Submission from the John Walsh Centre for Rehabilitation Research on the Insurer claims handling and dispute resolution in compulsory third party (CTP) motor accident insurance discussion paper

The plan to move to a defined benefit scheme that focusses on quicker outcomes with emphasis on health, work and quality of life is strongly supported. The reasons for this were provided in our previous submission and, in summary are, that an adversarial fault based system does not assist injured people to recover, resume normal activities and to regain good health (Murgatroyd et al 2015a).

Effective claims handling, minimisation and quick resolution of disputes can assist in improving health. We have demonstrated this in an evaluation study in NSW. The new approach involved communicating effectively with injured people, early intervention, screening for adverse prognostic factors and focusing on early return to work and usual activities (Schaafsma et al 2012).

With reference to the questions posed in the Discussion Paper our responses are:

1. *What do you believe are the major issues, cultural or otherwise, for insurers, and other service providers, in moving to a defined benefits scheme?*

The insurers will need time to adapt to the (predominantly) no fault scheme with emphasis on quicker provision of treatment and resolution of disputes. It will take time to move from an adversarial mindset to one based on assessing factors that will assist recovery. Most injured people recover quickly and it is only a small percentage who have problems. There are well validated ways of identifying who will recover readily and who will not. These need to be applied universally and supported with the necessary data for analysis collected as part of outcome and regulatory monitoring.

Other service providers, particularly medical and other health practitioners, will also need to adapt. There is, on average, overtreatment of injured people currently. Using a tool to identify recovery prospects should mean that limited appropriate treatment is required for most people while detailed early intervention should be considered for the minority who will find it difficult to recover.

Unfortunately some medical practitioners continue to operate in a medical model of clinical practice, whereas it has been shown that a biopsychosocial model is more effective in assisting people to recover. Amongst the unfortunate effects of this are unnecessary and harmful investigations, particularly imaging studies and invasive treatments (including surgery) that have been shown to have poor outcomes.

There are also a group of practitioners, particularly medical practitioners, whose work is largely to provide medicolegal assessments. These assessments are disliked by injured people and the assessments can lead to disputes and elevated disability (Murgatroyd et al 2015b). Injured people believe that their credibility is being questioned. The structure of the new legislation is such that the work of these practitioners should be limited, but guidelines and enforced codes of

practice are also required. There are similar issues with reference to some legal practitioners and they also should operate within a code of practice that acknowledges their principal responsibility is to assist their client to recover.

Some service providers may see the defined benefits scheme as a financial disincentive. However it is known that lengthy, frequent treatment is not recommended in the majority of soft tissue injures. Frequent, prolonged treatment is associated with dependence and reduced motivation and self-management. Hence from a health outcomes perspective a defined benefits scheme (for soft tissue injures) should promote better health outcomes.

2. *What do you believe are the key considerations in establishing the support and advocacy service?*

The main considerations in establishing the support and advocacy service are that it is independent, and seen to be independent, and supports recovery and return to productivity. Health related goals are not currently well understood by stakeholders. With reference to health issues, its charter should be to explicitly promote health and independence. The service should have the capacity to inform injured people of the recommendations from clinical practice guidelines that are relevant to their situations.

3. *Which support and advocacy service option do you think would deliver the best outcomes for claimants and why?*

The option of a SIRA managed service is supported. The reasons are that SIRA is independent of the insurers and also has relevant general experience in this area as a result of operating a Claims Advisory Service over a long period.

These services should be delivered by a combination of phone, face-to-face, social media and on line methods.

The support and advocacy service should also offer the option of assisting the injured person to complete the claim form. It has been established that people who speak a language other than English, or who have difficulty with literacy and numeracy, find it hard to complete claims forms and a number seek legal assistance for this reason.

Success could be measured by assessing whether the issue was resolved. A reduction in the registration of formal disputes would also be an indicator of the success of this program. KPIs should be collected and publicly reported to guard against the development of an over bureaucratised system.

4. *What do you believe should be the powers of the Claimant Advocate?*

The Claimant Advocate should provide legal advice and assistance such as legal case appraisal and, if a dispute arises, the actual preparation of documentation for a merit review or medical assessment. The current system is such that it is difficult for an injured person to arrange a medical review without legal representation.

5. What involvement should SIRA have in the lodging and management of claims? Should there be early intervention or outreach for newly injured people?

As noted above the support and advocacy service should have the ability to assist an injured person to complete a claim form, and to explain how it can be lodged.

Outreach and early intervention as a general strategy is not supported because it could detract from recovery by raising issues that would not otherwise have been a concern to the claimant. However, early intervention should be available to injured people identified as being at high risk of non-recovery. This would be an option if a treating health practitioner identified these risks in the course of providing assessment and treatment.

6. What are your views on introducing term licences, rather than perpetual licences?

This would facilitate performance assessment and review, because there would likely be closer scrutiny of performance.

7. What are your views on the dispute resolution model, particularly the type of disputes dealt with at each tier?

Option 3 is supported because this would use established services and also provide an alternative to adversarial and costly Court processes. It is accepted that appeals about statutory benefits decisions and common law claims assessment would be transferred to a specialist independent tribunal which would operate at arm's length from SIRA.

Firstly and with reference to timing the following comments are made. For most injuries (particularly soft tissue injures such as whiplash that cost the scheme the most) the timing of the review is critical to facilitating improved health outcomes. Given most recovery occurs in the first 6 weeks to 3 months after injury, it is important to identify who is not recovering at or before 6 weeks after injury. This can now be done with validated prognostic tools. In the case of whiplash, those who are likely to recover can be identified early and should recover under minimal care (1-4 physical treatments). An adequate database to monitor progress of outcomes will be required to facilitate these processes, which should be held by the regulator with access provided to appropriate research institutions.

In contrast those who are less likely to recover (high risk of non-recovery) can also be identified. The SIRA Whiplash Associated Disorders guidelines recommend these people be referred to experts in whiplash early (by 6 weeks) after injury. This process has not been implemented and it is recommended to ensure that lengthy ineffective treatment is ceased, and claimants are directed to appropriate treatment in the timeframe that would allow for the intervention to influence recovery.

In relation to the timing of the second tier (Tier 2 or MAS), currently these reviews are done at time frames after treatment has been provided. In relation to soft tissue injures again, MAS assessors who are reviewing reasonable and necessary treatment do so after this has been provided in most cases, determining whether past treatment is reasonable and necessary. In the new scheme it would be logical to have a Tier 2 review that decided on reasonable and necessary

treatment in a timely fashion that has the capacity to influence not only patient treatment but reasonable and necessary future treatment. This will facilitate better health outcomes.

The same would apply in relation to causation disputes as they relate to treatment. This will occur because a number of people have pre-existing health conditions.

Hence the timing of the first review (at Tier 1) would ideally occur at or around 6 weeks after injury and at tier 2 before or at 6 months after injury. Process KPIs should be collected and publicly reported to monitor the achievement of these target outcomes.

Secondly, with reference to roles at each tier we suggest that the role of the reviewer at Tier 1 would be to advise appropriate treatment to the primary care provider. In other schemes (icare (WorkCover NSW), TAC Victoria) this person has often been a peer reviewer, who contacts the primary care provider and discusses the management. The scheme should consider whether these reviewers are internally appointed by the insurer or externally appointed by the regulator or another body.

The role of the reviewer at Tier 2 should be more formal and more legally binding. This person should truly be independently appointed and consider reasonable and necessary treatment, and causation from both perspectives. In our view the government regulator (SIRA) should appoint these as is the current process.

We support the independent tribunal at Tier 3. The model is less adversarial and likely to facilitate better health outcomes.

8. *What are your views on aspects of dispute resolution being provided by an independent tribunal and which types of disputes or appeals, if any, would be best dealt with by that tribunal?*

We support that decisions of the independent tribunal are legally binding.

The independent tribunal should consider appeals where there is reason to suspect that relevant guidelines and regulations have not been followed. It should not have a primary role in dispute resolution because there are other processes available for this purpose.

9. *Given each dispute resolution option has advantages and disadvantages, what do you see as the best option in a hybrid scheme and why?*

See comments made above in response to question 7.

10. *Do you believe any further powers would be required for internal claims assessors than currently exist for the Principal Claims Assessor or other SIRA staff assessors?*

No.

11. *Are there opportunities to pursue positive incentives for good claims management outcomes, along with the proposed actions already being taken by SIRA to address*

current claims management behaviours in the scheme?

The principal incentive for good claims management is that insurer costs are likely to be reduced because of better claimant recovery and fewer resources are devoted to disputes. This should assist in lowering Green Slip prices. In addition, and as noted above, it is important that health practitioners play a role in good claims management by providing treatments that are evidence based, monitoring their effectiveness, and setting appropriate expectations about recovery.

Greater assurance of early detection of at risk injuries could also be achieved by a single point initial claims database held by SIRA as regulator.

12.Any other item of relevance or importance requiring comment?

Effective claims handling and dispute resolution will be supported by appropriate revisions to the SIRA Permanent Impairment Guidelines. The current edition has not been revised since October 2007. Much has been learnt since this time and it has been convincingly argued that some aspects of the Guidelines encourage surgery (because it is defined as creating greater impairment) and also encourage pain and disability.

After the implementation of changes to the current system there should be a formal evaluation of changes that have occurred with reference to health of injured people. This was done in conjunction with the previous change in legislation in NSW and showed clear benefits to people who had sustained whiplash injuries (Cameron et al 2008).

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References

Cameron ID, Rebbeck T, Sindhusake D, Rubin G, Feyer A-M, Walsh J, Schofield WN. Legislative Change Is Associated with Improved Health Status in People with Whiplash. Spine 2008;33:250-254

Murgatroyd D, Casey P, Cameron ID, Harris IA. The effect of financial compensation on health outcomes following musculoskeletal injury: systematic review. PLOS One 2015a: DOI:10.1371/journal.pone.0117597

Murgatroyd D, Lockwood K, Garth B, Cameron ID. The perceptions and experiences of people injured in motor vehicle crashes in a compensation scheme setting: a qualitative study. BMC Public Health 2015b: 15:423 DOI: 10.1186/s12889-015-1739-9

Schaafsma F, De Wolf A, Kayaian A, Cameron ID Changing insurance company claims handling processes improves some outcomes for people injured in road traffic crashes. BMC Public Health 2012, 12:36