REPORT OF PROCEEDINGS BEFORE

STANDING COMMITTEE ON LAW AND JUSTICE

11th REVIEW OF THE MOTOR ACCIDENTS AUTHORITY AND MOTOR ACCIDENTS COUNCIL AND 4TH REVIEW OF THE EXERCISE OF THE FUNCTIONS OF THE LIFETIME CARE AND SUPPORT AUTHORITY AND THE LIFETIME CARE AND SUPPORT ADVISORY COUNCIL

At Sydney on Monday, 17 October 2011

The Committee met at 10.00 a.m.

PRESENT

The Hon. David Clarke (Chair)

The Hon. Peter Primrose
The Hon. Scot MacDonald
The Hon. Sarah Mitchell
Mr David Shoebridge

Transcript provided by Pacific Solutions

JAMES WALTER MIDDLETON, Rehabilitation Physician, Director, Spinal Cord Injury Service,

ADELINE ELIZABETH HODGKINSON, Rehabilitation Physician, Brain Injury Rehabilitation Unit, Liverpool Hospital, and

JOSEPH ANDREW GURKA, Rehabilitation Physician, ACI Brain Injury Program, Brain Injury Unit, Westmead Hospital, sworn and examined:

CHAIR: If you should consider at any stage that certain evidence you wish to give, or documents you may wish to tender, should be heard or seen only by the Committee, please indicate that fact and the Committee will consider your request. If you do take any questions on notice the Committee would appreciate it if the response to those questions could be forwarded to the Committee within 21 days of the date on which the questions are forwarded to you. Would any of you like to make a short opening statement?

Dr HODGKINSON: I have a short statement. The ACI New South Wales Brain Injury Rehabilitation Program is responsible for providing specialist multi-disciplinary rehabilitation services for adults and children with traumatic brain injury, via 14 programs in both metropolitan and regional areas in New South Wales. The New South Wales Brain Injury Rehabilitation Program has been providing specialist rehabilitation services to participants of the Lifetime Care and Support Scheme since 2007 and has provided feedback to each parliamentary review of the Lifetime Care and Support Authority since its inception. We are thankful for the opportunity given to us each year to contribute to the reviews.

Prior to the introduction of the lifetime care and support, about 25 percent of patients serviced by the Brain Injury Program had access to insurance claims such as CTP or workers compensation, which funded their rehabilitation equipment and care needs above that of the public hospital system. People without such claims had great difficulty accessing therapy, care and equipment after their hospitalisation because of the limitations in the public system to provide these services.

Since the advent of lifetime care and support approximately 60 percent of patients have either compensation or eligibility to be part of the lifetime care and support. This means that more victims of catastrophic injury from motor vehicle accidents have potential to access rehabilitation and care services following injury.

Despite this positive potential, the New South Wales brain injury program has significant ongoing concerns around the impact of the lifetime care and support procedures and processes are having on the operations and work practices of our programs. These concerns have been raised at each parliamentary review and despite recommendations to address them, there are still areas of concern. We feel it is important for the Standing Committee undertaking this review to be aware that there exists a high level of unresolved frustration amongst our staff working with the lifetime care and support.

The administrative demands of the scheme with its various forms and paperwork continues to take up a significant part of clinicians' time, which takes away from patients' therapy time. We have estimated a 25 percent reduction in direct treatment time as a result of the lifetime care and support processes. This is because staffing has remained the same. Only one of the many time consuming forms has been reviewed and simplified in consultation with the service providers in the past three years. This was the changeover of a community discharge plan to a discharge services notification form, which was a very welcome change and made a difference to our work practice and ease with which patients could be discharged into the community. Despite the expectation to do so, no other form has been reviewed collaboratively with us to reduce and simplify the administrative burden.

Frustrations exist amongst our staff in their workings with the scheme and its coordinators. We continue to experience inconsistent decision making in response to requests on behalf of patients. Requests are frequently met with rejection and requests for further information. It is particularly the request for further information that prolongs in time the time to discharge an appropriate introduction of care.

In an effort to circumvent such situations, service providers hold regular meetings with coordinators to discuss client progress and outline claims in advance of submitting forms and requests. Unfortunately this practice does not seem to have enhanced the understanding of the information to then result in greater approval rates. Some coordinators even pre-empt decisions before requests are submitted before the reason for the request is made.

The above frustrations and experiences has led to a general perception amongst staff working in the brain injury programs that their skills, expertise and knowledge of what is best for the clients is not well respected. Most clinicians working within our program have many years of brain injury experience leading to high levels of skill and knowledge, a level far outweighing that of the lifetime care and support coordinators. It is our view that some lifetime care and support decisions are in fact clinical decisions rather than administrative, which falls outside their role.

Another area of frustration is in the area of supported accommodation options, which has been identified as a large area of need at the first and subsequent reviews. These are now being established. For people with high support needs our experience is that the processes and bureaucracies which need to be negotiated in order to access these homes are time consuming, confusing and frustrating for the client and family.

One particular in-patient facility has four patients who are attempting to access supported accommodation over a six month period, none yet of which have been able to move out of hospital. The prolonged hospitalisation of these patients, while negotiating the bureaucratic processes has resulted in a worsening of challenging behaviour and institutionalisation. This is not the intention of the lifetime care and support scheme.

Lifetime care has clearly committed to reviewing its operations and processes. It has involved us in numerous reviews and produced many discussion papers. We are given the opportunity for comment although with some of these it is at a very late stage and the final stages of the policy or document, rather than in its formative stage. True collaboration in producing these reviews would improve the quality of the review and the benefit to patients.

We have a brain injury rehabilitation and Lifetime Care and Support Liaison Group which was established to monitor and improve the operation and working between the Brain Injury Rehabilitation Directorate. However, this has limited effect in addressing these concerns and we believe a new approach is required.

In summary, whilst the lifetime care and support is resulting in more patients getting access to rehabilitation and care following catastrophic injury, and we greatly welcome this, we believe much work needs to be done to improve the working relationship between the brain injury program and lifetime care and support. Currently we do not believe that our clients' needs are being maximally met under the scheme. There are aspects of the scheme which are counter-productive to client progress and outcome.

We would like to see a new approach, perhaps a workshop day between senior lifetime care and support staff and brain injury staff to tease out these issues and work towards a solution.

CHAIR: You talked about the tension arising between the different approaches between clinicians and coordinators and the approver and you have referred to a liaison group that you say does not appear to be working and there appears to be a need for a new approach. Would you like to

elaborate on that in specific terms as to what solution you propose to resolve this issue, which clearly is of great concern to you.

Dr HODGKINSON: I think one of the difficulties with the liaison group is it is a small group of people who represent a very large group and it is difficult in that group to focus on what are the true issues of conflict when the conflict is occurring across the whole state. I think that we have to go back to a meeting with the senior clinicians, perhaps in a large group, to actually work out how we will resolve some of the conflict issues, whether with a larger group, or more frequent meetings, or a rotating system. I do not have the solutions now. I do not know if Joe would like to talk to that.

Dr GURKA: I do not think we are sure. I think what is required is a brain storming session probably between senior members of the lifetime care scheme as well as the senior clinicians in the brain injury program to work out a way forward. We get the perception that there some lack of appreciation or lack of a full awareness of the issues that we face, because when they are raised they seem to be listened to but then there is very little that happens in response to that, so we feel as though we need to have our message be heard better and whether that is going to be through a workshop exercise or a brain storming exercise, I think we would like to try to work that out with the authority directly.

CHAIR: You have talked about this brain storming session, or get together. Have you sought to initiate that at this stage?

Dr HODGKINSON: I think that is the next step, yes.

Dr GURKA: Probably as a brain injury program generally, no. For my service at Westmead I have attempted to have a meeting with the general manager of the lifetime care authority. I wrote to him six weeks ago and only last Friday got a response and we are looking at having some sort of meeting in the next few weeks to address some of the specific issues at Westmead but, as a wider program, we have not.

CHAIR: How long has this problem been going on? How long has this tension been there, that you speak of?

Dr HODGKINSON: Having these yearly reviews does focus our attention on what has been achieved within the last year. Certainly the first few years we felt that we were making progress. There had been significant changes and we were hoping with the settling down of the program and some reviews of paperwork and processes and continued liaison that we would address some of these issues. I think, having focussed our mind now, the fourth review, what we feel is a sense of frustration that the change has been slow and that some of the solutions that we would have liked and certainly moving towards supported accommodation has been a big step forward and certainly there are possibilities, but I think the issue of the paperwork, the rejections of proposals, the toing and froing, if you can imagine you put in a plan, you wait 10 days for the approval time and then there is further questions, so you put in another review, another 10 days goes by and then another question and then finally you are able to see the way forward but what this has resulted in is a month to six weeks of delay before your proposed plan is approved and a patient kept in hospital that time is disadvantaged and it also disadvantages others who need to move through.

The solution then is that patients are discharged home without support or they are retained in hospital to their own frustration and disadvantage of others, so that is the tension that has continued. There has not been a real reduction in that time of approval process.

CHAIR: You have sent off a letter six weeks ago to seek to bring about a meeting to try to resolve these tensions and these problems?

Dr HODGKINSON: Yes. We also have raised them at the liaison committee and at other

meetings of the managers of the brain injury programs.

Mr DAVID SHOEBRIDGE: You got an answer the day before they turned up to a parliamentary hearing on the matter?

Dr GURKA: I actually had not heard a response so I chased it up myself at the end of last week and it was confirmed that the letter had been received and that somebody would be in touch with me this week to try to tee a meeting up.

Mr DAVID SHOEBRIDGE: To get a gauge on how the lifetime care and support is operating compared with your approval processes with insurance companies where you have a valid insurance claim made, how do they compare, in terms of response?

Dr HODGKINSON: Much more immediate response than, say, with workers compensation claim because with the CTP changes we rarely have a CTP, so it is with someone who only has workers compensation. If we wanted to discharge someone who would need substantial care we would ring up and submit our plan. It is approved and then it is progressed. There is no cumbersome form that needs to be completed and no quibbling over often what amounts to be small details, such as the nature of the timetable that the carers will be performing, and so on. A lot of that is left to our discretion and monitored on an ongoing basis, rather than put on paperwork to start with.

Mr DAVID SHOEBRIDGE: In some ways if the lifetime care and support people spoke with workers compensation and the three of you tried to work around what might be best practice for it, that might be one way of going forward.

Dr HODGKINSON: I think many of the people in lifetime care and support are aware of the processes of WorkCover but wish to I think fulfil stricter guidelines, they say for their auditors.

Mr DAVID SHOEBRIDGE: In terms of access to the scheme and eligibility, there are two issues about threshold that have been looked at by lifetime care and support. One is that they have a view that because post-traumatic amnesia scores are often not available due to coma or medication, they have an additional criteria, looking at significant impact to the head or significant brain imaging abnormality in determining that initial eligibility to the scheme, how do you think that is working or what is your view of that method of assessment?

Dr HODGKINSON: I think the eligibility on brain injury and neurological documentation of brain injury is fairly readily met. What becomes a bit of a contentious issue is that the other part on functional grounds, so there is a functional assessment measure, that is the FIM, and the functional independence measure is a measure that simply measures function but does not attribute diagnosis. It is a clinical judgment as to whether somebody's functional impairment relates to the neurological impairment or not. That is an area of ambiguity, I suppose, with someone who may have been pre-injury severe neurological impairment, severe orthopaedic injuries or developmentally delayed, so that is a concern for entry into the scheme. It does not seem to actually cause as much problem as those who have a neurological impairment of a very severe injury and yet improve rapidly so that some will get in the scheme, if they are assessed early, and some if their application is delayed by two or three months will not get into the scheme, even though they have similar injuries.

This may not be a problem if they then exit the scheme after the two year interim, but it certainly produces inequity when you have two people with fairly similar injuries, one who can have two years of treatment and care and one who does not.

Mr DAVID SHOEBRIDGE: Is that a question of just where you have a significant traumatic injury, having that early assessment, are people being prejudiced because they are not having that early assessment?

Dr HODGKINSON: Yes.

Mr DAVID SHOEBRIDGE: Who is responsible for doing the early assessment and getting the approval? Where does the responsibility for that lie?

Dr HODGKINSON: It lies in the acute treating team who have to be aware of the implications of what they are doing and that is something where the brain injury services are aware but many of the acute hospital services may not be aware.

Mr DAVID SHOEBRIDGE: We heard from the AMA that there is insufficient knowledge in the profession about eligibility and access criteria for lifetime care and support. Would you support that position?

Dr HODGKINSON: In the wider medical scene, yes.

Mr DAVID SHOEBRIDGE: And particularly at acute care?

Dr HODGKINSON: Yes.

Mr DAVID SHOEBRIDGE: The paediatric care and needs scale has been evaluated by the lifetime care and support and they say it is not a suitable assessment to use as a threshold criteria. What do you say about that view?

Dr HODGKINSON: I have not sought opinion from my paediatric colleagues so I cannot speak to that.

Dr GURKA: Likewise.

The Hon. SCOT MacDONALD: Do you think that there are any gaps in accessibility to treatment in regional areas? From reading your submission, places like Blacktown are serviced well but when we saw the map and the numbers of catastrophically injured people a lot of them were north-west and inland New South Wales. How are they serviced? Would you care to comment?

Dr HODGKINSON: I think it follows the general pattern of with greater distance reduced access to specialist care. Those in regional and remote areas receive less care and that is also difficult. They may travel to the city for their acute management and may have a period of acute rehabilitation in a metropolitan unit, but it is the resettlement back into their community that can be disadvantaged.

The Hon. SARAH MITCHELL: My question relates to the submission from the State Spinal Cord Injury Service and it is where you spoke about transitional accommodation and some of the frustration where, when a patient is ready for discharge, that the lifetime care and support will not assess of find them appropriate accommodation until the long-term accommodation has been sorted out. You talked about how this causes problems and can stress the family and take up a hospital bed. How would you propose that the issue be overcome?

Associate Prof. MIDDLETON: I think there are a few things to be considered. There are similarities to what has been described for brain injury, some of the problems with the lack of transparency of the processes and the inconsistency of decision making and clarity around that with some of the coordinators, there needs to be greater clarity around the process, the same as brain injury really. We have a liaison committee that has actually been working well in general but it is the same issue around frustration and lack of perception, of lack of recognition of specialist skills within the spinal cord injury unit, the same as spinal cord injury services, the same as the brain injury services. Again, because there is not good clarity there is discrepancy around the lifetime care model and the health model. We need to look over the two sides of the fence and understand better what the requirements of lifetime care are and have a better understanding of the pressures on the system. The

impact, as Adeline has highlighted, in terms of the delays on discharge and the subsequent exit blocks and blockages of the whole system, early access to care into the acute units, there is a bottle neck back through the system that has a really substantial impact on the whole system.

In terms of solutions, we proposed that consideration be given to the two processes working in parallel. Whilst there are efforts around finding long-term accommodation and the planning around that final destination, there needs to be at the same time, or even earlier than that, attention to the transition. It is very easy to identify the need for transitional accommodation and support early on. There needs to be a different process put in place to address that and I think it can be addressed.

Some of the issues get complicated around essential equipment for discharge and where someone has been discharged not to their final destination, their home, but to interim accommodation often there are issues around hire of equipment rather than finalisation of equipment, customisation, people with spinal cord injuries but the higher the level may get more complex in terms of their need for customised motorised wheelchairs and control systems and seating and pressure relief. All of those things can be more complex.

That is hard to accommodate in hire equipment and that whole process of customising adequately to prevent complications arising with interim equipment or pool equipment is actually another major job, so all of that effort - there are two discharge processes and twice the amount of work going on and I do not think there are adequate resources to do that either, so that is another point of process that ends up delaying the duration of that whole discharge process and the planning process and it is complex.

Sometimes there may not even be a final destination so there may be no long-term accommodation option evident during a person's stay, so that complicates things as well. The process needs intensive process and dialogue and support and better resourcing to allow that to happen in parallel.

The Hon. PETER PRIMROSE: In response to our questions about improving the effectiveness of the lifetime care and support coordinators, the authority noted that coordinators already undergo induction training and that the State Spinal Cord Injury Service delivered a training program for the coordinators and case managers in July this year. Does this training address the State Spinal Cord Injury Service's concerns that the coordinators and case managers need a better understanding of spinal cord injuries?

Associate Prof. MIDDLETON: That was a really successful initiative and that was evidence that our liaison work with the authorities was working well. I think over 60 people actually attended that. I think it was 66 people in all and it got very positively reviewed. The feedback was excellent. That was the first step and a really positive and excellent first step in raising lifetime care coordinators and the people associated with lifetime care, some of their contractors, to raise the whole awareness of the health issues, the complex ongoing health needs of someone with a spinal cord injury, the altered physiology, it is not just a physical impairment but the whole systems changes that occur with a spinal cord injury and the ongoing impact of that in terms of risk of developing complications and trying to prevent those. That was a really positive thing.

It needs to be ongoing, so there needs to be ongoing education and further development of that knowledge base but also I think the next step is incorporation of that knowledge and understanding into the model of care and so a wellness, health promotion and risk management approach should be incorporated into the lifetime care planning so the life plans need to have more of an ongoing specialist monitoring vice intervention model so that will be proof of the pudding.

At the moment I think the level of awareness and understanding has been raised but one concern and fear I have is that you have already heard that clinical advice and advice of clinicians is not necessarily being regarded perhaps. Again I think that part of it is misunderstanding of the roles

and responsibilities of the care coordinators for lifetime care but I think there is potential for those with that knowledge to now say we know about spinal cord injuries, so there could be potential to even make decisions and not rely on the specialists' knowledge even more. I hope that is not the case.

I hope that the increased understanding leads to an increased recognition of the specialists' role and it is highly specialised and that we do have expertise built up over many years in these services for a reason and it is getting access to that and somehow building the relationship which has developed well over the last four years but, as Adeline says, it has probably reached a point where now we need to refine it, we need to better understand both sides of the fence and it needs to be much more transparent. Often if you inquire into the reasons for the rejection they are not unreasonable reasons but a lot of those things could have been managed better along the way and an understanding at the outset could have prevented any of that wasted time and effort. I think there is a frustration.

We have had occurrences where therapists have made four or five requests and each time have had a rejection and it has not really been clear why that has been. That is a crazy situation really because that does not help anyone. It is an enormous waste of time and effort. That was around a piece of equipment for respiratory support in homes, so it is a piece of equipment that there was some argument about whether it was truly necessary or not for discharge. There was still a lot of time and effort around the decision making and my point of that illustration is the transparency and the lack of clarity on both sides of the fence and the understanding of the service providers, and they were senior therapists providing that advice to the authority, and not understanding why those decisions were being rejected and, looking at it the other way, not on unreasonable grounds but needing more clarity. It was not clear what the clarity was. I hope that answers your question.

Mr DAVID SHOEBRIDGE: Just going back to that discussion about interim and long-term discharge, do you think they should be de-coupled, the two decisions? There should be a separate decision on an interim discharge and facilities and equipment and then a further decision made about long-term? Is that the only practical way of doing it?

Associate Prof. MIDDLETON: I think that is a very reasonable suggestion. Yes, I think de-coupling them is good as long as there are resources to support both processes, because the long-term planning and equipment provision and prescription - there is often one bite at the cherry unfortunately so while the person is in hospital is often the time when they can access most of the expertise in a timely fashion. Uncoupling them would be good but both things would still need to be progressing and probably interim accommodation should be managed promptly so that their delayed discharge would not be delayed.

Mr DAVID SHOEBRIDGE: Lifetime care and support have said that they have introduced delegations for their coordinators to authorise the purchase of equipment that is considered to be low risk in part of the response to some questions we put on notice arising from the delays. Have you noticed those increased delegations working at all?

Dr HODGKINSON: I would like to say yes, I think that equipment is less of an issue these days.

Mr DAVID SHOEBRIDGE: How does this decision making compare to the decision making in the workers compensation scheme?

Associate Prof. MIDDLETON: I was not going to speak to workers compensation but I was going to speak to EnableNSW so in fact the delegations and the timeliness of provision of equipment decisions by these delegations can be much better than is happening through EnableNSW, but again we are working closely with Enable to look at that, so I guess that can work well. Some of it is still around the clarity and who has those delegations and at what level. Again, it is what amount of information needs to be provided to allow that to occur. I think the delegations work well when it is clearly understood what the scope of that is, what the necessary information is and how to approach

that, because in fact there has also been quite a need - sometimes there is urgent needs, particularly when people are in the community, to have some care implemented to avoid a complication. If someone skin's starts to break down there needs to be an immediate decision, not one in 10 days' time and some of those delegations we have had are working now, but it is still an evolving process.

Dr HODGKINSON: I think at lifetime care it is not only our liaison with the lifetime care coordinator but the presentation of that information to then a senior approver who is in the background, which sometimes given the inconsistency and sometimes obscures things so that if our liaison is with the lifetime care coordinator and we think we are explaining the situation and the context of it, all of that may not necessarily go into our paperwork which then is not seen, so what happens is there is a rejection despite what we have said and we have to come back and we have to put in words like "the difficulty with the patient's gait and walking arises from his brain injury" because we have not actually mentioned the brain injury in the description of his gait, the slowness of walking and balance problems. It is a matter of getting our words perfect and our submission perfect. To delay a patient's gym program by 10 days to two weeks, or 10 working days, which is two weeks, but it is also taking up a clinician's time and the frustration and why would the senior neurological physiotherapist be writing and requesting this if it was not actually related to the brain injury.

Mr DAVID SHOEBRIDGE: Would not part of the answer be a better form which just has a tick a box at the bottom, is this treatment related to the injury, yes or no?

Dr HODGKINSON: I think better forms would help. There has been resistance on simplifying and streamlining forms.

Mr DAVID SHOEBRIDGE: Just separately, I would like to discuss with my colleagues some questions on notice about the numbers of forms there are and a response from you about simplifying the forms on notice. I do not mean to give you paperwork on notice.

Dr HODGKINSON: Could I just can about the paediatric care and needs scale. Would you like us to answer that question?

Mr DAVID SHOEBRIDGE: Yes, please, that would be great. .

(The witnesses withdrew)

(Short adjournment)

ANTONY JONES, Policy and Advocacy Officer, Spinal Cord Injuries Australia, affirmed and

SEAN JOHN LOMAS, Policy and Advocacy Manager, Spinal Cord Injuries Australia, sworn and examined:

CHAIR: If you should consider at any stage that certain evidence you wish to give or documents you may wish to tender should be heard or seen only by the Committee, please indicate that fact and the Committee will consider your request. If you do take any questions on notice, the Committee would appreciate it if the response to those questions could be forwarded to the Committee secretariat within 21 days of the date on which the questions are forwarded to you. Would you like to start by making a short opening statement?

Mr LOMAS: Spinal Cord Injuries Australia has been supporting and working to empower the spinal cord injured community for over 44 years. From our early days of developing accommodation options through to our present form of working to get people, both newly injured and currently living in the community, moving ahead with their lives, we have always sought to remove any barrier we find to full participation.

Gaining a spinal cord injury is one of the most devastating things that can happen to an individual. Statistically most people gain a spinal cord injury between 16 to 25 years of age. Your whole world is turned upside down and the many years that you have had creating who you are, basically from birth, has to be re-undertaken as you go through rehabilitation. We define ourselves by what we do. It helps create a person. When you gain a spinal cord injury that persona and what you do is often left at the scene of the accident.

The lifetime care scheme is a comprehensive scheme that seeks to support people traumatically injured via motor vehicle accidents. Roughly this covers around 40 to 50 percent of all people acquiring a spinal cord injury.

Whilst a comprehensive scheme aims to be with the injured person through hospital and back into the community, the sheer requirements for accountability, ongoing development of and adherence to new guidelines, the lengthy approval process and a lack of joined up areas of funding, for example, accommodation and aids and equipment, do not necessarily always support the best outcome for the client.

We find ourselves moving philosophically into a new model of support for people with a disability, one where people are individually funded, placed front and centre of their services and generally moved up from the bottom of the service delivery chain to the top. New demands on existing systems will be placed on lifetime care scheme clients. There will need to be change.

Additionally, we also see the development of the National Disability Insurance Scheme. Whilst not a certainty by any means, with no federal party stating outright that come what may it will occur, we still need to reflect on the recommendations of the Productivity Commission's report into long-term care and support for people with a disability, particularly in relation to the Lifetime Care Scheme, that could see a greatly expanded role as part of the National Disability Insurance Scheme. Possibly also as an advisory scheme to the National Disability Insurance Scheme on health and disability services interrelation.

We would like to thank the Members of this Committee for reviewing our submission and requesting that we be available to answer questions on our submission, questions on our organisation's experiences of working with the Lifetime Care Scheme and its clients.

CHAIR: Your organisation's submission notes that there is now enough anecdotal evidence to indicate that people are being over-prescribed carer hours for their level of need. Can you provide the Committee with some examples of how this negatively affects a participant's care?

Mr LOMAS: Interestingly enough we have more evidence that this is occurring but we reported that last year to this Committee and there has been little that has changed around that. A great example of that is there is certainly a lady who lives on the northern beaches who receives 24 hour care and it is absolutely driving her crazy. She wants to go out and she wants to do things. She wants to live her life and she wants to get on. However, when you prescribe care of that intensity onto a person, you really foster a sort of cotton wool kind of covering environment that really does not do anything to grow that person.

If you look at the services, we classify services into two camps, fundamental services and enabling services. Fundamental services are the ones that get you out of bed in the morning and make sure that you, as an individual, are ready to go and enabling services are the ones that drive you forward and take you out into the community and expand your life. If you over-emphasise in the fundamental area then you are never going to get anywhere near any of the enabling aspects that you need to have to be able to take you forward. It is quite a negative thing.

We do not quite know why there is this over-prescription of care hours occurring. It does not make any logical sense. This lady is more than capable of supporting herself to a greater degree than that. Engaging even in her only home in tasks and activities is still expanding her and pushing her forward, making cups of coffee, making her lunch. These things are not outside the realms of possibility but with 24 hour care there is very little change to be able to do that.

CHAIR: Are you finding that people are complaining of under-prescription of care hours?

Mr LOMAS: Not so much within the lifetime care scheme. Generally in the bigger pool there is a complaint that there are not enough care hours to support people who are living independently in the community, but in the lifetime care scheme there is not that much that is going around about an under-prescription of care.

Mr JONES: However, the area of recreation perhaps might be something that lifetime care and support could look at to assist people getting out into the community more.

CHAIR: Is this something that you have raised with them? Have you raised these concerns that you have just raised and also the concern about the over-prescription of care hours directly?

Mr LOMAS: We have raised some of the issues that we have put in our submission and the ones we have put in previous years submissions.

CHAIR: Directly to the organisation?

Mr LOMAS: Yes.

CHAIR: And the response that you get?

Mr LOMAS: This is very interesting. We will take it into consideration. Thank you very much. That is if you get a response, and goodbye.

Mr JONES: I think in the 2009 review of lifetime care and support there was some acknowledgement that recreation might be looked at as an area that could be looked into. Often people who have got a certain amount of hours, be it personal care or whatever, we talked before about over-prescription of hours but there are other people who might feel a little bit isolated at home and if they felt that they could get some kind of support to go out, to go to the movies or perhaps to engage in community events with the assistance of someone, that might get them out of the house and make them feel that they are engaging in the community a bit more.

The Hon. SARAH MITCHELL: With, for example, the lady that you said has the 24 hour care, is the suggestion or the solution just for the hours to be reviewed more often? You said you raised this last time and nothing has happened. What can we do as a Committee to help that issue? What would be the suggestion?

Mr LOMAS: Dr Middleton certainly spoke about there being this new sort of training that is happening with regards to lifetime care scheme case managers et cetera, to get them to understand the needs of people with spinal cord injuries. We have not seen the benefit of that yet. I am sure there are benefits or there may be benefits which are happening which have been analysed enough to be able to see that. That may be a way of addressing that and really understanding the needs.

There is also a change in the philosophy of the case manager and the way the case manager is thinking. Is the case manager thinking about sheer care needs or sheer physical requirements for an individual, or are they thinking we have this individual here, how are we going to get this individual back into the workplace, or how are we going to be able to get this individual to be a productive member of their local community, or national community, depending on which community they want to be a part of. That is the kind of thinking. There are two separate camps. Certainly an over-prescription of carers would foster the let's wrap people up and make sure they are safe physically but do little to address the other.

Mr JONES: Improving communication between case managers and coordinators and the individuals that they are assisting would help. These things always help. Often there is not enough communication in all services aimed at people with disability and this idea of person centred that we seem to be heading into now is a way of dealing with that in the future, I would hope.

The Hon. SCOT MacDONALD: I have two issues, I suppose. Can you give us a little bit more about fund transition or accommodation support for the individual to move back into their respective communities? That seems to be a bit of a problem according to your submission, especially if you are a little bit further out of the major centres. You can give us your ideas on that? Further, we hear a bit of this from other witnesses in submissions, just the delays in access to aids and services. Why? We have heard there are delays but what would you put the delay down to and how can we overcome that?

Mr JONES: With regard to transitional accommodation, often people who have had their accident in rural or regional areas obviously are having to go to Sydney to receive that care through the spinal units, so they are away from family and friends and the difficulty then is trying to get back into the community and they are not being given any of the transitional support to actually speed up the process of them leaving hospital and spending much longer time in hospital waiting for approval of accommodation services.

The Hon. SCOT MacDONALD: So if you come from Gunnedah or from near Armidale and you have a catastrophic injury you are taken usually to Hunter in Newcastle. It is quite difficult for the patient and maybe a couple of people around him or her trying to organise all the future accommodation needs back in Gunnedah.

Mr JONES: There are limited options as well for suitable accommodation once you have had a spinal cord injury, even in Sydney.

CHAIR: What sort of limited options are you talking about?

Mr JONES: Transitional accommodation specifically. We have a number of places ourselves but, again, it is just limited as to what is available and then there is the possibility of any options to move into private rental, that has barriers itself. If it is not accessible, how do you make it accessible? How are landlords going to accept making changes and then gaining approval through lifetime care and support to make those. An OT might come in and say this needs to happen and this

needs to happen to make it accessible. This is a lengthy process. Meanwhile someone else has offered up the bond to move into that rental accommodation and the place is no longer available.

The Hon. SCOT MacDONALD: So that would come down to the lifetime care coordinator?

Mr JONES: Yes, if that sort of process could be sped up.

Mr LOMAS: I think Dr Middleton was identifying that as an issue that there is bed block and overspill from spinal units into acute and other areas where really you need to get these people out. They are ready to go out and start facing the community, or at least go through some sort of transition which would enable them to succeed in the community as opposed to being thrown out the back end. It is trying to get them to that stage where there is something available for them. Last year we put forward a plan as part of our presentation to the Committee around trying to create an accessible housing registry throughout New South Wales which would enable us to at least have a starting point to understand exactly what there is, whether it is private or public housing and from there start to look at strategies, to start growing the amount of accessible housing to meet the need.

The Hon. SCOT MacDONALD: You are mainly talking about non-home owner, people when they have had that injury they have been in rental or in social housing of one sort or the other, so someone who has come from their own home. Inevitably that would be easier because they would get a bit of guidance about the shower or the stairs.

Mr LOMAS: They would receive funding under the home modifications maintenance scheme.

The Hon. SCOT MacDONALD: You are talking about the non-home owner, I gather.

Mr JONES: Specifically, yes, but there are issues as well if you are a home owner in gaining approval for modifications.

The Hon. SCOT MacDONALD: This approval, is that from the lifetime care or from your local council to do a DA?

Mr LOMAS: Approval that degenerates in the lifetime care scheme. Anecdotally we have certainly heard from number of OTs who conduct these assessments of existing properties and who also do surveys of properties that we are looking at. They write reports on the number of modifications required and they have seen lifetime care scheme coordinators flip to the back page and say no. That is it. Thank you very much. These reports take quite some time and are quite costly to compile, so it comes down to a question of dollars rather than the actual benefits that this can bring to an individual.

The Hon. SCOT MacDONALD: How did your register go? You were talking about it last year.

Mr LOMAS: It was really just looking at all different sources of information and pulling that together with the support of the lifetime care scheme. We are looking at where applications have been made to local councils, where a property is modified, so taking that stuff back, looking at properties that have been modified under the home care modifications maintenance scheme, anywhere at all, and also perhaps putting a line into the census, asking would you classify your property as wheelchair accessible or would you classify your property as different degrees of accessibility. What features do you have to qualify that. You can start to build a bit of a picture about what sort of housing you have out there. It would take some time, but it would certainly be a good exercise but would help government with driving itself towards accessible properties.

The Hon. SCOT MacDONALD: The second part of my question concerns the delays which we hear about from a lot of people. What are we putting down to that delay? What is the root cause of that?

Mr LOMAS: Generally the over-bureaucratic approach to getting these things through. Recently there has been a bit more of a marriage between the lifetime care scheme and EnableNSW with an aim of trying to speed up how basic equipment is sourced. Yet it still does not seem to be necessarily bringing the benefits. It has to a degree but it has also brought in new issues. Today I heard, about two hours before we came in, so it is nice and fresh, about a lady who wanted to access transitional respite. She is a lifetime care scheme client. To access that transitional respite she needed to use a BiPAP machine, which is a breathing machine. She was told she could do that, however she would need to trial a BiPAP machine for three months at her own expense. Once she has done that she will be provided with the equipment if it is the right one and she can access the transitional respite. That seems bizarre because the individuals is going to be deterred from trialling the items because it is going to be at her own cost. She may not necessarily have the money to do that. The fundamental need, which is the transitional respite, is dead in the water because of a new thing that has come out.

There are certainly a lot of things that are happening around continence supplies with Enable. I understand that leads on, to a degree, into the lifetime care scheme. They are playing around with what is available, what is not available, and changing lists. It is a bit of a mess. You have your lifetime care scheme coordinator trying to work in with this, trying to recommend these items through and they are hitting a bureaucratic weird thing that is going on, which is preventing those items from being properly sourced and purchased and provided to the client.

Under EnableNSW it is from the standard public purse that these items are funded, whereas under lifetime care scheme they come from the lifetime care scheme coffers, which we understand to be large and generally quite weighty. Surely it should be a question of the client requires an item of equipment, quite obviously requires this type of equipment, honey is easily available to do this, go out and buy the item and give it to the client. Situation resolved.

The Hon. SARAH MITCHELL: Is that example a common occurrence?

Mr LOMAS: I cannot say because I have not heard that one before. I only heard that a couple of hours ago and I have not really had a chance to dig around and find out if there are other instances of this kind of thing happening. It is certainly a bit of a weird one.

Mr DAVID SHOEBRIDGE: You are not the first person to make a submission concerning transitional accommodation and the difficulty in getting transitional accommodation approved. One suggestion was decoupling the decision making about transitional from final. What do you think about that?

Mr JONES: We listened earlier to that and that seemed like a worthwhile thing to look into, yes, definitely.

Mr LOMAS: I certainly would agree it is a very interesting idea that you have perhaps a bucket of money ready to go to get a person to a certain stage immediately and then you can fight whatever bureaucratic fights you need to fight to get the long-term situation resolved. I think getting a person moving forward as quickly as possible is an essential thing.

Mr DAVID SHOEBRIDGE: In terms of the best way of caring and the impacts on care, do you view that failure to readily approve transitional and readily achieve that transition out of hospital as one of the big issues or is it a second degree issue in the scheme for your participants?

Mr JONES: It is certainly a big enough issue. If you are spending longer in hospital than

you need to, nobody benefits from that.

CHAIR: Your submission emphasises the importance of recreation and leisure in a participant's rehabilitation and in it answers to questions on notice the authority stated that it is "not funded to pay for participants' leisure and recreation costs but will fund leisure and recreation activities for participants when the activity is part of a rehabilitation program and will assist the participant to develop independent living skills". To what extent does the scheme's response strike the right balance? I know this is something that you referred to earlier, Mr Jones.

Mr JONES: All I know is that often when it comes to things like recreation in all services that seem to be available, that there perhaps could be more recognition of the value of it in a person's life in getting them out and about more, especially if you do not work and you find yourself at home a lot. We are talking often about people with very high level needs, who need a lot of support when they leave the home and so this is often a deterrent if you have only got a very limited amount of hours in which you have got support. People then feel like they do not have the confidence to leave the home, or often family are not around if they are living in an area like the city and are originally from a regional area.

CHAIR: Mr Lomas, do you have anything to add?

Mr LOMAS: The policy around this is not quite clear-cut. I understand there is a funding of an exercise program called Burn Rubber Burn, by the lifetime care scheme, which is not part of any recognised rehabilitation process. It is a community based exercise program which provides pasta nights and things like that as well, which is absolutely wonderful. They have recognised from that that there is a benefit in recreation, in particular to link up with exercise for individuals with spinal cord injuries because it has numerous health benefits for the individual. You can have a decrease in pain levels and can have an increased ability to be able to breathe and be in control of your diaphragm. There are many things which can benefit the individual through exercise, so having a comprehensive policy that addresses support available for recreation and a particular exercise is an absolute must for lifetime care, even if you are just maintaining the core physical strength of the individual, to see them going forward as opposed to putting them in a position where they can deteriorate physically.

Mr DAVID SHOEBRIDGE: We have heard from a number of submissions that on occasion the lifetime care and support seem to be effectively double guessing clinicians, or suggesting to participants in the scheme alternatives approaches to those that their clinicians have been suggesting, which can create difficulty for participants because they have been told something by their coordinator or case manager on the one hand and they are getting different information from the clinicians on the other hand. Do you have any experience of that or any knowledge about that happening?

Mr LOMAS: We have certainly heard of it occurring. I certainly have not heard of it occurring in the immediate past. Tony was largely responsible for putting together our submission and doing the research around that, but I know that last year there were certainly instances where we were hearing of lifetime care scheme coordinators going up against clinicians, which is deplorable. The clinician is the person who understands the physical situation that the individual is in. We have heard instances of questions around medication, which is not a debate which a lifetime care scheme coordinator should be involved in whatsoever, seeing the clinicians and the specialists are the people who are trained to do this to support the individual. It is not up to a lifetime care scheme coordinator to start talking about medication.

Mr JONES: Which is why I mentioned in the submission the possibility - and the previous submission from the State Spinal Cord Injury Service did mention the training of coordinators in the area of spinal cord injury, the specifics of it, and I think that definitely would assist in improving the communication between individuals and case workers when it comes to spinal cord injury and the specifics around it.

Mr DAVID SHOEBRIDGE: When you speak of training, that is not training them up to become specialists?

Mr JONES: No, of course.

Mr DAVID SHOEBRIDGE: But training them to recognise how to value the clinician's considered opinion, which is the tension on that training.

Mr JONES: Yes.

Mr LOMAS: Is that something that should be trainable? Should there not be a general understanding as a human being that if you enter into a hospital and there is a specialist who has spent many years working in the field and writing numerous papers, who is an absolute star in this whole issue around spinal cord injury, certainly you would not want to be going in this there saying I think perhaps you should be looking at this or doing that. I think that is inappropriate on a basic fundamental level.

Mr DAVID SHOEBRIDGE: But there does need to be administrative decision making in terms of cost control and so on.

Mr JONES: I think it is just an understanding of the health risks involved with someone with spinal cord injuries and an acknowledgement by the coordinator or case manager of what those issues are, so that when dealing with that individual, whether it is around pressure care, or infection, things like autonomic dysreflexia, the specifics of spinal cord injury, as opposed to just physical disability.

Mr DAVID SHOEBRIDGE: Have you had any concern about timely decision making? We have heard earlier today about initial requests being made, it taking 10 days, unless it is urgent.

Mr JONES: It might be around approval of things that assist in pressure relief, so the type of cushion for someone's wheelchair, or air pressure mattresses that they lie on at night, which prevent pressure, and the approval of those things. If a case manager has a good understanding of what those issues are around health then that can only improve things.

The Hon. SCOT MacDONALD: Just a quick clarification, you say participant representation, and you want two people, is that necessarily including an SCI, or just a participant?

Mr JONES: Participant. That information I got from the 2010 review and that was one of the recommendations and we would just be keen to see that take place if it has not already. We just think that would be a good thing for the scheme and for the authority itself, to just have a better understanding of what participants have to go through themselves in receiving the services.

The Hon. SARAH MITCHELL: One of the things that this Committee is considering is whether or not we could do the review of the lifetime care and support biennially, instead of annually, and you mentioned today there were a few things from last year that had not been addressed. What would be your view of it being done every two years as opposed to every year?

Mr LOMAS: Given that we put forward a fair few suggestions last year, and I think we did it the previous year and I do not think any of them got through. If we go out to every two years that is probably not a good idea actually, back tracking. Thinking about the development, and I mentioned in my opening statement that there is some stuff on the horizon, the National Disability Insurance Scheme, the National Injury Insurance Scheme development, and the lifetime care scheme was developed by John Walsh. John Walsh is one of the architects of the National Disability Insurance Scheme as it stands now. He worked at the Productivity Commission. There is a natural link coming

into this.

The role of this Committee to analyse the lifetime care scheme on a 12 monthly basis is very important now, seeing the discussions are going on about what is the National Injury Insurance Scheme going to look like and there is every chance that it could be a greatly expanded lifetime care scheme. Getting the lifetime care scheme right is so utterly important because it is going to go from hundreds of people in New South Wales at the moment to thousands of people Australia-wide potentially. It could end up being a hybrid between the lifetime care scheme and the Transport Accidents Commission in Victoria. We would certainly want to have the best scheme we can have in New South Wales, going forward and making sure we get it right. I certainly think 12 monthly is the right way to go.

CHAIR: Unfortunately we have run out of time for this part of our hearing. There may well be more questions in a members of the Committee would like to put to you and it would be of great assistance to us if you could get a response to those questions back within 21 days of them being received. That would help us certainly in our deliberations.

(The witnesses withdrew)

FRANCES ELLEN O'CONNOR, Director, Injury Management IQ Pty Ltd, affirmed and examined:

CHAIR: If you should consider at any stage that certain evidence you wish to give or documents you may wish to tender should be heard on seen only by the Committee you can indicate that to us and we will give consideration to that request. If you do take any questions on notice the Committee would appreciate it if the response to those questions could be forwarded to the Committee secretariat within 21 days of you receiving them. I understand you had a PowerPoint presentation but unfortunately our system is down.

Ms O'CONNOR: That is fine. As an opening statement I thought to recap the key points of my submission it is better done diagrammatically, so if I can talk you through the document I have provided. In my submission I was basically going to get everyone to stand back and take a more fundamental view of a personal injury scheme and then zero in on what an effective insurer role needs to be. If you look at the actual high level view it has objectives, a legal framework, which defines theoretically the compensation available, insurers who do the practical application and a regulator who needs to be able to oversee the effectiveness of a scheme design and insurer performance and make improvements where necessary.

If you look a bit more closely then you need to determine what the roles and functions need to be. First of all, the objectives need to be specific enough to define what sustainability really is within the scheme. The legal framework needs to be acknowledged as having limitations, in that it cannot anticipate every possible injury scenario and it also relies on accurate application case by case.

A regulator needs visibility of the scheme in practice, both in terms of assessing the scheme design and insurer performance. The insurer role then has implications in that it is responsible for generating that information for evaluation and being able to integrate any improved standards as a result of that analysis.

To understand what the insurer role actually looks like first hand, if you turn to the second slide, the process always begins with an injury. That sets up a medical management process, which is quite dynamic in the clinical setting, so the process of determining a diagnosis and the treatment, is dynamic and ongoing and there will be an outcome of either full recovery, partial recovery or no recovery process.

When a claim is submitted that starts a parallel process and a claim assessor's role is essentially to receive all information pertaining to that claim and there are vast amounts of information, and it is very highly technical, from multiple sources, but mostly the medical information and to determine the significance of each piece of information in terms of the objectives for the claim, the needs of the claim to facilitate progress, and to make decisions based on their understanding of the implications of that information.

To assess the effectiveness of all of this, two questions need to be answered: One, were the outcomes reasonable for that particular claim profile, and two, how were those outcomes actually achieved by the insurer, so what actually happened in that assessment and decision making process. At the moment with current insurer practice standards, neither of those can be answered on a claim by claim basis unless you look through the whole file, but certainly not on a large scale and certainly not across the scheme.

In the final slide, to get an understanding of what is actually required for that level of evaluation, you are really looking at insurers needing to be able to generate and integrate evidence from their practice. The first component of that is data capture design, so a minimum standard for all insurers across the scheme to enable performance evaluation of distinct claim segments.

The second component would be risk identification control, so using the data that has been

collected and analysed to assist claims staff to identify and understand what are the risks that are being presented on individual claims as they arise.

The third component is risk management control, so as risks arise on a claim what the best practice is to actually manage those risks, to guide their management. At the moment that, in a nutshell, is what 21st Century claim practice should look like, given the advent of IT, but it is nothing like that in practice at the moment, hence a lot of the problems with visibility and the role of a regulator in evaluating scheme design and insurer performance.

The Hon. SCOT MacDONALD: I think this was the last one I read. I think your submission came in a bit late.

Ms O'CONNOR: Thank you. I was not even expecting it to be received, so I appreciate that you did receive it.

The Hon. SCOT MacDONALD: One of the themes I thought we saw through all these submissions was people feeling dis-empowered, they did not have the information, they did not have access to the information, it was poor timeliness of getting responses, getting paperwork in. People were obviously doing their best. I am talking about coordinators and probably even the scheme, but there seemed to be blockages everywhere in the timeliness and accessibility of the information, so I thought surely we must be thinking of going down the road with this sort of thing and the fellow before you, sitting on the left, was sitting there with his iPad so I would like to think that if we could improve all this information flow, someone like that will feel a lot more empowered and would know why he is not getting the request for the aid responded to. Is that what you are offering up? Is that what you are suggesting?

Ms O'CONNOR: Exactly. I think there is this idea in the community, and certainly from speaking with people, that insurers with the vast amounts of money that they have at their disposal must have fairly slick operations in-house and they are absolutely flabbergasted and outraged at just how laborious the work is and the lack of controls and that someone with no professional education in medicine, allied health or any of these areas is actually making decisions, without any real effective controls to help them to even understand what that information means and hence the lack of timeliness of decision making, but also the ineffective decision making, so apart from catastrophic claims all the claims for people who are out in the general community trying to return to work but who need extra support or treatment to do that, who are missing out or having their treatment being questioned or else likewise those who are not moving on to return to work and all of that who actually should be, there is a lack of a scientific focus within insurance companies because of these knowledge deficits and the lack of controls.

The Hon. SCOT MacDONALD: To follow up on that, comparing things with WorkCover, does this exist anywhere else, WorkCover or anywhere else?

Ms O'CONNOR: This is universal. That is why I made the point about the design of disability schemes. The whole personal injury insurance industry is very introverted. Insurance staff move readily from one scheme to another and in income protection insurance as well. The problem cuts across all of them. I now work across all areas and analyse the practices and there is no difference anywhere. They are learning from each other but unfortunately that cross pollination of ideas is not necessarily innovative ideas on this scale. It is more just learning to increase complexity with more focus on micro processes, rather than critical thinking which actually expedites decisions.

Mr DAVID SHOEBRIDGE: When you talk about data capture, we had some concern from some earlier submissions about privacy rights, particularly in the Lifetime Care and Support Scheme where there is a large amount of data capture happening, and they had concerns that it might be quite intrusive of participants, the degree to which data is being captured in the Lifetime Care and Support Scheme. What do you say about those privacy concerns?

Ms O'CONNOR: Insurers are already capturing an enormous amount of data but they are not capturing it in a way that is practical to actually evaluate.

Mr DAVID SHOEBRIDGE: I think the concern is not capturing the data for the assessment of the individual claim, but then using the data you capture in an individual claim for general scheme purposes and it is the transfer of data across and the privacy concerns.

Ms O'CONNOR: Obviously in any particular computerised system where you are looking at details, you need to be able to segregate personal identifiers from claim profile data. That is a given. At the moment a lot of CTP insurers are not even using IT. They just have claim files. If someone was to go through a claim for auditing purposes or anything like that, there is no way of segregating personal identifier information from general claim profile information.

Mr DAVID SHOEBRIDGE: You said before you looked across different schemes and you have reviewed different schemes and they all seemed to adopt this ad hoc kind of individual claims.

Ms O'CONNOR: It is endemic.

Mr DAVID SHOEBRIDGE: Are there any that come to mind which are better than the others and might be the starter model?

Ms O'CONNOR: No. Like I said, the industry is very introverted. There is not much competition in claims practice amongst insurers. It is not like it is the kind of business where a new insurer is going to pop up and do something new and innovative that actually puts pressure on the others.

Mr DAVID SHOEBRIDGE: Have you looked off-shore, maybe to some other jurisdictions?

Ms O'CONNOR: Absolutely.

Mr DAVID SHOEBRIDGE: Have you found any better schemes off-shore?

Ms O'CONNOR: No, not really and nobody is really integrating any kind of decision support or critical pathways into the claim management process. That is the key because if you could picture the amount of dynamic information exchanged, that all claim assessors are handling on every claim, and multiple claims at a time, it is not like they dedicate their time to one claim and see it through, there are multiple claims that they are juggling and the time pressures and the knowledge deficits.

Mr DAVID SHOEBRIDGE: Often cycling through claims managers on an individual claim?

Ms O'CONNOR: Exactly. It is completely impractical to think that anything is going to help them to identify the real needs of a case if it is not embedded into the claim process. Hence IT, using electronic file management, would enable that but even as some insurers are starting to use IT applications they are not actually setting them up in a way that organises the data to actually pop up and say you have entered this information, this represents a risk that you need to do something about on this claim.

Mr DAVID SHOEBRIDGE: So you envisage that if you did it properly you would have a class of injuries, maybe a lower spinal injury, a moderate lower spinal injury, where three or four months post-injury there is a request for certain physiotherapy services which are made by a claimant and if that is properly data matched there will be a risk point come up when the claims assessor looks

at it and it says in the 90 cases where we refused this we have incurred these costs and in the 100 cases where we have approved it we have had these lower costs, therefore this is a risk point, you should therefore most likely approve the service, or not, as the case may be.

Ms O'CONNOR: Yes, on a very basic level and then multiply that by the number of different claims. The portfolio segmentation by injury type is really the same concept as a hospital. A hospital is set up so that people with cardiac problems are all grouped together and people with orthopaedic problems are all grouped together because medical specialists know that they have common issues that need to be managed. It is the same concept with personal injury because they are receiving claims for similar groups of injuries and once you put that data together there are common principles that a claims assessor should be looking out for and should be doing on a claim.

Mr DAVID SHOEBRIDGE: The information has not been getting to the regulator. That is your other primary concern?

Ms O'CONNOR: Exactly. How can the regulator be sure that they are actually managing claims to the best of their ability without this information.

The Hon. SCOT MacDONALD: Is it a big up-front cost? Are there cost savings? I suppose it is a leading question. Do you offer up cost savings to the scheme do you think?

Ms O'CONNOR: I am not an IT specialist myself. I do process modelling, which is the foundation for IT design. I was speaking to a like minded colleague yesterday about this and he was saying to me that the old legacy systems that they are currently using that are completely inflexible are costing them a fortune and some of them are moving on to replacing paper files with the new generation of IT applications available, but they are not used cost effectively, so even if they are outlaying those costs they are not organising the data and are not putting the right profiles together to understand how to improve their management.

The Hon. SCOT MacDONALD: They are just saving filing space.

Ms O'CONNOR: In some cases they are actually increasing the task orientation because it is all task oriented processes that are now computerised and electronic file notes.

CHAIR: Unfortunately the time has expired for this part of our review. There may well be some questions that arise as a result of comments and submissions that you have made, so it would be very helpful to us if you could respond to those and preferably within a period of 21 days from the time of receiving them. That would certainly help us and facilitate our deliberations.

(The witness withdrew)

(Luncheon adjournment)

SUSAN RHODA FREEMAN, Acting Deputy General Manager, Motor Accidents Authority, and

ANDREW PHILLIP NICHOLLS, Acting General Manager, Motor Accidents Authority, sworn and examined:

CHAIR: If you should at any stage consider that certain evidence you wish to give or documents you may wish to tender should be heard or be seen only by the Committee, please indicate that fact and the Committee will consider your request. If you do take any questions on notice, the Committee would appreciate it if you could give your response within 21 days from the time that you receive those questions. That would certainly facilitate us in preparing our report. Do you wish to make an opening statement?

Mr NICHOLLS: I do have a statement if that is okay. I would like to acknowledge that Ray Whitten, who is the Chair of the Motor Accidents Committee and of the Motor Accidents Board is in attendance today. In the normal course of events our board chairman would be here but, having been appointed for all of about two weeks, we thought it appropriate to have myself and Sue here today.

I would like to open with some comments on the Motor Accidents Scheme. This was a compulsory scheme providing benefits to injured people, funded by vehicle owners. These two groups are our customers, along with the Minister, as representative of the community of New South Wales. The scheme is underwritten and delivered by private insurers in competition with each other, all within a legislative framework set by Parliament and rules and regulations overseen by the Motor Accidents Authority.

The central challenge in the scheme revolves around the fact that the scheme has competing interests between what motorists think is reasonable as a cost for their green slip and how injured people are treated as they attempt to recover from their injury. There are other views from service providers, such as legal representatives, questions about what is reasonable compensation and what the insurers think is a proper return on the capital they have tied up in the scheme. For this reason the key challenge of the scheme is balance, balance between sustainability and affordability.

This Committee has heard about profit and benefits and I can advise that almost all of the letters received by the Minister for Finance and Services are also from vehicle owners concerned about green slip price increases. In many ways the issues before us are not new. However, in our current environment, issues affecting global markets and direct scheme impacts, such as improved benefits for injured people, increasing claims and, for example, increasing overhead costs, are all applying increased pressure on the scheme.

The current green slip scheme is entering its 13th year of operation. It is in the normal life cycle in a scheme such as this that we need to look for ways to maintain and improve the balance within the scheme and to improve it for the vehicle owners of New South Wales who are funding it and the injured people who rely on it to fund their recovery from injury.

The Minister for Finance and Services has announced a review of CTP pricing. While the terms of reference for the review and the processes are still being finalised, I understand the review will consider insurer profits and costs, transparency in legal costs to ensure that injured people get a fair level of their entitlement in their hand, fair and affordable CTP green slip pricing and, in particular, whether the Motor Accidents Authority has optimal regulatory powers when it comes to pricing and costs. The review will take into account the views and ideas of all stakeholders.

Now, if you would be happy for me to continue with a few key statistics in the scheme, I will continue. As a result of the series of initiatives introduced since 2006, the scheme now provides support to many more injured people in crashes on New South Wales roads than it did 13 years ago.

The scheme continues to return a greater share of the green slip premium dollar to injured people than the scheme it replaced. Today every single person injured in a crash now can access some benefits, irrespective of fault.

Every person injured in a crash has their public hospital and ambulance services paid for. Every person injured in a crash can access up to $5,000 of benefits for medical expenses or lost wages. Every person catastrophically injured in a crash is looked after for life. People not at fault can access further benefits for medical and related expenses, lost wages and, in the case of severe injuries, non-economic loss.
It is simply not true that 90 percent of people receive no benefits in this scheme, as some parts of the media have reflected in recent days.

Everyone injured in a car accident has access to the scheme. However, the focus of the scheme is on early intervention, recovery from injury and restitution of the injured person to their usual role in life. This is commensurate with the evolution of all personal injury schemes in Australia and overseas from the old common law concept of monetary compensation for injury to an emphasis on early assistance and appropriate treatment.

Green slip premiums remain lower today in real terms than they were 10 years ago. When the scheme commenced in 1999 premiums were about 55 percent of average weekly earnings. Today it is around 33 percent. Maintaining scheme affordability is a major challenge currently facing the scheme. CTP insurance is unique in that it is a long tail insurance product, taking many years to finalise a claim. This is in contrast to short tail insurance products, such as motor vehicle property damage or home and contents insurance, where claims are made and paid in the same year as the premiums are collected.

Over the past three years there has been an upward pressure on premiums, due in a large part to the impact of the global financial crisis, which lead to a reduction in investment returns for CTP insurers and their need to ensure adequate funds are available to make claim payments that will meet the needs of injured people into the future. This has resulted in a deterioration in the scheme's affordability index. Premiums are now around 33 percent of average weekly earnings, compared with less than 30 percent five years ago. Although over the past 12 months the index has been relatively stable, the future investment environment remains uncertain, if not volatile.

As a result of consolidation in the market in the first half of the 2000s, the New South Wales CTP market is now highly concentrated. Promoting competitive pricing remains a priority for the MAA, which will be considered in the review of CTP pricing, building on the work conducted in the competition review and which will now feed into the pricing review.

After a long period of steady decline in the number of claims per year the indications are that claims are now increasing. Over the period 2000 to 2010 claims frequency has increased from 23 claims per 10,000 vehicles to 28 claims per 10,000 vehicles. While some of this increase was to be expected with the extension of benefits, the increase in total notifications is greater than the impact that can be attributed to these initiatives.

In fact, the road accident casualty rate has continued to decline from 56 to 53 per 10,000 vehicles so, given these trends in claim frequency and casualty rates, the propensity to claim is thus rising, increasing from 41 percent of people who are able to make a claim and who do, to 52 percent since 2007.

I acknowledge there is community debate around the level of insurer profit in the scheme. There are influences on the level of realised profit that are not apparent until many years after the premium is written, despite assumptions being considered reasonable at the time, particularly the expected cost of claims.

There has been a demonstrable variation between projected profit margins and ultimate profit margins for several years in the early part of the last decade. The range of such variations and/or their consistency can call into question whether the scheme is achieving the right balance between affordability, viability and fairness.

Some scheme stakeholders have taken a clear view that currently the scheme has not got that balance right and that profits are consistently too high when viewed with the benefit of hindsight. Other stakeholders have pointed to the fact that insurance companies take the risk and thus take the good with the bad. We should not forget that for several years in the mid-90s CTP ran at a loss.

I understand the discrepancies between prospective and actual profits will be looked at more carefully as part of the CTP pricing review announced by the Minister. Importantly, I can also advise that since the last review by this Committee the authority has been actively looking at the rigour of the regulatory tools available to it within its legislative powers.

The Premiums Determination Guidelines have been revised to require greater insurer disclosure in regard to projected profit and rates of return. The authority has also developed a financial modelling tool to enable a more rigorous assessment of the assumptions used by insurers in setting target profit margins. This tool is being utilised in the authority's review of the current premium filings submitted by insurers for premium setting in January 2012.

Compared with earlier years of the scheme, legal representation is increasing and more matters are bypassing the alternative dispute resolution service provided by CARS than in the past.

In 2002, 43.7 percent of year one claims involved legal representation. By 2010 this has increased to 56.2 percent. As well motor accidents pursuing litigation through the court system have risen from 11 to 14 percent of all claims. At the same time fewer matters are going through the alternative to court claims assessment process, declining from about 16 percent to 10 percent of claims. These trends not only incur additional costs for the scheme, but can also affect the amount of compensation actually received by the injured person at the settlement of their claim.

Currently there is no transparency on the overall level of scheme legal costs being met by injured people out of their settlements, or whether these ultimate payments are fair or reasonable to meet the needs of the injured person into the future.

The Minister has also asked the MAA in undertaking the review of CTP pricing to examine transparency in legal costs. This will build on the work conducted to date in the CARS review and for the review of the costs regulation.

I would like to take a moment to reflect on some positives from the past year. The authority continues to promote competition through the green slip calculator. The green slip calculator, which is one of the top 25 most popular web sites of the NSW Government, has been upgraded and a successful advertising campaign saw an increase of almost 30 percent in web hits. This year the authority launched a new on-line training package to allow more rehabilitation practitioners, particularly those in regional New South Wales, to undertake training.

Over $2.6 million has been invested in research aimed at improving health and social outcomes for people injured in motor vehicle accidents, including trials of early rehabilitation assessment and a trial of providing roadside specialist medical assessment for people who have sustained a severe head injury.

The Committee also has a role in reviewing the activities of the Motor Accidents Council. I am pleased to report that the council was re-established last year and now has in place a constructive forward program of activities and I might table that forward program for the benefit of the Committee, along with the membership of the council.

CHAIR: Thank you.

Mr NICHOLLS: Finally, this Committee found in its last review that the scheme continues to perform in an effective manner. Although I have been acting as general manager for less than a year, I agree that the scheme is generally healthy but can see that there are areas for improvement and review, particularly in relation to pricing as it relates to overhead costs such as insurer profit and legal costs. I fully support the CTP pricing review process outlined by the Minister. I am looking forward to assisting the Minister in the conduct of the review. The review will enable discussion of these concerns about affordability and sustainability to ensure that the scheme continues to meet the needs of the New South Wales community in a balanced way. I would be pleased to answer any questions.

CHAIR: In the Committee's 10th Review the authority advised that in relation to insurer profits it had commenced a competition review. The Committee subsequently recommended that the authority consult with the regular stakeholders who contribute to our reviews. We understand that the Law Society, the Bar Association or the Australian Lawyers Alliance were not consulted during that review. Is that the situation?

Mr NICHOLLS: That is correct.

CHAIR: What would be the reason for that, for there being no consultation?

Mr NICHOLLS: The competition review was initially an internal review conducted by the authority, for the authority to identify issues that it may be appropriate to then move to a more public consultation process. That review has been finalised in recent months and, as a result of some of the findings from that review, we have identified that these are issues that are appropriate to be considered as part of the broader CTP pricing review. Our intention is that there will be full consultation with stakeholders on the issues arising from the competition review but it will be done within the context of the CTP pricing review.

CHAIR: You do not think that the Committee's recommendation was appropriate, to consult with those stakeholders?

Mr NICHOLLS: I think any consultation on the reforms in the scheme is something that is a matter for the Minister and Government to agree to and the process that I have outlined will still involve public consultation. The intent is to still have public consultation.

Mr DAVID SHOEBRIDGE: I think there was a fairly clear question there. I assume the Motor Accidents Authority determines who you consult with, is that right?

Mr NICHOLLS: Not on matters of Government policy.

Mr DAVID SHOEBRIDGE: In terms of the competition review, did you consider who you consulted on the competition review?

Mr NICHOLLS: We determined who we consulted with in the development of the internal report.

Mr DAVID SHOEBRIDGE: The Chair asked you the question, did you think it appropriate or did you cavil with the recommendation of the last Committee which recommended a consultation with those bodies which you did not consult with. That was your decision. What is your view about that recommendation and why did you not adopt it?

Mr NICHOLLS: The decision was not a decision of the Motor Accidents Authority. Any consultation on government policy needs to go through a government process and I have outlined that

the Government has received the report and we have identified the need to conduct the very consultations we are talking about as part of the broader review.

Mr DAVID SHOEBRIDGE: If I can ask about insurance profit levels, do you agree in hindsight that insurance profit levels have been excessive in the CTP green slip scheme?

Mr NICHOLLS: I think it is important to put some context around that answer. I would be pleased to table for the benefit of the Committee a review by Taylor Fry that we have prepared, looking at the history of insurer profit, going back to around 1990 when the previous version of this scheme was first put in place, so if I could take the liberty of tabling that letter for your consideration. I think that evidence shows that the history of the profit in the scheme varies over time.

In the first two years, around 1990 to 1992, it is clear that there were very high levels of profit being taken by insurance companies in the years where the prices were set by Government. The subsequent three years showed that there were losses by insurance companies in the period around 1993 to 1995-96. Since 1996 I think it is fair to say that from then until the mid-2000s that period was characterised as a period where profits have certainly been significantly greater and at discrepancy with the figures that are in the files, as I outlined in my opening statement.

Mr DAVID SHOEBRIDGE: My initial question was in the last decade, during the currency of the current statutory scheme, do you agree that insurance profits have been excessive?

Mr NICHOLLS: In the first few years, from 2000 to around the mid-2000s where we can see the fully developed years, or close to fully developed years, I think it is fair to say that there is a large discrepancy between the level of filed profit and the level or realised profit as reported by the authority.

Mr DAVID SHOEBRIDGE: So for every year we have a full picture about what the real profit is, for each of those years insurance company profits have been excessive, now we have the full set of the data.

Mr NICHOLLS: It depends on the definition of excessive.

Mr DAVID SHOEBRIDGE: 27 percent, 24 percent, 31 percent, 29 percent, 30 percent, 21 percent, that level of insurance profit out of the scheme, do you describe that as excessive or acceptable?

Mr NICHOLLS: I would say that there is a high discrepancy between the rate of profit that has been filed and the rate of profit that has been published.

Mr DAVID SHOEBRIDGE: Is that discrepancy a good thing or a bad thing?

Mr NICHOLLS: I believe it is something that we certainly need to look at and I have said that in my opening statement, that clearly, within the way the scheme is constructed, you need to look at what the appropriate framework is for pricing going forward.

Mr DAVID SHOEBRIDGE: Have you been giving the Minister alerts about this and prompting the Minister with concerns, saying we have noticed this discrepancy, as you put it, and suggesting something needs to be done? Would there be a regular trail of correspondence from you.

Mr NICHOLLS: The Minister has announced his review.

Mr DAVID SHOEBRIDGE: What about in prior years? We are now in 2011. This scheme has been going for more than a decade. Is there a pattern of the Motor Accidents Authority communicating with the Minister and saying, to use your words, there are these discrepancies in the

profits and something should be done?

Mr NICHOLLS: I will take that question on notice because I have only been the acting general manager for less than a year.

The Hon. SCOT MacDONALD: I have a couple of angles to attack. I think I talked about it at the briefing, the timeliness of the reporting and the auditing. I think you touched on it a bit then, the GFC has eroded your investment. The gist of my question is threats to the companies' capitalisation. How quickly is that being responded to, reported to, so if you have GFC slicing and dicing the capitalisation of some of these companies, and it could be a threat to that long tail being able to be funded, from what I understood you were telling us there was a 12 month delay, or 18 month delay from the auditing and the reporting. We are looking at pretty volatile invest markets at the moment, so is that good enough? Can we improve on that? Is there a potential threat to any of the companies or the scheme?

Mr NICHOLLS: I am not sure that the authority has ever indicated that there was a delay in the reporting to us of any issues in relation to the prudential situation of a company. There is a delay certainly in terms of public reporting of data and I want to make that point quite clear as a distinction. We have a memorandum of understanding with APRA, following the Royal Commission that arose following the collapse of HIH. New prudential arrangements were put in place in which APRA became the lead agency for prudential monitoring within Australia and every state that has a prudential oversight role in a scheme, such as the CTP scheme, there is a memorandum of understanding with APRA to provide us with that early alert process.

We meet regularly with APRA. We have officer level attendance at APRA investigations of insurance companies. We receive the APRA reports. We engage in a review of those reports and we have an early warning system with APRA. Effectively, if there was something to arise of concern in relation to an insurer being in financial difficulties, we would have a very early alert on that.

The Hon. SCOT MacDONALD: How early is early?

Mr NICHOLLS: It is as early as APRA is able to receive advice. I cannot speak for APRA but I understand it is a reasonably quick process. They have fairly high prudential standards now and, as a result of the changes in the regulation, those standards make it less likely that a situation would occur that would not get an early warning with APRA, but I would have to say that APRA is better placed to answer that question than myself.

The Hon. SCOT MacDONALD: If I understand you correctly, you cannot give us absolute assurance that the taxpayer would not be picking up a failed insurance company?

Mr NICHOLLS: I could not give you that assurance, no. It is a matter of any market where the private sector is engaged to be the service deliverer that there is always risk of failure of an organisation. However, the authority has in place a range of tools in addition to our relationship with APRA. We have our own supervision. We have a fully funded test in our premium determination guidelines. We look at their premiums as far as if relates to CTP on an annual basis and we conduct audits of the insurers as it relates to CTP, to ensure that that part of the business is operating solidly.

The Hon. PETER PRIMROSE: I have been pondering the issue of price signals in this but I may come back to that later. Last Monday, Mr Stone from the Bar Association noted that CTP insurers do not necessarily want to have the lowest premium and the reason for this he gave was because this attracts the highest risk customers. If I can quote something he said:

> "What you really do not want is the 17 or 18-year-olds in the 10 or 15-year-old cars...so there is a fundamental flaw in the competitive model. One of the things that I would hope this competition review will look at is how to address that issue..."

I presume that may come as part of what you are calling your CTP pricing review. There are three questions. Do you agree that this is a fundamental flaw in the competitive model, as asserted by Mr Stone? The second question is, is this an area now that your CTP pricing review will be looking at and finally, if there is a problem, what could be some of the solutions?

Mr NICHOLLS: The premium guidelines set by the Motor Accidents Authority aim to deal with the issuing part. The authority's guidelines are designed so that there is what is called community risk rating. Community risk rating means that an element of the price setting is reflecting the risk of somebody having or causing an accident and part of it involves cross-subsidy between other users so that insurance premiums are not unaffordable for the groups of people such as 17 year olds. If young people were paying the full premium they would probably be paying something like three times the premium of somebody who was over 30 so clearly that would act as a disincentive for people to buy their insurance and remain insured on the road network.

We have premium determination guidelines in place that are deliberately designed to ensure that there is a level of cross-subsidy in terms of community risk rating between the better risks and those high risks, such as the 17 year old that you were referring to.

Those guidelines are complex but, putting it in simple terms, there is a cap and a floor in the price range that an insurer can charge for a particular individual. That cap is around, at the moment, 30 to 35 percent above what is called the base premium but it can go as low as 15 and sometimes up to 25 percent below the base premium for any class of vehicle. That range means that somebody who is a high risk, such as a young driver, might be paying in the order of 30 percent above this base premium while a better driver, who is over 30 might be paying something like 15 percent below. There is still a pricing differential between better risks and higher risks within the scheme.

However, necessarily, the capping and the floors mean that the range that should normally apply acts as a brake to those higher risks facing really high premiums. What we have within our guidelines, again without getting into too much complexity, is what we call the elastic gap. The elastic gap means that the lowest price, the floor price, can move much more freely than the higher price, meaning that insurers can move to some degree their pricing for better risks in order to not be facing the situation where the higher risks also come down in price and that insurer ends up writing all of the bad risk.

However, it is important to recognise that there is an element of the point that is being made, which I think validly needs to be picked up in our pricing review because it is certainly the case in a compulsory scheme that there are a number of risks that an insurer in the free market would not write at those particular prices, but what I would say is that it is absolutely essential that we do not design a scheme that sees people who are basically pushed out of affordability in the scheme.

The Hon. SARAH MITCHELL: I have a question relating back to insurer profits and I guess the term excessive insurer profits was something that came up last week in our hearings. When we heard last Monday from the Insurance Council of Australia, Mr Mobbs from that organisation explained to the Committee that this has been as a result of claim frequency reducing by half over the last decade, which was impossible to be predicted. Do you agree with the view that excessive profits are as a result of reduction in claim frequency and if, as stated by Mr Mobbs, there is no way to predict what will happen to claim frequency in the future, if there are any measures that the MAA can introduce to ensure that future CTP pricing is fair and reasonable?

Mr NICHOLLS: If I can go to the first part of the question, the paper from Taylor Fry which I tabled, summarised four key points that influenced the gap between the filed price and the realised profit some years after the event. They have identified four factors, three that have influenced profit higher than expected and one which was an influencer on profit, that reduced the level of profit.

The first is that there was a decrease in expected claims of high severity injuries so, in effect, high severity injuries, as you would expect, are more expensive in the scheme, so when there is a reduction in those claims obviously we see some lowering of costs. The average costs of finalisations in that period, that is claims that are finalised and settled effectively, also had an average cost much lower than what was originally expected and thirdly, there have been changes in the incurred costs and they are the combination of the final settled costs as well as the costs for expected claims and those have been trending downwards as well.

However, as I mentioned, there was a factor which ameliorated that, which was the declining interest rates and so an element of some of the profitability of the insurers have been offset by the fact that yield rates have been the lowest that they have been in about 50 years. The change in claims profile certainly offset that by a much larger degree, which is the principal explanation that Taylor Fry has given us in terms of that explanation.

Taylor Fry's explanation indicates that there is an inherent uncertainty when it comes to looking into the future, so coming to your question about the future, it is in the nature of a scheme such as this that claims do move in different trend lines. We saw in the period from 2000 to 2007-08 a demonstrable decline in claims. We have seen since 2008 a demonstrable increase in claims. As I mentioned in my opening statement, claims at the moment have gone from 23 per 10,000 to 28 per 10,000 vehicles.

To some degree those things have a certain level of uncertainty and that is something that we need to look at as part of this review and it is something that we are looking at with our actuaries to see how we might be able to improve that. It is important to note that in 2006 the authority introduced new guidelines for the assessment of files and those improvements certainly have lead to a tightening of the way the authority makes its assessments.

As I also mentioned also in my opening statement, in the last 12 months the authority has introduced two new initiatives in that we have revised substantially our premiums determination guidelines and we now require a lot more information from insurers about profit and their expected internal rates of return and future investment profiles. We have also worked with an economics firm, rather than an actuarial firm to build an economic funding model, a financial model, designed to enable us to run insurer filings through that model and assess those against what you might regard as a model insurance framework, to assess whether those assumptions in the filings are reasonable.

Certainly we have acted to address some of the concerns that have been raised and we aim to look at other ways that we can improve information in the marketplace to make better assumptions about the future as part of this pricing review.

Mr DAVID SHOEBRIDGE: Just following on from an answer you gave to the Deputy Chair, as I understood you, you said that there is competition because you have capacity to have elastic pricing with relatively low risk participants in the scheme. I understand that was your evidence. There is a degree of elasticity in pricing to encourage competition for relatively low risk participants in the scheme but, because you have a ceiling for a premium which may not actually reflect the full cost of the relatively high risk participants in the scheme, there is very little competition in that part of the scheme. Would that be a fair summary of your answer?

Mr NICHOLLS: Yes. Relative is the operative word. There is competition in the high risks. It is not the case that there is no competition but the variation, because of the way the guidelines and the formula is constructed the level of variation between prices and insurers to the high risks is less.

Mr DAVID SHOEBRIDGE: Basically they are an insurance company looking at profit, every one of those people you sign up is likely to cost you money.

Mr NICHOLLS: Yes.

Mr DAVID SHOEBRIDGE: Will the CTP pricing review be looking at how to put competition into that end of the market?

Mr NICHOLLS: The terms of reference for the review have not been finally signed off. I think that we should be looking at those guidelines, yes.

Mr DAVID SHOEBRIDGE: If I could turn back to the profits, I have not had the benefit of reading that report that you have just tabled obviously. There was a question put to you by the Hon. Sarah Mitchell, do you adopt the position put by the insurance company that the primary explanation for the surge in profits was a reduction in claim numbers, or perhaps even the particular groups of serious claims? Do you adopt that as a primary explanation?

Mr NICHOLLS: I think it is one of the major factors that can explain it, but it is more than simply the number of claims. The evidence in the paper that I have just tabled also indicates that the mix of claims was different to what was expected, including fewer high severity cases. We also have another factor that influences future projections, which is the number of registered vehicles that are in the marketplace at a particular time. I am happy to provide for the Committee, and I do not have it here it table, but we do track the number of registered vehicles and the number of claims and so there is certainly a factor that influences the amount of estimate that an insurer has around the amount of risk that they might be exposed to, that is the number of vehicles that might be out there.

Mr DAVID SHOEBRIDGE: The three primary elements you point to are the number of claims, the sheer number of claims, the number of severe claims and the number of registered vehicles, would be the primary determinants?

Mr NICHOLLS: Yes.

Mr DAVID SHOEBRIDGE: Could I put this proposition to you: All of those things would be known at the end of each claim year. At the end of the each calendar year you would know that information, is that right?

Mr NICHOLLS: For the past year.

Mr DAVID SHOEBRIDGE: For the year you have just issued premiums for.

Mr NICHOLLS: To some degree. The information about the profile of accidents and the number of claims potentially would not be knowable for several years after the event.

Mr DAVID SHOEBRIDGE: You would have a reasonable understanding the severity of the claims. You would have a good understanding of the number of registered vehicles and you would have a very clear understanding of the sheer number of claims at the end of each year, correct?

Mr NICHOLLS: Not at the end of each year.

Mr DAVID SHOEBRIDGE: Within 12 months?

Mr NICHOLLS: No.

Mr DAVID SHOEBRIDGE: Can I ask you then how it is that you have systems in place that do not capture that information within 12 months, or at the end of a financial year? You do not know about the number of claims, the severity of claims, or the number of registered vehicles. As the Motor Accidents Authority I thought that information would surely be in your hands at the end of a year.

Mr NICHOLLS: If I can explain how the system works, the claims are made by individuals. We rely on individuals to come forward and make their claim. Individuals have up to six months after the date of the accident before they need to notify a claim and in some cases we have people who come to the authority much later than six months and seek a special exemption to have their claim still considered.

Secondly, after that claim goes into the claims system, there is often a period of time while there is discussion and medical assessment, to determine the nature of the injuries and, in some cases, there is a period of time before an injury is stabilized so it is not yet clear if somebody, for example, has a mild brain injury, whether in fact they sustained that for a period of time with and with the expectation that might be through to the end of their life, or indeed whether they start to recover. So it is in the nature of a long tail, what is called a long tail scheme, such as CTP, that those issues around severity and indeed the basic number of claims that are going to be in the system are often not known for several years after the event.

This is not like a short tail insurance scheme where people make the claim in the year that they have had their house burn down or their car gets stolen and that gets settled quickly. These are matters that can take some time to filter through the system and if there is a dispute over some element of it, it can take even longer than that.

Mr DAVID SHOEBRIDGE: I put this proposition to you: Say, for example, if we take the 2004 underwritten year. I think your underwriting years end 30 September. In your 2005-06 profit projection you estimated a 9.3 percent profit projection for that year's premiums. That jumped by 10 percent to 19 percent in the 2006-07, so now more than six months after the premium year you have jumped 10 percent in that next 12 months. By that stage you know how many registered vehicles there are. You know essentially how many claims there are and you would have a good handle on how severe they are. The profit projection jumps again the next year to 21 percent and jumps again the following year to 25 percent, a four percent increase in the following year. Clearly there is something more than just those three factors, number of claims, severity of claims and registered vehicles which is driving insurer profits and I am bemused to know what it is that is driving those profits three to four years out from the premium.

I will be quite honest with you, I am not satisfied with your explanation. I cannot but see that the great majority of claims, the severity of it, the nature of it and the number of them would be known at least two years out from a premium year.

Mr NICHOLLS: I refer to my previous answer. It is a long tail scheme and it takes a number of years. It takes seven years before 95 percent of claims are moving into the stage of finalisation and the remaining five percent of claims, that is after seven years, are typically the claims that are the largest dollar value claims, which are the ones where there might be dispute over severity or some other causal factor.

Mr DAVID SHOEBRIDGE: By that stage you have had the claims for five years and you would have a good handle on what the risks are in relation to those claims. They have been in the system for five years and if you have a bunch of them surely you would know on balance what the likely risk of that bundle of claims that has been in your system for five years is.

Mr NICHOLLS: I think in that regard that is why the scheme actuaries who prepare the data that you are talking about make adjustments every year to their projections on what is happening in that particular year.

Mr DAVID SHOEBRIDGE: You have power under section 27 to actually reject insurance premium. Has that ever happened?

Mr NICHOLLS: Yes it has.

Mr DAVID SHOEBRIDGE: When did that happen?

Mr NICHOLLS: There have been three rejections in the last two years. Prior to that was before my time but I am aware of at least one other occasion.

Mr DAVID SHOEBRIDGE: Maybe four in the entire scheme?

Mr NICHOLLS: I would not like to speculate.

Mr DAVID SHOEBRIDGE: Could you give a full answer on notice?

Mr NICHOLLS: I will take that on notice.

CHAIR: Can you remember why they were rejected?

Mr NICHOLLS: I will take that on notice as well.

Mr DAVID SHOEBRIDGE: Could you describe in general the basis upon which your authority would reject an insurance premium?

Mr NICHOLLS: If an insurance premium is excessive, if an insurance premium is insufficient, and if an insurance premium has projections or estimates within it that our independent actuaries do not agree with, these are all grounds for which we would often go back to an insurer and question them and if we are not satisfied with those answers we would and we have rejected them.

CHAIR: Has there ever been a situation where there has been a rejection because it is insufficient?

Mr NICHOLLS: I will take that on notice. I am not aware of that.

CHAIR: Is there a mechanism by which any future excessive profits made by insurance companies from the CTP scheme could be returned to injured persons?

Mr NICHOLLS: In the current scheme, no.

CHAIR: There is no mechanism whatsoever to do that, to consider that?

Mr NICHOLLS: No, not in the current scheme design.

CHAIR: Why is that? Why is there no mechanism? Is this something that you have explored?

Mr NICHOLLS: It is not something we have explored, no, but in the current scheme design there is no regulatory power or authority for the authority to do anything in response to realised profits.

CHAIR: You could make a recommendation, could you not?

Mr NICHOLLS: We could.

CHAIR: But that has never happened?

Mr NICHOLLS: It is not something we have turned our minds to, that I am aware of, in the

time that I have been in the position.

The Hon. PETER PRIMROSE: Following up on the same point that the Chair has just asked you about, the excessive profits, a mechanism to return to injured persons, is there a mechanism to return it to CTP green slip payers?

Mr NICHOLLS: No, in the same way, no. The mechanism that the authority has under its control is the review of premiums at the filing stage, which we talked about in response to the previous question, as regards the sorts of things the authority takes into account.

I think it is probably useful to put some context around this debate. The scheme, as it is currently designed, was designed in the late 1990s which is when the micro economic reforms were at their height and there was a very strong emphasis on the market based delivery of public services and the CTP scheme is no different to that. The CTP scheme as it is currently designed, was designed as a model where competition between private insurers would be the primary mechanism by which pricing would be achieved and fair pricing would be achieved and out of that model, the Motor Accidents Authority has effectively a watch dog role. We do not set the prices. We do not even approve the prices. Our role is merely to look at premiums that insurers are proposing to charge and if we see that there is an element of their proposal that is not consistent with the legislation or the guidelines, then we have grounds to raise an objection.
If we object then that either means that the insurer withdraws and makes a new submission or an insurer may send it to an arbitration process if they believe that we are in error.

Essentially the design of the scheme is one in which free competition between insurers, as is the case in many markets, is the mechanism by which fair pricing is maintained and so that is essentially the scheme design that we have. It is important to note that the scheme was designed in the late 1990s when there were 14 licences in New South Wales providing insurance, so that was a fairly competitive market. It was designed at a time when in the mid-nineties there were three years when insurers ran at a loss, and so the scheme was designed at a time when the view of government at that time presumably was that those market forces would be the primary means of delivering fair prices to the community, so we very much have a monitoring role in that.

The Hon. PETER PRIMROSE: In very non-economic simplistic terms, I see a compulsory requirement for drivers to have something. I see the tick off from people with far greater access to information and skills than I do say that we are going to make X amount of profit, a percent, and then what we are seeing is, however, over a considerable period of time and repeatedly, people making much greater profits than they have proposed. The question keeps coming back that there is not actually full competition, because full competition would surely require there to be full disclosure of information, so you can have price signals, so consumers presumably would decide I do not want that. I do not want to choose that.

We can keep going back to the same problem, people are obliged to have it. We are told that competition between the insurance companies is what is reducing and will keep the prices down and yet we have been given evidence that is not working. If you like, the IPART equivalent, the group who are saying we are going to give that the tick off, because we are not objecting to it, is you. Yet we consistently and continually have people with the information not able to give us an accurate or yet to give you an accurate prediction of how much their profits will be year in and year out. I do not know where the price signals actually exist there.

Mr NICHOLLS: I guess it is worth taking a couple of moments to consider the nature of super profits and the way super profits arise. If we look at it in economic terms, super profits occur where one of three things generally are taking place. One is where there might be imperfect information in the marketplace and we have heard evidence here and I have tabled evidence from our actuaries, which indicates that one of the aspects of this scheme is the capacity to make really accurate predictions about what might happen in the future, what might happen to claims, severity of claims,

interest rates, the number of vehicles being purchased, all are influencing factors in premium setting, that the benefit of 20-20 hindsight can often indicate could have been done differently.

The second way that they arise is through competition in the marketplace. I mentioned there were 14 insurers in the late 1990s. There are seven licences today operated by five insurance companies, so one of the drivers is in fact potentially the impact of the level of competition, which is why it is important for us as an authority to continue our efforts in promoting market competition.

The third area was touched upon by the previous question which goes to the heart of the nature of regulations of government, so where government intervenes in marketplaces that influences the way pricing occurs.

Those three factors are all things that we need to look at as part of the CTP pricing review so that we can really diagnose which one of these factors, or elements of all of them, are factors that we need to take into account in making sure we have our regulatory model right going into the future.

CHAIR: Imperfect information is not one of the factors that would be a major factor. Would you agree with that statement?

Mr NICHOLLS: I think it is an important factor, definitely, the level of estimates into the future, of the size and frequency of claims in our system.

CHAIR: Are saying you are working in a situation where imperfect information is a significant factor for uncertainty with regard to profits?

Mr NICHOLLS: Not in regard to profits. I think it is useful to explain that the insurers when they make their filing are making an estimate of all of their costs, so it is a cost plus type model, putting it into accounting type terms, so you have a build-up of the different cost elements that you expect to spend. That might be an estimate around how much is going to be spent on marketing costs, or on claims management costs, or on the cost of claims and an element for profit, an element for legal costs, so all of these things are part of the cost build-up that an insurer makes when they make their filing with us.

They also have to make an assumption about what market share they are going to have and how many vehicles are out there and what level of risk they are going to adopt and what will that risk profile look like? Will they in fact end up with more of the higher risks, or more of the better risks, because again that will change their risk profile. There is a number of points where the insurer, when they are making their filing with us, need to make an assumption. Those assumptions have to be reasonable and valid, based on actuarial evidence and/or other evidence, economic evidence, and they are the things that we test as part of our filing assessment process. Those points of estimate are all points which in reality could look differently and to that extent there is a risk of information failure and there it is not information that is currently known, it is information that with the benefit of 20-20 hindsight might have meant that pricing would have looked differently.

If I can just add a point, when you start to see these kinds of assumptions not turning out to be exactly as you would expect, what you would expect is to see prices coming down in a competitive market. In a competitive market some of that greater clarity about what is starting to happen in the trend line gets passed through in lower prices. We certainly saw in the period 2000-08 that prices were in fact trending downwards. Prices in real terms were lower in 2008 by quite a significant margin, by nearly half of what it was in 1999. Certainly those trend lines in price were indicating that the market was doing exactly what we would expect it to do in a competitive environment.

Perhaps with the benefit of 20-20 hindsight those prices could have or should have been coming down even more dramatically but it was very hard to know whether we were on the crest of a wave with a new trend line, or whether in fact things were suddenly going to jag up again, as they did

in 2008 through to 2010.

The Hon. SCOT MacDONALD: I have two questions. Do you see any threats to the sustainability of the either the scheme or any insurers? I would like to hear your attitude to the exit possibilities and we had a number of witnesses talk about that and their preferences for self management and the discount rate. We talked about the discount rate with the Insurance Council. From memory it is sitting at five and to my mind that seems like a fairly high rate in this financial environment. How do you calculates that? Do you see yourself having another look at it?

Mr NICHOLLS: In terms of first question, I am not aware of any immediate or pressing threats to any insurance companies within our scheme. Certainly in the advice we received from APRA and the regular inspection processes that we undertake, as well as the review of our filings, we are not seeing any concerns about an insurer incident or an insurer that has any issues and in the event that we did so then obviously we would be very careful in the way we would be putting that information into the public domain, because obviously with a number of insurers and listed companies, an act by me as the acting general manager to say this insurer has an issue could be seen as a prophecy so it is information that we kept but the short answer to your question is we do not see anything that is acting as a threat to the scheme at the moment.

Coming to your second question on discount rate, five percent is the rate that is in the motor accidents legislation. Five percent is consistent with the rate that is used in other compensation schemes in New South Wales. Indeed, in most compensation schemes around Australia the rate is usually around five to six percent. In terms of whether it is large or small, the discount rate, when it comes to settlements for people's claims, is meant to reflect the net present value of that settlement payment and, as we know, interest rates can be quite variable over a long period of time. Two years ago interest rates were down at the lowest levels they were in 50 years, so interest rates were very low.

If we went back to the early 1990s interest rates were up to 10 or 15 percent or even more, so that variability in interests rates is something that the settlement that is made needs to withstand over a period of time and so five percent is seen in a number of jurisdictions, including our jurisdiction, as one that essentially is a reasonable rate, having regard to the level of volatility that might occur in interest rates over a period of time.

In effect, when somebody receives their settlement, if we have a period of high interest rates again then that is beneficial to the person who has received their settlement. If there is a period of low interest rates that may not be and the idea here is that you have got a discount rate that effectively averages that to some degree over time and if you move the rate around dramatically, based upon what is happening to interest rates at this particular point in time, you run into the problem that somebody who got a settlement two years ago might have had a very beneficial rate of interest. Somebody who settled back in the early nineties would not have done, so that interest rate needs to stand the test of time.

(Short adjournment)

The Hon. SARAH MITCHELL: I have a question relating to the Medical Assessment Service that was raised in our hearings last Monday on several occasions by different witnesses. Information was given to us then where some people felt that they were not the appropriate people to determine the causation. I think there was even one call for them to be looked at to be abolished. I just wondered if you had any view on whether the current system is not working or if there could be an improvement to it?

Mr NICHOLLS: The Medical Assessment Service, as it is currently structured, has been in place since the inception of current version of the scheme in 1999. We believe that there was a substantial benefit in moving to a process whereby people were less likely to be shuttled around between a range of medical professionals while they have their assessments conducted under the way the previous scheme operated, and so the Medical Assessment Service effectively is a way of being

able to fairly and expeditiously deal with medical assessments and indeed medical disputes.

There are a range of views about who is best qualified in relation to these matters. Clearly, there is a strong element of medical assessment that ought to be conducted by medical professionals, but I understand that there are views on some aspects of it, such as causation, that the legal professional is better able to deal with those. However, I would be concerned by any system that returns to a more adversarial scenario where injured people are put under more pressure and stress.

I think the evidence shows that the current assessment service is working effectively. We have a professional panel where the members of the panel need to be professionally qualified with their relevant college, and we have a performance management system. That performance management system involves training and induction at the commencement of their term as an assessor; it involves regular monitoring of the assessment performance, including providing feedback and information when we think that there might be an issue; and, indeed, in instances where we are not satisfied with the performance of a medical assessor, they may not be renewed on our assessment panel. So we have a very structured and constructive way of ensuring that our medical assessors are skilled and versed in the kinds of skills that they need to undertake the assessment.

If I might ask Sue to speak, Sue is currently the Deputy General Manager responsible for the Medical Assessment Service and I think the performance of the Medical Assessment Service is something that is worth taking on for the Committee's benefit.

Ms FREEMAN: Thanks. I do not have a lot to add, just on the issue of causation to say that the Act actually requires a medical assessor to make that decision in relation to injuries caused by the accident that is the subject of the claim. Where that has been questioned that has been upheld in a recent Court of Appeal decision. Currently our legislative framework does require assessors to make that decision.

Around the decision of causation might also be considerations about preconceived conditions and whether they have been exacerbated by the injuries sustained in the accident, and I think many people will agree that doctors are quite well placed to make that decision and review medical information in relation to pre-existing conditions and weigh up what the accident has and has not caused for the person.

In terms of the performance of medical assessors, I will just add one point, that in fact there are remarkably few complaints received in relation to medical assessors' performance. It is going back a while, but a survey of claimants some time ago which was commissioned by the authority, the University of Newcastle, one of the highest responses was in terms of the perceived objectivity of the medical assessor by injured people. I think it was up around 65 per cent of people had no problem with the way the medical assessment was conducted and that it was objective. So where there are a variety of views about the boundaries made by the medical assessor, I think overall we felt that it has been working well and is reasonably well received by injured people.

The Hon. SARAH MITCHELL: One of the points that was raised by a witness last week was that it took up to six months for one of their clients to see an assessor. Would that have been something that would have been outside the norm or are there concerns about the time period which it can take for people to see an assessor?

Ms FREEMAN: Six months would be unusual, but there is a great variety of matters going through the Medical Assessment Service and you would realise that a large number of cases involve multi trauma. The majority of cases that come to the Medical Assessment Service are in relation to the degree of permanent impairment, so for many cases that involves assessment by more than one specialist, because they have sustained different types of injuries to different bodily systems. Where that is required, there will be more than one appointment arranged. Those sorts of cases may take longer because they are going to wait for the appropriate appointments.

There has been a review of the time taken and I can give you some figures. Recently, just in the 2010/11 year, the median time taken to get an outcome from your assessment is 96 days, which is working days, which has reduced from the previous year. We have actually tried to understand if that is typical. In fact, a proportion of claims, around a third, might be deferred for some reason. If you

look at only those that were not deferred during the course but went straight through, then the turnaround time is a lot quicker. The figure is 84 I believe, but I can check on that.

This is something that has actually been happening recently, but in the last two or three years there has been an emphasis within the Medical Assessment Service on ensuring that cases that were referred to the assessor had all the necessary information available. Because we saw a pattern where people were not providing the necessary information, medical assessors were sometimes finding that they could not make the assessment. The claimant would have to lodge another application and start the process again. So there is a little bit more thorough review of files prior to referring to an assessor and around a third of cases were referred to obtain clarification and more information.

Overall, there has been a reduction in the number of further assessments, which was the intention. Overall, the timeframes are dropping.

The Hon. PETER PRIMROSE: I have a long preamble and then two questions. The preamble is: In the authority's answers to pre-hearing questions on notice, you stated that plastic surgeons who assess bodily scarring advice do take account of multiple scars as an integral part of assessing the skin as a body organ. Yet at the hearing last Monday we put your response to the Bar Association and I would like to read out Mr Stone's response:

> "The problem is if you have a two per cent scar, what happens if you have a second two per cent scar, a third two per cent scar and even a tenth two per cent scar. I have seen two cases in recent times where they have said, 'We will just assess the worst scar', and in effect every other scar after that does not get counted. The table for the evaluation of minor skin impairment does not cover cumulative situations...and it is a problem that needs fixing."

The two questions are: Can you please explain the difference between the responses of the Bar Association and the authority? The second one is: Do the guidelines cover cumulative scarring situations? If they do, can you please provide us with a copy of the guidelines that state that?

Ms FREEMAN: We are aware of issues of concern that have been raised about scarring, and in particular multiple scarring, and this was an issue that we referred to our assessor practice group to advise on whether the guidelines were deficient or required clarification. I have a response from them that explains that an assessor should take into account - the guidelines actually require that scarring is assessed as the skin is an organ, so the damage to one organ being the whole skin. It is a bit of an alien concept to lay people and we did quiz the medical experts about what does that actually mean in practice, if there is a scar in more than one place, is it assessed taking account of both scars, and we were assured by the plastic surgeons that they do take account of all the areas of scarring.

The guidelines do not specifically provide for accumulative assessment. So I do understand where the Bar Association is coming from. If you have a scar that could be assessed as two per cent and another one assessed at two per cent, the guidelines do not tell you that that should be four per cent. They tell you that you should make a clinical judgment as to the impact on the skin of all the scars.

So I think it is not correct to say that there is no account taken of multiple scarring, but I think it is probably true to say that the guidelines are not particularly clear and transparent about how that is done. Certainly, the view of the medical assessors and those with particular expertise in assessing scars was that the system works well, that they are consistent across the board in how they approach people who have sustained scars in more than one area, but as an outcome of that query we did actually list that this might be an area that we look at and try to seek better clarification in the future edition of the guides.

So out of the process whether either assessors or other stakeholders or the Bar Association raised issues about the impairment guidelines, we asked our medical assessors to look at whether clarification can be issued to improve consistency of the application of the current guidelines or whether there is a case that maybe the current guidelines should be reviewed and possibly changed. So in the case of scarring, we have added that to the list of issues that should be looked at when the guidelines are reviewed.

The Hon. PETER PRIMROSE: Can we please get a copy of the relevant section of the guidelines?

Ms FREEMAN: Certainly, yes.

The Hon. SCOT MacDONALD: I would like this to be taken on notice, if you could. It is just exploring the discount rate again. Could the MAA give more details on their calculation of the discount rate? Has the rate proved adequate to date? I think this one might have come from David a week ago. Would you see a role for IPART making a recommendation or having some input into that calculation of the discount rate? I think that was it.

Mr DAVID SHOEBRIDGE: Yes, that is right.

Mr NICHOLLS: I would be happy to take that on notice.

Mr DAVID SHOEBRIDGE: One of your jobs in the Motor Accident Authority is to ensure you have got a workable competitive market place for insurance, is that right?

Mr NICHOLLS: Yes.

Mr DAVID SHOEBRIDGE: How many new entrants have you brought into the scheme of the Motor Accident Authority in the last decade?

Mr NICHOLLS: I will take that question on notice. I alluded earlier to consolidation in the market place, but there has been a change in the mix of insurers as a result of mergers and acquisitions that may have entered the market that was not clear at the start of the decade. So I would need to check that and I would like to take that on notice.

Mr DAVID SHOEBRIDGE: What are you doing as an authority to entice new players in? If you have gone from having 14 licensed insurers before the 2000 Act or the 1999 Act came into play, I think you are saying now there are five insurers in the market place, what are you doing as an authority to get new entrants in?

Mr NICHOLLS: I cannot comment on what might have happened in the past as I was not in the authority in terms of those sort of discussions.

Mr DAVID SHOEBRIDGE: Sorry, can I just stop you there. It is really unfortunate that you are here and only able to give answers for the last year. You are the Acting General Manager. Surely you have some institutional knowledge as to what happened before you took your position. I do find it difficult that you say you can only answer for the last 12 months.

Mr NICHOLLS: I will take the question on notice.

Mr DAVID SHOEBRIDGE: Then what have you been doing in the last 12 months?

Mr NICHOLLS: As I indicated earlier, we have been working on a competition review and flowing from that is the CTP pricing review that I think should look at this very issue.

Mr DAVID SHOEBRIDGE: So is it a specific term of the CTP pricing review to look at encouraging new entrants into the market place?

Mr NICHOLLS: The terms of reference have not been settled but I am happy to give consideration to it.

Mr DAVID SHOEBRIDGE: In terms of whole person impairment and access to non-economic loss, and I am happy to describe it as either general damages, pain and suffering, non-economic loss, but the class of damages related to the nature and severity of the injury, would it be true to say that 90 percent of injured people receive no compensation for non-economic loss in the current scheme?

Mr NICHOLLS: The figure is close to 90 percent but it is not quite 90 percent. I am happy to take that on notice and give you the exact figure. I have got it right here in fact.

Ms FREEMAN: The data I have here scheme wide in 2010-11 was 14 percent of claims. I should explain this is claims finalised in the 2010-11 year. They may relate to accidents that occurred several years earlier, but of those claims finalised in that financial year, 14 percent were over the 10 percent threshold so received some amount for non-economic loss. The year before that in 2009 it was 15. It seems to have fluctuated between 13, 14, 15 since about 2006. In 2005 it was 11 percent, so since 2005-06 it has hovered at around 13, 14, 15 percent.

Mr DAVID SHOEBRIDGE: So it would be fair to say that every year you have figures for, at least 85 percent of people who have been injured in motor accidents receive no compensation at all for non-economic loss or general damages?

Mr NICHOLLS: That is right.

Mr DAVID SHOEBRIDGE: Do you have as an authority have any view about whether or not that is a fair outcome for injured persons on New South Wales roads?

Mr NICHOLLS: The legislation that the Parliament puts in place that guides the actions of the authority makes it quite clear that the intent in establishing that threshold was to limit access to that head of damage only to the most severe cases. That is the legislation that the authority has to work within and that is reflected in these figures.

Mr DAVID SHOEBRIDGE: Does that provide the most severe cases being 12 or 13 percent of those injured? Is there any percentage guideline in that legislative provision?

Mr NICHOLLS: I am not sure what you mean.

Mr DAVID SHOEBRIDGE: Does that legislation mandate a percentage provision?

Mr NICHOLLS: No. There is a 10 percent whole person impairment threshold that an injured person needs to exceed in order to obtain those damages, but there is nothing in the legislation that says it is 10 percent or 20 percent or 30 percent.

Mr DAVID SHOEBRIDGE: Do you, as an authority, go through and review those people who miss out, those people who might be getting 10 percent whole person impairment, or seven or eight percent, to see if they are people who may fall within the class of severely injured, or seriously injured, but are not accessing compensation pursuant to the statutory objectives? Do you do that review?

Mr NICHOLLS: We do conduct a review of the performance of our assessment services and I can add that we have established a working party of our Motor Accidents Council, which is our stakeholder group that, among a range of issues, is looking specifically at that very issue.

Mr DAVID SHOEBRIDGE: Has the organisation historically done that review and looked at those people getting eight, nine, 10 percent whole person impairment and worked out whether or not they were seriously injured people who should have been having access or not having access to benefits? Have you done that historically?

Ms FREEMAN: I guess the difficulty with that question is that there is a range of views about what would fall into the class of seriously injured or not seriously injured. We are well aware of the range of views and the use of the impairment assessment guidelines is one method which is a reasonably objective and transparent method. It is a fairly blunt instrument. We understand that, so

certain sorts of fractures, with healing with a certain range of movement may just get over 10 percent and a similar fracture, which may have been a more painful fracture, heading with a different range of movement may not. We are aware that it is a line and injuries fall on either side of the line. Certainly the most serious in terms of life threatening injuries fall on the high side of the 10 percent. Around the 10 percent area there are a lot of injuries that are reasonably similar to each other. Some fall on one side, some on the other.

Mr DAVID SHOEBRIDGE: Do not you see it as a central problem? Your job is to put in place a scheme that gets the balance right. If you do not ever go back and have a look at it and if you do not have a comprehensive system in place to actually work out whether you are getting the balance right, whether or not people are being chopped off and getting no benefits for general damages when they have been seriously injured and should, if you do not look at it, how do you know you are getting the balance right?

Mr NICHOLLS: One of the things that we measure our performance by is how frequently we see requests for reviews and how frequently we see challenges to decisions by assessors as part of that process. So, for example, in 2009-10 we performed 4,109 medical assessments, the majority of which were looking at the question of whole person impairment. Around 16 percent of those resulted in a request for a review and significantly less than half of those ultimately had their assessment figure changed as a result of moving into the review process. One would expect that if people were coming close to that 10 percent margin and really believed that the review was unfair, or had done the wrong thing, that we would be seeing a much higher rate of review, I would expect.

Mr DAVID SHOEBRIDGE: That answer is about a review under the current guidelines and people would be making an assessment as to whether or not there was an error on the current guidelines and whether or not they had prospects of success on a review. It has nothing to do with whether or not the current guidelines are producing fair outcomes. You would agree with that?

Mr NICHOLLS: Our roles is to implement the guidelines and the legislation as it is put in place.

Mr DAVID SHOEBRIDGE: But you have a role in establishing the guidelines and reviewing the guidelines and working out whether or not they are fair, do you not?

Mr NICHOLLS: Yes.

Mr DAVID SHOEBRIDGE: That is what I am asking you. Have you ever gone and looked at them system wide and worked out whether or not they are producing the outcomes that are fair?

Ms FREEMAN: We do have data that looks at the nature of the injuries that are falling under and over 10 percent and I think, as Andrew just mentioned, the Motor Accidents Council has recently expressed interest in having a look at that data which has been provided to them, so they are reviewing that data now. It is complex and, as I said, there is no simple answer as to what is right when you ask us have we looked at establishing whether it is the right balance. There is a range of views.

CHAIR: In their submission the Law Society argued that the 10 percent whole person impairment threshold for non-economic loss should be replaced with section 16 of the Civil Liability Act 2002, which has a threshold of 15 percent of a most extreme case. Have you looked into what the ramification of that would be?

Mr NICHOLLS: That threshold was the threshold that previously applied before the 1999 reforms, so if we take what was happening in the pre-1999 reforms as a guide, approximately 40 percent of claims were able to access the threshold under the Civil Liability Act. Estimates conducted

in 2005 of the premium impact was around $116 at that time. I am not aware that that has been updated. The impact of a return to the civil liability 15 percent threshold is estimated at about $116 in 2005, per premium, I beg your pardon.

CHAIR: What about in regard to profits? Has there been any modelling as to how it would affect the profit situation?

Mr NICHOLLS: No.

CHAIR: Is that something worthwhile to do?

Mr NICHOLLS: It may be as part of the CTP pricing review but what I would like to explain is the way the heads of damage work and the way the filing process works is that if the Parliament were to decide to return to the civil liability type threshold, that would likely have the effect of increasing the amount of liability that an insurer would face. So when they make a filing with us they would apply a larger figure for the capital they would need to hold to pay for that particular head of damage. It does not follow then that the insurer would reduce some other element of their cost structure. Profit would be one of them but there might be acquisition expenses or claims expenses to offset that payment unless there was a change in the regulatory model.

The Hon. SCOT MacDONALD: We had a good session with the Motor Cycle Council last week. They touched on a few issues such as quad bikes on farms, farm bikes, and rider training for the under 21 riders. Obviously with those farm bikes and quad bikes there is a bit of grey area about whether they are on public roads and that sort of thing. Can you tell me if the MAA is looking at the spike we have seen in those quad bike deaths? Does that come into your remit? Have you got anything on your radar with that?

Mr NICHOLLS: The short answer is no, the authority has not specifically looked at quad bikes. We have been, however, looking more generally at recreational bikes, particularly motocross bikes, and other off-road type motor bikes and working with a working party chaired by DPC with a number of government agencies. We have been undertaking modelling as part of that process to identify if there is an opportunity to extend a class of vehicle in the registration system that would pick up recreational type bikes. We specifically have not in that analysis looked at quad bikes in particular.

The Hon. SCOT MacDONALD: I would draw your attention to that. There has been a big spike in quad bike deaths and without being flippant, I have a bit of an interest in it. My son was on a first name basis with the local hospital because of trail bikes. He is okay. He got very familiar with the first aid station.

The Hon. SARAH MITCHELL: In relation to legal costs, in the pre-hearing questions on notice you talked a little bit about a working party that has made some recommendations. Can you tell us a little more about that please?

Mr NICHOLLS: I am presuming that you are referring to the review of what we colloquially call the costs regulation, which is the regulation that determines the medico legal recoveries that insurers are able to make. We initiated a working party to look at ways of reviewing that cost regulation, to try to get it structured in a way that was ensuring that we were rewarding the kinds of behaviour that we wanted to see in the scheme, that is, that we were having involvement of legal professionals in the higher value matters and having their involvement early in the process so that we could move to a quick settlement.

We had a working party that consisted of representatives of the legal profession as well as representatives of insurers, the MAA, and chaired by an independent person. That working party made a number of recommendations that essentially involved removing the capacity to claim legal

fees in matters below $5,000, which is equivalent to our threshold for early accident notification, moving to a model where there would be no contracting out of legal expenses for matters up to $20,000, providing front end loading, which effectively means a higher rate of recovery for matters early in the process, such as with the new 89a settlement process and then tailing off the amount that might be recovered when matters go on for a significant period of time.

The cost regulation recommendations are now something that are subject to a Government process. Obviously a regulation is something that a Minister makes on the recommendation of his or her agency and we are currently going through that internal process at the present time.

The Hon. PETER PRIMROSE: I have a question for carers week. Carers NSW in their submission to us made the following statement:

> "Carers NSW made several recommendations to the previous review in 2010, including the recommendations that both the MAA and the LTCSA use the term 'carer' and provide information on their web sites about services for carers, so as to better support carers and assist family members to identify their caring role. Identification as a carer is an important step in accessing support information carers in their caring role. Currently both the MAA and LTCSA web sites have few references to carers and there is confusion between paid care workers and carers. It is inappropriate to refer to paid care workers or volunteers who assist members of the community as carers. Greater consistency is also needed so that carers are uniformly referred to as carers throughout the web site and other publications".

Would you consider contacting Carers NSW to look at revising the terminology on the web site?

Mr NICHOLLS: Yes, and I am pleased to advise the Committee that we have conducted a full review of our web site and all publications on our web site, to identify all documents that have "carer" in it and we have in place a policy within the authority that as those documents are replaced and updated, as the web site is updated, we are making the appropriate words, but I am more than happy to contact Carers NSW and I believe my predecessor may have written to Carers NSW last year. I will check that but I believe we have already made contact with them.

Mr DAVID SHOEBRIDGE: Mr Nicholls, you provided this Committee earlier with a report from Taylor Fry reviewing in hindsight insurer profits. Do you remember that?

Mr NICHOLLS: Yes.

Mr DAVID SHOEBRIDGE: What relationship does Taylor Fry have with the Motor Accidents Authority?

Mr NICHOLLS: Taylor Fry is our scheme actuary.

Mr DAVID SHOEBRIDGE: How long have they been the scheme actuary for?

Mr NICHOLLS: I do not know. I will take that on notice.

Mr DAVID SHOEBRIDGE: So as far as you can recall, for the length of the scheme, so far back as you can recall?

Mr NICHOLLS: I do not know.

Mr DAVID SHOEBRIDGE: Would you not agree that if they had a substantial role as scheme actuary for a significant period of time then they would be a difficult choice for getting disinterested actuarial observations about the effectiveness of the actuarial assumptions when they

were in place? There is a conflict there, is there not?

Mr NICHOLLS: I think it is essential that the authority has an independent scheme actuary. As part as the engagement of Taylor Fry they are not able to perform work for other CTP insurers in the broad area that we engage them. We need that independent advice because I would be more concerned around having an actuary who was also performing work for one of the insurers and is thus in the role of reviewing filings, for example, that in fact they may have had a part in developing or providing input on. I think it is fair to say that having an independent scheme actuary is essential to the good running of the scheme.

Mr DAVID SHOEBRIDGE: I perfectly accept you would have an independent scheme actuary which each year acts for you and tries to make sure in each year that the various insurers' actuarial assumptions are fair. I perfectly accept that and that is the role that Taylor Fry currently undertake, is that correct?

Mr NICHOLLS: That is correct.

Mr DAVID SHOEBRIDGE: And has for some time?

Mr NICHOLLS: I believe so.

Mr DAVID SHOEBRIDGE: If they have had a role of checking the actuarial assumptions of the private insurers, but we know with the benefit of hindsight that has not been particularly effective, because the assumptions have proven to be quite substantially at deviance to reality, there is a conflict in having them review their work in prior years in holding to account the insurers actuarial assumptions. There is a conflict there, you would agree? They are reviewing their own work.

Mr NICHOLLS: Well, they are building on the work that they conduct each year and using the methodology in a consistent approach every year. I am not sure that is a conflict. I do not see the conflict.

Mr DAVID SHOEBRIDGE: Do you accept that if they are going back in hindsight they are reviewing their own work as actuaries for the scheme in making sure that the insurers' actuarial assumptions are fair?

Mr NICHOLLS: They are using a methodology that has been agreed with the authority and Taylor Fry, in their letter that I tabled earlier outlined that methodology in some detail and that methodology has been tested against the methodologies, and I think they mentioned Affinity in this letter, and other actuaries who perform work in this area, and Taylor Fry are making assessments based on actuarial professional standards.

Mr DAVID SHOEBRIDGE: Just on another tack, why is it that the Motor Accidents Scheme has guidelines whereby you cannot aggregate physical and psychological injuries for the purposes of whole person impairment?

Mr NICHOLLS: I will take that question on notice. I do not know the origin of why.

Mr DAVID SHOEBRIDGE: Do you have any opinion, as Acting General Manager, as to whether or not that is a fair and reasonable thing to do, to treat psychological injuries effectively as a special class of injury that does not allow for aggregation?

Mr NICHOLLS: I suspect, although I will check it in terms of clarifying when the legislation was drafted, but I suspect that the reason was so that you did not have a scenario where somebody who had two relatively minor injuries could aggregate those in terms of obtaining a major.

Mr DAVID SHOEBRIDGE: Do you agree that in 2011 things have changed as to how they were in 1999 and we have used psychological injuries differently and perhaps with more respect in 2011 than we used to in 1999 and maybe we should review that?

Mr NICHOLLS: I am happy to give that consideration.

CHAIR: Returning to the section 89a compulsory conferences, Mr Stone from the Bar Association told this Committee that parties are now having pre-section 89a conferences and he said:

> "It is so complex that you now have people holding pre-section 89a settlement conferences because you want to try to settle it before you have to do all the work with the section 89a conference".

Is the authority aware that this is happening, that these pre-section 89a conferences are becoming a normal part of the system and, if you are aware of this, do you think that this is something that needs to be looked at again?

Mr NICHOLLS: Based on advice that I am receiving from stakeholders, I believe that it is the case, that people in the ordinary course of settling a motor accident matter will have pre 89a discussions and indeed before the 89a provisions occurred, also had discussions prior to moving into the formal processes. I think the fact that there would be informal processes to aim to settle a matter before it moves into a formal process is something that you would expect and indeed would encourage in the scheme, to ensure you can move quickly to a settlement

CHAIR: Except this is a conference before a conference, this is not a conference before a court hearing. What would that suggest, do you think?

Mr NICHOLLS: Potentially there is greater formality that needs to be in the 89a settlement conferences and that is something I am happy to look at. The purpose of it is to get to a point of early settlement of matters before it needs to go into the more formal processes. That was the intent of 89a and I am happy to take on board any views of stakeholders about ways that we can improve that process.

CHAIR: You are aware that there are concerns about this. Is this something that you are already looking into?

Mr NICHOLLS: We are. Part of the work of our CARS review, which is still going through an internal process of review, it is a significant review, does indeed touch on the matter of 89a settlements. What I would say, however, is that I am equally concerned if people who are attending settlements are doing so ill-prepared and I would expect that people who are going to settlement conferences, whether that is on the insurance side or on the claimant's side should nonetheless be across their briefs and be prepared for those matters, as they would if they were moving straight into a CARS assessment or straight into a court process.

CHAIR: Have you found that to be a major problem?

Mr NICHOLLS: It has been raised with me by a number of stakeholders since 89a has come in, but I am not sure it is a first order issue.

The Hon. SCOT MacDONALD: Looking at the Motor Accidents Council and its content is put together under the Act, I am guessing none of those people live outside Sydney on there. Would you support a bit of regional input into it, either from Local Government and Shires Association or someone like New South Wales Farmers?

Mr NICHOLLS: I believe that there is at least one member of the council who comes from

the South Coast of New South Wales, I believe from Merimbula, and I would need to check the others but I suspect that is the only regional member. There were legislation changes made late last year that introduced the capacity for greater flexibility around membership of the Motor Accidents Council. Those legislative changes now mean that the Minister may appoint up to four people of his or her own choosing, if the Minister is of a mind that there is a particular interest group that should be represented on the council. At this stage there are three positions on council where the Minister has not exercised that decision. The membership of the council is a matter for the Minister. The Minister makes those appointments and I am happy to take your thoughts forward to the Minister.

The Hon. SARAH MITCHELL: You just referred to the CARS review that is taking place. Last week we had Mr Stone from the Bar Association speaking to us about that and he mentioned that the Bar Association would participate in the review. One of the issues he raised was in relation to late claims and his view that perhaps some amendments could be made to replace the current regime with a late financial penalty instead. Could you tell us more about what the current late claims process is, how many are made in a year which are late, and whether or not you think there is any merit in the proposal of the Bar Association?

Mr NICHOLLS: I will touch on the process and I might turn to Sue or take on notice the question of the data. Essentially somebody who has had a motor accident has six months to make a claim. It is reasonable that the insurers should know within a reasonable period of time whether or not they are on risk for motor accidents. However, there is a capacity for people making a claim to come forward and ask for special exemption to pursue a claim if they are making a claim after the six month date. This is an area of potential contention within the scheme where an insurer may, for example, deem that a claim is late and decide not to accept it and that will then see that the person making that claim able to seek special permission for that claim to be considered

The statistics on late claims, I am not sure if we have that. I will just check.

Ms FREEMAN: I can give you an overview. We do know that the number of late claims that are lodged with the Claims Assessment and Resolution Service is increasing but that is where there is a late claim dispute. We understand that around 20 percent of claims in the scheme are made late and most of them are not disputed, which would mean that the insurer accepts the person's explanation for why a claim is late.

215 late claim disputes were lodged in 2010-11 and that is where the insurer does not accept the claimant's explanation for to why it is late and they then ask for an assessment as to whether the claim can be made. That has increased over the last two years. There was 177 the year before. It has been increasing over two years.

The other thing that we have found is that the decisions made by the claims assessor, the number that are found where a late claim may not be made, in other words, that the claim was rejected and the insurer was right to challenge it, has halved so there are more of them and more of them are being found that the claim may be made. That is the data. This is fairly recent data. It looks like a very recent trend. Am I clear in what I am saying? It is not a double negative. In other words, the insurer challenges the person's explanation.

CHAIR: 215 were challenged?

Ms FREEMAN: In 2010-11. Of those, in 12 cases the finding was that the claim may not be made, so the person's explanation is not accepted, so in the vast majority of cases the finding is that the claim can be made and the explanation for being late is reasonable. In other words, they are increasing but they are not being rejected, they are being mainly accepted.

Mr NICHOLLS: To finish with your last question, I think given those statistics, we agree with the Bar Association that is something we need to look at because there is a large number of

people who, when a dispute is raised, in fact are deemed to have had reasonable grounds.

If I can just use a fairly typical example, which is somebody brings a matter under a different jurisdiction, typically workers compensation, and then at some time into their claim they identify that in fact they should have made a motor accidents claim, and the statutory time frames have expired, so given that there is a large proportion of claims like that, where the person has tried to do the right thing, they just do not know which jurisdiction to go to, or they do not get the advice about which jurisdiction to go to, they are the sorts of things that we really should be looking at and seeing if we can improve the processes.

CHAIR: Particularly when 95 percent of those rejected claims are eventually allowed to proceed.

Mr NICHOLLS: To proceed anyway.

Mr DAVID SHOEBRIDGE: It is even more troubling. 20 percent of claims, how many would that be that are claiming late? What was the number last year?

Mr NICHOLLS: 10,000 to 12,000 claims.

Mr DAVID SHOEBRIDGE: You are putting claimants through. Let's say that is 2,400 instances where they are having to go through a late claims process, it is 20 percent of late claims.

Ms FREEMAN: No, what we are saying is very few of them come to CARS and are disputed so, of those others that are made late, the insurer must be accepting the explanation and allowing them.

Mr DAVID SHOEBRIDGE: That is right, but they go through a process where in 20 percent of cases they have to make a claim and an explanation for why they are late and then out of 2,400 where you are requiring the paperwork, the process and the decision making, some 12 of them or so, a tiny minority, end up with a dispute where they are rejected. Maybe some more are rejected in the course of the process. We are talking about a tiny minority being rejected.

Mr NICHOLLS: That is where the individual has sought to appeal that decision.

Mr DAVID SHOEBRIDGE: Do you know how many of the others, of the 20 percent, have been rejected for being late?

Ms FREEMAN: No. We would check that out. I would assume that if a late claim is rejected by the insurer those are the ones brought to CARS to have the dispute overturned.

Mr DAVID SHOEBRIDGE: Do you see that there may be literally thousands of people going through a process which is producing a next to inevitable result in most cases that they are being accepted and that is a cost to the scheme, a stress to the litigant, which may be set at the wrong level if you are having this level of challenges and outcomes.

Mr NICHOLLS: Yes, and I think that is why we agreed with the Bar Association that we should look at late claims. As regards the figure on how many are being rejected, I am happy to take that question on notice

CHAIR: Most are actually accepted in the beginning, are they not?

Ms FREEMAN: That is my understanding. There is no dispute. They may have been lodged late but there is no dispute and the claim proceeds. It is only 215 in the last financial year that had a dispute assessed and that has increased. For example, in 2007 there was only 100.

Mr DAVID SHOEBRIDGE: That is cost and expense and delay in a scheme for 20 percent of claims which may be entirely unjustified. Historically what have you done as a Motor Accidents Authority to look at this issue?

Mr NICHOLLS: It was a key issue that the CARS review addressed. It was an explicit part of the terms of reference. Although the review has not finally gone through all the processes, I can assure the Committee that late claims was certainly an area that was looked at and I reiterate my answer to the Committee that I agree that it is something we need to look at

The Hon. PETER PRIMROSE: Turning to traffic crash data, the Motor Cycle Council expressed their dissatisfaction with RTA crash data when they addressed the Committee and referred us to what is happening in Western Australia. Your answers to pre-hearing questions on notice also referred to some work that the authority has been doing in this area. Could you please expand on that for us?

Mr NICHOLLS: The authority has looked at the West Australian crash model and in fact we invited the West Australian Insurance Commission to give a presentation here in Sydney to the authority and to a range of key stakeholders in the scheme, both client groups and insurers, as well as government agencies such as the RTA and the police. Flowing out from that presentation it was agreed amongst the government agencies that were present at that presentation that it would be useful for the authority to commission a scoping study on what something like that would look like for New South Wales. We have recently finalised that scoping study and now that is something that would need to go into a government process.

It is probably worth explaining what the crash reporting tool is, if that is of benefit. In Western Australia when you have a road crash, instead of having to go to the police and provide a report to the police and then turn around and make a claim in the motor accidents system, in Western Australia you do all of that notification as part of one process. In essence, you can do it on line or you can do it at your local police station. The information that you fill out advising the police is also the trigger for your claim and provides the initial data that you need for your claim.

In Western Australia you will instantly get a claim reference number that will enable you to go and start expending for medical treatment and so on within 24 hours or so of first notifying the system. The West Australians have identified the benefits of that system in that it has got a lot of police back on to the front line, so instead of them being in police stations filling out paperwork, individuals are doing that at terminals themselves and it has created quite a robust crash database that sits behind the front end, which is very much the reporting and claim initiation process.

In Western Australia now, and they are probably a world leader in this space, they are finding that they have got really good data now on where the crashes are occurring, how they have occurred, what factors were involved. Previously, and it is still the case in New South Wales, that data was and is, in the case of New South Wales, fragmented so we have police report data sitting in one place, we have road crash data, hospital data and our own CTP data all sitting in different places.

In Western Australia now that data system has unified all of that information. It means that the insurer has the police report really quickly, so there are no delays, as happens now in New South Wales. It is much less labour intensive. You can see the full history of a claim by looking at different interactions and there is a detailed database which helps the road authorities start to form a view about where risk is occurring, so a risk based evidence based approach can be taken in addressing black spots and high priority road safety initiatives.

That is something which I think we should look at in New South Wales and that is why I have commissioned a scoping study and I am looking forward to working with my fellow agencies who are all very interested in looking at this.

(Short adjournment)

DOUGLAS DUGAN HERD, Project Manager, Lifetime Care and Support Advisory Council, Level 24, 580 George Street, Sydney, affirmed,

DAVID BOWEN, Executive Director, Lifetime Care and Support Authority, affirmed, and

SUZANNE MARGARET LULHAM: Director, Service Delivery, Lifetime Care and Support Authority, sworn and examined:

CHAIR: Mr Bowen, would you like to make an opening statement?

Mr BOWEN: In starting, the Chairman of the Board, Mr Nicholas Whitlam, who has appeared before this Committee asked me to pass on his apologies. He has will a long standing commitment in another city which simply prevented him from attending today.

In opening I want to briefly address a number of issues that have again been raised in submissions and hearings and then go on to mention some of the significant changes and developments over the last year. Some of these address matters that came up in submissions and hearings in the current inquiry or have been repeated from earlier inquiries.
I think the first one is exactly what the scheme covers.

The scheme pays for treatment, rehabilitation and care and there is a range of other matters which it specifically does not deal with that seem to have been the source of some questions. The first is accommodation. The authority is funded to meet the cost of home modifications and we will stretch that to assist people in moving when their prior place of residence is no longer suitable, but the authority is not funded to provide accommodation.

Other matters that are regularly raised are the cost of leisure and recreation and travel costs. We very well understand that after a significant injury, participants and their families are stretched for money. It is not an uncommon result of accidents significant enough to get you into a lifetime care scheme. However, the scheme is funded for a specific set of services only and we cannot step outside those statutory boundaries.

The second one is that the authority has a specific statutory obligation to determine that the services requested are reasonable and necessary. Let me start with the suggestion that in exercising this discretion the authority somehow curtails clinical judgment. It should be noted that in the context of medical and rehabilitation requests there is a significant discrepancy between what is prescribed by a clinician for public patients and what is often prescribed by clinicians for lifetime care and authority participants. When this occurs it is reasonable for the authority to require a clinical justification for that higher level of service and that is not uncommon if you visit the units, clinicians will indeed tell you themselves that there can be two people in adjoining beds and the lifetime care participant is going to get a higher level of service and a quicker decision than the person who has come in through the public system.

For a large number of services it is also reasonable for the authority to require sufficient information to determine that the request is reasonable and necessary and this is particularly true for a range of prescribed equipment, therapies and the like. The staff of the authority who make these decisions are themselves very well qualified. I think the impression may have been given to you that clinical programs and proposals are coming in and that we have a range of administrative staff who are considering these. In fact many of our staff come out of the specialist units. Virtually all of those who are dealing with those requests at either a coordinator or a service review level, have allied health qualifications, often to a higher level than the person who is putting in the request to them. They come from a variety of background, including OT, physio, social work, speech pathology and rehabilitation counsellors.

I would reiterate the point that what they are doing is not saying you are wrong, what they are saying is we need justification from you for why this is appropriate so that the authority can make the decision as to whether or not that is reasonable and necessary.

The matter that often comes up in this context is that of paperwork. It gets raised here regularly how much paperwork the authority creates. We have done a lot of work over the years to address this and we have more work planned. The first one that I would note, and I believe it may already have been brought to your attention, is that to assist in discharge planning the authority issues a list of pre-approved equipment that can be prescribed directly by the hospital without the need to refer it back for further approval. Requests are only required for equipment that is outside that list and that list keeps growing as we discuss matters with the clinicians in the rehabilitation units. In addition, the authority provides coordinators with the delegation to approve services or equipment to about $5,000 through a much more simplified process.

It is important for me to note to you that the types of requests that we are dealing with in seeking justification for are not insignificant. It is most common for rehabilitation plans that are submitted to the authority to be in excess of $50,000. That is a significant amount of expenditure and we would be failing in our fiduciary responsibility not to properly examine whether those requests were reasonable and necessary. I would have to say to you that the compensation authority's internal audit review has looked at our processes and confirmed the need for proper controls on such expenditure.

the other matter that I would note in the context of paperwork, and I have noted it here before, is that the authority already pays well above public hospital bed rates for rehabilitation beds and associated services and over the top of that we specifically pay a rate for the preparation of reports. You will recall, Mr Chairman, that this issue has been ventilated here before and that part of the complaint of clinicians is that their specialist units are not seeing the extra funds that we pay. We are not in control of the payments we make, to area health services previously and now local health networks, whether they put that funding back into the rehabilitation units where the work is done and I know that this Committee has raised that previously with the Minister for Health.

The third is the issue of delay. we recognise that getting accommodation remains the single biggest reason why people are unnecessarily delayed in rehabilitation units. I would make the point that I believe that lifetime care participants get out of those rehabilitation units much quicker than other patients because of the resources that we can bring to bear but we cannot directly fund accommodation. We do fund accommodation for very high needs patients, where they have no prospect at all of going elsewhere and where it is in the context of some savings to the authority through congruent care arrangements.

All other requests that we obtain are determined within our timeframes that are set down in our guidelines and our practice notes. Sometimes a request will be deferred. We are seeing requests for equipment often made early in the rehabilitation process, before the injury is properly stabilized, and we have had experience where meeting those requests has meant that we have had unnecessary equipment or inappropriate equipment for the person because it has had to generate a further request later.

We are particularly concerned not to finalise requests for equipment until a discharge destination is known, so that we know that the equipment that is being prescribed for a person's home in terms of hoists, in terms of beds and mattresses and the like, is suitable and can fit into it. That point being made, it would be extremely rare for that to delay a discharge from a rehabilitation unit.

The fourth issue I want to address that has been raised with you is that of consistency of decisions of the authorities, coordinators and service review officers. I must say that I smile a little bit when this comes up because I recall that when this legislation was being debated in the Parliament and in the lead-up to that debate the legal profession were very critical that the Lifetime Care Authority or

the Lifetime Care Scheme was going to be a one size fits all, that it would not be able to meet individual needs. Quite the contrary, we very much pride ourselves on the ability to review the needs of each individual participant, to work with that participant in setting their goals so that we are supporting their goal setting and meeting their particular needs.

Our work is very much tailored to that. That does mean there will be differences in outcome. People will have a similar level of injury but will have different and very specific needs and therefore different outcomes. We think that that consistency in approach to how we deal with things is important but we do not think that that should lead to consistent outcomes, in fact quite the contrary, we think it should be about individualised outcomes.

The final issue I want to deal with that has been raised is that of transparency of decisions of the authority. This has come up to you from a number of service providers. I make the point that every single decision that the authority makes is communicated back to the participant with the reasons for the decision given. Our obligation is to the scheme participant and in the circumstances where they cannot be the decision maker, their family. Our obligation is not to the service provider.

We will ensure that as far as possible we communicate decisions to the service providers, but that is not always possible, either on privacy grounds or necessarily desirable in the circumstances where a participant wishes to change providers. The important thing is that in every single case the information, the reasons for the decision, is in the hands of the participant or their legal representative or the person exercising guardianship.

Now I will turn and look at what I think may be some of the highlights of the last year. Very much the focus of the authority is on the growing number of participants in the community. I mentioned this last time but it is particularly stark now. The number of participants in hospital, in either acute care or rehabilitation at any one time is now stable. It is around about 50, coming in, going through the hospitals and going out, while the number of participants in the community is currently around 520 and that number will keep growing and growing, so it is not unexpected that our focus is now on supporting people in the community.

The point that does not come through yet when you look at our financial statements is that 80 percent of the cost of the scheme is about supporting people in the community, provisions of services in the community, and we should not let the acute and rehabilitation services overshadow that which is by far the biggest single thing that we do and, to some extent, the most important thing that we will do.

As you know this year, and we have provided you with a copy of the further participant survey, what it is demonstrating to us is that participants want services close to where they live. It is a necessary fact of the arrangements of our acute trauma services and our rehabilitation services that they are very Sydney-centric. When people go back home they want to be able to get the services they need to support them in their community, in their communities as far as possible and we make the effort now to, as well as providing the attendant care, or providing the participant with a choice of attendant care, as in their locality, of providing rehabilitation support from a variety of both government and non-government providers back out into the community.

We think that that is meeting an important principle behind this scheme of maximising participant choice and maintaining a quality service. Participant choice will be further facilitated because subsequent to putting the answers to the questions on notice into the Committee, we have now received the approval from the Australian Tax Office to allow us to enter agreements with participants whereby we can provide them with the funding so that they can self-manage and self-direct their own care. It is an incredibly important option to have available to participants.

The importance of the tax ruling was to make sure that any such payments were not treated as income. We have previously obtained, and it remains current, a similar determination from the

Minister, the Commonwealth Minister responsible for pension and carer payments.

The authority also recognises that choice is constrained by the availability of service providers and we are working to build up that service capacity. We put out a new tender last year and that was filled earlier this year, as a result of which the number of approved attendant care providers has increased from 14 to 22. I thought that was good. We had really more applicants than we had work available to them, but given the growth of the scheme it is great to have that there. That means that virtually in every area of the State we can offer our participants a choice of approved attendant care provider, which is quite important.

There will always be problems in getting individual carers in a work force where someone is remote from a town. To some extent some of those matters become quite impossible or quite difficult to deal with. I think the other important aspect of that new tender is that as part of it we have required all of the attendant care providers to be part of a new industry based quality accreditation program, so rather than trying to set up our own standards we have established a co-regulatory arrangement with the Attendant Care Industry Association, whereby they have put a quality program in place and I am getting some complaints that it is a little bit too rigorous for some people to get through, but I do not think that is necessarily a bad thing for the first up quality audit.

We are still working with the Spinal Cord Injury Network and the Brain Injury Rehabilitation Program to build up expertise across the whole of the State in rehabilitation services.

Finally, I would like to point out that we pride ourselves on being able to look at maintaining an innovative approach to services in this scheme. This year we launched the in-voc program. It is mentioned in detail in response to one of the questions on notice, providing a vocational employment support for people with spinal cord injury that starts at the rehabilitation area. We had very strong support and very strong involvement from the spine rehabilitation units. Over the next year we will take on a more challenging task of trying to develop a similar vocational employment program for people with brain injury.

We are funding a number of pieces of research that are aimed at improving service delivery. It is directed research to inform us as to ways in which we can provide different and better services. One of the ones that we recently had a presentation on, as recently as a fortnight ago, was the result of a pilot program that was aimed at building resilience amongst families of people with spinal cord injury. It was phenomenally successful. It addresses an issue that the health services are very much set around, providing the services to the injured person. Quite often the family is going through their own turmoil, their own difficulty in how they cope with supporting their family member, and we have already identified on the basis of that pilot that there is scope and that it would be desirable to roll out a family support program right across the whole scheme, so that is a couple of the matters that we are looking at.

CHAIR: Mr Herd, as Chair of the Advisory Council, are there any comments that you wanted to make at this stage, or you will wait for questions?

Mr HERD: I think I will wait for questions if that is okay, Chair.

Mr DAVID SHOEBRIDGE: Thank you for that very thorough presentation, Mr Bowen, a very interesting presentation. I appreciate that any questions that we may have about critiques is viewed in the scheme. Almost everyone who has come and spoken speaks very highly of the scheme. It has been a major step forward. I think everyone agrees with that. There is some concern from a number of different clinicians about the role that the assessors are taking, or role that the scheme is taking in, if you like, double-guessing clinical decisions by clinicians. I think in your presentation you effectively said that you have skilled people who you would expect to do that, given the nature of the requests that are coming. There is obviously a dichotomy. Clinicians believe that is not the role for the authority, that clinical decisions should be made by the various specialties on the grounds. How

do you navigate that divergent view, because potentially it is conflict and it is potentially difficult for the scheme.

Mr BOWEN: We do not try to put ourselves and even the very qualified staff do not try to put themselves in the position of making a determination of clinical needs. That is a matter for the clinicians who are seeing the person as a patient at a rehabilitation unit or through a community program, but we do require clinical justification to be given and I think that that it is absolutely fair and reasonable to get a request, a service request, that says this person needs a rehabilitation program and it will cost $60,000, without any justification for the elements of it and how it will meet rehabilitation outcomes, given that the logic behind that is something that has to be addressed in the construction of the program is not, I do not believe, a big ask, to ask for that justification and a necessary ask for us to be able to approve the expenditure.

Mr DAVID SHOEBRIDGE: We have had clinicians as recently as this morning say that some 25 per cent of their time is devoted to the paperwork associated with getting approvals through. They often put initial paperwork in, they get a response in 10 days for more information, they get a further response in 10 days for that initial response; that the sheer volume of the paperwork is a repeated concern and it does seem to be taking away clinicians from care and directing them to paperwork. Do you have a system-wide review of that?

Ms LULHAM: We have a system-wide review of the discharge process as David has mentioned and we have revised that. That has certainly simplified the process in terms of getting people out of hospital.

I think in terms of the complexity of the paperwork, it now really varies provider to provider. Some struggle with it a lot more than others and I think for some it is not such a problem at all. It does vary unit to unit and person to person.

We are also in the process of just about to roll out another new review which is of our attendant care assessment, our assessment of people requesting for care needs, which the preliminary information we have had in the roll out that we have done over the last four to six weeks would indicate that that will also simplify that process a lot as well.

We are trying to do it in some respects but I guess our point is that we cannot take it away altogether.

Mr DAVID SHOEBRIDGE: Particularly in relation to the interim accommodation approvals, the submissions said that the paperwork and the level of complexity required for an approval under your scheme was very poorly contrasted with the relative ease and accessibility of the WorkCover scheme, when you are both applying the same test for this, which is reasonable and necessary. Have you consulted with WorkCover and reviewed their process?

Ms LULHAM: WorkCover for the level of injury that we cover are now using our process and forms and where we have a joint claim being managed through both Workers Comp and us, it is our forms and our decisions that are used.

Mr DAVID SHOEBRIDGE: The clinicians who gave evidence just this morning indicated there were quite different responses.

Ms LULHAM: I cannot say. They may be for different levels of injury but certainly for what they are calling the very serious ones that would meet our thresholds, they are using our processes and our forms and guidelines, and they are going to roll that out in all areas fairly soon.

The Hon. SCOTT MACDONALD: Can I just take you back to the participant choice. I think you answered most of the opt out sort of options I suppose, but it was good to hear, it sounds like you have got an ATO determination that means it is not going to eat into their capital or pursue the pay out. I have got a couple of follow up questions on that.

Mr BOWEN: The participants in the scheme, they will have all of the treatment care rehabilitation payments paid on an as incurred basis. About 50 per cent of our participants will also have a CTP claim for other heads of damage, which if successful that will constitute capital payment, but we do not hold our funds individual to each participant, we pay the costs as they arise.

The new arrangement will allow us to enter into an agreement with a participant to say your care needs are quite stable over this next - it can be three, it can be six months and eventually it could be quite a bit longer than that. We will enter an agreement with you, we will make this deposit directly into your nominated bank account on a monthly or whatever basis it is in advance and that will allow the person then to purchase their own care and to manage their own services as much as they like.

There are some limitations that the Tax Office imposed that have had to be included in that agreement. The participant has to confirm in the agreement that they will only spend the funds on those purposes, for the purpose of care and the like. They also have to agree that any unspent funds will be returned and agree that they will not use any of the funds to employ a direct family member who is living in residence with them.

The Hon. SCOTT MACDONALD: Are there any other barriers to opting out?

Mr BOWEN: There is no barrier for opting out of the scheme. No one is forced to stay in the scheme but they will not have access to payment for the treatment, care and rehab services. So that is the barrier.

The Hon. SCOTT MACDONALD: So they cannot get a lump sum?

Mr BOWEN: They cannot get a lump sum for medical care.

The Hon. SCOTT MACDONALD: If you are a very stable injured person and you can see the next 20 or 25 years that you will not have any other issues besides ageing. You cannot say: Thanks very much, we work out the present value and off we go?

Mr BOWEN: This issue was very heavily ventilated at the time the scheme was first brought in Parliament and beforehand. All of the reviews that have looked at long term outcomes for people with this level of serious injury have found that funds either usually do not last the person's life or that the person dies prematurely and it goes over to the family.

The policy behind the scheme was having the funds available for as long as the person needed them, which in effect was for the rest of their life.

The Hon. SCOTT MACDONALD: What is the percentage increase annually, what is the CPI for your industry?

Mr BOWEN: For our costs our actuary uses an inflation amount of four per cent, which is based on long term projections for average weekly earnings. We allow slightly higher than that for our expected inflation for our attendant care due to potential workforce problems.

The Hon. PETER PRIMROSE: I have a question, which I think you have almost answered, and that is the payments to family carers. You just alluded to the issue in relation to the Australian Tax Office determination.

Basically I understand we have been advised that in rare circumstances the Authority has been prepared to pay family members to act as carers for the participant in the scheme. This might occur, for example, where the participant lives in a regional remote area. The AMA expresses concern that there has been some discussion of removing the possibility of these payments.

Are we just talking about the ATO determination or have there been other discussions?

Mr BOWEN: I think we only have once circumstance where because of the remote location the family member is employed as a carer, but in a circumstance where they became an employee of

one of our brief care providers to ensure that all of the OH&S standards were met, that the training was met and that they had the competencies to do the work.

Mr Herd might want to mention generally this issue the Council has reviewed on a number of occasions, the issue of using family as carers. I would mention that the Productivity Commission's report on establishing national disability insurance scheme also looked at this. The Commission came down in favour of not having family members employed as carers for the same reason as had been ventilated before the Council, although it did note that there had been one or two examples where it had worked successfully against a body of evidence where it had created problems and suggested that the National Disability Insurance Authority, which is yet to be created, at some point in the future may look at a bit of a small pilot around it. I say that we are very much open to working in that same space.

Mr HERD: The Council's view and I have to say my own personal view is unambiguously clear on this issue that to establish any mainstream uniform arrangement by which I could become or somebody like me could become the main source of income for a direct family member living in the same residence is a recipe for disaster.

It distorts natural family relationships. It makes both the service user and the family member depend upon one another in a way that is mediated through cash and it creates problems in the longer term that may be insurmountable when some crisis emerges.

In as much as it is humanly possible for us, we should avoid any temptation to go down that route, except in those circumstances where it absolutely is the last resort to prevent any other individual going into some kind of institutional or inappropriate medical care.

The trouble that I think we have is that until you have been around the traps once or twice, in the situation of being a person dependent on the support of others to get through the 24 hours of any day, you do not know the risks that are involved in that kind of relationship and it is in very unique circumstances that it can be developed and sustained over any length of time.

So we have continued to caution against it because we think it just throws up problems for the future, however superficially attractive it may appear.

The Hon. PETER PRIMROSE: Is it a restriction that is proposed where you will be saying the participant does not have the opportunity to exercise this? Is it a guideline that you strongly, for various reasons say so or do the individuals have the right to exercise that personalised funding option?

Mr BOWEN: The restriction in the legislation is that the Authority has to approve care providers. We have done that, so the only circumstance in which a family member has been paid is when they are an employee of those care providers.

The issue of paying family members direct from the Authority is something that, for reasons on the advice of the advisory council, we do not do. In the circumstances where we are entering agreements with a participant as we will be into the future now, the Tax Office has put in that obligation that under the approved agreement that they require to give that approval, the person if they are getting that funding direct cannot employ a family member.

The Hon. PETER PRIMROSE: What I am pushing towards is let us say it is July 2014 and the person is able to select under government policy an individualised funding package. Again, how is that going to work? Is it extreme caution, advice, warning in relation to all these matters or is it where you are going to exercise a prohibition?

Mr BOWEN: The individualised funding arrangement will be under that agreement between the Authority and the person, the participant. Under the current ATO ruling, and the ruling specifies the form of the agreement, they cannot use those funds to employ a family member for which they will be deemed to be receiving income.

The Hon. PETER PRIMROSE: Leave the ATO out of it. Will there continue to be prohibitions or will the individual be able to exercise their own determination under a personalised funding arrangement?

Mr BOWEN: What I could say is that we will not pay family members direct other than that very specific circumstance that I already mentioned where they are an employee of an agency. If the person is getting the funding under a self funding arrangement, they can choose, I suppose, to employ a family member but they run the risk of being in breach of the ATO approval and the funding we give them proved as income. They would be well advised not to do that.

Mr HERD: There is I think a tension between the approach we recommend and take at the moment and the future after the Stronger Together date comes in. At the sound of being hoist by my own petard if I may say so, I think the overriding principle when we get to that date will be freedom of personal choice, because I think that is a bit like pregnancy - one either is or one is not. One either has freedom of choice in this regard or one does not.

I cannot remember how my term of office works out, but if I am still the chair of the advisory council, my advice to anybody at that stage will be you really do need to think very clearly about this and I would advise you not to do it.

Here is the thing, we will get to the position where putting it in perspective of numbers, all the evidence we have from Australian and overseas jurisdictions about the direct funded option and the direct payment option is that less than 10 per cent of clients will ever take up that option. Not because they have any kind of ideological disagreement with it, it is just that it becomes all consuming. If you are responsible for the management of essentially a small business, which is what happens to you, if you receive support that might be worth $100,000 a year, you have to organise personal staff rotors. When I have been involved in it in the past in the UK helping to advise people whether or not to do this, some people, to maintain a kind of two/one roster or say a month's roster of people who can come in to help them, would have to have maybe 20 or 30 people that they could call on on their books as potential employees, and for most of the people who do it, they think this is how I want to live my life, but most of the people do not do it and it is the overwhelming number that recognise that it is very time consuming. You have to act as if you own a small business employing quite a large number of casual small employees.

That is why it is a very small proportion of the total base. An even smaller proportion will be people who will choose the direct funded option and choose, for whatever reasons, to make payments to direct family members. I would have to say, as a long-term advocate, as some of you know, of the rights of people with disability if, in the final analysis, that is what they choose, then we ought to be able to support people to make that choice. We ought to have in place agencies in the non-government not for profit sector that will advise them on the best way of going about that, but still my advice is do not do it because it has the potential to ruin your relationship with your mother, father, brother or sister and the day that happens you will rue your decision to pay them anything at all, not because you do not love them but because you do.

The Hon. SARAH MITCHELL: I have a question relating to leisure and recreation which is something that has come up with previous witnesses today. In some of my pre-hearing questions on notice there was some information from the authority saying that they had developed a draft guideline for the funding of leisure and recreation activities and that had been approved by the council. Will you outline for the Committee a little bit more about what that guideline contains in terms of what is permissible under leisure and recreation?

Ms LULHAM: The guideline is still in draft but hopefully will be gazetted soon. The guideline reiterates the fact that the authority does not pay for leisure and recreation. It is not a service for which we are funded. It does, however, say that we will fund the acquisition of the skills that a person needs to develop a recreation and leisure, so someone for instance with a brain injury who might need to develop the behaviour management skills or the acquisition skills or the cognitive skills to put together a recreation program, that we would certainly be funding that but not the actual cost of the leisure and recreation itself.

We will, however, fund the attendant care required for a person to access their leisure, their recreation and leisure, so if they need an attendant care worker to assist them partake in their recreation and leisure, we will fund that.

The Hon. SARAH MITCHELL: The examples given this morning of going to the movies, for example, in terms of people who might not work and might not get out of the house and to stop them from being stir crazy to get out and go and do something, how would that fit in, or would it not be something that you would fund?

Ms LULHAM: It probably will not fit in. It is a very difficult situation because we recognise that many of our participants do not have a lot of resources or a lot of funds but it is not a cost that we can meet. However, if they need an attendant care worker to assist them to get to the movies and to assist them in some way or, for instance, swimming might be a better example, so if they decide they want to go swimming, they pay their own way into the swimming pool but they might need an attendant care worker to assist them with the actual swimming, so we will pay for that attendant care worker.

Mr DAVID SHOEBRIDGE: Mr Bowen, you said at the beginning that 80 percent of the participants in your scheme are out in the community and only about 20 percent are in hospitals or going through. S I will not hold you to that.

Mr BOWEN: Probably 90.

Mr DAVID SHOEBRIDGE: When I look at the submissions, 90 percent of the submissions are about that clinical critical process and there are very few submissions about the bulk of participants in your scheme, which makes me think of two things: One is that it is absolutely perfect, the way the scheme is operating for 90 percent of your participants or secondly, it may be very good but there is no actual advocacy body that is representing that 90 percent of participants out in the scheme. Can you respond to that concern?

Mr BOWEN: I will respond by saying a couple of things and I will address of the issue of advocacy because I think it is a particularly important one. First, there is always a risk of losing touch with people, once they get back into the community. Through the process of both our coordinators and case managers we feel confident that for those people in Australia at least we still have good contacts with all of them and are as aware as they want us to be of their circumstances. Some people choose to have limited contact and we would respect that.

We follow that up with the participant survey, to see whether there are any issues that resonate right across the board. For example, the problems that can come up for people back in the community are often about the quality of the individual care that they are getting and you can get quite significant variations, really quite excellent attendant care workers who go in, who work with the person on meeting their goals, who assist them in doing what that person wants to do and, at the other end, you get those attendant care workers who will go in and turn the TV on.

They are really not assisting the person with anything at all. Partly our quality program tries to address that by ensuring that the approved providers, which are the agencies, have appropriate training in place. We pay for a lot of training for the attendant care staff so that they know what their priorities are and the like. The issue of advocacy is one that has been raised with the authority and that we took to the Advisory Council. It was the view of the council that there were sufficient existing advocacy bodies, certainly both spinal cord industry and brain injury, there are advocacies bodies who usually make contact with the person and/or their family at that acute care rehabilitation level and there are other mechanisms available. I am sure Mr Herd knows much more about them than I do.

Mr HERD: I will try to answer in two ways if I may. One is about the extent to which the

participants will be able to influence and guide the future development of policy so I think we discussed at the council already, with the help of the authority, ways in which we might work towards a position where participants are in some way represented in the advisory council's deliberations. That sounds like motherhood and apple pie, good idea, let's get on with it but it is not that simple for a couple of reasons, not least of which is this is, forgive me for saying so, a relatively young agency with a comparatively young and small core of participants and it is a complex one.

If we have 500 people out in the community and 50 going through hospital at any one stage at the moment, that means that the adults who are going through it with severe spinal cord injury or brain injury may be at the moment little more than, at the most, two or three years away from injury and representation in a democratic forum to present a point of view is not necessarily uppermost in one's might at that stage on the rehabilitation path, I have to say and we also have the complications of having people with a spinal cord injury, people with a brain injury, and we need to find over course of the next few years the ways in we can get participant representation to feed into the council so there is a very direct connection between the advice we give to the authority.

The sooner we can come back and report that that has been done in the past tense to you the better, but that is separate from independent advocacy, which needs to be absolutely fundamental to the provision of support to people. I am not personally sure that there is any particular authority related advocacy role, if you like. It is slightly bigger than just the people sitting in this room. I suggest that we need to try to ensure that we have robust, independent, autonomous disability advocacy organisations across the system in New South Wales.

The State Government currently spends, I believe, about $6 million a year on those advocacy organisations, People With Disabilities, Physical Disability Council, Brain Injury Association, and trying to make sure that our participant base has the knowledge and information that will allow them to go to those organisations, know how to get to them and make use to them at any point they may wish to make use of them, whether it is in relation to the authority or not, I think is part of the responsibility that we have, but we need to make sure those advocacy organisations are properly funded. I do not think that is the authority's role.

Mr DAVID SHOEBRIDGE: In your role, what do you have in place to make sure that your participants know who those advocacy organisations are, have the contact details and the capacity to actually contact or engage with them. Obviously some of your severely brain injured participants will have different abilities to participate than others.

Ms LULHAM: We have put together some information for them and a list of contacts for different advocacy organisations. Our trouble is that because when people access an advocacy organisation they remain anonymous, so to speak, to the organisation that they are about, so it is very hard for us to know the extent to which those advocacy organisations are being used.

Mr DAVID SHOEBRIDGE: In light of that, I was going to ask about the approved case manager initiative that was rolled out in August 2011 and if you can just talk about what the impetus for that was and how that might relate to relations with participants.

Ms LULHAM: This is, I guess, our big project over the next 12 to 24 months. Case management we recognise as being a very vital service in our scheme. It is also not a profession as such, it is a group of people with a group of skills that come from a variety of professions. They could be occupational therapists, rehab counsellors, social workers and case management works very differently according to who the funder is. We are putting together our own case management initiative where we will ask people to apply for the status of what we are calling approved case manager, so they will be on our books as a case manager.

We are also, as part of this, rolling out a mentoring program. The impetus for this is because there are not enough case managers out there. At the moment our rough count of the figures is that we

have used about 130 different case managers across New South Wales and our need is growing and getting bigger and so we need to try to grow more of these case managers out there. That is part of the impetus for this.

So the actual getting of approved case manager status goes hand in hand. If you do not meet those requirements you can be mentored so you will have an experienced case manager oversight your work for a six month period until you can become an approved case manager. We will be developing a database so that people can access it on our web site, so there will be a list of all the case managers across New South Wales and their expertise, whether it be spinal cord, brain injury, burns, amputation, so people can, if they wish, choose or have some assistance to choose a case manager closer to their area.

At the moment we are in the process of running question and answer sessions for anyone at the moment, for anyone interested in this. We have held two big sessions at the authority and this week we are holding three teleconferences for people in rural and regional areas. We have been overwhelmed, I guess, with interest, it would be fair to say.

Mr BOWEN: Could I add, Mr Shoebridge, that the Productivity Commission looked at this very closely in term of its proposed structure for national disability and, as you know, recommended individualised funding, recognising that in the middle there would need to be some sort of occasionally a brokerage service, occasionally a service offering assistance with decision making and that would be funded through the insurance body, but it also specifically recognised that over and above there needed to be something completely outside that to provide general advocacy on behalf of the whole sector and that should be directly funded by government, not through the insurance authority because of the problems that would create for conflicts of interest.

Mr DAVID SHOEBRIDGE: I suppose it is hard to tell at the moment from the information I have about what this approved case manager will be, but it seems in part ways an advocate, in part ways a bit of pushing in terms of potential treatments and clinical matters, and how that fits into the current scheme, because we already have clinicians saying they are concerned about their clinical opinions being second guessed. Have you worked out how that will fit into the scheme?

Ms LULHAM: Many of those clinicians will be case managers in this current scheme and certainly at the moment about 40 percent of our case managers actually come from the public system. That will get less as more in the private sector grow. We are not actually seeing these case managers as being advocates for the scheme. Their role is to actually assist the participants to develop their goals about where they want to be, to help them put together the services they need to achieve those goals, to review those services on a timely basis.

The participant survey that we are halfway through at the moment, we have completed the qualitative component of that. We had about 15 participants interviewed and the overwhelming response that came back, because we did ask them questions about their services, was that they would really would like their services provided locally and would really want case managers who were locally based. That has been another part of this impetus to try to build the capacity of case management in more rural and regional areas.

The Hon. SCOT MacDONALD: We had someone talk earlier about web-based client management, I suppose. Can you give me some idea how accessible the information is to a participant? If they want to know their history, or they want to get into contact with clinicians and want responses, their plan, I guess, have you got to ring up and someone sends you out a letter, or is it available on line to them? I am trying to get a picture in my head.

Ms LULHAM: It is not available on line to them at the moment. We certainly used e-mails and that side of the technology a fair bit. We are tending to use Skype more and more and certainly case managers at the moment, particularly if they have some rural participants, tend to use Skype a lot

in terms of contacting them. It is something that we certainly have in mind and we will certainly be working towards but, in our view, it is probably still a few years away. We do envisage a time where a participant will log on and just view all of their own information.

The Hon. SCOT MacDONALD: And even see from the day of their accident almost, to where they are up to at the moment?

Ms LULHAM: Yes, but we are not there yet.

The Hon. PETER PRIMROSE: This might be a slight flight of fancy but I understand, Mr Bowen, you have been involved in one of the advisory committees in relation to the National Disability Insurance Scheme. As I said, it may still be a flight of fancy, but can you tell us how you envisage at this stage the operations, functions, costs et cetera of a national disability scheme in relation to the operation of the authority?

Mr BOWEN: The second part of that is hard. I was on the independent panel that advised the Productivity Commission and the Commonwealth Minister. The Productivity Commission released its final report to the Commonwealth Government at the end of July and it was tabled in early August, the week after to COAG, and COAG has established now a Select Council which will progress this matter. In fact I believe that council is meeting in Sydney this week. It is comprising Treasurers and Disability Ministers and I think that will very much set the implementation program for the further work to be done.

The response to the Productivity Commission's report was very strong support across the whole political spectrum, so I suspect it will be implemented. There is quite a bit of work obviously to work out between the Commonwealth and States about unwinding current Commonwealth-State disability funding arrangements to put into the new National Disability Insurance Scheme. I think we will let that take its course.

The other recommendation that the Commission made was to establish a national injury insurance scheme as a federated traumatic injury scheme. Effectively that would be each state establishing something similar to the Lifetime Care Authority and over about five years expanding that to cover all injury of that level, whatever its mechanism, so in New South Wales the Lifetime Care Scheme covers only motor vehicle injury, and that is about 50 percent of spinal and brain injury and, in fact, certainly more than 50 percent by dollar value because motor vehicles tend to create high severity injury than you get with falls and otherwise.

That will also go through a Commonwealth and State process. I think it is still intended to be a separate committee looking at that achieved by the Commonwealth Assistant Treasurer, but with similar sorts of reporting timetables and again, the issue of the Commonwealth-State funding is something that will determine how far and how quickly that goes.

CHAIR: The Australian Medical Association stated last week that in general GPs have a lack of understanding about the scheme. What mechanisms do you have in place to inform service providers, including GPs, about how the scheme operates?

Ms LULHAM: We do not have, I guess, very many mechanisms in place to inform GPs. On discharge from a hospital it is usually the role of the discharging medical team to provide the information to the GP. I guess it is something that we are happy to look at but there is information we have available for GPs, but they have to be prepared to actually read that information, but I am not sure that we are actually doing anything specific with the GPs. Some of the case managers will contact GPs and provide information, sometimes even sit in with GPs, including the spinal cord service, but it is not an area that we have done a lot in.

CHAIR: Do you think it would be an area that would be good to be taking a proactive move

in?

Ms LULHAM: It is something that I think is worth looking at. The last time I looked at GPs there were something like 8,000 GPs in New South Wales. I am not sure what the numbers are now. We have 500 or say 600 participants. It is a matter of targeting who the information is going to. It may be a matter of developing some resources that when a person goes to a GP that they can take with them.

CHAIR: There has been a suggestion that the AMA could work with the scheme's administrators to develop a method to provide more information to GPs. What would your view be of that? Do you think that would be a good basis to be active in this area?

Ms LULHAM: The AMA would be a good organisation to work through, if they are happy to do that. We will take them up on the offer.

CHAIR: You will take them up on that and see what results from it?

Ms LULHAM: Yes, definitely.

Mr BOWEN: I tend also to think that it will become increasingly important. At this stage most of the participants in the scheme who have a medical problem would be going back to see their rehabilitation physician because it is usually going to be associated with their injury. They would probably see GPs mainly for pain prescriptions and the like, but even then I suspect that a lot of that goes back to the rehab physician. As people get stabilised in the community I think that needs to broaden out that specialist service.

CHAIR: This area of contact with GPs is an area to be developed, is it not?

Ms LULHAM: Yes. We have done very little on it to date. If they are willing to work with us we are happy to take them up on their offer.

The Hon. SARAH MITCHELL: I wanted to ask about over-prescription of care hours. It was raised with us this morning by Spinal Cord Injuries Australia. They said they have anecdotal evidence that there were some participants under the scheme that were having too many care hours prescribed to them for their level of need. Do you have any thoughts or comments on that statement?

Mr BOWEN: It took us a little bit by surprise when they reported that. It is certainly the case that a good percentage of our participants do not utilise all of the care that they may be assessed as needing, and that is often to do with choices that they are making about what is important. If they want to forego a little bit of care because they need to get to a job, or because they are getting it elsewhere, or because they are self-caring, then that is their choice. As long as we are not dudding them of what they need it is okay for them to take less.

I would think occasionally there have been circumstances where we have approved care packages higher than perhaps a person needed, but it was to meet a short-term issue. The classic case there is where someone, as a result of their injury, has a certain amount of physical care need but they have an anxiety about perhaps being left alone, or self-managing. In those circumstances we will provide a higher level of personal care in conjunction with working with the person to set individual goals about becoming more independent, being able to get back into managing their own transport, being able to manage their own domestic arrangements. I do not regard that as over-prescribing. I think that is a very tailored program for a specific period of time.

The Hon. SARAH MITCHELL: The example that was given this morning was one woman has 24 hour care and she does not think she needs it. It sounds like there is obviously consultation between the participants and your authority, so there is a mechanism for someone in that

woman's situation to come and say I do not want as much care?

Mr BOWEN: We certainly do not send carers into people's houses. It is their choice. It is a two staged process. There is an assessment of need and then there is a service request. We, at the moment, measure both but really we are only interested in the service request and whether that is reasonable or necessary. No-one is required to take care that they do not need.

The Hon. SCOT MacDONALD: Do you see any threats to the sustainability of the system? By that I mean availability or work force? Obviously you probably have a view about finance and capitalisation behind it. Anything else? The work force would be the one I would imagine, but are there any other you could see down the track would be an issue for you?

Mr BOWEN: Availability of the work force I think is the single largest issue for the scheme to keep a close eye on. We provisioned for an increase in care costs well above the average weekly earnings, based on work that we did with Access Economics and Allen Consulting Group, about what the long-term trend would be for care costs. It was based on looking at the profile of the attendant care work force. It is an older work force. It is ageing. It is quite lowly paid and it is in a context where there is likely to be a significant increase in demand, one from the natural ageing of the population. People who are older need more care, particularly at home, and also secondly, potentially as a result of the introduction of something such as the National Disability Insurance Scheme, which will create a much higher demand for a work force.

We are comfortable with where we are, having provisioned for that already, but there may well be a case where it starts to get hard to get carers. The Productivity Commission recommended this and has suggested the governments, both Commonwealth and State, need to look at more informal care arrangements, more flexible care arrangements, such as arrangements with neighbours and the like, so I think that will be very much on the books for a little while.

I suppose the other area to keep a very close eye on is medical technology. The costs can be astronomical on the introduction of new technology, new procedures, and we would have a requirement that that would need to have some sort of evidence base to it, to show that it is justified, that it meets the reasonable and necessary test, but it is also quite exciting in what may be delivered there over a period of time and we indeed see ourselves continuing to promote research in those areas as being a long-term pay off for the scheme.

The Hon. SCOT MacDONALD: On that work force question, is there a claim going through now, an award claim for that industry?

Mr BOWEN: It all came under a new Fair Work Australia award as of July last year, that took over from three or four state awards that existed. That changed the classifications and some of the conditions around shift allowances and the nature of shifts. We are reasonably comfortable with that because we were paying above the minimum classification already.

The Hon. SCOT MacDONALD: So New South Wales was at the top of the pool?

Mr BOWEN: We were in a comfortable position. At the same time the union lodged a gender equity claim. That has been delayed now twice, I think in both cases, at the request of the union. Unless it is an enormous surprise, we think that the provisioning that we have already allowed for inflation above AWE in our evaluation is sufficient to meet the impact of that gender equity case.

Mr DAVID SHOEBRIDGE: I suppose the longer the delay the more so that is the case, because you have factored it in for a couple of years now, is that right?

Mr BOWEN: We have factored it in for one year. The basis of the claim was for an increase that would have been around about 35 percent over five years. We would normally have

allowed for a cumulative 20 percent over that period. The impact very much depends how much of that is front end loaded and how much of it is spread over the period and until they came down with the decision as to what it is and how it is spread, we do not know.

Mr DAVID SHOEBRIDGE: I fully accept that you are responsible for a pool of public money and you need to make good decisions and careful decisions but there is a tension between getting a perfect decision and a timely decision, particularly for the provision of equipment. The 2010 satisfaction survey scheme of participants repeated the 2009 survey results, saying that issues of delay in approval for equipment and services is one of the participants' primary concerns. What are you doing to monitor those delays and minimise them and to whom do participants direct their inquiries if there is a delay, in order to get them?

Ms LULHAM: We are aware that any decision, whether it be about equipment, whether it be for a $100 piece of equipment or a $25,000 wheelchair, or for a $60,000 community living plan, we make those decisions within 10 days. We have a turnaround within the authority of 10 days and the majority of times we meet that. The delays are actually a delay that the participant perceives because it is a delay from the time they perhaps were assessed by whoever is doing the script for them. They go away, fill in the form, talk to the case manager, go back and then come back to us. The delay from our end, we still only take 10 days but the participant perceives it as being much longer.

We are looking at ways of addressing that. One is to better inform the participant about how long it does take at our end, but also we have been doing work with EnableNSW around scripts for things like wheelchairs and trying to improve the evidence base around those sorts of scripts and we will be rolling that out in a program across New South Wales. It is an interesting one. The delay is sometimes a perceived delay and not a real delay.

Mr DAVID SHOEBRIDGE: Even on your description, the delay is between the need, the observed need and the agreed need and the provision of the service or the equipment. What are you doing to try to reduce the timeframe?

Ms LULHAM: For instance, with equipment we have what we call a discharge equipment list, that people pull off and do that side of things. Things like continence products and scripts we are about to implement an internal process where most of that will be routinely approved, so it does not have to through various delays. In terms of equipment and scripting, if there is not a discharge destination confirmed, we are really trying to encourage people to use hiring of equipment. It gives you more flexibility. It might not be the perfect piece of equipment but at least it is a piece of equipment to get you home while you take the time to script it properly.

Mr DAVID SHOEBRIDGE: I was asking before about contact with long-term participants in the scheme. About a quarter of those participants who were surveyed called for further contact between themselves and the scheme. Given that you are getting that question of demand from your participants, what are you doing to kept in contact with them?

Ms LULHAM: We are looking at our internal processes at the moment. We are looking at a system where participants have to be contacted three monthly, six monthly and annually, so there is a minimum period of contact for any person at some point in time. We are reviewing that at the moment.

Mr DAVID SHOEBRIDGE: I heard the answer from Mr Herd about whether or not it is an appropriate role for the authority to have an advocacy process, but might there not be some consideration for funding that advocacy process to go through and do that contact so they get, if you like, a kind of independent contact at the same time?

Ms LULHAM: It is worth considering. When we started our work on advocacy, I guess our assumption was that we would actually end up funding something around the advocacy area, but the

advice we got back was there was enough advocacy services out there at the moment and that we did not need to do that, but it is something we are happy to keep under review.

Mr DAVID SHOEBRIDGE: Have you asked your participants whether they feel there is enough advocacy out there for them, in your surveys

Ms LULHAM: No, we have not asked that question but we have asked them about the contact and they have mentioned that they would like more contact.

Mr DAVID SHOEBRIDGE: Do you think that maybe asking them that simple question in your survey might be useful in future?

Ms LULHAM: We could put that in next year's survey. We survey annually.

Mr BOWEN: We have certainly built it into our workforce plan for staffing levels to allow for more coordinated contact. I have said that is important. Mr Clarke, you will recall that when we first started we had the concern expressed from the hospitals that they did not want us having early contact with participants. They thought that we were coming in too early, so we probably stepped back a little further than we needed to. It is a matter of finding the right spot that individuals are comfortable with to. Some people who are stabilized in the community are really only happy to hear from us once a year when they might need a new plan approved.

CHAIR: Mr Herd, what would be the one outstanding thing that you would want to see improved in the scheme? Does anything stand out in particular?

Mr HERD: No, nothing does. Here is what I am going to say in answer to that question, forgive me. If I go back to your first comment, if I may, Mr Shoebridge, the Council, appointed by the Minister, as we are, have three clinicians, one executive officer of an advocacy organisation, the chief executive of a service provider, former chief executive of a service providing peak body and we are an advisory body that comes out of the disability community that provides clinical advice to the council members you heard from earlier today in a different capacity, both clinicians and the disability community that supports them, so we have a direct and active engagement with the client base, although from a variety of perspectives and we have now been together mostly, with one or two changes, as a council for, I think, five years and have watched the authority grow and develop from having no clients to now approaching 600 and to become part of the modelling of what I read as recently as Sunday's Sydney Morning Herald, may become a national system for supporting people with disability as earlier as 2013 now, rather than initially 2017, so things in this space are moving rather more quickly than any of us might have imagined. In the course of that development we have given the advice that we can from our variety of perspectives to a scheme that I think is generally regarded as being perhaps the leading scheme of its type in the country, a model that is looked at overseas.

I say this with some degree of independence from the authority but respect for it. I hope you will believe that I mean this when I say it, but I have no reason to say it other than because I think it is true, it is staffed by a bunch of professionals who are doing a quite remarkably good job and it is, of course, right that we should be held to account and examined for what the authority does and how it does it to make sure that for the end users it can be the best system in place possible.

I think the Parliament of New South Wales that set it up and the agencies that put it in place and the professionals that manage it can be satisfied that this is about as good as a scheme of this type gets to be, and so in that context it is very difficult for me to pick out one thing that one would say one wished to see improved, developed or come out of it, because I think we have got a very good scheme and that is down to the staff that manage it, I have to say.

If I can prolong this answer even more, forgive me, there is also a perverse kind of indicator

about whether or not it is working and this is me when I put my glass half full hat on, if that is not mixing a metaphor which is, I speak as someone with a spinal cord injury 27 years in the chair, although I did not acquire it in a motor vehicle accident. I regard my life as being of good high quality because I almost never go back to the service system to ask for support, because I am supported independently to live in the community and I am getting on with my life and not going back to the authority is a sign of success. Not being constantly on the phone saying where is it, when is it coming, is a sign of success. Not hearing from 90 percent of the clients most of the time is a sign of success.

What I would like to hear or like to see, as we know because we can protect the numbers with tragic precision, sadly, is that as the numbers go from 500 to a thousand to 10,000 people over the next few years, we will hear just as little from those end users as we currently hear from them. We will not have people in crisis as we have had in the previous main stream disability services because we have an adequately resourced, well organised system that takes people from discharge to the community and then lets them get on with their life.

That is what I hope the authority will succeed in doing and, as I say, biased as I may be because I have been involved with it marginally since the beginning, I this we have with the New South Wales Lifetime Care and Support Authority an authority that is doing the job that Parliament set it and it is doing it very well and the proof of that pudding is the Commonwealth is picking it up and taking it as a model for what might happen in the future.

Satisfied customers is, I think, the sign that we are looking for, to be honest.

Mr DAVID SHOEBRIDGE: The Children's Hospital at Westmead were particularly concerned about the potential second guessing of their clinical decisions. They showed a willingness to sit down and speak with the authority about it. Is that a willingness that you share, that you would be willing to sit down and meet with them to talk about those concerns?

Mr BOWEN: It is absolutely appropriate for people to come along to the Parliamentary Committee and raise these issues, but in all of the cases where these issues have been raised we have standing meetings with all of the clinicians you have heard from and all of the hospitals you have heard from. We have regular meetings with the Children's Hospital to thrash through issues. I would have thought that most of the matters they have raised we have been in the process of addressing. Ms Lulham is involved in those detailed discussions. She might like to add to that.

Ms LULHAM: We certainly meet very regularly with the brain and spinal units. For the last 12 months we have been trying to meet regularly with the Sydney Children's Hospital, I think quarterly, and we are more than willing to keep doing that. I guess it is worth noting that they did cancel their last meeting with us so they could actually write their submission to the Law and Justice Committee, but we really do want to keep working with them.

Mr DAVID SHOEBRIDGE: They mentioned the establishment of a protocol about communications with clients. Would that be something that would interest you?

Ms LULHAM: I think that would be an excellent idea.

Mr DAVID SHOEBRIDGE: In relation to the establishment of forms and documentation, I have heard all of your answers here and they have been thorough and considered but, on the whole, defensive about your current system in place and your current forms and requirements for information. I am concerned about a willingness to go back and review the level of documentation, the amount of time clinicians are spending. I have not heard that willingness come from you, yet it has been a repeated element in the submissions. Can you give me some ease about what you are considering doing in terms of that documentation, or whether you believe you have got to that perfected state.

Mr BOWEN: We are extremely open to altering both the approvals and the payment arrangements. The one that would be the most administratively convenient for us would be to make a bulk payment to NSW Health for all of the rehab and discharge services and leave it to them, but I do not suspect that you are going to hear very strong clinician support for that type of arrangement, simply because lifetime care is paying, as I mentioned previously, well above what the other public hospital patients are getting in the nearby beds.

Having said that, we are probably working with the continuation of the current system, streamlining it. We will have more and more on-line applications. We are setting our system up to be able to receive that next year.

Ms LULHAM: Depending on the technology.

Mr BOWEN: We have a work project for that to be done. We will probably have to assist the units to set up to do that. I hate to give you the impression that we are making this more complex than it needs to be. At this point in time a whole lot of the services that a person is getting out of a spinal unit, out of a brain injury unit, while they are individualised they are individualised within a fairly common range of parameters and they should be conducive to using well-established precedents that just need a little bit of additional comment to them. It does seem to be a particular failing that everything gets re-invented on every individual case and then you get the complaint about too much paperwork. We do not demand that. We are quite happy to say for a person with this level of lesion and this score in a spinal unit this is the package that they will get, plus they might need these little bits and here is the justification for the bits extra. That is really all we are asking for.

Mr DAVID SHOEBRIDGE: Have you developed that documentation or have you a process in place to develop that documentation?

Ms LULHAM: We certainly have our spinal cord guidelines and if what people are asking for is in relation to those guidelines we ask for very little else. I take your point. We are prepared to continue to have discussions with them to streamline things as much as we can. However, we also have requirements imposed on us about having to justify the expenditure of money, so it is a system that we have to work out to meet all our needs.

Mr BOWEN: Mr Shoebridge, could I make a little further comment? It might also answer your question, Mr Clarke, from my perspective. One of our concerns has been with in fact the limited nature of rehab. Rehab has very much been constrained by the system it grew out of, which was cost contained and all about getting someone medically fit for discharge. We initiated a major project late last year, looking at models of care for neurological injury and 99 percent of people in this scheme have a brain or spinal injury, so it is a common neurological injury.

To try to refocus rehab space away from just getting someone fit for discharge, to giving them the skills that they need to be able to live as independently as possible within the community, we had excellent cooperation from the clinicians through that process. We had our first round of meetings in January, which is a terrible time, as you know, to hold meetings. All of the senior clinicians made themselves available. We had that from pre-hospital, through the acute care, through the rehab, through to back in the community process, and they all recognised that what they do has to be measured not by how well the person is when they hand them over to the next practitioner, but how well the person is capable of functioning within the community.

Rather than being limited in how we view rehab, we would be quite happy to have a much more expansive rehabilitation system because our investment in that, putting extra dollars into that means that a person copes better in the community and their long term care needs are significantly less, so we get a pay off. We get an enormous social benefit for the participants as well. We are continuing to progress those discussions at the moment and hopefully we will get something out of

that which is able to say here is a real gold class standard that is very different to the current medical model.

CHAIR: The Committee is considering whether the review of the authority should be conducted on a biennial basis. Do you have a view on that?

Mr BOWEN: I think we said in response to the question we are happy to come along every second year but I think it has been put to you over these hearings that there are enough matters going on at the moment. The scheme will continue to improve. The numbers are not going to change dramatically. The services might change a little bit but the operating environment is changing quite a lot. That is your call. We are more than happy to come along whenever it is of assistance to you.

CHAIR: There may be further questions which arise from what we have heard today and we would be very grateful if there are such questions you could answer them and we certainly would be very appreciative if you could get answers to us within 21 days from the time that you receive any such questions if indeed there are any.

(The witnesses withdrew)

The Committee adjourned at 4.47 p.m.