provide clarity on these diseases and therefore provide you with more claims to pay for—although it is not the case for dust diseases because you pay on a per claim basis—is it 68 per cent?

Mr BHATIA: Correct, at the central estimate level.

The Hon. DANIEL MOOKHEY: Of assets to liability?

Dr ALLSOP: Yes. So the assets are much less than the liabilities, but it is a pay-as-you-go scheme. The levy we collect in each year funds the expenditure in that year, so the benefits out and the expenses of administering.

The Hon. DANIEL MOOKHEY: Essentially you are operating out of cash flow?

Mr BHATIA: That is exactly right. For us, if there are more schemes that need to be included, there needs to be a natural recalculation of incident rates, what the cost of care would be.

Mr DAVID SHOEBRIDGE: And adjust the levy.

The Hon. DANIEL MOOKHEY: So we do have to worry about those other things that are associated?

Mr BHATIA: That is correct.

The CHAIR: You have a schedule of allowable expenses for patients and dust diseases, tick a box, you get paid.

Mr BHATIA: Yes.

The CHAIR: I will come back to them in a minute because it overlaps with some of the evidence we heard earlier today. What is the criteria for family members to apply?

Mr DAVID SHOEBRIDGE: Dependency.

The Hon. DANIEL MOOKHEY: For Lifetime Care?

The CHAIR: No, this under dust diseases.

Mr KOUTOULAS: It is dependency.

The CHAIR: Not widowers, it is dependency?

Mr KOUTOULAS: It is based on dependency, yes, on the worker who was exposed and diagnosed with a dust disease.

The CHAIR: Do they have to be alive, or is it ongoing?

Mr KOUTOULAS: No. If they had not made a claim or put in an application prior to death, we would still need some form of evidence.

The CHAIR: To be blunt, there would be a cohort of widows of the men who were exposed in 1950s and 1960s?

Mr KOUTOULAS: Yes.

Mr BHATIA: You are absolutely right. Out of the 4,200 people we are talking about, 2,500 are those.

The CHAIR: Widows?

Mr BHATIA: Yes.

The Hon. DANIEL MOOKHEY: I want to continue with the question on dust diseases that was prompted by the Hon. Trevor Khan which is to do with incidences of current work exposure, essentially beyond the point of asbestos production or construction in the first wave but rather incidental exposure, have you undertaken any researcher as to whether this is a concentrated problem or prevalent problem? Are there parts of the building industry or other areas, and is that information being shared with SafeWork NSW, because it does strike me that you are likely to have the best intelligence on this.

Mr KOUTOULAS: Certainly for our listed diseases we have quite a lot of data and quite rich data extending back for the duration of the scheme on incident rates, exposures, industries, employers, and we actually share and make these data sets available to research organisations like SafeWork Australia.

The Hon. DANIEL MOOKHEY: In respect of the national asbestos removal strategy, and the people who apply it, which is predominantly a process led by SafeWork Australia, is the level of interaction and information exchange adequate from your perspective and their perspective?

Mr KOUTOULAS: Our information is available, if they seek it. Usually we are jointly involved in quite a lot of research projects and so forth. A good example is our heads of asbestos co-ordinating authorities we are a member. We work with a lot of the other regulatory agencies, including local government, SafeWork and we have joint programs.

Mr DAVID SHOEBRIDGE: In relation to Lifetime Care and Support, a whole series of issues have been raised this morning. Suncorp was seeking a change of when lifetime care and support liability kicks in to either the date of the accident or the date a claim is made on the scheme. What, if anything, is your answer to that? They sought it for a couple of reasons, one of which was that it would have the law more closely align itself with, if you , self interest. If these insurers have a claim that they think is going to go into the scheme there is some self-interest in delaying payments or services until they go into the scheme.

Mr FERGUSON: I think that is quite insightful, the challenge being in relation to perverse behaviour. We certainly do not want to see any postponement of important services for people, particularly those with serious injuries, as early intervention is absolutely key. The supports that are provided in the first instance, whilst people are in hospital, are covered under a bulk billing agreement that we have with the health system. Irrespective of liability those services are made available. There is no consideration of ability to pay for the funder before they are made available.

Mr DAVID SHOEBRIDGE: They effectively accepted that point. A catastrophic motor accident, all of that is being provided at a hospital and nobody is making discretionary calls about service providers. It is probably more the marginal injuries.

Mr FERGUSON: Yes. There is a very small number of individuals that sit at the margins, if you like, particularly around mild brain injury where the certainty of recovery may be unknown and even the level of severity. It is probably for that smaller group that I think that we could potentially look more closely at how we resolve the issue of timeliness and decision making and clarity of liability between insurers and lifetime care. It is not something that has been raised as being of great significance to us but it is an area where there is uncertainty because of the lack of clarity around the level of severity of an injury.

Mr DAVID SHOEBRIDGE: Could you on notice consider what the impact would be of changing it so as liability for the scheme coincided with the time of the claim as opposed to the date of the accident?

Mr BHATIA: Absolutely. We will take it on notice.

The Hon. DANIEL MOOKHEY: Does that require a legislative change or is it a matter of policy on your part?

The Hon. TREVOR KHAN: Or a regulatory?

Mr BHATIA: Or regulatory change. We will take that on notice. I think it may be an Act change but I will take it on notice.

The Hon. TREVOR KHAN: I ask in a related sense, if you think there is some merit in it—I am quite convinced by the argument of Mr David Shoebridge that the date of application seems attractive—is there some other trigger apart from the date of the application that may be a more suitable day?

Mr DAVID SHOEBRIDGE: Do not be trapped by the question if there is another date?

Mr BHATIA: No. We want to make sure that we have more efficient interaction with the CTP insurers upfront at the time of accident so that there is by any chance no cracks that those individuals fall under. I think as Don said, it is really at the margins but even if it just one person it is not good enough. So from our perspective we will take that on board.

Mr FERGUSON: One of the challenges in relation to that is that if the liability does sit with lifetime care from the time of application there are different behavioural patterns that could—

Mr DAVID SHOEBRIDGE: You may have other concerns? It's not my money, who cares?

Mr FERGUSON: Yes, that is right. It is just something that we need to work through with other stakeholders.

The Hon. DANIEL MOOKHEY: While we are on the topic of perverse incentives, what steps is icare taking in respect of preparing a lifetime care scheme for the five-year transfer from CTP to lifetime care and support?

Mr BHATIA: I will start and then pass on to Don to talk in a bit more detail. The first thing is that understanding clearly in terms of what those eligibility criteria are which would be post five-year treatment and care requirements for those people injured in road accidents. I think one of the biggest questions for us is how do we price that? How do we make sure that we adequately fund for that?

The Hon. DANIEL MOOKHEY: When do you have to price that?

Mr BHATIA: In the next couple of months.

The Hon. DANIEL MOOKHEY: You cannot wait until year four?

Mr BHATIA: No. We have to start collecting today because accidents will start happening today. If the new scheme goes live as planned on 1 December 2017 we need to make sure that any CTP policies issued at that point in time are starting to collect the premium.

The Hon. DANIEL MOOKHEY: That will be collected through the Medical Care and Injury Services [MCIS] levy?

Mr BHATIA: Yes, it will be a separate component of that.

The Hon. DANIEL MOOKHEY: That will be the recovery mechanism.

Mr BHATIA: Yes, that will be the levy mechanism in a similar way that we do with lifetime care participants, we would have a similar levy that would be charge. It would basically mean that we can cover for people post five-year period when they are come into—

Mr DAVID SHOEBRIDGE: You would be recovering in 2017 for services that will be delivered in—

Mr BHATIA: In 2022.

The Hon. DANIEL MOOKHEY: Hence my interest in the area.

Mr BHATIA: In no way different to lifetime care scheme where we are recovering today and will be paying in 2082.

The Hon. DANIEL MOOKHEY: I had the misfortune of renewing my CTP this week—

Mr BHATIA: Misfortunate or fortune?

The Hon. DANIEL MOOKHEY: Misfortune because now I know more about the scheme. It reported to me quite clearly what my MCIS levy was. Would this recovery cost be reported separately to the MCIS levy or would it be reported in the same way?

Mr FERGUSON: The information that is provided on the MCIS levy is determined by SIRA. It is not a level of detail that we have discussed with them yet in terms of clarification. I wondered if I might just go to the point in relation to your mention of gaming the system, or words along those lines.

The Hon. DANIEL MOOKHEY: I have not got to that point yet. What steps are you taking to prepare for this, given as you have just said, that you will have to start charging and recovering this cost pretty soon?

Mr BHATIA: To Don's point, I think he is going to get there in terms of the fact that the one thing we are always very keen about is to make sure that we can talk with SIRA so that it has the appropriate teeth to ensure that during that five-year period there is no delay of treatments; that there is no perverse outcomes that come through for all these individuals who, maybe even in year two, it is very clear to the insurers that may form part of cohort. As a result we do not want delayed treatments so that they say after a five-year period "it is not our issue so we will just delay treatments."

The Hon. DANIEL MOOKHEY: If that were to happen absence of such protections or guidance, or at least clarity or visibility, is it likely that you will have to essential recover a higher cost in the MCIS?

Mr BHATIA: Absolutely right.

The Hon. DANIEL MOOKHEY: What steps should be taken to mitigate this risk? I am not asking it from the perspective of CTP, to be very clear, and nor am I quibbling with the design of the CTP scheme, I am asking: how is team getting ready for this?

Mr BHATIA: I think that those powers actually rest with SIRA because it monitors the CTP scheme. I think that they need to have a supervision mechanism where they are looking at identification of that cohort where possible and ensuring that there is timely treatment approvals coming through in the first five-year period. We have also had a conversation if at an earlier point in time it is very clear that these individuals are going to form part of that cohort, maybe there is an early transfer.

The Hon. DANIEL MOOKHEY: You would need SIRA to have that in place as soon as possible because you have to make the pricing decisions very quickly?

Mr BHATIA: That is right. We would make that on that assumption, absolutely.

Mr DAVID SHOEBRIDGE: The Bar Association and the Australian Lawyers Alliance have been involved in extensive discussions with you about the guidelines for the lifetime care and support. Three issues really bubble to the surface.

The Hon. TREVOR KHAN: It is to the credit of everyone that they are talking to each other.

Mr DAVID SHOEBRIDGE: They said it is a very positive relationship in terms of communication and you do not often get the kind of submission about government bureaucracies.

Mr BHATIA: Hopefully we are not a government bureaucracy.

Mr DAVID SHOEBRIDGE: But you are so that is a good thing. One of their concerns is about where the treatment of service is for the participant's family members. They gave an example of regional travel from Cootamundra to Wagga Wagga. They said that the sister of the participant was available and wanted to do the travel but there was no agreement to pay so, instead, a much more expensive non-family service was provided. They said it is basically a philosophy in Lifetime Care and Support not to pay for family members.

The Hon. TREVOR KHAN: I am not being critical of you but were you watching the evidence?

Mr FERGUSON: Yes.

Mr DAVID SHOEBRIDGE: There is also the payment for any service that is of a parental nature. The last was about general discretion.

Mr FERGUSON: I am happy to go through all three of those. Just to clarify, I had some of my team watching and sending me email updates.

The Hon. TREVOR KHAN: I am not being critical but I would have been surprised if you were not taking an interest in what was going on.

Mr FERGUSON: Could I start by noting that with the review of our guidelines we take seriously the process of consultation. We get enormous value from the feedback that we get from a whole range of stakeholders, including some of the people who have been here this morning, who take great interest in providing us very detailed feedback—similarly with the New Bar Association and the Australian Lawyers

Alliance. Of the matters that have been raised going to the point of it being a philosophy around the payment of family members, I will answer a couple of those. One is that we do avoid paying family members, except in exceptional circumstances. We will pay for a family member to support an individual where there is an unavailability or it is just simply impractical for a paid carer to be made available.

What I would say is from a philosophical perspective—to use that word—I think we have been great custodians of the scheme for the first 10 years, being a young scheme, and I think we have probably been quite conservative in some of our decision- making. I think we are also open to being able to understand, now that we know that a broader level scheme is very sustainable, that some of our decision-making could be more nuanced. There are circumstances such as the impact on a loved one in relation to travel that we would be happy to look at in more detail now that it is coming back.

Mr DAVID SHOEBRIDGE: So can we expect, now that you are aware of the issue and are engaging in it, that the new guidelines will reflect a more nuanced position? Is that the hope?

Mr BHATIA: I think that is exactly right. From our perspective some of the other feedback we also heard this morning was about being overly prescriptive and not leaving enough discretion in our coordinators to be able to approve such things. We are very aware of that and receptive of that as well.

The CHAIR: There is quite a contrast to the NDIS model—in globo budget and a more independent approach to care for themselves.

Mr BHATIA: We have—

Mr DAVID SHOEBRIDGE: I think that is a different issue that would be good to address.

Mr BHATIA: We can address that separately.

Mr DAVID SHOEBRIDGE: Can we just go through those three elements? The other one was the parental responsibility?

Mr FERGUSON: That was really in relation to the line we take in terms of paying family members, there are exceptions—we have examples of exceptions where we have either difficulty in finding a care provider to provide that support because of rural and remote locations; and we have an individual who has particular language difficulties and the only person who is able to communicate effectively with them is a family member.

The Hon. TREVOR KHAN: Does that mean members of the Indigenous community?

Mr FERGUSON: No, actually it is a person with a Chinese dialect.

Mr BHATIA: A very rare Chinese dialect. She is 80 years old. It is more worthwhile that she is accompanied by a family member as opposed to—

Mr DAVID SHOEBRIDGE: There are two aspects. One is where the family member is providing the transport or the assistance and the support. The other one is where, say, a child is injured and it would be expected that the parent would go to the doctor's appointment, but in order to do that they have to take a day off work and they are not being compensated. That struck me as an unfairness.

The Hon. TREVOR KHAN: It is more than unfair. It is actually very discomforting.

Mr BHATIA: As we have said, we have taken that on board and those are things we are going to look at from a nuanced perspective. In those cases we can put ourselves in the shoes of those parents. We have young children and I completely understand where they are coming from.

The Hon. DAVID CLARKE: Have you been receiving many complaints in that area?

Mr FERGUSON: It is not something that has featured highly but there have been individual cases where it has been raised with us. What we have really tried to do was to think laterally about how we can best meet those needs, but we have been cobbled a little bit by our own approach in relation to payment of family members. It is really against the broader concerns about payment of family members. I think within that broader approach we have caught up some of these more specific situations that could benefit from it.

The Hon. DAVID CLARKE: For how long have you been looking at this issue?

Mr FERGUSON: This is something that we have only recently started to look at specifically in relation to how we can apply a more nuanced approach. Previously when we have had these issues raised with us we have looked at how we can try and find a suitable solution within the rulebook, if you like. So we have not looked laterally about how to change the rules previously.

The Hon. TREVOR KHAN: Can I say we had a similar time frame issue dealing with the State Insurance Regulatory Authority on one occasion and the answer that came back to us was less than satisfactory. Without defaming them too far, it was along the lines of "We will make our mind up in the fullness of time." You have never been like that when you have come to give evidence before the Committee. Are you able to give a time frame as to when you might be able to tell us as to what maybe a change in policy or the like?

Mr FERGUSON: We would be pleased in our questions on notice to be able to come back and provide the Committee with more details.

The Hon. TREVOR KHAN: That is an excellent answer, thank you.

The Hon. DAVID CLARKE: Is it already in progress or are you starting to look at it?

Mr DAVID SHOEBRIDGE: The last two things on the guidelines were the general discretion and the concern about a no-more children policy.

Mr FERGUSON: On those two points, the general discretion is something that we received feedback from the New South Wales Bar Association on. We have taken that on board and we are looking at how we might be able to maintain it. So that is something that we are in agreement with and we are pleased to look at ensuring that we retain that discretion. What we do not want to end up with is black and white letter of law decision-making. That is exactly opposite the direction we are going. That discretion power is really important.

Mr DAVID SHOEBRIDGE: The computer says no.

Mr BHATIA: Absolutely.

The CHAIR: Mr Ferguson, Mr Clarke asked you a question and you nodded. Was the answer that it is already in progress?

Mr BHATIA: Yes, it is in progress. Over the past few months we have been bringing in participants to help point out some of the pain points. One of the pain points is about how to make sure that there is a nuanced, not the one size fits all which has plagued accident compensation schemes for a very long period of time. What Mr Ferguson said about the nuancing is something that we are definitely taking on board. From a parental perspective there is a lot more merit in the parent actually attending and being compensated for taking the day off. We will look into it and come back to you with a time frame for when we can implement it.

The Hon. DANIEL MOOKHEY: I return to the line of questioning started by the Chair around the concept of an NDIS-style budget for people who are capable of acting independently. What are the reasons why that should not be adopted?

Mr FERGUSON: We are already adopting a similar approach. So we have been trialling for a while an approach that is called self managed funding for self-directed care. We have done that in a pilot way. Everybody in the lifetime care scheme has a very severe injury; the NDIS has a much broader base so there are possibly many more people that it may be more immediately suitable for. Notwithstanding that, we are starting from a position of saying that we would like everybody within the scheme to choose just how much control they have over choosing their service provider and managing the purchasing of those services after us getting out of the way as much as they would like us to get out of the way—so providing budgets with obviously checks and balances along the way to make sure that things are being properly spent. We have collaboration with the NDIA as well some of the other jurisdictions to make sure that we are learning from how we are all moving down the road of providing people greater independence and choice.

The Hon. DANIEL MOOKHEY: For how long has the trial been running?

Mr FERGUSON: The trial ran for about 12 months, it has been completed. Off the back of the trial we have developed significant insights into how we can make sure that we can put whatever safeguards and assurances we need at the back end of the process rather than at the front end—instead of putting hurdles in the way of giving people that control, you can put those assurances at the back end and not get in the way. We are now scaling up that program to make it available to everybody as we speak.

The Hon. DANIEL MOOKHEY: How many people do you think would be eligible for transferring to a scheme like that?

Mr FERGUSON: We are making it available to everybody. I think there will be some limitations on people with severe brain injuries. The choices that we are providing though actually put it more in a continuum so people can take whatever level of support they choose to.

At one end of that continuum we will provide everything in terms of choosing service providers and payments and so on. At the other end of that spectrum we will provide funds for the individual and they will do all of that themselves, whether it is an on-panel provider or an off-panel provider or a care provider, and they can purchase their own insurances and we provide them with funding to employ their own care team. We have a recent example of a person who lives in a regional location who has been involved in our pilot program who is now seen as an employer within his region rather than a recipient of care from a welfare program. It made a dramatic change to that person's life.

Mr BHATIA: If I can just add to that? When we spoke with him, one of the key things that he said is that now he is actually employing people to provide care for somebody else as well. That kind of changes even the way the community looks at an individual like that. But I think one of the key points there is that it is not just a binary solution between complete budgeting or complete care.

The CHAIR: Of course. The continuum is fantastic.

Mr BHATIA: I think the continuum is the main thing, which I believe is the Holy Grail of customer experience, which is a choice—I can choose what I want out of the model offering.

The Hon. DANIEL MOOKHEY: But when do you expect this continuum to be designed and operating, and when will people be operating on the continuum?

Mr FERGUSON: It is now being designed off the back of the pilot. We are in the process of publicising it as widely as possible and have already started doing that through newsletters that are distributed to our participants and out to providers. Training is being provided to our internal staff and the staff that work within the broader system. So that is now available; it is available to all people—that is literally occurring as we speak. The numbers at this stage are the people who have been involved in that pilot, and we are in discussions with about another 35 people at the moment who have expressed very keen interest and we provide them training.

Mr DAVID SHOEBRIDGE: How many in the pilot?

Mr FERGUSON: Ten people in the pilot, and there are an extra two people who have joined since then. There are another 35 that expressed an interest. So we have publicised it widely, plus we have reached out to individuals who we think may be particularly interested, and help to get them into that program.

Mr BHATIA: I have got about 800 because the others are still temporary. They are in turn participants.

The Hon. DANIEL MOOKHEY: You would have heard the other concern of the Bar Association in describing this, which is this is all well and good if the services that are available on the continuum are, essentially, pre-approved, but there is a category of services that are not recoverable, or at least are subject to contest. Did you hear that part of the evidence?

The CHAIR: You are talking about the gardening.

The Hon. DANIEL MOOKHEY: Yes, I am talking about things like.

Mr FERGUSON: There are services that fit within the domestic category, if you like, and gardening is a really, really good example. I do remember at one stage having a conversation with a team quite some time ago where I tried to mark out the equivalent of a home paddock to determine what is an average size of a garden block, because that is how much we will pay for, and if it went for a little bit over that, that was outside of what we were able to pay for.

The CHAIR: We heard that today: six metres.

Mr FERGUSON: There you go. So that is a really great example. It is not that we are going to maintain a 60-acre property, but whether or not it is a usual garden block or a little bit bigger than that is of little consequence and something that we are not so focused on.

The CHAIR: Surely the objective is quality of life.

Mr BHATIA: Absolutely.

The CHAIR: And if someone is in this catastrophic injury area and gardening or enjoying the garden in their mobility chair is part of their quality of life—or we heard evidence about paintings in the house, that that covered hanging paintings up, that maybe the art is important for them. You have got to be flexible and tailor it.

Mr BHATIA: Absolutely. We have got a great example of a participant, [EVIDENCE OMITTED BY RESOLUTION OF THE COMMITTEE 2 JUNE 2017]. She was a deputy mayor at Kurrajong and she had a road accident. One of the biggest therapeutic cures for her was a vegetable patch. It was in a block which was sloping at the back and she could not access that. We actually moved that and put it in the front yard so that she could do that. That created a big, positive recovery path. She has now exited the scheme. She had a brain injury but she has recovered much better than what the expectations were and she is now back and living an independent life, which is fantastic.

The CHAIR: And I am sure there are pets and other areas too.

Mr BHATIA: Yes, there are.

The CHAIR: We also heard evidence, and I bristle at too prescriptive forms, that NDIS looks at travel budgets in globo for a client and the Lifetime Care and Support is very specific. They gave an example of with the NDIS you could go to church or to the cinema and that cost is covered out of your travel budget; but under Lifetime Care and Support it is not covered and they have to do an expense claim every trip. Are you addressing that in your pilot scheme?

Mr FERGUSON: Lifetime Care's funding is not established just to provide general transport for individuals but what we do do is provide for any of the costs associated with transport towards things related to their injuries—medical appointments, for example—as well as things that are involved within their goals; that might involve participating in community activities, and we do meet all of those costs of transport as well.

The CHAIR: Because someone in the catastrophic injury category we are talking about, going to church or going to the cinema, the social engagement—non-isolation could be very much part of their recovery or their quality of life.

Mr FERGUSON: And if that is identified as something that is part of their recovery we will pay for that.

Mr DAVID SHOEBRIDGE: But what about if it is "I used to go to the cinema every months or every two weeks before my accident. Now I can't afford to go because it is a very expensive transport cost and I need a carer to come with me", are you accepting liability for the transport costs and the carer?

Mr FERGUSON: We pay for the carer to accompany an individual. We pay for whatever level of care that individual needs to participate in whatever activities they choose to, including going on holidays. We do not pay for separate transport. So for somebody to be transported independently to participate in the community, the transport is not what we are paying for; we pay for the care to assist them with that access. That is probably the difference.

Mr DAVID SHOEBRIDGE: I have got to say, from an external perspective it seems a very fine and kind of arbitrary distinction. Maybe you could expand upon that on notice about how those decisions are made and whether it is a legislative imperative or a policy imperative.

The CHAIR: When you consider the depression and engagement—

The Hon. TREVOR KHAN: I am not joining in this because I think there are lines that are going to be drawn—

Mr BHATIA: There are.

The Hon. TREVOR KHAN: —and we can sit here and throw everything up in the air and—

Mr BHATIA: And the costs will go up as well.

The Hon. TREVOR KHAN: That is right, there is an outcome to all of this.

Mr DAVID SHOEBRIDGE: That is why I said we might ask this on notice, because these decisions seem arbitrary but there is sometimes very good rationale behind them.

The Hon. DANIEL MOOKHEY: Except for the fact that, I think, the Bar Association's proposal was that should a proportion of an entitlement or a budget be essentially provided at large, without necessarily being tied to this, that that is a cost savings device and is just a better way of structuring it because it avoids the disputation argument. I accept that there is a category of things which we will look forward to on notice, but is there policy merit in establishing a form of entitlement like that that would avoid disputation, avoid the need for you guys to have to make decisions on things like this all the time?

Mr FERGUSON: Part of looking at how we become more flexible with individuals within the bounds of the scheme—so we are not looking at making changes that have a direct impact on levy setting—but where we can introduce flexibility that achieves greater outcomes for individuals and we do not have to make as many line item decisions, that is exactly what we are looking at at the moment.

The Hon. DANIEL MOOKHEY: But that would require us to somewhat loosen the nexus between entitlement and the injury. Is that correct? Because you are saying to us that there has to be a connection between the injury or the recovery from an injury—

Mr DAVID SHOEBRIDGE: The law says it.

The Hon. DANIEL MOOKHEY: That is my point: it is what the law says. But what I am asking is if there were to be a relaxation of the law, would that make things easier for you?

The Hon. TREVOR KHAN: That is where I would like to go. I think that is more productive.

The CHAIR: We are running out of time and we want to move on to the discussion about NDIS and the nexus.

Mr DAVID SHOEBRIDGE: Could I just ask, if everyone is comfortable with it, if that answer could be provided on notice?

The CHAIR: Yes, please take that on notice.

Mr BHATIA: Absolutely.

Mr DAVID SHOEBRIDGE: Could we just have a five-minute extension to address some of those concerns about the NDIS? We had two very powerful submissions about the interaction between the NDIS and the Lifetime Care and Support.

The Hon. TREVOR KHAN: They heard it.

Mr DAVID SHOEBRIDGE: Did you hear that?

Mr BHATIA: Yes.

Mr DAVID SHOEBRIDGE: Particularly the transition, when NDIS is making decisions and there are a couple of potential options for resolution floated. Could you give us your observations on that?

Mr BHATIA: This is more in the case of the in turn participants who may come out of the scheme and then get into the NDIS scheme.

The Hon. TREVOR KHAN: Or not.

Mr BHATIA: Or not, and I guess if they do get to the NDIS and if there is a gap in between of their exiting our scheme and getting into the NDIS—obviously we are all learning, NDIS is new in the market and we are all learning to understand how it is—one of the key things that we have undertaken is to work with the NDIS so that we can, for those individuals, do an early eligibility criteria, not after they exit the scheme but pre that. For example, if it is a three-month or four-month process they want to undertake, we will start the process with the NDIA before that and ensure that should they be eligible for the NDIS, we underwrite any gap that may exist.

The Hon. TREVOR KHAN: That is more positive than I was expecting.

Mr DAVID SHOEBRIDGE: That is excellent. We were hearing that the—is it NDIA or NDIS?

Mr BHATIA: The scheme is NDIS; the agency is NDIA. So sorry for interchanging and using that.

Mr DAVID SHOEBRIDGE: So the NDIS is refusing to even start making a determination until they had exited Lifetime Care and Support. Is that happening?

Mr FERGUSON: The NDIS is large and rolling out very, very rapidly. What we have encountered is that some of the experience at the front line is not necessarily consistent with the conversations we have had at a more senior level with our counterparts. We have had some confusion for individuals; we have had some level of fairly specific advice given that we would not agree with so we have needed to start working at a much more cooperative level, at a more senior level, with the NDIA in order to make sure that we can work through those issues.

We have tried to take a fairly beneficent approach because of the uncertainty between the two schemes, being as comprehensive as we can in meeting the needs of an individual who maybe sitting at the nexus of eligibility between the two schemes because of some level of other disability that may exist but the principle that we will be operating under is really on a case-by-case basis. There are individuals who may have severe mental health issues as well as a road accident where it is legitimate to think that there would be a responsibility for the two schemes to support that individual but, in the main, a person's need should be wholly met as pertains to a disability or an injury under one scheme or the other.

Mr DAVID SHOEBRIDGE: But if you do not have a statutory obligation to meet a pre-existing mental health condition, what happens in those circumstances?

Mr FERGUSON: That is exactly the same as it is today. We would negotiate with that other partner in the system to ensure that they are receiving the level of support they need from whatever that other system is. What we try not to do is that if the injury overshadows the pre-existing condition and with or without that pre-existing condition they will have a very high level of need, trying to sort of forensically differentiate is not in the person's best interest so we try not to argue the case.

Mr DAVID SHOEBRIDGE: Or in the scheme's interest in terms of costs?

Mr FERGUSON: No.

Mr BHATIA: Absolutely and we do not want them to go from pillar to post trying to find the right agency to support them for which need. It is not fair.

Mr DAVID SHOEBRIDGE: So there is no administrative determination or broad approach from Lifetime Care and Support to say, "You can't have an entitlement for both". It is just where the motor accident injury is the overwhelming issue, you will deal with it singularly through Lifetime Care and Support but there is room for both schemes to operate, is that right?

Mr FERGUSON: In the event that there is something else contributing to that need; so if the need is specifically related to the motor vehicle accident, then the Lifetime Care and Support Scheme is the appropriate scheme in which to have those needs met. If that person also has an intellectual disability and we have examples of that, then some sort of cost-sharing arrangement between the two schemes would be appropriate.

Mr DAVID SHOEBRIDGE: Potentially all being provided by Lifetime Care and Support but with some contribution coming from—

Mr FERGUSON: Yes.

Mr DAVID SHOEBRIDGE: Do you have an agreement to that effect with the NDIA?

Mr FERGUSON: We do not have a formal written agreement; we have an undertaking that we will look at cases on a case-by-case basis.

The CHAIR: Is that back of house? I mean, the client themselves are not managing this divide between what will be paid by you and what will be paid by the NDIA. You do it all upfront and then claim it back. It is seamless for the client, is that right?

Mr FERGUSON: That is exactly what we are looking at.

The CHAIR: That is what it should be, I would think.

The Hon. TREVOR KHAN: That is what you are looking at or that is what you have got?

Mr FERGUSON: Because the NDIA has not fully rolled out yet we have people who receive services that were under the old State-based disability schemes, for example, that had a pre-existing disability. We provide funding to meet the needs of that individual so we have some of those arrangements in place. If and when they emerge through the link between Lifetime Care and the NDIS we would undertake that same approach, the first principle being that the individual's needs are met as seamlessly as possible and leave the recovery matters in the backroom. I did notice that there is some existing confusion and that is why we need to collaborate more closely.

The CHAIR: We have not had evidence about that but I would imagine that would be a very stressful thing for carers or the clients themselves, if they are fully aware of the divides.

Mr DAVID SHOEBRIDGE: Could we get a little more detail on notice about the formal or informal arrangement with the NDIA. I note that Ms Morris, who gave the evidence, is in the room so maybe you could have a talk with her as that would be really helpful.

The Hon. DANIEL MOOKHEY: In addition, could you on notice describe the mechanisms of interaction between icare and the NDIA on a formal level? Is there a council or committee and how often do you talk? That information would be really useful. Secondly on notice relating to dust disease, can we get the dates of all meetings of the board and board membership?

Mr BHATIA: Yes, absolutely.

The CHAIR: Thank you for appearing today. You have taken some questions on notice. I ask that you provide written answers to those questions within 21 days.

(The witnesses withdrew)

The Committee adjourned at 13:36