Questions on possible options

1. What should be the most important features in any scheme reform?

That the injured get timely, evidence-based treatment.

2. On balance, which option or combination of options do you believe best addresses the priorities for improving the scheme and why?

Option three as it provides for the seriously ill, de-emphasises costs and pays for ongoing rehabilitation if required. It also is most likely to be accepted by all parties as there is room for some litigation in instances where the scheme doesn't fit the individual circumstance.

3. Does fault in an accident remain the most acceptable way of determining eligibility for benefits or is it more important that anyone injured on the road is covered, even if this means fewer savings in any reform?

No - it creates a 2-tier system for the compensation of injury.

4. Is it more important to reduce CTP prices or to extend benefits to more people?

Extend benefits

5. Are people better looked after if receiving a negotiated lump sum (often years) after the accident or receiving prescribed weekly benefits shortly after making their claim?

Prescribed weekly benefits

6. Should a greater proportion of funds go to the more severely injured, even if this means capping benefits or introducing an excess for low severity injuries?

Yes - the more seriously injured will require the larger proportion of costs

7. If Government retains common law, should there be tighter restrictions and caps on various benefits as is the case in other States, or if the Government adopted defined benefits should the caps and thresholds reflect what is paid in other States?

Costs of living in NSW are the highest in the country so the various benefits should reflect that and be pegged to CPI

8. If the Government retains common law, what is the best method and threshold to determine eligibility?

Functional status and ability to self care, return to work and drive.

9. If Government retains common law, what mechanisms should be adopted to resolve claims more quickly and avoid lengthy negotiations and disputes?

Set time period for assessments by the courts to ensure active treatment is being pursued at 6 months and 12 months

10. Should there be limits to legal expenses, especially for small claims, and should legal expenses be linked to the work performed or the value of the claim?

Limits to small claims, not linked to work performance but to injury, and to function.

Questions continue on the next page

Questions on other policy considerations

1. Should there be support or a safety net for anyone injured on the roads by vehicles that are not part of the insurance system (like bicycles) even if that increases the overall cost of CTP?

yes

2. Is it better to make a claim against your own insurer as opposed to the insurer of the at-fault driver, if so why?

Your own insurer, so you can control what benefits that you wish to pay for in the event of injury and what excesses

3. Should Government retain competitive private underwriting, or give consideration to a return to public underwriting delivery?

Public underwriting

4. How should Government best deal with fault (including injuries without another party to sue), illegal acts and contributory negligence in any reform?

They should all be covered by a no fault approach.

5. What changes to the CTP scheme could increase competition?

Allowing you to claim your injuries from your own insurer.

Catalogue no. SIRA 08056
State Insurance Regulatory Authority
Motor Accidents Insurance Regulation,
Level 25, 580 George Street, Sydney NSW 2000
General phone enquiries 1300 137 131 or
Claims Advisory Service 1300 656 919

Website www.sira.nsw.gov.au

NSW GOVERNMENT SIRA State Insurance Regulatory Authority

ST VINCENT'S HOSPITAL SYDNEY
A FACILITY OF ST VINCENT'S HEALTH AUSTRALIA

St Vincent's Hospital Sydney Limited
ABN 77 054 038 872

390 Victoria Street
Darlinghurst NSW 2010

Telephone 02 8382 1111
Facsimile 02 9332 4142
www.stvincents.com.au

21st April, 2016

CTP Review
State Insurance Regulatory Authority
Level 25, 580 George St
Sydney, NSW 2000

To the Hon Victor Dominello and all members of the CTP Review body,

Re: Options for reforming Green Slip insurance in NSW

As the Director of Rehabilitation and Pain Medicine at St Vincent's Hospital Sydney, and a researcher in the area of post-trauma rehabilitation, I and my research team welcome the opportunity to provide feedback on the proposed reforms to CTP insurance in New South Wales.

On the basis of my clinical experience together with my involvement in a number of large, multi-site clinical rehabilitation trials, including those specifically targeting road-trauma survivors, I offer the following comments.

- The provision of optimal patient care and thus the ability to achieve optimal functional outcomes following road-traffic related trauma is dependent on the implementation of evidence-based treatment. Thus robust clinical research needs to be integrated into our models of care whereby the provision of 'data' is an integral part of service provision, to ensure that treatments are effective and target outcomes are achieved. We propose that insurers only make payments for non-evidence based therapies, experimental and/or expensive treatments conditional upon the clinician's provision of appropriate functional patient outcome data before and after the procedure. This should not involve any treatments in the first 72 hours of injury.

- Imposing greater accountability for medical services offered following trauma may be another means of promoting evidence-based best practice. We suggest that the introduction of a PBS-like system for regulating post-trauma medical services may be warranted. Here, a 24-hour telephone hotline could be established from which

medical and surgical providers needed to seek an approval number for reimbursement prior to implementing a given treatment. This would be a fast system without delayed processing times, but could ensure that only justified, evidence-based treatments are being funded.

- While there is evidence to support the importance of integrated and early rehabilitation post-trauma, in reality we know that access to rehabilitation services may still be problematic. Data from linkage studies indicates that only approximately 1/3rd of patients admitted to hospital with moderate to severe injuries following road-traffic related trauma are accessing rehabilitation services 3-months post-injury. Patients state distance and inconvenience as major barriers to rehabilitation follow-up after trauma, and many have ongoing issues with pain, mental health disorders and limited functional independence. We propose that innovation in required to address this problem, and suggest telehealth as one possible solution. Providing rehabilitation consultations with specialist medical staff and rehabilitation interventions such as physiotherapy, occupational therapy and/or psychological follow-up/counselling via telehealth would be a cost-effective and timely means of engaging at-need patients in the rehabilitation process.

- From data collected in trauma rehabilitation trials, certain patient factors are associated with greater risk of persistent problems and hence slower rate of return to work following road-trauma injuries. Specifically, those patients with more severe injuries, greater levels of anxiety and higher catastrophisation scores at 2-4 weeks post-injury were identified as a group at high risk of chronic problems. We propose that this subpopulation is a particularly important target for rehabilitation services, and need to be identified early in the acute trauma setting. This also has important ramifications for the compensation process, by identifying individuals at high risk of ongoing dependence, disability and prolonged income compensation.

- Data is integral to advancing evidence-based treatment. From our experience, data currently collected from ITIM for acute trauma patients needs to be expanded and made more accessible via de-identified databases. In particular, Date-Of-Birth, Injury severity scores below 15 and discharge destination are insufficiently recorded at present. Measures of catastrophisation and psychological well-being would also be of value to facilitate the identification of high-risk patients, as above. In this way patients with high risk of chronicity and high rehabilitation needs could be identified early after injury and may receive early treatment either directly or via telehealth.

- We propose that introducing an index of case complexity may be useful to inform the allocation of funding, whereby complex cases require intensive resources, medical management and hence funds. We also note that case complexity should be monitored across public and private service providers, to ensure that private facilities are not exclusively dealing with less complex cases.

For the reasons I have outlined, data is critical to evaluating and improving optimal patient care and outcomes following road-trauma related injury. Via innovative approaches to data usage and the regulation of evidence-based service provision, the above suggestions aim to improve management of trauma survivors in a manner that is timely, cost-effective and feasible.

We thank you for your consideration of this feedback, and welcome further consultation and/or discussion on any of the issues raised.

Yours sincerely,

A/Prof Steven Faux
MBBS, FRACGP, FAFRM (RACP), FFPMANZCA

Director of Rehabilitation and Pain Medicine
St Vincent's Hospital, Sydney
Level 2 Sacred Heart Building,
170 Darlinghurst Rd,
Darlinghurst, NSW 2010
Email: [redacted]
T: +61 [redacted]
F: +61 [redacted]

Dr Jane Wu
MBBS, MPH, FAFRM (RACP)

Staff Specialist in Rehabilitation Medicine, PhD Candidate
St Vincent's Hospital, Sydney
Level 2 Sacred Heart Building,
170 Darlinghurst Rd,
Darlinghurst, NSW 2010
Email: [redacted]
T: +61 [redacted]
F: +61 [redacted]