The problems with the Authorised Health Practitioner concept are a symptom of a wider malaise within the WC and CTP systems that need to be stated. Certainly the problems with the AHP cannot be fixed without a wider review of the system. The system is inherently adversarial, a fact that SIRA seems unwilling or unable to deal with. SIRA's model is fundamentally flawed. One of the most obvious manifestations of this is SIRA's continued use of the term 'Customer' to refer to the patients for whom it is responsible. A customer is someone who purchases an item, usually with some discretion and the option not to purchase it. Taxpayers are not usually referred to as customers, as they have no choice in whether they pay or not. People injured in CTP accidents are patients and they have to have treatment. The fact that Medicare is inadequate and a private insurance CTP system has been set up to treat them does not make them willing 'customers' of the insurers. They are there because they have to be. WC insurers cannot argue that the patients are their customers, as it was the employers not the workers who purchased the policies. CTP Insurers may argue that since the people purchased the Green Slips they are 'customers', even though they are now patients also, (though often not of the insurer that they purchased the policy from). But SIRA cannot argue that they are SIRA's customers. SIRA sold them nothing, and most patients are unaware that SIRA even exists. SIRA is responsible for the treatment of injured patients and needs to acknowledge and face up to this responsibility. The fact that SIRA was set up by insurance industry people with the model that it was to save money and keep premiums low is the historic reason both for the term 'customer' and the wrong-focused nature of SIRA's endeavours. When SIRA starts to realise that its principal task is to ensure that insurers actually pay for treatments rather than maximising their profits, it will begin to be useful. To do this it needs to acknowledge that it is regulating an adversarial system with a huge power imbalance between the participants and to behave accordingly.

This submission will deal with the problems of the AHP system, but also suggest what needs to be done to repair the system. These are repairs are certainly beyond the scope of a discussion of the AHP framework, and probably beyond the power of SIRA.

The AHP concept is quite a good one. The legal system is so expensive and so slow that it is incapable of resolving medical issues within a realistic and cost-effective time line. It is an adversarial and confrontational system, where deciding a medical issue involves getting a number of medical witnesses to pit their opinions against each other, coached and presented by lawyers. The cost of this process is usually more than the cost of the treatment, and the time delay is likely to send the patient broke and his or her morale beyond repair. The use of doctors to make medical decisions is obviously better, though there are some caveats on this approach.

The first is to recognise the artificial nature of the AMA Guidelines to the Measurement of Impairment. These were designed in an agreement between the AMA in the US and the insurers and attempts to be a neutral assessment of impairment, made objective because pain is not considered. Removing pain may remove an unmeasurable variable, but since pain is often the main reason that people are disabled the percentage becomes meaningless. In many cases the easily measurable things do not correlate well with the degree of impairment because of the pain. There is also no distinction between impairment and disability. (If I have poor vision I am impaired, but if I wear glasses I may have no disability- so the lack of a work context also undermines the AMA guide's credibility).

The second is the other influences on the examining practitioner. If he or she is paid three times as much to find not much wrong with someone, as he or she might be paid in a normal consultation, there is a

considerable incentive to find for the person who pays. It is interesting to look at the www.ratemds.com site where some of the IME examiners have patient feedback. Some IME doctors have glowing references from all the patients that they have treated, but scathing references from all the people that had IME examinations from them. We might term this the 'Dr Jekyll and Dr Hyde' syndrome and wonder at its origins. It may be that some doctors have the view that many people fake illnesses and that they must look for inconsistencies in the history or examination which allow them to diagnose faking or malingering. Buoyed by their egos, political and social views, insurer blandishments and possible venality they may decide that the medical problem is not real, was there before the accident (which was presumably coincidental to its manifestation), or is largely made up or exaggerated. When they accept people as they find them, they can make quite reasonable medical decisions.

But it seems that the essence of the AHP system was to have a cadre of doctors in Workers Compensation and CTP. Years ago, a Dr Kelvin Wooler was employed by WorkCover and tried heroically to educate doctors (principally GPs) in Occupational Medicine and even produced guidance notes that were superior to any textbook available at that time. He is sorely missed, there appears to be no training for doctors to become AHPs- they merely apply. Unsurprisingly, the 'qualification' is barely noted and rarely sought after by anyone referring. GPs who give away their WC and CTP patients do so not because they want the excellence of an AHP, but because they cannot stand the extra paperwork and insurer harassment that these type of patients create. Usually they do not even think whether the doctor they give them to is an AHP or not- they are handing over a problem that they do not want.

Given the delays and costs of arguing over whether treatments should be given or not, the idea of having an AHP with relevant expertise to adjudicate the merits of the case is a very sound idea. The legal system has been abandoned and the DRS and PIC systems have long delays, which were bad before COVID and are now worse. The question may be asked, 'Why is this AHP idea not used more?'

The low profile and status of the AHP system might be offered as a reason, but if insurers and plaintiff solicitors were genuinely searching for referees in their disputes it is unlikely that finding such would be beyond their collective wit. Fundamentally the treatment disputes are created by insurers who do not want to pay for treatments. This author has followed more than 200 IME appointments. As an NTD he has got the results of about 20% of them. In almost all cases where the plaintiff solicitors have chosen the IME, the specialist has agreed with the treatment suggested. In most cases the insurer-chosen IMEs find against the treatments, their advice is taken and the NTD does not even have the courtesy of a copy of the advice. It is noteworthy that SIRA has declined the author's repeated requests that the insurer be required to give a copy to the NTD, whose treatment is being denied. At times when the author has received such IME reports, they have often contained errors or been irrelevant.

One orthopaedic surgeon had to examine a patient's wrist which had a residual step in the articular surface after a very nasty compound fracture. He got the patient to squeeze his fingers with both hands and said that the patient's power in both hands was the same. Serial measurements comparing the hands quantitatively with a JAYMAR on 5 occasions by the NTD showed that this was not so.

In another case the insurer did not want to pay for weight loss surgery in a patient who needed it prior to back surgery (that the insurer had previously tried to prove unnecessary). A Professor of Gastroenterology was enlisted to prove that the patient has been obese prior to the accident, a fact that was blindingly obvious and readily conceded. What it illustrates is that insurers will pay almost anything to anyone if they think it will save them more money than the treatment suggested. 3 years after the accident the plaintiff

lawyer seeming has to prove that the insurer is responsible for treating the patient as they found them, and obese patients cannot have treatment refused merely because it is more trouble. In this case the insurer is paying for regular psychological help to stop the patient committing the suicide that he has threatened, but still cavils over the length of the NTD visits as the Community Mental Health Team, activated by the local police after a triple 0 incident call for details.

It might be noted that there is an increasing tendency for cases to settle before treatment that were denied are completed. As time goes by the patient becomes more and more demoralised. They often become behind in their house payments, or are evicted for not paying their rent. Their relationships fall apart. They become profoundly depressed. The plaintiff solicitors have not been paid, but get quite a lot of money for a quick settlement, so have an incentive to settle. If the patient has spinal surgery, the insurer has to pay for the surgery, and the fact that they have had the surgery gives them a greater percentage impairment in the AMA Tables. So the insurer sees themselves as paying twice, so they want to delay as much as possible. The patient, browbeaten into taking a settlement, then has to spend quite a lot of it getting the treatment that he or she should have years ago, and knows that they will probably not be able to live in the residual sum.

This is why insurers do not pay. It makes perfect sense as an economic rationale, because the insurers are in there for the money. They are in a total conflict of interest position at all times, as any money they do not pay to patients they keep as profits. There are no figures comparing their case management records in paying or not paying injured people, so consumers have no knowledge of what CTP coverage they will get. As the author has informed SIRA on a number of occasions, some insurers are more reluctant to pay for treatments than others, but SIRA has declined even to collect figures that would allow comparisons, let alone collate these and make them public. It might also be noted that in this supposedly collegiate system the patients' most confidential records are freely available to insurers, but the insurers' records are not available at all. In that they are both a record of treating or the reason for not treating, it should be asked 'Why not?'

If SIRA wanted to improve the situation with the use of AHPs to resolve disputes, it would have to be in the interests of insurers to do this. Currently, if treatment is refused a number of things may happen. Most commonly the NTD tries to get the patient treatment either from his or her private insurer, or from Medicare (which for most non-emergency operations takes a year). In some cases the patient merely waits and suffers. This is particularly the case with migrants and visa holders who have no Medicare and may go home in despair to their own countries. It seems that some insurers are quite keen to look at the visa status of patients in the hope that this will happen. In all the above scenarios, the insurer saves money. If the patient goes through the usual process and sees an IME for the insurer, then an IME for the plaintiff solicitor, then a DRS or PIC process and the insurer 'loses', the insurer has no penalty. They merely have to pay for what they would have had to pay for anyway. So the insurer is like a kid shoplifting where their worst penalty is to have to put it back, and that does not happen often.

Until SIRA monitors and enforces insurers paying for NTD's treatments the situation for patients will not improve, and AHPs will continue to have only marginal relevance.

While the inquiry is examining it accreditation of doctors it need to look at the process of accrediting the doctors who do the DRS medicals. The author notes that in the application for this, doctors had to supply samples of medical examination reports done for both insurers and plaintiffs. In that insurers create almost all of the disputes that need to be adjudicated, and that they are unlikely to give work to doctors who do

not find for them, this changes the pool of doctors who might apply for such positions. The author understands that there is an insurer representative on the final selection panel for these doctors and if this is so would comment that this is most inappropriate. It assumes as collegiate approach by SIRA and insurers which does not exist. The reeality is an adversarial framework, and while SIRA continues to take this naïve approach, patients will continue to have their treatment denied. Insurers should have no part in DRS doctors' selection.

This is not to say that SIRA's role is easy. The history of regulation in Australia is not a proud one. The banking inquiry did not come from the ASIC or APRA, but from whistleblowers. The casinos had regulatory bodies in each state, but again appalling things were uncovered by whistleblowers. The Parliamentary attention to iCare came not from the regulator, nor from patients' complaints but from a whistleblowing inside auditor complaining about the misappropriation of monies.

A possible inquiry into the NSW WC and CTP insurers were truncated in the case of the Hayne Royal Commission who did not get time to look at the State insurance bodies. The Dore inquiry found the problems but was very euphemistic in laying the blame, and had solutions that were merely management gobbledegook without hard targets or actions. iCare was able to accept its tepid recommendations. Even then the report's release was delayed until just before Christmas to ensure that there was no political story. Unsurprisingly the outcome of the Dore report was that nothing changed, and the McDougall Report has followed the same path. Now there is the statutory review report by Clayton Utz and Deloittes. Why would anyone think that corporate lawyers and accountants would have a clue what is happening? How many doctors are paid a fortune to advise on corporate tax and law?

The problems of the overcharging by sections of the medical profession could also be addressed by SIRA. MRIs can be obtained for $250, but the charge is $1750. The author is at a loss to know how this occurs. If NTDs were supported by SIRA in terms of getting information about what consultants charge and who does what this could be also be addressed. Ideally there would be monitoring of consultants' results in a way that would let NTDs compare the results of specialist interventions; this might help also. This should be done at a national level, and SIRA could seize an initiative to catalyse this with the cooperation of the medical colleges. SIRA's lack of engagement with them is another manifestation of the problem of a financial orientation in the WC and CTP systems. The AHP system is sadly irrelevant in all of this.

The key problem is that the Minister, SIRA and many others see the WC and CTP systems as a financial problem, which brings this submission back to the first point made. These schemes should be about Patients, not Customers. The word is important because it reinforces the focus. Until the CTP system is forced by the regulator to be a system to pay to treat injured people and the insurers are forced to do just that it will still have the problem that the money goes into anything but paying to treat patients.