REPORT ON PROCEEDINGS BEFORE

STANDING COMMITTEE ON LAW AND JUSTICE

THE FIRST REVIEW OF THE DUST DISEASES AND LIFETIME CARE AND SUPPORT SCHEMES

At Macquarie Room, Parliament House, Sydney on Wednesday, 28 June 2017

The Committee met at 9:00 am

PRESENT

The Hon. Shayne Mallard (Chair)

The Hon. David Clarke
The Hon. Trevor Khan
The Hon. Daniel Mookhey
Mr David Shoebridge
The Hon. Lynda Voltz

The CHAIR: Welcome to the first review of the Dust Diseases and Lifetime Care and Support schemes. This is the second hearing of the Law and Justice Committee's first review of the scheme. Before I commence I acknowledge the Gadigal people, who are the traditional custodians of this land on which we meet. I pay respect to the elders past and present of the Eora nation and extend that respect to other Aboriginal people present or participating in the hearing. Today is the final hearing the Committee plans to hold for this review. The Committee will hear from the Law Society of New South Wales, the Thoracic Society of Australia and New Zealand, the Bernie Banton Foundation, Maurice Blackburn Lawyers, the State Insurance Regulatory Authority [SIRA] and the National Disability Insurance Agency.

Before we commence I will make some brief comments about the procedures for today's hearing. Today's hearing is open to the public and is broadcast live via the Parliament's website. A transcript of today's hearing will be placed on the Committee's website when it becomes available. In accordance with the broadcasting guidelines, while members of the media may film or record Committee members and witnesses, people in the public gallery should not be the primary focus of any filming or photography. I remind media representatives that they must take responsibility for what they publish about the Committee's proceedings.

It is important to remember that parliamentary privilege does not apply to what witnesses may say outside of their evidence at the hearing. I urge witnesses to be careful about any comments they may make to the media or others after you complete your evidence as such comments will not be protected by parliamentary privilege if another person decides to take an action for defamation. The guidelines for broadcast of proceedings are available from the secretariat.

There may be some questions that a witness could only answer if they had more time or with certain documents to hand. In these circumstances witnesses are advised that they can take the questions on notice and provide an answer within 21 days. I remind everyone here today that Committee hearings are not intended to provide a forum for people to make adverse reflections about others under the protection of parliamentary privilege. I therefore request that witnesses focus on the issues raised by the inquiry's terms of reference and avoid naming individuals unnecessarily.

Witnesses are advised that any messages should be delivered to Committee members through the Committee staff. To aid with the audibility of this hearing I remind both Committee members and witnesses to speak into the microphones. In addition, several seats have been reserved near the loud speakers for persons in the public gallery with hearing difficulties. I remind everyone to turn their mobile phones on to silent for the duration of the hearing.

TIM CONCANNON, Partner, Carroll and O'Dea, appearing for the Law Society of NSW, sworn and examined

DAVID ANDERSEN, Partner, HWL Ebsworth, appearing for the Law Society of NSW, affirmed and examined

The CHAIR: I welcome our first witnesses from the Law Society of New South Wales. Would you like to make a brief opening statement?

Mr CONCANNON: I will say something about the Lifetime Care aspect of it. I am here solely for that aspect of the inquiry and Mr Andersen is here with regard to the dust part of it. On behalf of the Law Society of NSW I welcome this opportunity to give evidence at the Standing Committee's first review into the functioning of the Lifetime Care and Support Scheme. The society continues to support the scheme and its stated purpose of providing lifetime medical treatment and care for those catastrophically injured in motor accidents in New South Wales on a no-fault basis. For the most part the society also supports the efforts of the Lifetime Care and Support Authority in administering the scheme in an efficient and accessible way. In particular, the society applauds the recent extension of self-management options to those long-term members of the scheme who are capable of wholly or partly administering their own treatment and care needs. This restores some measure of autonomy to those rendered wholly or partly dependent on others, often through no fault of their own.

The society does still have some lingering concerns in two areas. First, the appeal mechanisms for questions of eligibility to the scheme and for assessment of whether treatment or care is considered reasonable or necessary are embedded in the authority itself. There is no independent means of testing these decisions that is accessible to the average participant. A Supreme Court summons is not a viable option for the impecunious participant who faces an adverse costs order if the summons is unsuccessful. The society has no particular issue with the decision making of the authority at the moment, but that is not the point. The point is that in the future there is a risk that an organisation which is not subject to external scrutiny will fail to adjust to community expectations.

Secondly, there have been two recent Supreme Court or Court of Appeal challenges by insurers relevant to scheme eligibility. One of those is *Insurance Australia Limited trading as NRMA v Milton* [2016], another is *Nominal Defendant v Adilzada* [2016], both decisions of the Court of Appeal. These decisions do cause me to question whether the right of insurers to lodge applications for an injured person's entry into the scheme should be limited in some way in terms of time or the number of applications. Regrettably, there have been a number of cases where the insurer has lodged the application two to three years down the track and thus delayed the finalisation of the associated common law claim for damages.

There is a real incentive for insurers to lodge such applications as a successful application will transfer the liability from the insurer to the scheme itself, which is funded by the Lifetime Care and Support Levy. This can lead to the perverse situation where an insurer will seek to argue that the claimant's injuries are severe in order to comply with the eligibility guidelines under the scheme and the claimant, who might often prefer the autonomy of a once and for all settlement to ongoing medical coverage, seeks to argue that the injuries are not that severe. One such case was the Supreme Court decision of *Cruse v Review Panel Established under the Motor Vehicle (Lifetime Care & Support) Act 2006 [2012]*.

Another option to reduce the incentive for the insurer to lodge such applications would be to require the third party insurer to continue to make some contribution towards the participant's treatment and care needs which would then offset the current amount of the Lifetime Care and Support Levy. This contribution could then be capitalised at the end of a five year period, let us say, and transferred to the Lifetime Care and Support Authority consistent with the latest changes to third party legislation. That is all I would like to say with respect to Lifetime Care.

The CHAIR: Mr Andersen, do you have an opening statement?

Mr ANDERSEN: Likewise, I thank the Committee for the opportunity to speak on behalf of the law society and I am happy to answer any questions you have. This can be kept similarly brief. In short, the feedback is that since the creation of the Dust Diseases Authority in management of statutory claims for dust diseases in September 2015 and the takeover of functions by Insurance & Care NSW [icare] that the process has sped up markedly and that there is customer satisfaction in relation to the services on the ground. I really only want to raise one particular issue. That is, a number of submissions seek an expansion of the definition of "dust disease".

As currently drafted, the definitions are set out on page 3 of Maurice Blackburn's submissions. As it presently operates, to be eligible for compensation under the 1942 Dust Diseases Act a worker must have one of the scheduled diseases or be exposed to dust capable of causing one of those scheduled diseases. The definition under the Dust Diseases Tribunal Act is a bit broader and has a catch-all provision that if the dust causes any condition of the lungs—peritoneum or pleura—the tribunal has jurisdiction. The submission seeks to marry them up and adopt the Dust Diseases Tribunal Act definition. All I want to say about that is, of course it is a matter for Government but it can have the consequence that it will expand common law liability. Most significantly, claims under section 15B of the Civil Liability Act 2002.

In its response to questions on notice, icare referred to the need to look at funding issues at responses five and six. I am not giving a view advocating one way or the other; ultimately it is a matter for Government. But you should be aware that if you change the definition of dust disease so as to expand the range of diseases that would attract compensation under the 1942 Act, it could well have the consequence that there will be expanded liability for common law claims, particularly, as I said, section 15B of the Civil Liability Act. One aspect that the submissions do not refer to is that if you have a disease caused by dust but you do not qualify under the 1942 Act, of course you have your statutory rights under the Workers Compensation Act 1987. That is all I want to say by way of opening.

The CHAIR: Thank you. I noted on page 2 of your submission you talked about the need for a distinction between malignant and non-malignant claims with respect to access to the tribunal. Can you explain the circumstances and why you think that should be revisited?

Mr ANDERSEN: I am sorry, I should have covered that off at the beginning. At the time I assisted the Law Society with the drafting of these submissions I was under the impression it was to look at the common law and statutory aspects. As I now understand the terms of reference, it appears to be restricted to statutory aspects so those submissions may be outside your terms of reference. I am happy to answer your question.

Mr DAVID SHOEBRIDGE: I find it remarkable that you reference a 2008 decision, the Dawson case. We are now in 2017 and it seems to me that what is an obvious procedural problem still has not been remedied. Is that the situation?

Mr ANDERSEN: That is correct. I am a member of the Dust Diseases Tribunal Rules Committee and we have had discussions about amending the Dust Diseases Tribunal Regulation 2013. It has been amended a number of times.

Mr DAVID SHOEBRIDGE: Where have those nine years of discussion taken you?

Mr ANDERSEN: I have only recently become a member. I do not know what representations have been made.

The Hon. LYNDA VOLTZ: There certainly have been no changes?

Mr ANDERSEN: Correct.

Mr DAVID SHOEBRIDGE: Can you identify in a paragraph what the appropriate change would be? You have identified the problem. What is the remedy for it?

Mr ANDERSEN: That when you have a malignant claim, the matter should be referred to directions within seven days of the filing of a statement of claim. That is to say, directions before a judge of the tribunal and then it is at that time orders can be made to clarify just how urgent the plaintiff's condition is, and, if necessary, not have them subjected to what I might call a paper-driven process, which takes about three months leading to a compulsory mediation. What sometimes happens is that it is very difficult for plaintiff solicitors in a busy practice to keep track day by day how urgent a plaintiff's condition is getting and how they might be deteriorating with their condition. When they get a doctor's report saying the prognosis is very, very short, then they can come to the tribunal and take the matter out.

That is what I might call a reactive process rather than a proactive process. If it is put before the judge immediately, that kind of difficulty can be avoided where a plaintiff suddenly deteriorates to a point where he or she cannot usefully give evidence—they are too ill or they pass away suddenly. Particularly in mesothelioma claims, a person can appear reasonably well one day and be deceased very soon thereafter with little or no notice. It would be a win-win in a sense; the plaintiff being well enough to give oral evidence at the outset and then the matter case managed. It is good for the plaintiff's case, but it is also good for defendants because they get an opportunity to ask a plaintiff questions when he or she is well enough which might assist in contribution claims against other tortfeasors.

The Hon. TREVOR KHAN: I am not against you on the proposition you put forward, but are you saying that, in a sense, all malignant claims would be fast-tracked irrespective of the gravity of the condition?

Mr ANDERSEN: Fast-tracked in the sense that it gets immediately before a judge, orders can be made to clarify the medical situation and then if it is not sufficiently urgent, put back in that paper-driven process, always with liberty to come back if something happens. But perhaps to take the plaintiff's evidence so that it is on the record and all parties have the benefit of that oral evidence straightaway.

Mr DAVID SHOEBRIDGE: What you are saying is that it should get immediate judicial attention so if that is the appropriate thing to be done, that is what the judge should determine?

Mr ANDERSEN: Correct.

Mr DAVID SHOEBRIDGE: The tribunal is a competent tribunal and when you talk to practitioners, they say they understand the nature of their jurisdiction and the nature of the diseases they are dealing with. Why is there resistance in the tribunal for doing this? I would have thought if it is as you have set it out and given the nature of the tribunal, they would have been—

The Hon. TREVOR KHAN: Because the regulation does not give them the opportunity of doing this.

Mr ANDERSEN: That is correct. It is not reluctance. In fact you will see the quote from Judge Kearns. He is very eager for that to occur. As I say, it can be a win-win. One of the other difficulties you should be aware of is that under the regulation the plaintiff solicitors have to prepare what is called a form one. It is a detailed question and answer of matters relating to liability, that is their exposure history and quantum. What one could do is modify those requirements and get the plaintiff's exposure history. One can always deal with matters of quantum later, but as long as you get the factual history that assists the plaintiff getting it on the record and defendants knowing about the case and investigating a matter.

The Hon. TREVOR KHAN: Are you talking about the issue you raised at about point 6 on page 2?

Mr ANDERSEN: Yes. What is occurring now is that the nature of the claims has changed from heavy factory day in, day out exposures where liability is quite clear. We are now getting what I might call one-off exposures. You might have heard of washer women cases. They are fairly well established now, as a matter of fact, but we are getting exposure cases where it is more nebulous exposure, unusual factual circumstances that a defendant has never faced before. So if time is ticking away while the claimant is completing the form one, the defendant is oblivious about the case until the last moment. As Judge Kearns said, it is much better if the defendant gets a heads up straightaway that this case is coming and this is what it is about, and if there are unusual allegations at least the defendant is on notice.

The Hon. TREVOR KHAN: Is the heads up filing the statement of claim?

Mr ANDERSEN: Correct. So that issue with the form one can be hived off and dealt with by the judge.

The Hon. DAVID CLARKE: Did I understand you in your opening comments to say that your committee had made recommendations prior to the time you went onto the committee?

Mr ANDERSEN: No, not that I am aware of. I am not sure.

The Hon. DAVID CLARKE: On this general issue?

Mr ANDERSEN: I am not sure.

Mr DAVID SHOEBRIDGE: It was brought to my attention about two months ago or maybe less that there is a statutory corporation that manages a variety of claims from insolvent former workers compensation insurers which sometimes include common law liability for those policies, but there was a radical change in management of that corporation at the direction of State Insurance Regulatory Authority [SIRA]. The management team that had been there for the better part of three decades was removed and a new management team was brought in. There was concern about the loss of corporate knowledge in what is often extremely detailed investigations to find who has cover and the terms of that cover. Has anything to that effect come across either of your desks, probably more you, Mr Andersen, given that we are going back in time in a lot of these dust disease claims?

Mr ANDERSEN: I am not aware of that occurring but as a general proposition both in the government sphere and the private sphere when there are mergers or takeovers of corporations that is an issue.

Mr CONCANNON: I was aware that Corporate Management Services, who are the former organisation that took on that role, have disbanded. I cannot say I am aware of the new organisation but I can confirm that the people who you dealt with at Corporate Management Services had been within the workers compensation system for 30 or 40 years and had, I agree with you, a very extensive knowledge of insurance over that period. If that knowledge has been lost it is very unfortunate. For instance, it is my knowledge that WorkCover, now SIRA, only had insurance records from 1987 onwards. If they had some independent knowledge and that has been lost then that is particularly unfortunate.

The CHAIR: What quantum of people are going through the process you described with malignant diagnoses? One is too many, but is it one a month or something different in your experience?

Mr ANDERSEN: It is very difficult to answer because I only act for certain defendants. I think I would be speculating. But because we are dealing with these more nebulous exposures they tend to only result in a malignancy. Such slight exposures do not usually give rise to a non-malignant disease, so as a proportion I suspect it is increasing.

Mr DAVID SHOEBRIDGE: We have had submissions from the Thoracic Society of Australia and New Zealand, who are very clear that they want to expand the compensated occupational lung disorders to include occupational asthma, occupational chronic obstructive pulmonary disease [COPD], occupational lung cancers, dust-induced occupational pulmonary fibroses and occupational pneumonias, amongst others. As a matter of basic fairness it does seem odd that we are stuck with a 1940s list when medical knowledge and social understanding has come a long way since then. As a matter of basic fairness, is the schedule 1 list relevant now?

Mr ANDERSEN: Undoubtedly the science has progressed but, as I said in my opening, if you do not fall under the 1942 Act you get benefits under the Workers Compensation Act 1987 or its predecessor, the 1926 Act.

Mr DAVID SHOEBRIDGE: Few people are leaping into the 1987 amended Workers Compensation Act as their favourite place to go for compensation. The 1942 provisions are more generous for most people.

Mr ANDERSEN: I have not done a line by line comparison. That may well be so. But, as I said, if you are going to go down that path obviously the funding requirements need to be considered and also what I alluded to about common law liability. That could give rise in particular to that head of damage I referred to, section 15B of the Civil Liability Act.

Mr DAVID SHOEBRIDGE: That is attendant care, is it?

Mr ANDERSEN: It is an extension of it, if I can put it that way. That is to compensate a plaintiff who because of his or her dust disease is unable to look after a disabled member of the household. It is quite common in asbestos claims when the plaintiff is elderly and you have got the classic case of the husband with mesothelioma and a wife with arthritis and other medical condition. Because he can no longer look after her that is to be compensated at commercial rates. That can become quite a large head of damage in those cases and if they are looking after grandchildren. I think that was in the case of Justice Kearns that we have referred to. It could give rise to quite a large head of damage if common law proceedings are taken pursuant to an expanded definition of dust diseases. At the moment, because they fall under the 1987 Act, if they want to sue at common law there is no section 15B and, as you probably know, it is quite restrictive.

Mr DAVID SHOEBRIDGE: There is a narrow definition of economic loss.

Mr ANDERSEN: That is right. That is all you get compensated for at a common law damages action. If you are going to change the definition, as I think icare pointed out in its answers to questions on notice, you need to become fully acquainted with the epidemiology and become clear on what might be coming. No-one has mentioned this expanded common law liability and where the funding might come from for that.

Mr DAVID SHOEBRIDGE: Currently, under policies that have been written to date, if we expand the definition going forward the funding would come from the pool of funds set aside under past policies. Where would the cost pressure turn up if we went down the path of expanding the definition? Who would ultimately be paying for that?

Mr ANDERSEN: I think it is under section 6 of the 1942 Act. I think SIRA has the power to levy and the funds can also be provided by Parliament.

Mr DAVID SHOEBRIDGE: SIRA told us that that scheme has in the order of approximately $1 billion sitting in a surplus fund. I do not think they quite described it as a surplus fund, but there was something in the order of $1 billion sitting aside and then there is an annual levy to meet the ongoing actual costs of the scheme. It would seem there is an opportunity at least to consider expanding it in those circumstances?

The Hon. TREVOR KHAN: It is not lollies you are handing out. One would think that one would have to do some sort of assessment of the cost.

Mr DAVID SHOEBRIDGE: I am not suggesting otherwise, but if we were to go down that path it would require actuarial advice and a recommendation that actuarial advice be obtained and perhaps tabled and referred back to this Committee and stakeholders so as we could understand the costs of it. Is that where you are going, Mr Andersen?

Mr ANDERSEN: Precisely. It would have to be drilled into, so to speak. As you said, the premiums collected in dim, dark past days just do not match the liabilities of today. For example, a head of damage at 15B was not a creature of the law at the time those premiums were collected.

Mr DAVID SHOEBRIDGE: The statutory benefits are paid through annual levies so it is not a long tail scheme in that regard. The statutory benefits are paid, as I understand it, through annual levies to meet the annual costs. But I am asking about the common law. Where are the funds for common law benefits?

Mr ANDERSEN: I think you are probably right, it is from past premiums collected. As I say, at the time they were collected there was no section 15B.

Mr DAVID SHOEBRIDGE: But, on the contrary, at the time they were collected the very narrow definition of damages that is now in the 1887 Act was not there either. There was a far greater scope of general common law benefits; there was not just the work injury damages definition. It is a bit of swings and roundabouts, is it not?

Mr ANDERSEN: Under the 1942 Act I can tell you that as at 1967 the definition was even slightly more restricted than today. In the 1942 Act, the definition said "dust causing a scheduled disease or some other disease actually accompanied by a scheduled disease". Today's definition says "a scheduled disease or another exposure to dust that may cause a scheduled disease".

Mr DAVID SHOEBRIDGE: I think we are talking mildly at cross-purposes, and it is probably my fault. What I was saying was, before the changes that were made to work injury damages about 10 years ago in New South Wales, the premiums that were collected for common law claims were to meet more than just the narrow definition of future economic loss. They were also to meet the other heads of damages—gratuitous care, ongoing medical expenses and the variety of other damages. The fact that we would be asking prior policies to meet the 15B liability—it is not fair to compare that to the narrow definition of work injury damages, because at the time they were writing those policies the damages they were covering at common law were far greater than the narrow definition of work injury damages. Sorry, that is a complicated question. Do you understand the point, Mr Andersen?

Mr ANDERSEN: I do, and you may well be right. I had not considered that. That should be factored in, as it were.

Mr CONCANNON: However, having said that I would have said that section 15B damages, which used to be known as Sullivan and Gordon damages based on the High Court decision and what used to be called Griffiths and Kerkemeyer damages which are now reflected in, for instance, section 141B of the Motor Accidents Compensation Act have been far more readily awarded over recent years than they were in those days. I do not know what the age of Griffiths and Kerkemeyer was, but I think it was in the 1960s.

Mr ANDERSEN: It was 1977.

Mr CONCANNON: Yes.

The CHAIR: Mr Concannon, in your submission and in your opening statement you mention appeals to the Supreme Court and suggest an alternative mechanism. Could you outline what you are suggesting in that regard?

Mr CONCANNON: I am not sure there is at the moment an independent mechanism that is available. That is the real difficulty, I suppose. The only one that theoretically is out there could be the NSW Civil and Administrative Tribunal [NCAT], where there is no exposure to damages to an adverse costs order if the claimant loses. If that sort of dispute was to be referred to NCAT then I would have thought you would need a very specialised branch of that tribunal. I am not sure of the capacity of NCAT to provide that sort of specialty with the appropriate tribunal members to cover that sort of issue.

The CHAIR: But you are suggesting a body along those lines.

Mr CONCANNON: Yes—something where you are not faced with a potential adverse costs order if you lose. In most cases we are not talking about huge sums of money, so the prospect of a $50,000 adverse costs order for a claimant who wants another prosthetic, let's say, and the authority disagrees with it, is just not feasible.

Mr DAVID SHOEBRIDGE: You would almost think—whether it is lifetime care and support, CTP or workers compensation—that for all these statutory schemes we kind of need a standalone statutory tribunal or a division of NCAT that has the kind of expertise to deal with these miscellany of rats and mice and serious claims that turn up in these schemes.

Mr CONCANNON: I think that is probably right.

The Hon. LYNDA VOLTZ: Mr Andersen, given that you practice in this area, the reforms were meant to simplify and make the process more streamlined, but I am hearing reports that it is actually making it harder. Yesterday some hearings were being held and it was pretty chaotic in the courts. How are you finding the changes?

The Hon. TREVOR KHAN: What are we talking about?

The Hon. LYNDA VOLTZ: The Dust Diseases Board with the dust diseases hearings.

The CHAIR: You are referring to the restructure.

The Hon. LYNDA VOLTZ: Yes.

Mr DAVID SHOEBRIDGE: The board or the tribunal?

The Hon. LYNDA VOLTZ: The board.

Mr ANDERSEN: The board?

The Hon. LYNDA VOLTZ: Sorry. With the changes to the Act and the streamlining in the 2015 changes, it was meant to clarify it and make it simpler. The complaints I am getting from lawyers are that it is actually slowing the process down a lot. Are you finding that it is harder since those changes have come in and that it is less streamlined or that it is actually more streamlined? The changes that have been coming in are meant to make it simpler. I am hearing that it is actually making it harder.

Mr ANDERSEN: Because I only act for defendants I am not au fait with those practical difficulties but what I can say from reading the Bernie Banton submission, for example, is that in fact the response times have been very quick. I think there are some teething problems in trying to make the forms easier and icare is redesigning that, but basically the feedback on the ground—

The Hon. LYNDA VOLTZ: On the whole it is quicker.

Mr ANDERSEN: Yes. And icare has put out fairly precise statistics about a very significant increase in speed in approving, managing and dealing with applications and also giving the services on the ground, as it were, out there. But as I say, I am only going off the submissions. I do not have direct experience of that.

The CHAIR: Thank you for that.

Mr DAVID SHOEBRIDGE: Mr Concannon, we had a series of submissions which raised concerns about insurers having repeated goes to try to put a claimant into the Lifetime Care and Support Scheme because of their financial interests. Do you see that in practice?

Mr CONCANNON: I do on a regular basis. As I said in my opening address, the real issue is particularly when it happens two to three years down the track and therefore has a significant delaying effect on the associated common law claim. If you look at a number of those cases that I referred to in the opening addresses, the matter of Cruse I think was an original application by the claimant that was then rejected in terms of participation in the scheme and then the insurer had a couple of goes. So regrettably I think there has to be some cap on the number of goes you can have, particularly I would have thought on the part of the insurer, particularly if there is a financial incentive for them to transfer the liability to the scheme.

Mr DAVID SHOEBRIDGE: I suppose that is what I am getting to. What is the reasonable cap? Should they have one unlimited go and then only an additional go if there is some kind of exceptional change in circumstances? What is the kind of limitation you would be recommending or do you want to take that on notice?

Mr CONCANNON: I think I would have to take that on notice because it is probably a policy decision on the part of the Law Society as to which way we would recommend that.

Mr DAVID SHOEBRIDGE: If you are taking that on notice, the concern—

The Hon. TREVOR KHAN: I am not being critical, but you came here identifying the problem of these repeated claims. Does the Law Society have any position as to how you address the repeated claims?

Mr CONCANNON: I think I said in the addresses a few ideas that I had personally with regard to it. I personally think that any application beyond, let's say, two years after the accident would have some issues attached to it and would have to have very special circumstances. I would have thought something along the lines of what Mr Shoebridge has said about having to seek leave for a second application would be a reasonable idea. And I think the third idea I outlined in the addresses was perhaps creating a system where the insurer continued to have some skin in the game, so to speak, in terms of ongoing liability, perhaps on a proportionate basis and perhaps on the basis that at the end of five years whatever liability there is can potentially be sold on to Lifetime Care consistent with the new scheme in third party. That is a little bit out there, I suppose. But in terms of disincentivising that behaviour on the part of the insurers, that is an idea that came into my head.

Mr DAVID SHOEBRIDGE: So where it is a close call, you could have an arrangement whereby the insurer and the scheme could say, "Why don't we agree on an 80:20 funding mix and resolve it?" as opposed to having this black-and-white—

Mr CONCANNON: Yes. You can understand why the insurers are making the applications. There is a lot of money involved there. If you disincentivise that behaviour then I think it is a positive thing.

The Hon. DANIEL MOOKHEY: Do you have a view—or is this awfully naïve—

The Hon. TREVOR KHAN: Never on your part.

The Hon. DANIEL MOOKHEY: Certainly not. Do you have a view that perhaps the automatic transfer after five years in the CTP scheme at least in that period between two years and five years is likely to provide a bit of a disincentive on repeated claims or if an insurer knows that within a couple of years they will be transferring anyway? Or do you have a view that the magnitude of financial difference is still significant enough for an insurer to want to pursue?

Mr CONCANNON: I do not think there should be an automatic transfer after five years. I think I did say in the addresses that it can then be capitalised at the end of five years. So there would be a reduced financial incentive for them to transfer it to the scheme. There would still be some incentive, of course, but nowhere near as much as would otherwise be the case.

The Hon. DANIEL MOOKHEY: I was making reference to the change to the compulsory third party [CTP] provision, which you would accept is not within the realms of this inquiry—

Mr CONCANNON: Yes.

The Hon. DANIEL MOOKHEY: —but in terms of whether or not it is significant enough as a liability for the Lifetime Care and Support Scheme. Do you think that is going to have a positive or negative effect or no effect whatsoever?

Mr CONCANNON: I could not speculate. That is a tough one; it is probably one for actuaries to look at rather than myself. I would have thought that it is potentially creating a very long tail for a scheme that is going to be left with the authority or government rather than the private insurers, and I would have thought that is a very dangerous thing for the third party scheme in the long run. But I am not the actuary who has done those calculations to work-out whether that is financially viable or not.

Mr DAVID SHOEBRIDGE: I bring you back to the concern that you have raised about repeated applications by insurers. You are not the only person to have raised that theme. Indeed, it has been a common theme in a number of submissions. If you provide a ready avenue to resolve that—in the Supreme Court, which is expensive, cumbersome and slow—and you actually put it in an administrative tribunal, those two things may work against each other.

Mr CONCANNON: That is probably right, I think.

Mr DAVID SHOEBRIDGE: They would have to come together—a recommendation for a better venue to resolve it, together with some kind of statutory restraint on the number of applications and the circumstances in which applications can be made—would they not?

Mr CONCANNON: Absolutely.

The CHAIR: You have 21 days to respond to any questions taken on notice. The Committee may also have further questions. Thank you for the evidence you have given in this review this morning.

(The witnesses withdrew)

SUSAN MILES, Respiratory and Sleep Physician, NSW Occupational and Environmental Lung Disease Special Interest Group, Thoracic Society of Australia and New Zealand, sworn and examined

ANTHONY JOHNSON, Respiratory and Sleep Physician, NSW Occupational and Environmental Lung Disease Special Interest Group, Thoracic Society of Australia and New Zealand, sworn and examined

ROD SMITH, Awareness and Support Coordinator, Bernie Banton Foundation and member of the Dust Diseases Board, sworn and examined

The CHAIR: Would all or any of you like to make a brief opening statement?

Dr MILES: The New South Wales branch of the Occupational and Environmental Lung Disease Special Interest Group of the Thoracic Society of Australia and New Zealand welcomes the opportunity to make a submission regarding the Dust Diseases and Lifetime Care and Support schemes. The Thoracic Society of Australia and New Zealand is the only peak body in Australia that represents all health professionals working in all fields of respiratory health. We believe that occupational lung disease is significantly under recognised in New South Wales and that resources need to be directed towards early diagnosis of these disorders and towards optimal management. The term "pneumoconiosis" refers to a group of lung diseases caused by the inhalation and retention of dust in the lungs. The Dust Diseases Authority, also known as icare dust diseases care, currently has a list of 13 compensable lung diseases. The most common of these are asbestosis, asbestos-related pleural disease, and silicosis. It does not include coal workers' pneumoconiosis, which is appropriately at this time supervised by a separate organisation, and it is a source of considerable concern to us that this has re-emerged in Queensland.

Although other diseases maybe compensated under the current legislation, it does not appear that they are actually compensated in practice. There is no data regarding the incidence and prevalence of occupational lung disease in Australia; therefore, it is impossible to know how many of these cases are left undiagnosed. The Thoracic Society special interest group notes that the Dust Diseases Authority is now somewhat dated and that 95 per cent of the claims processed are related to asbestos exposure. The Thoracic Society special interest group also points out that current legislation limits compensation in several diseases well established to be associated with dust inhalation. These include occupational asthma, including reactive airways, dysfunction and occupationally exacerbated asthma, as well as occupational lung cancers, including those related to causes other than asbestos such as arsenic and silica, dust and juice pulmonary fibrosis, chronic obstructive pulmonary disease due to dust, fume and mist exposure, and pneumonia related to occupational exposures. These disorders are successfully identified and compensated in other countries, particularly in Europe and Canada.

In terms of administrative issues—that is, the diagnosis and assessment of disablement—the medical process for the award of disablement, as well as the assessment of disablement, is not always accessible to either the applicants or their caring doctors. The special interest group calls for greater transparency regarding the exact criteria used for diagnosis and assessment of disablement. We recommend that the Dust Diseases Authority openly conforms to current international guidelines both for the diagnosis and assessment of disablement. The American Medical Association's guidelines on permanent impairment, edition 5, would be the most authoritative of these. We also not that there is no formal process for decision-making. This can result in legal action with associated long delays entailing considerable cost and distress for applicants. Where a difference of opinion has arisen on a medical matter, this would be best resolved by a medical appeals process involving independent medical experts.

The Thoracic Society special interest group therefore recommends that the Dust Diseases Authority should review the current standards for diagnosis of occupationally related lung diseases in New South Wales, as well as the disablement assessment and develop a process whereby these standards are publically available. It is also suggested that the Dust Diseases Authority should give consideration to establishing a medical appeals tribunal whereby medical decisions can be resolved rapidly and without adversarial process, and according to up-to-date established medical evidence. In terms of prevention of occupational lung disease, the Dust Diseases Authority deals with compensation; it does not contribute to the prevention of dust diseases, nor feedback its findings to existing prevention processes. This seems to be a missed opportunity for prevention. Recently there have been several cases of silicosis diagnosed in New South Wales from the engineered stone products industry—that is, the manufacture of Caesarstone—which have arisen despite existing legislation. One of these patients is currently awaiting a lung transplant.

When new exposures cause disease, the Dust Diseases Authority should notify SafeWork early to allow a workplace assessment with appropriate improvement of toxic exposures where applicable. In terms of accurate data, there is an urgent need for accurate data on the numbers of cases of occupational lung disease in New

South Wales and in Australia as a whole. There is no centralised process or system for collection of information on occupational lung disease in New South Wales, unlike other countries. We recommend that data collection like this should be the responsibility of the Dust Diseases Authority, and a mandatory notification process, such as is used in infectious diseases like tuberculosis, is an effective measure and it is one option that could be considered. We note as a positive initiative that there has been a movement in Parliament, supported by The Greens, to establish a central registry for reporting.

In summary, the Thoracic Society Occupational and Environmental Lung Disease Special Interest Group believes the reforms of the policies and practices of the New South Wales Dust Diseases Authority is needed to bring it in line with current epidemiology and practices of occupational lung disease. We recommend expanding the compensated occupational lung disorders. We recommend greater transparency in the diagnosis and assessment of disablement. We recommend consideration for the establishment of a medical appeals tribunal. We recommend expansion of the scope of operations including early feedback to relevant agencies involved in the prevention of cases of occupational lung disease. We recommend improved data on cases of occupational lung disease. Mandatory reporting of cases to the Dust Diseases Authority could be considered.

The CHAIR: Dr Johnson?

Dr JOHNSON: I have nothing to add.

The CHAIR: Mr Smith?

Mr SMITH: First, thank you for inviting me to talk today and to give evidence. Just a little bit of brief history. Nine years ago, pretty well to today, my life totally changed when my late wife began to have tests and at the end of July she was diagnosed with mesothelioma. That set in a chain of reactions, if you like, for the next three years where, thankfully, I was able to look after her at home until she passed away in September 2011. That has meant a journey now that is all-encompassing; it will be a never-ending journey, I am fairly sure, for myself. But what it has meant now, through being the Support Coordinator at the Asbestos Disease Society of Victoria for a number of years and now with the Bernie Banton Foundation for five and a half years, we have supported many hundreds of people directly, many thousands now indirectly, and it ideally places us. In New South Wales at the moment we have over 270 direct support people that are on our support contact lists, just in New South Wales; the vast majority of those are with the Dust Diseases Care system—not all but the vast majority.

In 2015, when we were asked for comment about changing and embracing new regulations, we certainly embraced it because we felt that the old system was very tired and we felt that it was perhaps like an FJ Holden car that was quite trustworthy but just was not really going anywhere. With a number of amendments made, which I proudly can say that was our doing with Reverend Fred Nile, we came up with a new solution to get things moving quickly, and I believe it has. From the actual side of things of approvals it has—not on the medical side; I think that still is very much the downside, getting medical information and so forth out of hospitals, and that is the let-down of the system at the moment.

I think our earlier speakers were able to quite rightfully say that there is still more to do when it comes to getting the law, I guess, and getting things moving a lot quicker. We seem to be dealing more and more with more elderly people. When I say "elderly people", at the moment I would think the majority of the people we support are in their eighties—almost eight out of 10 are certainly in their late seventies, but the majority would almost, at the moment, be in their eighties that are coming on board. So this gives some urgency that possibly was not there before. We have had one man come on recently from the Central Coast who first came to light on the Thursday, his daughter spoke to us on the Monday, we had a bedside sitting on the Friday and he died on the Saturday morning. That is the sort of thing that we are constantly dealing with right through the whole care package and everything else.

With the Dust Diseases Board what do we want, what do we need? I think it needs a total overhaul, to be honest. I think we have started off right. I would have to say that the new regime in place with icare is very holistic. Almost daily we do have occasion to talk on behalf and to go into bat for sufferers and their carers. I can say that the response is almost immediate and we always get a satisfactory resolution. But it is all very reactive; it is not proactive at the moment, and this is what we really need to look at in everything we are doing. For example, this happened yesterday, we had a gentleman who has been upgraded in care needs and he has been upgraded to needing constant care, so he cannot be left alone. His young son and daughter-in-law are looking after him—they have young children, they both run small businesses. There was nowhere in the care assessment form to allow for this—it is right out of the dark ages; it has not upgraded such as the Federal Government aged care has, for example; there is nowhere in there for a companion carer, and so we had to shift heaven and earth to get things, and there was a satisfactory resolution straightaway.

Dealing with the new icare is absolutely brilliant in that sense—the people at the top, everyone—but I think they are hamstrung by age-old regulations that do not allow them to do what they actually want to do. I think the other thing that we need to be looking at, and this, of course, means money—one of the big things is we do not have any possibility within the regulations to look after the carers. As a foundation, the main thing we look at is carers because if the carers are not surviving then the sufferers are not surviving. So we would like to see changes made within the regulations where icare or Dust Diseases Care can actually look after the carers. For example, at the moment if a sufferer goes into, say, full-time care or hospital or whatever and the carer is suddenly left at home all by her or himself, that carer then has to go through myriad aged care with the Federal Government to get any help. That person cannot get a pension or so forth while the sufferer is still alive. It makes it an extremely stressful and difficult circumstance, and we have a number at the moment in that situation where, basically, they are on their Pat Malone. They have been diligently looking after someone and caring for someone and suddenly they are thrown to the wolves and icare cannot do anything about it because the regulation is not there to allow them to. I think that is one big change we need to really make in the whole scheme of what we are doing.

The CHAIR: You are saying that they lose the carer's pension and fall between the cracks—

Mr SMITH: Normally they will not have a carer's pension. They could have that carer's pension, but it is the sufferer that gets the pension, and the pension is a little bit overrated anyway in a lot of cases because it comes in on the left hand and goes on the right. If they have got an aged pension, the Dust Diseases Care pension is considered an income, so, depending where it is, you start to pick up that side, you drop that side and, quite often, as I say to people, it really does not mean a heck of a lot in most cases—it does for the younger demographic but not really for the old ones. It really is a point of concern, I think, that we seem to only focus on the sufferer and the scheme only focuses on the sufferer; it does not look at the side peripherals of everything that happens.

The CHAIR: Thank you for that. I will open up to discussion and questions.

The Hon. LYNDA VOLTZ: Dr Miles, the diseases that are not covered by compensation that you raise in your submission, I am surprised that brucellosis is not in there but farmers lung is. I find that extraordinary. Is that because of the nature of the scarring or the way it is diagnosed that the list has come out the way it has?

Dr MILES: Yes, the majority of the diseases are pneumoconiosis, which is due to the retention of dust and lung fibrosis. That is the most common, with the exception of the asbestos related diseases of the lining of the lung and the cancers. The difficulty is that the other illnesses I suggested should be part of this list, such as chronic obstructive pulmonary disease [COPD], are due to dust. A proportion of them occur in non-smokers and are due to occupational dust, about 15 per cent. It is the same with asthma, 15- to 20 per cent are occupational exposures. I think brucellosis is a form of occupationally acquired pneumonia and that is other group we are suggesting should be covered by the Dust Diseases Board.

The Hon. LYNDA VOLTZ: The disease you spoke of from chicken farms used to be known as pigeon fancier's disease, and that is from feather exposure?

Dr MILES: That is correct, yes.

The Hon. TREVOR KHAN: When you talk about feather exposure what mechanism does that set up in the lungs? Is it an allergic reaction to the feathers?

Dr MILES: Yes, it is. It is what is called a hypersensitivity pneumonitis. It is an allergic inflammation of the lung.

The Hon. TREVOR KHAN: And that differentiates it from the dust diseases?

Dr MILES: I suppose that is correct, but in the end it leads to a form of lung fibrosis. That is the difference.

The Hon. TREVOR KHAN: The mechanism that leads to the result?

Dr MILES: Is different, yes.

Mr DAVID SHOEBRIDGE: All these questions are predicated on the assumption that there is an overall theoretical construct around schedule 1 in the 1942 Act. Is that the case or is it a quirk of history?

Dr JOHNSON: That Act was written with the medical knowledge at the time and what was important at the time. Medical science has advanced since then and things like occupational asthma are more important and recognised.

Mr DAVID SHOEBRIDGE: With your medical expertise can you see a basis, based on medical classification, for saying that schedule 1 diseases are over here and the list of other diseases are over there? Is it a medical classification that is dividing them?

Dr JOHNSON: No, I do not think so. They are occupational lung diseases.

The Hon. LYNDA VOLTZ: You raise secondhand exposure to smoke. Are cases getting through of compensation around those types of lung cancers where you have a non-smoker, pub workers in particular?

Dr MILES: Yes. I believe there would be cases of that because the risk of secondhand smoke is significant towards the risk of malignancy, yes.

The Hon. DANIEL MOOKHEY: Is it your view that we should expand the list, or is it that we have to design alternative mechanisms that do not freeze thinking in time but allow you to demonstrate some proximity to occupational lung or dust disease?

Dr MILES: Personally, I believe the list should be expanded. They should be given equal importance to other diagnoses.

The Hon. DANIEL MOOKHEY: Which diagnoses should we be including that are not there now?

Dr MILES: Dust related chronic obstructive pulmonary disease, occupational asthma, reactive active dysfunction syndrome, irritative asthma, occupational pneumonia and dust induced pulmonary fibrosis.

The Hon. TREVOR KHAN: Is that list longer than the list on the page 2 at point 4?

Mr DAVID SHOEBRIDGE: You did not include occupational lung cancers or occupational COPD. I assume you stand by the list on page 4?

Dr MILES: Yes, we do; that is the list.

The Hon. DANIEL MOOKHEY: Can you give a description of the incidences or how common these diseases are that we can put to regulators for actuarial assessments?

Dr MILES: We believe 15 to 20 per cent of asthma cases are occupationally related.

The Hon. TREVOR KHAN: How many is that? If we put in a recommendation that essentially is completely changing the scope of the scheme it degrades the value of our report because they will say they are crazy.

The Hon. LYNDA VOLTZ: They may not, they may say "maybe these things should be considered".

Dr JOHNSON: From the literature, it is about one in eight new asthmatics are due to occupational exposures. I think if you look at, for example, the Finnish groups and oversees groups who have a better method of assessing cases in the population, the number for occupational asthma is broadly similar to the number of cases of mesothelioma. You are talking about 200 to 300 cases in New South Wales per year.

The Hon. LYNDA VOLTZ: Are you finding that you get plateaus in certain diseases, for example, lung cancer from exposure to secondhand smoke? If you worked in pubs in the eighties and nineties you would have heavy exposure, now you would not have that exposure, so you find you get the hill table?

Dr MILES: That is absolutely correct. With some diseases there is a latency. For instance, with asbestos there is a latency of 30 to 40 years for the development of mesothelioma, so we are expecting to see a peak in 2020 and then it will depend in what way you have been exposed. There is the first wave, the second wave and the third wave. The third wave will be the home renovators who have inadvertently been exposed.

The Hon. LYNDA VOLTZ: And those of us in the defence force who did not have an exemption and still had to change our asbestos brakes?

Dr MILES: That is correct.

The Hon. DANIEL MOOKHEY: With respect to the expanded list of diseases, is there a significant cost difference in treatment that would be compensable? I am not an expert in how you treat mesothelioma or the asthma you described. The first question that we will be asked by an insurer is how much does treating each one cost.

Dr JOHNSON: There would be differences because mesothelioma has a median survival of nine months, so your treatment costs are, on average, for nine months. Whereas a person with occupational asthma will not necessarily have a reduced life expectancy. Your treatment costs may be for the rest of their lives. The same with COPD and pulmonary fibrosis. The prognosis is different. Obviously with a fatal illness the treatment costs are going to be more per day but over the period of time it may well be more.

The Hon. TREVOR KHAN: In regard to icare the treatment mechanism is different. The patient with asbestosis or mesothelioma is an intense period of support for a relatively short time, whereas if what we are talking about is occupational induced asthma we are talking about a whole different mechanism of support?

Dr MILES: That is correct.

Dr JOHNSON: With regard to the numbers, we can take that on notice. For COPD and pulmonary fibrosis it might be much more and I do not have those numbers in my head.

Mr DAVID SHOEBRIDGE: Not every one of the schedule 1 diseases are mesothelioma and have such dramatic impact upon life expectancy.

Dr JOHNSON: Absolutely.

Mr DAVID SHOEBRIDGE: It may be that a number of those other diseases are much less common now because of significant improvements in occupational health and safety or industrial changes but they are not all that short-term dramatic reduction in life expectancy?

The Hon. TREVOR KHAN: There would be virtually no cases of bagassosis any more?

Dr JOHNSON: That is correct.

Mr DAVID SHOEBRIDGE: That is what I am asking. I do not know about farmers lung. But silicosis is still present?

Dr MILES: Yes, it is still present in the manufactured stone industry. There have been new cases of silicosis.

The CHAIR: Is the industry aware of that? You have said there is not a role for the Dust Diseases Authority to provide educational awareness to inform the public or workforce that there is exposure being picked up. That is the first I have heard about the engineered, man-made stone products with a silicon problem. Is the industry being informed in order to improve the work conditions and stop exposure?

Dr JOHNSON: It is a huge problem. I am aware of five or six case in the last 12 months in New South Wales.

The Hon. TREVOR KHAN: Of silicosis?

Dr JOHNSON: Silicosis from the manufactured stone industry. It is a huge problem.

The CHAIR: This is bench tops?

Dr JOHNSON: Yes.

The CHAIR: Is it pots and paving?

Dr JOHNSON: No, it is Caesarstone manufacturers. A lot of them are small-scale places and when you talk to the people the dust suppression is non-existent or inadequate.

The Hon. TREVOR KHAN: Is that in the same way—it is a long time since I have done it—as the surfboard-making industry and the like?

Dr JOHNSON: That is fibreglass. That is not silica so that is not a big issue as far as your lungs go.

The Hon. LYNDA VOLTZ: It does not scar the lungs.

Dr JOHNSON: No, it does not scar the lungs.

Mr DAVID SHOEBRIDGE: It seems remarkable when you work with it. The other concern that has been raised is the amount of underground work that is going on involving Sydney sandstone.

Dr MILES: Yes, that is correct.

Mr DAVID SHOEBRIDGE: That has been a traditional cause of concern for silicosis and lung disease, maybe not just silicosis. Is anybody watching that at the moment?

Mr SMITH: The unions.

Mr DAVID SHOEBRIDGE: Apart from the unions?

The Hon. LYNDA VOLTZ: They are not necessarily allowed on site.

Mr DAVID SHOEBRIDGE: You would expect that the authority should be looking at that?

Dr JOHNSON: Yes, you would. So far as the manufactured stone products, we have notified those cases to WorkCover and I understand WorkCover was planning to inspect some of these sites. That is as far as we have got. I do not think anybody is watching them, as you say.

Mr DAVID SHOEBRIDGE: If we go back to one of your earlier submissions, we need a central point to not only gather the data but to be the canary in the goldmine.

Dr JOHNSON: Absolutely.

Dr MILES: Absolutely.

Mr DAVID SHOEBRIDGE: WorkSafe is probably not the place to do that because they do not have the links to the medical profession where the first set of data is coming from.

The Hon. TREVOR KHAN: If there was mandatory reporting, it could be to WorkSafe, or whatever it may be called.

Dr JOHNSON: Yes, that is right. As long as there is an action and some sort of feedback so we know that some action has been taken.

The CHAIR: Is that also underpinning your argument for expanding the group of lung-related diseases from the current list, which we acknowledge is historic and outdated? Centralising lung dust diseases allows us to have data to inform any new emerging problems.

Dr MILES: Yes, that is exactly correct.

The CHAIR: Is the other reason that because it has the expertise of your medical profession that you want to bring them together and have them dispersed into workers comp here and other areas, not to corral them together?

Dr MILES: Yes, I think that is correct, so it is dealt with by people with the expertise and training.

The Hon. TREVOR KHAN: Can I go back to mandatory reporting. Who do you say should report mandatorily?

Dr MILES: It would be respiratory physicians who diagnose these illnesses, in the same way as tuberculosis or HIV or those illnesses are mandatory to report.

Mr DAVID SHOEBRIDGE: I assume from your submission you do not anticipate any opposition from the medical profession in this regard; the medical profession is happy to assist with it?

Dr MILES: Yes, I think so.

Mr DAVID SHOEBRIDGE: They would like their information to go somewhere that is useful?

Dr JOHNSON: Yes.

Dr MILES: That is correct. If it is enforced by law it will be done. It is unlike the Surveillance of Australian Workplace Based Respiratory Events [SABRE] scheme where people had voluntary reporting. That, therefore, significantly underestimated the incidence of disease.

The Hon. TREVOR KHAN: I do not want to be critical in respect of your proposition, but would the mandatory reporting fall on the thoracic surgeon, the thoracic specialist or would it fall on the general practitioner [GP]? If it potentially falls upon the GP, should we be asking the Australian Medical Association [AMA] what it thinks?

Dr MILES: Yes, I think that is correct, although you would probably find in most cases that a GP would refer on to us, respiratory physicians, for a second opinion.

The Hon. TREVOR KHAN: I anticipate they refer people on for just about anything now.

Dr MILES: They do, that is right.

Mr DAVID SHOEBRIDGE: You have the specialty and the knowledge to ensure you are properly diagnosing the disease?

Dr JOHNSON: That is right.

Mr DAVID SHOEBRIDGE: Which is the information you want to go, with no disrespect to GPs.

Dr JOHNSON: That is right. No disrespect, but it would be better to come from us.

Mr SMITH: If I might add a couple of points about the funding. Something that has not been mentioned is that mesothelioma, for example, can be an extremely expensive disease to fund as far as treatment goes. Asbestosis, possibly not, if you take Bernie Banton's eldest brother. He has now lived for 40-odd years. He essentially has no treatment. He has only 30 to 40 per cent lung capacity. He does not have oxygen. His cost to the Dust Diseases Care would be very minimal. Adding diseases on is not necessarily saying it is going to cost a heck of a lot more. It all depends on each person. So far as the mandatory reporting, we already have the Australian Mesothelioma Registry that could be used as a model. That is with the Federal Government. However, it could be used as a model. It is starting to work quite effectively.

It is taking some time, but it is a model that could be used and it at least gives us fairly reliable data now on how many cases there are. For example, we know in 2015, with the adjusted figures, there were 212 mesothelioma cases in New South Wales. Through the respiratory physicians, we could look at a model. Another thing the Committee might need to look at is, do the regulations allow the Dust Diseases Authority to do a lot of these things? My understanding is when the regulations were changed in 2015, and certainly it was a fairly quick cramming of the entire Act, but not a heck of a lot of things were changed in that. I am not certain that some of these things are allowed under the current regulations, but I am not saying they are not. I certainly believe it needs to be looked at. My experience is that so far most of the problems we are encountering with the dust diseases care, it is not the people, it is not the will, it is that they do not have the mechanisms that allow them to do things.

The Hon. DANIEL MOOKHEY: Mr Smith, that is a segue to the questions I wanted to ask you. You are suggesting there is a suite of regulations that is impeding the ability of icare to modernise its interactions with victims and their carers. Are you able to specify what regulations you are talking about?

Mr SMITH: No, not actual regulations, but when I talk to the staff and say, "Why can we not do this?" they will tell me, "This is what we have to work with." For example, with their assessment forms for caring, they have not upgraded them. Whether they can or not is going to be a study of the regulations. I equate it at the moment to working with an FJ Holden or EJ Holden rather than a brand new car. I do not think it is the will.

Mr DAVID SHOEBRIDGE: The problem is that the authority has no authority.

Mr SMITH: Sorry?

Mr DAVID SHOEBRIDGE: The authority is a reference point; it does not have any authority.

Mr SMITH: That is it. It is a bit like the Dust Diseases Board. The Dust Diseases Board does not have any authority.

The Hon. DANIEL MOOKHEY: To take your metaphor further, what I am getting at, is it the design of the car or the way the car is maintained that is causing the issues? Are these things solvable by us telling icare to modernise their systems or are there certain laws that Parliament has to change?

Mr SMITH: I am not certain, but I would like to know. If there is a means of changing it and it is not being adopted at the moment, it is certainly not my side of things, if you like.

The Hon. DANIEL MOOKHEY: Has this been canvassed with the board? Has the board, if you remember, canvassed the issues? Have you made formal representations?

Mr SMITH: The board's role is purely to give out research grants and issue grants to support organisations. The board can make recommendations, but its role is not to do that. The board's role is one of overseeing research grants, and also overseeing giving out support organisation funding.

Mr DAVID SHOEBRIDGE: When you say board, do you mean authority?

Mr SMITH: No, I mean the Dust Diseases Board.

The Hon. DANIEL MOOKHEY: To the extent that other people have come before the Committee and said that the board has an advisory role, that it is able to help with the design and help inform how these policies and practices are working, your evidence is that it is not in fact the case and that you guys are allocating the grants?

Mr SMITH: That is purely as I read it, that is our role. We are able to advise, if we are asked, in which way to go, but certainly from the internal side of things as to how the Dust Diseases Care operates, we have not.

The Hon. DANIEL MOOKHEY: Are you aware of any body that is able to provide the voice of claimants, victims, and carers directly to icare that the board is not practically performing that function?

Mr SMITH: The Bernie Banton Foundation does it almost every day.

The Hon. DANIEL MOOKHEY: But you have no statutory recognition for that purpose, do you?

Mr SMITH: No, ours is purely an advocacy role. We go in to bat, as I call it.

The Hon. DANIEL MOOKHEY: Alongside a whole range of other advocates who also perform a similar function?

Mr SMITH: I do not know if there are that many that actually do that, not with the asbestos-related disease organisations. I would think that we would be the most prevalent in that sense, but you would need to actually ask Chris Koutoulas, the operations manager, how many of the others actually go in in that side of things. Certainly if there is a problem we take it on board. We are totally support focused and we are totally there for the client.

The Hon. DANIEL MOOKHEY: Should we be recommending the establishment of a formal consultative mechanism to icare to allow the problems that you describe, the practical inability of icare to change fast enough, to be resolved?

Mr SMITH: I think the whole procedures need to be looked at. I know Chris Koutoulas and so forth and his staff are very much looking at those as they go. Whether they have the ability to change them or not from a legislation point of view—it is a little bit like what are talking about with our list of diseases. A lot of stuff in the legislation goes back to 1942 or whatever. It was not all upgraded in 2015. Whether they have that ability to actually change some of these things I do not know. Certainly from an operational point of view things are slowly but surely changing. As I say, we only have to generally make one phone call, explain a situation and it is resolved in that sense. Whether it is resolved within the entire framework, the staff certainly have the will to change it and they make it happen.

The Hon. LYNDA VOLTZ: The board of the Dust Diseases Board will become an advisory committee providing expert advice to the new insurance and care entity. Have you been asked to provide any advice?

Mr SMITH: No, not to my knowledge.

The Hon. LYNDA VOLTZ: Have you had any meetings where any matters have been referred to you?

Mr SMITH: No, not to my knowledge. I am not even certain that is within our scope. I know that is what it was supposed to be.

The Hon. LYNDA VOLTZ: You were given the powers. That is why I am wondering if you are being used in that role. It would appear that is not the case.

Mr SMITH: No, not at the moment. I must admit the first 12 months of the board was primarily taken up with procedural matters getting things really going. Because it meant a total change for the research, for example, and because there used to be a research committee on the old Dust Diseases Board, it has meant a total change. That is now in place. I think that will change the whole scope of what the board can do from now on and how quickly it can do things. If we are asked, we will certainly give opinion. It is that simple.

Mr DAVID SHOEBRIDGE: Dr Miles and Dr Johnson, one of the reasons I assume you are putting forward the need for urgent action once these occupational diseases become apparent is that they are almost all preventable. Can you explain that?

Dr MILES: Yes, I think that is correct, they are almost all preventable. We think they are being underdiagnosed. Often they begin to develop before you are symptomatic. Generally the symptoms of an occupational lung disease are cough, breathlessness and wheeze. That will then come to the attention of a doctor but it may be misdiagnosed as an airways disease or something. That is the difficulty. Also if you can reduce the exposure early you may truncate the illness or slow down the progression of the illness. That is the other reason to try to diagnose early.

The Hon. TREVOR KHAN: Are you linking the need to identify the prevalence of the disease with the misdiagnosis—that is, because some doctors are not aware of the prevalence of the disease they are misdiagnosing the condition?

Dr MILES: Yes, that is correct, and we think that should lead to greater education of doctors to recognise these illnesses earlier, especially amongst general practitioners.

The Hon. TREVOR KHAN: I am not being critical of anyone in the exercise. There is a need to build up a statistical base in order to educate the profession and so forth?

Dr MILES: Yes, definitely.

Mr DAVID SHOEBRIDGE: "Look out for silicosis because it is happening" is the message to GPs. If they think silicosis is a disease of the 1970s they are not going to be looking for it in their patients.

Dr JOHNSON: That is right. And that is what we thought until the Caesarstone, it was a historical disease and all the people we saw were exposed in the 1960s and 1970s. Now we are seeing people who were exposed this year and last year.

Dr MILES: There has been an article published with these as case reports in a prominent medical journal in order to raise awareness.

Mr DAVID SHOEBRIDGE: To get an understanding of silicosis from the manufactured stone industry, what is the length of exposure required as a general rule before we are seeing it? Is this something that people are exposed to for 10, five years or two years?

Dr MILES: With a heavy exposure you can get acute silicosis which is a proteinaceous process which can be lethal acutely. That is with a very heavy exposure. Otherwise it is generally a slower progression maybe over five to 10 years. You get calcium deposits and the lymph nodes get calcified, but it is not such a quick process.

Mr DAVID SHOEBRIDGE: Is there a degree of urgency then in this regard?

Dr JOHNSON: Absolutely.

Mr DAVID SHOEBRIDGE: We should be urgently seeking to get the direction either to WorkSafe or the Dust Diseases Authority, probably both, to first of all be targeting the industry for inspection and, secondly, getting the information out to the medical profession?

Dr JOHNSON: Yes, absolutely. And these people are young. The patients we are seeing are in their forties and they have got a fatal illness.

Mr DAVID SHOEBRIDGE: Is it a fatal illness?

Dr JOHNSON: Yes, for the person who is going to have a lung transplant. You go for the lung transplant if your expected survival is less than two years. If he has a lung transplant his median survival is probably five years. For some of these patients it is a fatal illness.

Mr DAVID SHOEBRIDGE: Doing nothing is quite literally killing people?

Dr MILES: Yes.

Mr SMITH: One thing I might add on the costing is that I think "we" now call asbestosis in Australia a dying disease because it is actually getting less and less. The same with most of the occupational type of asbestos diseases that are non-cancerous. Mesothelioma does not seem to be dropping but certainly from our experience the non-cancerous types of diseases seem to be going down. That makes sense because I think my learned friends here would be able to say that asbestosis, for example, is well known as needing high exposure in a work environment and we are not getting that type of high exposure anymore. I am not saying it cannot happen; of course it can happen, but we do not have mines and we do not have manufacturing in Australia anymore. I guess what I am saying is that as one disease becomes less prevalent for the dust diseases care or board another disease is coming up. From a financial point of view I really cannot see that it is going to be that bigger burden on dust diseases care.

The CHAIR: The issue is though is there an epidemic coming up unbeknownst to us, as was asbestos exposure, which I suggest probably was the reason for the Dust Diseases Board being created, or is it being managed in the general health system with specialists?

Mr SMITH: At the Dust Diseases Board, and I do not think this is confidential, Dr Ryan Hoy gave a wonderful presentation on manufactured stone silicosis which really put it out there about the potential of this. This is what we have to look at. We need to learn from the past with the asbestos side of things.

Mr DAVID SHOEBRIDGE: The point is you had a great presentation that made it very clear there was a problem but you did not have any power or authority to do anything.

Mr SMITH: As the Dust Diseases Board it is not our—no, I guess you would say we do not have—the Dust Diseases Authority most likely can do it if that was decided. I mean, they have funded awareness programs and that in the past.

The CHAIR: We might put that question on notice back to the authority about what steps they are taking to alert the industry to this emerging problem.

The Hon. TREVOR KHAN: Dr Johnson, in cases that have arisen, are those arising with people who are working essentially in the manufacture of Caesarstone or is it in the kitchen fabrication industry, for instance, where the stone goes and is then cut again to put in sinks and whatever else?

The Hon. DANIEL MOOKHEY: Or both.

Dr JOHNSON: Probably it is both. But there are factories where it is cut to size for your bench and then finished. Those are the people that we have seen so far, in general.

The Hon. LYNDA VOLTZ: Mr Smith, if it is in writing and is not confidential, could you provide us with a copy of that presentation?

Mr SMITH: It was actually a video presentation. Dr Miles might have seen it—have you?

Dr MILES: Yes, we did.

Mr DAVID SHOEBRIDGE: You could maybe give us the video presentation.

The Hon. LYNDA VOLTZ: Only if it is available and they are happy to.

Mr SMITH: I certainly do not have it.

The Hon. TREVOR KHAN: We will go and ask the authority.

Dr MILES: Yes. Ryan Hoy is the formal president of our special interest group. He is an occupational and respiratory physician from Melbourne. We could contact him.

The Hon. LYNDA VOLTZ: Thank you—only if he is happy to.

Dr MILES: Yes, of course.

Mr SMITH: He is also a board member, by the way.

The Hon. LYNDA VOLTZ: Oh, is he?

Mr DAVID SHOEBRIDGE: Just to go back to Mr Mookhey's question about how you would enter new diseases on the schedule, I think Dr Miles said you would just list these ones that you have identified. I suppose first of all we would need to get some actuarial understanding of what the costs would be and that should be part of our recommendation. Do you agree with that?

Dr MILES: Yes, I agree with that.

Mr DAVID SHOEBRIDGE: I think Mr Mookhey's second question was about the fact that we do not want to just freeze a new list in 2017. Is there a review mechanism that you could recommend? Should it be a five-yearly review? Should it be an ongoing thing for the authority or the board to look at? Should there be a catch-all?

The Hon. DANIEL MOOKHEY: Alternatively, should we applying a general test?

Mr DAVID SHOEBRIDGE: For instance: occupational diseases of the following type, and then describe it in a generic way.

The Hon. LYNDA VOLTZ: Perhaps you can take the question on notice and come back to us.

Dr MILES: We will take that on notice. We could perhaps discuss it with our special interest group and raise that with them.

Mr DAVID SHOEBRIDGE: That would be really helpful.

Dr MILES: Okay. We will certainly do that.

The CHAIR: Thank you for that. Thank you to the three of you for your evidence today. It has been very enlightening for us. We appreciate your expertise and your experience. You have taken a few questions on notice and there may be some more that come through to your from us. You have 21 days to respond to those questions to help our inquiry.

Mr SMITH: If I could just clarify something—

The CHAIR: Yes, Mr Smith.

Mr SMITH: In relation to dust diseases care, in taking advisement from them and so forth, I will say this: Every time they ask what should be done in our opinion, as far as the Bernie Banton Foundation goes—and I believe this applies to other support organisations as well—they take it on board and they are acting on it at this point with procedures and so forth. My only comment about that was that I am not certain how far they can go within the legislation with some of these things.

The Hon. LYNDA VOLTZ: Your concern was not about the procedures; your concern was about the carers and how they are treated under the scheme.

Mr SMITH: Yes, and whether or not they can actually progress into the twenty-first century in the same way aged care has.

The CHAIR: Thank you for clarifying that. Thank you very much.

Dr MILES: Thank you very much.

(The witnesses withdrew)

(Short adjournment)

THEODORA AHILAS, National Practice Head, Asbestos and Dust Diseases Department, Maurice Blackburn Lawyers, sworn and examined

The CHAIR: Would you like to make a brief opening statement?

Ms AHILAS: I am the national leader of the Asbestos and Dust Diseases Department of Maurice Blackburn Lawyers. I personally have been practising in the area of dust diseases and asbestos litigation as a lawyer since 1990. In the past 26 or 27 years I have seen firsthand hundreds of people exposed to asbestos and other dust diseases. We deal predominantly with cases in the Dust Diseases Tribunal or other Supreme Courts in other States and internationally. In our work in the Dust Diseases Tribunal and in our New South Wales practice we come across hundreds of people exposed to asbestos and dust disease in an occupational setting. Some of those very deserving clients of ours missed the opportunity to have the ambit of the valuable entitlements available through the Dust Diseases Board, now known as the Dust Diseases Authority [DDA], because they fall outside the ambit of the jurisdiction of the Dust Diseases Authority in section 3 of its Act.

Our submissions relate in part to those issues. I am in a position to give this Committee three to four recent factual inquiries of cases that we have been involved with where very deserving plaintiffs and their families lost the valuable entitlements to make a claim through the Dust Diseases Authority. Not only do we wish to extend the jurisdiction of section 3 to mirror section 3 of the Dust Diseases Act, which deals with a tribunal, but also to talk about issues in relation to extending the right to make a claim where people are diagnosed very late in their disease process and cannot make a claim in time through the Dust Diseases Board for valuable entitlements. I can give the Committee a very pertinent example of something that happened to me very recently with a gentleman in Darwin. We did make submissions. I am here to talk to our submissions and answer questions, and to raise some practical issues about the real problems associated with missing out on entitlements.

Mr DAVID SHOEBRIDGE: I thought we might start with those practical problems. Often we deal with this in the theoretical, tell us what it actually means for one of your clients?

Ms AHILAS: I will give you three examples that go to jurisdiction and I will give you one example that goes to the possibility of missing out on an entitlement because of diagnosis late in the day. I will not give the full names of these clients. The first one is Mr F and his family. Mr F worked in a cardboard producing factory where dust was produced through the manufacturing process. So he had exposure to a dust in the course of his employment in New South Wales. Our expert evidence indicated that his dust exposure was causative of his pulmonary fibrosis—so he had a diagnosis of pulmonary fibrosis. The problem was that there was no schedule 1 disease that deals with this particular exposure scenario. Further, none of the other diseases which appear in the schedule are caused by dust exposure through cardboard dust and, accordingly, he was locked out of obtaining benefits through the DDA and, in turn, he was locked out of the paying benefits through the Dust Diseases Tribunal.

He did have entitlements to make a claim through the WorkCover scheme as a worker; however, in order to do that he had to give away any common law entitlements he had because he had very serious debts to pay for his medical expenses. So he had to trade some of his entitlements away for some others. That is the difference with the Dust Diseases Authority entitlements and the Dust Diseases Tribunal entitlements at common law, they are concurrent entitlements. A person facing an entitlement through the Dust Diseases Authority does not have to trade away his common law entitlements, which is what happens under the draconian workers compensation scheme in some instances, not all.

The Hon. TREVOR KHAN: Can I just interrupt you there?

Ms AHILAS: Certainly.

The Hon. TREVOR KHAN: It is my understanding that bagassosis is a dust disease principally seen in the paper industry.

Ms AHILAS: In some paper industries I understand. Let me just go to my submissions. He did not have bagassosis; this gentleman had pulmonary fibrosis. It was a non-specific pulmonary disease that the doctors were saying was caused by is exposure to dust. There was no particular title for his disease process and because they could not identify it as bagassosis or silicosis or one of the diseases under schedule 1, he fell outside the ambit of the jurisdiction.

Mr DAVID SHOEBRIDGE: There is no broader definition. If you are not on the list, the computer says no.

The Hon. TREVOR KHAN: I understand that. As I understand it bagassosis is a condition relating to exposure to pulp dust?

Ms AHILAS: Pulp, that is correct.

The Hon. TREVOR KHAN: Cardboard is made from pulp. Having worked in the paper industry, I am just wondering if anyone made that connection?

Ms AHILAS: He worked in a cardboard manufacturing plant.

The Hon. TREVOR KHAN: I understand it is the corrugation of the board that is made in the paper mills. I understand the whole process but it strikes to me as remarkably close to working in the paper industry and dealing with pulp. Anyway, it was not diagnosed.

Ms AHILAS: You are correct but, to raise what Mr Shoebridge has said and what I am saying, there is no catch-all phrase so because he had a disease that was not specified he fell outside.

The second example is Mr K. Mr K worked as a jackhammer operator for 20 years. He had silicosis, so he was able to invoke the jurisdiction of the Dust Diseases Authority, but had nil disability flowing from his silicosis. So whilst it was determined that he had a dust disease within the ambit of the authority, he had no disability flowing from it. However, Mr K had severe renal failure; he was on haemodialysis for 25 years and was 100 per cent disabled as a result of his renal failure. There was a link between his renal failure and his silica exposure and there was a causative link according to the epidemiology. But because there was no connection with that under schedule 1 he was not able to get the benefit of a dust diseases pension. I have seen that a lot; I have acted for hundreds of people with silica exposure who have silicosis with nil disability but have myriad Pandora box diseases flowing from it, such as autoimmune diseases such as systemic scleroderma, lupus, renal failure, and that is a big issue.

The CHAIR: There is a direct link between the two?

Ms AHILAS: There is some correlation and epidemiology to suggest in that particular case that there was a direct link—not in every case, but in that particular case.

The CHAIR: Secondary diseases are not covered under schedule 1?

Ms AHILAS: No. The third one was a classic example of that. We appealed the decision of the Dust Diseases Authority and were successful, but in doing so it ran in the residual jurisdiction of the District Court for a matter of 10 days and at much expense to our client but also, we won the case, so to the taxpayer. Let me give you the example of that. Mr P is a 46-year-old male with systemic scleroderma, an autoimmune disease which causes a form of fibrosis in his lungs as well as a skin disorder. He is severely disabled—in fact, is 100 per cent disabled—with a very limited expectancy. He worked as a bricklayer and had gross exposure to silica dust. The Dust Diseases Authority found that he did not have a disease within the ambit of their jurisdiction because his disease was systemic scleroderma, which is not a disease by Schedule 1 or an ancillary disease. He had pulmonary fibrosis, but, of course, pulmonary fibrosis is not a schedule 1 disease.

We appealed the decision and it was found that there was scarring on his lungs which was silica-related and, thus, the residual jurisdiction of the District Court could invoke the auspice of the DDA because of the silica-related scarring of the lung. But in order to get that, it took many, many days of trial, many experts were called, indeed international experts were called, for us to be able to bring that home. That is another example of taxpayers' money being used or wasted, shall I say, for a better word, in a case where he really did have a claim under the DDA, or could have had a claim under the DDA under normal circumstances.

Mr DAVID SHOEBRIDGE: Can you explain what the residual jurisdiction of the District Court is?

Ms AHILAS: The residual jurisdiction of the District Court hears appeals from the Dust Diseases Authority. So if you make an application to the Dust Diseases Authority and you fail at first instance, you can ask for a review and if you fail on the review you have six months to make a claim to the District Court to appeal the decision. The point of making an appeal to the District Court is that it is a costs-based jurisdiction, so if you lose the appeal then you bear the onus of paying the costs for the DDA, which could be hundreds of thousands of dollars. People who are in this position do not have the funds to do that, and where a case is perhaps a 50/50 per cent chance of being successful they may decide against it, where they may have a very good claim. In this case that is what happened here.

The Hon. TREVOR KHAN: So what are you suggesting, that there should be no appeal to the District Court or—

Ms AHILAS: There certainly should be an appeal. I am suggesting we extend the jurisdiction so that these cases are covered so we can deal with them at first instance rather than get to a point where we have to make an appeal. There should always be an appeal process—it should always be available to people because it is not always necessarily going to be an issue of jurisdiction; it might be another issue that is appealed.

The Hon. TREVOR KHAN: But even if you expand the jurisdiction there are going to be cases that are at the periphery which are going to need the appeal process.

Ms AHILAS: Certainly.

The Hon. TREVOR KHAN: So there is nothing wrong with the appeal process as such.

Ms AHILAS: No, I am not disputing that. What I am saying is that in this instance, the example I am giving you, it cost hundreds of thousands of dollars before we were able to get a determination and that perhaps if it could have been looked at first instance or second instance in the process we could have stopped that. That is what I am suggesting in that particular case.

Mr DAVID SHOEBRIDGE: I am not quite sure how you would do it other than, say, have a review to something like the District Court. Is the question that costs should follow the event or it should be a no-cost jurisdiction?

Ms AHILAS: That would be great too for plaintiffs.

Mr DAVID SHOEBRIDGE: Like the workers compensation jurisdiction. Provided you have a viable case, if you do not succeed you do not pay the costs of the other side.

Ms AHILAS: Or there could be a Bullock order, which is another thing that you could invoke to get your costs paid. The reason I draw on that point is that in some instances deserving claimants, or appellants, will not make a claim because they do not have money. They are worried about if they lose they will not be able to—

Mr DAVID SHOEBRIDGE: Or they have a house and they do not want to hand it over if they lose the case.

Ms AHILAS: Certainly. No-one would want to do that. You may respond to that by saying litigation bears a risk, but we are talking about a different issue here rather than actual common law litigation. The fourth example I wish to provide the Committee is an example about making a claim late in the day for someone who has an asbestos disease. The facts of this particular case were as follows. It was Saturday afternoon on the last October long weekend that I got a phone call from a respiratory specialist in Darwin to tell me he had a client with mesothelioma, who was just diagnosed, who had, at best, a couple of days to live, and could I get to Darwin to take instructions to start a common law claim for him, which I did.

I got to Darwin and took instructions from this gentleman, who was lucid and was able to provide instructions. He had exposure in the course of his employment in New South Wales in an occupational sense. He had Dust Diseases Tribunal entitlements and Dust Diseases Authority entitlements. I was trying very hard to get a common law statement of claim filed in the Dust Diseases Tribunal to protect his entitlements, because general damages die if you do not start in the plaintiff's lifetime. I was able to file a statement of claim that evening at 9.00 p.m. because the Dust Diseases Tribunal stays open 24/7. It is deemed that you have filed your statement of claim when you have lodged it electronically. He also had Dust Diseases Board entitlements and it was a long-weekend. I was thinking how am I going to get this man's entitlements filed in time before he dies? He was literally at death's door.

I had to ring the general manager of the Dust Diseases Authority to talk to him about it on a Saturday night and ask him to give me an undertaking that this claim was to be filed on Saturday although I could not physically file the claim until Tuesday morning.

The Hon. TREVOR KHAN: In terms of that claim, that has to be filed in hard-copy form, does it, or can that be filed electronically?

Ms AHILAS: No, you cannot file it electronically with the DDA; you have to file it in hard-copy form. So there is that issue as well.

Mr DAVID SHOEBRIDGE: That could be solved, could it not, literally by a 24-hour electronic registry—

Ms AHILAS: So easily, and that is what the Dust Diseases Tribunal has done. With all credit to the general manager of the Dust Diseases Authority, who I phoned on a Saturday evening of a long weekend—and it happened to be the long weekend of the football game, if I recall correctly, and everyone was going to football parties; nobody wanted to answer their phone. He did answer it and he did give me an undertaking that that would happen. But I appealed to someone's goodwill and I had his phone number to be able to do that on a Saturday night. That is not always going to work and it was fortunate that I had the connections with the people who I needed to have to be able to do that. That is not a foolproof method.

The CHAIR: There is clearly a disconnect from the first claim you lodged, which you said was electronic 24/7, and then the second part of the same organisation.

Ms AHILAS: Correct. That had a very happy ending: both the common law claim and the Dust Diseases Authority application have been successful. The widow of our plaintiff got a good outcome with that, or the estate. So that is a happy story in the end, but it was stressful at the time not only for getting it done but for the family to fill out the paperwork. He was very, very unwell.

The CHAIR: Have you raised that with the authority?

Ms AHILAS: I have spoken to the general manager and I have raised that in passing but I have not raised it formally with them.

The Hon. LYNDA VOLTZ: The Saturday night phone call probably sharpened their view.

Ms AHILAS: They are the four examples. There are many others. They are the four examples I wish to give on the practical issues that arise in this space when dealing with people who are very ill. We are dealing with very stressed families and people of non-English speaking background. There is a whole cohort of issues that arise when dealing with this sort of situation and the emotions that are involved.

The Hon. DAVID CLARKE: Ms Ahilas, you want a review of the dust diseases currently listed in schedule 1. Have you made any representations to the Dust Diseases Authority?

Ms AHILAS: No, I am doing that here.

Mr DAVID SHOEBRIDGE: They have not got the power to change schedule 1?

Ms AHILAS: No, they do not.

Mr DAVID SHOEBRIDGE: It is Parliament's job?

Ms AHILAS: Indeed.

The Hon. DAVID CLARKE: You have not made any representations to anybody?

Ms AHILAS: I have discussed them in passing. I have asked.

The Hon. DAVID CLARKE: Prior to today?

Ms AHILAS: No. I have made representations in my submissions to this Committee. No, I have not.

Mr DAVID SHOEBRIDGE: It does seem strange, from an outsider's point of view, that there is one definition for the tribunal and another definition for the 1942 Act. At a minimum should we look at marrying up the two definitions to at least include the catchall phrase from the tribunal, in terms of industrial related condition, "any other pathological condition of the lungs pleura or peritoneum that is attributable to dust"?

Ms AHILAS: Absolutely.

Mr DAVID SHOEBRIDGE: That would be a good starting point?

Ms AHILAS: That would be the best starting point. Beyond that the rest flows more neatly because you have two married legislative schemes. In law it becomes difficult because the wording is quite different and it is interpreted quite differently.

Mr DAVID SHOEBRIDGE: The advantage of the tribunal definition is we know what that covers as there is a body of case law and it is a known corpus that can be costed and understood.

Ms AHILAS: Absolutely. I cannot imagine that the cost would be so onerous to the Dust Diseases Authority. To make that point, they respond to our submissions by saying 97 or 98 per cent of the applicants are within schedule 1. I appreciate that, but there are 3 per cent that miss out. What about those that do not apply because they fall outside schedule 1.

Mr DAVID SHOEBRIDGE: They acknowledged that fact in their evidence before the Committee. They said there is a 98 or 99 per cent approval rate but people only apply if they are on the list. It does not take the argument much further than 98 per cent approval rating.

The Hon. TREVOR KHAN: In favour of that argument, that means that members of the legal profession are capable of discerning the definition or distinction?

Ms AHILAS: Certainly. Not everyone who makes an application to the Dust Diseases Authority [DDA] will see a lawyer. It is not a jurisdiction or an authority that involves lawyers. We see people because they come to us to make inquiries about a common law entitlement and we talk to them about their DDA entitlements. We help them when we need to help them. Most people try to file the paperwork themselves. We will give them advice as to whether we think they will be successful or not. For example, I do a lot of cases in the Australian Capital Territory where people say to me, "But Fred across the road made an application to the DDA. Why can't I do that?" And you explain, "Because you were not exposed in the course of employment in New South Wales, you were exposed in the Territory." Trying to explain that to a lay person is difficult. That is a different issue but an example of things we have to deal with when we deal with people making applications.

Mr DAVID SHOEBRIDGE: The tribunal would not pick up the renal failure case you spoke of?

Ms AHILAS: Not necessarily. You are right. Perhaps we can extend it to be broader than "any other pathological condition of the pleura, the peritoneum and the lung". I appreciate that is a specific example.

The Hon. TREVOR KHAN: Broaden it to what?

Ms AHILAS: I would like it to be much wider to include the host of other diseases that are caused by dust. Saying that, there will always be something that falls outside it because as time passes more dust diseases are discovered. Pulmonary fibrosis was never deemed to be a dust disease but we are seeing that a lot more. Occupationally induced COPD is something that is live, but some people say that is tobacco induced. It is hard to broaden it completely or in full terms because someone will fall outside. If you have a catchall phrase and there is an interpretive value in that it could be broadened.

Mr DAVID SHOEBRIDGE: Concentrating on the causative agent, which is dust, rather than the lungs, which was traditionally seen as the only site of disease?

Ms AHILAS: Indeed.

The Hon. DANIEL MOOKHEY: While maintaining the nexus with occupation and work?

Ms AHILAS: That is a given. We see a lot of people exposed in a domestic setting but they fall outside. For example, with mesothelioma they do not have an entitlement to make a claim through the DDA if it was not in the course of their employment. It has to be occupationally based, that is the point of the scheme.

The Hon. DANIEL MOOKHEY: Should we proceed with the proposal it would essentially mean that we broaden the diseases in schedule 1 and we put a catchall or a test that anything not listed in that schedule you could pursue through that test?

Ms AHILAS: Indeed.

The Hon. DANIEL MOOKHEY: That is your preferred design?

Ms AHILAS: Yes, I would prefer that.

Mr DAVID SHOEBRIDGE: The off-the-shelf solution is the one in the tribunal Act?

Ms AHILAS: That is the off-the-shelf solution, but if you were brave you could make it broader.

Mr DAVID SHOEBRIDGE: I am probably with you.

The Hon. LYNDA VOLTZ: Brave is not a word they use around here.

The Hon. TREVOR KHAN: In a practical sense, the effect of broadening it will be to widen the class of persons who retain their common law rights? Is that the principle?

Ms AHILAS: Yes, to answer the question in the first instance, but noting that if you have a common law entitlement you have to prove negligence.

The Hon. TREVOR KHAN: It maintains the common law right, it does not mean they succeed in the claim.

Ms AHILAS: That is correct.

The Hon. TREVOR KHAN: That is the practical effect. In a sense what you propose is to carve out, testing the theory, a set of workers to give them a common law right when the workers comp reforms that we put through, in essence, remove those common law rights?

Ms AHILAS: I guess, yes. It carves out a set of workers who miss out on entitlements who have a dust disease more. Not everyone who makes a claim through the DDA will make a claim at common law. A lot of people do not want to do that because they are happy with the valuable entitlements they get through the

DDA. It is a security factor. It is knowing that if they die from a dust disease, which a lot of these applicants do, that their families will continue to be protected and their families or dependants become entitled to a claim through the DDA for a lump sum. There are a host of entitlements. The other thing is medical expenses. Anything deemed reasonable for their treatment is covered by the DDA for the medical expenses. In the case of Mr F he had a lung transplant. His expenses were huge and he could have had the benefit of the medical expenses through the DDA. There are a host of trials going on at the moment which may have some success with people with dust diseases.

The Hon. TREVOR KHAN: Medical trials?

Ms AHILAS: Medical trials. If you have the entitlement through the DDA for the medical treatment you can be part of a trial or covered for an expensive drug that is not covered by the Pharmaceutical Benefits Scheme. They are important practical issues for families facing uncertain futures caused by dust exposure. In some cases we are dealing with relatively young people. Mr P was 46 years old when he was diagnosed. Mr F was in his mid fifties and we are seeing younger people coming to us with dust disease at our work. Not mesothelioma and asbestos disease, I am talking about other dust diseases where the entitlements are extremely valuable to them and their families.

Mr DAVID SHOEBRIDGE: We heard about a spate of silicosis through the manufactured stone industry. Are you seeing that in your practice?

Ms AHILAS: In the last week we have taken instructions for three claimants in that scenario.

Mr DAVID SHOEBRIDGE: Working in the manufactured stone industry?

Ms AHILAS: Yes.

Mr DAVID SHOEBRIDGE: What age are these workers?

Ms AHILAS: In their forties.

Mr DAVID SHOEBRIDGE: What is their life expectancy?

Ms AHILAS: At this stage, we have not seen one of them yet so we do not know. Their life expectancy is probably diminished to a degree. They do not know to what point. It is the quality of life that is diminished. When you have a 40-, 46- or 50-year-old working in that industry who is in the prime of their earning capacity, who has a young family and a mortgage and they cannot work in that industry, it is a serious problem, as is the black lung issue, which is a different issue, but it is a serious problem because we are talking about people who are younger who work in that industry.

Mr DAVID SHOEBRIDGE: To the extent that we expand or modernise the definition of a dust disease in the 1942 Act, that would carve those workers out of the 1987 Workers Compensation Act because of the way you have those carve-out provisions? That is right, is it not?

Ms AHILAS: That is correct.

Mr DAVID SHOEBRIDGE: Your position on that is that it is treating people fairly and consistently about a dust disease? That is how we should be looking at this?

Ms AHILAS: I totally agree with that.

The Hon. TREVOR KHAN: I understood that is what she was proposing.

The CHAIR: Thank you for your evidence today and your submission. I do not think you took any questions on notice, but if did you have 21 days to provide answers in writing.

Ms AHILAS: I did not receive any.

The Hon. TREVOR KHAN: But you never know.

Ms AHILAS: Okay. Thank you.

Mr DAVID SHOEBRIDGE: I have one more question I was going to ask. We have had doctors and the Law Society say that there should be some kind of administrative review from medical decisions being made. There was a suggestion that maybe the place to go is a standalone division of the NSW Civil and Administrative Tribunal rather than a court, particularly the Supreme Court.

The Hon. TREVOR KHAN: That might be putting the Law Society submission a bit high. I do not know that that is necessarily what he was strongly putting.

Mr DAVID SHOEBRIDGE: There was a suggestion there. He said he would have to go back and talk to somebody. From your long experience and practice would that kind of administrative review be of assistance?

Ms AHILAS: That would be terrific, actually. Reviews are not just because you fall outside the jurisdiction of the DDA. They are medical reviews. What I understand happens is that three doctors sit with many cases on the day and have the burden of dealing with things quickly, so sometimes things need to be looked at a bit closer and more carefully. If there was a standalone medical-type review panel or administrative appeals review-type panel with three experts in that space to look at it, it would be fantastic. It would help a lot of people who in some instances we might feel or they might feel they have more disability flowing from the disease process than has been accounted for.

Mr DAVID SHOEBRIDGE: You would want a three-member medical panel to take the review to?

Ms AHILAS: I think that should be the way. I will give you an example. I was recently involved in a review in Queensland for a person who had a cancer through their work situation. It went through their WorkCover scheme. He failed the first instance and then there was a review by a three-member medical panel. The applicant was allowed to appear and his legal representative was allowed to appear with him. It was an excellent process. We were able to bring everything to this panel. They were able to ask questions, look at everything and then make a decision. From there, he still had appeal rights to go to a court. That is a step in the middle of the process.

Mr DAVID SHOEBRIDGE: Thank you.

The CHAIR: Again, thank you for coming in.

Ms AHILAS: Thank you very much.

(The witness withdrew)

(Short adjournment)

ANDREW NICHOLLS, Executive Director, Motor Accidents Insurance Regulation, SIRA, sworn and examined

CAMERON PLAYER, Executive Director, Dispute Resolution Services, SIRA, affirmed and examined

The CHAIR: Welcome to the first review of dust diseases and lifetime care support schemes. Would either of you like to make an opening statement?

Mr NICHOLLS: I would like to table an opening statement, if that saves the time of the Committee. The statement, by way of brief summary, outlines our roles of regulator of workers compensation, motor accident schemes and the home building warranty legislation. We are not the direct regulator of Lifetime Care and Dust Diseases Care, but we have a role in relation to levy setting. In the case of Lifetime Care, we have a formal role in relation to disputes. Obviously we work closely and collaboratively with those agencies. Overall, we have a good relationship with them. From our perspective, both of those schemes are working very well at the moment. We are happy to go to questions.

The Hon. DANIEL MOOKHEY: You mentioned that SIRA has a role in the levy setting for lifetime care and support. Can you explain to us what role that is?

Mr NICHOLLS: With the establishment of SIRA and the icare arrangements one of the key changes that occurred in relation to lifetime care and indeed in relation to dust diseases, both of which are relevant to this Committee, is that SIRA plays now the role of determining the appropriate levies that ought to apply to green slips and to employers' contributions for workers compensation, including the levies that apply collecting the revenue for the Lifetime Care and Support Authority.

The Hon. DANIEL MOOKHEY: Is the levy you are talking about the medical care and injury services [MCIS] levy?

Mr NICHOLLS: Correct. The MCIS levy has two components. There is the component that funds SIRA, but mostly that is funding public hospital and ambulance services, so the majority of those funds go there, and the balance of the levy goes to the Lifetime Care and Support Authority. Previously those component parts were managed separately. What it meant is there was not a holistic approach to ensuring that those levies were being applied appropriately and having regard to questions like affordability. In the legislative changes that established SIRA, a key role for SIRA was to have line of sight over price setting for both schemes including the component that funds lifetime care. The role of the SIRA board is to consider the totality of that MCIS levy and to then determine how to allocate that across all the different vehicle classes and do that on a holistic basis but based on the advice of lifetime care. We do not have a role of telling lifetime care what they can and cannot collect, but their role is to tell us what the quantum is that they require and then we work how to distribute that across each of the vehicle classes based on their policies.

The Hon. DANIEL MOOKHEY: Did you have the opportunity to read the icare evidence to this Committee before you came?

Mr NICHOLLS: I did read it at some stage, yes.

The Hon. DANIEL MOOKHEY: You would have seen that icare said they have already started collecting an additional MCIS levy for the transfer after five years from compulsory third party [CTP]. Did you see that?

Mr NICHOLLS: I did. Although if I may make a correction, they will be collecting an additional levy; that has not happened yet. That will apply from 1 December this year.

The Hon. DANIEL MOOKHEY: They made a point that it is the responsibility of SIRA to maintain visibility as to how insurers treat people in the first five years to make sure that liability is not deferred for them to pick up. Can you outline what steps is SIRA taking to maintain visibility of that liability in the first five years?

Mr NICHOLLS: Thank you for that question. I will answer that with just three main components to the answer. The first part is about SIRA having the legislative powers and the additional resources and additional data that it requires to be an effective regulator. The legislation that this Parliament saw fit to pass in relation to CTP, which I think is a very good piece of legislation, has given SIRA more powers and more authority to be able to effectively manage and supervise the scheme beyond the powers that we previously had. That is important but that is not the whole of the story.

The second part for us is building up our resources. The Government has seen fit to approve an additional $17 million of resources to SIRA to provide us with the capacity and the capability to more effectively manage insurers in totality but also to manage individual claims and to intervene where we think there are problems or issues with claims. The third plank of this is the data that we require so that we can actually do that and give effect to that. We are building a new data system that will not just give us the global view on what is happening with the scheme but will actually provide us with individualised case management records around every single claim that is going through our system. With these extra resources and capability SIRA will be able to play two important roles. The first is to provide a leadership role in setting the guidelines, setting the standards, setting the requirements and driving the expectations of change that we need from the service providers in the system in order to ensure this is effective, but also giving us more teeth to respond when we review and we see that there are failures in the system where insurers do not succeed.

The other two points that I wanted to make is in addition to giving us those roles and functions which I think are important to make this succeed so that we do not have people who arrive in lifetime care that have not been well treated, firstly the legislation has given us a three-year review. I think it is really important that happens at the three-year point so it is before the five years. It is before people are going into that new system. We get an opportunity in a very formal sense to see whether SIRA is doing its job properly or whether the insurers are doing their job or indeed any of the other service providers and it allows us to correct things before they end up in lifetime care.

The final thing I would draw attention to is that in the legislation there is a final safety valve where the Lifetime Care and Support Authority will have what is sometimes called a true-up position. That will enable them to recover from insurers. If there has been any mismanagement of that claim despite all of those processes in place they will have a right of recovery back against the insurer for any extra costs that arise that ought to have been costs that the insurer expended. There are a number of really important aspects of this legislation. I think that is where it is a really well designed piece of legislation because it allows for a number of pressure points that mean that if we see that there is a claim that is not being handled well there are ways to deal with it, but absolutely the insurer does not get off the hook because of those final safety valve provisions.

Mr DAVID SHOEBRIDGE: Sorry, I do not know what the practical meaning of "a leadership role driving the expectations of change in the system" is. What does it actually mean you do on a daily basis?

Mr NICHOLLS: It is setting guidelines.

Mr DAVID SHOEBRIDGE: How is that "driving the expectations of change"?

Mr NICHOLLS: The way we are approaching the guideline setting process is not about mechanistic processes—that is important—you know, "You must do this within 10 days," or whatever. It is also establishing principles and objectives against which we will hold the insurers to account.

Mr DAVID SHOEBRIDGE: Such as? Give us something practical.

The Hon. TREVOR KHAN: Just let him answer.

The CHAIR: Order.

Mr DAVID SHOEBRIDGE: I just want something practical. I do not know what any of this data means.

The Hon. TREVOR KHAN: Do not be unpleasant; just let him answer the question.

Mr DAVID SHOEBRIDGE: Something practical.

The CHAIR: Let us allow Mr Nicholls to explain.

Mr NICHOLLS: There is an expectation that an insurer should be treating an injured person in good faith. So if an insurer is playing games or something like that they cannot just hide behind the letter of it and say to SIRA, "We did that within 10 days." Your intention was not to do that properly and you clearly are not complying with the spirit or the principles that we have established here and we are going to hold you to account for that. It is a way of being able to say that there are objectives about looking after injured people and putting injured people right at the centre of this scheme and we are going to hold you to account for delivering that outcome as well as the strict letter of the actual law.

Mr DAVID SHOEBRIDGE: I suppose I want to know what that means. What does "hold them to account" mean? Does it mean write them an angry letter, send them a nasty email, give them a call up, fine them, punish them?

Mr NICHOLLS: It could be all of those.

The Hon. LYNDA VOLTZ: How many instances have you had, say, over the past 12 months in which you have issued an official warning?

Mr NICHOLLS: I would have to take that on notice but we have had a number of inquiries in the current scheme. But I think the new scheme—

The Hon. LYNDA VOLTZ: Not inquiries—I asked how many instances have you had in issuing an official warning.

Mr NICHOLLS: I would have to take that question on notice.

Mr DAVID SHOEBRIDGE: What about a fine, a punishment or anything?

Mr NICHOLLS: We have certainly issued fines to insurers.

The CHAIR: You might take that on notice to give us information on that.

Mr NICHOLLS: I think I will take those on notice.

The CHAIR: It would be interesting to us.

Mr NICHOLLS: Yes. Absolutely.

The Hon. DANIEL MOOKHEY: Going back to your triangle of powers, resources and presumably what you have just described as strategy—

Mr NICHOLLS: And data was the other part.

The Hon. DANIEL MOOKHEY: I think the question from Mr Shoebridge is how is all that culminating into a strategy through which you are dealing with insurers. That is the first point. The second point is how are you going to report that? How are you going to publish your results? How are you expecting us to hold you to account for what it is saying?

Mr NICHOLLS: Starting with that question, I think one of the virtues of the new legislation is that there are now broader reporting capacities for us. The legislation we are currently governed by has secrecy provisions in it which in some cases are valid but in some cases act against the ability to make appropriate reporting. The new provisions allow us to do that and we intend to do that. I think it is an important part of the arsenal of the regulator to be able to do public reporting and then use processes such as these to be able to hold—

The Hon. DANIEL MOOKHEY: When you say you intend to do it, do you intend to do it yearly or monthly? What is the thinking here?

Mr NICHOLLS: It will vary on a case-by-case basis, but we are already reporting quarterly the performance of the scheme. That would continue but I think for some things we would be providing information in the short run and some things it would be in the longer run. It will be a mix of those.

The Hon. TREVOR KHAN: In reporting quarterly—I am sorry to show my ignorance that I do not look at these—are those quarterly reports tabled in the Parliament or elsewhere?

The CHAIR: The website, I think.

Mr NICHOLLS: We publish them on our website, so you can go there right now and find the quarterly reports going back. We also have an annual scheme performance report that we provide to this Committee.

The Hon. TREVOR KHAN: Right. Good.

The Hon. DANIEL MOOKHEY: Drilling down further, have SIRA prepared projections as to how many cases you will be applying all this scrutiny and all these powers to, particularly a three-year review? How many people each year do you expect to have to be reviewing at that level of detail to make sure that insurers are not deferring their liabilities?

Mr NICHOLLS: The approach that we are taking is effectively to triage claims depending on the severity of the injury and if there are other signals at the point of lodgement of the claim. What we are moving towards is a system whereby all injury notifications will come to SIRA rather than go off to the insurer. So the first point of contact for the injured person will be through SIRA, which means we get the first ability to look at those claims and make an assessment. And then it is very much about triaging those according to how severe the injuries are, how long that might take, how likely it might be that due to the nature of this claim it might end up in dispute. And then it will be about developing different approaches. So this is a fairly standard approach. And icare is developing a similar approach with their support services so that effectively the bulk of people you would expect to come into the system will be dealt with quickly and appropriately and move out of the system. It is more about providing them with support and information, but at the other—

The Hon. DANIEL MOOKHEY: I accept that and appreciate the elucidation of the process by which you would do this, but can you just give us the ballpark figures, either now or on notice?

Mr PLAYER: I might be able to help there on the disputes front. I think the issue you raised earlier—I will not be able to tell you about forecasts, because that is obviously a matter for Mr Nicholls—on the ability for an injured person to make sure they are not being poorly dealt with before they transition to a lifetime care scheme I think it is important to draw the Committee's attention to the fact that the claimants have significant rights during that period. Leading up to that five-year period, if there is a dispute with the insurer around treatment and care and whether it is reasonable or necessary, the claimant has the right to seek to have a decision which is binding on the insurer made by the dispute resolution service around that.

The Hon. DANIEL MOOKHEY: I do appreciate that. I am not wanting to repeat a contest about whether or not that is the case when it comes to CTP because that is obviously a disputed view. My final question is: As a result of all this, are you saying to us that when icare tell us that they are essentially having to accumulate a little bit of additional premium to account for that risk of deferred liability that there is no basis for them to have to make that decision and pass that cost on to premium payers?

Mr NICHOLLS: Sorry, I perhaps misunderstood your previous question. No, there are costings around that. As we move into a new scheme where we have now effectively treatment and rehabilitation benefits for life, which I think is a really important aspect of this new scheme, we are breaking new territory. We are dealing with costings. Costings necessarily have their hypothetical assumptions behind them but those costings have been developed looking at the experience in other jurisdictions and applying those to the New South Wales situation. Off the top of my head—but I am happy to take it on notice—the estimate is something around a $60 million impact.

The Hon. DANIEL MOOKHEY: On notice as well, can you also elucidate the level of dialogue you have with icare? It seems there is a bit of a discrepancy here with icare seemingly unaware of all these steps you are taking to mitigate the risk. It would be very helpful if you were able to provide that detail. We can put the same question to them about it so we are able to make sure that you are talking.

Mr NICHOLLS: Absolutely. I am very happy to take that on notice but I can assure you we have a very constructive and collaborative relationship with icare. We have had a number of engagements about this process. We have shared the costings with them. They are aware of the likely numbers that will be coming into that cohort and it is on that basis that they are developing the levy component that we talked about before. But I would be happy to give you more detail on notice if that is helpful to you.

The Hon. TREVOR KHAN: Mr Player, you are very expressive in your facial movements.

Mr PLAYER: Sorry.

The Hon. TREVOR KHAN: I am not being critical at all, but you would be terrible at playing poker, I suspect.

Mr PLAYER: I am terrible at it—absolutely.

The Hon. TREVOR KHAN: When Mr Mookhey made an observation about access to the dispute resolution process relating to CTP you, in a sense, screwed your face up.

Mr PLAYER: Yes. I was unsure what Mr Mookhey was referring to. I think maybe there might be a difference in the workers compensation scheme versus CTP, perhaps, that we were thinking of. I am not quite sure.

Mr DAVID SHOEBRIDGE: It may not be covered by this inquiry.

The Hon. DANIEL MOOKHEY: That was more my point—that we are not here to repeat that.

The Hon. TREVOR KHAN: There was an observation made and he looked somewhat concerned.

The Hon. DANIEL MOOKHEY: You should have the right to reply.

Mr DAVID SHOEBRIDGE: Could I just ask a question that relates to our terms of reference?

The Hon. TREVOR KHAN: That is very unusual for you, Mr David Shoebridge. You normally take us down every burrow known to man.

The CHAIR: Out of order.

Mr DAVID SHOEBRIDGE: It is a red-letter day. Which agency would be responsible for giving advice to the Government on the costings and the merits of expanding the definition of dust disease in the 1942 Act?

The Hon. TREVOR KHAN: If requested by the Minister, one supposes.

Mr NICHOLLS: The substantive Act is allocated to the Treasurer. There are some parts of the Act that are allocated to the Minister for Finance, Services and Property—I hope I have got that right in deference to the Minister. But the primary legislation is managed by the Treasurer so I would expect that in the ordinary course it would be the Treasurer who would ask for that advice and icare, as the primary manager of the Dust Diseases Scheme, would provide advice back to the Treasurer in that regard.

Mr DAVID SHOEBRIDGE: If the question was not about managing current claims but was about changing the regulation to potentially expand the definition—

The Hon. TREVOR KHAN: Changing the regulation or changing the Act?

Mr DAVID SHOEBRIDGE: Would that not be an element for SIRA to have a role in that?

Mr NICHOLLS: There would definitely be a role for us in that process at the very least to have regard to how it integrates with the wider workers compensation system, absolutely. But again, coming back to my response, the Treasurer would be the primary Minister here and it would be up to the Treasurer to determine what advice he may want to seek from us in another portfolio.

Mr DAVID SHOEBRIDGE: Are you aware of the calls from multiple stakeholders to expand the definition of "dust disease" under the 1942 Act to, at a minimum, include that broader catch-all phrase from the tribunal Act, which is the second element of the definition—schedule 1 plus certain lung diseases?

Mr NICHOLLS: Certainly in the context for preparing for this hearing I took the opportunity to read the submissions and previous evidence. I understand icare has provided an answer both in writing and in response to your queries and, in view of their expertise in this area, I would defer to their expertise. Certainly it is something that we would be happy to take note of in terms of the concerns that have been raised, and communicate and discuss with icare around those issues definitely.

Mr DAVID SHOEBRIDGE: Do you agree, given that you have the oversight of the different statutory schemes, that one thing that frustrates claimants is where you have inconsistent definitions between different statutory schemes? Inconsistency is a problem that not only frustrates claimants but also stakeholders, lawyers and everybody.

The Hon. TREVOR KHAN: Point of order: Mr Shoebridge is starting to ask—and I am not being derogatory—a public servant issues that relate to policy. I think that is perhaps entrapping these gentlemen into a difficult position.

The Hon. LYNDA VOLTZ: But it is their job to administer policy.

The Hon. TREVOR KHAN: Their job is to administer policy, not to make it.

Mr DAVID SHOEBRIDGE: What I am saying is that when you have inconsistent definitions you are one of the few people who have this sort of helicopter view of all the different statutory schemes. Inconsistent definitions between the statutory schemes creates frictions and problems, does it not?

The CHAIR: Mr Nicholls can choose whether or not to answer the question.

Mr NICHOLLS: I am happy to answer the question. I acknowledge Mr Khan's point. I think there is a point at which parliaments have to decide these things, but each of the schemes have their own dynamics. My observation in having just gone through the compulsory third party [CTP] reform process was that there were often instances where the question might be put: "That might be done differently in workers comp" but when you come to look at it the circumstances are different in each of the schemes and there are nuances. I think the answer to your question is that absolutely sometimes it is correct that inconsistent definitions are a problem, but sometimes they are different for a reason. To just artificially say that we need consistency no matter what can actually create unintended consequences, and I have observed that firsthand in our recent review. But I think the point you are making is well made. I think there are absolutely instances where those inconsistencies are valid but that is something for SIRA to consider and to give advice to government because it is ultimately a matter for the Government and the Parliament.

Mr DAVID SHOEBRIDGE: Are you aware of the concerns from stakeholders about the absence of an achievable, independent review mechanism from decisions being made by the Lifetime Care And Support Authority, particularly about decisions on eligibility? Are you aware of those concerns from stakeholders, particularly lawyers groups?

Mr PLAYER: I was in the room earlier when Ms Ahilas was giving her evidence. She is clearly an absolute subject matter expert in this area; having practised in it for 20 years—

Mr DAVID SHOEBRIDGE: Twenty-seven years.

Mr PLAYER: I do not profess to be an expert. Our dispute resolution services do not have a role in the dust diseases area. On the basis of her information alone, it is quite clear that the stakeholders have concerns about the level of ability to access a review of those determinations.

Mr DAVID SHOEBRIDGE: I think we are talking about two different things—we might get back to dust diseases in a minute. Are you aware of the concerns of stakeholders that if eligibility for lifetime care and support is disputed they will find them disputed in the Supreme Court in very expensive and stressful litigation and that it can often be repeated efforts from insurers that see them in the Supreme Court?

Mr PLAYER: We definitely are aware of that in the lifetime care space, as opposed to dust diseases. I misunderstood your question, I thought it was dust.

Mr DAVID SHOEBRIDGE: That does not matter. I will come back to dust diseases later.

Mr PLAYER: On the lifetime care front, the process for those disputes being resolved does include a number of stages to those processes. The dispute that arises can arise between three parties—the CTP insurer, the claimant or participant in the Lifetime Care and Support Scheme and the authority, as well around eligibility for the scheme. All three of those parties have the right to contest a decision of an independent medical panel around whether or not somebody satisfies those medical eligibility criteria. That question is one of the most hotly disputed issues that arise in the CTP scheme as a whole. As you can imagine, it is a major issue for a vulnerable, injured person who has potentially got catastrophic injuries going into that scheme or not going into that scheme.

Mr DAVID SHOEBRIDGE: All the merit review steps are within the authority.

Mr PLAYER: Within the Lifetime Care and Support Authority?

Mr DAVID SHOEBRIDGE: Yes.

Mr PLAYER: Within the authority but determined by independent medical experts who are on those panels. The first step is a decision by a member of staff, as I understand it, of the authority. The second step is on the question of eligibility, a panel of three medical experts.

Mr DAVID SHOEBRIDGE: Chosen and appointed by the authority?

Mr PLAYER: Yes, who make a decision on that issue. The third step is where we become involved in an administrative sense—there is a proper officer gateway threshold test to determine whether there is a reasonable cause to suspect an error in the decision that could warrant the dispute moving to a further panel of three dispute resolution assessors, who are appointed by the Lifetime Care and Support Authority.

Mr DAVID SHOEBRIDGE: That is all within the authority?

Mr PLAYER: That is correct.

Mr DAVID SHOEBRIDGE: My question was predicated on the assumption that all those merit reviews are within the ambit of the authority and the call is for an independent agency of some description—court, tribunal or otherwise—to be able to determine it, which does not have all of the costs, expense and delays in going to the Supreme Court. It is not a merit review anyhow; it is just a jurisdictional review.

Mr PLAYER: I think that is a valid point.

Mr NICHOLLS: I think that is a fair comment.

Mr PLAYER: But I would say that there is a very, very small number of claims that we are dealing with. It is incredibly traumatic and difficult for people to go—

The Hon. TREVOR KHAN: How small is "small"?

Mr PLAYER: At that tier of medical eligibility disputes, I will have to take it on notice, but it is less than half a dozen disputes a year that have come towards the third tier of medical eligibility dispute resolution that we see and there has literally only been one that has been decided.

Mr DAVID SHOEBRIDGE: How many get stuck in the teeth of the proper officer though?

Mr PLAYER: It is less than half a dozen a year.

Mr DAVID SHOEBRIDGE: That come to the proper officer at all?

Mr PLAYER: Yes.

Mr DAVID SHOEBRIDGE: As opposed to go through the gateway of the proper officer?

Mr PLAYER: Yes.

The CHAIR: Could you take that question on notice and provide the Committee with the figures for that.

Mr PLAYER: I will take it on notice. It is certainly less than double figures, and I think it is less than half a dozen.

The Hon. LYNDA VOLTZ: How many quarterly reports have you released in 2017 and are they available on your website?

Mr NICHOLLS: They are, yes.

Mr DAVID SHOEBRIDGE: Have you released any in 2017?

Mr NICHOLLS: We have, yes.

The Hon. LYNDA VOLTZ: I could not find them on the website.

Mr NICHOLLS: Okay. They are definitely there.

The CHAIR: Could you take that on notice and come back to the Committee about that?

Mr NICHOLLS: I am happy to take that on notice and I am happy to provide them to the Committee.

The Hon. LYNDA VOLTZ: Can you provide in detail when it was released?

The CHAIR: There may also be a question as to their visibility on the website.

Mr NICHOLLS: I will take that on notice.

The Hon. LYNDA VOLTZ: In your 2016 report you talk about upward pressure on premises and the 2015 report states word for word "contribution factors are increasing claims frequencies, significant increase in both number of small claims, low bond yields and wage inflation." I think people would be surprised that wage inflation has been included.

Mr NICHOLLS: Wage inflation is a factor in determining the value of settlements that are made for economic loss. So the rate of wage inflation impacts on the size of settlements and therefore can inflate them or deflate them as applicable.

The Hon. LYNDA VOLTZ: In 2015 and 2016 you have included wage inflation as a contributing factor in upward pressure on premiums.

Mr NICHOLLS: Yes.

The Hon. LYNDA VOLTZ: Do you mean your anticipation of what future wage inflation will be?

Mr NICHOLLS: Correct.

The Hon. DANIEL MOOKHEY: What are you forecasting it as?

Mr NICHOLLS: I would have to take that on notice.

The Hon. TREVOR KHAN: Is this part of our inquiry?

The Hon. LYNDA VOLTZ: It was directly referred to, which is why we are trying to ascertain what it is.

Mr NICHOLLS: I will take the technical detail on notice, but there are a number of upward pressures on the scheme that we have seen particularly since about 2013 and, quite rightly, through 2015 and 2016 those pressures were certainly there. We have seen in the last six months a reversal on those things—bond yields have softened in terms of the downward pressure they were previously under—but we have particularly seen a real change in claims numbers, a dramatic change in claims numbers.

The Hon. LYNDA VOLTZ: Just clarify for me because I assume when you as actuaries do it right at the beginning you anticipate that when you are making a payment you are taking growth in wage into your initial assessment anyway. Given we are in a period of wage stagnation, why is suddenly wage inflation an upward pressure when that would have been counted as part of your actuary anyway?

Mr NICHOLLS: The comments are really trying to refer it to a time series over time of what is different in relation to those actuarial assessments and so the statement in our report is trying to illustrate the variables, if you like, in the assumptions that actuaries will use over a period of time that impact on the reasons why prices would go up.

The Hon. LYNDA VOLTZ: So what you are saying is that instead of it just being part of what you would anticipate normally for your actuaries, that wages would go up, what I am trying to ascertain is are you seeing some different growth in wages that is extraordinary to that?

Mr NICHOLLS: No, over time in terms of time series. With inflation, wages typically move in line with inflation. So if inflation is moving then the expected wage inflation will also move and over time, because payment of economic loss is an important part in the scheme, movements in wage inflation will affect the underlying liability in the scheme.

The Hon. LYNDA VOLTZ: But when I see a significant increase in small claims I would assume that that is putting upward pressure because it is unusual and unexpected.

Mr NICHOLLS: It is, yes.

The Hon. LYNDA VOLTZ: If I see wage inflation in there I assume that there has been some extraordinary wage inflation that has not been anticipated. I am not sure why that would not be normal pressure rather than upward pressure.

Mr NICHOLLS: Sure. I think we are now getting into the realm of actuaries and their definitions. I would be happy to take on notice the way the actuaries view wage inflation.

Mr DAVID SHOEBRIDGE: I suppose we are getting into the realm of whether or not your reports are actually a cut and paste of previous reports or are actually turning your mind to the real pressures that people want to see reported on.

The Hon. LYNDA VOLTZ: Let me clarify this: you raised the quarterly report as being the policies and procedures upon which you put pressure on insurers. I am going to your quarterly report, which is the document you pointed to as the reason for where you implement your policies and procedures and, quite frankly, on reading that it looks to me like (a) a cut and paste but (b) is not an actual reflection of what is happening. If I was an insurer reading that I would do what I have done and go—

Mr NICHOLLS: Insurers receive a more detailed version that does not have the removal of some of the information that is commercial in confidence. But coming back to the answer to my previous question, I was responding to a question about how we are going to manage claims in the new CTP scheme that is starting from 1 December. One of the questions was how we might be able to use data and reporting of data better and I indicated that we would be initiating a much broader array of datasets over and above what we already report on that quarterly basis. If I provided any misapprehension to the Committee I was not attempting to imply that those quarterly reports alone are the sole basis for the way we hold those to account.

The CHAIR: Can you provide to us on notice what you are suggesting the datasets would be for the improved reporting capacity?

Mr NICHOLLS: Absolutely. I am happy to take that on notice.

The Hon. DANIEL MOOKHEY: But the question was directed at how you are managing the transfer of liabilities between CTP and Lifetime Care and specifically if you are planning to modernise the reporting framework of doing it, if you can specify how you intend to do that?

Mr NICHOLLS: If I could perhaps answer your previous question, Mr Shoebridge? In relation to us monitoring and changing our opinion, you will see that in the most recent quarterly reports our opinion has changed.

Mr DAVID SHOEBRIDGE: I cannot find your most recent quarterly reports because they are not on your website.

Mr NICHOLLS: I am happy to provide that to you. I apologise if our website is difficult to navigate.

The Hon. LYNDA VOLTZ: Certainly the 2016 and 2015 as you defined, and the 2017.

The CHAIR: Allow Mr Nicholls to answer the question.

Mr NICHOLLS: I am responding to a question about whether we are cutting and pasting and I am just assuring you that that is not the case. We have gone through a period in the 2015-16 period where the trends were consistent. Those trends are not there now and that is not what we are reporting at.

The CHAIR: The Australian Lawyers Alliance submitted to us that insurers are making multiple applications on behalf of individual claimants to have them accepted into the Lifetime Care and Support Scheme and says, "The Alliance believes insurance should be limited to one application per claimant". How common are multiple claims? Is that an issue you are concerned about? Should it be limited to one or two? What is your response to that?

Mr PLAYER: I will answer that. I think we will take on notice the numbers. We will need to go and report back in detail because I do not want to place any misapprehensions, but it goes to the question—

The Hon. TREVOR KHAN: Over the length of the scheme can you do?

Mr PLAYER: I think we will take that on notice and we will aim to do that. The scheme has been running since 2007 with very small inception numbers over the years. I think we are now up to around 1,000 participants in the scheme. Those numbers vary over time. We will try and do that. But it goes to the question Mr Shoebridge raised earlier around those dispute resolution processes within the Lifetime Care scheme. Having read the evidence from participants earlier in the Committee, those avenues of review and appeal are open to all parties. We will take on notice the question about the volume of those that might be exercised on multiple occasions by insurers, but the right exists for a claimant to do that as well.

The Hon. TREVOR KHAN: Do they exercise it in that way?

Mr PLAYER: Again, I will take those—

Mr DAVID SHOEBRIDGE: Let us get the numbers of the three participants, the applications by three participants.

Mr PLAYER: I can tell you that there have not been any applications that have come to our end of the dispute processes at the tail end around eligibility that relate to an application by the authority; it has only ever been the CTP insurer or the claimant. We can take those on notice and come back to you. But it is incredibly small numbers, which is very hard to draw broad conclusions from, we are literally talking handfuls of people—but for those people it is very traumatic and it is a lifetime-changing decision, so they are very important decisions.

Mr NICHOLLS: If I could just add, I read that submission with a lot of interest. Although the numbers are small, every individual that gets affected by it is one too many.

The Hon. TREVOR KHAN: That is right. If the insurers are doing over one, that is one too many.

Mr NICHOLLS: Exactly. I look at the legislation and I go, "Why is it one-sided? Why does SIRA have the power to direct an insurer when they are tardy in submitting an application?" I have that power now; I can direct an insurer when they are tardy. But the reports that are coming to this Committee show that it is not tardiness that is the problem; it is issues to do with the insurers who are overreaching. Sometimes it might be legitimate but sometimes it is not. I do not have the power to step in and go, "Well, that's an overreach and you should pull back and you need to manage that person effectively".

The CHAIR: Just to be clear, what are you calling an overreach?

Mr NICHOLLS: If an insurer is effectively sending somebody into dispute over and over and over again to try and get them into Lifetime Care, to get rid of the liability, and they are doing it as a game, frankly.

The CHAIR: How common is this?

Mr NICHOLLS: It is very small numbers, but one is too many. I just look at the legislation and I go, "Why would I have a power to deal with tardiness but I don't think that's the problem we are dealing with here?"

The CHAIR: You are suggesting to us that you need the power to be able to—

Mr NICHOLLS: Something the Committee may want to think about is to provide SIRA with the balance to be able to intervene both ways where an intruder might be tardy. I think that is appropriate because we do want to ensure that somebody who needs to get to Lifetime Care gets there quickly if an insurer is tardy, but also a power to be able to—

The Hon. DANIEL MOOKHEY: Vexatious litigation.

Mr NICHOLLS: Yes, to deal with vexatious aspects. But we need to be careful because sometimes it is going to be legitimate because somebody's injury changes over time and legitimately the insurer is coming back and saying, "I think now we need to—

Mr DAVID SHOEBRIDGE: But should that not be maybe where we are looking rather than the sort of broad discretionary powers, you are not sure when to call it in?

Mr NICHOLLS: Perhaps, yes.

Mr DAVID SHOEBRIDGE: But the other suggestion that has been put is that insurers get one go and they only get a second go if there is a very substantial change in circumstances or some other sort of exceptional circumstances test, and that might be a better construct and more consistent with other Acts.

Mr PLAYER: I think, Mr Shoebridge, that what you are suggesting is what is in place at the moment. I do not think that we are seeing multiple repeat applications for insurers. I think what we are seeing is one application by an insurer that might go through multiple stages of the review processes, but I do not think that at the end of that process what you are seeing is the insurers coming back in six months' or nine months' time having another shot. I do not think that is what is occurring. We will have to look at the numbers.

Mr NICHOLLS: Maybe we will take that on notice.

Mr PLAYER: I think the issues that were coming up in the Committee were that insurers were using all of the available steps through the process, I suspect.

The Hon. TREVOR KHAN: That was not my impression. The impression I perceived from the evidence was that they were chopping in twice.

Mr NICHOLLS: Could we take that on notice, because that was my read of it as well?

Mr DAVID SHOEBRIDGE: But it may well be that some of the frustration we are hearing from the lawyers is explained also by those multiple internal reviews. Maybe if you could give an answer on that.

The Hon. TREVOR KHAN: It may well. If two applications actually mean six processes that is a hell of a thing.

Mr PLAYER: We will take both issues on notice. The volume on the first stage and whether any come back for a second shot.

Mr DAVID SHOEBRIDGE: Part of that is whether or not some kind of threshold might be required before insurers lodge reviews from the first medical panel?

Mr NICHOLLS: That is definitely worth looking at, yes.

Mr DAVID SHOEBRIDGE: One suggestion mentioned by the Law Society—and not necessarily with the law society stamp of approval—rather than black and white insurer wins all when they get it into the scheme or loses all when they fail, whether there would be scope to have a negotiated outcome?

The Hon. TREVOR KHAN: I think that was Tim Concannon's view.

Mr DAVID SHOEBRIDGE: That is how I pitched it.

Mr NICHOLLS: I need to understand that a bit better.

Mr DAVID SHOEBRIDGE: If the insurer succeeds in having a claim accepted by the scheme, bang, they cure themselves of liability and it is a substantial windfall. If they lose then they maintain the liability.

Mr NICHOLLS: One hundred per cent liability.

Mr DAVID SHOEBRIDGE: In most commercial relationships there is an opportunity for a negotiated outcome rather than having to do that. That may be unattractive to the authority because you may say, "We have a clear decision making process and we will let the cards fall where they do". Have you thought about having a commercial resolution process?

Mr NICHOLLS: I am happy to consider those options. I think there might be some merit in looking at that further but I have not turned my mind to it.

Mr PLAYER: An important issue is that once they are in the Lifetime Care and Support Scheme, that is the treatment and care component of their compulsory third party [CTP] claim rights that are paid for life gradually by the Lifetime Care and Support Scheme. The rest of the CTP entitlements, which might be non-economic loss for those with a greater than 10 per cent whole person impairment threshold are still covered and able to be paid out by the CTP insurer at whatever point in that claim they are able to be resolved. The ongoing treatment and care payments that lifetime care pay for life is what Mr Concannon is talking about. The rest of the CTP can be commuted into a lump sum and paid out.

Mr DAVID SHOEBRIDGE: When you are talking about the level of injury to get access to the scheme, most of the dollar value of the claim is almost always the element met by the scheme?

Mr PLAYER: Which is for treatment and care expenses for future and current needs. In terms of the fund available from a CTP claim, such as non-economic loss component, that is still accessible in the CTP scheme.

The Hon. DANIEL MOOKHEY: Mr Nicholls, in your opening statement you made the point that a serious legislated role in relation to workers comp dust diseases, and secondly, to determine the rate of the dust diseases levy according to industry. Are you noticing any changes in the patterns of industries that are subject to that levy or is the incidence of the levy changing as the nature of dust diseases is changing? What research base do you maintain? What projections have you got? How are you planning for the future, particularly as we are seeing a whole different category of dust diseases than the ones that the first scheme was designed for?

Mr NICHOLLS: I will take some of that question on notice, appreciating that I have had responsibility for the Dust Diseases issues for four days and I am still learning about it. There is an approach in the current levy setting process whereby there are effectively nine classes of employer, depending on the historic level to which those different classes of employer contribute towards dust diseases. You have eight assessable groups. Every employer in the State makes a contribution but the vast bulk make a small contribution of 0.01 per cent of the payroll.

The Hon. DANIEL MOOKHEY: Construction and mining pay a lot more.

Mr NICHOLLS: They pay a lot more. It goes up to 1.2 per cent. I am happy to take it on notice and give you the exact figures for the high risk. You have a small group of employers where direct exposure is part of their job. People who might go and clear an asbestos site and they have no option but to deal with asbestos, because it is the nature of the work, they are a special category and they pay 4 per cent of their payroll. Those classifications, to your point, have been in place for some time. It is something that I would have to take on notice to consider the efficacy of those.

The Hon. DANIEL MOOKHEY: The Committee is particularly after time series data that looks at the changing of the incidences and where the liabilities are moving to. In addition, what is the research base you are maintaining around this? How are you forecasting, are you collaborating with safe WorkCover and other authorities to minimise risk and liability?

Mr NICHOLLS: We collaborate with Safework and particularly icare. icare maintain the primary role in relation to research in this area and we take their advice and information to help us in the levy setting process so we are allocating it fairly. One of the challenges we have in levy setting is that it is based on injuries that occurred sometimes 20, 30 or 40 years ago. The challenge we have is how do we fairly allocate the levy to employers today? You may have an industry employer today that has first class safety management systems in place and all the research and evidence is showing that this risk is well managed but we are dealing with people in that industry that 30 or 40 years ago got an injury that is unrelated to the current management.

The Hon. TREVOR KHAN: It may be unrelated to the current engineering or the way work is done in the industry.

Mr NICHOLLS: Correct. Things have changed.

The Hon. DANIEL MOOKHEY: How are you doing it?

Mr NICHOLLS: We have to apply some level of historic allocation but with a level of cross-subsidy. Effectively, all employers in the State make a base contribution but then industries that have historically contributed more get a loading. You could argue that is a little bit unfair because of those changes but there is no other way of doing with it without it being unfair on other employers that have nothing to do with that history. That is the inherent problem with levy setting in dust diseases.

The Hon. DANIEL MOOKHEY: Will you take that on notice?

Mr NICHOLLS: Yes.

Mr DAVID SHOEBRIDGE: The disputes in relation to medical treatment or care or eligibility disputes in Lifetime Care and Support, can you explain how they are dealt with under the current system?

Mr PLAYER: Lifetime care disputes, treatment disputes, have a different process to the eligibility disputes. In my earlier evidence I referred to the processes that are available when there is a medical eligibility dispute. There are two other types of disputes that can arise in the Lifetime Care and Support Scheme: Treatment and care specifically. The first determination is made by a single dispute assessor appointed by the authority and their decision is made and subject to a potential review by either party by a panel of three dispute assessors.

Where my team in the State Insurance Regulatory Authority [SIRA] are involved is the proper officer of the medical assessment service is the person who determines that threshold gateway test of whether a decision can move from a single dispute assessor to the panel of three Lifetime Care dispute assessors. Those decisions made around the treatment and care issue are binding on the parties. All of these dispute processes, as Mr Shoebridge mentioned, are subject to potential inherent jurisdiction of the Supreme Court, which has administrative law oversight of all statutory administrative decision making. But, that is the process for treatment disputes.

Mr DAVID SHOEBRIDGE: If a participant desperately needed a different wheelchair and they put an application in and that was rejected, they would go to the proper officer for review?

Mr PLAYER: Yes.

Mr DAVID SHOEBRIDGE: If the proper officer determines there is a valid dispute it goes off to a review panel?

Mr PLAYER: A panel of three.

Mr DAVID SHOEBRIDGE: What would be a reasonable amount of time, as a guide for your agency or the average, for determination? What is your aim? Is it to be done in 14 days, 30 days or 60 days?

Mr PLAYER: In these different dispute types, particularly with the catastrophic injuries we are dealing with in Lifetime Care, it varies depending on the nature of the individual case. The first tier, which is the proper officer gateway threshold test, we would expect to be done within 30 days. A period of that time is taken up by giving the opposite party, whoever has not lodged the review, the opportunity to respond and once we have received their submissions on their response to the application and their submissions on the issues that have been raised in the application, the proper officer would consider the information and determine whether that legislative statutory test has been met and issue a decision to the parties about that. That is normally 30 days.

Mr DAVID SHOEBRIDGE: The full review process?

Mr PLAYER: Again, it depends. Averages are probably not the right number to use given we are talking about small numbers of disputes, literally handfuls in any one year.

Mr DAVID SHOEBRIDGE: I am happy with a median. The answers you have given say it is an average of 150 calendar days?

Mr PLAYER: I suspect that is more than outlier with a very small number of disputes being determined rather than a standard process, but you would not accept 150 days. You would think something closer to 90 to 100 days would be an appropriate period of time for a standard dispute with lots of—depending on whether a medical examination of the applicant is required. If it is treatment and care that is not likely to be the case. It is more likely that there is a significant dispute on the evidence about whether that care is reasonable or necessary to satisfy the test.

Mr DAVID SHOEBRIDGE: Is there a dashboard that shows you are reporting on those things, because I cannot find it.

Mr PLAYER: That could certainly be something we are reporting in SIRA's annual report, in terms of the work that SIRA performs. Given it is Lifetime Care's dispute assessors that are making these determinations, and it is Lifetime Care's medical appeal panel of decision-makers and they are not SIRA-appointed decision-makers, they would be best to report on that in its annual report.

Mr DAVID SHOEBRIDGE: Who is responsible for managing the process, bringing the submissions together?

Mr PLAYER: The ultimate responsibility is the Lifetime Care Authority. Our role in those disputes is limited to that proper officer gateway threshold test. Once the panel is convened, SIRA has a role in convening the panel for them, but it is a Lifetime Care Authority appointed panel and the ultimate responsibility is theirs.

Mr DAVID SHOEBRIDGE: Is the delay in convening the panel, or is the delay in the proper officer determination? Where is the delay?

Mr PLAYER: I am not sure there is a delay.

Mr DAVID SHOEBRIDGE: On average, it is 150 calendar days. I would call that a delay.

The CHAIR: We have to conclude questions with this witness. You might want to take that question on notice and give us some more information about the performance in the area and where you are reporting it, as discussed, because it is an issue that we are concerned about. If members have any other questions, they might like to put them on notice or give notice of them now.

Mr DAVID SHOEBRIDGE: I will put them on notice.

The CHAIR: The Committee has resolved that questions on notice require an answer within 21 days. Thank you for your evidence and your time today, gentlemen.

(The witnesses withdrew)

DAVID BOWEN, Chief Executive Officer, National Disability Insurance Agency, affirmed and examined

The CHAIR: Welcome to the Legislative Council inquiry's first review of the dust diseases and lifetime care and support schemes. Would you like to make an opening statement?

Mr BOWEN: No, I am in the Committee's hands as to what you would like to discuss.

The CHAIR: This inquiry has received evidence that the National Disability Insurance Scheme [NDIS] overlaps with some of the clientele that we are inquiring about. We thought we could explore some of those issues today.

Mr BOWEN: Sure. There has been a small number of people who gained access to the NDIS whilst still in the Lifetime Care and Support scheme (LCSS). Mostly this has been the result of some transitional issues while we get set up and the way in which the National Disability Insurance Agency [NDIA] has received data from the State and Territory, particularly Ageing, Disability and Home Care [ADHC] as part of the Department of Family and Community Services. The process that was adopted to advise the NDIA of transitioning State clients has been that ADHC has had to seek that information from the service providers. This is a typical example. The service provider has added on to the list everyone who is living in a particular supported accommodation location. All of that has come through the NDIA and we have popped it through our systems and entered the person into the NDIS. There is a number, and I believe it is somewhere between 50 and 60 people in the NDIS who are also in LCSS. The majority of those are probably in that by accident.

We are close to finalising a memorandum of understanding [MOU] between the NDIA and icare, as we are with all other State and Territory compensation schemes, to allow us to data share so that we are not getting these accidental overlaps. There is a prospect of there being a person who would be eligible for both schemes if they had a pre-existing disability at a level that would get them into the NDIS, and then they were subsequently injured in a motor vehicle accident. Two comments on that, generally the criteria for entering the LCSS, the level of catastrophic injury would pretty much overwhelm the pre-existing disability and it would be very difficult to unwind. But if it was possible to say these supports are associated with the motor vehicle accident, then LCSS would be responsible for it and NDIS would be responsible for whatever other supports they may need as a result of their pre-existing disability. But it will not be a large number of people and it will not be a large cost.

Mr DAVID SHOEBRIDGE: How is it going to be managed?

Mr BOWEN: How will it be managed?

Mr DAVID SHOEBRIDGE: For instance, if someone had a congenital or acquired brain injury which gave them entry into NDIS and they were then a passenger in a vehicle and had a catastrophic orthopaedic injury, you would not want to have them go to the NDIS for the brain injury and then to the LCSS for their orthopaedic injury. That would be a terrible outcome.

Mr BOWEN: They will have to go to each scheme separately because they have separate and distinct statutory entitlements—one under State legislation and one under Commonwealth legislation. Through data sharing we would ensure that there are no overlaps and no gaps in the services that are being delivered.

Mr DAVID SHOEBRIDGE: We are meant to have person-focused care. It seems to me to be a very poor outcome if somebody is going to have two distinct providers providing them with treatment. You would hope that they would be treated as a whole person and looked at in their totality.

Mr BOWEN: Let me say this: People with disabilities access many, many, many different systems and it would be an absolutely wonderful circumstance if all of that was coordinated, but that is not the reality of the situation. If you look inside just New South Wales, people are accessing compensation schemes, health services, housing services, they might be involved with criminal justice support, they might be involved in a range of other human services. Each of them have their own criteria to assess and their own services that are set out by legislation to deliver. That is the reality of the circumstances in which we live.

The CHAIR: It is contrary to icare's evidence to us, and you have probably had time to read the evidence. We were given evidence by icare that there are some cost-sharing arrangements between the two schemes to support individuals who may have eligibility for different services under both schemes.

Mr BOWEN: My understanding is that we have a small number of people who have overlapping support needs and we share the information. We work it out at the local level. The starting point is not about drawing hard boundaries, it is that there are no gaps in the services that the person is accessing.

Mr DAVID SHOEBRIDGE: You say we should accept the fact that people go here for this service and there for that service and another place for another service. I do not accept that fact if you are talking about someone with a severe disability. I would have thought there is an obligation on governments to ensure, so far as possible, that they can have a single access point and they can be treated as an entire person by the one agency. That might take a bit of doing, but surely that is preferable?

Mr BOWEN: Why do you not start by looking at that inside New South Wales before asking a Commonwealth agency to do that type of arrangement?

Mr DAVID SHOEBRIDGE: No, I am suggesting that the State agency cooperate with the Commonwealth agency for an MOU—

Mr BOWEN: I have just indicated in response to you that we do cooperate, we do share.

The CHAIR: One at a time for Hansard.

Mr BOWEN: We coordinate supports, but we each have to, under our own legislation, independently determine eligibility for each scheme and the support that is to be provided by each scheme. That is a function of directions that are given to us by our respective parliaments.

The Hon. LYNDA VOLTZ: Just take the housing example, if you wanted to work through a State Housing Authority you would need to meet the criteria of means testing and a whole range of things?

Mr BOWEN: That is correct.

The Hon. LYNDA VOLTZ: They are the kind of examples you mean when you are talking across State agencies.

Mr BOWEN: Yes.

The Hon. TREVOR KHAN: Where somebody has been in the Lifetime Care and Support Scheme and they have been assessed as not requiring the lifetime care and support, when can they make an application to then be accepted into the NDIS? Do they have to go out of the Lifetime Care and Support Scheme before the application can be done?

Mr BOWEN: No, we will entertain an application from a person really at any time. The issue, and I am aware of this circumstance, is where a person has had interim eligibility in the LCSS and they may no longer be eligible for it. Because the NDIS has slightly wider criteria for eligibility they may still be eligible for the NDIS. They can make that application and have that determined. The issue will be that the time at which they get a support plan in this transitional period is governed by the bilateral agreement. If the person is living in an area where the NDIS is yet to roll out they will not get a plan until we are up to that point of the rollout schedule.

The Hon. TREVOR KHAN: I think the evidence in regards to this issue was given by a witness from Newcastle. I can think the scheme has rolled out in the Newcastle area, has it not?

Mr BOWEN: Yes, that is correct. Well, over the last year. It rolled out in three of the local government areas over the trial but over the whole Hunter-Newcastle care area it was over the last 12 months, that is correct.

The Hon. TREVOR KHAN: The example that was being given in terms of Newcastle may simply be a reflection of timing?

Mr BOWEN: It may be a timing issue. The person will still, of course, need to satisfy the NDIS eligibility criteria.

Mr DAVID SHOEBRIDGE: The evidence we had was that this was not happening. They at least had the impression—I do not know who gave it to them—that they could not put the application on to NDIS until they had exited the Lifetime Care and Support Scheme.

Mr BOWEN: That is not correct. If they were given that information that is incorrect information. They can make the application and have that determined at any time.

The CHAIR: Whilst still in the Lifetime Care and Support Scheme?

Mr BOWEN: The limit is they cannot get any supports under the NDIS until such time as they are outside the LCSS unless there is an overlap.

The CHAIR: Is there a gap? If you have assessed it said and they are entitled to it, does it pick up the next day?

Mr BOWEN: Let us assume we are over the transition period, the person should be able to make an application whilst still in the LCSS and have the supports that are provided by the NDIS upon ceasing to be a participant in LCSS. That is subject to meeting the eligibility criteria.

Mr DAVID SHOEBRIDGE: Does that mean before they leave the Lifetime Care and Support Scheme you have got the care plan and everything else sorted so that when they leave they immediately access services, or are you saying they leave the Lifetime Care and Support Scheme and then you start work on the care plan?

Mr BOWEN: We cannot start work on the care plan until they are outside the LCSS.

Mr DAVID SHOEBRIDGE: How long does the care plan take?

Mr BOWEN: At the moment they are taking about 21 days on average.

Mr DAVID SHOEBRIDGE: So there will be a gap. Then once the care plan is done providers have to be accessed in accordance with the care plan?

Mr BOWEN: We are now hypothesising, but I am assuming the person has a support need. If the reason they are existing LCSS is that they no longer have a support need then what is the gap in services? I share the concern, we do not want people having a gap in services, but what are the circumstances in which a person is exiting LCSS while still receiving services? I am not sure of that.

The Hon. TREVOR KHAN: Let us suppose that somebody has a significant cognitive impairment that has the person on the NDIS. They then have a serious motor vehicle accident that puts them into lifetime care and support on the interim basis. Then the requirement for lifetime care and support because of the motor vehicle accident resolves but the cognitive impairment does not. You have an ongoing issue that would have given them eligibility to the NDIS?

Mr BOWEN: Let us fast forward to where the NDIS is fully rolled out. That person was already in the NDIS, they have a motor vehicle accident as a result of which they have got additional support needs that are provided by the lifetime care scheme, they will still be getting supports from the NDIS at that pre-existing level. Lifetime care will be responsible for the additional supports over and above the underlying disability-related supports. When those supports are no longer required and the person exits lifetime care there will just be seamless continuation of NDIS supports.

Mr DAVID SHOEBRIDGE: That is not the scenario I was discussing. It was far more simple. Someone has a catastrophic injury that is initially thought to fall within lifetime care and support, maybe it is an acquired brain injury. Over the course of two years of treatment the brain injury partly resolves but they still have a substantial ongoing disability. That is when there is a gap, because when they exit lifetime care and support they then have to get the care plan in place and then access the providers under the NDIS, which I accept is on the assumption that they are eligible under the NDIS.

Mr BOWEN: I know quite a bit about the New South Wales Lifetime Care and Support Scheme of course and the circumstances in which a person would exit that scheme because they no longer needed support.

The CHAIR: You say you know quite a bit about it?

Mr BOWEN: I was the chief executive officer when the LCSS was set up.

The CHAIR: I was not aware of that.

Mr DAVID SHOEBRIDGE: You characterised my question incorrectly. I am not saying they no longer need support. I am saying they no longer meet the definition of catastrophically injured because it has partially resolved.

Mr BOWEN: The issue for us to assess and how that is applied in lifetime care—there would be very few circumstances in which a person was exited through the interim eligibility criteria where they still had a support need.

Mr DAVID SHOEBRIDGE: But for the ones that are, which are obviously troubling, there will be a delay.

Mr BOWEN: I am struggling to consider the circumstances in which they are being exited from LCSS and have a significant ongoing support need. I think the proposition is not right.

Mr DAVID SHOEBRIDGE: That is contrary to the evidence we heard from a person providing these kinds of services in Newcastle, but I suppose we are stuck with your answers and I do not intend to go beyond them.

Mr BOWEN: I am happy to look at the particular circumstances.

The Hon. TREVOR KHAN: I do not know if that is a correct characterisation of what she said. The characterisation she dealt with was the example that I gave.

The CHAIR: What we might do to resolve this is review the evidence and then, Mr Shoebridge, do you want to submit a question on notice?

Mr DAVID SHOEBRIDGE: Not particularly.

The CHAIR: I am just suggesting a way if you want to get more information because there is a dispute here.

The Hon. TREVOR KHAN: There is simmering outrage.

The CHAIR: I am only trying to resolve it.

Mr DAVID SHOEBRIDGE: I do not have any simmering outrage, I just do not find it particularly useful.

Mr BOWEN: I am happy to look at the particular circumstances and provide advice.

Mr DAVID SHOEBRIDGE: You can do whatever you like. It is not useful.

The Hon. LYNDA VOLTZ: There are instances where people come out of lifetime care and support after two years. From memory, head injuries were a good example. They are coming up with new medical technology and improvements and there is a range of reasons why they come out of the system. That is normally in the two-year period. That is when you find you are getting that transition across. I guess the issue is how you are going to resolve that transition.

Mr BOWEN: The interim eligibility was set up just because the trajectory for recovery of brain injury is extremely uncertain at the point of injury and there is no clear correlation between the preliminary assessment under any of the scores and what the person's ongoing prognosis will be. A person who has made a recovery over that two-year period and exits the LCSS would generally no longer need any support because they have made a recovery.

The Hon. LYNDA VOLTZ: Some of the examples were things like they actually have personality changes and other areas in which they need ongoing help and assistance to live, but not being on the Lifetime Care and Support Scheme.

Mr BOWEN: Yes, but they will still need to qualify for the NDIS. The NDIS requires that a person has a permanent disability, so they will meet that criteria, and a substantial functional impairment in one of a list of different domains. The person will need assistance with activities virtually on a day-to-day basis to qualify for NDIS. So I am really grappling with the circumstances where someone has exited LCSS because they have made a recovery and they no longer need that support and are being left, as Mr Shoebridge has indicated, with a significant gap in their care needs that NDIS will fill. I just do not think it is a real example.

The Hon. LYNDA VOLTZ: I think the only gap would be the gap in between that 21 days—because obviously with a head injury a person can be completely comatose at the beginning and completely reliant on having every need provided for, but over time that improves. But it is those ongoing issues where if a person has a carer who provides food and makes sure that—

The Hon. TREVOR KHAN: Then that person would remain in Lifetime Care and Support.

Mr BOWEN: You would remain in the LCSS.

The Hon. DANIEL MOOKHEY: There are other reasons why people leave the Lifetime Care and Support Scheme that are not related to care needs—do you accept that?

Mr BOWEN: No. I would like to know what examples there are other than people choosing to exit.

The Hon. DANIEL MOOKHEY: We received evidence from a cluster of people which suggests that, whether there are revisions around the causal framework or there are further discoveries or elucidations about a care need that is not necessarily linked to the injury, it comes out through the course of their involvement in the scheme—do you accept that that happens?

Mr BOWEN: I think I have answered that. If a person has a support need that is not associated with the motor vehicle accident then they will be assessed under the NDIS and they will get those support needs met. That would be—

The CHAIR: That would be seamless once you get them rolled out.

The Hon. DANIEL MOOKHEY: That is the question—if there is seamlessness of the transfer. I accept, of course, that you have to assess them under your laws, using a different criteria. You have been very clear about that point. What we are trying to understand is for a person who has to do that, practically, what is it like? Is it simply a case of, if you have had no contact with them beforehand, the first time you even know about them is when they make their first application? Is that the most likely scenario?

Mr BOWEN: If they are in the LCSS then part of the arrangements that were set up in the memorandum of understand [MOU] will allow for that data sharing so that we all have prior knowledge of the person. They still need to make an application. Unlike a State client it is not a matter of a simple transition from one service system to another, so they will still need to make an application, but we have people who can assist with that. Our local coordinators would assist with that and really minimise any period in which there is a gap. But we are dealing with a really rare circumstance where the person has perhaps been wrongly assessed for LCSS and that has been reassessed because there has been a determination that primarily their functional impairment is not due to the motor vehicle accident.

The Hon. DANIEL MOOKHEY: This might be an unfair summary of your evidence—if it is, please tell me—but are you essentially saying that because these things are so rare it is not really worth the time, attention or investment or at least it is not worth prioritising—

Mr BOWEN: No, what I am saying is we can set it up to make sure that it occurs, that it is as seamless as it possibly can be, but the NDIA still needs to make an assessment as to whether or not they meet our functional impairment requirements or our access requirements.

The CHAIR: You were indicating that NDIA is establishing a relationship with State based disability organisations such as icare with an MOU. What else will that MOU cover?

Mr BOWEN: It is primarily to cover data sharing so that we know when people are in both schemes. But icare is part of a broader discussion between Commonwealth and State governments around the National Injury Insurance Scheme. The manifestation of that at this point in time is that people who have their impairment as a result of a motor vehicle accident and workplace accident over the transition period are principally covered or required to be covered by State schemes. If they are not and they enter the NDIS, we recover the full cost of that from the State Government through the normal billing arrangements, given the State Government is a funding partner in the NDIS. Clearly we overlap in terms of our engagement with the service provider system. Clearly we share a great deal of interest in making sure there is a workforce available to deliver the services and supports.

Clearly we share an interest in the evidence base that supports different types of therapeutic interventions. So there is enormous opportunity to share here. The State compensation schemes also have tremendously good longitudinal data as to the trajectory at least for the types of disabilities that those schemes deal with and the efficacy of different types of interventions, treatments and service provisions. The NDIA sees enormous benefit from that data sharing, beyond just overlaps and gaps and going to an understanding of the whole pathway for people inside the scheme and that focus on outcomes.

The CHAIR: It is probably a bit early for you to answer this because you are just at the beginning of the national scheme, but is there anything we should be looking at to improve the relationship and the intersect between our State based scheme and the national scheme?

Mr BOWEN: I think it is in the areas where the NDIS is changing the way services are delivered to focus upon them being, number one, outcome based. So our plans start with the goals and aspirations of the individuals and the outcomes that are to be achieved and then look at the supports to help the person achieve those outcomes. To some extent, compensation schemes do that because they understand that the cost of an intervention is well warranted if it delivers a good outcome for the person because it will know what they want to achieve, but that provides a saving in the long-term cost because you go from a static care based system into one that is much more dynamic and is about enabling the person to take more control in their own life. From what I have seen, icare is very much focused on that type of approach as well.

Some of the work that we have done has been to build an outcomes framework. We have now baselined outcome information on around 80,000 people who are in the NDIS at the moment. We will start to measure the trends over time of how people are self-reporting their ability to participate in the economy and in the community, and the extent to which they have control of their own lives. The strength of that is that we can do an analysis that says, "What are the correlations between good outcomes and the types of supports the person has received?" The best evidence base over time does not become some clinical study; it actually becomes what has really delivered good outcomes for people inside the NSIS. From what I have seen, icare is probably starting to move in that direction as well.

The CHAIR: I think that is the sense we get as well. Recognising that lifetime care and support is for people with much more catastrophic injuries than what you are dealing with, generally speaking, would it be right to characterise icare and their approach—which I think is changing—as much more prescriptive about entitlements? "You can have a wheelchair," or, "You cannot have this," as opposed to your organisation which is much more holistic, giving clients some control. We have received evidence—although it was disputed, from memory—that a taxi could not be used for going to the cinema. I think that was from the Hunter.

The Hon. TREVOR KHAN: That is a slightly different issue to the one that you are raising.

Mr DAVID SHOEBRIDGE: I think that was in Riverina.

The CHAIR: Yes, but what I am saying is that travel would be generally accepted under the NDIA approach. My question is: Is it right to characterise it that way?

Mr BOWEN: The construct of a plan under the NDIS is that there are three categories of funding. The great bulk of it is for core support, generally personal care but it would include transport, which would be another big one, and it might include some domestic assistance. It would also include some support for participation in community, recreational activity. So long as the expenditure by the person is related to their support needs, then they have full flexibility in how they use core supports. We say it is fully fungible across the different support types—if they want to use more in one area and less in another, that is a choice that they make. The other two categories are capacity building—this is funding to help a person achieve a specific goal. A very good example might be a person who needs assistance to be able to travel independently. So it is a training program to help the person travel independently because that will enable them to get out into the community more, maybe get into a job a little bit easier. That funding has to be used for the purpose for which it is given. So all our vocational, most of the employment goal support sits into those categories. What defines it is that it is for a particular purpose, for a particular time and to achieve a particular goal.

The third area for which the funding is locked is capital, which is for any equipment, home or vehicle modification over $5,000. Anything under $5,000 is in core supports. We do not require someone to get an occupational therapists [OT] prescription to buy a shower chair. If they want to just go and buy one themselves they can go and buy it themselves and include the funding in it, but once it goes above $5,000 the nature of the funding is such that the NDIA amortises that over five years. So we assume, apart from children who need equipment turnover much more quickly, the turnover is every five years. Obviously, the funding can only be used for that purpose. If it is there to buy a wheelchair, it is there to buy a wheelchair; it cannot be used on something else.

The CHAIR: That is quite different to your experience in being a chief executive officer of Lifetime Care and Support Authority?

Mr BOWEN: But different times—it is eight or nine years later. It would be something that I know the Lifetime Care and Support Authority are looking at and other State compensation schemes are looking at. Governments are always concerned about this full flexibility because of the prospect of fraud. It is a real live issue and you have to keep a close eye on it but the overwhelming evidence is—

The Hon. TREVOR KHAN: Is that fraud in the context of somebody having a lend of the—

Mr BOWEN: Misuse of the fund, yes. Because the funds are able to be used all over the place they are much more susceptible to misuse than when you have a very rigid, prescriptive system as to how the funding can be used. However, we know from overseas studies of where independent support packages have been introduced that generally people make better decisions about what they need than government makes on their behalf—there is probably no surprise there. Generally when people receive the funding in that format they treat it much more like their own funding. So they actually guard it more jealously and use it more appropriately, and they get better outcomes. The evidence overwhelmingly is that the more choice and control you give people they get better outcomes and lower costs because of it over time.

The CHAIR: Recognising that some people do not have the capacity to make those decisions and need some guidance.

Mr BOWEN: Part of our assessment of whether or not a person can fully self-manage that package is around the risks that it poses to themselves or to others from it. So there is a formal risk assessment as part of that but we do not apply a strict legal capacity test to it.

Mr DAVID SHOEBRIDGE: Are you establishing accreditation standards for, say, attendant care providers or domestic care providers?

Mr BOWEN: The Commonwealth Parliament has before it, or is about to have before it, a piece of legislation to set-up a national quality and safeguards commission. At present all of the standards that the NDIS operates under remains state-based systems. We register providers but we do not do the accreditation, we pick up whatever is applicable in the relevant States. Complaints against providers over these transition years remain within the jurisdiction of the State but the national quality and safeguards commission, or something to that effect—I am not entirely sure what the name will be—is intended to be established from 1 July next year. That has been agreed by Commonwealth and all State governments nationally.

Mr DAVID SHOEBRIDGE: So currently you are using the standards adopted by icare or by who?

Mr BOWEN: No, we use the State disability arrangements in place. Let me take a real circumstance. If someone who is a participant in the NDIS has a complaint about service provision in New South Wales at the moment they go to the Ombudsman.

Mr DAVID SHOEBRIDGE: I am not really talking about complaints, icare was saying, for example, for attendant care services there are not any readily identifiable service standards that they can find. So they are establishing some service standards in order for attendant care providers to be accredited and then they will be on a panel which icare participants can choose from. Is there a similar process in the NDIS?

Mr BOWEN: Our process of registration at the moment picks up the State accreditation, with the exception of self-management. So where a person is determined okay to self-manage and they choose to self-manage they can buy their supports wherever they like. They do not have to go to disability service providers. If they want to engage someone down the road they are welcome to do that. The State accreditation systems really are around the risk to the people who are particularly vulnerable. So in New South Wales—the Committee really needs to take the expert evidence on this from the State department—but there are higher standards imposed on service providers that are operating, say, shared supported accommodation or providing supports with complex support needs, particularly behavioural support needs and the like. That will all be replaced by a national arrangement from July next year.

Mr DAVID SHOEBRIDGE: Because currently you do not have those safeguards. The claimants under the NDIS can—

Mr BOWEN: Currently they operate under the agreement between the Commonwealth and the State—

Mr DAVID SHOEBRIDGE: Sorry, could you just let me finish my question. Currently you do not have those safeguards in terms of claimants or participants in your scheme. They can spend the money on the bloke down the road or their cousin or whoever?

Mr BOWEN: If they are self-managing.

Mr DAVID SHOEBRIDGE: When I was hearing the evidence from icare I thought it was probably a good thing to have standards and accreditations so particularly vulnerable people will not be exploited or potentially abused. I am just wondering what the rationale from NDIS is not to have those protections?

Mr BOWEN: We undertake a risk assessment before determining whether a person can self-manage. Obviously, if the person is particularly vulnerable or is in a circumstance where they could be exploited or abused then we would not permit self-management to occur.

The Hon. DANIEL MOOKHEY: So you are focusing essentially on the client, not the provider?

Mr BOWEN: We assess the client, not the provider. If the person is not self-managing because they choose not to or we do not permit it, then they have to use a provider that is registered with the NDIA but the registration at the moment imports all of the State accreditation requirements and over these transition years all of those go back to the State.

The Hon. DANIEL MOOKHEY: During these transition years do you have the independent ability to refuse or withdraw registration, irrespective of State accreditation?

Mr BOWEN: We do but we generally do that in discussion with the State or Territory, and not every type of service requires accreditation at a State level. Unfortunately, it varies significantly from State to State but that is just the functions of a rollout.

Mr DAVID SHOEBRIDGE: One of the gaps that was identified by icare was domestic care; there is not necessarily a clear accreditation and that is why they are working out their own accreditation. We had a submission from the industry itself saying that they do not want to have two different standards. It sounds to me like they might be going down a path where we have two different standards.

Mr BOWEN: If icare are moving to accredit every service that someone might get from their scheme, then we are definitely going down two different paths.

Mr DAVID SHOEBRIDGE: I did not say that, nor was that their evidence. They were talking about this particular gap.

The Hon. TREVOR KHAN: At the moment there are about six or seven different standards, I take it, because every State you are dealing with has slightly different criteria.

Mr BOWEN: That is right, and there are areas where—and I would think domestic assistance would be one of them—we want people with a disability to be able to access broad markets. One of the real problems is if you only define disability services as being ones that are provided by traditional disability service providers you really limit the opportunity for innovation and a broader view on it. So we are quite encouraging an approach that limits the need for accreditation to circumstances where the nature of the service or the nature of the client creates a particular vulnerability or risk.

Mr DAVID SHOEBRIDGE: We heard, and it has been a repeated theme in these inquiries, icare, and before icare the Lifetime Care and Support Authority, has a philosophical opposition to payments being made to family members to provide for care. What is the NDIA's position on that?

The Hon. TREVOR KHAN: That was not in the evidence.

Mr DAVID SHOEBRIDGE: I am telling you what I understood the evidence to be. What is the NDIA's view?

Mr BOWEN: We have probably a very similar view, which is that the payment of family members to care for family members, there is a strong presumption against it because it distorts the family relationship from being one of natural support to an economic relationship. Having said that, there are circumstances where because of cultural reasons or a simple lack of any other alternative, that we will pay for it. Having said all of that, when that does occur we would like the family member to be properly employed, covered by workers compensation insurance, subject to the same sorts of training as a disability care worker, and we are quite encouraging people who have lived experience as family carers to be deemed qualified to be able to provide disability supports far more generally.

Mr DAVID SHOEBRIDGE: The specific examples that were given earlier was, say, a parent having to take a day off work to take a child to a medical assessment or a sibling having to transport somebody, say, 300 kilometres in the country to attend a regional assessment, they have to take a day off work and they have a substantial loss and that is not being recompensed under the Lifetime Care and Support scheme. In those kinds of circumstances what is the NDIA approach?

Mr BOWEN: Where the NDIA requires someone to have an assessment as part of eligibility or a determination of support needs, we will pay the transport costs of the participant there.

The Hon. DANIEL MOOKHEY: This is more beyond the point of assessment and application. This is a point where in Lifetime Care and Support they have been deemed to be eligible, they are entitled to it. The specific narrative that was put to us was—two, actually: one was a Riverina-based example where a person could not access any other forms of transport and their family member had to take time off work and they could not be compensated for lost wages of transport. The second one was massive anxiety issues to do with a person from Tamworth having to come to Sydney to attend specialist appointments and the only person who they would trust would be a family member. We are not talking about the mass distortions in relationships that you are describing.

Mr BOWEN: The NDIS does not cover any health or medical or clinical supports. The nature of the services and supports we pay for are certainly not found in every community but it would be rare to require transport hundreds and hundreds to be able to get a service.

Mr DAVID SHOEBRIDGE: I am not asking you about rare. Are those kinds of costs met by the NDIS if the sibling loses a day at work to transfer—

Mr BOWEN: No, we would not pay for a family member to do that. But if the person had needed care support we pay a care worker to go with them.

Mr DAVID SHOEBRIDGE: It just may be vastly simpler to have the family member provide that one-off service rather than have an external provider attend. That was what was being put to us.

The CHAIR: We are not inquiring into the NDIS; we are looking at the intersect between the two schemes. Mr Bowen, we are grateful you came and presented to us. We appreciate you must be very busy rolling out this scheme. It has certainly informed us more strongly about some evidence we heard. You may have taken some questions on notice—

Mr BOWEN: If there are particular examples that you would like to put up to me I am more than happy to give you a written indication of what we would do in that situation.

The CHAIR: We will do that on notice, and you have 21 days to respond to our inquiry. We will look forward to seeing you in two years' time when we are doing another review.

Mr BOWEN: You will not be seeing me in two years time; I am retiring at the end of this year. Someone will be able to come along.

The CHAIR: By then we will have a lot more experience of the relationship between the two schemes to explore because we hold this inquiry every two years. Thank you very much.

(The witness withdrew)

(The Committee adjourned at 13:05)