National Injury Insurance Scheme: Motor Vehicle Accidents (2014):

"Consultation Regulation Impact Statement"

A submission by the

The Australian Orthotic Prosthetic Association (AOPA)

Submitted to:

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THE AUSTRALIAN ORTHOTIC PROSTHETIC ASSOCIATION Inc.

Executive Summary

The Australian Orthotic Prosthetic Association Incorporated (AOPA) is the peak professional body representing orthotist/prosthetists nationally and provides this response to the National Injury Insurance Scheme Regulation Impact Statement on behalf of the Australian profession.

Orthotist/prosthetists are tertiary qualified Allied Health Professionals who assess the physical and functional limitations of people resulting from illnesses and disabilities, including limb amputations, and provide orthoses and prostheses to restore function or compensate for muscular and skeletal disabilities. (Appendix One: Profession summary).

AOPA agrees that both the problems raised within the Regulation Impact Statement and additional problems require addressing in order to ensure adequate, consistent and tailored lifetime care and support for individuals who suffer injuries in a motor vehicle accident. Support for people with catastrophic injuries varies substantially across Australian States and Territories and is essentially a 'post code lottery' which creates inequity within our society.

For this reason AOPA strongly opposes both the base case and option 2 which fail to meet the objective of providing adequate, consistent and tailored lifetime care and support, regardless of the jurisdiction in which that person lives or was injured. AOPA do not believe option 2 is equitable in its impact on the residents of each State and Territory. Option 2 risks the integrity of the National Disability Insurance Scheme at a time where the program is still under development and its own aims and objectives have not yet been realised.

AOPA supports the concept of option 1 in relation to the areas of no-fault and common law but does not find the minimum benchmarks reasonable and appropriate. The minimum benchmarks do not support the objective of encouraging rehabilitation and early intervention to facilitate independence and participation and do not allow for delivery of patient centred care.

The AOPA strongly believes that all individuals undergoing any form of limb amputation, at any level, as a result of a motor vehicle accident should be included within a National Injury Insurance Scheme. It is AOPA's position that for optimal and timely treatment provision, all treatment prescribed by an AOPA certified orthotist/prosthetist as a part of a treatment care plan should be considered reasonable and necessary. In addition, the National Injury Insurance Scheme model must facilitate true choice of practitioner across both the public and private sectors for all consumers.

AOPA believe that the implementation of option 1 in its current form will also further fragment the health care system, increase the difficulties for consumers and practitioners to navigate the system, increase staffing and administration costs for service providers, increase numbers within the government funded National Disability Insurance Scheme and state funding models and restrict the ability of these schemes to achieve optimal outcomes for their clients.

It is AOPA's opinion that all individuals who sustain injuries as a result of motor vehicle accidents should be managed within a National Injury Insurance Scheme which is funded through CTP insurance or a suitable alternative, but which is not the National Disability Insurance Scheme. The potential for cost-shifting between government funded programs must be avoided in order to allow each scheme to achieve its intended aims and objectives.

AOPA would be pleased to discuss further any aspect of this submission upon request.

THE AUSTRALIAN ORTHOTIC PROSTHETIC ASSOCIATION Inc.

Introduction

The Australian Orthotic Prosthetic Association Incorporated (AOPA) is the peak professional body representing orthotist/prosthetists nationally. Orthotist/prosthetists assess the physical and functional limitations of people resulting from illnesses and injuries, including limb amputations, and provide orthoses and prostheses to restore function or compensate for muscular and skeletal disabilities. (Further detail, Appendix One: Occupation summary).

The AOPA have provided responses to only the relevant sections of the National Injury Insurance Scheme Consultation Regulation Impact Statement.

Nature of the problem

1. ***Is this chapter a correct statement of the problem?***
2. ***Do you think there were other problems created by the status quo as it stood in 2011?***

Generally, the Australian Orthotic Prosthetic Association (AOPA) supports the description of the many problems within the regulation impact statement (RIS). AOPA agrees that these problems require addressing in order to ensure adequate, consistent and tailored lifetime care and support for individuals who suffer injuries in a motor vehicle accident (MVA).

AOPA believes that the following are two of the most significant problems stated within the RIS:

1. Support for people with catastrophic injuries varies substantially across Australian States and Territories and is essentially a 'post code lottery' which creates inequity
2. There are a number of challenges in utilising the National Disability Insurance Scheme (NDIS) as a *'safety net'* alternative to a National Injury Insurance Scheme (NIIS):
    a. The NDIS will not be completely rolled out until at least June 2019
    b. There would be limited mechanisms to address moral hazards and reduce accident related risks

c. Responsibility for acute and rehabilitative care costs would remain jurisdictional as it is not supported by the NDIS and therefore care would likely remain disjointed and inequitable

d. Inequity between States and Territories would remain given some states already cover catastrophic and other injuries via alternative mechanisms.

Additional Problems

AOPA have identified the following additional problems with the status quo:

Using the NDIS as a safety net:

Given eligibility to the NDIS is restricted to individuals aged under 65, there does not appear to be an option for individuals who suffer an injury after the age of 65 if the NDIS is to be utilised as a safety net. It would appear that these individuals would be managed through the state based schemes which the *"Productivity Commission regarded as generally inadequate taxpayer-funded health and disability services".*

Eligibility benchmarks:

The agreed minimum benchmarks for eligibility rules detail the definition of catastrophic injuries based on the New South Wales (NSW) Lifetime Care and Support (LTCS) model. This model manages approximately 10 amputee clients, exemplifying that such definitions result in a minimal number of individuals being eligible to such a scheme.

AOPA highlights that restrictive eligibility definitions which result in the provision of care to small groups raises the following problems:

1. Further fragments the health care system, increasing the difficulties for consumers and practitioners to navigate the system, resulting in the scheme not being utilised as it was intended.
2. Creates uncertainty as to whether an individual is eligible and therefore does not facilitate optimal rehabilitation and early intervention processes.
3. Increases staffing and administration costs for service providers.
4. Requires the insurance scheme to develop and/or engage the expertise to adequately manage individuals with specific injuries in order to understand 'reasonable and necessary'.
5. Limits the provision of patient centred care as the assessment of 'catastrophic injury' is relative and personal.

6. Increases numbers within the government funded NDIS and state funding models, restricting the ability of these schemes to achieve optimal patient outcomes for their clients.

Objectives of government action

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

AOPA agrees with the objectives of the program outlined within the RIS.

However as highlighted, the Productivity Commission recognised *"adequacy of care should be defined by certainty, timeliness and quality of access"*; AOPA does not believe that this statement is well reflected within the objectives.

As discussed throughout the document and summarized within the response to Question 28, whilst the listed objectives are supported, they are not well reflected within the models presented.

Options

5. Do you agree with the description of the base case?

AOPA does not believe that the base case meets the first listed objective of providing adequate, consistent and tailored lifetime care and support regardless of the jurisdiction in which that person lives or was injured. Neither will the base case achieve equality in its impact on the residents of each State and Territory.

The base case assumes that the NDIS will cover all individuals who are not already covered by the scheme in their jurisdiction. The RIS and the additional problems highlighted within the 'Nature of the problem' section at the beginning of this document, highlight why this is not a suitable substitution for an NIIS. In particular, the needs of individuals who may suffer an injury after the age of 65 are not addressed.

The base case does not address the issue of no-fault as options one and two do.

6. Are options 1 and 2 reasonable and appropriate?

Summary:

AOPA supports the concept of option 1 in relation to the areas of no-fault and common law but does not find the minimum benchmarks reasonable and appropriate.

AOPA is unsure of the purpose of such restrictive eligibility criteria which is in contrast to successful models currently in place, such as TAC/Worksafe in Victoria. **The AOPA strongly believes that all individuals undergoing any form of limb amputation, at any level, as a result of a MVA should be included within a NIIS.**

The minimum benchmarks do not support the objective of encouraging rehabilitation and early intervention to facilitate independence and participation and do not allow for delivery of patient centred care. Additionally, AOPA is unclear how a scheme designed for such a minority group is congruent with the current Federal Government's focus on deregulation.

AOPA strongly opposes both the base case and option 2 which fail to meet the first listed objective of providing adequate, consistent and tailored lifetime care and support, regardless of the jurisdiction in which that person lives or was injured. Option 2 is not equitable in its impact on the residents of each State and Territory. Option 2 risks the integrity of the NDIS at a time where the program is still under development and its own aims and objectives have not yet been realised.

Reasonable and appropriate factors related to options 1 & 2:

Fault or no-fault schemes

Based on the information within the RIS relating to fault and no-fault schemes, AOPA supports the structure presented in option 1 as AOPA agrees that *"compensation outcomes from litigation typically fall well short of meeting an individual's lifetime needs".*

AOPA believes that lump sum payments in relation to healthcare are of significant risk to the injured individual. Lump sum payments for healthcare needs place a burden on expert practitioners to predict the lifetime needs of an individual in a constantly changing healthcare and technological environment, without knowledge of an individual's lifespan. These factors create a very high risk that funding may not be available to meet optimal care provision into the future.

In addition, the health system will ultimately carry the burden of individuals requiring ongoing care where lump sum payments are not adequate for the term of an individual's life. For example, the Queensland Artificial Limb Scheme reportedly provide care for individuals who received a lump sum payment more than 10 years prior and have previously invested personal funding in prosthetic services.

Unreasonable and inappropriate factors related to Options 1 & 2:

Minimum Benchmarks:

Definitions - Type of Injury:

The minimum benchmarks for catastrophic injury notes 'significant amputation' must occur for an individual to be eligible for the scheme. The separate document: 'agreed minimum benchmarks for motor vehicle accidents' defines significant amputation as:

> *"Multiple amputations of the upper and/or lower extremities or single amputations involving forequarter amputation or shoulder disarticulation, hindquarter amputation, hip disarticulation or 'short' transfemoral amputation involving the loss of 65% or more of the length of the femur".*

It is apparent that this definition is in line with the NSW LTCS eligibility definitions. AOPA would question how an amputation involving loss of, for example, 45% of the femur, is not as significant as the above definition and how any amputation of a limb could not be deemed significant. Parkes (1975) reported that the grief endured following the loss of a limb is comparable to that of losing a partner. Therefore, all amputations are significant and individuals who have such an injury from a MVA should be included within the NIIS.

Furthermore, the loss of an anatomical joint is highly influential on functional ability when assessed against the International Classification of Functioning (ICF). Functional loss and therefore an individual's ability to return to work and participate in society more broadly, is more highly linked to the loss of a joint, such as the knee joint, rather than boney length.

It is AOPA's position that all individuals who require amputation as a result of an accident are included within any NIIS.

Patient centred care:

AOPA does not believe that the eligibility criteria allow for patient centred care.

Timeliness is identified as one of the necessities for the provision of adequate care, however eligibility criteria such as

> "spinal cord injury, with evidence of a permanent neurological deficit"

could not be determined immediately following a traumatic accident. In addition, new limb salvage surgical techniques often result in multiple amputation surgeries over a period of time, at which point within the care continuum would an individual be assessed and their eligibility to the scheme determined?

The proposed criteria therefore create eligibility uncertainty which results in unnecessary stress during a time of already high personal stress for clients and does not facilitate optimal rehabilitation and early intervention processes. AOPA refer to the Victorian TAC/Worksafe model as an example where peace of mind at the time of an accident is provided to all individuals.

In an attempt to address such a situation, the NSW LTCS program have developed a policy where injured individuals are provided a 'provisional' eligibility status for a two (2) year period, after which eligibility is then finalised. This policy creates an undesirable situation where an individual may receive a certain level of support which is then removed from them. Flow on effects relating to functional decline and/or financial strain for optimal care will then result.

The eligibility assessment criteria are extremely specific, AOPA questions who will be the healthcare provider to determine results against these criteria? It will be extremely difficult for any healthcare professional to conduct an assessment against these criteria in a way which will allow patient centred care and the development of a relationship based on trust for future healthcare provision. Furthermore, what is 'catastrophic' is relative to the individual, their situation and environment, including their family and religious and ethical beliefs and the functional outcomes they are able to achieve following an injury; to set such specific criteria to define catastrophic is in contrast to the core principles of patient centred care.

Minimal Numbers:

Using these minimum benchmarks, the NSW LTCS program provide assistance for the ongoing needs of approximately 10 people with amputations, all remaining clients with limb loss receive their prosthetic care through the government funded state scheme. In contrast, in Victoria under the

TAC/Worksafe eligibility criteria, there are few individuals who have experienced limb loss through a MVA receiving their prosthesis, orthosis, rehabilitation and/or therapy needs through the state funded schemes.

Advances in medical treatment mean that very few individuals would undergo an amputation deemed 'significant' enough to meet the proposed eligibility criteria for the NIIS.

Reasonable and necessary supports:

Determining reasonable and necessary within the NDIS has to date proved inconsistent, with similar participants receiving very different care plans. One reason for this may be that where individuals require the support of relatively small professions such as Orthotics and Prosthetics, those determining reasonable and necessary have little understanding of the benefits such a profession can provide. This leads to complex, costly and lengthy processes for clients, service providers and the insurance scheme themselves.

These problems are highlighted by the process NSW LTCS employ when trying to coordinate and develop the expertise to adequately manage individuals with an amputation. Due to the small numbers of amputee clients managed through LTCS the requisite expertise are unable to be developed internally. The scheme administrators therefore engage the State funding system to provide support during the administration and assessment phases. The required process is exemplified by the flow chart produced by NSW LTCS for AOPA members to assist with navigation of the process (Appendix 2). The cost of the time and resources to provide oversight to a profession with high levels of self-regulation and instead defer to a system with very different criteria and objectives for decision making is unnecessary.

It is AOPA's position that for optimal and timely treatment provision, all treatment prescribed by an AOPA certified orthotist/prosthetist as a part of a treatment care plan must be deemed reasonable and necessary.

Scope of Motor Vehicle Accidents

It is AOPA's position that other modes of transport which require registration, such as trains and trams must also be included within the benchmark criteria for the MVA component of NIIS. Not only is it likely that injuries resulting from an accident with these types of vehicles will be catastrophic, further confusion is added regarding eligibility, particularly in the critical early moments of acute and rehabilitation care if such distinctions are made.

Option 2:

AOPA does not support this option as it does not meet the stated objectives of adequate, consistent and tailored lifetime care and support regardless of the jurisdiction in which that person lives or was injured and is not equitable in its impact on the residents of each State and Territory.

Such a model would create opportunities for cost-shifting between States and Territories, delay treatment and further increase the complexity of scheme navigation, abolishing the client centred focus such a scheme should deliver.

Increased complexity

There are four detailed benchmark minimums noted under the title 'Which jurisdiction's NIIS should provide cover?' (Appendix 3). These benchmarks indicate why without national consistency, inefficiencies and confusion will be created among consumers and health care providers. Differences between State and Territory schemes will increase eligibility confusion, increase navigation complexity and further restrict the timeliness of service provision.

Opportunity for cost-shifting

A review of the financial burden in relation to liability for services provided to non-residents only occurring every 5 years is inadequate. AOPA believe such a system will result in NDIS participants within certain States and Territories being disadvantaged for significant periods of time. Individual's suffering 'catastrophic' injuries as described within these models will have particularly high care needs and will significantly reduce the amount of funds remaining for distribution between the many remaining participants for whom the NDIS was originally intended.

Problems created by using NDIS as a 'safety net':

The National Disability Insurance Scheme (NDIS) is a *"no-fault safety net that will provide high quality care and support for all Australians with significant and permanent disability regardless of how or when it was acquired*". However, using the NDIS as an alternative to a national insurance scheme has a number of challenges which do not allow use of this model:

- The NDIS will not be completely rolled out until at least June 2019
- AOPA does not believe the NDIS is yet functioning at a level which allows adequate assessment of whether the scheme is a suitable base on which to inform another vital scheme for Australian's

- There would be limited mechanisms to address moral hazards and reduce accident related risks
- Responsibility for acute and rehabilitative care costs would remain jurisdictional as it is not supported by the NDIS and therefore care would likely remain disjointed and inequitable
- Inequity between States and Territories would remain given some states already cover catastrophic and other injuries via alternative mechanisms
- It is unclear which scheme would be available for individuals over the age of 65, potentially creating another level of inequity
- Resources intended to be directed toward individuals currently eligible for the NDIS and State and Territory schemes will be redistributed amongst a larger group, with the inclusion of individuals with high needs.

It is AOPA's opinion that all individuals who sustain injuries as a result of MVA's should be managed within the NIIS which is funded through CTP insurance or a suitable alternative, which is not the NDIS.

Impact analysis

Option One

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

AOPA firmly believes that the noted benefits of:

- Receiving care and support much sooner
- Realising better rehabilitation outcomes and
- Lower longer term care costs; will only be realised if eligibility criteria are more patient centred and inclusive.

Given there are numerous states who already meet or are above the described minimum benchmark, with only two states requiring significant change, AOPA is concerned that the NIIS will provide benefit to very few individuals. AOPA is concerned that setting such low benchmark minimums may have potentially unintended consequences such as preventing schemes from having

reason to strive for improvements and/or encouraging schemes above these standards to further limit their schemes and shift costs to the NDIS.

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

AOPA suggest it is highly likely due to the minimum benchmark eligibility criteria that most individuals will be managed within the jurisdictional public system for acute and rehabilitation needs whilst eligibility is determined. Therefore, a cost to the treating healthcare organization will be incurred.

The introduction of another system, particularly one which covers so few people, will further fragment the health care system. Dealing with a different and additional scheme requires personnel time to understand the scheme and become familiar with how to utilise it. As a result there will be a further cost to organisations (usually public hospitals for trauma related incidence) in the form of staffing and administrative burden. In cases where these aspects are high and patient numbers are low, there is a significant risk that these processes will not be conducted accurately, resulting in further costs to the organization providing care.

15. Are there any other costs or benefits to states and territories of option 1 that are not identified here?

Severely restricting eligibility to the scheme will result in increased numbers within the government funded NDIS and State and Territory funding models which further restricts their ability to achieve optimal patient outcomes as described above. The outcomes of less than optimal care create costs to the individual and society more broadly.

Where individuals are unable to achieve their potential, a concomitant decrease in functional ability, ultimately resulting in a decreased ability to participate in society is likely. Decreased participation can limit an individual's ability to work and increase their dependence on others, contributing further costs to society.

In states where there is no alternative scheme individuals under the age of 65 will be managed following rehabilitation within the NDIS and those over 65 years of age within current state based government schemes. In both cases the government would incur the acute and rehabilitation costs of treatment.

Option Two

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

It is AOPA's opinion that given the Productivity Commission have already established the inadequacy of current systems in some States, 2019 is an unacceptable timeframe for residents of these States to wait for improvements in care which they may require following accidents which are out of their control.

The costs associated with decreased availability of resources for all other participants of the NDIS must be considered within this model. Whilst increases in CTP payments from residents and subsequent transferring of funds to the NDIS is proposed within this model, AOPA would express concern regarding the burden of the stringent over sight required to ensure the realization of such a model as intended.

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

AOPA believe it is vital that careful consideration is given to which practitioners may provide services into the NIIS.

AOPA recommend that only AOPA certified practitioners prescribe and provide orthoses and prostheses to clients of the NIIS. This would ensure the safety of the consumer as all certified practitioners must have the required level of education and current and competent knowledge and skills to provide appropriate treatment. The safety of the consumer is further assured by a pathway for recourse against the practitioner if such a necessity were to arise.

AOPA understand that the NDIS is now functioning as a 'top up scheme'. Such a scheme requires the existing State or Territory scheme to fund the maximum dollar amount a client previously received within the scheme, with the NDIS paying the remaining required funds to ensure 'reasonable and necessary' treatment provision. The current policies of some State and Territory funding schemes for orthosis and prosthesis provision restrict funding access to practitioners providing services within the public sector. Where such policies are in place, consumers are limited in their choice of service provider and the ability of the private sector to assist with meeting consumer demand is restricted.

AOPA believe the NIIS model must facilitate choice of practitioner across both the public and private sectors for all consumers.

Conclusion and Recommendations

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

AOPA disagree with the RIS assessment of the way in which each option meets the set objectives:

- As a result of the minimum benchmark eligibility criteria, in reality, all options will not provide certain, timely and quality lifetime care and support to individuals catastrophically injured in a MVA
- If eligibility remains ambiguous, none of the presented options will ensure individuals receive funded medical or rehabilitation services via this scheme in a timely manner
- Both the base case AND option 2 lack equality between States and Territories, AOPA is concerned that only the base case is identified as not meeting this objective

In addition, AOPA do not believe that *"adequacy of care, defined by certainty, timeliness and quality of access"*; is achieved by any of these objectives in light of the benchmark minimum standards and eligibility criteria applied to all models presented.

Appendix One: Occupation Summary

Description: *Orthotist/Prosthetists are tertiary qualified Allied Health Professionals who assess the physical and functional limitations of people resulting from illnesses and disabilities, including limb amputations, and provide orthoses and prostheses to restore function or compensate for muscular and skeletal disabilities.*

Tasks of the occupation include:

- assessing clients' emotional, psychological, developmental and physical capabilities using clinical observations and standardised tests
- administering muscle, nerve, joint and functional ability tests to identify and assess physical differences among clients
- assessing clients' functional potential in their home, leisure, work and school environments, and recommending appropriate technology to maximise their performance
- designing, prescribing and fitting orthoses and prostheses to meet the clients' personal and treatment goals
- providing gait training, education and continually monitoring, assessing and evaluating orthoses and prostheses and treatments evaluating treatment provision and client's personal and functional outcomes in relation to established treatment goals
- working with other Health Professionals to enhance collaborative practice to improve client access to care via coordinated team reports and care plans
- adjusting and modifying orthoses and prostheses to accommodate minor changes to the client's neuro-muscular skeletal system
- working with external bodies to provide specialist advice to specific client groups such as those requiring third-party compensation and medico-legal representation
- recording clients' progress and maintaining professional relationships in accordance with relevant legislative requirements and ethical guidelines
- maintaining and extending professional competence to ensure new techniques, technology and evidence are integrated into practice

Entry level qualification to practice in Australia:

An Australian Qualification Framework Level 7 qualification (Bachelor Degree) is required for entry to this occupation in Australia. This is reflected in public sector awards and the AOPA membership

eligibility criteria. The only Bachelor Degree accepted for entry into the profession is a Bachelor in Prosthetics and Orthotics. A generalist health degree or alternative allied health qualification does not allow entry into the occupation. The current minimum tertiary education available in this profession in Australia is a Master in Clinical Prosthetics and Orthotics through LaTrobe University, Melbourne.

Orthotics and prosthetics is a self-regulated profession. The AOPA membership accounts for 70% of the profession nationally. Whilst registration or licensing is not mandated, some funding body guidelines restrict the provision of funded services to those with AOPA membership. Further to this Public Sector employment is increasingly restricted to those practitioners who can demonstrate membership eligibility to the AOPA.

Further requirements:

Ongoing AOPA membership is restricted to practitioners who adhere to the mandatory, annual Continuing Professional Development program requirements, scope of practice and code of ethics for the profession. The AOPA requires all members to demonstrate knowledge currency and adherence to the 2014 competency standards.

Definitions:

> ***Orthosis (pl.Orthoses).***
>
> An externally applied device used to modify the structural or functional characteristics of the neuro-muscularskeletal systems. Orthoses may be Prefabricated, Customised or Custom Made (International Organisation for Standards, 1989). An orthosis is the true term for a brace or appliance that is designed and fitted external to the body in order to achieve one or more of the following goals: control or alter biomechanical alignment, protect and support a healing injury, assist rehabilitation, reduce pain, increase mobility, increase independence.
>
> ***Prosthesis (pl.Prostheses).***
>
> An externally applied device used to replace wholly, or in part, an absent or deficient limb segment" (International Organisation for Standards, 1989).
>
> ***Prosthetist (pron: Prosthe-tist).***
>
> An allied health professional who is clinically responsible for the assessment, prescription, design, manufacture and fitting of all types of prostheses to patients (International Organisation for Standards, 1989).

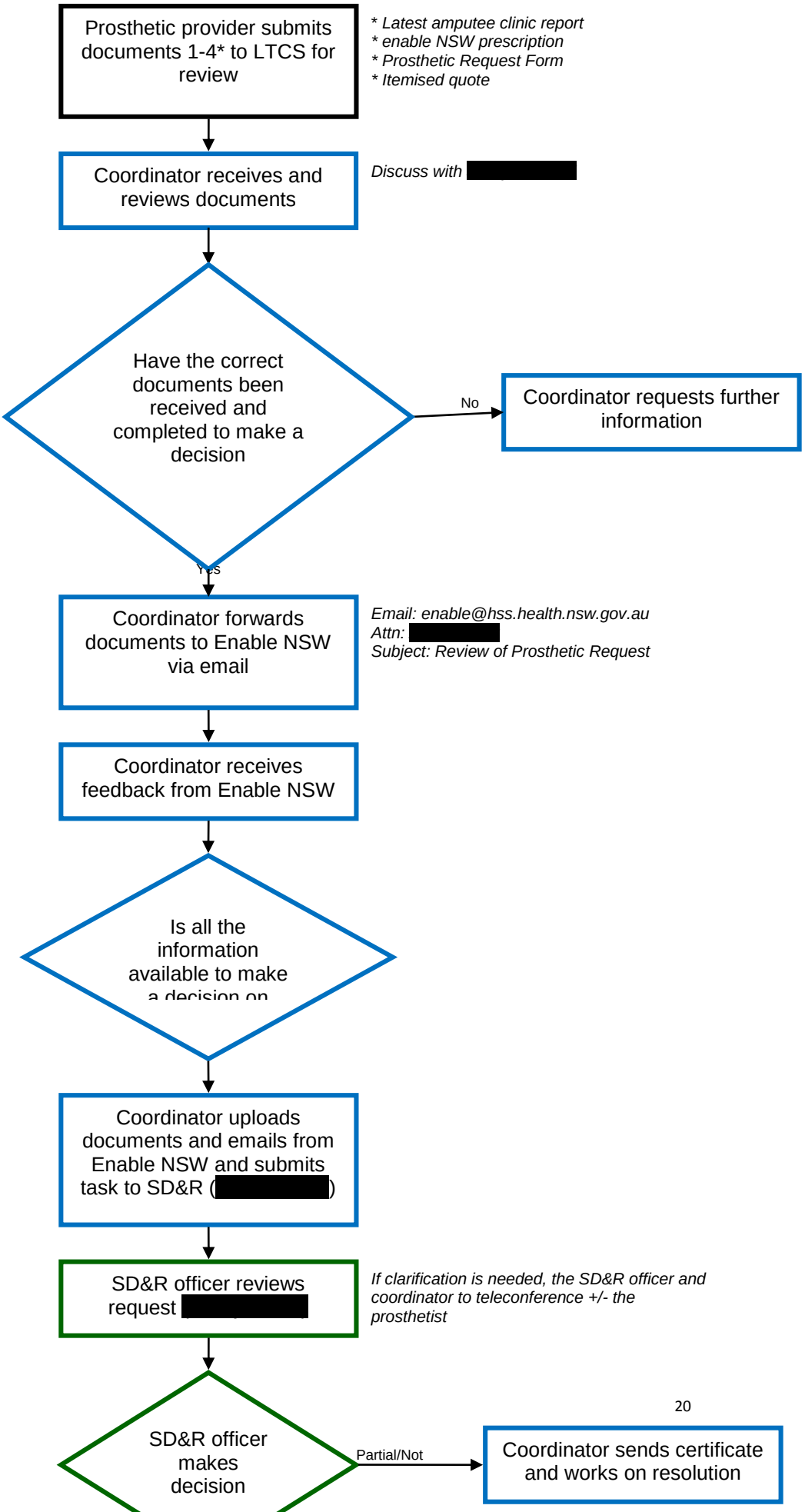
Orthotist (pron: Ortho-tist).

An allied health professional who is clinically responsible for the assessment, prescription, design, manufacture and fitting of all types of orthoses to patients (International Organisation for Standards, 1989).

Appendix 2: New South Wales Life Time Care and Support process chart for approving reasonable and necessary in relation to orthoses and prostheses

THE AUSTRALIAN ORTHOTIC PROSTHETIC ASSOCIATION Inc.

Prosthetic Request - Process Flowchart



Appendix 3: Which jurisdiction's NIIS should provide cover?

- At a minimum each jurisdiction's NIIS will cover people who are catastrophically injured in motor vehicle accidents which occur in that jurisdiction. Jurisdictions may, if they wish, provide broader coverage extending beyond their jurisdiction.
- State and Territory NIIS schemes will establish arrangements to purchase care and support services from each other when a scheme participant resides in a different jurisdiction to that which assumes funding responsibility.
- A review will be undertaken every 5 years to assess the extent to which State and Territory NIIS schemes face differential (net) financial burdens in relation to liability for services provided to non-residents.
- In all cases the jurisdiction assuming financial responsibility should retain the right to seek recovery from the CTP insurer of an interstate registered vehicle.