UNCORRECTED PROOF

REPORT OF PROCEEDINGS BEFORE

# STANDING COMMITTEE ON LAW AND JUSTICE

# TENTH REVIEW OF THE MOTOR ACCIDENTS AUTHORITY AND MOTOR ACCIDENTS COUNCIL
# AND
# THIRD REVIEW OF THE LIFETIME CARE AND SUPPORT AUTHORITY AND LIFETIME CARE AND SUPPORT ADVISORY COUNCIL

---

**At Sydney on Monday 21 June 2010**

---

**The Committee met at 9.30 a.m.**

---

## PRESENT

The Hon. C. M. Robertson (Chair)

The Hon. J. G. Ajaka
The Hon. D. J. Clarke
The Hon. G. J. Donnelly
Ms S. P. Hale
The Hon. L. Voltz

**FRANCES MONYPENNY**, Manager, State Spinal Cord Injury Service,

**JOSEPH GURKA**, Medical Director, Westmead Brain Injury Service, and

**ADELINE HODGKINSON**, Co-chair, Brain Injury Rehabilitation Directorate, and Director, Brain Injury Rehabilitation Service, Liverpool Hospital, affirmed and examined:

**CHAIR:** Welcome to the second public hearing of the Standing Committee on Law and Justice's Tenth Review of the Motor Accidents Authority and Motor Accidents Advisory Council and Third Review of the Lifetime Care and Support Authority and the Lifetime Care and Support Advisory Council. Today we will be hearing from representatives of the Brain Injury Rehabilitation Directorate, the State Spinal Cord Injury Service, the Royal Rehabilitation Centre Sydney, Australian RehabWorks and Spinal Cord Injuries Australia. We will also be hearing from two scheme participants and from four family members who provide care to scheme participants. We are particularly grateful to these people for taking the time to come and talk to us today. At the end of the day we will be hearing again from representatives of the Motor Accidents Authority and Motor Accidents Advisory Council and the Lifetime Care and Support Authority and the Lifetime Care and Support Advisory Council.

Before we commence, I will make some comment about aspects of the hearing. I will not read about the broadcasting guidelines. They are available for people who require them. If you have anything that you wish the Committee to have, the secretariat will pass that to you. Committee hearings are not intended to provide a forum for people to make adverse reflections about others. The protection afforded to committee witnesses under parliamentary privilege should not be abused during these hearings. I therefore request that witnesses avoid the mention of other individuals unless it is absolutely essential to address the terms of reference. Could everyone please turn off their mobile phones for the duration of the hearing, as they still interfere with Hansard's recording of the proceedings.

If you should consider at any stage that certain evidence you wish to give or documents you wish to tender should be heard or seen only by the Committee please indicate that fact and the Committee will consider your request. If you do take any questions on notice, the Committee would appreciate it if the response to those questions could be forwarded to the committee secretariat within 21 days. However, if that is not possible, the secretariat will negotiate. It gives us time to do the report, but we recognise how busy you are. Would you like to make a short opening statement?

**Dr HODGKINSON:** I do not have a formal opening statement. The Brain Injury Rehabilitation Directorate has made a submission that is a combination of something more general and something more specific from the Westmead Brain Injury Rehabilitation Service. You will see how that flows in our submission. This is the third review. Certain recommendations coming out of the second review have been implemented and their full effect is yet to be seen. The Lifetime Care and Support Scheme is maturing and we are learning how to work with it and getting some adaptation. There is a very positive feel about how the scheme is working, but there are some continuing issues of concern that we wish to present.

**CHAIR:** We look forward to hearing about them.

**Ms MONYPENNY:** Thank you for the opportunity to provide comment to this Committee in relation to the third review of the Lifetime Care and Support Scheme. I am representing Associate Professor James Middleton, who is the director and chair of the State Spinal Chord Injury Service, and the co-chair, Mrs Jenny Johnson. Our responses reflect the views of the clinicians in the adult Spinal Cord Injury Service of New South Wales. The State Spinal Cord Injury Service represents a network of specialised spinal chord injury services at the Prince of Wales Hospital, the Royal North Shore Hospital, the Royal Rehabilitation Centre Sydney, the Spinal Outreach and Rural Services and the Hunter Spinal Cord Injury Service. These specialist services provide a coordinated multidisciplinary model of service delivery in inpatient settings across acute, subacute, rehabilitation, outpatient and outreach services environments to individuals who have acquired a persistent spinal chord injury as a result of trauma or from a non-progressive disease condition. The service works in partnership with key stakeholders involved in the provision of support services for people with spinal cord injury, including the Lifetime Care and Support Authority, Enable New South Wales, the Department of Housing and non-government organisations such as ParaQuad and Northcote Paediatric Spinal Outreach Services.

We wish to reiterate previous comments that the introduction of the Lifetime Care and Support Scheme by the New South Wales Government funded by levies on the CDP insurance premium has been most beneficial for reducing delays in the provision of no-fault funding for supporting treatment, rehabilitation and lifetime care costs and improving outcomes for people who have been severely and permanently injured in motor accidents. Over the past 12 months the scheme has continued to evolve with further development and clarification of supportive policies, guidelines, systems, procedures and forms regarding issues such as eligibility criteria, treatment, rehabilitation and care needs assessment, services that will be funded, dispute resolution and so on. In particular, the introduction of the discharge services notification form has streamlined some of the paper processes for clinicians and acknowledges that people with catastrophic injury will commonly require a range of services available on return home.

Work by Lifetime Care and Support and Enable New South Wales towards aligning their application and paperwork requirements has considerably reduced clinician confusion and frustration. In addition, establishment of the Spinal Chord Injury Service and Lifetime Care and Support liaison committee, which meets quarterly, has provided an effective communication forum to identify and address difficulties and inconsistencies experienced by the Spinal Chord Injury Service in relation to the management and discharge of scheme participants.

We outlined some issues and areas that we feel could be improved in our submission. Two issues in particular are worthy of note and deserve special attention. Firstly, there is continuing confusion, variation and inconsistency in the roles and processes followed by different lifetime care coordinators and appointed private case managers. We believe that providing greater clarity, transparency and consistency in requirements and processes would be very valuable for clinicians and case managers alike.

We also reiterate that clarification of the expectations and delineation between the role of clinicians as managers of patient care and the role of coordinators as administrators of the scheme, as well as involvement of case managers during the inpatient phase, is necessary. Secondly, we are extremely concerned by the fact that there is no agreement in place with area health services or expectation by New South Wales Health that revenue generated under the scheme be directed towards provision of services to lifetime care participants but, rather, cross-subsidising other services, which in our view is jeopardising the viability of specialised spinal cord injury services to meet the expectations of the lifetime care support authority in the future. Finally, we do see our role in a positive relationship with the lifetime care scheme and authority. It is achieving improved outcomes for clients in providing clinical leadership, expert care and advocacy for client-centred outcomes within the clinical and environmental context.

**CHAIR:** The brain injury rehabilitation directorate submission recommends that the Lifetime Care and Support Authority establish a prioritisation system under which urgent requests can be approved quicker than the normal 10-day time frame. In response the authority noted that its coordinators have sufficient financial delegation to approve requests within the 10-day period where the participant may be at risk of imminent harm or adverse outcome. Does that address the concerns you have raised in your submission?

**Dr HODGKINSON:** Only in part.

**CHAIR:** Are some of these too big for the financial delegation?

**Dr HODGKINSON:** There are two ways in which you need rapid decisions. One is if the clinical condition or circumstances of a participant change in a crisis situation, and then may put that person at risk, for example, they may become significantly more unwell or their support structures which are currently informal fall away very quickly. Then there may be a crisis. I think lifetime care and support have been able to respond to crisis situations where there is a real risk. The concern that is not being met by that recommendation is when the scheme needs to move very quickly because the patient is moving very quickly. So in the situation of a patient with a severe brain injury who may come to our ward, one of the clinical circumstances of severe brain injury is that they may improve very quickly, very rapidly, from a physical point of view and want to be home with their family as soon as possible.

Although they may need care and therapy, within two weeks of an admission they will be ready for discharge. It is against their interests to keep them in for another 10 days or two weeks waiting for approvals, and any capacity we have to guess what their needs may be when they arrive is often inaccurate. When you first see a patient within the first day you only have a feeling for what they may need, not be able to complete a care and needs assessment. It is that need to respond rapidly. So the lifetime care's discharge procedures have addressed that for therapy needs—occupational therapy, physiotherapy have now pre-approved hours which addresses that issue, but it is more the care that may be needed. Where a person may go home and be expected to participate in their family with support and may need quite substantial hours of care in order to continue to improve, that is being delayed.

**CHAIR:** Would there be any way that an interim emergency process could be developed? Two weeks in hospital and then home might be a very short period of time to authorise and deliver long-term service provision, and in two weeks it might have changed again.

**Dr HODGKINSON:** Yes.

**CHAIR:** Would there be any way that an interim emergency—I am calling it emergency because it would be called in quickly—process could be developed? It would not be 100 per cent because it would not have gone through all the process of thought and choice and whatever.

**Dr HODGKINSON:** An idea that if a person requires care, those hours of care could be flexible. If you identify that on discharge a person may need hours of care and you may initially guess 25 hours but it may turn out to be 40, there should be a capacity to rapidly change that within the first month, by which time you will have properly assessed the situation.

**CHAIR:** You would have a proper case manager process.

**Dr HODGKINSON:** Yes, and proper assessment process.

**CHAIR:** Would it be too hard?

**Dr HODGKINSON:** I do not think that would be too hard.

**Dr GURKA:** In answer to the original question, I agree with Dr Hodgkinson that it is only partly addressed by the response to the issue because it is not purely a delegation issue. We have had lots of examples where, despite the delegation of a certain amount of authority to the coordinators, we are still waiting beyond the 10 days to get responses on some very simple, basic things.

**CHAIR:** Can you give an example?

**Dr GURKA:** Just simple things like having a pharmacy account finalised, some items of equipment that are not that complex. We are still chasing responses to some of these requests, even beyond the 10 days. So it does not appear to be just a delegation issue. It appears as though there might be a workload issue on the side of the coordinators that they are finding it difficult to respond to requests in a timely fashion.

**CHAIR:** A common problem or occasional?

**Dr GURKA:** Lately common.

**CHAIR:** Just lately.

**Dr GURKA:** Yes.

**Ms SYLVIA HALE:** Ms Monypenny, in your submission you note the ongoing concerns about the return of revenue gained through the scheme to the clinical unit actually providing the service. Can you elaborate on those concerns and particularly about the statement from New South Wales Health that when the scheme was established "there was no expressed intention that revenue generated by New South Wales under the scheme should be protected for services for scheme participants only"? How did the difficulties you have described in obtaining reimbursement affect the actual service delivery?

**Ms MONYPENNY:** Every service within the public health system has a revenue target so that is one aspect. The other thing is that the lifetime care refund is part of that revenue. Initially, our concerns were that the area health services did not have in place a process to bill lifetime care. After our perseverance—and I am sure it is from everyone—that seems to be in place. The clinicians see that there is an increased workload in relation to lifetime care clients. At this stage we are not 100 per cent clear what the expectations for that fee are so the clinicians continue to provide the service as they would for everybody else in the ward in a fair and equal manner. However, the paperwork has created as increased workload and they see it as increasing maybe 10 to 20 per cent, taking away from their clinical time. It means they are taking 10 to 20 per cent of their precious clinical time away from contact with the client because they have to fill in the paperwork.

Their view is that if we are getting that revenue part of that revenue should be allocated to provide support mechanisms to help fill that gap, either by extra clinicians or someone who can do the paperwork. The only facility that has achieved that is the Royal Rehabilitation Centre, Sydney, and there is a compensable case coordinator who manages all compensable patients and supports the clinicians in doing that. So the revenue raised through lifetime care, number one we are not sure whether it comes back to the units, and number two we know that if it does come back it is only as part of that sometimes somewhat unrealistic revenue target that we have. We are a public service; we cannot go out and canvass people to have a spinal cord injury so that we can raise revenue. Therefore it can be very difficult, and the clinicians see it as frustrating. The issue that we said highlighted about New South Wales Health is we were only commenting on their response to a request made, I think from this Committee, to New South Wales Health to review the impact of lifetime care. So we were only commenting on that.

**Ms SYLVIA HALE:** I think you said that in the case of the royal rehabilitation hospital they have a compensable case coordinator. Would that be an appropriate position to create in all locations across the State? Would that in itself be quite a heavy cost, just providing that person?

**Ms MONYPENNY:** I guess each service would be able to identify where that revenue would best be targeted in supporting their clinicians because some services have maybe more administrative support—so whether it be to increase the clinician hours or to increase the case coordination hours while they are an inpatient or whether it be to do the paperwork. Obviously the paperwork has to be completed by clinicians because it is making an assessment on the client.

**Dr GURKA:** If I may comment on the original question, whilst Health says that it was never intended for the revenue to go back to directly support participants I find it hard to reconcile that with the practice of them then setting us a revenue target to achieve if that is not going to be the case. It does eventually affect services you provide to clients because the revenue targets that are set are unrealistic and beyond what you will ever raise. When there is a shortfall it basically means, at Western Sydney, we have not been given the okay to keep our staff establishment to the level it needs to be to provide services. So, there has actually been a downgrading of services at Western Sydney in the brain injury program and we are now struggling to meet the client need. It is definitely affecting health.

**Ms SYLVIA HALE:** Do you have any involvement when the revenue target is set?

**Dr GURKA:** No.

**Ms SYLVIA HALE:** It just comes down from on high and then it is used as a mechanism whereby it is somehow indicative of your inefficiency that you do not reach it?

**Dr GURKA:** Yes.

**Ms SYLVIA HALE:** To your mind what is the advantage of having a revenue target?

**Dr GURKA:** There is no advantage. I would prefer to have a situation where I am guaranteed an expenditure budget and the area can keep whatever makes it terms of revenue or alternatively there is more negotiation around what revenue is appropriate so that they then provide the appropriate amount of supplementation, but there is no process that supports that.

**Dr HODGKINSON:** The revenue component is very important. They have said that at the inception of the Lifetime Care and Support Scheme there was no plan to return the funding to the services providing that funding. However, at the beginning of the brain injury rehabilitation program there was a clear intention that moneys set aside from revenue would be included in the expenditure budget of the brain injury program so that it became part self-funding with a set expenditure budget and protection of that expenditure budget from other constraints in the area health services. They may have put in a revenue target but there was an agreement to meet any shortfall. There are large fluctuations from year to year in how many people you have that are compensable, who pays up, and what other constraints there are. A buffer zone where there is an expenditure budget and a guarantee is much more reasonable. Incentives could be put in for the services so that if they exceed their revenue targets they could receive funding back. But to have a situation, with Western Sydney in particular, where they are set an unrealistic revenue target they will never meet and are then penalised because they do not meet it and their service is shrunk and their capacity to earn revenue is even less, is really crazy thinking. It seems particularly the case at certain area health services. There are currently eight area health services so it is not a consistent theme but it is certainly a huge problem where it occurs.

**Ms MONYPENNY:** In addition to that, a service fee or facility fee is imposed on services, which we seem to be moving more towards and which has never been part of our budget. In particular it affects the Royal Rehabilitation Centre because they are a third schedule hospital that is funded through an area health service.

**CHAIR:** We are hearing from them a little later.

**The Hon. JOHN AJAKA:** Can you explain what you mean by their being charged a services fee?

**Ms MONYPENNY:** Understandably the facility has to be cleaned and it has to have laundry et cetera, but there is a greater focus on that because we are so stretched from the budget perspective. I guess if Royal Rehab is presenting they may raise this, but from our perspective as the statewide service, any revenue that is raised would be chipped away by the area health service before it actually goes to Royal Rehabilitation and then it is chipped away again before it actually reaches the service. Whatever revenue we raise has already been cut back.

**The Hon. JOHN AJAKA:** I want to clarify a couple of things. You indicated you are not certain you are receiving all of the moneys raised through the scheme. You are assuming that, if I can put it that way. It brings it down to one of two scenarios: either you are not receiving all of the money raised or you are receiving all the money raised but it is not sufficient. Would that be a fair comment?

**Dr HODGKINSON:** The problem with the brain injury rehabilitation program is that probably 60 to 70 per cent of our patients are covered by compensation or the Lifetime Care and Support Scheme—that is new patients—and yet we are expected to provide a service to non-compensables, so we will never be fully self-sufficient or fully financial in terms of receiving our revenue because we assume it is a fair cost. There is always that other component.

**The Hon. JOHN AJAKA:** When you say "We are not receiving" or "We may not be receiving" all of the funds being collected for the scheme, what do you mean by that?

**Dr HODGKINSON:** The revenue is raised by the area health service. They are the only people authorised to issue invoices apart from the schedule 3 hospitals. That revenue goes into general revenue. It may be marked as being received because of our bills but it very much goes into one big bucket called general revenue. It is not directed to our service.

**The Hon. JOHN AJAKA:** To go back to the beginning, it was interesting to note and pleasing to hear that when there is a crisis rapid decisions are being made, but you are saying decisions are not being made as rapidly when the situation is one of improvement. Is that correct? When a person has improved more than expected and wants to go home, suddenly we are back into the 10-day waiting period or beyond.

**Dr HODGKINSON:** The 10 days are there; sometimes it is beyond. It is a hold-up because often you reach that point of knowing, having completed your assessment at the end of two weeks in hospital, that they need to be at home but there are another 10 days before services can be put in place.

**The Hon. JOHN AJAKA:** Decisions are not being made as rapidly if you have a positive improvement situation as they are in a crisis situation. Is that what you are trying to explain to us?

**Dr HODGKINSON:** Yes.

**The Hon. JOHN AJAKA:** It has been acknowledged there is potential for tension between the clinicians and the coordinators when the clinicians recommend an action that does not fall into the category of treatment, rehabilitation or care service. Can you give examples of where that occurs?

**Dr HODGKINSON:** Sometimes what you would class as rehabilitation can be debated. Medical care is quite obvious, particularly if it is related to the injury, but there are tensions around a few decisions. One was quite a simple issue where we applied for a hearing aid that had been lost in an accident. The patient had a hearing aid beforehand but it went missing in the emergency situation, so he was then quite deaf and we had difficulty working with him. He did not understand therapy, it was harder to communicate and he could not make himself understood. We applied to Lifetime Care for a replacement of that aid, because to hear was part of his rehabilitation, but because he did not require that hearing aid as a result of his accident the initial response was to reject it. After some discussion we got the hearing aid but it was not really smoothly done.

Another issue was when we discharged a patient who needed care and support. She was unable to drive as a result of her injury, she had decision-making problems and would not cope well with stress, yet she was expected to take her children to school and continue their after-school activities as well. She had three children, all at the same school fortunately, but three or four different after-school activities. Approval was given for transport of the children with the mother assisting them but getting the additional time to take the children to after-school activities was disputed. Yet that was equally her role and it was equally important in the longer term for her and her children to maintain whatever role she had and to enable the children to continue their after-school activities. In a global sense it was very important to maintain all aspects but to divide an essential service from something that was additional to their schooling—

**The Hon. JOHN AJAKA:** What was the final result of that situation? Did she get approval?

**Dr HODGKINSON:** I think in the end we will win. I do not know that the approval has happened yet.

**The Hon. JOHN AJAKA:** It is still happening?

**Dr HODGKINSON:** Yes.

**The Hon. LYNDA VOLTZ:** I refer to the revenue. You say that because of staff shortages people are being referred to outside providers.

**Dr GURKA:** Certainly that is happening at Westmead because of inability to recruit to certain positions, which our area health service will not allow us to do because we are not meeting revenue targets and FT targets they have set us.

**The Hon. LYNDA VOLTZ:** Which positions are not being recruited?

**Dr GURKA:** Positions across the whole service. There are some on our in-patients program, such as speech pathology and social work positions. On our community team there is a psychology, a social work and an occupational therapy position, so there are a variety of positions across the broad aspect of the program, which means we are looking to refer people to different services when they leave us. That is not hard to do in terms of finding a service to manage them but it is not ideal in terms of continuity of care and handing over of care when you have established a relationship with that client, and they with you, and there is a lot of existing knowledge in managing them and you have to hand them over to a more disjointed service rather than have it all coordinated through one program. Sometimes it is not necessarily a specialised service either.

**The Hon. LYNDA VOLTZ:** So those positions are not just for people coming under the scheme but obviously to service patients from outside the scheme?

**Dr GURKA:** Yes, definitely.

**The Hon. LYNDA VOLTZ:** Are you finding there is a problem because there is conflict where people are part of the compensable scheme and there is an income stream for their treatment, as opposed to the public health sector that has traditionally been funded through government?

**Dr GURKA:** Yes. We tend to protect our resources for those people who have no other source of funding and treat the public patients, and we are beginning to farm out those who have funding through a scheme like this or other forms of compensation to the private sector, which is less coordinated and sometimes less specialised.

**The Hon. LYNDA VOLTZ:** Is this a trend now with public hospitals becoming more part of an integrated private sector, not just through Lifetime Care? Obviously you would expect a speech pathologist within the public health system.

**Dr HODGKINSON:** To step back a bit, when an area health service may have budget constraints and FTE constraints, they may say, "We need to reduce our FTEs in allied health by a certain percentage".

**The Hon. LYNDA VOLTZ:** Could you explain FTE, please?

**Dr HODGKINSON:** Full-time equivalents, sorry.

**Dr GURKA:** Number of staff.

**Dr HODGKINSON:** Then as the allied health positions become vacant, they are not recruited to until that target is met, but this may result in a very uneven loss of staff, so you may lose two social workers from your inpatient service, but still have a full complement of other staff, or you may lose two speech pathologists and then you have no speech pathology service. So it is a very uneven setup. I think that creates a lot of difficulties, so that when you come to discharge a person to the community, rather than being able to provide a comprehensive team-based service centred around the person and the service that they are used to, you may send them off to a variety of different private practitioners.

**The Hon. LYNDA VOLTZ:** Has your budget been decreased?

**Dr GURKA:** I can only speak for western Sydney. Our budget has not been decreased, but our full-time equivalent staffing target has been, so I have a situation where my staffing complement has been reduced and I am not able to recruit until that is at a certain level, despite the fact that I theoretically have budget available to me to recruit, but part of that budget is a so-called revenue target, which I am not meeting either.

**The Hon. LYNDA VOLTZ:** So in real terms has your budget decreased?

**Dr GURKA:** Yes.

**The Hon. LYNDA VOLTZ:** Do you know by what proportion it has decreased in real terms?

**Dr GURKA:** Between 15 and 20 per cent.

**CHAIR:** This is not really part of our terms of reference.

**The Hon. LYNDA VOLTZ:** Sorry, no, I was trying to clarify where the real problems lie and whether it is part of a shift. At the moment there is not an ability to address staff shortages?

**Dr HODGKINSON:** In western Sydney, no. Some area health services are in a similar situation to Westmead and others are not, so they are travelling better.

**The Hon. GREG DONNELLY:** One of the questions on notice is that the Lifetime Care and Support Authority has noted that the draft guidelines for case managers have been amended following feedback and now include "increased reference to the specific health management needs of people with spinal cord injury". Have you seen the amended guidelines?

**Ms MONYPENNY:** The amended guidelines were uploaded on the website on Thursday afternoon, so no. Certainly they have not been distributed.

**The Hon. GREG DONNELLY:** So you have not had a chance to have a look at them and reflect on them?

**Ms MONYPENNY:** No.

**The Hon. GREG DONNELLY:** Could you let the Committee know about the level and degree of interaction that you have with the Lifetime Care and Support Advisory Council?

**Dr HODGKINSON:** We continue to have two people from the brain injury program and one from the spinal injury program on the Lifetime Care and Support Advisory Council, which has just recently been reinstated as a council, so it met as a committee for about eight months before this next meeting when it will be a council. Myself, Denis Ginnivan from south-western—

**CHAIR:** Sydney south west?

**Dr HODGKINSON:** No, from Albury.

**Ms MONYPENNY:** Greater southern.

**Dr HODGKINSON:** Greater southern—it used to be south-west—and James Middleton are on the advisory council.

**CHAIR:** When was it reconvened?

**Dr HODGKINSON:** It continued to meet as a committee, so at our last meeting we were still a committee, and now it has been reinstated as an advisory council.

**The Hon. GREG DONNELLY:** The last question is a bit of a Dorothy Dixer in that it invites you to cover anything you would like to that you have not already covered. Do you have any further comments to make about the Lifetime Care and Support Authority or the Lifetime Care and Support Advisory Council?

**Dr HODGKINSON:** With regard to revenue, I would appreciate it if the Lifetime Care and Support Authority would assist us in negotiating with the area health services as to how the revenue can be used to benefit lifetime care participants. I think it is very complex and budgets are very difficult things to manage and there are many different rules across the State, so I think if we simply begin with negotiation and assistance to liaise with them, that would be sufficient.

**Dr GURKA:** One of the positive things over the past 12 months has been the amount of effort that has gone into trying to review some of the forms and processes, and there have been some good outcomes from that and some of that work is still ongoing. However, I would like to make the point that it does not really matter to what extent we do that, the scheme is always going to be an increased workload for service providers no matter how streamlined the process has become and how acceptable they end up becoming for us, so in terms of going back to your earlier question, I think it would be really good to see the opportunity for all services to get some equitable resourcing to meet that additional service demand to meet the administrative requirement because there is no doubt that clinical time has been compromised by the introduction of this scheme, and there is a limit to how much the scheme is going to be able to change that for us, I believe, so the onus then goes on to the scheme and/or health to look at how our resources can be improved to meet additional demand.

**Ms MONYPENNY:** Could I add to that? There has been an enormous amount of work done by lifetime care and Enable to try to standardise, so that they both request the same sort of paperwork, and that is very good. The processes behind it are somewhat more delayed through lifetime care, so we would certainly encourage further work on that, but the other key things, going back to the issue of support of us by lifetime care and trying to negotiate a better understanding of the revenue of area health services, we have previously suggested a memorandum of understanding, which I think was also a recommendation of the second review, but in addition to that, greater clarity of what the expectation for that fee is. We know what the patient requires, but what are their expectations? We have had some conversations with them. The other key thing that needs further work is that we understand, because it clearly says on the website what the role of a lifetime care coordinator is and now with the new guidelines for the private case managers, where the boundary is between the clinicians and the coordinators and the case managers because that overlap and lack of understanding creates an enormous amount of tension.

**Dr HODGKINSON:** For those entering the scheme with brain injury, there is a two-year interim period and then they are assessed as to whether they remain in the scheme or exit the scheme. Brain injury can often have quite significant improvements and at the point two years post injury there are some who are clearly extremely disabled and remain in the scheme, and there is not really a lot of dispute about those, but it is more the people who are at a higher level where the tool we are using to assess whether they are in or out of the scheme needs to be tested as to whether this is truly the right way to measure those people who will need extensive care and those who will not.

**CHAIR:** Is it a bit too crude?

**Dr HODGKINSON:** Well, I think we need to explore it. I think it may be sufficient. The other issue is to see how those exiting the scheme continue to need care or therapy and those remaining in the scheme at the higher level—

**CHAIR:** A research project?

**Dr HODGKINSON:** Yes, and I think it should be something that is carefully looked at in case the tool that we are using is too blunt or whether additional measures are required. The other issue, of course, is education. I have two participants' families who feel that they would prefer to be out of the scheme so that they can get a larger lump sum payment under their CTP claim, so there is still perhaps some lack of understanding and maybe it needs to be tested as to what will really occur in the long term.

**CHAIR:** Thank you very much for your valuable input. I recognise how much of an impost it is on your lives, but thank you very much for coming. There will be some questions from this morning's session and the secretariat will be in contact with you in relation to those questions.

**Dr GURKA:** Thank you.

**(The witnesses withdrew)**

**STEPHEN PAUL LOWNDES**, Chief Executive Officer, Royal Rehabilitation Centre Sydney, sworn and examined:

**CHAIR:** Thank you for appearing before the Committee today. This is the second public hearing on the third review of the Lifetime Care and Support Authority and the Lifetime Care and Support Advisory Council. If you have any messages that you wish to deliver to us during the process, the secretariat will look after those. If you have a mobile phone, could you please turn it off because it interferes with Hansard recording mechanism?

**Mr LOWNDES:** Yes.

**CHAIR:** If you have any evidence that you may wish to give that you would like to be confidential, let us know and we will consider that request. If you take any questions on notice—which is possible, as we often need more detailed information—we ask that you respond within 21 days. If that is not possible, you can negotiate that time frame with the Committee secretariat. Would you like to start by making a short statement?

**Mr LOWNDES:** The Royal Rehabilitation Centre Sydney is an affiliated health organisation that forms part of the public health service. We provide rehabilitation services for people with, generally, traumatic-acquired disability. In that capacity we have a number of Lifetime Care and Support clients. We operate inpatient services. We operate also supported accommodation services and long-time care. We have Lifetime Care and Support clients in each of those settings. We form a part of the statewide Spinal Cord Injury Service and we are part of the statewide Brain Injury Rehabilitation Service. We get most of our referrals through those networks in regard to Lifetime Care and Support clients. Approximately 70 per cent have traumatic brain injury, about 30 per cent have spinal cord injuries, and of those a number have comorbidities. Currently we have five spinal clients and two brain injury clients in our inpatient setting and we have one with long-term complex rehabilitation needs, I think an amputee. We have three permanent and long-term residents in supported community homes, whom we have had for some time.

I made some comments in my submission about the effects of the introduction of the scheme two or so years on. I think it was introduced for adults in October 2008. There has been significant improvement in the administrative processes. I am keen to say that. There has been a lot of good collaboration, particularly over the last 12 months or so, and we seem to have ironed out a lot of issues that we did have. It is still quite a significant administrative burden, we find, particularly the approval process for every aspect of the service. Even where it is an inpatient referral to one of our specialists, that has to be supported by paperwork and approval. That seems to be still quite onerous. However, unlike the rest of at least the Northern Sydney-Central Coast Area Health Service, of which we form a part, we have a direct billing arrangement with Lifetime Care and Support since its introduction. That now works well.

**CHAIR:** That is the rehabilitation centre?

**Mr LOWNDES:** That is right. That now works well. However, at the moment we are under some significant strain in that we have to make good an apparent overpayment of some $3.7 million from the Northern Sydney area health service that goes back historically to the transition of the Motor Accidents Authority and the introduction of the Lifetime Care and Support Scheme. As I think you are aware, previously—and still for many other providers—it was done through a bulk funding arrangement through New South Wales Health. The Northern Sydney area health service has continued to pay as a subsidy in respect to what used to be Motor Accidents Authority payments. There is no transparency about how those funds were received. So it has only come to light very recently that those were, in fact, subsidy payments for those services that since the introduction of Lifetime Care and Support we are now billing directly for. That has created some issues for Royal Rehabilitation.

However, it does go to the point that the current arrangement we have where there is a direct billing arrangement for services provided is much more efficient, much more transparent and much more effective. That is because while there is significant administrative cost in the processing and the paperwork involved with Lifetime Care and Support clients, at least that is a cost that we absorb and are recompensed, if you like, from the Lifetime Care and Support payments. I think where those payments go through New South Wales Health and area health, again, there is a lack of transparency. But I am not convinced that the full amount of that rebate is passed on.

**CHAIR:** I believe they have said quite clearly it is not.

**Mr LOWNDES:** That is right. Again, the point of that is there is no transparency. It just comes as a block funding subsidy payment. So I would not know.

**CHAIR:** The Royal Rehabilitation Centre must be one of the few health facilities that did get direct funding from the Motor Accidents Authority process rather than just across general revenue?

**Mr LOWNDES:** No. Previously we received block funding subsidy payments from area health in respect to Motor Accidents Authority payments. Since the introduction of the scheme, we have been in a direct billing arrangement with Lifetime Care and Support clients.

**CHAIR:** I understood that. I do not believe that the Motor Accidents Authority did it across the board either.

**Mr LOWNDES:** No.

**CHAIR:** You were quite different.

**Mr LOWNDES:** Yes.

**The Hon. GREG DONNELLY:** The Committee has provided you with some questions on notice, so you would have been exposed to them. I want to pick up on some of the comments you have made already. Would you elaborate on question No. 2 and give a broader description of the various services you provide, namely, home-based, long-term support, community housing and outpatient? Would you elaborate on what you provide?

**Mr LOWNDES:** In both inpatient and community settings we provide a rehabilitation model, which is a multidisciplinary model. We have physiotherapists, speech therapists, psychology-social workers and occupational therapy support. It is a multidisciplinary approach. It is more intense, of course, in the inpatient setting. It is all about improvements in the functional improvement module [FIM] scores. It comes in through health-funded services in the inpatient setting and there is generally an agreed service plan with the client and their families. It is about a discharge and an outcome. So it is very much outcome focused. Generally when they leave the inpatient setting they would be placed into community care of some description back in the region they come from. On a few occasions they could be referred into our own service, although that has tended not to happen yet.

We have a brain injury community rehabilitation team that after discharge continues to provide rehabilitation support in their home or in their community setting. That tends to be time limited though and it applies to brain injury clients only. In supported homes we are just in the process of applying for accreditation as an attendant care provider. Royal Rehabilitation has not been credentialled as an attendant care provider. So we have consequently not had a significant number of referrals from Lifetime Care and Support. That is the model that they prefer. We are just in the final throes of going through that process. Having said that, we do provide long-term rehabilitation for slow-to-recover clients. Increasingly, I think, Lifetime Care and Support is recognising that, as a model, rehabilitation is not continuous and it is not linear. It is quite episodic. There is increasingly overwhelming evidence that many people, particularly with traumatic brain injury, do continue to make significant gains and improvements over the very long term. So that is a changing model of care.

**CHAIR:** Longer than the two years?

**Mr LOWNDES:** Yes, definitely longer than two years. Of course, the Lifetime Care and Support Scheme is relatively new, so a lot of that assessment is going on now. We generally organise the housing through affordable community housing. Lifetime Care and Support has more recently started to build its own houses, but I have some comments about that perhaps a bit later. That is reasonably it. We have a staff of rehabilitation specialists, both medical practitioners and a very extensive team of allied health people across all the disciplines.

**The Hon. GREG DONNELLY:** You have touched on this to some degree with your comment on the nature of the administration and the paperwork. Would you elaborate and give us your general experience as a private service provider to the Lifetime Care and Support Scheme? Could you give us some details about what the organisation's experience is in dealing with the scheme?

**Mr LOWNDES:** Yes. Bearing in mind that I myself do not complete the burdensome forms, I am reliably advised it is quite extensive paperwork in support of the payments. It has not melded with any of the other third party compensation payments, so there is significant variation. That has added complexity, I guess. When the Lifetime Care and Support coordinators and case managers were first introduced there was a lot of tension with some of our services.

**CHAIR:** Professional tension?

**Mr LOWNDES:** Yes, I think so, about who knows best about what the client needs. Of course, Lifetime Care and Support, working within a funded model, had very strong views about those things. However, through ongoing consultation and collaboration and, I guess, a bit of a change in perspective from our own case managers there has been improvement. We have case managers as well, and that is particularly where the difficulties have arisen. Our case managers, in fairness, are looking at health-related services particularly and Lifetime Care and Support probably is looking at it more expansively. There has been considerable improvement in those working relations. As I said, there is the remaining issue about the need for constant validation of individual services even within an approved program, which seems to be unnecessarily burdensome. We have had to put on full-time Lifetime Care and Support coordinators, even though for a relatively small number of clients, because of the level of detail and information required. Of course, that investment having been made and better systems now it is much improved, but still quite significant.

**The Hon. GREG DONNELLY:** Are there any other matters relating to your interface with the scheme that you would like to comment on?

**Mr LOWNDES:** As I said, there are some ongoing tensions with other service providers, where we get our referrals from and other places within the Brain Injury Rehabilitation Service. There have been differing opinions and views about the best case management model. Again, that is generally resolved through liaison with the Lifetime Care and Support people. We have good relations with them.

**The Hon. DAVID CLARKE:** Mr Lowndes, you referred to a $3.7 million overpayment to the Royal Rehabilitation Centre. Who was the provider of that payment? Who made that overpayment?

**Mr LOWNDES:** The Northern Sydney Central Coast Area Health Service.

**The Hon. DAVID CLARKE:** Do they pay you a budget per year, or do they pay you according to services so that it is a varying amount?

**The Hon. JOHN AJAKA:** Good question, judging from the expression on your face!

**Mr LOWNDES:** It is a very complex question and it is not a simple answer because it is in transition. That $3.7 million does go back to the introduction of the scheme. So I think in the financial year just gone, it represents about $2.5 million.

**CHAIR:** That is the Motor Accidents Authority scheme, not the Lifetime Care and Support Scheme, which we are dealing with.

**Mr LOWNDES:** Yes.

**The Hon. DAVID CLARKE:** It is important that we get to the bottom of it.

**CHAIR:** Not in these terms of reference, but perhaps later.

**The Hon. DAVID CLARKE:** Just if I can finalise the point I was making, Madam Chair, it might very well impact on the capacity of the Royal Rehabilitation Centre to perform its responsibilities under the Lifetime Care and Support Scheme. It is very important from that point of view. Just continue with your answer.

**Mr LOWNDES:** Yes. In part it has arisen, I guess, because of the introduction of the scheme, and that coincided with a move by New South Wales Health from block funding to case management payments. We are now funded, for the majority of our services, on a case-mix basis, so it is an agreed number of admissions or episodes at a given rate.

**The Hon. DAVID CLARKE:** You have been provided with funds per service.

**Mr LOWNDES:** Essentially, yes. There are some ons and offs in that, particularly because it was a transition from block funding to case-mix funding, and some attempt I think—

**CHAIR:** Client service, not actually case?

**Mr LOWNDES:** Yes.

**The Hon. DAVID CLARKE:** More or less it is the same thing.

**CHAIR:** No.

**Mr LOWNDES:** We get funded by a certain number of cost weights.

**CHAIR:** That is right.

**Mr LOWNDES:** But, in general recognition that the clients with whom Royal Rehab deals with are complex, there was a top-up adjustment made in the event last year. We also, though, still receive block funding payments for outpatient services and other things that are not specifically identified. Once that funding equation is allocated or determined, there is then a revenue target, which is established by area health, that is purportedly to represent the amount of revenue that they expect we will derive from private patient fees/third party payments, including from the Motor Accident Authority as it was then. So they established quite a substantial revenue target for us based upon historical Motor Accident Authority payments. Of course, the Motor Accidents Authority payments generally did not cease but had become much less prevalent since the introduction of the scheme.

**CHAIR:** In your service?

**Mr LOWNDES:** In our service, yes.

**The Hon. DAVID CLARKE:** Over what period of time was that $3.7 million overpayment made? Was it one payment or was it a number of payments, and over what period of time did that take place?

**Mr LOWNDES:** Essentially over the last two financial years, but the bulk of it in the last financial year.

**The Hon. DAVID CLARKE:** Have you been—

**CHAIR:** Will you move onto something to do with this project?

**The Hon. DAVID CLARKE:** Yes. But just to reiterate what I indicated earlier, Madam Chair—the question I am getting to is whether this has impacted on the capacity of the Royal Rehabilitation Centre to adequately provide services. I think you can see the point that I am coming to, Mr Lowndes.

**Mr LOWNDES:** Yes, I can.

**The Hon. DAVID CLARKE:** Thank you. When this was found, were you asked to refund, essentially, that amount of money?

**Mr LOWNDES:** Yes, we were.

**The Hon. DAVID CLARKE:** Is that impacting upon your capacity to give services now under the scheme?

**Mr LOWNDES:** To date, this financial year, or over the last three months of this financial year, the Northern Sydney Central Coast Area Health Service has unilaterally reduced funding by $513,000.

**The Hon. JOHN AJAKA:** Per annum?

**Mr LOWNDES:** No. That relates actually to the payments prior to the 2009-10 financial year.

**The Hon. JOHN AJAKA:** What was the total payment you are going to receive for the year that has now been reduced by $500,000-plus, so that we can work out a percentage?

**Mr LOWNDES:** Yes, $3.7 million is their estimate of the total overpayment that extends from October 2008.

**The Hon. JOHN AJAKA:** I understand, but what would you normally get in funding for that year that they are now going to take $500,000 off?

**CHAIR:** Who? The Lifetime Care and Support Scheme?

**The Hon. JOHN AJAKA:** I am just trying to establish—

**CHAIR:** No. This is totally off the terms of reference.

**Mr LOWNDES:** If I can try and get back onto that basis then, it means that in total we will repay $3.7 million, of which $513,000 will have been repaid by June of this year. So the balance is $3.2 million in relation to which Northern Sydney has asked us for a repayment plan. I have a meeting with area health on Friday as to how we are going to make good that repayment. They anticipate that repayments will start from 1 July. How they will, in effect, do that, I am not sure. I imagine it would be a contra against what we would otherwise be funded. In terms of its impact upon us, it will be considerable, particularly depending upon the terms of the repayment. It could be a liquidity issue for us. However, I am hoping that area will not be so onerous.

**The Hon. DAVID CLARKE:** You say it will have an impact on your service. In specifically what way do you anticipate it will have that impact?

**Mr LOWNDES:** We anticipate that we will have to make a considerable reduction in our staffing levels, wherever possible. I am looking to make those from the administrative rather than the clinical area. We cannot in fact make annualised savings of $3.2 million from staff retrenchments alone. However, we do have some liquidity support, albeit not a long-term sustainable one, because we are in the process of selling our land. We expect that transaction to be completed within the next week or so, and that would give us a significant cash injection.

**The Hon. DAVID CLARKE:** But that is eating into capital, is it not?

**Mr LOWNDES:** And Royal Rehab for many years has supported its services from its own capital.

**The Hon. DAVID CLARKE:** As a result of this impact on the services you can provide, it has a flow-on impact to the services that you provide under this scheme, or could have?

**Mr LOWNDES:** It could have, but only in a general overhead sense. The remuneration and the funding levels that we get for Lifetime Care and Support clients is better, higher, than what we receive under case mix cost weightings for other clients. We have taken the view that the Lifetime Care and Support clients are, in effect, fully funded.

**The Hon. DAVID CLARKE:** My final question is: it is a very unsatisfactory situation, is it not?

**Mr LOWNDES:** Yes. It is not one that we would prefer, but anyway we hope we can have some constructive negotiations with area health.

**The Hon. DAVID CLARKE:** Good luck.

**CHAIR:** I call the Hon. John Ajaka—about the Lifetime Care and Support Authority program, thank you.

**The Hon. JOHN AJAKA:** I think the questions were relevant to that, Madam Chair.

**CHAIR:** It is a nursing homes question.

**The Hon. JOHN AJAKA:** I think the questions were relevant to that, Madam Chair. If we could ask our questions, please?

**CHAIR:** No. In relation to the terms of reference, you can ask questions, thank you, Mr Ajaka.

**The Hon. JOHN AJAKA:** And that is what he was doing, Madam Chair.

**CHAIR:** No.

**The Hon. JOHN AJAKA:** You are just wasting time, Madam Chair. You really are.

**CHAIR:** I am not.

**The Hon. JOHN AJAKA:** Mr Lowndes, I apologise for that.

**CHAIR:** I beg your pardon, Mr Ajaka?

**The Hon. JOHN AJAKA:** The—

**CHAIR:** I really do beg your pardon.

**The Hon. JOHN AJAKA:** I do not have any questions, Madam Chair. You obviously are not going to let me ask any, so what is the point.

**CHAIR:** It is your time for asking questions.

**The Hon. JOHN AJAKA:** No, thank you. You are not letting me ask them. I will ask them on notice.

**Ms SYLVIA HALE:** The Royal Rehabilitation Centre is a private company. Is it a for-profit, or not-for-profit, organisation?

**Mr LOWNDES:** It is a not-for-profit organisation. It has an independent board of directors, and it is a public company limited by guarantee. However, we are an approved affiliated health organisation under the Health Services Act. As such, all of our operations, notwithstanding that a significant proportion of their operations are funded by Disabilities and Health Care, are considered to be a public health organisation and form part of the public health system.

**Ms SYLVIA HALE:** I notice that you said when you were speaking that you have your own case managers, you have coordinators and you are about to become an attendant care provider. In effect, you are providing essentially a public service.

**Mr LOWNDES:** Yes.

**Ms SYLVIA HALE:** I hope this is within the terms of reference. Do you see a benefit in having a private company meshing with a public organisation? Particularly, how does this impact when you are dealing with something like the Lifetime Care and Support Scheme?

**Mr LOWNDES:** Because of our circumstances—and this, I am sorry, is not to do with Lifetime Care and Support but with the recurrent funding that we receive from New South Wales Health, which we think is largely inadequate for the complexity of the services we provide—Royal Rehab is strategically looking at the options of providing private hospital and private health services and changing our corporate entity, while still remaining not for profit. But that is a sustainability-viability issue. Although not well progressed, I think I can say we have had some very constructive discussions with Lifetime Care and Support about providing services for them, without going to the health system.

**Ms SYLVIA HALE:** At one stage you did say that your case managers look only at the health issues, whereas you thought that presumably case managers from the public sector had a broader perspective when dealing with clients. Why is yours narrower in focus?

**Mr LOWNDES:** Because of funding. Our case managers, particularly, are in the brain injury unit and work through our brain injury community rehabilitation team. They coordinate community services but it tends to be time limited, and generally up to two years. I think the Lifetime Care and Support case managers have hitherto not had any longer than two years, but now they will be looking much longer term. We do recognise, as we do in our community housing area, that there are changing needs of Lifetime Care and Support clients over time, and so case management is a sort of episodic intervention as well. Because of the way we are funded, it is difficult for us to provide that.

**Ms SYLVIA HALE:** You did say earlier that you would like to expand upon your housing programs. Could you do so in relation to the Lifetime Care and Support Scheme?

**Mr LOWNDES:** Yes, and we are; but I did make a comment that the Lifetime Care and Support Scheme does have well-established interfaces and interactions with New South Wales Health with the health system, but in our observations less so with the Department of Ageing, Disability and Home Care, and less so with the Department of Housing. It seems that Lifetime Care and Support has embarked more on the path of establishing and building services from the ground up on its own. We straddle a lot of those services and just felt that, in time—I think it will happen—there could perhaps be better interfaces between established service providers in housing, community support and Lifetime Care and Support.

But for Lifetime Care and Support, particularly in regard to challenging behaviours, there are areas of expertise that are a bit more demanding and do not necessarily fit a group housing model so much. Again, we have had very constructive dialogue with Lifetime Care and Support. They are looking at reviewing their models of care. We have had some very good discussions with them about those models of care, particularly looking at the needs of people with acquired brain injury challenging behaviours. But, as I say, ADHAC—

**CHAIR:** ADHAC?

**Mr LOWNDES:** It is the Australian Department of Disability and Home Care. They have some well established services for people with acquired brain injury. In time there should be better dialogue between Lifetime Care and Support, the Australian Department of Disability and Home Care and the Department of Housing about the provision of supported accommodation homes. Often there is a client waiting for a house. So providers like Royal Rehabilitation have to pull the threads together to put the funding from Lifetime Care and Support together with the funding from the Department of Housing.

**The Hon. GREG DONNELLY:** I refer to question 10, about the kids' rehabilitation at the Children's hospital at Westmead. It suggests that information from prior requests for services should be stored by the Lifetime Care and Support Authority as a cumulative history in relation to a participant to avoid the repetition of this historic information each time a new request is made. Do you have a view about that idea?

**Mr LOWNDES:** Just a general one. It sounds like a good and sensible idea. We have not yet encountered where Lifetime Care and Support clients come back into our service system. In general, having centralised client records is a good idea. That holds throughout the health system. Yes, it has to be meritorious as far as I can see.

**The Hon. GREG DONNELLY:** I take you back to your answer about the challenge of administration/paperwork. How do you and your organisation think that can be addressed? Is there a straightforward or clear way of addressing this issue?

**Mr LOWNDES:** More could perhaps be done at the front end to approve agreed programs. There is a review and monitoring process, but within that there is a reasonable degree of latitude to work within the confines of that agreed program and the general funding for it.

**The Hon. GREG DONNELLY:** Is that for subsequent approvals?

**Mr LOWNDES:** Yes. However, as I said, everyone is comfortable with a reasonable audit and review program along the way. But there needs to be a bit more finetuning.

**The Hon. GREG DONNELLY:** Are you saying that we need a clearer determination up front of the range of possibilities that might be accessed and once that is agreed to, at least in principle, to be able to operate within the parameters?

**Mr LOWNDES:** While I can understand from Lifetime Care and Support's perspective the need to ensure some independence and separation of service provision and case management, there could be a system of credited case management. We are credentialed with the Australian Department of Disability and Home Cares for the services we provide. If there were that sort of recognition of a good credentialed case manager, referring and coordinating a series of services, that need not be removed from the service provider. We provide a number of services competently, but they have some caution about our case managers referring clients back into our services. I could understand that from a commercial perspective, but we are not particularly commercial. We are a not-for-profit organisation and we provide good quality services, and we are well credentialed to do that. There could be some accreditation of case management that would help with much of the administrative paperwork.

The other issue we contend with arises because of the nature of the services we provide to inpatients, but it is not necessarily an issue for Lifetime Care and Support. I refer to the two-tiered system. Lifetime Care and Support clients generally have better access to services and equipment and that provision is more timely than it is for some of the more compensible clients or, indeed, public health clients. That creates some tension for staff. The only thing that Lifetime Care and Support could do would be to facilitate or participate in a general review with other third party payers about compensation schemes and to look at any ways to streamline and coordinate procedures. Third party WorkCover claims and processes may be totally different in respect of home modifications than Lifetime Care and Support modifications. The outcome is largely the same, but the timetables can vary greatly and the administrative processes vary hugely between the various payers. Lifetime Care and Support could play a part in helping to review that and looking at the possibilities for streamlining and synergy.

**CHAIR:** Thank you very much for appearing today. The Committee recognises that your service is an incredibly important component of the whole process and your input is also important. I am sure that the Committee will want to ask some questions on notice and the secretariat will contact you about that. You can negotiate the timeframe if the 21-day return request is difficult for you.

**Mr LOWNDES:** Our service participates significantly in research. We are a teaching hospital at the University of Sydney and we have a number of research units that are increasingly looking at outcome measures that are client centric and community based. Lifetime Care and Support is very supportive and at the forefront of those types of developments. That is a tremendous part of the scheme.

**CHAIR:** That is excellent. The last witness addressed the issue of research. Thank you for appearing before the Committee today.

**(The witness withdrew)**

**(Short adjournment)**

**DAVID EDWIN HARRIS**, and

**NICOLA MATTHEWS**, sworn and examined:

**MARK HARRIS**, affirmed and examined:

**CHAIR:** Welcome to this second public hearing of our third review of the Lifetime Care and Support scheme. If you have any messages or documents you want to tender to the Committee, please attract the secretariat and they will pass them to us. The Committee hearings are not intended to provide a forum for people to make adverse reflections about others. The protection afforded to Committee witnesses under parliamentary privilege should not be abused during these hearings. I therefore request witnesses avoid the mention of other individuals unless it is absolutely essential to address the terms of reference. If you have a mobile phone, please turn it off as it interferes with the recording system.

I welcome the Harris family to come and speak to us today. It is necessary for me to say upfront that the Committee is unable to look into individual care and claims under the Lifetime Care and Support scheme—that is not within our terms of reference—but we value your submission and will value what you have to say to us today. We appreciate you coming to speak to us today about your experience so we can identify and address systemic issues within the scheme. In what capacity are you appearing before the Committee today?

**Mr D. HARRIS:** I am here as Mark's father as I have been involved all the way through his recovery.

**Ms HARRIS:** I am here for Mark Harris, my husband, and to let you know how the Lifetime Care and Support scheme has affected us.

**Mr M. HARRIS:** I am here to represent myself and to give my opinions about Lifetime Care and to give you an idea of where I would like to go in the future with the scheme.

**CHAIR:** If you should consider at any stage certain evidence you wish to give or documents you may wish to tender should be heard or seen only by the Committee, please state that and the Committee will consider your request. We have a system of taking questions of notice. If we ask questions that are a bit hard for you to answer or you want more time to give us the information, you can tell us you would like to take those questions on notice or the Committee may afterwards think of things they would like to know as well. The secretariat will send those questions to you or contact you and let you know what they are, and we ask for a response within 21 days but if there is a problem you can negotiate that with the Committee secretariat. Would all of you or one of you like to start by making a short opening statement?

**Mr M. HARRIS:** I will start. We come here to represent me, to give evidence about me, what has happened in my experience with Lifetime Care and where I would like to go in the future. If possible I would like my father to start by reading his statement, followed by my wife and then I will give a little bit of information but basically I will have the questions directed at me, if that is okay with you.

**CHAIR:** That is fine, thank you.

**Mr D. HARRIS:** To begin, I would like to make it clear that I wholeheartedly support the idea of a motor accidents support scheme for people who are victims. I know from those I have met on the scheme that there are many dedicated and hardworking people within Lifetime Care and Support. However, there have been some serious shortfalls in the operation of the system, and to overcome those I believe payment of a lump sum to mentally competent, not-at-fault participants would allow them to manage their own care. As I have mentioned, as Mark's father I have been involved in all aspects of Mark's recovery since the accident. I am aware that there have been serious delays in processing many of Mark's requests for lifetime care and unaccountable differences between statements by one member of Lifetime Care and another. However, there are only three particular instances that I have any detailed knowledge of and I will leave the detail then to Mark and Nicky.

Those three instances: the first was a delay that Mark endured and a fight he had with Lifetime Care and Support to obtain approval for a tennis chair, even though playing wheelchair tennis was clearly a key part of Mark's rehabilitation. This was only finally resolved by the assessment of an independent medical expert—and months' delay, I might add—who happened to be assessing Mark when I was present. The second instance:

Lifetime Care's delay in paying a chemist, which resulted in the chemist refusing to supply Mark with essential drugs until he was able to contact Lifetime Care and obtain a payment commitment from them. This could have created a crisis situation for Mark. There was a further occasion when the chemist claimed he had not been paid and refused further supply, and stated he would never work with Lifetime Care again. In that instance the chemist had misplaced a Lifetime Care payment. Despite that payment, Lifetime Care still owed money to the chemist.

While this was an error by the chemist, the reputation of Lifetime Care and Support for late payments is such that the automatic response of all those concerned was to blame Lifetime Care. The end result was the person put at risk was Mark because he could not get supply. I will leave it to Mark and Nicky to provide further detail, but I would like to emphasise that all of those problems could be avoided by payment to a motor accident victim who is mentally competent—and Mark clearly is—of a lump sum and allowing them to manage their own care. Someone in Mark's position suffers enough indignities. Allowing them to manage their own care restores a level of independence and improved self-worth. Thank you for the opportunity to speak to the Committee. I would like to hand out copies of that statement. I also have copies of four letters over the period from February to May from the chemist to Lifetime Care and Support requesting payment.

**Ms HARRIS:** I am here today to provide you with an insight to how the Lifetime Care and Support scheme affects my life and Mark's life. Lifetime Care and Support was a huge weight off my shoulders at the beginning. It offered me hope and an ease to a nightmare of a situation I had found myself in. The future was so uncertain to me, my whole world had just been turned upside down. Not long after Mark had woken from his induced coma we received a visit from our Lifetime Care and Support coordinator. Sometimes I wish I could go back to this moment because this was a moment I remember so clearly. It was a moment when everything seemed it was going to be okay and not so daunting. Why? Because of promises given to us by our coordinator. He promised us the world. He told us the things we could have and anything we needed in help of Mark to get his life back to normal.

I remember the feeling of relief and I was so happy Lifetime Care was going to do so much for us. This feeling however did not last long. I am being bluntly honest here but I believe the scheme has been more of a burden upon our shoulders and the extra added stress on top of everything else we have to deal with, and I feel if we continue for our whole lives it would continue to be a bit of a burden upon us. Promises were made that day and one of those promises was the funding of accommodation for myself while Mark was in hospital. Our coordinator had gone so far as to say the scheme would set me up in an apartment and pay for my rent, and would even help me look for a place to live. Until this happened the scheme would pay for a room in the hospital so I could be close to Mark.

I did not mind staying in the hospital, but I thought if they are going to pay for an apartment I would be able to rest properly, cook my own food and would still be close to Mark. And besides the hospital accommodation was only temporary as it was for emergencies only. I found a real estate agent who was willing to help as they provided accommodation for another family in the same situation. I called our coordinator and let him know. He told me he would give me a call back. Three days I waited for a call. I tried to get in contact with him but he did not return my calls. This would be the first time Lifetime Care and Support would start making things very hard in a series of broken promises in a situation where things were so tough already.

I did receive a call back from him and he advised me that the scheme would not provide me with a rental property but would continue to pay for a room at the hospital. I accepted it and was grateful for the funds towards a hospital room but it hurt me because I got my hopes up. It was something to look forward to and was my little ray of light in a dark and scary circumstance. I lived in the hospital down the road from Royal North Shore, where Mark was, for three months so I could stay by my husband's side and give him all the support he needed and be on call if he wanted me or I was there if there was a problem. It was hard for Mark to go to rehabilitation. Lifetime Care agreed they would fund my on-site accommodation at the rehabilitation so I could continue to support my husband.

I cannot be clear on how long it was until this happened, but approximately four weeks after Mark was admitted to rehabilitation I received the news that Lifetime Care would not fund my accommodation at the rehabilitation any more. This was a huge blow for me, especially when I was working so hard to be positive and a strong influence on my husband and giving so much energy to help him through a traumatic time.

The reasons were clear. They based it on the fact that technically I lived in Sydney. Mark and I had moved here from Perth three weeks prior to his accident. After it was explained to me it made sense in the end, but this was promised to me from the beginning, so why turn someone's life completely upside down again? I demanded a meeting with our Lifetime Care coordinator and his superior and they both came to the Rehab where they both confirmed the scheme would not continue to pay for my accommodation. I continued to debate them and they finally agreed they would continue to pay.

This is how our relationship with Lifetime Care and Support continued to go on and still does. I believe Lifetime Care does not work for us. I know it can work for people, but everyone is in a different situation. I recently contacted some other families that I know had a lot of the same problems that we faced while Mark was in hospital. One person I spoke with said, "We have just accepted that it's a government scheme and we can't expect too much."

The scheme makes us feel somewhat degraded in a way. I appreciate the scheme does fund a lot of things but we are always asking for things. We always have to ask for equipment and personal things and discuss our lives with everyone. We have to beg for everything and it seems we have to put up a fight to get things that we are entitled to. The scheme pays for unnecessary things that we would not pay for, for example, case managers, coordinators and occupational therapists. Our lives are always on show to everybody. There are always so many people who have to be involved in everything, our personal lives and private matters—coordinators, occupational therapists, case managers, doctors. We feel we should only have to discuss these things with medical professionals. Also, we lose a lot of independence being part of the scheme. I feel somewhat trapped at times. For example, one of the things Mark and I would love to do is move to New Zealand and have a family, but with all the issues we have faced in Australia with Lifetime Care and Support how would it work in a different country?

I have written up a brief summary of some specific problems we have faced, some things that have had a huge impact on our lives and caused us a huge amount of stress. I will hand that over for you to read. Thank you for your time.

**Mr M. HARRIS:** I have a list of difficulties that I would like to read out and some recommendations, and following that you can direct questions to me based on these or on my submission. The difficulties I have had obviously include Nicky's accommodation, as she has just expressed. I had a battle to get a tennis chair, as my dad mentioned. There was a slow response time to questions, which is frustrating. You do not know whether they have got through and then you are waiting and it builds up tension. There are problems getting correct answers to my questions. There were problems getting approval for rental accommodation modifications and finding a doctor that would deal with Lifetime Care and Support. A lot of doctors do not want to do that. Then there was a problem finding a chemist because other chemists that have taken on patients with Lifetime Care and Support in the past do not want to do it again because they have had the problems we have had with the bills being paid. My dad mentioned that.

My home care and catheter changes were cancelled without my knowledge. This is something that has to be done; it is very serious if it is not done, as I am sure you are aware. I was not told about this. I called up and left messages and eventually they told me, "We are finding another care agency for you", but I was left in the lurch in the meantime. I had to go back to the other care agency and get them to come back and do one last catheter change for me. It is not the kind of thing you want to deal with after a hard day at work.

They are very slow with reimbursements. I had a bill for a mattress because I had to use a replacement air mattress, and also the electricity bill. That went on for several months, possibly six months. I have not yet been able to have a meeting or even a phone conversation with my new Lifetime Care and Support coordinator. He has been in charge since December, so it is quite a long time. I have been asking to speak to him and I have not had a meeting as yet. It makes me feel there is a power that controls what I can and cannot do and can and cannot get and yet I do not seem to be able to have any interaction with them. It makes me feel left out of the picture.

As Nicky mentioned, there is having to share all my private information with so many people. As my dad mentioned, I have lost all my dignity with what I have been through. It is like starting again as a baby. Then to have everybody talking about it, it seems everybody knows your business and it is quite embarrassing. I always have to argue and beg to get what I am entitled to. It really takes it out of you. I am trying to work full time, which is hard enough, but I have to beg and fight for everything I want and need. We recently bought a house and we had to get a Lifetime Care-approved home assessor to come in. We let them know beforehand that we were looking to buy a house and we found one that we wanted. We called up to organise for the Lifetime Care assessor and nothing happened. We ended up putting a deposit on the house anyway because we really loved it and it is well set up for wheelchairs. It took two weeks before my Lifetime Care and Support coordinator called the home assessor to let them know to give me a call. That is all he had to do and it took two weeks to do that.

The biggest problem of all is the stress it puts on not just me but also my wife. She has to do so much around the house, all the cleaning and everything. It has got so bad at the moment that she has had to leave her job. We do not get any support from Lifetime Care for her being the carer. There is nothing there, yet she does so much.

My recommendations are that perhaps there should be more training of Lifetime Care staff on the regulations and what can and cannot be approved because at the start they told us we would get everything, as Nicky said. You get a feeling of relief that things are going to be okay—I might not be able to walk and I might not be able to use three-quarters of my body but there is someone there looking after me. Since then there has just been a steady decline. Perhaps there should be a small payment to primary carers because if they were not there you would have to have a nurse come in all the time and that would be a significant fee every day or whenever I needed it. Staff should be taught to listen to participants and to respond quickly to their phone calls. Perhaps there should be a bit more interaction. It has been several months and I have not had a phone call or anything. I also do not think I need to have so many people looking after me. There should just be one person and if they need other things they can source them from their contacts. That way I do not need to keep explaining my situation to every single person I meet. As I said, I lose all privacy by doing that.

The most important change I would like to make is to let people in my situation have the option of opting out of Lifetime Care if they are mentally sound and capable of looking after their own finances.

**The Hon. DAVID CLARKE:** Mr Harris, you have given specific instances of difficulties you have had, such as getting approval for a tennis chair. Is it fair to say you felt a sense of deep humiliation as a result of that incident?

**Mr M. HARRIS:** Absolutely. I would like to show you a sign that was made by my wife and me when I was in the intensive care unit, showing short-term and long-term goals. As you can see, it says "play table tennis" and then "tennis", as one of my main goals. As soon as I could, even before I could bend my legs properly to get into a tennis chair, I was down on the court training, in a normal wheelchair. I play with my dad every day and with my coach. I pay for my private lessons. I even had to hire a basketball chair at the time so I could play. I applied for the chair. I had been playing all the time and had even enrolled in a tournament but that was not enough. I have played tennis my whole life, so it is not just a recent thing. Then I got turned down for the tennis chair.

**The Hon. DAVID CLARKE:** Is this incident with the tennis chair merely symptomatic of a whole process you are going through? This is not just a one-off; this sort of incident is happening continuously.

**Mr M. HARRIS:** If that was a one-off I would not be here today.

**The Hon. DAVID CLARKE:** Do you confirm the statements of your wife when she said that other people in the scheme are experiencing similar problems and a sense of humiliation with regard to the way the scheme is operating? Do you concur with her on that?

**Mr M. HARRIS:** Absolutely.

**The Hon. DAVID CLARKE:** Do you concur with her that you have found medical practitioners and chemists who are very unhappy with the way the scheme is working and do not want to participate in the scheme?

**Mr M. HARRIS:** Yes. It took us quite a while to find doctors and chemists.

**The Hon. DAVID CLARKE:** Do you present yourself here today as a person who has full mental capacity to best know life choices and do you concur with your father when he says that a lump-sum scheme, at least for some people, particularly those who are catastrophically injured, would be an appropriate way to go? Do you feel if there was such as scheme you would not be facing this almost daily sense of humiliation and being made to feel like a child?

**Mr M. HARRIS:** Definitely, I could not have put it better myself. I also have information about how I would manage a lump-sum payout, so if you would like to go through that with me—

**The Hon. DAVID CLARKE:** Because of time constraints would you like to present that to the Committee so that we can go through it?

**Mr M. HARRIS:** Sure. You might have some questions at a later date.

**The Hon. DAVID CLARKE:** If you could make such a document available to us we would be very appreciative.

**Mr M. HARRIS:** Sure.

**The Hon. JOHN AJAKA:** The information all three of you have given us so far has been wonderful. Ms Harris, in relation to staying at the hospital for three months, can you indicate where you stayed and what facilities were made available to you?

**Ms HARRIS:** At the beginning, at Royal North Shore there is emergency family accommodation so that families in my situation can stay and be close to our loved ones. It was just a temporary thing and then I moved—

**The Hon. JOHN AJAKA:** Can I stop you there? I am trying to understand the difference between that and having your own place where you can cook and take care of things. Were you in a flatette on your own where you could cook or were you provided with a bed and you had to go out and get meals?

**Ms HARRIS:** I was provided with a bed at Royal North Shore and a microwave, but nothing else. Blue Gum was a little bit better but it was a shared kitchen and we had to share fridges and food would go missing and things like that.

**The Hon. JOHN AJAKA:** The reality is there would have been more cost for you in staying in that environment than in being able to cook for yourself and buy groceries.

**Ms HARRIS:** I was spending $20 a day on food.

**The Hon. JOHN AJAKA:** With everything else happening, you were suddenly having to find more money just to be able to feed yourself.

**Ms HARRIS:** That is right.

**The Hon. JOHN AJAKA:** You mentioned that you have a new coordinator who you have not been able to see for over six months—which is astonishing—and it is almost a situation where you would say that, on the one hand, there are too many people in your life, but you cannot actually get the people that you need to speak to to contact you. Did I understand that correctly?

**Mr M. HARRIS:** That is exactly it. All I want to do is just deal directly with my lifetime care and support coordinator. He knows all these people and, if he needs to go to a physio or this and that, he can speak to them and organise it. I just want one person to deal with, so that he knows my information and I do not need to tell everybody every time.

**The Hon. JOHN AJAKA:** This probably will come from your information, but on the other side of the equation, one of the fears of allowing you to take a lump sum payment is the fact that it might be great in the beginning, but if you dissipate the money or, to use the old colloquialism, blow the money, in your older age there will be nothing left for you. How do you argue against that?

**Mr M. HARRIS:** I understand that fear and I have read that up to 40 per cent of people who have received lump sum payouts have spent it within 20 years, so to counter that I have offered to put one-third of my payout into a 20-year long-term bond. From that, I have also decided, the interest I get just in the first year I will put into a separate emergency savings account, which can only be accessed if I have serious medical needs and I need to take that out. Over the rest of the time, each year I will be entitled to the interest and I can use that interest, but that way I would still keep the lump sum there and I would also have an emergency savings fund if I need to for hospitalisation fees or whatever.

**Ms SYLVIA HALE:** There seem to be phenomenal problems interacting with the bureaucracy. Do you have any feeling as to why that is? Do you feel that they are understaffed, under-resourced, or is it a view that somehow you are mendicants, you come cap in hand to the system and you are lucky to get whatever they care to give you?

**Mr M. HARRIS:** I believe there are definitely some people working with lifetime care who are very caring and are very good at their job. A couple of people I have spoken to there have been very helpful. I just think that perhaps some of the coordinators might need a bit more training or a bit more general knowledge of how to deal with these types of people. I do think the scheme is a good idea, but just not for everybody.

**Ms SYLVIA HALE:** You say you have a new coordinator. What happened to the initial coordinator?

**Mr M. HARRIS:** He just disappeared. We were not informed what happened, I was just told one day that I now have a new coordinator, and I just have not seen him. He is a ghost as far as I know.

**Ms SYLVIA HALE:** Were you ever involved in any discussion as to the sort of person you would like as a coordinator, or even their suitability once you have dealt with them?

**Mr M. HARRIS:** No, I did not have a choice. I did make some complaints about my first coordinator, which I guess led up to the change in the end, but there was never a question, I was just appointed a new coordinator.

**Ms SYLVIA HALE:** You say that you have made contact with other families in similar situations. I suppose this is really informal where you happen to encounter people, or is there any means by which similar participants in the scheme can talk to each other?

**Ms HARRIS:** These are two families who were at hospital at exactly the same time Mark had the injuries nearly, a few days apart, and they had major issues, the same as us, at the beginning. To be honest, I haven't spoken to them since Mark left rehab and we all sort of went our separate ways. I just made contact with them to see how they were going in the scheme, just asked their point of view.

**Mr D. HARRIS:** May I comment on that? Mark has a solicitor who obviously is going to be involved in a third party insurance claim and when he knew Mark was coming along here he, in writing, stated that he had half a dozen clients who all wanted to opt out, so it is not just Mark.

**Ms SYLVIA HALE:** One of the problems would seem to be that there is no coordination between the participants in the scheme in terms of being able to present a united front to the scheme.

**Ms HARRIS:** Yes, that is true, but at the same time we do not have time. I do not want to be unemployed, I want to work, I want to live my life out, and I have had to give all that up.

**Ms SYLVIA HALE:** What financial assistance are you receiving as a carer?

**Ms HARRIS:** Mark.

**Mr M. HARRIS:** I work full-time and that pays for everything.

**Ms SYLVIA HALE:** So you are not entitled to—

**Ms HARRIS:** No. I am from New Zealand, I do not have citizenship of Australia, so I am not entitled to any help.

**Ms SYLVIA HALE:** If you were a citizen, would you be entitled to it?

**Ms HARRIS:** Yes, I think so. I have not looked into it.

**CHAIR:** Commonwealth carers allowance.

**Ms SYLVIA HALE:** Is that restricted only to Australian citizens?

**Ms HARRIS:** It takes a while to become a citizen anyway, so it is something that would take two or three years as well.

**The Hon. LYNDA VOLTZ:** I think what Sylvia Hale was getting at was a support group for people who are in the scheme. Quite often before committees what we see is, say, parents of kids with disabilities who get together and have a support group, and they come and talk as advocates on their behalf. There is no group such as that that you are aware of?

**Ms HARRIS:** No. I think there should be some sort of group like that, especially in the beginning when all of this is going on, all the traumatic things that we have to deal with.

**The Hon. LYNDA VOLTZ:** Someone who has experience and can guide you from the start?

**Ms HARRIS:** Yes, and we would have definitely benefited from a group discussion where someone would come in and we could have questions and answers.

**Mr M. HARRIS:** That is something we have been thinking about doing, actually going to Royal North Shore and speaking to people who are in the scheme and giving them tips on how to get what they need out of the scheme.

**The Hon. LYNDA VOLTZ:** There seems to be conflict about whether the coordinator is working on your behalf or acting as a buffer to the scheme against you. It seems to me that the way you feel about it and what would work well for you is if it was your coordinator and you had confidence that they were out there advocating for you rather than you feeling like they are a buffer, but sometimes you have to go and advocate on your own behalf rather than this person, whose role is probably crucial to giving you confidence in the scheme?

**Mr M. HARRIS:** Yes, I would agree with that.

**The Hon. LYNDA VOLTZ:** If the coordinators were fulfilling that role, would that give you more confidence in the scheme itself?

**Mr M. HARRIS:** As long as the person was competent and they could do their job, yes.

**The Hon. LYNDA VOLTZ:** We had some earlier evidence that, particularly in relation to brain injury, progression over time can sometimes be faster than people expected, that there are different rates of healing and there should be a kind of gap time to allow proper assessment before any opt-out clauses are available?

**Mr M. HARRIS:** I believe that the two-year period is good because that is when you do your second assessment after people are in and then you make an assessment whether they are going to stay in the scheme. I think the two-year period would be a good time to choose whether to opt out or not, as that is when most of the recovery is done, in the two years.

**The Hon. GREG DONNELLY:** Do you have in front of you the questions on notice that were provided to you?

**Mr M. HARRIS:** I don't, but I can answer them.

**The Hon. GREG DONNELLY:** I want to direct you to question 7, which is that the Lifetime Care and Support Authority has noted that whilst it does not make lump sum payments it can enter into arrangements to allow scheme participants to manage their own care and that it is developing guidelines to allow participants to receive periodic payments to cover their costs. The second part of the question is what are your views about this option. My question is this: Has the Lifetime Care and Support Authority had any discussion with you about that particular option or possibility?

**Mr M. HARRIS:** No. The first I heard of it was when I received these questions. I do not agree with it because it does not allow for any out of the ordinary expenses, so if something happened, say I hurt myself and I needed to go and get special medication or see a specialist, I would then have to pay that and then I would be out of pocket, and some of the reimbursements are taking six-plus weeks to get back to me. I have a big mortgage over my head and I cannot afford to make these.

**The Hon. GREG DONNELLY:** Could you take us through an example of submitting a claim for pharmaceutical expenses, just so we can get a sense of the process?

**Mr M. HARRIS:** Okay, well, when I needed another air mattress—

**Ms HARRIS:** I have typed it out.

**Mr M. HARRIS:** Yes, we were going to pass that around.

**The Hon. GREG DONNELLY:** Okay.

**Mr M. HARRIS:** We put that in and it was approved by my case manager—she said, "Yes, that's fine"—so we sent it off with the receipts, and how long was it?

**Ms HARRIS:** Six weeks it took. I followed those receipts up because we needed the money urgently.

**Mr M. HARRIS:** This was not just handed in and left. We did follow it up with emails and phone calls.

**Ms HARRIS:** Nearly every second day I was following up where the reimbursements were, because our accounts had gone into overdraft from other bills and things like that, so yes, I told them that. I followed it up nearly every second day and it took a pretty vicious email from myself to get some answers. Six weeks later we received the funds.

**Mr M. HARRIS:** And we are then left also having to pay the overdraft fee, plus the embarrassment of going into overdraft as well.

**The Hon. GREG DONNELLY:** Of course, yes, I appreciate that. In terms of the relationship between the case manager and the coordinator, how do they work in tandem with each other or how are they meant to work in tandem with each other?

**Mr M. HARRIS:** The case manager will get my opinion of what I think I need. They will then assess what they think is right and they will tell me what they think is right. They will then give that information to the lifetime care coordinator and they will either legally approve it or not.

**Ms HARRIS:** But that timeframe from when we go to the case manager—she might have a whole pile of things she needs to do. She cannot just go, "Okay, Mark, I think you need this, we will put in a request straight away". It could be a few days—it could be up to a week—before she has time to actually submit that request through.

**Mr M. HARRIS:** So you are looking at a week there and then, when it goes to lifetime care, you are looking at another week before it gets approved, and once it gets approved there are other things to go through and you are looking at two or three weeks, and it is all this type of thing where we are left out of pocket, which now with a mortgage I can no longer afford.

**The Hon. JOHN AJAKA:** And that is if it is approved.

**Mr M. HARRIS:** Exactly, and then if it does not get approved, well, sell the house. I do have other things why I do not agree with the scheme, if I have time?

**CHAIR:** Yes, we have finished, but I was just about to ask if there was anything else you would like to tell us.

**Mr M. HARRIS:** I will be quick, sorry. It is just that I will still have to justify all the expenses. I mean I am sure you are not going to give me money and just let me spend it on anything, which therefore means I will have to justify it, so I again lose privacy. If my health expenses go up, I will then have to argue with lifetime care to give me more money because they are going to say, "Why do you need it? You were surviving on this before". Then I am going to have to go through this whole process again. This could take six weeks. In the meantime I could be missing out on medication or whatever I need for my health because I am waiting for it to be approved, or I have to pay for it myself and be out of pocket. Another thing is that the system would make the participants have to do all the organising, go around and organise everything, therefore doing part of lifetime care's work without really getting any benefits from it.

**The Hon. JOHN AJAKA:** This is in relation to getting a certain amount of money every three months?

**Mr M. HARRIS:** Yes.

**CHAIR:** Thank you for your thoughtful information today.

**The Hon. JOHN AJAKA:** It has been very helpful.

**CHAIR:** It has added value to our inquiry and assisted us in the questions we have to ask of the system. I recognise that you probably have a million things you want to tell us. The Committee secretariat will contact you with any further questions we may have and you are welcome to send to us within 21 days any further information. I apologise that we were able to provide only half an hour for your evidence. I wish we could have given you a whole day, but you have been very good in providing us with information.

**Mr M. HARRIS:** I will pass forward my submission on how I would manage my lump sum.

**CHAIR:** Thank you, that is very important.

**Mr D. HARRIS:** I should emphasise that Mark is making an assumption that he is going to get a third party payout. He has just guessed a $1 million lump sum, which I expect is far too small. He would put that aside. Obviously, the $2 million that he has assumed here that would come from the third party is something for him to take care of anyway.

**CHAIR:** Do not hesitate to send us anything after you sit down and mull over today's hearing. The evidence taken by the Hansard reporters, who do a good job reporting and transcribing everything that is said, will be available on the Internet on our inquiry site within about three days. You will be able to read what you said and consider it in retrospect.

**Mr M. HARRIS:** As you have an actuarial assessment of the net present value of my future medical-related expenses, can you give me some idea of what that would be?

**CHAIR:** We do not have such information. We are the parliamentary oversight Committee and we conduct our inquiry on the basis of the terms of reference under the legislation. We do not have the skill base for actuarial advice. That comes from the Lifetime Care and Support Authority.

**Mr M. HARRIS:** Am I able to ask them for that?

**CHAIR:** I do not know the answer to that. Perhaps we could formulate that question to them this afternoon.

**Mr M. HARRIS:** Sure.

**Ms HARRIS:** With the lump sum payment, I wanted to add that I would not financially benefit from any of the money that Mark receives as compensation for the accident. I have signed documents stating that in the event we got divorced I would not benefit. We are just fighting for our independence really.

**CHAIR:** That issue came up last year. We discovered that some persons in divorce settlement were putting a claim on the money. Thank you for your attendance.

**(The witnesses withdrew)**

**IAN FRANKLIN**, and

**LYNDON WAIT**, affirmed and examined:

**DANIEL STRBIK**, sworn and examined:

**CHAIR:** This is the third inquiry into the Lifetime Care and Support Scheme. Our function as a parliamentary oversight Committee is not to control or run the program. We hold an inquiry yearly into the Lifetime Care and Support Scheme because it is a new scheme and so as parliamentarians as a group, with your assistance, are able to value add to the process and work through any issues. I state upfront that the Committee is unable to look into individual cases and claims under the Lifetime Care and Support Scheme. That is outside our terms of reference. We appreciate your coming to talk to us today about your experiences so that we can identify and address any systematic issues that you present. I have referred earlier to the broadcasting guidelines. Would you state the capacity in which you appear before the Committee today?

**Mr FRANKLIN:** I am here on behalf of my son who is in the scheme just on two years. He cannot be here today because he had surgery for his back last week and he was not well enough. I am here to represent him and give my ideas about a few things.

**Mr STRBIK:** I am the father of Lydia Strbik, who is a Lifetime Care and Support participant. I am here to answer any questions in relation to her.

**Mr WAIT:** I am here as a participant in the Lifetime Care and Support Scheme. I have been in it for about 18 months. To date I have been quite happy with things.

**CHAIR:** Do you have an opening statement you wish to make?

**Mr FRANKLIN:** Are you interested in the history of the injuries?

**The Hon. LYNDA VOLTZ:** Would you give us a brief overview of each person's personal circumstances?

**Mr FRANKLIN:** My son is now 22. He was 20 when he had his accident on a motorbike, a single vehicle so he was at fault. He just came home after all the house modifications probably a month ago. So he has only just returned back to home.

**Mr STRBIK:** Our daughter was eight years old when we were involved in a motor vehicle accident, hit by a semitrailer, 62 ton fully laden, from behind. There were five of us in the vehicle and my daughter suffered severe brain injury. She was in a coma for well over six weeks and she had severe bleeding. Amazingly, she has been recovering and she is now in school. It is a miracle from where she was and what the doctors said—that she was going to be a vegetable, no hope for her at all. In the first few days the doctor said that she is not even going to make it at all. The swelling was massive. Her head was about the size of a soccer ball, that is how much bleeding was in the brain. She miraculously recovered.

**Ms SYLVIA HALE:** How old is she?

**Mr STRBIK:** She is now about to be 11. It is two years on.

**Mr WAIT:** I sustained a fall from a motorcycle on the road. I was on a corner, travelling quite slow and there was a diesel slick. I had a fairly small tumble. I had all the safety equipment on, back brace, the works, because I was really strict with safety things with a bike. I obviously fell the wrong way. I did not sustain any injury, no skin, just a back break which has left me with paraplegia. I had six months in North Shore and rehabilitation and then immediately after I have returned to work full-time.

**The Hon. GREG DONNELLY:** Thank you for your overviews. We will continue the questioning in the same order. Would you describe your dealings with the Lifetime Care and Support Authority? How have you found that experience? Feel free to comment on both the positives and negatives of your experiences.

**Mr FRANKLIN:** From Jonathan and my point of view, we have had some difficulties in terms of house modifications, but that was more with changes that we needed to make because of changing circumstances and our "wonderful" local council and approvals. Having said that, the experience we have had with Lifetime Care has been fantastic. There is a period where you need to get into the routine and know how the system works in terms of approval periods, how you need to apply for things, which channel you need to follow through. Once you understand that, it actually works quite well. It is a good system. I think we would have been struggling a lot more had we not had it.

**Mr STRBIK:** In our case, we were in hospital for a three-month period. During that time we were introduced to the scheme by the hospital staff. We were unaware of the scheme altogether. The co-ordinator came to visit us in hospital and explain what the program is about. They reviewed the situation, put her in the scheme and straight after Lydia leaving hospital she was pretty well assigned a case manager and the whole thing took over from there. So we have had nothing that we had to look after ourselves. It was all looked after by the case manager and made simple for all the therapies and all the approvals that had to go through.

**Mr WAIT:** I agree with Ian. To know how to utilise the scheme from the beginning was hard and going through all the processes. It did take quite a few months to work that out and to utilise the scheme. Once you know the motions of it and the processes, from this point or probably within maybe 6 to 12 months it was quite easy. I am very happy with the system.

**The Hon. GREG DONNELLY:** Anyone can comment on this question. It has been put to us in relation to case management that the roles of the coordinator and case manager sometimes do not gel well and the capacity of the person to make contact with the coordinator is sometimes difficult. Would you comment on the experiences that you have had dealing with the coordinator and the case manager, the relationship between the two and the communication channel?

**Mr FRANKLIN:** I have not had any complaints or dramas. We have an external consultant employed by Lifetime Care and Support and then we have Tracey Graham from Lifetime Care as our coordinator. We have never had any dramas with anything.

**Mr STRBIK:** I had no difficulties at all either. It looks like there is a good relationship between our coordinator and the case manager. The coordinator always emails me what is going on, what approvals have been approved, so that I am aware exactly what is going on. So there are no difficulties.

**The Hon. GREG DONNELLY:** Have you been able to contact either of them without difficulty?

**Mr STRBIK:** Very easily, no difficulties at all.

**Mr FRANKLIN:** We are quite welcome to speak to either of them. When you need to go through the formal process of submitting something you have to do it the other way. But we can talk to either of them and they communicate between the two and get back to us, no problems.

**Mr WAIT:** I found a very similar situation. The early days I dealt directly with the Lifetime coordinator and later the case manager was brought in, I guess to make the process easier for myself. I guess I am not a high maintenance participant, but once most things are set up, I think weekly or monthly there is probably little or no contact required.

**The Hon. GREG DONNELLY:** I have just one further question for anyone to comment on: The turnaround time in terms of submitting a claim for expenses you incur, and ultimately for which you seek reimbursement, would you like to comment on that turnaround timeframe of the claims, and comment either positively about your experience or, if you have had a negative experience, comment on that?

**Mr WAIT:** I have found anywhere between 7 to 14 days for reimbursement, and I am quite happy with that. There are things such as the country flights down for medical reasons and accommodation, within reason. Obviously, you would not stay at the Hilton or something like that.

**CHAIR:** No.

**Mr WAIT:** Obviously, that is not cheap, but if things are quite reasonable—like, if my requests are quite reasonable—they go straight through.

**Mr STRBIK:** In our case, because our daughter still goes to school, most of the Lifetime Care looks after her. She has a teacher's aide for full-time care, and there is someone who looks after that at school. They submit all the applications way in advance so that when the right time comes, appropriate funding is there for her for that, so we have no problems.

**The Hon. GREG DONNELLY:** You do not find yourself out of pocket, waiting for the money to turn around?

**Mr STRBIK:** We ourselves have not received any money from Lifetime Care at all. It has all been from other sources that look after her.

**Mr FRANKLIN:** In Jonathan's case I think the only thing that we have really claimed for has been medication. Generally the claim takes two weeks or something, but lately we have found pharmacists that will bill directly to Lifetime Care. Once you find a chemist to do it, we are not actually involved in claiming anything or in being out of pocket, or paying any money.

**CHAIR:** Was it hard to find?

**Mr FRANKLIN:** There were a couple that sort of said, "No, we don't want to do it." I think they were more scared of the fact that everybody seems to lump the idea of Lifetime Care in with a third party, and then they all run away.

**CHAIR:** It is all insurance companies.

**Mr FRANKLIN:** Yes. So you have to get past those initial barriers, but once you do that and they understand that they get paid fairly quickly, most of them are quite happy to do it. That is part of their service.

**The Hon. LYNDA VOLTZ:** Lyndon, the idea came up with the last witnesses about having a support group and having someone there at that initial phase when you are in the hospital. Would that have made it easier to you to understand the scheme from the beginning, if there had been a support person there?

**Mr WAIT:** Definitely. When my Lifetime coordinator visited, basically it was more verbal, and just about what the scheme can offer. There was documentation, obviously, to fill out, but I found most of my research was basically off the net about what the scheme offered and what I may be offered. I do not know whether at that stage there was a reference booklet in regards to it, or whether there is one now; I am not too sure. But something like that definitely would have helped—maybe just a small booklet outlining what the scheme did and what it would provide. There were a lot of things that were unclear about whether it was minimal or what. At that stage we did not really know. But, as you say, if there was maybe a group, which could elaborate on the services, yes, it would be beneficial.

**The Hon. LYNDA VOLTZ:** Mr Franklin and Mr Strbik, as parents what would your views be on an opt-out clause of the scheme? Obviously, for parents, there will be a lifetime issue. The idea has been raised that people who are mentally competent should be allowed the option of opting out.

**The Hon. DAVID CLARKE:** Being given a lump sum payment.

**Mr STRBIK:** Oh, I see. In our case, we were told by the solicitor that she would not even have access, or they would not even look at the case, until she turns 18. So there would be a big blank of space from age 8 to 18 where she would not fit any care. As you know, with solicitors it is a drawn-out process. We are happy to be in a scheme where she is looked after and funding is provided to her at this time when it is necessary.

**Mr FRANKLIN:** In the case of Jonathan, I do not know; I think I am happy with the scheme the way it is. I would not want to take a lump sum. I think that would then introduce a whole new layer of bureaucracy. Once money starts becoming big, all these solicitors and everything would be coming around. I would not want it to become a de facto third party scheme. Here, it is good. You have the need, you can demonstrate the need, and it is taken care of for you. Just to sort of give you money and let you run away, certainly I do not think that is a good idea.

**The Hon. LYNDA VOLTZ:** Thank you.

**Ms SYLVIA HALE:** Mr Wait, what would your opinion be?

**Mr WAIT:** In regards to a lump sum?

**Ms SYLVIA HALE:** Yes.

**Mr WAIT:** It is a hard one about identifying the goalposts in regards to payout—whether it is based on my medical requirements as a minimal or whether it entails pain and suffering. I guess my capacity earn money is much reduced and whether that is factored into that, I do not know. There are so many things that need to be factored in. I am now restricted up to the working age of 75 to be provided for, and I do not know whether that payment is based on that period. Without knowing the goalposts of payments, it is a hard one for me to answer.

**Ms SYLVIA HALE:** The evidence of the three of you is like chalk and cheese compared with the evidence from the previous witnesses. They found a scheme that was unresponsive to their needs, that caused them to raise their hopes in terms of how the scheme would deal with them, but your experience seems to be quite different. Mr Strbik and Mr Franklin, is it because your family lives were not as disrupted? Did either of you have to give up your jobs to become a full-time carers for your children, or was it something that, because they were young and you are already supporting them, did not impact on your lives?

**Mr STRBIK:** Initially it did impact in the first few months when we spent a lot of time at the hospital. My wife and I were changing her and looking after her.

**Ms SYLVIA HALE:** Did you need accommodation in that period?

**Mr STRBIK:** We did for a short period. For a 10-day period, we were at the hospital itself, and then we had another further week at Ronald McDonald House.

**Ms SYLVIA HALE:** Apart from that, you had your own home too.

**Mr STRBIK:** That is right, yes. They moved her from that hospital. Initially we were at Randwick and then we moved closer to our home in Westmead.

**Ms SYLVIA HALE:** And Mr Franklin?

**Mr STRBIK:** No. We did not have any issues. I am a widower, but I do have a fairly extended family in terms of other people who assist. Jonathan was in hospital and rehab for nearly six months. Okay, I did 80,000 kilometres in those six months, but other than that I had a very good work environment where they allowed me time off and I could make time up, and those sorts of things.

**Ms SYLVIA HALE:** Neither of you was required to become a full-time carer for your children?

**Mr FRANKLIN:** No.

**Ms SYLVIA HALE:** Mr Wait, what about you? What did you find in terms of your family relationships? Did you find members of your family were forced to become full-time carers for you?

**Mr WAIT:** I am married and, yes, my wife did. Basically she used up annual leave and then some, even to the point where she did lose her job from having that amount of time off. In regards to Lifetime Care, we basically paid for flights down and accommodation and then, as I said before, within 10 working days they reimbursed for those costs. That was ideal in the beginning because we thought we were just going to use up our savings really quickly. Long-term repercussions were that she eventually did lose her job over absence from work, which I can sort of understand from an employer's point of view. They needed her there, and she basically took a couple of months off within six months of having taken leave.

**Ms SYLVIA HALE:** She received no form of compensation for that from the scheme at all?

**Mr WAIT:** No. She has gained a new job now. It is very disruptive in regards to a spouse's employment. Even I was very worried about my own employment because my injury occurred in 2009 in that economic climate. I was in the building industry. The company I worked for had basically laid off a third of its staff. Being in the position I was in, I thought I would definitely be one that would be let go, but I managed to sort of hang onto it. It was very difficult.

**Ms SYLVIA HALE:** Did the three of you know each other prior to the last week or so?

**Mr FRANKLIN:** No. Actually, we just met for the first time in the corridor.

**Mr STRBIK:** Ten minutes ago, outside the door.

**Mr WAIT:** Yes.

**The Hon. JOHN AJAKA:** Mr Franklin and Mr Strbik, did either of you or anyone else in your family received any carer's assistance by way of other money paid to you, or other forms of assistance from Lifetime Care and Support?

**Mr STRBIK:** My wife receives a carer's allowance, $50 a week.

**CHAIR:** That is the Federal one.

**The Hon. JOHN AJAKA:** That is the Federal one, not related to Lifetime Care.

**Mr STRBIK:** Not related to Lifetime Care, no.

**The Hon. JOHN AJAKA:** And all the time spent looking after your child, et cetera, has that placed any financial difficulties on either yourself or your wife in the sense of a reduction in income into the household?

**Mr STRBIK:** Not directly relating to the injury of my daughter. I was injured in the accident myself and I have changed my job to light duties with less income.

**The Hon. JOHN AJAKA:** That will be something different, I understand.

**Mr STRBIK:** It is not that relevant, yes.

**The Hon. JOHN AJAKA:** Mr Franklin?

**Mr FRANKLIN:** No, nothing—no payments from Lifetime Care or anything like that. I was very lucky in that my employer was very good. I still work my hours and I get the job done. They do not really mind whether I do it at home or whether I do it at work, so it works out quite well.

**The Hon. JOHN AJAKA:** The only other question I have for the three of you is: Do you see a need for both a case manager and a coordinator, or do you believe that one would be sufficient? We will start with Mr Franklin?

**Mr FRANKLIN:** I would need to ask Jonathan the question because he deals a lot more with the first category. I guess it really is just a question of how much coordinating they do. Obviously there is a lot of paperwork to do. I imagine if you started sending everything directly, they would have to start sending things back to us because it is not complete, and stuff like that. I think you probably need both of them.

**Mr STRBIK:** I think you need both because the case manager needs to research what therapies are needed and needs to own the report in an appropriate way, and the coordinator needs to review that to approve it.

**The Hon. JOHN AJAKA:** Consider the situation of the case manager looking at all the medical and other needs, almost from a counselling-medical side, and the coordinator being more—I do not want to use this terrible term—the bean counter who will say, yes, it is needed, or it is not.

**Mr STRBIK:** Very much yes.

**The Hon. JOHN AJAKA:** Mr Wait?

**Mr WAIT:** Yes, I would agree, particularly in the early stages where, if it is medical, they are in a better position. Generally the case manager is an occupational therapist who knows.

**Mr FRANKLIN:** They have some qualifications. They are an OT.

**Mr WAIT:** Yes, that is right. I would agree it is a requirement, particularly with paperwork. There is a high degree of documentation for each request.

**The Hon. JOHN AJAKA:** Is the paperwork too much? Is it like the old Army example of everything having to be triplicate and you need a form to order a form or is it reasonable?

**Mr WAIT:** It is only one request form. There have to be decent grounds for a request for a piece of equipment. I have had several rejected based on inadequate information given. After learning the system and what is required, they have generally approved it.

**Mr STRBIK:** We have not had any complications because it is all out of our hands. The case manager looked after the paperwork.

**Mr FRANKLIN:** It is the same for us. We have not had much to do with it. I have read some of them and they are quite repetitive. If I was designing a form I would not do the same thing. It is not as though Jonathon is making claims every week; it is only for major equipment or something else comes up. It is not a burden. As I said, once you get into the format and you know what needs to be done it is not an issue.

**The Hon. DAVID CLARKE:** Mr Wait, did you say you are still working?

**Mr WAIT:** Yes.

**The Hon. DAVID CLARKE:** If you had not had this injury, would you be earning more now than you are?

**Mr WAIT:** I would definitely be earning much more.

**The Hon. DAVID CLARKE:** So you have not been compensated for that, have you?

**Mr WAIT:** No.

**The Hon. DAVID CLARKE:** You are losing every week.

**Mr WAIT:** Over the six months I had off I chewed into my long service leave to keep going financially.

**The Hon. DAVID CLARKE:** In other words you were not paid for that either.

**Mr WAIT:** No.

**The Hon. DAVID CLARKE:** When you were asked earlier about whether you were happy about the present scheme or whether you would prefer a lump sum scheme, you pointed out that you would like to know the terms of such a scheme.

**Mr WAIT:** Yes.

**The Hon. DAVID CLARKE:** You would want to know whether it involved compensation for diminution of income and so on. That would be the sort of factor that would influence you in coming to a decision.

**Mr WAIT:** Yes.

**The Hon. DAVID CLARKE:** I understand the reasoning behind that. Mr Strbik, you said that the medical bills are paid on your behalf direct to the doctors and so forth. Is that correct?

**Mr STRBIK:** Yes.

**The Hon. DAVID CLARKE:** You do not pay and get--

**Mr STRBIK:** Not so much with the medical bills. It applies more to the occupational therapists and speech therapists.

**The Hon. DAVID CLARKE:** Do you know whether they are paid on time?

**Mr STRBIK:** I think they are because the applications are submitted well in advance prior to the expiry of the prior claims. The initial one may have taken some time, but after that they knew how the process works. There is a time lag between the application and funds coming through, so they submit it in advance.

**The Hon. DAVID CLARKE:** Does your wife work?

**Mr STRBIK:** No, she is at home.

**The Hon. DAVID CLARKE:** Was she working at the time of the injury?

**Mr STRBIK:** No.

**The Hon. DAVID CLARKE:** Mr Franklin, I think you indicated that you are not happy about a lump sum scheme because of the bureaucracy and the involvement of lawyers.

**Mr FRANKLIN:** The present scheme is working well for what it is. If you want to change it to a lump sum third-party scheme, you would have to look at all these others things. But I would be paying much more than $90 annually on my registration.

**The Hon. DAVID CLARKE:** Setting that aside for the moment, would your answer be similar to Mr Wait's; that is, you would need to compare the present scheme with a lump scheme? You would need to know what was paid through the lump sum scheme before you made a decision?

**Mr FRANKLIN:** You would have to look at the detail and see what it involved. Would it be needs based, would you be able to top it up in special circumstances. What happens if he has another accident? How would you define what was due to the original accident and how much has been contributed by a new accident and so on?

**The Hon. DAVID CLARKE:** Are you saying that as far as it operates you are getting by with the scheme but that you cannot make a decision about anything else until the other alternative is put forward, specified and quantified?

**Mr FRANKLIN:** I still like the idea of it being needs based. If Jonathon has a need, they approve it and it is done. There are no grey areas. He might like a car and then we get into whether he really needs one, how bad is the injury and so on. It goes on and on and I would not want to do that.

**The Hon. DAVID CLARKE:** What about someone who is working and as a result of an injury they are working less. Is that needs based and should they be compensated for a drop in income?

**Mr FRANKLIN:** The accident was Jonathon's own fault and he has to take responsibility. I do not think the taxpayers should pay a huge lump sum to compensate him for the rest of his life.

**The Hon. DAVID CLARKE:** What about someone who was not at fault?

**Mr FRANKLIN:** The existing third party system covers that. I do not know whether it works well.

**The Hon. DAVID CLARKE:** Under this system, if someone is an innocent party and they suffer a drop in income they do not get compensated for that.

**Mr FRANKLIN:** Fair enough.

**The Hon. DAVID CLARKE:** The summary would be that you would want to see what the lump sum scheme involved before making a final judgement.

**Mr FRANKLIN:** Correct.

**The Hon. LYNDA VOLTZ:** Mr Strbik, do you have other children?

**Mr STRBIK:** We have two other children. Lydia has a twin brother aged 11 and we have another daughter aged 8.

**The Hon. LYNDA VOLTZ:** Was there provision for children with a disability when she went back to school?

**Mr STRBIK:** They have good support. They have support staff specifically for children with needs. Because Lifetime Care and Support is looking after she has been assigned a full-time teacher's aide, which has really helped.

**The Hon. LYNDA VOLTZ:** Mr Franklin, you said that you had difficulties with the council with regard to the modifications you wanted to make to your house.

**Mr FRANKLIN:** Yes.

**The Hon. LYNDA VOLTZ:** Did that slow down the modification process?

**Mr FRANKLIN:** Yes. It was a question of whether the dwelling was going to be classified as dual occupancy. If I did it as dual occupancy the problems would have gone away, but that would have meant that I was paying two lots of rates and so on. I resisted that and we have done something totally different from what I originally planned. It works reasonably well.

**The Hon. LYNDA VOLTZ:** Are there conflicts between what the council wants and what Lifetime Care and Support approves?

**Mr FRANKLIN:** Lifetime Care and Support's attitude is that whatever we do must be approved by the council. They do not care what the council says as long as we have approval.

**The Hon. LYNDA VOLTZ:** If council demanded a dual occupancy arrangement it would not cover the rates?

**Mr FRANKLIN:** I never had that conversation. I did not want to do it.

**The Hon. LYNDA VOLTZ:** Did you build a separate facility?

**Mr FRANKLIN:** It is on the existing property. I changed all the rooms around and put in a new bathroom for him and I moved to the back of the house.

**Ms SYLVIA HALE:** One of the concerns of previous witnesses relates to lack of privacy. So many people have to be told at varying stages and they have had to go through their entire history repeatedly. That was very embarrassing and raised personal information that in their view was unnecessarily shared with other people. They saw that as an invasion of privacy. Did any of you have that experience?

**Mr WAIT:** No. The information is passed only to Lifetime Care and Support to my knowledge.

**Ms SYLVIA HALE:** You would tell Lifetime Care and Support and they would be responsible for ensuring that whoever was coming to provide a service to you was aware of that information without you having to go through it again?

**Mr WAIT:** As I said, I am probably a low-maintenance patient.

**CHAIR:** You are not a patient anymore.

**Mr WAIT:** No;, I am now a participant. It may be totally different for people needing a higher level of care.

**Mr STRBIK:** I have no difficulty with anyone else knowing. In our case we are simply grateful that she has recovered a lot. It is a testament to them.

**Ms SYLVIA HALE:** She is a young child at the moment, but when she gets older she may feel differently if she has to recount personal details. She may feel that she has to do it unnecessarily frequently.

**Mr STRBIK:** That will be up to her when she grows up.

**Mr FRANKLIN:** I do not think it is an issue. It has not been an issue for Jonathan. He has not said anything to me. The people who need are the doctors and those involved in the operations. It is good idea to have the coordinator, because she has the history and she knows what is going on. We have not had to repeat the story to 35 different people. We did not have to explain the situation to the builders. Obviously he knew Jonathon was a paraplegic. Other than that everybody has been professional. People have simply wanted to know what needs to be done and how the modifications can be done to achieve that. There have been no privacy issues.

**The Hon. JOHN AJAKA:** I refer again to the lump sum buy out. That option is not available now. Taking into account what you have said, do you feel that you should have that option? If you have done your sums and homework and you believe that that is what is right for you, do you believe you should have that option?

**Mr WAIT:** Definitely. I do not know whether the process would involve Lifetime Care and Support rather than solicitors. They could do their own sums and both parties could arrive at a figure. It could be between the participant and Lifetime Care and Support. I would be more than happy with that situation.

**The Hon. JOHN AJAKA:** The choice is then yours to say yes or no.

**Mr WAIT:** Yes.

**Mr STRBIK:** I mentioned the time lag earlier.

**The Hon. JOHN AJAKA:** Assume that she is 20 years old.

**Mr STRBIK:** If she were older we would probably look at it differently. At the moment this is definitely appropriate.

**The Hon. JOHN AJAKA:** But should she at least have a choice?

**Mr STRBIK:** Maybe just to compare.

**The Hon. DAVID CLARKE:** Would you like her to have that option when she is mature? In other words, it would be put on hold and she would be cared for in the meantime and when she was 18 she could then opt for a lump sum or continue under the present arrangement. Would that deal with your concerns?

**Mr STRBIK:** At the moment we are happy with the scheme she is in. It could be just to compare with another option.

**Mr FRANKLIN:** I think it depends on the details of the scheme. It might be a good idea to have the option. I do not think the family is clear headed enough in the first two years after the accident or injury to assess the situation and to make a choice. You could introduce such a scheme and stipulate two or three years for surgery and so on. Jonathan has been in hospital twice since the accident. We did not know that he would have to go back to hospital. As I said, if you agree, can you go back and top it up for these things and so on. After two or three years you can move on.

**The Hon. JOHN AJAKA:** It would be good to have an option, but you would want to make a decision when everything settles.

**Mr FRANKLIN:** The benefit of this system is that it removes stress. It is a terrible event and you do not think clearly. It gets better as you progress. Once you get to that point, away you go.

**The Hon. LYNDA VOLTZ:** Mr Strbik, did you say that you think that option should be available when your daughter turns 18?

**Mr STRBIK:** We were told by the solicitor that they would not consider a payout.

**The Hon. LYNDA VOLTZ:** As a parent, do you think it would be appropriate to offer that option to an 18-year-old about their lifetime care?

**Mr STRBIK:** For the pain and suffering part, yes.

**The Hon. LYNDA VOLTZ:** But not for the lifetime care?

**Mr STRBIK:** No.

**CHAIR:** Do wish to make any further comments? Of course, you are welcome to send the Committee any further information you believe would be helpful.

**Mr FRANKLIN:** I would like to make a couple of comments. As I said, Jonathon was two weeks off being a chef. With his injury he is not likely ever to go back to cheffing because people just do not set up kitchens that way. At present Lifetime Care do not consider retraining as part of the scheme. I think they should. My son is 22 now. We are lucky that he has gone back to university to go and do something different. I think it would be a good idea if they looked at retraining costs as part of the scheme.

**The Hon. DAVID CLARKE:** Have you sought retraining costs?

**Mr FRANKLIN:** We have asked whether it is possible to have these things done. As far as I understand it, they look at it, if you go back to your workplace they will look at modifications in your workplace to fit back in, a few changes like that. But to go from being a chef to a businessman, no, it is not covered.

**The Hon. DAVID CLARKE:** It is not available to you?

**Mr FRANKLIN:** No, it is not available.

**The Hon. DAVID CLARKE:** Do you see that as a defect in the present situation?

**Mr FRANKLIN:** In the long term, yes, because they have been doing something. They wanted to do it and now they cannot do it anymore. Lyndon is lucky and has been able to stay in the same profession.

**The Hon. DAVID CLARKE:** On a lesser income.

**Mr WAIT:** I have put the proposal to Lifetime for further education and they have paid for that.

**Ms SYLVIA HALE:** Was that within your current area or beyond that entirely?

**Mr WAIT:** Initially it was rejected because I said I am a tradesman based but the last 10 years I was more clerical with project management and so forth, but part of my job was still practical, which I am now unable to fulfil. I had to document that very well to prove that I needed to do these extra studies to stay employed and eventually they agreed.

**CHAIR:** What was that?

**Mr WAIT:** It was two-year, part-time TAFE. It was only about $1,200 but they have paid it. I basically paid it and then got reimbursed.

**The Hon. JOHN AJAKA:** How many times did you have to back to them to get them to finally pay you?

**Mr WAIT:** Quite a few. I do not mind. It was just in email format, playing email tennis.

**Ms SYLVIA HALE:** Again, if there was a support group that kept you informed as potentially where other people have succeeded or failed, would that be useful?

**Mr WAIT:** If you can stress the need for it, that is probably the key item of the scheme. They are not just going to give it away but you have to set, really lay out quite firm the reasons why and in maintaining employment. I think that is an area where they probably need, because I guess the golden thing for the State is to not have people unemployed, get them back, rehabilitated and get them into work as soon as possible. I think that is an area where they could enforce assistance. I was very motivated to get back to work. Luckily I had a very good employer that I had been with for 17 years and they accommodated me quite well. With regard to workplace modifications, that was then passed onto a Federal, came out of WA which funded—

**The Hon. DAVID CLARKE:** Is there anybody you can go to for independent advice apart from your coordinator, who is in fact part of the scheme?

**Mr WAIT:** Generally, I have not had any major issues. Any approvals, we were able to resolve them. I did not need to go over my case coordinator's head. I never have. I like to keep things professional, on a professional basis between ourselves because it is, as it is stated, lifetime. You do not want to be offside from the beginning. I think keep it fluent and professional all the way through, and eventually things fall into place.

**CHAIR:** This training stuff you have brought up is a very special issue. We will bring that up this afternoon and then consider it when we are deliberating on our recommendations.

**Mr FRANKLIN:** I guess the goal is to make sure you end up back in the workforce and you are doing something that you like doing.

**CHAIR:** Functioning at best capacity. Thank you. If we have further questions we will send them to you. As I told earlier witnesses, in a couple of days on our website you will find a copy of the transcript, which actually gets sent to you for checking. If there is anything that you want to add, do not hesitate in getting the information to us. That would be very well received. Thank you for coming. You have certainly value added our inquiry. I do not just say that off pat to you. It is very useful. Did you have something else you want to say?

**Mr WAIT:** Probably as a participant, the thing I did find, going through the whole system, is there is sort of a tiered level of care for patients, from hospital through to rehabilitation, where you might have workers compensation and third-party claims, which I would say may be the premium care, then lifetime and then there is this level where people have injuries in their home and there is basically very little. I think that is an area that maybe needs to be looked at. How the money is collected, I do not know. Whether it is a tax that is put onto rates to cover domestic style, but probably 50 per cent of injuries out there do not have any coverage at all. Being in a scheme, obviously things like wheelchairs are provided but in that area there is very poor coverage. I feel for those people.

**CHAIR:** You are addressing a very legitimate issue.

**Mr WAIT:** Obviously, with vehicles you can tag it on to third party but I do not know how to suggest raising revenue for that.

**CHAIR:** It is a big issue.

**(The witnesses withdrew)**

**(Luncheon adjournment)**

**ANNA LOUISE CASTLE-BURTON**, Occupational Therapist, Director, Australian RehabWorks, sworn and examined:

**CHAIR:** Welcome and thank you for coming. This is our second public hearing in our third review of the Lifetime Care and Support program. If at any stage you consider that something you would like to say or any information you may wish to give should remain confidential please indicate that to the Committee and the Committee will consider your request. Please return answers to questions of notice to the secretariat within 21 days. Would you like to make a short opening statement?

**Ms CASTLE-BURTON:** I would like to thank the Committee for the opportunity for me to give evidence today in my capacity as an occupational therapist for the past 21 years and director of a private rehabilitation service, Australian RehabWorks [ARW], for the past 13 years, which specialises in neuro-rehabilitation. ARW provides a range of allied health services, including physiotherapy, occupational therapy, speech pathology and case management services, to people with a traumatic brain injury or a spinal cord injury in Sydney and the surrounding areas.

Therefore, over the past three or more years we have been working increasingly with the Lifetime Care and Support Scheme [LTCSS] in assisting participants to access quality treatment and rehabilitation services. We currently have approximately 15 Lifetime Care and Support participants, each accessing an average of two or three services from us, such as case management, occupational therapy or physiotherapy. Our experience with the Lifetime Care and Support Scheme has been a positive one to date, due to the collaborative and consultative process between the provider and the LTCSS coordinator for the betterment of the participant.

We would like to see a change in the policy relating to the funding of transportation of participants for leisure activities, allowing them to more easily access leisure, as well as greater uniformity in the skill level of Lifetime Care coordinators. Furthermore, we advocate for the use of approved assessors early on in the rehabilitation process to ensure that the provider-participant relationship is preserved, and to reduce the likelihood of disputes down the track.

**CHAIR:** Last year, and this year to a small extent, we heard from providers about difficulties, perceived or otherwise, with the case managers and the coordinators from the Lifetime Care and Support group. Can you talk a bit about that issue?

**Ms CASTLE-BURTON:** Can you expand on that a little in relation to difficulties?

**CHAIR:** Conflicts that sometimes occur between the case managers from Lifetime Care and Support and the professional teams that have often been working clinically in that environment for a very long time.

**Ms CASTLE-BURTON:** The relationship between the coordinator and the case manager within a team? My experience has been outside the public hospital system. We operate in the private market and in our relationship we have not experienced those difficulties between case manager and coordinators, so it is difficult for me to comment on that. We have had positive experiences in dealing with coordinators.

**The Hon. JOHN AJAKA:** Most of your communication would be direct with the coordinator as opposed to a case manager?

**Ms CASTLE-BURTON:** Yes. We are the case manager.

**The Hon. JOHN AJAKA:** Were you given a copy of the possible questions?

**Ms CASTLE-BURTON:** Yes.

**The Hon. JOHN AJAKA:** Can I take you to question No 6, because it intrigues me a little? The kids rehab at the Children's Hospital at Westmead has suggested that information from prior requests for services should be stored by the Lifetime Care and Support Authority as it accumulates in relation to a participant to avoid the repetition of the historical information each time a new request is made. Before we go into what you think I want to go back a couple of steps. Your view is that basically it would be nice to have one place where all of this information is accessed so that if anyone dealing with the participant needed information it would be readily accessible, or is it simply that Lifetime Care and Support has to go out and ask the same questions over and over again through different branches?

**Ms CASTLE-BURTON:** Just to clarify: we are not kids' rehab.

**The Hon. JOHN AJAKA:** I understand that. I am just getting your view.

**Ms CASTLE-BURTON:** I understand the issue coming from kids Rehab in relation to not repeating the same information, but we feel that the forms and the systems that we are required to use all have such different purposes that often the information that you need to highlight in a particular application is different from form to form. For instance, if you are filling in an equipment request, the information that you may want to highlight out of a participant's history may be different from if you are filling in a service request. Generally we find that the basic information, that is, the participant's address, details, et cetera, is very easily just copied over from form to form. As this is our core business we do not find that part onerous, and we feel that there should not be proformas in filling out the forms; they should be specific to whatever request or service you are asking for. So your request should be specific.

**The Hon. JOHN AJAKA:** Just leaving aside the issue of privacy and confidentiality, which opens up a whole different area, if a participant is being seen by you and assisted by you, you would have your own information on that participant?

**Ms CASTLE-BURTON:** Yes.

**The Hon. JOHN AJAKA:** And as the matter develops so does the information. Is that a fair comment?

**Ms CASTLE-BURTON:** That is right.

**The Hon. JOHN AJAKA:** But you do not have any access to other information that, for example, Lifetime Care and Support would have if they were storing everyone's information? In other words, there is no central computer database, is there?

**Ms CASTLE-BURTON:** No, but as a case manager one of the roles of case management is to collaborate on the reports and the treatment that your participant is undergoing. So in terms of treatment you would have a fairly good idea of what everybody is saying because they have to send their reports to you for you to write the report that goes to Lifetime Care.

**The Hon. JOHN AJAKA:** So the reality is at this stage in one way, in an ad hoc fashion or as the default mechanism, you would have that central information on the participant?

**Ms CASTLE-BURTON:** That is right.

**The Hon. JOHN AJAKA:** But that is only in relation to participants in the scheme that you actually deal with?

**Ms CASTLE-BURTON:** Yes.

**The Hon. JOHN AJAKA:** You do not deal with every participant in the scheme?

**Ms CASTLE-BURTON:** That is correct.

**The Hon. JOHN AJAKA:** Even with the ones that you deal with where you now have this semi-central information, are other people able to access it or do they have to formally request it from you and you would decide what, if any, to give?

**Ms CASTLE-BURTON:** We are a multidisciplinary practice, so generally all the services that the client is accessing they are accessing through us as one group. So yes, we keep a central file on the participant but we also work with outside. There are obviously outside providers who often provide a service and they would need to seek that information from us—is there any history of something or is there something in the past they need to know about. It is up to us to write them a good brief if we are asking them to provide a service on a participant's behalf. So yes, they would need to ask specifically or we would need to provide them—

**The Hon. JOHN AJAKA:** And then you would have to prepare the report?

**Ms CASTLE-BURTON:** Yes.

**The Hon. JOHN AJAKA:** Looking at it from a lawyer's perspective, where I come from, my information on clients was always in paper form in a file; occasionally some would be in a computer, but not all. Is yours set up the same way?

**Ms CASTLE-BURTON:** Yes, we follow medical records procedures as they would in a hospital, so we keep a file that is formal documentation of every time there is any interaction on the file and we print out emails, because obviously a lot of communication goes on by email, and all the reports that we have written and the forms we have set up for Lifetime Care are copied and put in the file. But there is also, obviously, an electronic file in our server because the documents electronically go to the data principal.

**The Hon. JOHN AJAKA:** So they are not really going to be able to access a file?

**Ms CASTLE-BURTON:** No.

**The Hon. JOHN AJAKA:** What they will need is for you to write a report to them picking what you think is the important—

**Ms CASTLE-BURTON:** That is right, or provide them. We would have to provide upon their request to us, say, "We need to see the neuro-psych report", we would then have to provide that to that person.

**The Hon. JOHN AJAKA:** Could I take you to questions 8 and 9, which ask whether you have experienced any delays? We have heard from some participants that it works brilliantly and they are very, very happy, and we have heard from other participants that there are delays and that by the time the case manager puts in a report to the coordinator, the coordinator deals with it if it is approved, et cetera, there is too long a delay. What is your experience?

**Ms CASTLE-BURTON:** Our experience has been probably at both ends. When we have absolutely needed something approved as a matter of urgency, whether it be an equipment request or a service request, that is actioned very quickly. But there are always natural delays as in once the therapist has seen the client and said, "Yes, we believe that that equipment or service is reasonable and necessary", we then write to Lifetime Care and it is then another 10 days that Lifetime Care and Support have to reply. So if you have taken two or three days to action that and then they have got 10 days, to the participant that is a long time—it could be two weeks.

If it is an equipment request they do take more time to develop because you have to go out to the marketplace and get three quotes on the equipment so that you are showing a comparative. It is often not done in one day and not done in a couple of hours; it could be done over a week. So then you are looking at three weeks until you may get a reply from Lifetime Care in relation to whether you have been successful or not.

**The Hon. JOHN AJAKA:** One of the other witnesses earlier made an interesting comment that a very positive side of it was that in cases of emergency, crisis, et cetera, they are very quick to respond. That was wonderful to hear, but it was interesting that the opposite seemed to happen that where a participant had improved enormously enough to be able to go home, all of a sudden there seemed to be this terrible delay in getting through requests that were no longer being dealt with in that crisis situation, which was very frustrating for the participant who simply wants to go home and does not want to stay in the facility for another two weeks. Have you experienced that as well?

**Ms CASTLE-BURTON:** We have experienced that, but it has improved with the change in the discharging procedures where the units are not required to fill in a community discharge plan, which was quite timely for them and quite difficult, and then transitioning to a private service. There definitely was some down time or there was some difficulty there. But I think with the new discharge procedures that should be minimal, where services can be streamlined from hospital to home. So yes, we have had instances where there have been hold-ups.

**The Hon. JOHN AJAKA:** Some of the participants indicated that they were a bit frustrated with a situation where they would request something—a piece of equipment, et cetera—a case manager would even recommend it and it would come back "no". It would be requested again and it would come back a "no", and after repeated requests there would finally be a "yes", which seemed a little frustrating for them, as you would appreciate. Have you experienced that situation?

**Ms CASTLE-BURTON:** Not really. I guess we are quite used to having to justify the prescription of equipment and I think if the time is put in upfront in doing the necessary research and clinical reasoning, we have probably had 100 per cent success with equipment requests. Sometimes, maybe if it is rushed or if the participant is putting pressure on the case manager and the request goes in and then the coordinator says, "I need a little bit more", and it comes back, that can also lead to delays. We have had good success with equipment requests.

**The Hon. DAVID CLARKE:** Your submission refers to the differences you have experienced in dealing with the Lifetime Care and Support Authority compared with other third party funders. Can you tell us a little bit about those differences?

**Ms CASTLE-BURTON:** Certainly. In the business we work with other third party funders such as the CTP system and the workers compensation system. We find that without the legal aspect attached to the client, particularly with CTP cases, the planning becomes quite centred and looking at more of the participant's long-term needs. We find that the relationship between the coordinator and a provider is much more consultative and collaborative and there is more scope to request services and treatment that we know maybe upfront seem costly but we can rationale it down the track long-term, that are going to make quite a large difference to a claimant. We find perhaps with some of the other schemes that they are not really open to long-term planning, particularly as the legal issues come about after a certain number of years. We find that the relationship with the injury management advisers, that there is a different relationship between a provider and an adviser when there is a legal aspect.

**The Hon. DAVID CLARKE:** Except with the other systems you really would not know what is going to be provided down the track, would you, so you are surmising, in a way? There is not an assumption there that they are necessarily going to be worse off under these other situations; it is just the way this particular scheme is geared because of the payment of monies—there are no lump-sum payments and so forth?

**Ms CASTLE-BURTON:** Yes.

**The Hon. DAVID CLARKE:** That is the way it has sort of dribbled out in a way over a period of time rather than the injured party having control over their own affairs. Would you agree that that is basically the difference between the two?

**Ms CASTLE-BURTON:** Yes, I would. Maybe I have not explained myself well enough. When you are dealing with a third-party insurer such as CTP it seems to us that providers are interested in cost containment, so they do not want to open up the doors to a head of damage that may end up costing them money down the track. So when we are looking perhaps at a broader picture or we are looking at a service or a piece of equipment we know will assist in long-term management, they tend to want to just focus on the here and now rather than perhaps allowing us to look into the future and say give them this now because this is going to reduce care costs in the future or it is going to increase their independence so they will not be so reliant on family, et cetera, et cetera. We just do not find that the negotiation or the collaboration is there so much with the injury management advisers; it is more almost an us-versus-them situation, whereas with the coordinators it is more about "let's look at this together, let's look at the whole picture". Particularly if a participant looks like they are going to be in the scheme for life, there is much more openness to looking at support over the lifetime.

**The Hon. DAVID CLARKE:** Except what would you say as a response to that, that when you talk about the other schemes appearing to be based on cost containment, is not the truth of the matter that the entire scheme of the Lifetime Care and Support Authority is based totally on cost containment and that is why it does not allow lump-sum payments and so forth? Specifically this system was brought in to bring about cost containment and to reduce the amount of money that was available as a pot to injured parties. Would you see that aspect as something of relevance?

**Ms CASTLE-BURTON:** Yes, and I do not want to wander outside my area of expertise here. Purely the basis that we deal with is meeting their treatment and rehabilitation needs. We are not as exposed to that element of the cost containment and reserve setting and things like that. I am probably not a good person to answer that question.

**Ms SYLVIA HALE:** We had evidence earlier this morning from the Brain Injury Rehabilitation Directorate that suggested that often there was confusion, variation and inconsistency when you had to deal with private case managers. What is your experience of that?

**Ms CASTLE-BURTON:** I would have to say that I do not agree with that description. Any time there is a transition from a public service to private, there is probably an element where there can be delays. I would not see that as an issue that we deal with or have had feedback in relation to. In fact, the referrals we have received from units, we have been able to help by going in a little bit earlier to facilitate the efficiency of that process from the public service to the private. Any time, regardless of the system, there is that transitioning from hospital to home there is always an element of delays, particularly if care needs to be organised. That will also complicate and often there are delays in that sort of service.

**Ms SYLVIA HALE:** You said if you go in earlier there may be fewer problems. At what stage do you usually become involved in the process?

**Ms CASTLE-BURTON:** We like to be involved and generally it is accepted that we go to one of the last couple of discharge meetings with the treatment team. We will go and sit in on that meeting to understand when the discharge is anticipated, what sort of services they are requiring, particularly care. Often at that stage they invite us to assist them to complete the relevant paperwork to facilitate efficient discharge. We have quite frequently written the community discharge plans [CDPs] for the unit so that the process is streamlined and there is not any time delay in services. That is when we find it works best, when we are involved at that level rather than perhaps being referred after they are at home or just as they are about to go home. It does not give us a lot of time to do what we need to do.

**Ms SYLVIA HALE:** Does the scheme participant or the family have any say in whether their case is referred to you for handling?

**Ms CASTLE-BURTON:** You would need to ask them, the referrals, the units; I am not sure.

**Ms SYLVIA HALE:** I am interested in how the system works. Are there other providers that go in early or do you work on a one-to-one basis with whichever hospital?

**Ms CASTLE-BURTON:** We service Sydney and surrounding areas. So we will accept a referral from any of the major brain injury units. It tends to be a bit more locality based. We are based in the north of Sydney, so we tend to get referrals from the brain injury unit that is close to that area. That is generally how it tends to work. There are not a lot of practices that do what we do as a group practice. There are probably maybe two or three others. Then there are single disciplines, single occupational therapists or physiotherapists that they may refer to. I do not know if it is their practice to go in early. It is certainly something that we advocate and request because it has been proven to us and to the units to be a very efficient way of managing the discharge.

**Ms SYLVIA HALE:** Do you expect to have a fairly lengthy relationship with the participant in the scheme?

**Ms CASTLE-BURTON:** Yes.

**Ms SYLVIA HALE:** What would that relationship be—a matter of months or years?

**Ms CASTLE-BURTON:** A service like case management can go on for a lifetime. The intensity can vary from very intense in the first 6 to 24 months and then become episodic over their lifetime, depending on their needs.

**Ms SYLVIA HALE:** In this period would you interact a great deal with the family?

**Ms CASTLE-BURTON:** Yes.

**Ms SYLVIA HALE:** And other carers?

**Ms CASTLE-BURTON:** Yes, we do.

**Ms SYLVIA HALE:** One of the issues raised earlier was an apparent lack of compensation for family members who have to leave their job and look after a person on a full-time basis or close to a full-time basis. Is it your experience that is a common occurrence?

**Ms CASTLE-BURTON:** I can only talk for our participants, the ones we have had since the scheme started. I cannot think of anybody who left a job to care for the person. I am certainly aware of many of our clients whose partners and spouses have been put under stress because of the additional care responsibilities they have had to assume. But none of our participants or their families, nobody has given up a job to provide the care.

**Ms SYLVIA HALE:** Are you conscious of any ways in which that stress could be alleviated?

**Ms CASTLE-BURTON:** The best way is for paid care to be put in place.

**Ms SYLVIA HALE:** That is infinitely more expensive, is it not?

**Ms CASTLE-BURTON:** That is right. It is all about what is reasonable. If you are in the house anyway, care overnight becomes a reasonable expectation. I would hope that by doing a full and proper job of the care needs assessment we would not be expecting a family to do anything that brought undue stress on them; that we would have identified it. If there is that much stress, it means the participant had a significant need, therefore paid care is probably warranted.

**The Hon. LYNDA VOLTZ:** I want to go back to the point the Hon. David Clarke raised about cost containment. You said that your experience with Lifetime Care was different. Would you say that when you deal with Lifetime Care and Support that its main aim is not cost containment?

**Ms CASTLE-BURTON:** No, I do not think that is the case at all. I think that the planning for us is more around the willingness to fund and approve services, equipment and treatment that we can show will be of benefit in the long term. In fact, they are probably looking at cost containment in terms of the long term. They are willing to look at the long-term picture rather than when we deal with another third party system, which may knock back requests without any real understanding or acceptance of the long-term implications because they are looking more at a short-term involvement.

**The Hon. LYNDA VOLTZ:** That is the third party insurers?

**Ms CASTLE-BURTON:** Yes.

**The Hon. LYNDA VOLTZ:** The Hon. David Clarke raised the issue that the Lifetime Care and Support Scheme was set up as a cost containment. That is opposed to my impression, which is that when 40 per cent of people had spent their money within the first 20 years the scheme was to look at the long-term outcomes of the participants. Would you say that the scheme is not driven by cost containment necessarily but more an effective long-term outcome?

**Ms CASTLE-BURTON:** Can you run through that again?

**The Hon. LYNDA VOLTZ:** Cost containment is not driving the decisions of the Lifetime Care and Support Scheme; it is about the longevity of the medical treatment for the people within the scheme?

**Ms CASTLE-BURTON:** I think both actually. I do not know because that is not the end I deal with. The end that I deal with, our experience is they are more open and willing to discuss and be involved in decisions that initially may not make sense but long term will be for the betterment of the participant. That may mean long term that the cost will be less. Maybe an example would help—such as, funding for case management services to help someone who was without a home to put some resources towards assisting them negotiate the Department of Housing scheme. Long term, if the participant is to have a house, that will assist in all sorts of ways down the track. We may not have been as successful in being given case management hours for that purpose through the CTP system as we might through Lifetime Care, who recognise the long-term benefits in having that participant housed.

**The Hon. LYNDA VOLTZ:** The issue of family members and the stress on them also has been raised. We have spoken to other witnesses about a support group for people who have been through the scheme. There does not seem to be such a support group. Do you think in the long term there would be some efficacy in a support group?

**Ms CASTLE-BURTON:** Definitely, yes. Support groups are very valuable.

**The Hon. LYNDA VOLTZ:** The change to lifestyle following these types of accidents is very traumatic. Obviously, some consideration must be given to those most affected by the trauma who are not the victims in terms of their ability to talk about problems and express their feelings?

**Ms CASTLE-BURTON:** Yes.

**The Hon. LYNDA VOLTZ:** But nothing like that is provided at the moment?

**Ms CASTLE-BURTON:** In terms of funding for partners or spouses to access adjustment counselling?

**The Hon. LYNDA VOLTZ:** Or even the setting up of a support group?

**Ms CASTLE-BURTON:** That is true.

**The Hon. GREG DONNELLY:** We have provided questions on notice to you. I refer to question No. 7, which you have answered in part, about the work you do with the Lifetime Care and Support Authority coordinators. How do you generally find that working relationship? Does it work well or not? Could you give us an overview?

**Ms CASTLE-BURTON:** We have had positive experiences with the Lifetime Care coordinators that we have worked with. We find that the relationship is, as I have said a number of times, a supportive and collaborative relationship. There is a focus on working together towards the betterment of the participant. They are open to feedback and they are open to discussion, which is helpful as a provider. Working with people with traumatic brain injury is not the easiest line of work. They have often got difficult behaviours and things come up in practice and in providing them with treatment all the time. So it is useful to have somebody to talk through those issues and the ways to manage a particular case. We have always found the coordinators we work with to be very supportive and to help us work through a particular issue with clients. We have not had any negative interaction.

**The Hon. GREG DONNELLY:** You may not be able to answer this question. Feel free to say so if you cannot. How many coordinators have you dealt with personally in your current role?

**Ms CASTLE-BURTON:** I could give a range of probably five to seven.

**The Hon. GREG DONNELLY:** Do the comments you have just made apply fully to that group of five to seven?

**Ms CASTLE-BURTON:** They probably apply to five of them.

**The Hon. GREG DONNELLY:** In relation to the other two, what is your experience?

**Ms CASTLE-BURTON:** I think it is the knowledge base. We find a coordinator that has come out of an injury management position or has been a provider themselves to have an understanding of the field perhaps better than others who have come from a different area.

**The Hon. GREG DONNELLY:** They have a more thorough understanding?

**Ms CASTLE-BURTON:** Yes.

**The Hon. GREG DONNELLY:** I want to refer to your experience of the way in which expenses or costs are turned around in terms of claims made by individuals who are seeking, for example, a piece of equipment or pharmaceutical needs. We heard evidence earlier today that it can be a prescriptive, time-consuming process that can take, in some cases, many weeks. The alternative view is it is quite efficient and turns around between 7 to 14 days. Are you able to comment on that, in your experience?

**Ms CASTLE-BURTON:** I agree with all that you have said. It is all those things. It depends entirely on what equipment is being prescribed. Some is very simple and can be justified in a matter of an hour's worth of paperwork. Others such as a bicycle can be a long process of investigation of cost and quotes. It can take up to 10 or more days for that to be approved. I think they may even have 21 days for a larger piece of equipment. So it varies, it is variable. As I said before, we probably have had 100 per cent approval on the equipment that we have requested, anything from iPhones to bikes to computers. Because our core business is providing private services, we perhaps are used to having that time to put in requests.

**The Hon. GREG DONNELLY:** In relation to factors that may lead to delays in the provision of services to participants, is the key issue the nature of the claim and what it is for? If it is more expensive and complex does that take more time and if it is not, it is less time. Is that the general proposition?

**Ms CASTLE-BURTON:** Yes, also if it is usual piece of equipment. If it is something for someone with a spinal cord injury and an accepted piece of equipment that will be easier than something like a bicycle that is not really a generally accepted piece of equipment for traumatic brain injury. It is going to require greater levels of clinical reasoning, more supporting documentation and then just the getting of the appropriate quotes for the specifications that you require?

**The Hon. GREG DONNELLY:** Your submission refers to the importance of recreation and leisure activities for scheme participants. Do you want to elaborate on that suggestion in relation to funding for taxis that should be provided to people to be able to facilitate that?

**Ms CASTLE-BURTON:** We find it limiting that taxi funding is only for treatment and rehabilitation purposes. We have had many participants who, had they been able to use taxi, could have accessed increased social and leisure opportunities. They have not required an attendant carer to accompany them but they have required the transport for mobility or location issues but have not been able to access appropriate leisure.

**The Hon. GREG DONNELLY:** Because they cannot afford it essentially?

**Ms CASTLE-BURTON:** They cannot afford it, yes, and also the funding of the taxi is only for treatment and rehabilitation. We found that just the limitation in us trying to meet goals of independence and long-term restoration of function that we feel that if there was some expansion of taxi vouchers for attendance at leisure and social activities that that would be of significant benefit to participants.

**The Hon. GREG DONNELLY:** In relation to support for taxi trips for treatment, is there a threshold limit on how much that can be in any 12-month period?

**Ms CASTLE-BURTON:** Not that I am aware of.

**The Hon. GREG DONNELLY:** No, limit as far as you know?

**Ms CASTLE-BURTON:** No, we have to request based on the number of vouchers.

**The Hon. JOHN AJAKA:** Do you have occasions when you believe all the paperwork and its cost, and the repetitious requesting for items suddenly involves more expense than the actual price of the equipment? Do you think you have just spent a couple of hundred dollars arguing about whether you can buy a bike which costs only $100?

**Ms CASTLE-BURTON:** We are used to filling in paperwork to justify whatever cost or service we need. It is what I have done in my practise for 13 years so it is no different for us to have to do that. Yes, we have found that once the major piece of equipment is approved there may be a sub-piece, for example, a helmet for a bicycle. The request went back and forth mostly because the participant was not happy with the type of helmet that we said would be fine for him. It sort of got ridiculous because it ended up being a $230 item but it consumed a week of time. Yes, it does happen.

**CHAIR:** Do you want to say anything special?

**Ms CASTLE-BURTON:** No, thank you very much for allowing me to appear.

**CHAIR:** If we have any further questions we will send them to you. If you want to tell us anything later, we would be happy to receive that within three weeks.

**(The witness withdrew)**

**SEAN JOHN LUMAS**, Policy and Advocacy Manager, Spinal Cord Injuries Australia, and

**GREGORY WAYNE KILLEEN,** Policy and Advocacy Officer, Spinal Cord Injuries Australia, sworn and examined:

**CHAIR:** I will not read the formal pages about this hearing because I know that you have heard their contents many times before. Do you want to make an opening statement?

**Mr LOMAS:** We wish to withdraw an element of our submission, in particular point four. Our submission has been compiled from a few resources within ourselves internally and we do not think that is a fair representation of a policy that exists within the lifetime care scheme. It is about funding for sporting activities in total because we are aware that the lifetime care does, in fact, fund different or recreational and sporting activities.

**CHAIR:** Yes, they did not last year.

**Mr LOMAS:** No, it did not last year; it does now. We have got to recognise that. We have got to be fair.

**Mr KILLEEN:** Do you need a revised submission?

**CHAIR:** It would be very good if you wrote in a statement of what you said with a retraction of that section of your submission.

**Mr LOMAS:** Spinal Cord Injuries Australia, formerly known as the Australian Quadriplegic Association, was established in 1967 by a group of young men who acquired and survived a spinal cord injury resulting in quadriplegia. They survived due to advances in medical science, but there were no government funded disability support services and programs to enable them to have the opportunity to live in the community and be productive members of society. Spinal Cord Injuries Australia continues to represent and support people with spinal cord injury or similar conditions. It employs many people with disability and provides a number of services including information and referral, advocacy, peer support, out-of-hours emergency nursing service, accommodation and employment services.

Spinal Cord Injuries Australia is aware of the ongoing benefits to people with disability, their family, friends and carers due to the provision of disability support services and programs, particularly those that have effective and efficient management and that are appropriately funded to meet their needs. Many of the current services and programs, including those funded or directly provided by government, were established due to the proactive and adversarial role undertaken by Spinal Cord Injuries Australia. It has played its part in the establishment of personal care being provided by New South Wales Home Care, the creation of the National Attendant Care Program, accessible buses, trains, ferries and related infrastructure and access to premises and the built environment to name a few. We played a part in that. We are not the sole people who drove all of that.

Spinal Cord Injuries Australia also contributed to the planning and development of the lifetime care scheme, and we might also categorise it as being the "ant's pants" of current support services and programs, as quoted by the Law Society of New South Wales, so we would like to thank the parliamentary committee for providing this opportunity to contribute to the review.

Finally, it would be remiss of us not to take this opportunity to state that Spinal Cord Injuries Australia would like all people with a spinal cord injury or similar condition, who are reliant on government-funded support services and programs, to be provided with the equivalent level of service and support provided by the lifetime care scheme. You are aware that some inquiry participants have concerns that the lifetime care scheme was potentially producing a tiered system in which people with similar injuries did not have access to the same level of equipment or care.

Notwithstanding the work currently being undertaken by the Productivity Commission into the prospects of a national Disability Care and Support Service, Spinal Cord Injuries Australia would like to request this review committee make a recommendation that an appropriate government or independent body calculate the cost, and related revenue options, to extend the eligibility of the lifetime care scheme to people acquiring a spinal cord injury or brain injury through non-motor vehicle-related accidents who are also not eligible to seek compensation or damages. I am happy to table a copy of that statement.

**CHAIR:** What work have you done dealing with participants in the lifetime care scheme?

**Mr LOMAS:** As a front-line organisation it is generally through our peer support services. They are people who have acquired spinal cord injuries themselves and they go and work amongst those within the spinal units in Sydney, in particular, Prince of Wales and the Royal North Shore hospitals. They go around and work with the social workers, the occupational therapists, individuals and try to marry them together, understanding what some of the doctors are talking to them about, trying to hear some of their concerns and try to develop the individual back, because we recognise that acquiring a spinal cord injury is one of the most devastating things that can happen to an individual because it is a complete re-jigging of your life. So by having people that have actually gone through it and have, as it were, come out the other side inasmuch as you can, I think it is good for them to be out and about talking to people.

**CHAIR:** Has any of your work been working with support systems for the lifetime care and support process for the individuals who are utilising it?

**Mr KILLEEN:** Prior to being in policy and advocacy I worked in the Spinal Cord Injuries Australia information service. We would regularly get requests from families of people who have been newly injured who are lifetime care scheme participants. Often case managers or coordinators all seeking different things, being family seeking information about spinal cord injury and often the coordinators seeking information about where they can they find accessible accommodation for participants to actually transition from hospitals into the community, because accessible accommodation, finding it, is not easy and I know it has been raised by a number of people about the difficulties of finding accessible accommodation. Another thing we provide is different information resources. We put together a community survival kit and we have just actually completed the back on track resource kit, which is available for all people with spinal cord injury but also lifetime care recipients as well.

**The Hon. GREG DONNELLY:** In your submission you propose that the Lifetime Care and Support Authority establish a home modification panel to review the highest 5 per cent of applications by cost and that the remaining 95 per cent should receive pre-approval pending standard process. How would pre-approval pending standard process differ from the processes that currently operate, particularly in terms of the experience of the applicants?

**Mr KILLEEN:** I think the aim of that was—with the experience this is their third year of the actual program—to have some sort of idea of average cost of the home modifications, albeit homes and renovations are quite different. There was an allocated amount of money that was pre-approved. We have heard this morning about some of the difficult process of time lag of filling in forms, putting in the applications and getting them approved and then getting people to go out to do the assessment and then on, and on, and on. The idea would be to have some pre-approved money which could allocate up to 20,000, 30,000, 40,000, 50,000 for a renovation, just to try to speed up the process with the pre-approval. If someone owns a home, or is renting privately, they will be able to get action much quicker. I am aware of one situation where applications went in in January and the modifications are just being undertaken this month.

**The Hon. GREG DONNELLY:** I will take you to question No. 5. Your submission states that the Lifetime Care and Support Authority has not supported the cost of participating in physical exercise programs.

**Mr LOMAS:** That is related to the one we withdrew.

**The Hon. GREG DONNELLY:** I am sorry.

**Mr LOMAS:** It is particularly for that reason we withdrew it. It is not correct.

**The Hon. GREG DONNELLY:** I withdraw that. The Lifetime Care and Support Authority has indicated that it does not consider it to be its responsibility to maintain a registry of wheelchair access for housing, as you propose in your submission. What is your response to that view? In particular, is it within the scope of activities of Spinal Cord Injuries Australia to develop and maintain such a register?

**Mr LOMAS:** We certainly feel that it is a function that should be looked at by the Lifetime Care and Support Authority, just as it should be a function of the New South Wales Government to ensure that there is adequate accessible housing made available for all people who require it. Where it impacts on the Lifetime Care Scheme is that you get to bed block, or you get people who are transited through to alternative accommodation whilst they wait and properties are sourced. That is not a particular problem—just the link to the Lifetime Care and Support Scheme.

Obviously, if you are going through a spinal unit as a non-Lifetime Care Scheme client, you come up against the same issues. Although I will argue that the accommodation that you are offered to get you out of the spinal unit after you have been in for a lengthy stay is not as good as it is if you are in the Lifetime Care Scheme, by looking at the development of the housing register, we certainly are aware that one existed. It was developed by ParaQuad New South Wales. It looked at properties that were either modified or in which people had made tiny little changes that could make them either universal or of benefit. They tried to list and compile those together. That is out of date.

Really someone needs to pick up the baton and run with updating that. We put in our submission a variety of different sources or ways that we think the information could be renewed and brought up to date. In relation to the issue of whether it is done by ourselves as an organisation—I could cry poor and I could say that we have no money to develop something like that—we would love to look at a project like that, if it was all worked out alongside the Lifetime Care Scheme to develop something. But it is something that affects the Lifetime Care Scheme clients, so they have buy-in to this as an issue.

If it is as simple as understanding where the accessible properties are and understanding where the properties are being built—such as properties for the elderly or people with disabilities—then a simple database will make everybody's life a whole lot easier.

**Mr KILLEEN:** Currently, a lot of the councils require a percentage of multi-dwelling apartments to be either accessible or adaptable. You have the Local Government and Shires Associations of New South Wales who would be the umbrella body for all the councils. You would hope that, with all these applications going in and the requirement for the councils to say that one or two of the apartments have to be accessible, they will know the locations of where these places are, or where all these new developments are.

If they were able to catalogue where they were, at least that would be a start that would also contribute to a database of where accessible accommodation actually is. You have to start somewhere, but not knowing, and nobody doing it, that just makes it more difficult to source accessible accommodation. Buildings are built to last 50 to 100 years.

**Mr LOMAS:** You may have seen that the large part of our submission is around housing and trying to address that. That is one of the biggest issues that comes to us by Lifetime Care Scheme participants and people within the spinal units themselves. It comes down to the inability to be able to transition out. I have just successfully advocated for a lady who has been in hospital for two years. It is a very long complex issue, but it has not been good because she has not been able to find a property to be able to get out. Everybody has been trying endlessly to get her out. We ended up having to find a house-finding service. Even then they took some time trying to find somewhere to get her out. There just are not the properties out there. What properties there are, just not known about.

**The Hon. LYNDA VOLTZ:** Just on that point, would Planning New South Wales, as opposed to the Local Government Shires Associations, be a more appropriate place in which to coordinate that type of information?

**Mr KILLEEN:** As in New South Wales planning?

**The Hon. LYNDA VOLTZ:** Yes.

**Mr KILLEEN:** The higher you get to the top of the tree, the better, I suppose.

**The Hon. LYNDA VOLTZ:** They are the approval agency. It is a large government agency and they would have an idea. They oversee councils in terms of planning measures. They are probably more likely to have access to that information.

**Mr KILLEEN:** Yes.

**The Hon. LYNDA VOLTZ:** I was also interested to hear about your work in hospitals. Previously we heard witnesses who said they did not know about the Lifetime Care Scheme until after the accident, and they did not have experience with other people other than those who might have been in hospital at the same time. We put to a number of people the idea of a support group for people in Lifetime Support Care who can work with each other and point out to people the best way to go for support. Given that you guys already offer that kind of role—and I understand that some of these people also have brain injuries—where would you see that kind of support groups sitting, necessarily?

**Mr KILLEEN:** Our peer support?

**The Hon. LYNDA VOLTZ:** Not your peer support, but a peer support group for people within the scheme.

**Mr LOMAS:** It is interesting. I know this is slightly outside the terms of reference, but we are just finishing off our submission to the Productivity Commission on the national disability insurance scheme, or whatever it is going to be called. One of the things that we put forward as a proposal is that once you are in a scheme, you are looked upon almost as a director, or it is like a co-operative and you buy into the elements that are driving the system. You attend an annual general meeting and you receive regular reports. In this kind of way the support group could be anybody who comes into the Lifetime Care Scheme as a recipient of services and they could then be a service driver. It would sit under the Lifetime Care Scheme.

They would have to form a few groups of members and find out what they think about the scheme, find out how they think it is developing, find out where the issues are and use that as a service driver. It could be a way of doing it. Our peer support service probably is not geared up to do something like that because they are very much a one-on-one when people are going through the most traumatic elements of the acquisition of their injury. Our information service would come in after that to support them, once they are out in the community with regular visits from peer support. It is not quite our function.

**Mr KILLEEN:** In relation to Lifetime Care, with any group that has something in common, it is always good to be able to discuss the good, the bad and the ugly and to try to problem-solve, particularly among users. It would be a good support. Many organisations are using this free-list service through Internet service providers. They can join in and then someone can raise a question or pose an issue, and people can feed back if they wish. Everyone receives the question and information, and everyone can contribute to it in that way. That would be a fairly good thing, but someone will need to drive that. I suppose the families who were here today presenting a number of issues would be persons who could possibly get behind driving that, or starting that, maybe.

**CHAIR:** That is right. It has to come from the ground.

**The Hon. LYNDA VOLTZ:** Yes. They always have to come from the ground up, but a bit of support never goes astray, though.

**Mr KILLEEN:** Information is a powerful thing.

**The Hon. LYNDA VOLTZ:** That is right. Getting back to the idea of home modifications, do you know of any protocols with local governments about where there is an issue about disability with development applications and whether they have processes that will speed up home modification applications, particularly development applications? Some councils can take time doing these things.

**Mr KILLEEN:** Often home modifications are not structural. It is ripping out a bathroom and fixing up the bathroom and the toilet or putting a ramp in. It is sometimes difficult. Some people own two-storey homes.

**The Hon. LYNDA VOLTZ:** And all the buildings have narrower doorways and that kind of thing.

**Mr KILLEEN:** The homes are on terraces or on a hill, and there are certain building-to-ground ratios or percentages on what you can build on. There is a whole raft of stuff. I do not think there is any application that gets a priority if you have a disability.

**The Hon. LYNDA VOLTZ:** So there are no protocols within councils?

**Mr KILLEEN:** Not that I am aware of. There are access codes, but they are for public buildings. You can develop your own home and have it to meet your needs. It does not have to comply with Australian Standards in relation to access.

**The Hon. LYNDA VOLTZ:** It is not so much the standards as opposed to when you are in the situation, you do not want to be caught in a situation where a development application takes longer than it necessarily should, and where they have protocols in place, particularly for modifications. Even with an ageing population, we are going to need those kinds of modifications in a lot of properties.

**Mr KILLEEN:** No.

**The Hon. LYNDA VOLTZ:** That is fine. I was just asking the question.

**Ms SYLVIA HALE:** It was my understanding that aged care and housing came under what was formerly State environmental planning policy 5, which relates to aged care and disability developments, that there was a requirement for universal design. That is often more observed in the breach than in the reality, and I have had complaints about that. Have you had any experience with that at all?

**Mr KILLEEN:** In regard to the application going in?

**Ms SYLVIA HALE:** And a building being non-compliant with those requirements?

**Mr KILLEEN:** No.

**Mr LOMAS:** There are plenty of those around.

**Mr KILLEEN:** I think there are a lot of buildings that sometimes do not reflect what is on the plans, once they are complete. That is unfortunate.

**Ms SYLVIA HALE:** That is a reflection of a lack of adequate supervision or inspection.

**Mr LOMAS:** Not just in the bricks and mortar. It may well be in things such as the doors, and they may well put doors in that are too weighty. The building is rendered inaccessible because the person who is in a wheelchair cannot get the door open.

**Mr KILLEEN:** There is often the difficulty where there is an existing building and someone, for whatever reason, acquires a disability. They have problems because the body corporate will not allow things like an easy access door to go on the front, or a push-button door, that is apparently coded. There are some issues around those. It is not the council but the body corporate that you are trying to deal with. They are not all that happy with someone wanting change to improve the access, which might make security a bit lax.

**Ms SYLVIA HALE:** I know you have withdrawn the part of your submission dealing with funding for physical exercise programs, but a previous witness gave evidence about how difficult it was to obtain funding for taxicabs for recreational or sporting activities whereas there was no threshold if you are using that for treatment or medical purposes. Do you agree with that? Is that your experience of what the position is?

**Mr LOMAS:** I was going to say that it would be my experience. It is probably one of the biggest problems set across a few questions that may well be asked today—the divorce between the policy-setting room and the practice room. There may well be nice policies that support people with disabilities from the Lifetime Care Scheme or Authority, but it is how they are actually enacted. It may well be that they start to apply artificial caps on taxi vouchers to attend sporting activities or exercise or rehabilitation activities as opposed to attending medical appointments.

**Mr KILLEEN:** The Lifetime Care Scheme, as I think was raised by the Chair or Mr Clarke, has tried to restrict the cost or expense of compensation being paid to people. I would suggest that if someone did receive compensation as a lump sum, they would be able to have the money to use cabs as much and as frequently as they like, for whatever purpose they like. It seems a bit restrictive if someone wants to do something social or exercise-wise, and what is impeding that is the cost of transport. I would certainly suggest that there should be some scope to fund transport provided by a taxi or some community transport provider, or some other means.

People have enough issues to restrict them from socialising, exercising and recreational activities. It would not be a proactive stance.

**Ms SYLVIA HALE:** You referred to unofficial caps. I assume that is also what you refer to when it comes to home modifications. Would you outline the concerns you have that with processes that currently are taking place?

**Mr LOMAS:** We have had brought to our attention by a number of OTs who conduct these assessments that it is usually a matter of spending hours, days and weeks producing these magnificent Documents—these great form-filling tests and exercises that they go through—and then they submit it to the assessor. Then the assessor just goes flip: No. That is a problem. It is causing morale issues among the OTs that are having to do these things and it is also causing great problems with patients who are going through the system and who need to get home modifications moving to gel with their discharge dates.

It does seem to be happening with increased frequency. It is being looked upon as dollar amounts. The occupational therapists I am quoting are very experienced—they are not fresh out of college or school. They know their business and they are quite well respected. If they put forward an assessment it is fair. They have worked in the public hospital system for a long time and they know not to put forward silly things that will not be funded. They put forward the most clinically appropriate modifications for the buildings and they are being knocked back. That is causing a lot of problems.

**Ms SYLVIA HALE:** We have had evidence today about reimbursement for the costs incurred by public providers—hospitals or whatever. Rather than any moneys going back to them, they go to general revenue. Are you aware of this or complaints about it?

**Mr LOMAS:** Do you mean the money raised per case going to the Lifetime Care and Support pot as opposed to being locked away for the individual?

**CHAIR:** It is the health service pot. The issue is that rather than going to the specific units it is going into the health service pot. The specific units are arguing that it should go directly to them as per case mix.

**Mr KILLEEN:** That is the money for Lifetime Care and Support participants in the hospital system. They are being paid so much a day for the bed. Is Lifetime Care and Support concerned about—

**CHAIR:** No, we are talking about the individual units.

**Mr KILLEEN:** Are they saying that the money is not going to them?

**CHAIR:** Yes.

**Mr KILLEEN:** I could not comment on that. I do not know what they are doing to fund the hospital system.

**Mr LOMAS:** We know there is an unofficial scheme whereby patients going through the regular hospital system with spinal cord injuries who cannot be discharged go on to maintenance budgets so they come off the spinal unit budget and go on to a more general budget.

**CHAIR:** They go past acute care?

**Mr LOMAS:** Yes. That is a way they can manage the costs. It also comes off the spinal-specific budget and ties the figure somewhere else.

**The Hon. DAVID CLARKE:** I refer to the issue raised by Ms Hale. I understand that your organisation believes that there is in effect a cap on home modifications. I also understand that the authority is denying that. Has it specifically denied that to your organisation?

**Mr LOMAS:** No, not specifically.

**The Hon. DAVID CLARKE:** To any other authority?

**Mr LOMAS:** I do not know how other organisations interface with Lifetime Care and Support. They may have had discussions.

**The Hon. DAVID CLARKE:** But you have no doubt from your inquiries and practical experience that there is in effect an unofficial cap being put on these home modifications because you have occupational therapists who are very experienced in these things. You have indicated that they are very reasonable in suggesting modifications and still they are being knocked back.

**Mr LOMAS:** Absolutely.

**The Hon. DAVID CLARKE:** If that is the case, it is a very serious matter. Home modifications are probably one of the most necessary supports for those with spinal injuries.

**Mr LOMAS:** Obviously it is very serious. We have noticed today a huge disparity between one case manager and assessor and the next case managers and another assessor. We do not know when we have talked to occupational therapists whether they are talking about one or two case managers who do not understand what they are doing or whether it is a systemic failure. It is getting more and more cloudy as to how far it goes down, but it is something that should be investigated to see whether it is an unofficial policy. We know these things go on in other government departments.

**CHAIR:** Even in peer groups.

**Mr LOMAS:** Yes.

**The Hon. DAVID CLARKE:** It is clearly of sufficient importance and concern to you to raise it. You clearly think it is more than just a case here and there. There appears to be a lot more to this than is desirable.

**Mr LOMAS:** If there were one or two cases you would think it is just that these things happen. However, when it starts to mount up you start to think there is more to it. It would be a good if the Committee were to examine it.

**The Hon. DAVID CLARKE:** You withdrew the statement referred to in response to question five about the Lifetime Care and Support Authority not supporting the cost of participation in physical exercise programs. Is that correct?

**Mr LOMAS:** That relates to the point we withdrew.

**The Hon. DAVID CLARKE:** That is correct. Are you accepting that it does support the cost of participation in physical exercise programs?

**Mr LOMAS:** Yes, it does.

**The Hon. DAVID CLARKE:** There can be a matter of degree here. While you may accept that they will support participation, is there any suggestion that it may be supporting it but not to the extent that the system requires? Is it being niggly and mean in the allocation of funds?

**Mr LOMAS:** You could say that a lot of the approval processes in the Lifetime Care and Support Scheme are a little bit niggly. It can be rationale on a case-by-case basis for everything. One of the points we made in our submission involved a minor amendment to number three.

**CHAIR:** That is an excellent recommendation.

**Mr LOMAS:** That addresses the question you are asking. We are trying to make it more defined to end that niggly aspect. Where you have a proven strength or commitment to a specific sporting activity you should be supported to continue that post injury.

**The Hon. DAVID CLARKE:** Were you here earlier when a witness referred to problems he experienced getting a tennis wheelchair?

**Mr LOMAS:** I am aware of that.

**The Hon. DAVID CLARKE:** Is that a frequent experience?

**Mr LOMAS:** It is not as frequent as you might think, but it certainly does happen. This is a great sporting nation and if we look at the statistics for spinal cord injuries we see that a sizeable percentage of people have been injured in sporting accidents. With modern technology there is no reason that the majority of people cannot maintain their previous sporting tasks with support from Lifetime Care and Support. After all, it is there as an enabler as opposed to an inhibitor.

**The Hon. DAVID CLARKE:** Sport and exercise are vital for a person with a spinal injury.

**Mr LOMAS:** They are fundamental on many different levels. They assist in maintaining chest capacity and therefore being able to breath effectively. They also build up muscle strength and may assist in restoring some function. They are also beneficial in pain management. People are taking fewer painkillers because they are exercising. They are also great for mental health—the rush of adrenaline helps.

**The Hon. DAVID CLARKE:** Do you think there is a little too much officialdom involved in this? The witness we spoke to was humiliated by the processes he went through to get access to a tennis wheelchair.

**Mr LOMAS:** That is the case. We made a submission about aids and appliances and referred to the economic hoops. They are things that hold people back. They present all sorts of barriers for people to jump over. If they are successful they finally get the money. That is not a very dignified thing for a proven tennis player to go through to get back on the court.

**The Hon. DAVID CLARKE:** Is it seen as putting participants through a series of economic hoops? Is that the expression used?

**Mr LOMAS:** I coined that term.

**The Hon. DAVID CLARKE:** It certainly has very bad connotations.

**Mr LOMAS:** It does.

**The Hon. DAVID CLARKE:** Do you think that is a fair summary of what many participants face in this situation?

**Mr LOMAS:** They are forced to go through various things they should not go through. Our proposal at point three is very clear: If you have a proven history in a sport you should do it.

**Mr KILLEEN:** We are aware of the limitations of other equipment programs and we participated in a previous review. That is often based on a lack of appropriate funding to meet the needs of eligible participants. I heard on 11 June that the Lifetime Care and Support Scheme and the authority are sitting on $1 billion. I do not see any benefit in refusing people the funds they need to purchase a wheelchair to allow them to participate in tennis. What benefit is that for the individual or the scheme?

**The Hon. DAVID CLARKE:** You see $1 billion sitting there and funds being dribbled out for essential equipment for rehabilitation.

**Mr KILLEEN:** The individual wanted to get back into life. We are talking about lifetime care. He wanted to get his life back on track and that included participating in a sport he was doing prior to his injury. To do so he had to hire a wheelchair and pay a coach. Wheelchair tennis is obviously different from regular tennis. I do not understand why they would restrict him.

**The Hon. DAVID CLARKE:** Nor do I.

**The Hon. JOHN AJAKA:** That was very informative. I draw your attention to what has been referred to as the buy-out scheme; in other words, a lump sum payment. Having regard to all of those who have indicated problems with having to go cap in hand—or jumping through hoops to use your expression—do you believe there is a need for a buyout scheme?

**Mr LOMAS:** Our organisation supports individual funding and this is an element of that. The participant has received specific funding from the Lifetime Care and Support Scheme to see them through the most vulnerable period—that is, the newly injured who are going through the hospital system and getting back into the community. If people are able to manage their funds, it should be an option.

I cannot remember the name of it, but a study was conducted in the United Kingdom a few years ago involving two separate groups of disabled people. One was empowered with enough money to source services, equipment or anything else they needed. The other group was rationed—that is, kept on bread and water. Those on the bread and water system ended up costing the State far more than those who had been empowered with funds.

**The Hon. JOHN AJAKA:** Can you provide the Committee with the details of that study?

**Mr LOMAS:** Yes, I can try to dig it out. It was about a year ago.

**The Hon. DAVID CLARKE:** It should also be available to the Lifetime Care and Support Authority.

**Mr LOMAS:** Yes.

**Mr KILLEEN:** Prior to the Lifetime Care and Support Scheme, there was the green slip CTP scheme, which was fault based.

**The Hon. JOHN AJAKA:** I understand.

**Mr KILLEEN:** This is a no-fault scheme.

**The Hon. JOHN AJAKA:** I also understand that.

**Mr KILLEEN:** But where fault can be attributed, you can still go to court to seek damages. Is that correct?

**The Hon. JOHN AJAKA:** Yes.

**Mr KILLEEN:** If they fail in court, they cannot have a second bite of the cherry and come back to the Lifetime Care and Support Scheme. People who opt in or who are covered by Lifetime Care and Support are receiving something from the green slip levy that they were not getting before.

**The Hon. JOHN AJAKA:** That is clearly understood. Let us assume that a person is injured and it is his fault. Under the old scheme, that person would have received nothing. They now have all the benefits of this scheme. In that situation, should those participants be given an option to remain in the scheme for the rest of their life and receive the benefits that the scheme offers or should they be given an option to opt out?

**Mr KILLEEN:** The individual would have to look at it on a personal perspective.

**The Hon. JOHN AJAKA:** Which means the individual would have to be given an option.

**Mr LOMAS:** Absolutely.

**Mr KILLEEN:** And given some proper guidelines. There may be some guidelines on where the money, although they have accepted it as lump sum compensation, had specific restrictions on the way it was being invested or used to protect that money for that person's life.

**The Hon. JOHN AJAKA:** If we term it in the sense of maybe the option should be permitted but with fairly restrictive either conditions or guidelines to ensure that it was not simply being dissipated.

**Mr KILLEEN:** They could possibly take out a number of annuities for 20 years to allocate bits and pieces of compensation so that it was protected from being used otherwise. The other issue is that, I know the witness here today was talking about investing money and living on the interest or using the interest. You have an issue around taxable income when it comes to income earned on assets. That would have to be dealt with. I could see a benefit of middle ground here where some people who are on the Lifetime Care scheme should be allocated some damages, whether it is $500,000 up-front. The difficulty, the spouse of a participant was saying, was that, promised the world and delivered not much in the initial stages. I cannot see why there is not the opportunity to, once the person is accepted in the scheme they should be given a nominal amount—$10,000, $15,000, $20,000, $50,000—up-front for the family.

Often the person may not be in a situation to, whether with an acquired brain injury or it could be an induced coma, to actually say yay or nay. But once the social worker has informed the family this is the situation, they notify the authorities, a nominal amount of money is paid straight away, no questions asked, gives them access so she could afford rented accommodation. You would not have all this toing and froing between where am I staying, in the hospital or down the street? They have some money to actually do something with, with no questions asked. If the authority wanted them to produce receipts at the end of all that to say this is how it is spent, fair enough, but let us get away from all this paperwork and bureaucracy. They know that there are costs involved with the actual set-up and issues around the family. If there are issues around the compensation, whether it is buy-out or stay in or somewhere in between, compensation—as you may be aware, anyone seeking third-party compensation, the bulk of the money is from your lack of option, the lack of ability to earn a living and the cost of the person's care. Pain and suffering are a very small component.

**The Hon. JOHN AJAKA:** Our dilemma is this—and I know this through my past experiences as a lawyer—you can make a lump sum payment that sounds wonderful, celebrations occur on day one and 20 years later there is nothing left and there is still another 20 to 30 year life span of the person who becomes completely destitute. On the other hand, you do not want a system where you are jumping through hoops, cap in hand, begging every time you want a chair or a piece of equipment or something that you would have been able, if you were managing your own life, to be able to obtain.

**Mr KILLEEN:** Is it the current situation where somebody who is injured, they make a claim against somebody, there is an insurance company behind them, and does not the insurance company have to accept that client up-front and then there is an agreement where certain amounts of money are paid up to or approved to cover the cost of certain things, whether it is, I do not know what they are, but there is a certain amount of liability on the insurance company? We are going from that scheme to this current Lifetime Care scheme. Why is some of that not built into the Lifetime Care scheme, where there is some money being provided up-front? Why all this paperwork? The lives for these people who are newly injured and their families is not all a bed of roses up-front. So who wants to be dealing with all this paperwork?

**The Hon. LYNDA VOLTZ:** You spoke earlier about the idea that a scheme like this should be extended to all people requiring long-term—

**Mr KILLEEN:** Research into that. The only issue we have here is how it is being funded.

**The Hon. LYNDA VOLTZ:** I am just wondering how you align that to this idea of having the opt-out component within this scheme if that is a long-term goal? The other thing I also wanted to ask, and perhaps you could take on notice is—it occurs to me because I have a neighbour two doors up with a child who has severe autism who is a teenager. The wife does not work specifically to look after the child and the husband has changed his job. Where do you draw the line on those lifetime care components when you are looking at the long term of people who will need care all their life?

**Mr KILLEEN:** If the family member chooses—you are talking about someone who has autism from birth, not the basis of acquiring a disability.

**Mr LOMAS:** That is why they are looking at the national disability insurance scheme covering every person with a disability, whether it is acquired, born—

**Mr KILLEEN:** The unfortunate problem is that when it comes to Federal payments and Centrelink benefits, there are issues where one spouse might work and their income is means tested against care of payment and care of pensions. If someone has a certain amount of income, although the spouse might not be able to work and supports the family member with a disability, they are not eligible. That is why the man here, his wife was getting the care of payment of $50 a week and not the carer allowance, which is the pension, because of his income.

**The Hon. LYNDA VOLTZ:** That is not quite what I was asking.

**Mr KILLEEN:** You wanted to know whether Lifetime Care should pay a spouse or a family member.

**The Hon. LYNDA VOLTZ:** No, I am asking why you would not include children with autism if they require long-term care. If that is the argument, how do you align that with the opt-out clause?

**Mr LOMAS:** The only reason why we sent other people with a spinal injury or brain injury is because the mechanisms are there. They are already functioning in the spinal unit. You have two beds next to each other; then you will have a case manager go to see a person on the Lifetime Care scheme and then you have the other people who acquired theirs through a fall or, as we have advocated for somebody who fell on a scrambler bike five metres from the road but on private property. Markedly different experiences of going through the thing but it could all just be patched together—

**CHAIR:** And working out who funds it.

**Mr LOMAS:** Yes, absolutely.

**CHAIR:** Thank you.

**Mr KILLEEN:** I have one more thing to say. The information, someone suggested that they did not know much about the scheme. They were verbally told a number of things about the scheme but did not know much about it. I would strongly support a recommendation that a resource kit, a booklet, be put together so participants are handed that by the case manager or social worker when they are ready to get an understanding of what they can expect and how it operates. One thing is that a lot of equipment, aids and appliances have been purchased for participants through the Lifetime Care scheme and often at some stage they have either outgrown or outlived its use or whatever. There is a lot of equipment out there which has been funded by the program. I was wondering what is planned for the equipment when it is no longer needed by the participant. Feed it back into PDP?

**The Hon. JOHN AJAKA:** What a great concept.

**CHAIR:** That is a good thought. If there is anything else you want to tell us, just send it in. We also need the little letter about the change to your submission.

**Mr LOMAS:** We may clarify some of the points that Mr Killeen made at the end and we will give more detail.

**CHAIR:** That would be very useful, thank you.

**(The witnesses withdrew)**

**(Short adjournment)**

**CARMEL MARY DONNELLY**, General Manager, Motor Accidents Authority, and

**GENIERE MAREE APLIN**, Chairman, Motor Accidents Authority, on former affirmation:

**CHAIR:** Welcome to the second hearing of the tenth review of the Lifetime Care and Support Authority and thank you for coming back. Do you want to make an opening statement to add to the statement you made at your last appearance?

**Ms APLIN:** No, but I have a document to table on behalf of Ms Hunt, who is on annual leave, which deals with the establishment of the structure of the compensation authority's staffing division.

**CHAIR:** That will be very useful. My first question is about affordability. The Motor Accidents Authority's response to pre-hearing questions on notice explains that in relation to green slip prices, the 13 per cent increase in average best price across the State reported in the 2008-09 annual report cannot be compared to the 1.5 per cent increase in average best price in metropolitan Sydney reported in the 2007-08 annual report. What is the best figure given in the MAA's annual report for the Committee to take as an indication of the scheme's affordability and where can this figure be found in the 2007-08 and 2008-09 annual reports?

**Ms DONNELLY:** That was an answer to one of the questions on notice about affordability. We found there were a couple of numbers in the annual report that were not strictly comparable. I have some recent analysis we have done that goes to affordability, which might be helpful to the Committee.

**CHAIR:** We had some quite conflicting evidence during the first hearing day.

**Ms DONNELLY:** In the meantime I have done some analysis going back over the past decade as a way of comparing affordability and I think analysis over time is a useful way to do it. We found that if we go back to June 1999, the best price available for a Sydney metropolitan family sedan was $397 in 1999 dollars, which was 50.3 per cent of average weekly earnings. Adjusted for wage inflation since then, this would be equal to $632 in 2010 dollars. However, the comparable best price figure for a Sydney metropolitan sedan owned by someone aged 30 to 54 is, from 1 July, $426.50, which is over $200 less than the price inflated from 1999. It equates to a much lower proportion of average weekly earnings. That is the way we measure over time, looking at the dollars on an inflated basis and comparing average weekly earnings.

In June 1999, the average green slip price across the State, not the best available for a Sydney car, was $460.88 in 1999 dollars, which was equal to 58.4 per cent of average weekly earnings. That would be equal to $733 today. In March 2010, the average green slip price paid across New South Wales was 33.7 per cent of average weekly earnings—so we are comparing over a half with a third—and $423.96 in current dollars. The starkest piece of data is that the average green slip price in 1999 was more in 1999 dollars than it is now in 2010 dollars. I think that is the best tracking indicator. With regard to your question, this is probably the sort of figure we need to highlight a little more in our annual reports to make it easier for the reader to track how we are going.

**The Hon. LYNDA VOLTZ:** Why are you doing that against average weekly earnings as opposed to the consumer price index or another indicator?

**Ms DONNELLY:** We use average weekly earnings in the scheme because most of the costs of compensation are related to health care, which has a high salary cost increase and is inflating faster. Even with services such as preparing people to go back to work or the claims management services most of the costs are wage related. The other reason is that it translates well into how much people have as household income and what proportion of that they are paying for a green slip.

**The Hon. LYNDA VOLTZ:** How do you get around the huge disparity in average weekly earnings where high incomes drag them up and the reality that in, say, the health sector, in particular carers, women are among some of the lowest-paid workers and there is a huge disparity?

**Ms DONNELLY:** That is a good question. I suppose we would address that if we were comparing the median green slip price to the median average weekly earnings, but I make the point that the green slip price is also skewed in the same way. The average green slip price includes the cost of commercial and fleet vehicles, trucks and so on. I am happy to take that on notice and look at how we could consider particular segments from an equity perspective, which is where you are coming from. We are not aiming to do that in looking at the average.

**The Hon. JOHN AJAKA:** I appreciate all the information you gave previously. I want to look at some of the negatives that have been raised. I am not sure whether you have been provided with a copy of Annexure A, which the Bar Association prepared, and whether you saw what they raised in that document. As I understood it, the Bar Association is basically saying that with the initial projections of profits that have been given by the insurers, years later when the real profits are shown the real profits well exceed what the projections were. So the Bar Association is contending that the insurers are obtaining a far greater dividend/profit from this scheme than they originally projected and therefore they are not putting enough back into the scheme by way of benefits. Are you able to comment on that?

**Ms DONNELLY:** I could make a couple of comments. Firstly I would start by saying that I think that it is a valid issue, that we need to be monitoring insurer profit. One of the points that I raised the last time we appeared was that more than that, it is my view that we should be better monitoring the net benefit that goes to claimants and, in fact, looking at the scheme's performance in terms of all of the different services that are provided and all of the different expenses that come out of the scheme and what is left for the claimants. So the first point I make is it is a valid issue for us to be monitoring.

I tabled a document last time after our independent scheme actuaries had had a look at some of the submissions, and there are a couple of points that are in that document that I tabled that I might highlight now. One is that there have been a few years in that table that the Bar Association and Mr Stone have been highlighting as being years where the amount of profit estimated had increased at a fairly steep gradient. From the 2006-07 annual report there was some refinement to the way that the MAA was reporting those estimates and that steep increase was driven by a methodology that we have since discontinued. So there is one aspect of not comparing apples with apples.

The other thing I would say is that Mr Stone is certainly right to be looking at a few years back because the first few years of estimates are not particularly reliable and, in fact, for the first few years after the 1999 amendment it is my understanding that the MAA did not publish estimates for a few years because they were regarded as probably so unreliable that they might be misleading. The other thing is that there needs to be an element of caution in assuming that the conditions in one particular year will necessarily mean that the same thing should follow. I know that you probably do not have it in front of you but there have been some years in the scheme—three years in a row in the nineties—where insurers made losses and in the preceding couple of years they made extraordinary profits. So there is a caution in assuming that what you see in a couple of years is a trend going forward.

That being said, the scheme that we are responsible for implementing has got regulatory oversight, to some degree, over profit. The way that that is designed in the legislation is that the MAA has the power to undertake a compliance assessment when insurers lodge a submission because they want to change their premiums, and we have a six-week period in which we can look at the compliance of the filing of that submission for a change of premiums against four criteria in the Act. We do not have the power within the legislation as it stands to claw back any excess profits if they eventuate over time.

**The Hon. JOHN AJAKA:** That was my next question.

**Ms DONNELLY:** We do not have that power.

**The Hon. DAVID CLARKE:** Have you made any recommendations to get that power?

**Ms DONNELLY:** What I have done since being appointed is initiate a competition review, which looks both at how do we sustain the players in the market and the environment of competition but also I have, as part of that, commissioned some work by the economist Dr Peter Abelson to undertake that review to look at improvements in financial modelling. It is quite a broad-ranging baseline review to help me to understand where there may be room for improvement, and I do not want to speculate but there may be some consideration of that.

**The Hon. JOHN AJAKA:** You can see the dilemma that I face is when looking at the negative aspects. Yes, there are some very good positive aspects, but looking at an improvement. Again, according to the Bar Association, in 2000 there was a surplus profit of $265 million; in 2001, $238 million; in 2002, $281 million. Then they say yes, in 2008 there is a projection of minus $106 million, but their view is that in another year's time we will suddenly discover that that is not correct, that again there was another surplus profit and no clawback provisions.

So you have a situation where you have some participants arguing that not sufficient compensation is being paid to those injured; insurers are having an unfair advantage when it comes to reviews, et cetera, especially in the issue of insufficient legal costs being paid; some arguments with maths not being sufficient, et cetera; then you are hearing years later, after projections, that the insurance companies appear to be taking a far greater profit than was estimated. Of course, you have commented today that on the way you have calculated it, insurance policies appear cheaper today than they were in 1999. The question needs to be asked: are we unfairly advantaging those who are injured in car accidents by allowing either the premiums to be lower than they need to be and should ask that they be increased, or are the insurance companies collecting far greater profits than they anticipated and not putting that money back into the scheme to help alleviate some of these problems?

**Ms DONNELLY:** I understand what you are saying and I can understand where that question would come from but I think that it is a little bit more complex than that. Yes, you have affordability being maintained at a certain level. Yes, we need to continue to improve our ability to see whether the forecast profit at the point where we have the authority to look at compliance, where we are improving the methodology there. But there is inherent uncertainty and, as I said, I think it would be a brave person who would speculate that because in year A the profit was very high, and if that was going to happen, and particularly when you know that those early years were the first years of the new scheme, claim frequency dropped considerably. It is now on the way back up, and we have had some years in between of quite stiff price competition where financial analysts were saying this is not sustainable, the insurers are not keeping up with inflation.

So there have been quite a lot of changing dynamics and it is very complex to judge. In terms of legal costs I think that is a separate issue. We are working towards a remade regulation, the Motor Accidents Compensation Regulation, and I am really grateful for the amount of effort, which has been a considerable amount of effort, that both the Insurance Council and the Law Society representatives on a working party have put in. They have a package which I am currently considering. I think it is a very good package and provided that I can cross the t's and dot the i's I expect to put that forward to government for the remaking of that regulation and I think we should go some way to certainly addressing those concerns about legal costs. I do not know that any of this table is a barrier to doing that.

**The Hon. JOHN AJAKA:** Going back to the clawback. Do not take these as my views; I am just addressing the negatives that have been raised to see where you come from there. Have you considered a clawback provision where, if the money is clawed back, it goes into a particular fund controlled by the MAA and that money is there to be utilised for either future projects or future benefits and if the insurers get into a situation two, three, four years later where the reverse occurs and they raise the argument as to why they should not be paying any additional profits because these are going to make up the losses, that those funds are available in that circumstance if it occurs?

**Ms DONNELLY:** I think there would be diverse views on that. That is a matter for government in terms of policy, although I do give advice.

**The Hon. JOHN AJAKA:** Your advice is greatly appreciated.

**Ms DONNELLY:** Some of the considerations I would just point to, and there may be a number of ways of addressing that issue. One of the things I am looking at is whether in assessing whether profit is adequate—our current framework looks at the underwriting year that insurers are suggesting new premiums for going forward—could we have a more multi-year approach? Within our current legislation I am certainly exploring options for enhancing our methodology to take that into account.

Moving to a more extensive clawback as a policy option for government, one of the things we would need to consider responsibly is that there may be years of losses and if the provision was there for a clawback of profits above a certain level, then would government have to underwrite the losses and would that change the behaviour of the insurers so that they know that if they do not fully fund government will effectively underwrite and would we have informally moved to a publicly underwritten scheme in which they are not actually bearing the risk? They would be some of the questions that I think would have to be considered.

**The Hon. DAVID CLARKE:** This question of profitability, you said that there have been bigger than expected profits. In fact, over four or five years there was $1.2 billion in profits. Is there not some suggestion that the figure should be around 7 or 8 per cent?

**Ms DONNELLY:** Do you mean 7 or 8 per cent of premium or return on capital?

**The Hon. DAVID CLARKE:** You tell me what the 7 or 8 per cent refers to.

**Ms DONNELLY:** I am not sure what the 7 or 8 per cent that other people have used in their submissions refers to.

**The Hon. DAVID CLARKE:** But clearly, I think you used the term "bigger than expected profits" that have been coming in over a period of years are actually far bigger than expected profits, are they not?

**Ms DONNELLY:** As I understand it, and I was not involved in the MAA at that time, it is unlikely that the insurers would have submitted a file saying, "This is the amount of profit that we are going to make", and what the drivers were is probably complex, but the reduction in the number of claims is one of the factors that different expert observers have pointed to as contributing.

**The Hon. DAVID CLARKE:** Is it not going to be like Joseph in ancient Egypt: there are seven years of plenty to set aside for seven years of famine? Are we going to have a situation where there are these years of plenty and then when famine supposedly comes insurers will be going to the government to say, "We need increases in premiums, we need assistance", which is something you alluded to? Is that a possibility of what could happen?

**Ms DONNELLY:** I do not think it is a possibility under the regime that is currently enacted in the legislation because in the same way that we cannot refer back to previous years and say, "Will you bring some of that profit forward", they cannot refer back to previous years and say, "We need to make up for that loss." What they can do, and what has happened in that period of, I guess, more troubled times I understand, they can exit the market if they do not think it is profitable, and we could end up with not enough players to have a competitive market where you move towards more of a monopoly or a duopoly.

But under the current regime we are protected from that because each time they put in a submission to increase their premium—let me tell you a little bit about what they need to do. They need to put in a very comprehensive submission, which is looking at the claims frequency of their own and the industry, the average cost of claims, the risk-free rate of Commonwealth bonds, inflation in the scheme, inflation in the economy—a large number of factors. They need to document those for the past and estimate them for the future. They need to have all of that signed off by independent actuaries according to a standard from the Australian Institute of Actuaries, then it needs to be signed by the chief executive officer and then it needs to be tabled with the insurance company 's board. Then they give it to us. They are only able to say, "We are setting a premium now for the policies that we intend to write in the next future period to provide for the claims that we expect to arise from accidents in the future period." At the moment we are protected from them coming back and making up for any losses.

**The Hon. DAVID CLARKE:** When my colleague earlier raised this issue of what seemed to be excessive profits, you referred to that as a valid issue because you said there were bigger-than-expected profits and that you need to be monitoring them. The Motor Accidents Authority [MAA] has been monitoring those over the past few years, has it not?

**Ms DONNELLY:** Not only that, we have been reporting it. That is part of the transparency and the monitoring. I would like to position us to have the disclosure that the working party on legal costs has put forward as a suggestion where legal practitioners will disclose to the MAA what the claimant gets in the hand net. We are monitoring profits and other costs in the scheme and what the claimant gets. Publicising that is one thing that we can do, and we do. We do not have an ability to claw back, as we said. The other thing that we can do is to continue to improve the regulatory methodology that we use to assess those submissions in advance.

**The Hon. DAVID CLARKE:** I am talking specifically about insurer profits, not other costs. Has the MAA come up with any proposals or suggestions during these years of monitoring as to how to deal with these apparently excessive, bigger-than-expected profits? Have you come up with any suggestions over the past few years to Government or otherwise as to what they should be doing about it? I understand that you have come into this situation.

**Ms DONNELLY:** I can really only talk about what I have done. I certainly have had discussions with Ministers about it and, as I said, initiated a review in order to inform us about additional methods we could be using.

**The Hon. DAVID CLARKE:** Does a check of what happened in the MAA before you came in reveal whether any proposals were put to the Government in the past to deal with this question of what appears to be bigger-than-expected profits?

**Ms DONNELLY:** I have seen a number of papers that indicated there was quite a lot of energetic debate about it. I cannot tell you. I will have to take that on notice.

**The Hon. DAVID CLARKE:** Would you take that on notice and come back to us as to whether there have been specific proposals over the past few years by the MAA as to how the Government should be dealing with this issue of bigger-than-expected profits, to use your words?

**Ms DONNELLY:** Yes.

**The Hon. DAVID CLARKE:** I preface that by saying, I understand much of this is prior to your time.

**Ms DONNELLY:** Yes.

**The Hon. LYNDA VOLTZ:** In relation to the operation of the industry, what effect would the collapse of insurers such as HIH have on the market?

**Ms DONNELLY:** We are still dealing with the impact of HIH. I am still a member of the HIH Creditors and Inspectors Committee. We still have claims from HIH that the MAA as part of the nominal defendant is managing. Those claims now are but a fraction of the original ones we inherited, if you like, but they are probably the most complex. They tend to involve quite severely injured children and it will take some time to understand what kind of compensation is appropriate for them. I would say, firstly, if that happened again, I would expect another decade of considerable impact. Insurers can exit in a range of ways. They may have a managed exit in which they sell their portfolio to another insurer, which is a different sort of situation.

**The Hon. LYNDA VOLTZ:** Obviously that created less competition in the market.

**Ms DONNELLY:** Yes.

**The Hon. LYNDA VOLTZ:** If you were looking at the profits within that period you would expect to see significant changes within the market as a result. Was there a marked increase in the cost of insurance at that time for motor vehicles?

**Ms DONNELLY:** I might take that on notice. I do not think that there was a marked increase. What is difficult is that it coincided with the implementation of the 1999 reforms and basically a new scheme. But certainly one of the factors that I was considering in initiating a competition review was to position us strategically to understand how we might attract new entrants into the market, protect us from having exits, or work out how we would be robust to that.

**The Hon. LYNDA VOLTZ:** If you look at the figures that have been provided by the Bar Association, those figures that are very high are in the years following the HIH collapse when there are fewer competitors in the market.

**Ms DONNELLY:** Yes. I know that it coincides with that, but whether or not that is the cause I think there would be different views.

**The Hon. LYNDA VOLTZ:** There are other factors that affect motor vehicle accidents. A long drive followed by a very big wet has a big impact on the number of motor vehicle accidents and the number of claims in a given period.

**Ms DONNELLY:** My understanding, and Ms Aplin may want to comment, is that wet weather is associated with a higher frequency of less severity injuries. People drive more slowly. There may be property damage but not necessarily more severe injuries, which are what drive the costs in our scheme.

**Ms APLIN:** There is definitely an increase in claims. To take the point about insurers, if there was a collapse of one it would have an impact. But, particularly with the competition review, we have looked at the market in Australia as there continue to be mergers. Ultimately, from the MAA and the regulator's perspective, we want to continue affordability, and competition helps that. If there are going to be increases in prices, it is not a situation that the MAA wants to be in where we have fewer competitors than our current seven, necessarily. We are looking at alternate models that help address affordability as well as profit in terms of the number of players.

**The Hon. LYNDA VOLTZ:** The other point the Insurance Council raised was that payments are over a long period, not a short period. In relation to the profits that have been presented—I know they are not your figures—are we talking about profits that have been returned as dividends or some being held long term and some being returned as dividends?

**Ms DONNELLY:** The figures by and large that are in this attachment that was handed up by Mr Stone come from estimates that we have commissioned, the actual estimates of profit. They are not what were actually paid to dividends. They are not necessarily what has been an accounting profit within the insurance company and they are across the whole market. They are an estimate.

**The Hon. LYNDA VOLTZ:** I want to ask you about the actual price differentiation between the different providers. I cannot remember the figure but I recall that you provided a figure that did not move out of a range of price differences for green slips. Some evidence that was given showed differentials between $100 to $200 per provider. Would you comment on that?

**Ms DONNELLY:** I am not sure that was evidence that I gave. I read through the transcript from the other day and noted a few points that were raised by other witnesses that perhaps might have given a conflicting picture. One of the witnesses was saying that there was not too much, maybe $30 variation between the insurers. That is looking across the insurers for a price for a particular type of vehicle and a particular age group. If you look at the prices coming in on 1 July for the best price for a Sydney family sedan there is about a $60 change between those. So it is still worthwhile looking around. That is the best price. The highest price varies by about $10 and there is a range between those. The insurers are allowed to reward safer drivers. They are allowed to rate on: Have you lost demerit points. Some of them use that. Some of them will use: Have you had a recent claim? Have you been an at fault driver? Obviously younger drivers, not individually but generally, on average are a higher risk. They have an overwhelming over-representation in our scheme.

**The Hon. JOHN AJAKA:** The type of vehicle makes a difference as well.

**Ms DONNELLY:** Type and age of vehicle. There are many factors that the insurers are allowed to use, as long as they have an objective relationship to risk. Within that range, whatever kind of vehicle you are driving and whatever part of New South Wales you are in, it is not uncommon for there to be a $50 or $70 difference. I certainly use our green slip calculator. I use it for everybody that I can. For family members there can be $200 difference. So there is competition. Some insurers will give an over-55 discount that is more generous than others, or if you have membership. The other thing we encourage people to do is if you have multiple policies with an insurer they may give you a multiple policy discount on another insurance product. That means that it is beneficial for you to take that into consideration. For the same vehicle for the same person there can be a range of prices, which is why we encourage people to shop around. When you look at the same category there can be a somewhat narrower range but still a range and at the moment it is around $60 for the best price for a Sydney sedan between insurers.

**The Hon. LYNDA VOLTZ:** The motorcycle lobby group raised a concern about insurers. I have done a five-week motorcycle course and I used to ride a motorbike in the Army. I have seen some of the crazy things people do on a motorbike that are bound to get a rider killed. I perhaps have a different view to the motorcycle lobby group about the way that some people ride. They will ride on the left wheel of a truck where there is no way the driver can see them. The motorcycle lobby group's concerns centre around the fact that every year they do not know the projections. Obviously, with motorbikes it is a much higher premium. Do you have a view on that?

**Ms DONNELLY:** I think there was some incorrect data introduced to that discussion. I saw in the transcript the suggestion that motorcycles in Wollongong pay a higher premium than Sydney cars. That is not true. Their relativity is below. In fact, about 93 per cent of motorcycles are in a price range that is less than a Sydney sedan, apart from the very big Sydney bikes. Their price range is based on evidence of the frequency of claims and the cost of those claims. One of the drivers of that is that pillion passenger injuries on average are the highest that we see in the scheme. It does not take much imagination to work out why that is, and they are claiming against the motorcycle rider.

In terms of their understanding, we have worked very hard over the last few years with the Motorcycle Council. We have a partnership and we have worked closely with them. We have, in fact, undertaken a special actuarial review of motorcycle pricing and presented data and made some changes to the guidelines in response to concerns. I know that some of the issues that were raised by the Motorcycle Council are more about the Lifetime Care and Support levy, which is really a matter for the Lifetime Care and Support board. I will not go into that. They have some of the same issues as may face any driver. If there is a change in your personal circumstances you may see a change in price. You need to shop around because you may be able to get a better price elsewhere.

**CHAIR:** They said to us that different insurance companies increase their rates each year and they have to shop around every year to find who is doing it cheaper.

**Ms DONNELLY:** I had a conversation recently with the new chairman of the Motorcycle Council. I was very heartened by the fact that he was a very big fan of the green slip calculator. Our latest data shows that one in five policy holders change each time they have a renewal. That is great for competition in the scheme. So I do not think they are alone in that. It is probably a marker of competition. I did note in the transcript that there was a comment about the difference for one motorcycle owner shopping around being as high as $600. I went through our data and I think even for an over 55-year-old person who is getting the maximum discount that is available to people in that age group, a $600 gap would not be compliant. We investigate all complaints, and that sort of thing is an individual complaint.

**The Hon. JOHN AJAKA:** You could find no evidence of that?

**Ms DONNELLY:** I have not got the details to investigate it but certainly if I had them I would be very pleased to investigate.

**The Hon. DAVID CLARKE:** Do you have a website as a guide to consumers as to the differences? There has been fuel watch, grocery watch—

**CHAIR:** CTP watch—

**Ms DONNELLY:** We do. We have what we call the Greenslip Calculator which is a free service. We load up objectively all of the insurer data and very quickly you can enter in your profile and find the price for all of them.

**The Hon. DAVID CLARKE:** For all the insurers?

**Ms DONNELLY:** For all insurers. We also have a phone service that people can ring in and if you have not got access to the Internet there is either a recorded message that will give you the most common categories or we have a hotline staff in business hours who are quite busy walking people through and helping them shop. By the way, the online service has 20,000 hits a week. It is very popular and I think the insurers may not like me doing this but the shop-around message is a really important one for us to get out there.

**The Hon. LYNDA VOLTZ:** You do not work for them anyway so do not worry about them. You work for the people of New South Wales?

**Ms DONNELLY:** That is right.

**The Hon. LYNDA VOLTZ:** The Motor Cycle Council said that uninsured motorbikes may be pushing up the premiums, particular the toy ones that kids are getting a ride on. They think claims are being made against them. Would you like to clear up that matter?

**Ms DONNELLY:** I am not sure that it is the issue that they think it is. There are always test cases around unregistered vehicles on a road or off road and so on. I am happy to take this question on notice and look at it. But I have noted that they registered the concern and they have mentioned it recently in conversation with me that there are people who are not paying for a greenslip on these bikes and they are somehow being subsidised by the people who are making a greenslip payment. I am not aware that it is a significant number. It may well be something that we could have a look at.

**The Hon. GREG DONNELLY:** Question seven states, "Section 27 of the Motor Accidents Compensation Act 1999 authorises the MAA to reject an insurance premium if it considers it to be excessive based on actuarial advice and other relevant financial information." Are you able to describe the circumstances of actuarial advice and other relevant financial information that could prompt the MAA to take that type of action?

**Ms DONNELLY:** Let me talk you through the process. I mentioned some of the data that we look at in that a compliance assessment against that section of the Act, claim numbers, the size of claims, the average time expected to settle claims, the expenses for managing those claims, the expenses for marketing and acquiring the policies and competing on that market, overhead expenses, re-insurance expenses, the policy numbers, the risk profile of the particular company's customers which can vary, inflation in the scheme, the economy, their profit target as we have discussed, the capital that they are required to have—there is a minimum capital requirement—and their planned capital in terms of conforming with APRA's requirements, their investment policy, estimated return and the risk-free rate. Those factors come into play.

When we receive the submission, and I talked you through the fact that they obviously have sign-off by the chief executive officer tabled with the board, independent certification, and then it is also something that APRA can ask to see and APRA does do pricing reviews in which we, with a memorandum of understanding with APRA, will participate. There is quite a lot of rigour in the submission before it comes to us. We have a process in which we have again independent actuaries who will review that in detail and advise us of any anomalies. We do not wait at that point. We immediately go back to insurers and ask pointed questions "this does not add up" or "that does not look right", and "what is the justification for this assumption?" I think they would probably say that it is a fairly strenuous interaction that we have there.

We also compliance assess ourselves against the Act. If we were to say "This is not compliant" and reject, we move into arbitration. We only have six weeks in the Act to do that and if the six weeks has elapsed and we have not, in writing, notified them that it is not compliant, those premiums can be charged. It is a fairly intense process, particularly when we require them all to submit at the same time so that we can do a comparison across the whole market. If we were to say, "It is not compliant" and reject, they can ask for us to reconsider. It goes into arbitration under another piece of legislation, a commercial arbitration. If there is no resolution there it can go to the Independent Pricing and Regulatory Tribunal [IPART] as an arbitrator and IPART can set a price. I think there have been two occasions in which I have in writing in my time in the MAA said to an insurer, "This is not complaint". In both of those occasions they have resubmitted a new submission with essentially a lower price.

There have been many occasions in which, much earlier in the process we have said, "We don't agree with this. Can you give us justification?" and they have come back and there has been some modification. What I would say is it is a very rigorous process. It is one in which, for the most part, we end up with a compliant submission through a process of negotiation rather than having to get to arbitration but that ability is there for us to move it into arbitration. If we do not agree on an arbitrator it would go to the Independent Pricing and Review Tribunal.

**The Hon. GREG DONNELLY:** Will you advise the committee more about the research centre being established by the MAA in partnership with WorkCover NSW and the Lifetime Care and Support Authority?

**Ms DONNELLY:** We have an expression of interest that we have issued recently jointly that would have closed Friday. The objective for that centre is to enable us to improve the health and social outcomes of the people who are injured in road crashes, particularly the people in our scheme. We already have a research centre, the Rehabilitation Studies Unit of Sydney University that we fund. What we want to do is to enhance the evidence that is available to us so that we can influence clinical practise, claims handling by insurers and all the services for clients to get better outcomes.

One of the things that we want to achieve is to build up in one place a strong level of capability for research that can accelerate our improvement of health outcomes. What we have found is that without that sort of centre with people brought in because they have got expertise in the particular areas relevant to the scheme you are trying to commission research and there is not necessarily someone who has that area of focus. The areas that we would like to grow our focus in are for brain injury, the Rehabilitation Studies Unit has been particularly exceptional in the most severe forms of brain injury but there is a whole spectrum of mild to moderate brain injury.

Mild brain injury may not be so obvious when someone has broken limbs and so on and it may be that down the track the diagnosis has been delayed and it is not until you have got headaches and some personality changes and you are unable to concentrate at work that the diagnosis is made. We would like to have all the treatment in place for the mild brain injury as well. We understand that for some people the psycho-social issues are what prevent them from recovering as well as they could. There are times where we will have people injured in road crashes whose physical injury is not necessarily so severe but the trauma is what is holding them back from getting on with their life. We want to enhance the amount of research we have got around those psycho-social determinants of recovery, knowing that they happen interactively with the physical recovery.

We are looking across lifetime care which has an interest in this, WorkCover, and ourselves have a point where we attract more expertise and we can commission more research, we can share it amongst ourselves and influence clinical practise and influence the insurer claims handling so that we have better outcomes.

**Ms APLIN:** If I may add, the board was very interested in that being a combined centre for the reason that there are some interesting statistics, for example, of injury of a particular type in workers compensation, that person might take a long time to return to work than when it is a motor vehicle. So the amount of sharing that can happen from a health outcome but also the pooling of resources there is very important to the board and the MAA.

**The Hon. JOHN AJAKA:** I refer to when insurance profit projections are much lower than actually received, so there is a much larger profit in year one, year two, year three and with no clawback. If you end up with another HIH event then there will be no going back to those additional profits? The Nominal Defendant would again suddenly have to meet or finalise the claims of those people. However, if those additional profits are left with the MAA on trust and if something like HIH were to occur at least the MAA would have some funds to assist the Nominal Defendant? Have you thought about that?

**Ms APLIN:** In relation to another HIH collapse, I think the memorandum of understanding that we have with APRA and the increased capital requirements in relation to insurers generally, you cannot ever say "too big to fail", or "unlikely to happen". You need to be very careful about going down that path. I think ultimately the MAA would see may be a more significant risk, particularly the way we look at them, thinking about profitability or competition, is the exit of an insurer by choice because of the lack of profit that they might necessarily in their particular line, and then ultimately how you would then handle that in terms of their claims and the model. When we look at that as a risk the competition review is a way for us to look at alternate models within New South Wales and ultimately insure that we then regulate appropriately. So not specifically in relation to clawback have we thought about a HIH collapse necessarily.

**The Hon. DAVID CLARKE:** Following on from that question, you disregard the idea or the suggestion that there could be another HIH collapse?

**Ms APLIN:** No, I do not. I did not say that.

**The Hon. DAVID CLARKE:** I am putting that as a question, rather than as a statement, for your response.

**Ms APLIN:** No, I do not. I think we have obviously capital prudential requirements, that APRA has increased capital prudential requirements for insurers. Ultimately though we could never say that ultimately would never happen.

**The Hon. DAVID CLARKE:** Last Friday we discussed the fact that the Motor Accidents Council had not met for 16 months because no appointments had been made to it. One of the functions of the council is to advise and make recommendations to the authority to keep under review the Motor Accidents Authority medical guidelines and the MAA claims assessment guidelines. In the absence of the council being there to do that, what steps has the MAA taken to ensure that those guidelines have been monitored and reviewed?

**Ms DONNELLY:** We have begun a process to review them, but one of the projects that we would want to take to the Motor Accidents Council as soon as we can is some further review of the claims handling, treatment, rehabilitation and attendant care guidelines. What we are proposing is that we would like to see those guidelines integrated so that we do not have a disconnect between claims management by claims managers and rehabilitation and so that we have all of those functions and the insurance company thinking about health outcomes.

**The Hon. DAVID CLARKE:** I may have given you the wrong impression. I was not talking about the future. I am talking about the past 16 months. What effectively has been done during that period to keep these things monitored and under review?

**Ms DONNELLY:** Apart from saying that I am pleased that we have the Motor Accidents Council so that we can use that forum during that time in an array of ways, we have consulted with different working groups and obviously with different lobby groups, one on one, on that and on other matters as well.

**The Hon. DAVID CLARKE:** You say that what the Motor Accidents Council should have been doing, but has not been doing because the Government did not appoint the members of it, is effectively carrying out the role, as it were, of the council on these matters.

**Ms DONNELLY:** I think it is true that whether the council was appointed or not, the MAA would have been consulting separately to that. I think I described to you when I spoke to you before that I have an open-door policy. There are times when different stakeholders will want to have a discussion bilaterally and put their views, not necessarily in a forum. That choice is always there, whether the council will be meeting or not.

**The Hon. LYNDA VOLTZ:** With these figures on the premiums collected, why have they dropped off?

**Ms DONNELLY:** I am sorry?

**The Hon. LYNDA VOLTZ:** In the first column for 2006 it is 1.426 and then it goes right down to 1.17 in 2008. That is a significant drop.

**Ms DONNELLY:** In 2007, that would have been the point in around 2007-2008 before the global financial crisis when there was very heated price competition.

**The Hon. LYNDA VOLTZ:** So it was kicking in?

**Ms DONNELLY:** Yes.

**CHAIR:** Our time has expired. We will have more questions that we will send to you. Thank you very much for returning today. An interesting issue came up during a previous hearing in relation to a request for legal participation in the medical review process. That will come to you. We do not have time now to access any thoughts you have on that issue. There was a concern that the claims assessment and resolution [CARS] awards are increasing. They are issues that you would have seen.

**Ms DONNELLY:** That follows on from issues discussed in the last review about super-imposed inflation. When we got the PricewaterhouseCoopers report, we went through a number of workshops to work out what might be driving that. There was some concern from the insurer's point of view, although there would be other views, that there were some benchmark settlements being set at CARS. That feeds into the review of CARS that we have planned.

**CHAIR:** Thank you very much. That is good.

**(The witnesses withdrew)**

**NICHOLAS RICHARD WHITLAM,** Chair, Lifetime Care and Support Authority, and

**DAVID BOWEN,** Executive Director, Lifetime Care and Support Authority, on former affirmations:

**NEIL JAMES MACKINNON,** Acting Director, Service Delivery, Lifetime Care and Support Authority, on former oath:

**CHAIR:** Thank you very much, the three of you, for coming back. I know we sprung it on you at the last hearing. It is very good to see all three of you here. We are sorry we made it inconvenient for Mr Herd, but I think he had his say last time, which is good. We picked up a few more questions during this morning's hearing. In relation to the Lifetime Care and Support program, does the third party insurance process still operate if there is injury at the fault of somebody else, or is that not possible under the Lifetime Care and Support program? Can people claim for loss of income, pain and suffering, et cetera?

**Mr BOWEN:** Yes. There are two schemes operating concurrently. There is the Lifetime Care Support Scheme, which provides medical treatment and care to everyone who meets the eligibility test based upon the severity of the injury. That is on a no-fault basis. They have to have been injured in a motor vehicle accident. For those people who are injured by the fault of another person, they can make a CTP claim, which is for their non-economic loss and their economic loss, which is primarily loss of future earning capacity.

**CHAIR:** Simultaneously?

**Mr BOWEN:** Yes.

**The Hon. JOHN AJAKA:** My question follows that question. If they do through the CTP claim for loss of income, pain and suffering and everything else, and if they also seek to claim all their medical expenses on future medical, does that exclude them from lifetime care and support?

**Mr BOWEN:** No. It is the other way round. If they are accepted as a participant in the Lifetime Care and Support Scheme, they cannot claim a lump sum for the matters that are provided by the scheme.

**Mr WHITLAM:** But if they did not?

**The Hon. JOHN AJAKA:** If they would do not want to apply for the lifetime care and there is no acceptance?

**Mr BOWEN:** An application to be Lifetime Care Scheme can be made either by the individual who is injured, or a CTP insurer. In the case in which a person has made a CTP claim, the insurer will often apply for the person to become a member.

**The Hon. JOHN AJAKA:** And if he is accepted, he is bound by that acceptance.

**Mr BOWEN:** Yes.

**The Hon. JOHN AJAKA:** That is the point I wanted to come to. In a sense, he cannot opt out of it and simply go seeking third party.

**Mr BOWEN:** No.

**CHAIR:** Even after the two-year review?

**Mr BOWEN:** No.

**The Hon. JOHN AJAKA:** That was the point I wanted to get across. I thought that was the situation.

**The Hon. LYNDA VOLTZ:** Even though they have opted in, they can still claim for their economic loss.

**Mr BOWEN:** Yes, if they can prove fault. Around about 60 per cent—somewhere between 50 and 60 per cent—of people in the scheme have a concurrent CTP component.

**The Hon. JOHN AJAKA:** We have restrictions of time. Clearly from all the witnesses we have had so far, there have been those who have been very positive about the scheme and aspects of the scheme, and there have been those who have been very negative about aspects of the scheme. I do not intend to say which side I take. In the questions I will ask, I will focus purely on the negatives that were put before us is to simply afford you an opportunity to comment. Please do not take those as my views.

**Mr BOWEN:** Understood.

**The Hon. JOHN AJAKA:** Thank you. I will go through the witnesses. Mr Harris really does believe that there should be a way to opt out of the scheme to seek his lump sum payment and opt out of it when there is no fault on his part. His exact words were that everyone is in a different situation and we should not have just one rule for everybody. He then raised many examples of why. He basically gave a terrible description of his experience, his wife's experience and his father's experience in relation to being part of the scheme. He has not heard from a new coordinator who was appointed in December, notwithstanding leaving messages. In six months, there has been nothing. He referred to the fact that he wanted to try to get a wheelchair to be able to play tennis and he described what he had to go through for that. He also described what his wife went through in the initial period of accommodation and staying near the hospital. What he says is: Why should you not be allowed to opt out and manage your own affairs? Are you able to comment?

**Mr BOWEN:** I am happy to comment on that. The provision of these sorts of services by ongoing payment for the service rather than lump sum is something that was very well ventilated when this legislation went through Parliament. I would note that a lot of other compensation schemes have moved in the same direction. For example, if you have a worker's compensation claim you get a periodic payment for your care and support. You are unable to get a lump sum. If we want to re-agitate that whole issue and what drove in part the creation of the Lifetime Care Scheme, it was the recognition that, for the great bulk of people, the funds ran out well before their lifetime.

It is not necessarily the case that they did not spend them or manage them properly, but they simply ran out. The person fell back into the disability support system. In essence, they double dipped into the system. Putting that aside, the authority is very keen to pursue the option of self-management, or an individual funding basis. To that end we instructed the Crown Solicitor, who obtained counsel's advice for us. We have had advice, which indicates that we will be able to structure a scheme that can make periodic payments to people to allow them to self-manage.

**The Hon. JOHN AJAKA:** It is not full opting out, but more of a compromise.

**Mr BOWEN:** It is not that we are going to give them a lump sum for life. It is that we are going to assess the value of care for a period of time, and that is somewhat negotiable. I suspect when we started that was for shorter periods for both the participants and ourselves to make sure we were happy with it. Counsel's advice indicated was that while he thought he was certainly capable of construction, it would be prudent to obtain a tax ruling from the ATO under direction from the Department of Social Security, so that those periodic payments did not constitute income for either tax or social security purposes.

The Crown Solicitor's Office is in the process of obtaining those rulings and directions for us. At that stage we will put a guideline out and invite those participants in the scheme who, firstly, have the competence to self-manage and, secondly, have a desire to do so, to make an application. We will reach an agreement with them whereby we make that periodic payment. I would note that that whole issue of individualised funding is one that is being looked at in a much broader disability setting. You may well be aware that the whole future of how we find disability services and whether it is through programs or through provision of funding to the individual, to allow them to buy into the marketplace and have some individual variation in choice, is one that is being looked at.

I personally favour moving towards that individualised funding scheme. I think it gives people far more control. We are in favour of that. We do want to have the capacity to allow people, who are capable of doing so, to self-manage their affairs. We are supportive of that.

**THE HON. JOHN AJAKA:** I will make a couple of statements of what witnesses have said and I will then ask you the question, rather than trying to do this as five questions.

**Mr BOWEN:** Yes.

**THE HON. JOHN AJAKA:** For example, Mr Franklin indicated in his evidence that there was an issue of retraining the participant. He indicated the difficulty that they went through to obtain the consent and the funding for retraining. They thought that was very frustrating. Another witness indicated, in relation to additional studies as opposed to retraining to enhance their current training, some of the difficulties of going back and forth before approval was finally obtained, and that that was frustrating.

Taking into account Mr Harris's evidence and taking into account another witness saying that by the time you got the case manager to agree, put in a report, and then days later the coordinator dealt with the report over a 10-day period, it was frustrating. Putting it all together, from my perspective it appeared that maybe one of the reasons some of these participants are becoming frustrated and want to opt out of the scheme, thereby watering down the positive effects of the scheme, is that either there are not enough coordinators, or the coordinators are not dealing with these issues quickly enough, or they were being rejected first or second time by coordinators, and finally they were being agreed to for the paperwork aspect of it. Could you comment on that?

**Mr BOWEN:** I will deal with the issue that you raised about Mr Harris and his inability to contact—

**CHAIR:** Remembering that we do not have any right to deal with individual cases.

**Mr BOWEN:** I refer first to the issue of contacting a coordinator. Each participant has a case manager and all the inquiries about applications should be directed through that person. Only when there are problems should the participant go to the coordinator about a service request or variation to services or care. The coordinators are there for secondary follow up, not primary care. All they will do is say that they will have to get a report from the case manager because they are not involved in that day-to-day aspect of the management. That has been communicated to all of our participants. As with any human relationships, it works better in some cases and not so well in others depending upon the interaction.

**The Hon. DAVID CLARKE:** You are assuming that he did not go to the case manager.

**The Hon. LYNDA VOLTZ:** We are not talking about a specific case.

**The Hon. DAVID CLARKE:** If he had gone to the case manager and was seeking some information or assistance, that period of delay would be very—

**Mr BOWEN:** Yes. I propose to the Committee that because we are dealing with individual complaints that have been put to it—

**The Hon. JOHN AJAKA:** I did not mean to put it that way.

**Mr BOWEN:** There are issues that we would like to answer, but I would prefer to do that in a confidential submission to the Committee. I am obviously happy for the Committee to make that available to Mr Harris, but I do not think it should be read onto the public record.

**The Hon. JOHN AJAKA:** I did not want my question answered from an individual perspective. It was purely seeking your view as to whether we have enough coordinators. Do we need more funding for coordinators? Is there a problem between coordinators and case managers? I was asking from a general point of view.

**Mr MACKINNON:** We are subject to the same staffing restrictions that apply in the public service. However, we have just received approval to recruit another four coordinators in the latter half of this year. That puts us about on track. I am monitoring that on the basis of cases per coordinator. That is a coarse measure when people are dealing with complex individuals at times. We are trying to refine that whole issue of caseload. Having numbers of coordinators is good. We also have a new and fairly complex system wherein coordinators are across a range of issues. It takes about six months to get across that sort of stuff, even if you come as a very experienced health care worker. There are many new things to get across. The concept of urgency, conveying that to the coordinator and getting an urgent response is complex. Many things go on in that communication at times and what is thought urgent by one person is not by another. Those things happen.

We are talking about things like education services. We do have guidelines covering those services and we fund a lot of school support for children. That is clear and bedded down. The education and support we provide for adults who have to retrain is not so well bedded down. Those services do not exist for many people. It is this complicated business of individual solutions. We have just initiated a protect dealing with spinal chord injury. Where are working on a concept of early intervention for return to work. The notion is that one can start very early having a conversation about going back to work. I am thrilled that people come to us and ask how we are going to help them to get back to work. However, that is not the majority. The majority are sitting back having decided that they will think it about it somewhere down the track.

The historical evidence from the spinal units is that once they are unemployed for two years it further compounds the problem of returning to work. We would like to intervene in the spinal units to start the process of returning to work very early. That will cover a number of these issues about pathways and the services that need to exist. With the changes in the various Commonwealth return-to-work programs many of these things have been watered down over the years. There is no clear pathway for someone who cannot go back to the same employer who is prepared to make minor amendments to their work. If do you not have that pathway it is pretty tough.

**The Hon. JOHN AJAKA:** Please correct me if I am wrong, but I have the impression that if, for example, a lawyer is injured and cannot go back to that profession and he or she wants to train in a completely different area that will not be funded by the Lifetime Care and Support Authority. On the other hand, if that lawyer wants to do a computer course dealing with a particular computer that would be funded. Is that correct?

**Mr MACKINNON:** The second scenario is easy. The first scenario is a bit more complicated in that we must try to work out where that course will go and whether it is a reasonable investment. I am not sure how the requests made by the witnesses today have been dealt with. I would have to look into those cases.

**The Hon. LYNDA VOLTZ:** Has any thought been given to establishing a support group for people dealing with lifetime care at the initial stages? There appears to be no support group. Some of the witnesses today would have benefited from talking to someone who had been through the system and who would understands how they are feeling. Have you considered setting up a support group?

**Mr BOWEN:** There are peer support groups operated through both the spinal units and the brain injury units. We have funded them in the past. We have set up a process to establish some participant forums. That is designed to get a participant representative on the council—which is a recommendation of this committee—and to provide another element of feedback to the authority on what people think they need and what gaps they have identified on their journey through acute care rehabilitation and back into the community. It did not come up as a particular gap in our survey. However, I am happy to look at it again.

**The Hon. LYNDA VOLTZ:** At least one of the caseworkers who gave evidence today from the private sector did not know about it. She said that she was not aware of any of them. Other witnesses also did not seem to be aware of them. Another idea was a kit that could be given to people when they are first admitted explaining the role of the scheme, what they can expect and who to approach. That could include peer group contacts. Has that kind of tool been considered?

**Mr MACKINNON:** We certainly give people brochures about the scheme and particular things as they arise. They get a fair amount of written information.

**The Hon. LYNDA VOLTZ:** I am talking about first contact. Could they be given a reference book, not just a brochure? It could detail what the scheme provides. These people are going through a tragedy and they are very distressed. One of the groups said they thought someone was going to come in with a magic wand and fix all their problems. They did not have any background about how the scheme works. That might assist them.

**Mr MACKINNON:** The point is taken. My background is in health care and I have been in those situations many times. People will hear what they want to hear.

**The Hon. LYNDA VOLTZ:** Of course.

**Mr MACKINNON:** That is why it is important from our perspective to go back and have another go at explaining. That is very important. The people we are talking about are in specialist rehabilitation units with psychologists and social workers. They run family groups that undertake a number of those activities. I am happy to explore the notion of a group that would talk about how to manage their issues with the Lifetime Care and Support Authority.

**The Hon. LYNDA VOLTZ:** I do not mean talking about their issues; I am talking about people who have been through the system helping out. If you are confronting a new situation it is a great help if you can talk to someone who has been down that path before.

**Mr BOWEN:** I am far more inclined to look at that now. We entered into the arrangements with the acute care and rehabilitation units slowly and carefully. I think members will recall that the Committee took evidence from social workers who suggested that we should not turn up at all while the person was at that level.

**CHAIR:** That was a touch of professional jealousy.

**Mr BOWEN:** I think we have now become an established part of the framework and sorted out the roles—who does what—and that we are valued for being there. But we will take that on board and make it a focus question to our participants. It is about the balance between getting enough and not overloading people.

**The Hon. LYNDA VOLTZ:** That is true. When people in hospital found out about the scheme it was a great relief. I took on notice that you are getting advice about the idea of periodic payments. Can you provide an actuarial report on the medical costs? Would you look at that kind of process so that people had a clear picture of their costs so that they are not concerned?

**Mr BOWEN:** We would enter into an agreement that specified the services that they were being funded to purchase. They would then have a choice about how much and what they purchased during that period. We are proposing that it would be for care only. Care constitutes 80 per cent of the costs of the scheme. If someone had a health event that required readmission to hospital that would be dealt with through the normal hospital invoicing processes and equipment and aids and appliances are usually dealt with under more regular payments because there is a lack of providers. There is no marketplace in which people can purchase a whole lot of that equipment. It is primarily intended for care arrangements. However, we would quantify the amount of care that we estimated they required and what the funding was for.

**The Hon. LYNDA VOLTZ:** What about pharmaceuticals?

**Mr MACKINNON:** That is possible if people were experiencing a common difficulty, particularly with pharmacies.

**The Hon. LYNDA VOLTZ:** The Motorcycle Council raised concerns about the cost of this scheme to cyclists. I have view about motorbikes and how some people ride them given the motorbike accident figures.

**Mr BOWEN:** Motorcycles represent between 4 per cent and 5 per cent of registered vehicles, but they comprise 25 per cent of the claimants in this scheme. The Motorcycle Council responds to those figures by saying that motorcyclists are injured by motorists. That is not true; the great majority of motorcyclists in this scheme have injured themselves. They also claim that the registered motorcyclists are paying for unregistered motorcyclists. That is also not true.

Injuries sustained by motorcyclists on a road are dealt with similar to nominal defendant funding; that is, it is spread across all vehicles owners. All vehicle owners pay a proportion of a contribution to this scheme that covers injuries suffered by someone travelling in an unregistered vehicle. Motorcyclists as a group are not picking up all the cost of people riding unregistered motorcycles; those costs are spread across the board. As a group, motorcyclists are the most heavily subsidised in this scheme. If we charged the full cost of the care of motorcyclists who injured themselves across motorcycle registration, the premium would increase between $500 and $1,500 per motorcycle.

**The Hon. GREG DONNELLY:** In response to an earlier question this afternoon, you made a comment that guidelines are being developed for the buy-into-the-scheme proposition. Can you explain where the development of those guidelines is up to?

**Mr BOWEN:** The guideline would specify the way in which the authority would enter into an agreement with a participant to fund them for a period. In essence, we have a draft guideline. The issue is that Senior Counsel has said to us, "We believe that you can construct it in such a way that that periodic payment does not constitute income". But it is always better to be prudent and get a tax ruling and get a department of social security direction. There are precedents for that for other no-fault compensation schemes. Both the workers compensation scheme and the TAC in Victoria have such rulings that allow them to make periodic payments. So we are reasonably confident that what we are doing will be able to be achieved but we would like to have those rulings in place first.

The second element of it, which is the same as for people who buy into the scheme, we have to be able to quantify the benefits that they would get over a period of time. That makes me believe that for episodes of these we will have a shorter period where we can quantify it more easily— sort of, "At this stage you are assessed as needing four hours care a day. Currently we are providing that." Or this has this sort of value, just add up the number of days over a three-month period, it is this amount of dollars, we will arrange to deposit that into a bank account. That is the sort of arrangement we are looking at.

**The Hon. GREG DONNELLY:** We had the Harris family here earlier today giving evidence and the substance of their evidence was, I guess, some dissatisfaction with the way in which the whole thing had worked for them. What struck me though was it seemed to me that there did not appear to be, at least in their minds, some understanding of a procedure whereby if they were experiencing frustration—the example they gave is, for example, not being contacted by their coordinator. They claimed there was an appointment of a second coordinator in December last year and no contact had been made since July. Inside the whole procedure is there essentially a grievance arrangement where things can get elevated and moved through if people are experiencing frustration? If there is, can you describe how that works?

**Mr MACKINNON:** I did bring the brochures with me, but we have a specific person in the authority who manages the assessment reviews and the complaints. That person sits separate to the people making decisions and then the coordinators. That person's name and number goes out on most letters so they can call that person. The Harris's have used that service and have used the disputes process as well, which has been decided. They have been part of that as well. Again, I think we might answer some of that in a separate letter.

**The Hon. GREG DONNELLY:** I certainly thought it would be unusual that there was not such a process but you have answered my question by confirming that such does exist.

**Mr BOWEN:** It is a good question. As the scheme gets bigger and we have more people in it there is certainly more scope for grievances often through matters of omission rather than exercises of commission. We probably do need to formalise that, have it a little bit stronger. We are also a State agency so we have all of the new other provisions that apply to State agencies, including access to the Ombudsman for people who are dissatisfied with what are essentially administrative decision that the authority makes.

**The Hon. GREG DONNELLY:** I am not sure whether you have seen this particular question on notice but I will read it. Notwithstanding sections 18 and 29 of the Motor Accidents Lifetime Care and Support Act 2006, which restrict a participant from recovering costs from the authority arising from a dispute about medical or clinical issues, are there any other options for participants to recover costs arising from such disputes?

**Mr BOWEN:** There are two sorts of disputes that a participant may have with the authority. The first is about eligibility to enter the scheme and a dispute over whether or not a matter is a motor vehicle accident is a dispute in which the authority does pay the legal costs of a participant. All other disputes relate to the level of services that a person may get, how much care they need, what sort of wheelchairs they need. We regard those disputes as being best dealt with through medical assessment and expert knowledge, rather than a legal system in which there is legal cost. The other critical factor to remember in that is that unlike litigation, where you are having that decided on a once-and-for-all basis to get an entitlement to money, this is a periodic decision that is open to ongoing and continuing review. There are also legitimate reasons why a medical assessment may come to a different conclusion than a legal assessment. Allow me to give you a very good example.

A person who, as a result of their disability, has a care need but overlayed over their physical disability they have a high level of anxiety, for example, about being left at home alone at night. A person could be an adult who has gone back and continues to live at home. In a legal dispute, in litigation over a lump sum, that person would be awarded 24-hour care because they have a care need associated with their anxiety. A rehabilitation physician will tell you that we need to deal with that anxiety and we need to provide them some support and some counselling. But we should not be entering an arrangement where we provide 24-hour care for a long period of time because entrenching their disability will lead to a situation where they can only live with carers in their house all of the time. It is better to overcome their anxiety and get the person where they can live independently. So you are taking a medical view of the situation rather than entitlement view as to what you might get at law.

**The Hon. DAVID CLARKE:** If a participant has disputed a medical issue and it has been found in favour of the participant, why should not the participant then get any costs associated with that decision?

**Mr BOWEN:** They certainly would get all of their travel costs and the like. It would be rare—we do not try to set up a situation where a person needs to gather a whole lot of evidence to say, "You've said I need this. I am gathering all this evidence to say here is my contrary argument." It is sufficient for us that a person expresses, in effect, dissatisfaction over the level of services or we have a difference of whether or not a person needs this wheelchair or that wheelchair.

**The Hon. DAVID CLARKE:** But he may want to bring medical evidence to the contrary. If it is found in his favour, why should he not—

**Mr BOWEN:** We would certainly pay for all of those medical reports. We would do that.

**The Hon. DAVID CLARKE:** And for doctors attending to give evidence?

**Mr BOWEN:** Yes.

**The Hon. JOHN AJAKA:** Just not lawyers.

**The Hon. LYNDA VOLTZ:** Those bloody lawyers!

**Mr BOWEN:** No. I am a lawyer and I think they do value add but I do not think that these are essentially legal disputes. We are trying to get away from legal disputes.

**The Hon. DAVID CLARKE:** Are you saying that the provision of those costs for experts and reports is not restricted under section 18 and 29 of the Act?

**Mr BOWEN:** No.

**The Hon. JOHN AJAKA:** Just lawyers.

**Mr BOWEN:** Just legal costs.

**The Hon. DAVID CLARKE:** Spinal Cord Injuries Australia believes that there is anecdotal evidence to suggest that there is a threshold above which the Lifetime Care and Support Authority rejects applications for home modifications. Apparently your authority denies that there is such a threshold. Is that the case?

**Mr BOWEN:** No. Our guidelines are quite clear and they put in a monetary amount, which we suggest beyond that we would need to have an indication that met special circumstances. I do not recall what the amount is.

**Mr MACKINNON:** It is $250,000.

**Mr BOWEN:** About $250,000, and it is intended to be indicative. It is not prescriptive. The guideline makes it clear that it is not prescriptive. There will be circumstances where, because of the severity of injury and, for example, if a person has lived all of their life in the one location, then of course you will make the very best efforts to modify that house. But the reality is that some places are not modifiable, just physically not modifiable. We have had people living in units where you could not get permission from the strata owners or the like to do the modifications so it tends to be physical limitations rather than monetary limitations.

**The Hon. DAVID CLARKE:** What concerns Spinal Cord Injuries is that recommendations from experienced occupational therapists are being rejected in sufficient numbers to give them cause for concern.

They say that these occupational therapists are people who understand the needs, they are being moderate in their approach on this, they are experienced, they are experts, they are professionals, yet there are sufficient numbers of their recommendations being rejected to cause them concern. How would you respond to that?

**Mr MACKINNON:** What we have arrived at is for the home modifications process, which, when we have spoken to every other agency, TAC, whatever, they go home modifications. It is hard work. It is trying to come up with a process that gets something built in the end that is useful. What we have is a pool of occupational therapists who we have put out an expression of interest for, they have met fairly stringent criteria, been assessed by their peers from the occupational therapy association, so we have a small group of occupational therapists who do home modification assessments for us, in conjunction with a builder, a project manager. Again, that has been sought through an expression of interest. What we have now is a system where these two people will assess a home, and they come up with a very realistic plan with a price and a scope of works. They discuss it with the family and we reach a determination, I think in fairly good time, for something that is very complex.

**The Hon. DAVID CLARKE:** So two occupational therapists?

**Mr MACKINNON:** An occupational therapist and a builder.

**The Hon. DAVID CLARKE:** Appointed by?

**Mr MACKINNON:** Us.

**The Hon. DAVID CLARKE:** What if the occupational therapist of a participant is unhappy with that? Is there a process of appealing that? This is a very big issue, the premises in which somebody is going to live.

**Mr MACKINNON:** The brief that is given to the occupation therapist around what are the requirements of a home modification, that is done in consultation with the treating occupational therapists. It might be a hospital person, around what the person's functional requirements are in their home.

**The Hon. DAVID CLARKE:** What if there is still dissatisfaction? What if there is dissatisfaction by the participant and his occupational therapist? Is there a process for that participant to appeal or to get an independent arbitrator?

**Mr MACKINNON:** That is right, it will be the same process. Where it comes to the point where we make a decision and we issue a certificate and then they might disagree with that and there is a dispute. The difference in the home modifications is that there is an extensive negotiation with the person to arrive to that point, because once we get to that point of a certificate we are actually committing to a building project.

**The Hon. DAVID CLARKE:** If there is a dispute, who then decides that dispute?

**Mr MACKINNON:** That would go back—we have our disputes assessors who are on our panel.

**The Hon. DAVID CLARKE:** But they are part of the team, as it were. They are not independent.

**Mr MACKINNON:** They would have had no contact with that participant or that project up to that time.

**Mr BOWEN:** We try to get the assessors who have the standing within their own profession, so for any dispute we try to deal with the relevant college or professional association to try to get a group of assessors who have high standing so that their decisions are well accepted.

**The Hon. DAVID CLARKE:** Do you keep figures on how many situations there are that are not resolved?

**Mr MACKINNON:** For home modifications, yes, we could do that. I think the point about why it is not resolved is an interesting one. I approved a building project last week, a $180,000 building project. It had been negotiated the whole way through. A phone call was made to the family and the mum, who is the homeowner, said, "I don't think I can bring him home". So that was the end of that. We will have to look at alternative accommodation for her adult son. It is a long negotiation process.

**The Hon. DAVID CLARKE:** At the end of the day with the two assessors you appoint it is basically take it or leave it, isn't it?

**Mr MACKINNON:** Take it or leave it? No, I think it is about persisting and trying to see whether there is something we can do right now to help and then maybe come back and revisit other aspects of the project later. We have done that on a number of occasions.

**The Hon. DAVID CLARKE:** Are you saying that if the two assessors come down and it is negative for the participant it is not a closed door and you will still continue to try to accommodate?

**Mr MACKINNON:** Absolutely. Sometimes it is a matter of going through some of this process with people to arrive at that decision that, "Even though we have lived in this home for a long time we can't modify this house."

**The Hon. DAVID CLARKE:** Do you have figures on how many of these disputes are accepted and how many—

**Mr MACKINNON:** I do not think we have run any home mods to disputes.

**Mr WHITLAM:** That is my understanding. The real issue is the modification of existing accommodation and the difficulties in modifying as opposed to finding alternate accommodation that is suitable. Of course, that is a subjective question. Indeed, it is not always just accommodation in that particular house or flat, but in that area. People want to live where they have lived, naturally enough, so my understanding from the anecdotes I have seen is that it is the practicalities of the modification to that place as opposed to finding, within all the budgets we have, alternate accommodation that would be suitable.

**The Hon. DAVID CLARKE:** That would be reasonable but those occupational therapists acting on behalf of the participant would take all of those things into account. They are also reasonable people who are looking for the art of the possible, what is practical and so forth, and you could still have disputes arising.

**Mr MACKINNON:** That is right. What we have now amongst our home mods assessors and the project managers is very good teamwork in delivering a building project, not just writing a report. They see building work done until it is occupied. That is something quite different. The average project is around $80,000, which puts it in the realm of category 3 for the home mods service for New South Wales and there are not a lot of those projects going on. I think amongst our pool of home mods occupational therapists we have the people who have done most of that work in New South Wales for some time.

**CHAIR:** In relation to the housing issues, we talked at the last review about a process for geographic mapping of the availability of accessible housing across the State. Has there been any progress on that? You were talking about working with housing. The spinal injury people came forward with quite a good thought about getting a picture from across the State of accessible housing.

**Mr BOWEN:** I think Mr Herd responded to that question from his knowledge within the disability sector that it is definitely an issue that requires work to identify the accessible housing that is currently available and to peer back on the Commonwealth Government's affordable housing initiative to make sure that a significant proportion of that is built as accessible housing, bearing in mind that accessibility for people with disabilities often has the same criteria as accessibility for people with aged needs. We will undertake to report further on that.

**CHAIR:** I also understand that some of the big developers are being required to build so many "accessible units" within their developments, but it would be difficult to catch up on that sort of data.

**Mr BOWEN:** I am not aware that there is a target under the Commonwealth Government's affordable housing funding but I am aware that some of the big providers that are looking at taking that up are intending to make a significant proportion of the places they build accessible. For example, we had a discussion with Mission Australia.

**CHAIR:** That is still a public housing process.

**Mr BOWEN:** It is the Commonwealth Government's affordable housing initiative, which provides a subsidy to builders provided that the properties they build are rented out at 20 per cent below market value to meet affordability criteria. In the case of Mission Australia, and I am sure it is true of a number of other providers, they intend to make 10 or 15 per cent of properties they build fully accessible. We were talking about partnering them in some of the areas where we would have a number of young people who require close proximity to transport and accessible premises.

**CHAIR:** So it is slowly progressing towards a solution to have a picture.

**Mr BOWEN:** Yes. There is certainly a shortage of accessible housing at the moment.

**CHAIR:** Recognising the progress that has been made by your program towards ensuring that Lifetime Care and Support participants have access to sport and recreation, the question of taxi fares for that specific purpose was raised with us today.

**Mr BOWEN:** This is something that has exercised the advisory council quite a bit and I have to say there are differences of opinion with the council, which is probably a healthy thing, as to what should be the level of support that the authority provides to recreational activities and whether recreational activities should have some rehabilitation focus, for example a gym, or whether it can be purely for recreation. At the moment we provide transport costs and also pay for a carer when they are needed to attend recreational activities with the person but with some exceptions we do not pay for the person's own fees to participate in a recreational activity. We are looking at that.

**CHAIR:** It was a big question last year.

**Mr BOWEN:** It is a very big question and I cannot see that it has been resolved anywhere. It is a matter that will eventually have to go to the board because it has some funding implications for the authority as well. Just putting aside an amount of about $1,000 a year per participant but then projecting forward over their lifetime adds up to quite a sizeable amount. It may be that that is the simplest way to do it rather than worrying about saying they can do this or that. We will just say they have a certain amount available to them to support recreational activities and they can spend it where they like. That is probably the pragmatic solution to all of this rather than trying to get down into the nitty gritty.

**CHAIR:** And having to tick off every point.

**Mr BOWEN:** Yes, otherwise you are approving tiny invoices.

**CHAIR:** We have discussed before the desire of families to move overseas once they have been put on the program. You put this on the agenda yourselves, I believe. Is it still an issue?

**Mr BOWEN:** It is an issue for us because we do fund people who return home and that probably reflects the fact we have grown out of a litigation-based scheme where people could get lump-sum damages that would then facilitate their return to country of origin. The funding restriction on that is that the person cannot get paid more than they would if they were a resident in Australia, so that puts some limitation on it. It is very administratively difficult to manage when people are overseas and we really are one of the world exceptions in providing that. In fact, I do not know of any other scheme that provides for care for people once they have returned home.

Indeed, most common law jurisdictions that pay lump sums, apart from those from direct English heritage, have very significant restrictions on the amount you can get in a lump sum. For example, if we go to the United States and are injured in a motor vehicle accident they have compulsory insurance but in California it has an upper cap. A few years ago it was $1.5 million, but I am not sure what it is now. Theoretically you can get more than that in damages depending upon how much additional insurance cover the driver has bought or what assets they have, but in practical terms that is about a cap. For someone with a catastrophic injury that would not be sufficient to fund their care when they returned. That is why you buy travel insurance when you go overseas.

We are in the odd situation of paying for the care of a New Zealand resident who was injured in New South Wales and has returned to New Zealand, but if a New South Wales person was injured in New Zealand the ACC would only pay for their care while they stay in New Zealand. It would not pay for it on their return to

New South Wales. I think at the moment we are erring on the side of generosity and perhaps it would be more reasonable to consider paying for the care of New South Wales residents in New South Wales vehicles when they are injured in another State that does not provide life-time care rather than worrying about people from overseas, but I will probably be at great odds with the legal profession over that, who I am sure will come back to you.

**CHAIR:** It might be one of those complex international reciprocal agreements, but it is not our issue today. Were there any results on the settlements and relationship breakdown problem where people were suing? It was about the opt-in question.

**Mr BOWEN:** This is the issue of Family Law disputes that Mr Clarke raised?

**CHAIR:** Yes.

**Mr BOWEN:** I believe the response from the Attorney General indicates that he has referred it to the Standing Committee of Attorneys-General. It will probably take a couple of years to go through that process.

**CHAIR:** With regard to the health review, there was a lot of evidence about there being no transparency in where the funds were going in the health system. We received a copy of the health review; did you?

**Mr BOWEN:** No, in fact we noted in the submission to you that it referred to it, but we did not have a copy of it.

**CHAIR:** So it is not appropriate to ask you any questions about it.

**Mr BOWEN:** There are some things I would like to say about it.

**CHAIR:** There is a letter that was published on our—

**Mr BOWEN:** I have seen the letter and the submission and it referred to the review having been sent to you earlier but we have not seen that. The arrangements in relation to the rehabilitation units have continued on from a bulk-billing agreement that was originally developed in 1990 between the Motor Accidents Authority and the Minister for Health. It provides bulk billing for all acute care but it quite deliberately carved out the rehabilitation units at that time on the understanding that there would be a direct payment so that the money would go to the units. Over a period of time, with changes in the structure of the Health Department, those units have collapsed into area health services, so the situation at present is that the billing for the rehabilitation units comes from the relevant area health service or, in the case of the Royal Rehabilitation Centre, directly from that centre. This overlaps with the issue of the amount of paperwork and complaints about that from the rehab units. The amount of money that we pay on a bed-day rate and for specialist services and allied health services is well in excess of the Medicare rate. It is probably more than double the Medicare rate.

**CHAIR:** In rehab or acute care?

**Mr BOWEN:** In rehab. It is well in excess of any comparable amount that a private medical fund would pay, so I believe that we are paying sufficient to enable those units to do all of the work, which includes, from our point of view, a reasonably modest amount of paperwork and, operating fairly much under template agreements, for us to be able to properly certify and verify that the service has been provided and that it is reasonable and necessary. Otherwise we will have problems with the Auditor-General. The issue is we are paying that into the area health service but it is not necessarily finding its way back to the units. I know the Brain Injury Directorate have raised this directly with the Committee and I would say that we are quite happy to work with the Brain Injury Directorate and the spinal directorate on an approach to the Health Department to make sure the services that are being paid for go to those areas that are providing it. It is a pretty straightforward purchaser-provider arrangement. We think that would facilitate those units being better able to service the needs of our participants. Bear in mind that we are a reasonably big purchaser in the rehab area—not in acute care; it is tiny in the acute care hospitals, but in rehabilitation probably over 50 per cent of the brain injury and spinal units are being paid for through the Lifetime Care Scheme, so we would like to see the money going back to those units.

**CHAIR:** I know this is not your responsibility now but with the Motor Accidents Authority process you do not fund the acute centres?

**Mr BOWEN:** It is funded, including from Lifetime Care, through a bulk-billing arrangement and that works well because that saves the cost of drawing invoices on every client who is running through the hospital system. So for all motor vehicle accidents on a no-fault basis, ambulance and hospital, acute care hospital services are provided under a bulk-billing agreement. The exception is specialist services in the hospitals from VMOs or salaried medical officers who have a right of private practice can bill directly to the authority, and that is an issue that we are reviewing in an audit later this year in conjunction with the Motor Accidents Authority and WorkCover.

**CHAIR:** Because they do the same as the insurance companies.

**Mr BOWEN:** It is all the same issue, yes.

**The Hon. JOHN AJAKA:** Just on what was raised by the Chair, and so I understand this clearly, you could get a bill from an area health service for $100,000 for treatment to participants at a particular rehab unit but what you do not know is if that entire $100,000 is going or not going to the unit, or do you know it is not going to the unit?

**Mr BOWEN:** We do not know where it is going, but our colleagues in the units would suggest to you—they are not suggesting to us, I think they are suggesting to you—that they are not getting it.

**The Hon. JOHN AJAKA:** I understood that part, but you yourself cannot say?

**Mr BOWEN:** No.

**The Hon. JOHN AJAKA:** From a systems documentary point of view, your organisation does not have a situation where for every single participant, all the information that has come from any source goes into one computer, if I can call it that, and you can access it all for that participant?

**Mr MACKINNON:** We do.

**The Hon. JOHN AJAKA:** Are all the other participants able to access that information or, due to privacy reasons, they can only do it via you?

**Mr MACKINNON:** They can only do it via us. That is the next stage of having a Web-based case management system: you can bring providers in directly into the system and they will be able to see their people—

**The Hon. JOHN AJAKA:** Cut out the paperwork?

**Mr MACKINNON:** That is right. You can go to an electronic form and start filling it in. That is the two-year sort of horizon, I think, at this point.

**CHAIR:** Thank you for coming back today and thank you for the work that has happened between both the Lifetime Care and Support organisation and the Motor Accidents Authority for the last eight years I have been here. It has been very satisfying work. I perceive that you people and this committee have value-added the process quite healthily. I wish you well for the future.

**Mr BOWEN:** Can I say, I am sure on behalf of my colleagues at the Motor Accidents Authority and the Lifetime Care and Support Authority, that we have always appreciated what comes up from the committee. As Mr Ajaka said, it is an opportunity to address issues and you can then work on solutions, although I am much happier to work on solutions. Can I thank you, Madam Chair, for your chairmanship over the period of time. You have indicated to me that you are moving on so this is probably the last occasion on which you will be chairing the committee at which we appear. Thank you for your interest in this scheme over many years.

**CHAIR:** Thank you. There could be further questions. We will send them to you.

**(The witnesses withdrew)**

**(The Committee adjourned at 5.18 p.m.)**