QBISM

8th January 2016

Research Director

Communities, Disability Services and Domestic and Family Violence Prevention Committee

Parliament House

George Street

Brisbane Qld 4000

Dear Research Director,

Thank you for the opportunity to respond to the parliamentary inquiry into a suitable model for the implementation of the National Injury Insurance Scheme in Queensland. Please find attached the Quarterly Brain Injury Services Meeting (QBISM) group response to the Council of Australian Governments (COAG) National Injury Insurance Scheme: Motor Vehicle Accident Regulation Impact Statement (NIIS:MVA RIS) developed in 2014. QBISM includes over 130 members, including representatives from public, private and non-government agencies providing services to people with brain injury in Queensland, brain injury researchers, advocacy services and policy makers.

QBISM members support the implementation of a no-fault Lifetime Care and Support Scheme (LTCSS) for all people catastrophically injured in road traffic accidents (RTA) in Queensland, as outlined in the attached letter to review committee members and our NIIS: MVA RIS response.

We would be very happy to provide further input to inform this important policy reform. Please do not hesitate to contact me via my Griffith email [redacted] or postal address listed below if you would like any further information in regards to this submission.

kind regards

Rosamund Harrington PhD
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[redacted]

Friday 8th January, 2016

Dear Committee Members,

Thank you for the opportunity to respond to the parliamentary inquiry into a suitable model for the implementation of the National Injury Insurance Scheme in Queensland. Please find attached the Quarterly Brain Injury Services Meeting (QBISM) group response to the Council of Australian Governments (COAG) National Injury Insurance Scheme: Motor Vehicle Accident Regulation Impact Statement (NIIS:MVA RIS) developed in 2014. QBISM includes over 130 members, including representatives from public, private and non-government agencies providing services to people with brain injury in Queensland, brain injury researchers, advocacy services and policy makers.

QBISM members support the implementation of a no-fault Lifetime Care and Support Scheme (LTCSS) for all people catastrophically injured in road traffic accidents (RTA) in Queensland. Through provision of services to participants in the NSW LTCSS, and the Victorian Transport Accident Commission (TAC) scheme, our members have experienced first-hand the benefits of a lifetime care model. The flexible, individualised, lifelong funding delivered under a LTCSS enables a focus on optimising independence, supporting opportunities for participation, and responding proactively to changes in individuals, their environments and life stages over time. A no-fault LTCSS can support clinically based service provision, in contrast to the resource rationing approach which appears to underpin existing responses to the needs of people catastrophically injured in RTAs in Queensland. Additionally, a no-fault LTCSS will enable opportunities for Queensland to honour the UN Convention on the Rights of Persons with Disabilities by addressing environmental barriers that hinder the full and effective participation of people with RTA acquired catastrophic injury in the Queensland community. Support for the development of specialist brain injury rehabilitation services which are currently lacking in most areas of the state (Queensland Health, 2015), will optimise opportunities for comprehensive rehabilitation for all Queenslanders with brain injury.

Fundamentally, the design of the proposed NIIS should promote opportunities for choice and control for people who acquire catastrophic injuries. Access to some form of lump sum payment and opportunities for self-directed funding can enhance opportunities for choice, enabling individuals to purchase suitable housing and choose how and where their lifetime care and support needs are met. Consideration of entitlements under the existing TAC scheme is recommended. Under the TAC scheme, seriously injured persons are entitled to pursue a lump sum settlement for economic loss and pain and suffering, but not future care, as care and support are funded on a lifelong basis by the TAC. Additionally, those unable to establish another's fault in causation of their injury are entitled to receive a 'no-fault' lump sum impairment benefit up to the value of $333,630. Adoption of similar entitlements in Queensland would enhance opportunities for choice and control for seriously injured persons. Additionally, opportunities for self-directed funding, through periodic payments to cover care and support needs should be promoted. Self-directed funding opportunities are currently available in other LTCS schemes, with the TAC finding that clients who receive monthly payments to cover their care and support needs report higher satisfaction, demonstrate improved outcomes and spend less than other TAC clients (Cromarty, 2014).

QBISM members identified a number of concerns if 'one-off' lump sum settlements for future care are retained:

1. Lump sum settlements are often inadequate to meet lifetime care and support needs after traumatic brain injury (TBI), sometimes expiring within five to ten years post injury (Harrington, 2013). If an individual's funds are dissipated within Centrelink preclusion periods, there are few viable avenues for providing ongoing support. This situation is likely to be exacerbated under existing legislation governing the NDIS and the NIIS MVA Agreed Minimum Benchmarks, which reduce eligibility for funded supports on the basis of compensation settlements.

2. Individuals with TBI and cognitive impairments who receive lump sum settlements are vulnerable to financial exploitation by others, particularly if a legal guardianship order is not in place. Difficulties with executive functioning and impulsivity increase the risk that settlement funds will be dissipated prematurely. While safeguards, such as legal guardianship orders and trustee management of funds may be in place, these measures do not guarantee the sustainability of settlement funds.
3. Service access often declines post-settlement under the existing CTP scheme, as families choose to discontinue services in an attempt to make settlement funds last. This is illustrated in the attached case studies 1 and 2, which are drawn from clinical practice. Case Management (CM) support is often the first thing that families drop. For those injured as children, this usually occurs just as a child is leaving paediatric services. This is a crucial time when CM needs to be in place to help the family appreciate that their child is an adult, with the right to make choices regarding how their care and support needs are met. CM and access to specialist therapies/supports, including vocational rehabilitation, enables opportunities for increasing independence, assisting young people to move out of home, develop employability skills, and participate in social and economic life. If individuals have negated their entitlement to LTCS through receipt of a lump sum settlement for future care these opportunities may be denied.
4. Housing accessibility is restricted once a compensation lump sum is received. Individuals receiving lump sum settlements are precluded from accessing social housing. However, if an individual uses their lump sum to purchase housing, they run the risk of running out of settlement funds within their Centrelink preclusion period. Individuals receiving lump sum settlements for economic loss, pain and suffering and future care are at risk of homelessness, if they are required to sell their home to meet their income and care and support needs within Centrelink preclusion periods. Case study 3 details an Administrative Appeals Tribunal of Australia case where this appeared to be the likely outcome.

Recommendations for Scheme Design

Adoption of the Clinical Framework for the Delivery of Health Services to guide funding decisions within the LTCSS is recommended. This framework has achieved national support from all Australian states and territories as well as a range of health peak bodies and associations (MAIC, 2016). The scheme should promote the core principles underpinning the clinical framework, including:

- measurement and demonstration of the effectiveness of treatment
- adoption of a biopsychosocial approach
- empowering the injured person to manage their injury
- implementing goals focused on optimising function, participation and return to work
- basing treatment on best available research evidence

Additional recommendations include:

1. Care needs to be clinically justifiable: Specialist private service providers are well versed in writing clinical justifications, linking with the legislation. Non-specialist/public providers will need to be upskilled in writing clinical justifications to ensure equitable access to services to empower injured persons to manage their injury, an implement goals focused on optimising function, participation and return to work. The scheme will need to employ and train highly skilled case managers who adopt evidence based practice and are aware of the full range of entitlements under the scheme.

2. Access to funding to provide one-to-one teacher aid assistance to children in schools, one-to-one support for young adults attending educational and vocational training, and on the job support for those entering the workforce is recommended. Development of specialist vocational rehabilitation services for people with brain injury is also recommended.

3. The legislation needs to reflect opportunities for social participation in addition to employment and education. The scheme needs to support leisure and recreation access, in the same way the NDIS does. Access to leisure and recreation is important for the large number of people with catastrophic injury who do not have the capacity to return to open employment. This is particularly important for children as they transition to adulthood and have not had the opportunity to develop employability skills.

4. In accordance with the UN Convention on Rights of People with Disability, LTCSS participants should be able to choose their place of residence and where and with whom they live on an equal basis with others in the community. Although existing lifetime care schemes will fund 24 hour in-home care to support an individual's move into an independent living environment, access to affordable modified housing is not covered under existing entitlements. QBISM members recommend the adoption of a no-fault impairment benefit, similar to provisions under the TAC scheme, which can be delivered in a lump sum to enable housing purchase. There needs to be protection for an individual if a family home is modified using insurance funding (e.g. addition of injured persons name to deeds of ownership to protect the individual's interest in the house). A LTCSS should promote choice in accommodation through adopting options available in other Australian states such as:

- supporting independent living through the provision of 24 hour in-home attendant care
- funding installation of a wheelchair accessible self-contained demountable unit if a home is unmodifiable
- funding home modifications/demountable installation, therapist travel time, and attendant care to enable rural and remote participants to continue to live in their local communities.

5. The scheme needs to support the sustainability of informal supports by funding access to counselling for family members, respite and family support and education programs.

6. Ongoing monitoring of care and support needs is required to promote individual opportunities for choice and increasing independence over time.

7. Current approaches to determining what is reasonable and necessary care after catastrophic injury are inconsistent across Queensland's multiple private CTP insurers. A centralised government body, established under the NIIS, should promote equitable responses to all people with catastrophic injury and help to deliver integrated care over each individual's lifetime. The presence of a centralised body in other Australian jurisdictions has promoted the development of specialist services focused on optimising function, social and recreational participation and return to work for those with serious injuries. The experience of no-fault jurisdictions is that integrated service delivery and the availability of specialist rehabilitation services has improved participant outcomes and reduced the lifetime cost of injury (Productivity Commission, 2011).

QBISM members value the opportunity to contribute to this important reform, which has the potential to significantly improve the long term health and wellbeing of people who experience catastrophic injury and their families in Queensland. We would be pleased to provide further information to support the committee's deliberation on the most suitable model for implementation of the NIIS.

kind regards,

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QBISM Convenor

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Case Study 1

Jordan is a 15 year old boy who sustained a severe traumatic brain injury in February 2012 (aged 11yrs) when he was struck by a car outside of his school. According to his MRI findings, Jordan also sustained spinal cord trauma with contusion seen within the spinal cord from C3-C7. Jordan also sustained multiple skull fractures, fractures of right femur, tibia and fibula and left undisplaced Os calcis (left foot) fracture. Jordan was known to have pre-morbid learning difficulties.

As a result of his TBI, Jordan has a right sided weakness, high frequency hearing loss, severe speech and language dysfunction, executive dysfunction and more severe cognitive difficulties. Jordan later developed emotional issues particularly low mood and difficulty relating to his brother.

Upon acceptance by his insurer, the following therapies and support were put in place after discharge from hospital:

- Speech therapy to improve literacy skills and social communication
- Physiotherapy to improve strength, balance and endurance
- Occupational therapy to improve ability to carry out everyday living skills
- In-home respite as parents ran a take-a-way shop requiring their attendance in the evenings. Jordan required supervision and it was deemed as inappropriate to expect the brother to provide this.
- Additional teacher aide time (in addition to teacher aide time provided by Education Queensland) at school to facilitate his adapted educational program. Jordan's parents were insistent that he attend the same high school as his brother but this school was not well equipped to provide specialist programs. The school accepted him after it was agreed that additional teacher aide time be funded by the insurer.
- Case management- to facilitate goal setting, co-ordinate services and liaise with school and respite staff.
- Psychological counselling for low mood and parents' concern about self esteem.

In addition Jordan was referred to Queensland Paediatric Rehabilitation Service, based at Lady Cilento Children's Hospital (formerly based at Royal Children's Hospital) for long term specialist support and monitoring. Jordan has also been provided with a range of medical/health services including audiology, ENT, orthopaedics, ophthalmology, respiratory physician.

Recently the family settled Jordan's claim with the insurer and a lump sum has been put into a trust fund. Since this time, the family have ceased all therapies, case management and extra aide time at school. They reported that they wanted to keep his funds for when he married. They also prefer to use the funds for eastern style medicine, including travel to Korea.

An immediate consequence for Jordan is not coping at his high school because extra supports are no longer in place and this particular school does not have an equipped special education unit. As well as teacher aide time, the private SP and OT were providing valuable information, programs and ideas for the school staff. A change in schools is now being considered. Jordan may be more susceptible to ongoing mood and esteem issues.

Case Study 2

Camy was 10 months of age when she was involved in a high speed MVA in 2009, travelling in an appropriate car seat. The vehicle was driven by her maternal grandmother and her young maternal aunt (aged 10 years) died in the crash.

On arrival of QAS, GCS was 3 with a blown right pupil. A left tension pneumothorax was decompressed at the scene. CT revealed right parietal, left occipital and left mastoid base of skull fracture. There was severe diffuse axonal injury, subarachnoid haemorrhage, bilateral subdural haemorrhage and a right thalamic intraparenchymal haemorrhage with associated IVH. Later brain imaging (MRI on 24-11-2009) showed features consistent with diffuse axonal injury and hypoperfusion injury.

As a result of her TBI, Camy has spastic quadriplegia, seizures, severe developmental delay, cerebral visual impairment, right optic neuropathy, hearing impairment, severe dysphagia, chemical burn to her left foot with subsequent grafting and varus deformity, PEG fed.

Upon acceptance of the claim, the following therapies and supports were put in place after discharge:

- Case management. The case manager's role was to seek out services, set up initial assessments, co-ordinate appointments, share information, provide and organise transport as required, assist with organising delivery of feeds and medications to local hospital, advocate on behalf of Camy and family.
- Physiotherapy, Occupational Therapy and Speech Therapy: The family had limited capacity and resources to get to appointments and therefore therapy was undertaken in conjunction with out of home respite, twice per week.
- Equipment, including modified buggy, bed, bath chair, seating equipment, hoist, standing frame etc
- When old enough for Early Childhood Development Program (ECDP) transport was funded by insurer
- Botulinum toxin injections for spasticity management
- Feeds and continence aids
- Air-conditioning

Camy's family sought early settlement and this was finalised in early 2015. Since this time, the family have ceased private therapies and case management. The family have private respite once per month. Camy's therapy program occurs at school with the Education Queensland Physiotherapist and Occupational Therapist providing consultation for needs relating to educational goals. Camy's access to Speech Pathology with Education Queensland is limited.

The cessation of therapies will impact on Camy's ability to reach full potential particularly with communication which is so vital to participation in later life. There is real concern that physical skill development may be compromised. Therapies are also able to delay further complications (contractures, hip subluxation, scoliosis) and therefore these complications may develop earlier.

As Camy has received a settlement, the family will not have access to government funded aide programs such as MASS (for equipment), continence aids subsidy scheme and disability funded schemes for respite, recreation etc. as these expenses will need to come out of her pay-out. Prior to the settlement the family demonstrated difficulty with following through with recommendations in respect to Camy's programs and therefore there is concern now how the family will cope with managing the funds themselves and sourcing Camy's needs.

Case Study 3

Brad acquired a spinal cord injury in a MVA in 1993 at the age of 16, which resulted in his being confined to a wheelchair with T11 paraplegia. In March 1997 Brad received a lump sum settlement of $1,120,000 which included a component of economic loss. He was subsequently informed that he would be subject to a preclusion period for Centrelink payments until September 2012. After deduction of costs and debts Brad received $890,000 of his original settlement sum.

Initially after his accident Brad returned home to live with his parents and completed year 12 in 1995. In 1996 he commenced a course in business administration at Maryborough TAFE, but during the year he lost interest in the course and did not continue with it. He moved into rental accommodation with his brother in Maryborough in 1997, and later moved in to a wheelchair accessible property with his girlfriend. His relationship with his girlfriend ended in March 1998 at which time he began use of amphetamines. Later in 1998, Brad met his future carer, Steve, who was also involved in using amphetamines, and was four years older than Brad. In 1998, Brad purchased the house where he was living, after much damage was done to the interior of the house during a period of high amphetamine use. Brad's drug-taking practice had commenced when he returned to high school with the use of marijuana, and developed in 1998 with the use of amphetamines. From 1998 to 2001 Brad was spending up to $500 per day on drugs. He had multiple admissions to Maryborough Base hospital from 1999-2001 for management of bilateral trochanteric pressure sores and subsequent infection of these. This medical condition was complicated due to his serious amphetamine abuse problems which impacted on his self-care and lifestyle problems.

In 2002 Brad had a difficult year as he withdrew from drug use. During this time, he experienced difficult personal relationships, including his relationship with his carer, to whom he supplied drugs, and who stole a sum of approximately $15,000 from him. By mid-2002 Brad no longer had any funds in managed investment. He applied to Centrelink to have his preclusion period for government benefits reduced in 2002 and later to the Social Security Appeals Tribunal in 2003. Both applications were unsuccessful. In May 2003, Brad sought a review of the SSAT decision by the Administrative Appeals Tribunal of Australia (AAT). At the time of his AAT review in March 2004, Brad reported that his only source of income was the $150 per week her received in rent from his live-in carer. His remaining assets included a car which had been modified to enable him to use hand controls, and a house. He valued these at $18,000 and $95,000 respectively.

Welfare Rights submitted to the AAT that Brad suffered from an extreme injury at a very young age which severely impacted on his mental health. They submitted that the underlying cause of Brad's drug addiction was the trauma and loss he experienced as a result of the loss of use of his legs, and that Brad had never received counselling to address the underlying issue of his loss and trauma, nor financial counselling prior to receiving his lump sum settlement. Brads *'drug addiction plus his lack of mobility led to a social isolation which left him in a situation with a carer who was similarly addicted and as a result took advantage of his ability to buy large quantities of drugs and eventually stole from him and destroyed his property'* (Marsh and Secretary, Department of Family and Community Services (2004) AATA 228 (5 March 2004), s.17). Welfare Rights expressed concerns that without a source of income and no savings, and with no training or employment prospects Brad would be at serious risk if his AAT appeal was unsuccessful, and he was required to sell his car and house. Brads AAT appeal was unsuccessful and it is unclear what is progress has been since that time.

National Injury
Insurance Scheme:
Motor Vehicle Accidents

Consultation Regulation Impact Statement Response

Quarterly Brain Injury Services Meeting Group
May 2014
Amended Version

SCOPE

The views presented in this response draw upon the experiences of QBISM members from public, private and NGO services for people with brain injuries and their families in Queensland. The response integrates data from published literature and recent research projects; previous consultations with QBISM members; the QBISM Positioning Paper: *A Comprehensive Service System for Queenslanders with Brain Injury* (August 2013)*;* the Queensland Government Office of the Public Advocate publication: *People with intellectual disability or cognitive impairment residing long-term in health care facilities*: *Addressing the barriers to deinstitutionalisation A systemic advocacy report* (October, 2013); and the 2014 Queensland Joint Solutions Forum coordinated by the Young People in Nursing Homes National Alliance. It is acknowledged that this response may not reflect the views of all QBISM group members, due to the limited time frame for developing a group response.

STATISTICAL SOURCES

Australian Institute of Health and Welfare 2011. Disability support services 2009–10: report on services provided under the National Disability Agreement. Disability series. Cat. no. DIS 59. Canberra: AIHW.

Harrison, J., Henley, G., & Helps, Y. (2008). Hospital separations due to traumatic brain injury, Australia 2004-05. (Injury research and statistics series no. 45. Cat. no. INJCAT 116) Canberra: AIHW. Retrieved from http://www.aihw.gov.au/publication-detail/?id=6442468147>

Responses to Questions

Question 1: Is this chapter a correct statement of the problem?

Response to Question 1:

Yes, this chapter is a correct statement of the problem. However, it should be noted that the long lasting impacts of catastrophic injury do not only fall on the injured person, but also on many others. The health and wellbeing of family members and loved ones, particularly those who undertake gratuitous care post-discharge, are particularly vulnerable. Failure to deliver timely and adequate rehabilitation, care and support services has significant impacts on the social and economic participation of both people with catastrophic injuries and their families.

Question 2: Do you think there were other problems created by the *status quo* as it stood in 2011?

Response to Question 2:

QBISM members identified other problems created as a result of the status quo as it stood in Queensland in 2011 as outlined below:

- People with ABI lack support to negotiate the pathway through medical services, hospital-based inpatient/outpatient rehabilitation, transition to the community and ongoing community-based rehabilitation to enable optimal outcomes after catastrophic injury.

- Existing fault-based insurance arrangements in Queensland do not ensure certainty, timeliness and access to services along the rehabilitation continuum. Access to specialist community based rehabilitation services, in particular, may be delayed due to disputes over liability to fund services, and a general lack of supply in the public health care system.

- In the endeavour to meet reduced length of stay requirements of the health care system, families or loved ones may be pressured to take clients home from hospital to release beds.

- Family members may feel pressured to undertake gratuitous care, with limited formal support or education available to help them sustain these roles.

- Lack of adequate resources leads to unsuitable and unsupported discharges of people with catastrophic injuries that can result in avoidable readmissions or further decline in functioning and independence.

- Bed Blocking occurs in acute hospitals and slow stream rehabilitation services – as outlined in the Office of the Public Advocate (2013) report on people with disabilities in long stay health care facilities. Prolonged stays in health facilities are most likely for three groups of people with catastrophic injuries including: non-compensable persons who are unable to access adequate funding for community based support; those with insurance claims pending; and those who have already received compensation settlements but have unexpectedly depleted their settlements, or are unable to purchase adequate services despite their compensation.

- People without compensation struggle to sustain the costs of prolonged admissions to state rehabilitation and residential facilities, shifting the economic costs of injury onto individuals and their families who often fund or deliver additional services.

- Some families fear that young persons will be discharged from health facilities to Residential Aged Care (RAC), and therefore advocate for young people to remain in costly institutions (hospitals and slow stream rehabilitation facilities) where they believe they will be cared for.

- Prolonged stays in health care settings can result in institutionalisation and loss of functional gains made in rehabilitation, increasing care needs and potentially escalating long term care costs and increasing the likelihood that compensation payments will be inadequate to cover lifetime care needs.

- Due to improved survival rates over the past two decades, there is increasing pressure on disability services to provide funding for catastrophically injured persons – both with and without compensation and those whose settlement funds have (or will) expire.

- There is pressure on not-for-profit service providers to cover gaps in allocated funding, often without sufficient resources or education to manage the effects of catastrophic injury.

- Settlements for lifetime care are prone to early expiration and unable to sustain the support needs of young people with significant disabilities. The longevity of settlement funds varies widely, however specialist brain injury service providers report that funds may expire within five to ten years in some cases of motor vehicle accident (MVA) acquired severe traumatic brain injury (Harrington, 2013).

- Despite advice to delay settlement until a catastrophically injured child reaches maturity and the full extent of their lifetime care and support needs becomes evident, some families settle early and are thus at risk of accepting inadequate settlement sums.

- There is a significant reduction in supports available as catastrophically injured children transition from paediatric to adult acquired brain injury services. Many young people become trapped in institutional care as family caregivers age and become unable to provide additional support, and as service options in the community decline.

- Consumers and their families do not have a good understanding of funding arrangements and services delivered across multiple government departments and service sectors. In the absence of a centralised funder, service access is often fragmented and difficult to negotiate, requiring families to act as case managers as well as providing significant amounts of care.

Question 3: Do you have any data of the quantum of these problems, i.e. existing costs?

Response to Question 3

Queensland has the highest national rate of ABI disability (82,600 cases reporting disability status after ABI compared to 77,800 in NSW, 73,800 in Vic, 31,000 in SA) (Australian Institute of Health and Welfare, 2007). In a single year (2004/05), there were over 8300 hospital admissions related to ABI in Queensland (Turner & Doherty, 2006). It is unclear what proportion of these admissions were attributable to MVA related ABI. However, road traffic accidents accounted for 61.4% of cases of Traumatic Brain Injury (TBI) (N=635) admitted to intensive care units located in major trauma centres throughout Australia and New Zealand over a 6 month period in 2000/01 (Myburgh et al., 2008). Over half (57.2%) of all cases had sustained a severe TBI.

Direct costs for hospital care for all cases of TBI in Australia were estimated to be more than $184 million in 2004-05 (Harrison, Henley & Helps, 2008). Those hospitalised as a result of MVAs (29.4% of all TBI as Principle Diagnosis cases) had the longest length of stay and the highest overall cost of hospital care (46% of total costs, $85.6 million) in comparison to other TBI related major injury groups, such as falls (42.2% of TBI as Principle Diagnosis cases, 34% total costs, $62.7 million), and assault (15% of TBI as Principle Diagnosis cases, 8.5% total costs, $15.6 million) (Harrison, Henley & Helps, 2008). In 2011, the anticipated length of stay for compensable adults with MVA related severe traumatic brain injury (sTBI) and high and complex care needs in state hospital settings in Queensland was twelve to eighteen months post injury, in the experience of focus group participants (Harrington, 2013). For those unable to access compensation, delays to discharge can be several years.

The Office of the Public Advocate report (2013) provides data regarding the number of young people with disability (including those with severe acquired brain injuries) residing in long stay health care facilities in Queensland and their length of stay. This report includes a cost analysis illustrating the cost saving benefits of supporting more timely transitions from acute hospital units to community based settings for adults with ABI and high care needs.

Question 4: Do you agree these are the main objectives for government action?

Response to Question 4:

Yes, these are the main objectives with additions suggested below.

Question 5: Have any important considerations been left out?

Response to Question 5:

Additional objectives suggested by QBISM members include:

- in a way that is consistent with the principles of the NDIS

- in a way that ensures appropriate, affordable accommodation options are available through partnerships with Disability Services, Housing, Health and the private sector, in line with the principles of choice enshrined in the NDIS.

- in a way that supports the sustainability of informal care networks and the caring role of families

How is equitable defined in regard to the impact of proposed changes on each State and Territory and their residents?

Question 5: Do you agree with the description of the base case?

Response to Question 5:

Yes. However, clarification of the role of government in negotiating adequate lump sum settlements for those entitled to pursue compensation, and in meeting the lifetime care needs of those whose compensation settlements expire is recommended under this option. It is unclear who will take on the responsibility to fund lifetime care for those who accept (or have accepted) inadequate settlement funds or whose funds expire.

In Queensland, service access commonly declines post settlements as families cease funding maintenance therapies and support services in an attempt to make settlement funds last. If this results in significant functional deterioration and increased long term care costs, who will meet these additional costs when family care is no longer sustainable?

Formalised systems for monitoring the care and support needs of persons who are catastrophically injured, in the years post settlement, are largely absent in Queensland. Individuals and their families often only contact specialist services in times of crisis or when settlement funds are about to expire. Hence, a proactive approach to supporting the sustainability of family care and preventing functional deterioration over the long term is lacking under the base case.

QBISM members have identified the lack of a range of appropriate accommodation options as one of the key priorities for brain injury service development in Queensland. Under the base case it is unclear how capacity building within the housing and supported accommodation sector will be facilitated to enable a range of accommodation options for people living with catastrophic injuries.

Question 6: Are options 1 and 2 reasonable and appropriate?

Response to Question 6:

Yes. Option 1 appears to be a fairer option.   The selected option should be the same in all states to ensure all Australians have equitable access to funding, rehabilitation and support services. Option 1 enables access to care, support and rehabilitation throughout an individual’s lifetime, and the adjustment of these supports as individual needs and circumstances change.

Option 2 appears to provide limited capacity for the development of an integrated systemic response to the needs of adults with catastrophic injury in Queensland.

Existing state government MVA insurance bodies, such as the TAC in Victoria, and the Lifetime Care and Support Authority in New South Wales, have invested in building capacity in specialist rehabilitation or lifestyle support services. They have also engaged in collaborations with a wide range of state government services to help improve the post injury pathways of people with brain injuries and their families. A recent inquiry by the Office of the Public Advocate (2013) indicated the need for similar integrated service planning to help better meet the needs for those with complex and high care needs in Queensland. The creation of a state based catastrophic injury insurance scheme in Queensland under option 1 has the potential to provide both the structure and funding required to promote capacity building in specialist rehabilitation services and improved management of transitions through the rehabilitation continuum.

Options need to be fair and equitable, ensuring that the costs of lifetime care are shared equitably across the Australian population. Under the base case (and to some extent option 2) costs are not shared equitably across jurisdictions, with some of the cost of MVA related catastrophic injury transferred onto commonwealth budgets, via funding for health care, community care, residential aged care, and disability support and carers pensions. It appears unreasonable to expect the commonwealth government to continue to fund these costs, which are borne by the Australian tax payer, when residents in states and territories with no fault schemes already pay higher CTP premiums to cover the costs of all catastrophic injuries under their own schemes.

Question 7: Do you agree that there are no feasible non-regulatory options?

Response to Question 7

Yes. Reform to court processes will not foreseeably impact on the adequacy of lump sum settlements negotiated predominantly through out-of-court processes or insure that funds awarded in settlement last an individual's lifetime.

Question 8: Is this a correct assessment of the base case?

Response to Question 8

It is unclear whether the projected costs of providing lifetime care to those whose compensation funds expire is included in the costs estimates provided. Does this need to be factored into the cost estimates?

Question 9: Do you have any data on current impacts such as scheme operating costs, CTP premiums or current NDIS contributions (i.e. prior to 2019-20)?

Response to Question 9

No

Question 10: Do you agree with the identified impact of option 1 on people with catastrophic injuries?

Response to Question 10

It is anticipated that option 1 will also result in additional quality of life impacts for people with catastrophic injuries and their families. The process of seeking compensation can interfere with the adjustment process after severe traumatic injury, and the adversarial nature of the litigation process adds to the experience of stress and trauma at a very stressful time (Gething et al. 2002). Harrington (2013) found that while people with MVA related sTBI and their families experienced 'pressured lives' in response to difficulties accessing adequate funding, services or support in Queensland, those compensated under the no fault TAC scheme in Victoria experienced a 'sense of security' in response to their clear entitlement to lifetime care and support. This sense of security helped to alleviate anxieties related to the claims settlement process, supported the sustainability of family care roles, and enabled the ongoing workforce participation of family members. Although these findings should be viewed with caution, due to the small sample sizes involved, they are consistent with the proposed benefits of no fault reforms to common law schemes.

Question 11: Do you have any data or analysis on the expected change in insurance premiums for individuals under option 1 (including on the level of current premiums)?

Response to Question 11:

No

Question 12: Do you have any data on any of the other identified impacts on individuals, businesses and the community under option 1?

Response to Question 12:

The presence of multiple CTP insurers in Queensland results in no consistent approach to services for individuals with catastrophic injury. Having a centralised funding and administrative body under the NIIS will alleviate inconsistencies and inequities for individuals and help build a strong community of services and supports.

Question 13: Are there any costs or benefits for individuals, business and the community under option 1 that are not identified here?

Response to Question 13:

Option 1 lays the foundation for capacity building in specialist rehabilitation and lifestyle support services which are currently lacking in Queensland. Early and sustained access to intensive rehabilitation after ABI helps to reduce disability, restore function and improve participation. Additionally, access to multidisciplinary teams with specific expertise in brain injury rehabilitation improves long term outcomes, decreases care needs and has the potential to significantly reduce long term care costs (Turner-Stokes, 2008). It is anticipated that adoption of option 1 will significantly improve functional recovery and participatory outcomes for both those entitled to pursue a common law claim, and those who are not, as funded access to specialist rehabilitation services is included under this option. Enhancement of specialist service system capacity in Queensland also has the potential to benefit those acquiring ABI from non-injury related causes.

Question 14: Do you have any data on the identified costs on States and Territories of option 1? Specifically, can you provide updates of number of annual expected claims, average size of expected claims and annual expected total costs including administration?

Response to Question 14:

Two common law settlements exceeding 9 million dollars have been reported in the media in Queensland in the past six years including a $9.6 million settlement awarded to a twelve-year-old boy who sustained non-MVA related, catastrophic injuries in an accident at his Southport School and a $9.5 million settlement awarded to a woman seriously injured during a police chase on the Gold Coast. It is unclear whether the value of these settlements will significantly affect the average size of expected claims in Queensland under option 1, but it may impact on anticipated claims costs if the base case is retained.

Question 15: Are there any other costs or benefits to States and Territories of option 1 that are not identified here?

Response to Question 15:

In addition to risk mitigation strategies focused on decreasing serious road traffic accidents, state governments may decrease the lifetime costs of injury through increased investment in developing an organised system of trauma care which includes the full continuum of rehabilitation services. The trauma system developed under the TAC in Victoria has been shown to reduce mortality rates and improve functional outcomes after serious injury (Gabbe et al., 2011, 2012).

Question 16: Do you agree with the impact of option 1 on the Commonwealth Government?

Response to Question 16:

Refer to response to Question 6

Question 17: Do you expect that jurisdictions will alter insurance premiums to target the risk profile of individual motorists?

Response to Question 17:

This would not reflect the history of the scheme in Queensland which has adopted a ‘community rating’ for CTP premiums in the past. However, it is unclear whether this would be retained under proposed changes.

Question 18: Do you have any information as to what the design of each State and Territory insurance provisions will be?

Response to Question 18:

No

Question 19: Do you have any data of the impact of option 1 on insurance design or insurance providers?

Response to Question 19:

No

Question 20: Do you believe this is a correct assessment of the likely impact of option 1?

Response to Question 20:

Yes

Question 21: Do you believe that States and Territories could pool their insurance? If so, what impact would this have on premiums and would it be government underwritten or provided by the private sector?

Response to Question 21:

Pooling of insurance by states and territories may negate the capacity or incentive for strategic service planning across health, disability and housing departments at a state level.

The history of privatisation within the New Zealand ACC scheme and subsequent reinstitution of government underwriting of the scheme would seem to indicate that government underwriting is a preferable option for Lifetime Care and Support Schemes.

Question 22: Do you believe this is a correct assessment of the impact of option 2 on individuals, businesses and the community?

Response to Question 22:

No. Consideration of the lost potential for recovery related to limited access to early intervention services and timely transitions through the rehabilitation continuum under this option is recommended. The Office of the Public Advocate report (2013) and YPINH report (2014) on the *Queensland Joint Solutions Forum* both highlight the functional deterioration experienced by young adults with disabilities residing in long stay health care facilities in Queensland. Under option 2 it is unclear whether these issues will be addressed. If there is no requirement for state governments to meet minimum benchmarks of the NIIS within a designated time period, it is unclear whether state institutional care will remain the fall back option for meeting the long term care needs of adults with MVA related catastrophic injuries and high care needs. Institutional care options, if adopted, may adversely impact on the quality of life and recovery of both those unable to access compensation currently and those who will lose their entitlement to awards for future care under this option.

There is potential that state governments may de-invest in delivery of specialist rehabilitation services to catastrophically injured adults with high and complex care needs under this option. A previous government inquiry (Review of the Queensland CTP Scheme, 1999) highlighted that while access to rehabilitation can significantly improve an individual’s quality of life it may not be translated into decreased claims costs. Access to rehabilitation under option 1 would be an entitlement for all persons catastrophically injured in MVAs. This would not be the case under option 2. In the absence of clear entitlements, it is unclear whether rehabilitation will be provided to those who are slow to recover after injury who require ongoing access to rehabilitation services to enhance their participatory capacity. Importantly, failure to provide rehabilitation in these cases means that opportunities for improvement may be overlooked. Similarly, access to specialist community based rehabilitation services which can improve social and workforce participation after injury may not be supported.

Specialist rehabilitation services for people with catastrophic injuries in Queensland have predominantly been delivered in state hospitals. Historically, a hospital and emergency services levy has been collected at the time of vehicle registration to cover a reasonable proportion of the estimated cost of providing public hospital and emergency services to compensable patients. In 2008, the cost of providing health care services, including rehabilitation, to CTP insurance eligible patients had consistently exceeded the revenue from the hospital services levy, with the state health department meeting the shortfall (Queensland Health, 2008, p.53). This was in contrast to other Australian jurisdictions, such as New South Wales and Victoria, which allow full cost recovery for health care services provided to compensable persons (Queensland Health, 2008, p.53).

Adequately funded public hospital and emergency services play an important role in promoting: timely access to required trauma and rehabilitation services while liability is determined on a claim; equity of access across compensable and non-compensable populations; and the development of integrated multidisciplinary care pathways. However, under current funding arrangements, most Queensland Hospitals do not offer the comprehensive suite of rehabilitation services (including community based rehabilitation teams for people with ABI) available in other jurisdictions (QBISM, 2013). A reliance on the rehabilitation services provided by public hospitals appears to have provided limited impetus (or funding) for development of private sector services in many areas. Hence, even those with private health insurance funding may not be able to access the specialist rehabilitation services they require to optimise outcomes after injury under option 2 (as private sector services may not exist in their local area). Those from regional and rural areas are at increased risk of inadequate service access, due to limited service capacity in these areas. Neglect of service development in this area restricts Queensland to a reliance on costly inpatient services rather than more sustainable community or private services.

Question 23: Do you believe this is a correct assessment of the impact of option 2 on State and Territory governments?

Response to Question 23:

The impact of option 2 on State and Territory governments is reliant on the negotiated level of responsibility for health care funding at a state level. If hospital admission costs are funded at a state level, then the Queensland state government would bear the full burden of current cost inefficiencies in the health care system. Under current funding models part of this cost is borne by the Commonwealth Government.

The potential for functional deterioration under option 2 could also significantly increase lifetime care costs for people with catastrophic injury who enter the NDIS at a later stage. These increased costs would be borne by the Queensland state government under option 2.

Question 24: Do you believe this is a correct assessment of the impact of option 2 on the Commonwealth Government?

Response to Question 24:

This assessment does not highlight potential cost increases to the Commonwealth Government by way of funding for Health, Commonwealth Rehabilitation Services, Carers Pensions, Carers Allowances, and Residential Aged Care (RAC) subsidies (if RAC remains a placement option while state based schemes are developing their policy response). Lack of specialist rehabilitation services, particularly in the area of vocational rehabilitation, may increase reliance on Disability Support Pensions for those unable to pursue common law settlements for economic loss.

Question 25: Do you believe this is a correct assessment of the impact of option 2 on injured people and service providers?

Response to Question 25:

There may be significant impacts on specialist private sector rehabilitation and case management services which predominantly cater for adults catastrophically injured in motor vehicle and workplace accidents if private CTP insurers are no longer required to cover these costs under option 2. Introduction of both the NDIS and the NIIS will require all service providers in the community to ‘step up to the plate’ and meet the increased demands of the sector. Retaining the existing expertise within specialist private sector services which provide services to CTP, TAC and LTCSS scheme participants, will help to enhance workforce capacity in response to increased demands. Maintenance of specialist expertise in state hospital and slow stream rehabilitation services is also vital.

Question 26: Do you believe this is a correct assessment of the costs and benefits of option 2?

Response to Question 26:

No. Refer to responses above.

Question 27: Do you have any data from consultation that has been conducted?

Response to Question 27:

The data presented in this response draws upon the experiences of QBISM members from public, private and NGO services for people with brain injuries and their families and other sources as outlined in the scope of this document.

Question 28: Do you have any comments on how each of the options meet the identified objectives?

Response to Question 28:

See responses above.

Additional consideration needs to be given to how the introduction of the NDIS and NIIS will meet the identified objectives for children with disabilities and their families. Parenting is integral to a child's development but the current system in Queensland does not always allow for adequate counselling for parents or engagement of families in the rehabilitation process which is known to result in improved outcomes. Therefore parenting capacity is compromised, and natural supports are depleted, leading to poorer outcomes for the child.

It is very unclear in paediatrics how the NDIS and the NIIS will affect services. There are concerns that current government therapy services (e.g. DSQ funded NGO's) will lose substantial funding which will lead to less integrated multidisciplinary services available to families.

Children with SCI or ABI have complex care needs, requiring tertiary level services. Currently, for children with funds via CTP or Better Start (cerebral palsy funding), it is difficult to find clinicians with the expertise or resources (equipment for trial, assessments etc.) to provide required services. There are negligible multi-disciplinary private practices for children.

Parents need specialist advice to make informed choices about service access. Who will pay for a child's health costs when they have further complications due to a family's ill-informed decisions to contract services which are not based on evidence or best practice guidelines? In order to ensure private therapies are evidence based and best practice, will there be supporting funds for research and health funded specialist tertiary services to provide/input into standards for ongoing care for children?

What if a child's or adult's injury is not deemed to be catastrophic? There are many children and adults who would fall into this category but still need services and support. People with SCI and ABI have complex disabilities. Many have comorbid medical or mental health conditions, or challenging behaviour, all of which can result in a high reliance on health care services and family care. Failure to meet these needs, or to respond in culturally sensitive ways to those from indigenous and other culturally and linguistically diverse communities, may undermine health, to the extent that individuals then become NDIS eligible. Under the base case and option 2, the Queensland state government would incur the additional liability of funding these NDIS participants.

Additional Comments from QBISM Members

The Base Case and the options only cover 'lifetime care and support' and not productivity losses. Any decision on the Options must include a strong emphasis on vocational rehabilitation and/or mechanisms to support claimants to pursue heads of damages for productivity losses (and the associated productivity losses of their caregivers).

Both Option 1 and Option 2 should include an opportunity cost for the value of lost wages forgone by the carer as part of the rehabilitation component and the potential for caregivers to provide rehabilitation or therapy assistance for their relatives in the absence of sufficient and more expensive therapy services.

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