Submission to SIRA Review- Dr Arthur Chesterfield-Evans

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Review - Terms of Reference

The review will be undertaken for SIRA by an independent expert, Ms Janet Dore and supported by independent actuaries Ernst and Young (EY) and authorised officers of SIRA.

Consistent with the objectives, functions, responsibilities and powers of SIRA under the *State Insurance and Care Governance Act 2015*, the WIM Act and the 1987 Act, the Terms of Reference for the review are to consult with stakeholders and undertake analysis of data to provide findings in relation to the NI's compliance and performance, in particular to:

- assess NI compliance with the MPPGs and identify any unintended consequences, risks and priorities for improvement in SIRA regulation of the premiums of the NI
- identify the benefits and risks to the performance of the NSW workers compensation system arising from iCare's implementation changes to the NI operating model and supporting digital platforms
- Assess the NI's performance in relation to return to work outcomes, claims management (including guidance, support and services for workers, employers and health service providers), customer experience and data quality and reporting.

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Summary

iCare and SIRA have both undergone regulatory capture by the insurance industry who have had far too much influence in setting up both bodies, their objectives, protocols, staffing and continuing operations.

iCare and SIRA have lost touch with the core objective of the Workers Compensation (and CTP system) which is to provide medical care and rehabilitation to injured people. Instead of this, the system has become little more than a niche scam, where a significant but unquantified percentage of patients have treatment denied to deliver super-normal profits to insurers and dividends to government, while leaving patients untreated, or transferring their costs to other funders within the health system after lengthy treatment delays which are often financially and emotionally crippling.

The protocol that allows IMEs (Independent Medical Examiners) to create medical disputes by denying treatment, and have this beyond the scrutiny of the regulator has allowed insurers to do what they like in the area of treatment denials, immensely empowering insurer interests against patients and treating doctors.

The terms of reference of this Review are far too narrow, and the Reviewer too close to SIRA and too close to the insurance industry to conduct such an inquiry, and a new inquiry with broader terms of reference is needed, with real efforts to get feedback from patients and treating professionals.

A Stakeholder Group comprised principally of patients, but with doctors and other treating professions is needed as an independent voice to balance insurance interests in the scheme.

Details of the delays and rates of denials of procedures by individual insurers must be kept by iCare or SIRA, and these figures must be made publically available to allow monitoring of the scheme and to allow choice of insurer or accountability of a monopoly insurer.

A more detailed critique of WC and CTP insurance exists in Dr Chesterfield-Evans' submission to the Haynes Royal Commission into Banking and Financial Services and this is also submitted for the attention of the Review.

Recommendations:

1. That SIRA acknowledge that it cannot set premiums as suggested in the terms of reference without examining whether the current level of treatment refusals is reasonable and justified.
2. That SIRA constitute a New Inquiry with broader terms of reference and an independent chair, preferably with links to the treatment sector rather than the financial sector.
3. That SIRA conduct independent investigations on claims denials, both of the initial claim and of treatments and referrals and publishes such figures by insurer regularly so that consumers can decide on a fact basis which insurer to choose or a monopoly insurer can be held to account.
4. That SIRA investigate the delay inherent in the insurance process, collect statistics of this and publish the delays by insurers so that consumers can decide on a fact basis which insurer to choose.
5. That the figures from SIRA of insurer refusals be a central part of the new Inquiry.
6. That SIRA reinforce the position of the NTD and ensure that the NTDs determine the treatment plans, not the insurers or rehab professionals.
7. That Rehab professionals be chosen by NTDs, not insurers so that they act in the interest of the patients not the insurers.
8. SIRA should establish a Stakeholder group composed of a majority patients' representatives, but also doctors, paramedical groups and Unions to assess the effect of policies and the effectiveness of the Workers Compensation and CTP schemes as a whole. There must be funding to allow such groups to contact injured people and to collect and collate information. Funding arrangements must be such that the Stakeholder group cannot have its independent compromised, and it must have the ability to advocate both within and without the framework of SIRA and iCare.

Submission

The first two terms of reference of this inquiry deal with what is merely one component of the function of the Workers Compensation system- its premiums. It deals with how they are set and what changes there might be from new management models.

The fact that changes to premium setting is the first two terms, and that the third merely has everything else in a 'catch-all' third term shows SIRA's preoccupation with its financial outcomes to the exclusion of other aspects of its obligations.

SIRA has to regulate the insurers to see that they deliver a cost-effective insurance to injured workers. This assumes that such a service will actually be delivered, not just that the cost will be minimised. iCare seems to do little to monitor how often insurers deny claims and treatments. If one is injured in anything other than a work or CTP situation, health insurers are obliged to pay for the treatments that the doctors order. In the case of WC (and CTP), insurers can delay and deny treatment at will and the regulatory function of iCare and/or SIRA on this aspect is negligible. The terms of reference of this inquiry are a further indication that the regulation of insurer behaviour is not even on their corporate radar and that they are totally out of touch with the interests of the injured people for whom the whole scheme exists.

The fact that an internal SIRA premium-setting employee is conducting the inquiry reinforces the absurdly narrow focus of SIRA and iCare.

SIRA and iCare merely serve to reinforce the insurers' hand against the interests of the injury victims, as they appear totally unaware of the rate of denials of treatment. iCare may have different subcontracting insurers and may claim to deliver the services. The nature of these arrangements are not clear to outside observers, but what is clear is that the regulators have so abandoned any position of advocacy for the injury victims against insurer profits that they are dangerous. They give an appearance of a regulated system when no such system exists, merely a facilitator of exploitation that would be better abolished than remaining in its current form. Perhaps then tort law or some other alternative could be considered.

Further evidence of the out of touch nature of iCare is provided in its annual report. Its Board has almost no one with any history of patient contact. The report is composed principally of management slogans, boasts and public relations statements. As an example, there is an index of customer relations, which is poorly defined, but is termed NPS, which presumably relates to some commercial survey methodology.

NPS is supposedly an index of customer relationships, but iCare or SIRA have has been extremely difficult to contact with complaints. The website and protocols have referred patients back to the insurer. Most insurers require that the patient contact their immediate case manager, who in practice has little say at all, then someone higher up the hierarchy, before iCare will even get involved. I received an online survey from iCare. This was after I had spoken to Ms [redacted] from iCare who had said that they were using the same company that did surveys for Coca Cola and McDonalds. The survey asked how my experience had been with insurers and intended that I give

them feedback, with all my contact details. It was as if the survey was for Coca Cola and any confidentiality did not matter, and the insurer had no control over the life of the person surveyed. Most patients are very frightened of the insurers as they know that a denial will put them into a parlous financial situation. This is why they are unwilling to complain about anything. My own letters to SIRA have led to no useful actions at all and merely state a backing of the insurers. One of these replies had a total of 84 pages, mostly of photocopies. I suspect that the reason the surgery was refused was because the patient, despite his pain had tried to continue his business and been photographed working by a surveillance camera, but naturally this was not mentioned in the 84 pages. The convenient assumption is made that if anyone works, there is clearly nothing wrong with them and no definitive treatment is approved. SIRA then supports this decision, despite receiving retailed medical information about the man's pathology and scan reports. The use of IMEs (Independent Medical Examiners) by insurers to turn the situation into a 'medical dispute' and then define it as beyond the remit of the regulator is an effective technique of insurers to allow them to refuse treatments. IMEs are dependent on pleasing insurers to get work which in the most euphemistic interpretation seems to influence their opinions. Agencies who choose IMEs are also under pressure to come up with doctors who are convenient to the insurers, so doctors working for these may not get work if their opinions are not favourable to insurers.

The delays in the system are inherent in the fact that the insurers have 2 weeks to approve treatments which in any other situation would be implemented as soon as the treating doctor ordered them. It must be noted that this alone means that the WC scheme causes a lot of distress to patients. But many insurance clerks work for home or job share, often working only 2 days per week. So the convenience of the insurer creates delays even within the 2 week time frame the insurer is working less than half the time. The delays caused by insurers checking previous medical records create delays much longer than 2 weeks and appear automatically tolerated by iCare and SIRA as the statutory periods are so long.

My patients feel totally depowered and the fact that iCare can pretend that it has good contact with 'customers' shows either that management are totally out of touch with the patients or that they wish to pretend that all is well when it clearly is not. My own view is that the former explanation is more likely as given the backgrounds of the board and upper management of iCare with an overwhelming preponderance of insurance manages, generic managers, lawyers and wealth manager and the total lack of anyone who actually speaks to patients, with the possible exception of [redacted] a unionist, or [redacted] who deals with the long-terms problems of the catastrophically injured or terminal conditions rather than the day to day problems of those who have their e]reasonable treatments refused by venal insurers. These two clearly cannot change the culture of the organisation.

The obvious conclusion is that iCare management are totally out of touch with what is happening and the response of SIRA has been to defend insurers as complying with procedures and having total discretion in their denials, with no input or oversight from SIRA at all. SIRA have told me that they do not collect statistics on what treatments are denied, so are naturally and by definition unable either to compare insurers or to state whether they are meeting their obligations under the Act actually to pay for the treatment of injured people. The State Insurance and Care Governance Act 2015 is

mainly concerned with cost control and as such may undermine the Workers Compensation and CTP acts that try to help injured patients, but it is surely the regulators job not merely to use cost control to render the other Acts meaningless and in practice transfer the treatment costs to Medicare, the Private insurance system and the patient. But this is what is happening, as NTDs try to look after their patients. Presumably it is not in the remit of SIRA and iCare to look at the alternative treatments that NTDs arrange, but it is their job to monitor unreasonable treatment denials by insurers, and this they fail to do. I have drawn this to their attention by writing letters about a number of patients and by giving a submission that I wrote to the Haynes Royal Commission to [redacted] Neither of these actions seem to have made the slightest difference to SIRA who have still organised this inquiry, done by one of their own with terms of reference that are minimal. They have made no serious effort to get submissions from patients or treating doctors, so clearly have no real interest in what they think or how they are affected by insurer policy and their non-supervision by iCare and SIRA.

SIRA has manifestly failed in its principal task which is to ensure that people injured in NSW are adequately treated and has instead seen its job as minimising costs of insurance. What should be a system of checks and balances has become one of cheques and bank balances. The boast by iCare that premiums have not risen for 5 years must be recognised as vainglorious idiocy[1]. The cost of treatment has risen faster than inflation; the number of claims has not fallen, so the only way that this could have been achieved is that less money has been paid out in claims. In that there is no analysis of what happens to claims in terms of what happens to patients when their treatment is refused, one can only conclude that iCare do not care about this at all and that their name is as false as their efforts are misdirected. In that SIRA supposedly monitors iCare, iCare's failure is also SIRA's.

A real effort must be made to have patient input, as injury victims are the reason for the scheme's existence. SIRA should survey all injured people independent of iCare and the insurers to monitor how effective the insurance and medical regimes are. NTDs should be similarly surveyed, and other treating professionals, such as rehab, physiotherapists, exercise physiologists and psychologists. The use of organised groups, such as professional bodies, such as colleges of the AMA need to be considered and Unions that collect information on patient outcomes should also have an input. Currently insurers appear keen to deal with patients directly and to by-pass treating doctors to increase their influence on treatments and costs, often using rehab professionals to develop management plans which the treating doctor is then pressured to comply with.

Restatement of Haynes Royal Commission Summary

I attach my submission to the Haynes Royal Commission, which is now a year old and also covers both the WC and the CTP system, which exists in parallel. The submission is still relevant as:

1. SIRA and iCare manage and supervise both WC and CTP in much the same manner, prioritising the cost control approach over the main function of the schemes, which are to treat people injured either at work or by motor accidents.

[1] www.icare.nsw.gov.au/news-and-stories/five-years-of-premium-stability-and-counting/#gref- attached as Appendix 1

2. The issues are the same as at the time of writing and the situation has not improved.

The key aspects that need to be re-stated from that submission are:

1. There are 83 patients whose histories illustrate unacceptable insurer behaviour either with:
    a. Unreasonable denials of investigations or treatment or
    b. Unreasonable treatment of the treating doctor, such as rehab professionals recommending the patient change practitioner to one more convenient to the insurer and failure to provide IME reports that are used to deny treatments.
2. The frequency of denials in a survey of my visits for 2 weeks were that 83% of CTP and 60% of WC patients had had a significant investigation or referral denied. As SIRA states that it does not collect these figures, it has no idea whether my sample is representative or not, and clearly does not want to know.
3. The frequency of denial of WC and CTP amounts to 17% of my billings in one year and 14% in another 6 month period so the insurers are denying all treatment to a significant number of patients. SIRA seems unaware what percentage of claims are denied or how many of these denials are reasonable.
4. A sample of radiology denials from other doctors appears to support the proposition that the rate of denials that I experience is not significantly different from other practitioners, but again, there is no data from SIRA on this.
5. Insurers are behaving far worse than the Banks were shown to be in the Haynes Royal Commission, and the regulation of them by SIRA and iCare is far worse than that shown by ASIC and APRA in their regulation of the banks. There has been regulatory capture of SIRA and iCare by insurance interest in its establishment and management by insurance personnel, and its focus on saving money by not paying benefits when they are clearly necessary.
6. The level of refusals of treatments by insurers has made the insurance schemes of WC and CTP in NSW little better than scams. The premiums were set with projected payout levels, but the lack of supervision and the encouragement by SIRA and iCare has allowed insurers to restrict payouts beyond their wildest dreams. They have taken supernormal profits in a protected market and there has even been a 'dividend' taken by the State government and given back to motorists as a pre-election sweetener. All this has happened at the expense of the patients who have gone untreated, or had their cost transferred to other parts of the health system, Federal, State, private health insurance or the patients' depleted resources.
7. The scheme has massively enriched insurers but mainly represents a transfer of costs from the State WC insurers to the Federal and other health payment systems and SIRA and iCare have aided and abetted this process.

Appendix 1 iCare News Release

Five years of premium stability — and counting Tuesday 29 January 2019

Jason McLaughlin, General Manager Prevention, Products and Pricing talks about workers insurance premium stability and how being safe keeps premiums low.

icare understands how important workers insurance is to NSW businesses, and we're committed to keeping it as affordable as possible. Thanks to a well-performing scheme and the great work NSW businesses are doing to keep their people safe, we've been able to offer five years of premium stability.

This year we're delivering premium savings of $76 million to over 280,000 NSW employers. The savings will benefit businesses in multiple industries, with a large portion going towards construction and manufacturing, industries that tend to have a greater level of risk.

It's the third year running that icare has been able to offer this discount and over those three years we have delivered $300 million in premium discounts. This year workers insurance base average premiums again remained at 1.4 per cent of wages.

This is the fifth year in a row that premiums have been stable at this rate despite the pressures of inflation. Delivering savings means our customers can channel them into things like hiring more staff, investing in efficient technology or initiatives to keep their workers safer.

While we work to keep premiums low and maintain a scheme that is as fair as possible, some businesses may still experience an increase in their premiums from time to time.

If you experience an increase in your premium, it's generally for one of two reasons:

1. Your business has grown (and you're paying more in annual wages)
2. An increase in the number of injuries in your workplace.

To help you manage expenses and invest in improved injury prevention when this does occur, icare has maintained a 30 per cent cap on premium increases.

It's also important to remember that when calculating your premium, icare considers factors such as the industry you operate in, the types of risks you face and your claims experience, as well as how much you pay in annual wages. Changes in any of these factors do impact your premium, which may increase due simply to your business growing.

Work with us to keep premiums low

NSW businesses can keep their premiums low by improving their safety record and supporting their injured employees return to work faster.

icare has been working directly with employers to achieve these goals. We're doing this through our:

- Protect Together program – partnering with businesses who need support with injury prevention and building stronger safety cultures together.
- icare Aware Awards – recognising those who have made efforts to embed a strong safety culture across their business.
- Paralympian Speakers Program - raising awareness of workplace safety through sharing personal stories.

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Our Award winners are demonstrating great safety improvements, including considerable productivity gains and reduced injury frequency rates, some by up to 80 per cent. They've in turn kept their premiums up to 50 per cent below the average for their industry by making processes safer and encouraging their people to speak up when something doesn't look safe.

At the end of the day, it comes down to doing what makes sense to keep your business growing and your people safe, and safety makes good business sense. We're keen to partner with more businesses to help them find ways to reduce injuries and keep their premiums low.

Submission to Royal Commission into the Banking and Finance Sector

Systemic Problems in the Insurance Industry with special reference to the NSW CTP and Workers Compensation

Dr Arthur Chesterfield-Evans M.B.,B.S., F.R.C.S.(Eng.), M.Appl.Sci.(OHS), M.Pol.Sci.

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Summary and Recommendations

I have extensive medical professional experience in CTP and Workers Compensation in NSW. I have similar but limited experience but similar with the Victorian and Queensland CTP schemes.

The actions of the insurance industry are wilful, unchecked and very similar to the recently revealed conduct of the banks. They arbitrarily refuse treatments, investigations or referrals with no real respect or concern for patients or treating doctors. They use investigators, rehabilitation professionals and a number of other strategies to minimise their costs. Instead of being a niche funding mechanism for a certain type of medical problem, they are a government-created opaque market with huge overheads and supernormal profits.

The legal system is so expensive that it has largely been excluded from the CTP and WC systems, and so slow that victims' physical and financial health is destroyed by the wait. The whole system immensely favours the insurers and the regulatory mechanism, SIRA (State Insurance Regulatory Authority) (of NSW) is a failure, as its principal aim is to minimise payouts rather than to ensure that insurers deal with injured people fairly.

The Rehabilitation profession is now highly corporatised , beholden to the insurance industry and acting in its interest rather than that of the patients.

Any money 'saved' by the CTP and WC system is merely transferred as delayed but still necessary treatment to be paid for by some other part of the health system. Hence it is an industry that merely shifts costs and wastes premiums that are supposed to benefit injured people.

Recommendations

1. That the Royal Commission investigate the insurance industry systematically.
2. That the Royal Commission look at existing regulatory mechanisms such as SIRA in NSW and assess their cost-effectiveness.
3. That a meaningful, simple and accessible regulator be established to be an avenue of appeal for insurance consumers that allows redress without the costs of court appearances.
4. That if private insurance is retained, treating doctors are paid in a similar way to Medicare or other private health insurers.
5. That standard contracts for insurance be promulgated by the regulator so that insurers compete for a known product and variation in wordings cannot be used to deny claims.
6. That the regulator keep records of comparative indices such as the rate of denials and payouts of insurers and make these public to allow an informed market to control costs.
7. That the Commission recommend that the NSW CTP and WC schemes be abolished in their present form.
8. That insurance be considered a public good, and a government-owned insurer be available for cost control in the market and with the reserves used for public projects.
9. That steps be taken to give control of rehabilitation back to treating practitioners and be made to act in the interests of victims, rather than insurers.
10. That all insurance schemes for accidents be 'no fault'.
11. That an inquiry into all of Health Insurance in Australia be initiated.
12. That Police be funded to document all accidents.

Submission to Royal Commission into the Banking and Finance Sector

Systemic Problems in the Insurance Industry with special reference to the NSW CTP and Workers Compensation

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Context of this Submission

I work as a doctor (NTD = Nominated Treating Doctor) providing medical services to people injured in motor vehicle accidents in NSW CTP and in Workers Compensation injury. I follow standard medical practice in my investigation, treatment and referral patterns. The commonest injuries in my GP practice are whiplash and back pain caused by road accidents, but I also do aftercare in patients discharged from hospitals after more major or more specific injuries. From the point of view of a treating GP the CTP and WC insurance systems deliver poor services at high cost. Ideally there would be an NGO or other body to point out the problems in this important sector, but I am unaware of anyone collecting figures or information in this area, so I have tried to make this a comprehensive submission so that the Royal Commission has a strong doctor and patient perspective to judge the situation in the WC and CTP insurance area, and I ask that the Royal Commission take this submission seriously. There is a public prejudice against compensation that allows insurers to be more aggressive to patients and further adds to patients' distress and alienation.

The introductory remarks make the key points, then the questions in the online form are answered with suggestions, and a number of appendices exist to give evidence for the submission.

I apologise for the length of the submission, and hope that others will reinforce its key points

Introductory Remarks

In my experience insurers in the NSW WC and CTP systems routinely refuse treatments to injured people who are entitled to these treatments and cause an immense amount of pain and suffering to those so refused. The relevant regulatory agency, SIRA (State Insurance Regulatory Agency) (of NSW) is so keen on cost control that it seems never to censure insurers for not paying. If the statements in insurer denial letters are to be believed, they claim that they are meeting the conditions of SIRA in their refusals. This systemic culture of denial has allowed insurers to make more profits than they had anticipated and for the NSW government to actually take a 'dividend' from the CTP scheme of $950 million. This is effectively a tax taken from motorists who bought the compulsory CTP insurance when they paid for their car registration. It might be noted that more of the premium income is spent on making sure that the money is spent wisely than is actually spent on the injured people that the scheme was set up for, and the insurer culture of unreasonable denial allows huge insurer profits. In my experience approximately 16% of my GP consultations are refused[1] and 76% of patients have investigations[2], referrals or treatments denied by insurers[3]. This makes normal treatment almost impossible and renders the whole schemes little more than a scam.

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[1] See [redacted]
[2] See Appendix 2
[3] See [redacted]

When insurers in NSW refuse many treatments that are standard they allege either that there is nothing wrong with the patient, or that they had the condition prior to the accident or that it is not 'reasonable and necessary' treatment. For example, although it is well known that X-ray appearances correlate little with pain, insurers claim that even a tiny anomaly on an X-ray was evidence of prior disease, and thus the pain is not caused by the injury. This occurs even if the patient was working up to the date of the accident and is unable to work after it. The insurers often just refuse treatment, but if pressed they hire some doctors for 'Independent Medical Examinations' that will usually find either nothing much wrong with the patient, or that they had previous pathology. The patient's response to this is sometimes documented in www.ratemds.com. It is interesting that some doctors who have glowing reports from patients that they have treated, have very negative reports from patients that have been assessed for insurance companies, suggesting that they are yielding to financial pressure. (I term this Dr Jekyll and Dr Hyde syndrome). It might be noted that some doctors are brought long distances, e.g. from Melbourne or Brisbane) to do a medical in Sydney. It is hard not to conclude that this is because of their pro-insurer reports.

At a personal level in the 1990s, when such cases went to court, I used to write reports as a treating doctor. Insurers would ring me up and say things like:

'Doctor, you have said that this patient is unlikely to return to work.'

I would reply 'Yes'.

'Doctor, if you say this it will make it difficult for us to win this case'.

'Yes'.

'Doctor, if you were to say that this patient might need retraining if they are return to work, that would make it easier for us'

'Yes'

(Long pause at this point)

'Doctor, do you think that you could change wording of the report?

Me. 'No I think the report is quite adequate. As it states; his age, education, skill level and language difficulties make it unlikely that he will work again in reality, so that is what the report needs to state'.

Thank you doctor, Goodbye.

After I had left that practice, I spoke to the secretary who used to type the letters. She said, 'Gee your reports were good, I usually only typed them once. Now Dr G. is doing your job he changes them a lot.'

Most of the cases do not go to court now. Doctors decide because the legal system has priced itself out of the business in most disputes[4], but the approach of insurers has not changed.

[4] Previously solicitors would line up expert witnesses to decide cases, but the cost of these hearings was so great that there was so little money left for patients that now the law is changed so that an expert doctor, or a

They write to doctors demanding previous notes to try to find evidence of prior injury that might allow them to refuse treatments. They also spend a lot of trouble chasing old notes from doctors to try to find such information. Doctors usually do not have notes relating to injuries that have not yet occurred, but if they do not reply, insurer say that they are waiting for the information and naturally will not pay until they receive it. The delay suits them and sometimes the patients go broke waiting for treatment, quite apart from the pain and suffering of delayed treatment.

It is as if the insurers' motto is:

'Delay, Deny, Dispute'.

Delay: I spoke to an insurance claims manager some years ago and asked why it took 28 days for a workers compensation claim to be approved, which had been my systematic observation. He replied, 'It is the (NSW) Government's fault'. I asked how this could be and he said, 'We have the money and it costs us to analyse a claim. If we do not look at it for 28 days we have the use of the money for 28 days- if the government wants us to look at it sooner they should shorten the statutory response time'. I do not think that the government official who allowed 28 days would have had any concept that this time frame would be abused in a systematic way like this. He/she would have assumed that this was a maximum time needed to make a decision. Normal people cannot understand the mentality of such insurers.

I do not believe that the times frames are now as long, but there is still some month to approve a claim and every new investigation ordered by a doctor on an existing claim has 10 working days to be processed. Insurers usually take most of this, even if the tests or referrals are standard and routine. I asked SIRA (State Insurance Regulatory Authority) (NSW) if they kept figures on the delays of insurers so that consumers could make an informed decision of which insurer to choose and they said that they did not.

Delay is very important in CTP. If the patient is not working, it costs them their wages for an extra week for every week that treatment is delayed. It costs the insurer nothing. Doctors try to get their patients treatment more quickly through Medicare, private health insurance of having the patient themselves pay. This is a major cost transfer to Medicare and other systems that may not be repaid. Even if Medicare expenses are repaid, it is much cheaper than the rates for CTP and Workers Comp. so the insurer is rewarded for their delaying. A number of treatments are also not available on Medicare or have such long waits that they need private insurance[5].

It might also be noted that patients with whiplash and back pain are sometimes in severe pain, which needs to be relieved by surgery. The delay is very traumatic for patients with delays in approving the claim, then each of the steps in treatment. In the meantime they are on strong painkillers, which they may become addicted to and these are subsidised by the PBS. Insurers pay only the patient's costs gaining the benefit of the PBS subsidy, which may be considerable. Even if there is not eventual denial, the delay is an important element in the cost-shifting behaviours of insurers that render the whole CTP and WC system a less cost-effective part of the health funding

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panel of same decide what treatment is 'reasonable and necessary' or how impaired a person is. This is the 'Medical Assessment System' (MAS).

[5] E.g. the waiting time for a neurosurgical consultation for non-malignant and non-life-threatening conditions, (such as debilitating whiplash preventing employment) is 7 months at a Sydney teaching Hospital, St Vincents.

system. In injuries like shoulder tendon tears the muscles retract, and delay gives a worse result and increased morbidity[6].

It might be noted that often the cars are repaired before the people's claim is even accepted, which says a lot about insurer priorities.

Deny: Many cases where patients were working normally before their motor vehicle accidents have their lives ruined by being unable to work. But insurers would like to prove that their problems are due to prior conditions. Rather than look at what work they were doing before and after the accident, they demand previous notes from doctors to try to show that there was pre-existing pathology and cavil over tiny changes on X-rays that might show previous disease, in which case they deny liability. Even if liability is accepted, they write to treating doctors claiming that treatments that are standard elsewhere are not 'reasonable and necessary', which is the wording of the Act. Many doctors are unaccustomed to this and some back off, not insisting on the treatment, which means the patient is treated less well than they would have been. Others, tired of hassles and the non-payment of bills simply refuse to treat Workers Compensation or CTP patients. (I do not think that there has been any survey of how many doctors are in this category).

Another source of denials is when patients have had more than one accident. Each claim is separate and each one tries to claim that the other is responsible for whatever symptom the patient has, or their inability to work, even if two claims are from the same insurer[7]! In practice, people who have more than one insurer are less likely to be paid by any of them. I have one patient with three separate injuries, refused by all insurers and of such complexity that no lawyer wants to deal with him. No one could seriously dispute that he cannot work. He is depressed and broke with his life and marriage falling apart[8].

Police are not keen to do the paperwork on motor vehicle accidents and tell patients that they do not have to report them if there is no serious injury and no debris on the road. In cases such as whiplash where the significance of the injury takes some time to emerge, the lack of such a record allows the insurer to deny the accident[9].

Patients on visas have their visas checked by insurers and it is difficult to believe that refusals or delays do not happen depending on their visa status. Many people on 457 or student visas are very vulnerable as they have no Medicare, are dependent on Employers for their visas, or have very limited financial reserves. They also tend to be exploited in the workplace with sub-award pay, conditions and work practices. The enforcement of reasonable pay and conditions is also very poor in NSW as Safework has replaced Workcover[10] and few inspections are done.

Dispute. Naturally, many claims are either refused outright, or their treatment is dictated by the insurers. The object is to take control of the claim from the treating doctor to the insurer. Rather than be an adjunct to the funding of medical services in the niche market, they create 'Management

[6] [redacted]

[7] [redacted]

[8] [redacted]

[9] [redacted]

[10] www.parliament.nsw.gov.au/committees/DBAssets/InquirySubmission/Body/42525/0073 Phillip Cantrell.pdf

Plans' and then try to make the 'Nominated Treating Doctor' comply with these. Letters are sent out to the doctor with fine protestations of how dedicated the insurer is to helping the patient back to work and health. Then the roles of patients, doctors, rehab professionals and insurers are all defined by the insurers, effectively on a 'take it or stop treating' basis, similar to conditions on a bank loan. The Regulator, SIRA in NSW, sets no criteria under which insurers work in terms of their contracts with GPs, so these one-sided definitions are signed. Insurers do not even agree to pay the treating doctors reasonable fees, or acknowledge that he/she sets the treatment priorities. There may be a dispute, which is created by the insurer refusing to pay, with or without an 'Independent Medical Examination' (IME). In NSW CTP the treating doctor or the patient's solicitor get another opinion that the treatment is necessary, and the dispute goes to an arbitrating doctor of the Medical Assessment Service, which guarantees a decision within 3 months. The whole process therefore takes about 6 months, which is considered better than the legal system in its timeliness but is slow enough to send many patients broke. Naturally the treating doctors try to get treatment paid for in other ways, which suits the insurers very well, but as the Medicare rebate to doctors has declined with inflation from 85% of the AMA fee to around 46% of it[11], most specialists simply will not see patients for this, particularly as CTP and Workers Comp are likely to give rise to litigation and the need for reports etc. for years, which means doctors usually charge a premium for this work.

The role of a number of other groups needs to be mentioned here.

Private investigators for the insurers try to find fraud and this often involves spying on people who are supposedly not working and are claiming benefits in Workers Compensation. But it also is used in CTP to claim that because people are working (i.e. 'fit') they do not need back surgery etc. and are therefore refused treatment. But in reality, people may be certified as unfit by their doctors and may be quite unfit, but are forced to either work or starve. Some work in a lot of pain, and insurers use this against them[12]. Very few people want to undergo unnecessary surgery, and very few doctors want to do it, yet the role of these investigators, whose evidence is almost never examined or discussed in an open forum, is presumably crucial in refusals.

Absence Management Consultants may be used. In the US some insurers run a parallel medical record and check and approve all medical actions. Sometimes nurses are used who do home visits and advise what activities are done there, then advise that office jobs, driving etc. can be done[13].

'Rehabilitation Provider' is a new specialty that is now used to liaise between insurers, doctors and other treatment professionals, employers and even relatives. They develop 'Return to Work' (RTW) plans and timetables and negotiate modifications to workplaces, or domestic premises. In theory Rehab Providers are chosen by patients, but in practice the patients and most NTDs have no knowledge of these and they are chosen by insurers or large employers. In some cases they are owned by the same insurers or employers[14]. Because insurers generally choose the Rehab

[11] AMA CPI v Medicare Rebate See Appendix 8

[12] [redacted]

[13] [redacted]

[14] (e.g. www.chandlermacleod.com/corporate/our-teams Chandler McLeod is a company listed in the Tokyo Stock Exchange which own Rehabilitation Services and Australian Hospitality Services, a labour hire company. When a patient was injured at AHS, a person from their rehab company called me to try to stop a WC claim being made, and offering to manage the claim. I was then asked by the insurer to provide far more details

companies, and because they pay them, rehab companies market to insurers and employers, mostly stressing their ability to reduce cost, as can be seen by a perusal of their websites. Individual or small group rehab providers who would ideally compete to offer personal services have largely been driven out of the market, so the practitioners get only a tiny fraction of the costs of this exercise. The insurers are aware of their power and dictate the actions of rehab professionals, and the new generation of rehab providers see their primary loyalty to insurers rather than patients, which is presumably not what they were taught at university. Indeed since many rehab professionals go into the doctors surgeries with the patients, confidentiality is often lost and information unrelated to the injury is relayed to the insurer. At times rehab professional actually act as spies for insurers. In one case a rehabilitation person in our office said he was not part of a rehab program but was doing a 'one off visit' and wanted to look at the patient's notes! Another actually suggested to the patient that he change treating doctors while in the surgery[15]! Some IMEs also work for corporations who have rehab services[16].

What is needed is far stronger regulation of the insurance industry and a strengthening of the patients' and doctors' rights against the money of insurers who now go far beyond their role of funders of medical services to controllers of it with cost minimisation as their primary goal. In practice in NSW CTP this translates into a system where the insurer profits, insurance infrastructure, government regulatory agencies, lawyers and the legal system and the doctors who do not actually treat cost more than is actually spent on treating patients. The overheads are 55%- an incredibly poor outcome for a financial system, yet it rolls on 'saving' money on treatment, creating costs which are then picked up elsewhere by the health system, as few of the treatments requested are unnecessary. It might be noted that Medicare's overheads are 4.7% and universal coverage could allow all doctors' cost-effectiveness to be compared.

It might also be noted that even as a treating doctor more than half the time spent at work is compliance with the insurance system demands. Requests have to be more detailed, there is far more reporting, and chasing up approvals or responding to denials is very time consuming. The defensive nature of practice is also time-wasting. E.g. If a person has a car accident, they might come in with a complaint and have treatment. They come in a few days later and say, 'I did not mention it last time but I also have another complaint'. In a normal context this would be accepted and treatment provided. In an insurance context, if there is no complaint initially the insurer often will not accept the later complaint as caused by the accident. So the treating doctor has to write a lot of detail that will later prove trivial, 'just in case'. This further lessens the cost-effectiveness of the insurance schemes. The adversarial nature of practice wastes time, and results in some doctors refusing to work in the system, still others to change their management plans to comply with insurers wishes.

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than usual before the claim was accepted. I engaged alternative rehab provider but have been under a lot of insurer pressure to return this patient to work, when I do not think that she is fit and believe that the repetitive work that she was doing was responsible for her injury. The patient is ethnic with poor English, needs a job and comments that 'there is a lot of staff turnover at this job'. She is reluctant to make any complaint herself. Case 58.

Allianz set up the Recovre Rehab group, which has since been sold, but continues to work with Allianz, advising them that patients are fit to return to work in material sent from the insurer to pressure the NTD.

15 [redacted]

16 [redacted]

Systematically Undermining the Nominated Treating Doctor's Role.

It is assumed in legislation that the treating doctor will be an advocate for the patient and that he/she is the key person in determining what happens to the patient, but it seems that insurer policy is to marginalise this role, in order to be able to minimise their costs. Medical practice is always in a state of some change and one of the current changes is the use of 'protocols' for certain treatments. Historically, doctors reasoned what was wrong with the person, and tailored a sequence of investigations and treatments depending on how the patient improved or not and the results of progressive tests. More recently, the sequence of these has become more discussed in the medical literature with large studies from linked teaching hospitals leading to flow diagrams. This has made it easier for managers to manage doctors, as the patients are then classified on a simple aspect and doctors are them criticised if they do not follow the protocol. Often the protocols involve a lot of tests, as they originate from big US teaching hospitals. There is also a view, particularly in the Emergency Department protocols that they most important thing is to get a diagnosis quickly as treatment delays are far more detrimental than the cost of the investigations. In other cases there is literature suggesting that a period of conservative treatment should be tried before investigations are done, as in some cases more aggressive treatment will not be necessary. But few, if any, of these protocols ever beat studies of good doctors arranging tailored treatment for each patient, so good medical judgement is still the best way to optimise treatment.

Insurers seek to undermine the doctor's role by refusing treatments, or pressuring doctors to alter their management plans. This happens in a number of ways:

1. Insurers cite guidelines of management protocols which suggest that investigations are premature as a longer period of conservative treatment is needed. Doctors need to judge each case on its merits, but are thus prevented from doing so in order to save insurers money. Insurers claim that they only have to pay for 'reasonable and necessary' treatment in these refusals.
2. Treatment doctors are not routinely informed of treatment denials by professional's other than those that they have ordered. For example, if there is a referral to a specialist who then orders a treatment, this may be denied to the specialist, the patient or the patient's solicitor, but the Nominated Treating Doctor may not be informed. Patients may be discouraged and not return, or not appeal the decision (not that the appeal does much good in most cases).
3. Role definitions of people involved in treatment are written by insurers for insurers and sent out for signature/approval like a bank contract- take it or leave it. It is assumed that as the insurers pay they can dictate the terms. The role of the doctors in determining treatment is not mentioned, nor is the obligation of insurers to pay. It might be noted that the regulator, SIRA, is totally silent and has no guidelines as insurers go about re-defining roles in their own interest. In the latest letters since the changes to the NSW Motor Accidents Act effective from December 1 2017, insurers only have to pay for 6 months treatment if it is a 'soft tissue injury', so they write to the patient with a 'Management plan' which they have decided on the basis of the Treating Doctor's first certificate and they then simply tell the victim that is they have any problem about the 'plan', they are to contact the insurer. The bottom line is that payments will cease in 6 months, and the contract is between insurer and victim, the doctor is not mentioned except as the source of the certificate and initial diagnosis. This is likely to result in many patients assuming that they are ineligible for treatment and need not

go to their doctor. Quite a high percentage of these type of injuries have symptoms that go on for considerably longer than 6 months. The government has changed the legislation to minimise treatment to save costs, to such an extent that one wonders what use the legislation is. After the end of May 2018, many patients are likely to fall foul of this.

4. Management plans are often worked out by insurers with the help of whatever internal advice they may have, and sometimes with the input of rehabilitation professionals. This is them presented to the treating doctors as a 'Return to Work' timetable for signature. It is often accompanied by literature which shows that patients recover much better if they return to work, and are much more prone to mental illness if they do not.
5. Rehabilitation providers are then sent in to case conferences and pressure the doctors to sign these agreements. I am unsure if there are bonuses for getting doctors to sign, but appearances would be consistent with this, as it seems a major imperative for Rehab providers to please insurers.
6. All the forms to be filled in have estimated return to work dates on them, and doctors are pressured to state a date, even if this cannot be known. If the doctor does not give a date, there is pressure to do so, and if this date is then not met, the doctor's competence is questioned.
7. If patients are not certified to return to work as quickly as the insurers would like, the rehab professional may then contact the insurer who may want to be present at the case conference (usually by phone). The doctors may then be told in no uncertain terms that his/her case assessment is not satisfactory and that 'evidence is being assembled to change your management plan'. This will involve a 'Functional Assessment' test by someone chosen by the insurer and/or an Independent Medical Examiner (IME), who is a doctor whose opinion is usually based on a single visit, very favourable to the insurer, and without consequence or responsibility for the IME.
8. A more recent variant of the above is the redefinition of the notion of unfitness. Previously a doctor certified a patient as 'Unfit for work'. But this is undermined as there is now a 'Certificate of Capacity'. The idea is to stress what the patient can do, and then tailor a job for that. But employers have incentives in terms of premiums to return patients to work, so will state that there is a job even if the patient has minimal capacity. Rehab providers then do home visits that show that patients can cook meals or do minimal housework, or persuade patients to move weights or do other tasks that show some capacity. The doctor is the pressured to sign these certificates of capacity. The patient is either forced back to work, or is deemed 'non-compliant' with reasonable treatment and assessment of his/her capacity and has their benefits ceased. Once 'back at work' the tasks as defined are often extended or the fact that they have such capacity is used to reduce any compensation that they may get at law. Insurers have actually stated that a doctor is not able to state that a patient is unfit, only to certify their 'capacity'. This is leading to a situation where everyone can be deemed able to work, and be disposed of later.
9. Should a doctor certify that a patient is unable to do the tasks that they have been deemed fit to do, he/she is put under great pressure with the suggestion that as he/she did not do the functional assessment, he/she is either going beyond his/her level of competence or is a dupe of the uncompliant patient. At times the rehab provider will go to a specialist as well as the NTD and take the certificate from the specialist, then tell the NTD that he/she must

comply. Specialists at times are somewhat optimistic about their post-op timetables and may not be aware of what the patients are actually going to be asked to do.

10. The negotiation of the tasks that will be done in a return to work situating may involve changes to the distribution of tasks done at the workplace and may involve quite sensitive negotiations with employers and other employees. It is important in this situation that the rehab provider is acting in the patient's interest, rather than as a cost minimiser for insurer and employer, but this situation is being continually undermined as stated above.
11. Insurance clerk frequently give doctors gratuitous advice about how to manage individual patients, as well as generic advice. This is a mild irritation, but more significantly indicates the patronising attitude engendered in insurance clerks. An interesting and ironic example is the advice from GIO which tells how it is much better to get people to return to work as it improves their mental health. It says that they are 6 times more likely to have mental problems and 40 times more likely to suicide if they cannot return to work. However, when people who cannot work and are depressed try to claim that their depression is related to the terrible change in their circumstances, the insurers will not acknowledge that it relates to the accident.
12. The systematic bullying of treating doctors, the continual demands for justification or information for every treatment requested, and the capricious and venal denials are what makes a considerable percentage of doctors either modify their management against the patients' interests or refuse to do this work at all. SIRA has done no surveys to look at this.
13. The continual change of personnel managing claims seems designed to stop any relationship developing between the patient and their claims manager, or any understanding of the patients' injuries, symptoms or problems. I have often invited claims managers to meet the patients, but they are rarely keen. NRMA have moved their staff to Newcastle, so that it is geographically impossible. Thus the people managing the cases are distant from the patients they are managing and more likely to see them as 'cases' or financial problems. There is presumably significant resentment and anger from patients as GIO no longer gives the surnames of the case managers, and neither will Allianz when they call clients, even if they initiated the call[17]. Allianz no longer has direct phone numbers. It is 1300 wait a long time. Case managers are frequently unavailable and insurers are poor at returning calls. It might be noted that 'all calls are recorded for training and quality control purposes' which is fairly intimidating. So as a trial, I asked that this be turned off. GIO staff are unable to do so, and state that they have to ask that it be deleted after the call is complete. Allianz cannot either and have to call back if you do not want the call recorded. The recording protocol is part of the assumption of an unequal power relationship.
14. When documents are demanded, the whole file is demanded. In most medical records, confidentiality is assumed for the whole record and compensable and non-compensable information is mixed throughout the file. If the file is computerised, nothing can be deleted untraced, and there is no edit function for later. In paper files, notes are usually chronological by visit and redacting would be very time consuming. One doctor that I know

[17] [redacted]

billed for time sorting out compensable from non-compensable information in a file that he had to submit, and the insurer declined to pay for this time.

15. Letters from insurers denying treatment sometimes do not even have the patient's names on them, merely the claim numbers and dates or invoice numbers. One cannot escape the idea that the whole case is merely a financial exercise.
16. QBE now have a 'Whiplash Recovery programme' that they are keen the doctors submit their patients to. It might be noted that they had already suggested the treatment to the patient before the treating doctor is informed of the programme. Given the delays and denials, one can only wonder if this 3 month programme will waste the time that insurers are liable for, which is 6 months, and it further takes control of the patient from the treating doctor. I attach a copy of this invitation in Appendix 5. No doubt they will claim that this is all in the patient's interest, but again it is another step of the insurers deciding the treatment, and as has been shown elsewhere in this submission, they deny and interfere in many treatments.
17. The refusal to fund such a high percentage of treatment or investigations seems inexplicable on medical grounds. However, in an adversarial legal framework it makes sense. If a patient has no proven pathology and no specialist confirming a diagnosis, their settlement will be lessened. It is difficult not to believe that this is major motivation in insurers' denials. To be fair, occasionally plaintiff's solicitors are keen that there be more investigations and referrals, but these are far less invasive to medical practice, as if they normal there is no change to the settlement, and such solicitors are willing to accept an opinion that there is no point in doing tests that are likely to be normal.
18. The precedents being set by insurers in the way that they dictate to treating doctors are likely to be extended as private insurance spreads as governments withdraw from funding treatment and Medicare withers. This is likely to lead to an American situation where health is a commodity and cannot be accessed if it cannot be afforded. This is already the case for many of my patients.

To answer the Questions on your website:

Which of the Royal Commission's terms of reference is your submission about?
My submission relates to all three of the Commission objectives as stated below:

1. Misconduct or conduct falling below community standards and expectations
2. Culture or governance practices and other
3. Effectiveness of redress for consumers

What did the financial services entities do that amounts to misconduct or conduct falling below community standards and expectations?

Insurers have provided very poor service and treated patients injured in NSW under the CTP and Workers Compensation systems with suspicion and contempt and treated the doctors trying to treat them similarly.

When did this happen?

This has been systemic for a long time.

What do you think caused or contributed to these events?

The Workers Compensation and Compulsory Third Party insurance systems pre-date Medicare[18] and were set up to provide insurance cover for medical treatment to people injured at work or in Motor Vehicle accidents. Hence there is a historic legacy of practice with legislative changes and economic factors modifying how the system is practiced.

When Medicare was introduced, it was possible to have universal medical services and treatment was available with most specialists willing to provide services. Even now, most people do not realise that many specialists have withdrawn Medicare services and waiting times are over a year for significant surgery.

The private insurance systems continued after Medicare was introduced because they were there and because they paid slightly more than Medicare, so were faster in getting people treated and back to work. Because people do not realise that Medicare will in practice not treat them for elective surgery, and because normal Private Health Insurance pays a percentage there is not as much attention from the public to the refusals of treatment by the CTP and WC insurance non-providers.

But the Workers Compensation system is seen by employers as a cost, and car registration was rendered more expensive by CTP, so there was pressure on the government to lower premiums. The insurance industry and perhaps their own ideology persuaded the government that competition would lower costs. The NSW government set up SIRA under the **State Insurance Care and Governance Act 2015** to regulate the payments, but the regulatory system has actively encouraged insurers to cost control rather than pay patients, so the insurer profits have blown out to far more than was expected because they have been able to refuse more treatment that they ever projected as possible, and the NSW government taken a 'dividend' from the scheme, which has become a 'refund' which the government hands back to motorists[19], while patients simply do not get treatment.

Under the Act Part 2 Division 1 Section 7 the Minister may direct the iCare board to act in the public interest. He has not done so.
It might be noted that the objects of SIRA[20] have regulation and cost control before the need for treatment and have no statement that the whole system has as its primary objective to look after the injured people, which is mentioned in (d).

23 Principal objectives of SIRA
The principal objectives of SIRA in exercising its functions are as follows:
(a) to promote the efficiency and viability of the insurance and compensation schemes established under the workers compensation and motor accidents legislation and .. the other Acts under which SIRA exercises functions,

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[18] Fronsko A, Woodroffe A, 'Public vs. Private underwriting and administration of personal injury statutory insurance schemes', Presented to the Actuaries Institute, Injury & Disability Schemes Seminar, Brisbane 12 – 14 November 2017 p3 www.actuaries.asn.au/Library/Events/
[19] https://www.nsw.gov.au/news-and-events/news/green-slip-refunds/
[20] www.legislation.nsw.gov.au/#/view/act/2015/19/part3/div2

(b) to minimise the cost to the community of workplace injuries and injuries arising from motor accidents and to minimise the risks associated with such injuries,

(c) to promote workplace injury prevention, effective injury management and return to work measures and programs,

(d) to ensure that persons injured in the workplace or in motor accidents have access to treatment that will assist with their recovery,

(e) to provide for the effective supervision of claims handling and disputes under the workers compensation and motor accidents legislation and the Home Building Act 1989,

(f) to promote compliance with the workers compensation and motor accidents legislation and the Home Building Act 1989.

The first two objectives of this Act are being more than adequately served, but the others are totally neglected. To be more specific re objectives c-f comments are:
(c.) The Workcover inspectorate has been gutted, so there is minimal inspection or enforcement. It has been renamed Safework for some reason. The paucity of the functioning inspectorate and few penalties for unsafe work practice has made for neglect of workplace safety, and bad work practices increasingly common[21].
(d.) I have written a number of very detailed complaints when insurers have denied treatment to CTP victims and SIRA has always supported the insurers[22], so supervision of reasonable treatment is minimal, if any.
(e.) They do not keep statistics of claims accepted, denied or the time lags before claims are acted on. As stated above, there is no supervision that ensures that victims actually get help. It may be that insurers' protocols are insisted on, but as a practitioner, no benefit to victims is evident from this.
(f.) In that the workers compensation and motor accidents legislation are to provide benefits to injured people and the object of this system is to minimise payouts, they are effectively working against the objects of this primary legislation.

Did you make a complaint in relation to what happened?

I have complained to SIRA both in terms of specific cases and in terms of the overall changes needed.
In terms of two cases[23] that I complained about in great detail, the complaints were dismissed and the insurer supported. I appealed and the same result ensued. I was given 84 pages of documentation, which did not include a reason why the claim was denied. (He was rear-ended at the traffic lights, so was presumably in the right from a traffic point of view). I wrote a long analysis of why SIRA was not helping the patients and how it might change and

21 [redacted]

22 [redacted]

23 [redacted]

got a patronising and dismissive letter that parts of my letter would be sent to the relevant parts of the department[24]. I can provide details of this if required.
More than this I have written to the Chair of the Law and Justice Committee who had a statutory review of the State Insurance and Care Governance Act 2015, which tabled its report on 17/12/17. Unfortunately I had not heard of this review until after it was tabled. As there were only 16 submissions and none from patients of their doctors, I was obviously not the only one who did not notice that it was reviewing. The Committee, saying little about the delivery of care to patients, and mistaking administrative arrangements as achievements in Sections 1.19 and 1.25 of its report[25], finds the system is working quite satisfactorily, and this is confirmed in my reply from the [redacted], attached in Appendix 7. I have also written twice to the Health Minister pointing out that these insurers are merely shifting costs to both the NSW and Federal Health departments as this Act is supposed to be funding the WC and CTP systems to supplement health resources. He referred me back to the minister responsible for this Act rather than looking at how it fits into a broader picture of health funding[26].

What culture or governance practices and other practices (including risk management, recruitment and remuneration practices and/or the use of a superannuation member's retirement savings by a financial service entity) of the entity are of concern and why?

The internal mechanisms of review by the insurers are not usually used by patients, and are generally not regarded as credible. For example, the NRMA's internal review used to involve 3 steps:

1. An appeal to the actual case manager, then
2. An appeal to the 'Team leader' and
3. An appeal to the chief claims officer of NRMA.

Almost no one went through these 3 steps and it might be assumed that if anyone did they might get different treatment from the norm as they had flagged themselves as dissatisfied and likely to make further trouble.
But only after one has been through the insurers' internal processes will the government regulator, SIRA, take appeals against treatment denials. They also had no actual appeal form on their website and no street address for conventional mail. (This is now rectified). But SIRA Disputes and Resolutions Service Executive Director, [redacted] claimed at a meeting of doctors at the Wentworth Hotel on 13/11/17 that there were very few disputes (less than 0.1%) on the grounds that he did not get any complaints. I wrote to SIRA stating that the insurers' guidelines were a farce and that they should have better procedures. In fairness there is now a one-step appeal process since the regulations associated with the new legislation have been introduced on 1 December 2017, but there are a huge number of people who were denied under the previous regime and who have no redress. It is yet to be shown that a single appeal to the insurer will make it much easier, as many people injured are unaware of their rights, and most doctors are unaware of the scheme changes, find Workers Compensation and CTP too time consuming and difficult to work in, have this part

[24] I am able to provide copies of this correspondence if required.
[25] www.parliament.nsw.gov.au/committees/DBAssets/InquiryReport/ReportAcrobat/6137/Final Report - Statutory review of the State Insurance and Care Governance Act 2015.pdf pages 4 and 6
[26] Appendix 7 Correspondence with Health Minister Hazzard and Committee Chair Shayne Mallard

of their practice as too small to worry too much about, and tend to work around the insurers' demands rather than confronting them on behalf of their patients.

My submission to this inquiry is that SIRA has not supervised the insurers adequately. It seems as if their object has been to ensure that as little money is spent on accident victims as possible, rather than the insurance monies being spent wisely to facilitate treatment of people injured in accidents, which is surely the object of the scheme more broadly. In practice it has allowed, accentuated and emboldened insurers to deny legitimate claims and treatments.

This is a serious regulatory failure, which I would like the Royal Commission to investigate.

It would seem that the regulatory capture extends beyond the bureaucracy to the Government itself and one must wonder at the relationship between the insurance industry lobbyists and the Minister, or at very least, the obsession with insurance monies over the broader objectives of the WC and CTP schemes as having their primary objective to deliver health care. The changes to the Motor Accident Injuries Act 2017 (NSW) which came into force in December 2017 allow accidents to classified as 'minor' by insurers based on the initial certificate from the doctor and then not pay after 6 months reinforce this impression. After 6 months in 'minor injuries' (or when the injured person is 61% at fault or uninsured), which are likely to about 98% of cases, payment is only required if it will 'improve the recovery of the injured person' Section 3.28(3). Given current insurers practice it is likely that treating doctors will be told that physiotherapy, pain medication, or perhaps even surgery visits will not 'improve recovery' and hence will not be funded and will be forced back onto other insurances. One asks whether this legislation is worth having.

The appeal system as described above has been replaced in December 2017 by a system whereby insurers have a single appeal, and after this there can be an appeal to SIRA. SIRA has created a large number of positions for doctors to act as 'Medical Decision Makers[27]'. This was expounded by the Executive Director of SIRA's Disputes Resolution Services, [redacted] on 13/11/17[28]. The reason that these medical disputes decision makers are needed is because insurers create disputes by refusing so many legitimate treatment requests, and rather than disciplining insurers, SIRA is cleaning up afterwards by resolving the disputes that they have allowed insurers to create. The doctors will be paid upwards of $400 an hour for their reports, but this is necessary as any judicial process is far more expensive than this. (The fact that the cost of judicial processes in Australia takes justice from a large section of the population is beyond the terms of this submission). Needless to say that all monies spent resolving these unnecessary disputes comes from the pool of money that could be treating accident victims, and is effectively an overhead in the scheme. As stated above there may be surprisingly few disputes as patients and doctors are so disempowered by the scheme.

[27] I must acknowledge that I have applied for one of these positions, and have been shortlisted at the time of writing this. I recognise that my historical criticism of SIRA and writing this submission may not further my job prospects.

[28] SIRA Seminar for Doctors Wentworth Hotel, Sydney 13/11/17

How effective are the mechanisms for consumer redress and how could they be improved?

The mechanisms are not effective, as is described above.
The first step in fixing the situation is to draw attention to its systemic failures as without this there will be not change.
Secondly the scheme needs to have its objectives clarified. It is an insurance niche which provides funds for workplace accidents and motor vehicle accidents. As such it must take its place as a cost-effective funding mechanism, and if it is not doing this, which it is not, it must be changed until it does.
Thirdly, the regulatory system must not consume so much of the funds it is supposed to protect and must regulate in the interests of consumers, not merely minimise payouts to patients, while allowing super-normal profits in a government-created market.
Fourthly, if there is to be competition (which I do not advocate), the regulator must produce performance figures which allow consumers to choose between companies based on their payment records. Such figures should include patient and doctor surveys of satisfaction.

My preferred solution to the Insurance problem would be:

1. That all the whole CTP and WC systems be abolished and replaced by an income guarantee insurance scheme and a universal health insurance scheme. This would require a huge improvement in Medicare. The Medicare rebate has been deliberately allowed to fall from the 85% of the AMA fee to around 46% of the AMA fee so very few specialists will use it, so patients simply would not be treated for at least a year, the current Medicare waiting time. Medicare could be improved by raising the rebate by supplementing their funding from the CTP and WC schemes which would be abolished and from taking the tax-deductibility and subsidy from Private Health Insurance. A new computer for Medicare could also control doctors' fees and also stop extra item numbers being used in many procedures.[29]
2. Assuming that Medicare will not be fixed to a level to make treatment of accident victims viable under it, money from CTP premiums could pay for police to document accidents. Such documented accidents requiring treatment would then be paid at a multiple of the Medicare rebate by the Medicare computer, in a special category of post-accident treatment.[30] The CTP fee would then be composed of a levy paid to the police to document accidents and potentially an income guarantee insurance component. The advantage of this would be that medical treatment would not be controversial as Police would have verified the accidents. There would be far less waste/overhead than is currently the situation.

What I would like the Royal Commission to do

[29] The overcharging and use of extra item numbers by some specialists in the CTP and WC system and elsewhere is acknowledged as a problem that exacerbates insurer resistance to treatment, but is not addressed in this submission, as the author does not have specific, quantative knowledge of it.
[30] I would estimate that a minimum multiple of two and a half times the current Medicare fee would be necessary, as the legal report needed mean that many doctors will not do CTP and WC now because of the extra time and stress involved. Assuming Medicare at 46% of the AMA fee, then 2.5 x 0.46 = 1.15 times the AMA fee.

1. Investigate the insurance industry systematically as it did the banks, and look at the profiteering, cost shifting, delays, cost effectiveness, callousness and arbitrariness of Insurer behaviour.
2. Look at existing regulatory mechanisms such as SIRA in NSW and assess their role in managing insurers and helping injury victims, and their independence, effectiveness, and cost-effectiveness.
3. Either examine the broader issue of health insurance in Australia or recommend that another similar inquiry do so.

What changes would you like the Royal Commission to recommend?

1. Ideally that private insurance be ceased for CTP and WC and either replaced by an improved Medicare as suggested above, or by a single government-owned insurer on a cost-neutral basis.
2. That a meaningful, simple and accessible regulator be established to be a cheap avenue of appeal for insurance consumers that allows redress before the costs of court appearances are necessary.
3. That if private insurance is retained, treating doctors are paid in a similar way to Medicare or other private health insurers.
4. That standard contracts for insurance roles be promulgated by the regulator so that insurers compete on price for a known product and complex variations in wordings cannot be used to deny claims or supplant treating doctors' roles.
5. That the regulator keeps records of comparative indices such as the rate of denials and payouts of insurers and make these public to allow an informed market to control costs.
6. That insurance be considered a public good, and a government-owned insurer be available for cost control in the market and with the reserves used for public projects.
7. That steps be taken to give control of rehabilitation back to treating practitioners and be made to act in the interests of victims, rather than insurers.
8. That all insurance schemes for accident be 'no fault' so that those who need treatment are not punished by the lack of it.

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Submission to Royal Commission into the Banking and Finance Sector

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Summary of Appendices

Appendix 1 [redacted]

Appendix 2 [redacted]

Appendix 3 [redacted]

Appendix 4 [redacted]

Appendix 5 has 3 items of insurer correspondence:

1. NRMA's internal appeal procedure after a denial of treatment
2. QBE's Whiplash Recovery Programme- home based and done by them
3. GIO flyer which encourages doctors to return patients to work, saying that the incidence of mental health issues is far higher in people who do not.

Appendix 6 [redacted]

Appendix 7 is my correspondence with [redacted] and [redacted]

Appendix 8 is an AMA document which illustrates how the Medicare rebate has declined against the CPI, making private insurance necessary for timely treatment from specialists, and also undermining GP services