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Dear [redacted],

Re: Frameworks for Non-Treating Practitioners

I am a doctor currently treating patients injured in NSW under the CTP and WC schemes regulated by SIRA.

My own history is that I started working at Sydney Water assessing back injuries in 1983 and thought that my clinical excellence would weed out all the 'shonks'. What I discovered was that very few workers faked injury as there was so little upside. Many cases that were accused of faking were found to be genuine when the CT machine was invented. My opinion is that is more important to judge the person than to try to assess their pain level. Few people claim to have pain when they do not, but very many insurers seek to pay as little as possible, and some are quite unscrupulous in the tactics that they use to avoid costs. This would give great scope for activity by SIRA in supporting patients and NTDs, activity which seems sadly lacking.

My view is that the current framework totally defeats the purpose of the legislation in that insurers are able to obstruct treatment so much that many people are not getting treatments that they need at all, and the regulators are either unaware or indifferent to this. There are a number of elements to this:

1. The unreasonable denials and standards of proof required by insurers in their approval process both of the claim and of individual treatments. Protocols are set to ensure that no excess money could possibly be paid, rather than to optimise availability of much needed treatment.
2. The assumption that the insurer 'manages' the case rather than the NTD. It would seem that the management role has been expropriated. The NTD should manage the case which means set the treatment. What else does 'manage' mean? The insurers should pay for it as a niche health insurer, not a gatekeeper that minimises treatment costs by minimising treatment. If a doctor consistently overtreats that is a matter for the regulator, but in the interest of the patient, the NTD should be assumed to be acting competently. New or experimental treatments may be defined as off limits, but this should be explicitly stated and peer reviewed, but this is not relevant to treatment denials is common practice.

3. The use of rehab providers chosen and paid by insurers as spies who do home visits, ask personal questions, undermine patient confidentiality in consulting rooms and bully GPs into sending people back to work when they are not really fit.
4. The vainglorious boasts of iCare that there have been no premium rises in the last 5 years. www.icare.nsw.gov.au/news-and-stories/five-years-of-premium-stability-and-counting/ Medical costs have risen faster than inflation, so the only way that this has been achieved is by denying treatment to those who need it. The fact that iCare is so out of touch that it appears unaware of this merely shows that they need a much stronger regulatory framework, or indeed to be abolished as useless to patients and hence the object of the scheme.
5. The use of IMCs and IMEs by insurers to deny treatment to those who need it.

If these criticisms seem harsh, my view is not only are they entirely justified but they are backed by a large number of case histories. I assembled 83 case histories and data from my practice from which I wrote 3 submissions to the Royal Commission on Financial Services. I have given a copy of these to Carmel Donnelly, so it is available to you within your organisation. I have also discussed this with both Carmel Donnelly and Petrina Casey. These case histories and data show that the system simply is not delivering care to those who need it and is little better than an insurance rort. More recent cases confirm that nothing has changed. If my data is wrong, then let someone investigate my cases and prove it. If my data is atypical for some reason, let SIRA either produce the data to prove this, or undertake wider investigations and data collection. In my correspondence with SIRA they stated that they do not collect data on how many referrals insurers deny, so it would seem that the latter option is necessary.

To return to the issue at hand, the Approval process for IMCs.

I applied to be an IMC and was shocked to find that a criterion for selection was that doctors had written reports for both insurers and plaintiffs. In that almost all the cases of disputes that I deal with have insurers backed by IME reports, to put insurers' doctors in charge of the appeal process would be like asking the criminals to choose the judges.

There is a website called ratemd.com, which is US site that rates doctors. It is not routinely used in Australia but many of the IMEs are on this site and patients give feedback. Some IMEs have almost universal negative reports, but this seems to make no difference to their careers with insurers. I do not know if SIRA is even aware of the site, let alone takes it into account as an IME or IMC performance indicator. There are also doctors whom I term, Dr Jekyll and Dr Hyde. You may be aware of this reference https://en.wikipedia.org/wiki/Strange_Case_of_Dr_Jekyll_and_Mr_Hyde

These doctors have high ratings when they treat their own patients, but very low ratings when they see cases for an IME. This suggests that they either have a prejudice against such patients which leads them to continually doubt their veracity or they are very keen to please insurers and gain lucrative work. To have them with the power of being in an MAS role is worrying indeed. It would seem that having doctors decide on treatments is because the legal system has priced itself out of such deliberations, but the least that should happen is that WIRO should also be able to intervene

in CTP cases. In terms of this inquiry, SIRA needs to consider IME and IMC performance from a patient's perspective. It is seemingly forgotten that the object of WC and CTP legislation is to get good care to injured patients.

SIRA needs to take the opinions of patients into account and keep statistics on IMEs and their functions. Frankly, those who swan around the country with addresses in Brisbane, Melbourne or Canberra and/or consistently find that NTD treatments are unnecessary need to be very closely scrutinised by SIRA and you in your regulatory role. My view is that this should happen after every IME or even IMC visit, as currently the atmosphere is so adversarial on the side of insurers that patients need all the advocacy that they can get, and SIRA's role must be to supervise an important area of health care delivery, not merely to keep premiums low, which would seem to be the principal function if the inane and unconstrained efforts of iCare are observed. The use of agencies for IMEs also needs attention. When insurers make agencies compete, the agency has an incentive to come to a conclusion that that suits its client's interest. It thus has an incentive to give work to doctors who find in favour of insurers' interests. The best way to have IMEs deliver a fair outcome would be to have very good IMCs in a pool from which opinions could be sought, but the seeking agency would be unable to choose which IMC they got. This would stop the current misuse of some practitioners. Agencies would also be redundant, and their layer of costs removed.

To deal with the subject questions in your 'Summary of Changes' document:

1. **SIRA contact with referees**: SIRA should not have the criterion of doctors having to have written reports for insurers, but should contact referees. The 'administrative burden' should not be reduced. It needs to be increased as IMCs, IMEs and MASs are monitored closely for performance with particular interest in the patients' welfare. The attention to the patients' interest should be a major criterion for appointment/approval. The idea that 'clearly meets selection criteria' can let someone sail through the approval process without vetting is part of the problem, and the opinions of a few referees are unlikely to unearth a history of grossly unfair decisions.
2. **Period of Approval**: This is not critical, but should be variable depending on performance criteria, the principal one being that patients are getting a fair deal. 'Reducing the administrative burden for SIRA' is anything but a worthy objective. SIRA is doing far too little regulation in this area.
3. **Provision of Information to SIRA**: The provision of documents to SIRA in some sort of bureaucratic form is only marginally helpful, and allows SIRA to be able to appear to be doing something when in fact supervision is totally inadequate. SIRA should be actively monitoring what is happening to patients and the relationships between IMCs and IMEs and insurers. They should keep statistics on approval and denial rates, get patient feedback routinely, and do surveys, as many patients are scared to complain or do not know how to. Fear of 'red tape' is again an excuse for 'laissez faire' with a 'tick box' approach to regulation and no idea at the top what is going on. SIRA needs to do a lot more monitoring, and needs to collect more meaningful data, but also to look at individual cases. 'Data' is one thing, what actually happens in practice may be quite another. SIRA needs to go out and get information, not sit there like Buddha waiting for it to be brought to it.

4. **Conditions of Approval**: I am unsure what this laundry list of conditions means. Presumably it will give more grounds for withdrawal of approval. This is not a bad thing, provided it involves a real performance-based regulatory role, not merely more boxes to be ticked in a periodic bureaucratic exercise.
5. **Mediation/Negotiation**: The increased training in this area may be useful, but I note the change so as to put costs onto the IMC. If the IMC has a medication role within the WC or CTP system, surely the cost of their training should be met from the WC and CTP administrative budget. As it is, bad practices in surveillance, needless IME medicals, insurers' administrative delays and supernormal profits are all part of the overhead costs happily absorbed by the CTP and WC systems. If the IMCs are to have some ideals left and see their task in any other light rather than a route to riches through expensive medical assessment, surely their education in a mediation role ought also to be paid by SIRA. The question remains also how much mediation and negotiation IMCs and IMEs do. Many tell patients that they are not treating them, and are supposedly objective. They do not negotiate or mediate at all. If IMCs have been needlessly tactless and have behaviour change as a condition of their continuing IMC status, this may be different, but routine training should be provided by SIRA without costs to the doctors. Again I am concerned that the 'reducing the administrative and red tape' seems to feature so prominently in the rationale for this change, for the reason stated above. Reducing SIRAs costs also looks like an unstated objective.
6. **Registration as Medical Practitioner with AHPRA**: Obviously all criteria from AHPRA need to be taken into account in eligibility, though SIRA should be able to use their discretion.
7. **Qualifications/clinical experience**: The AFOEM should not have special mention in the qualifications section. Their expertise as stated in their College criteria certainly used to be that they had the same clinical competence as a competent GP. Some of their decisions in disputed neurosurgical cases that they have given opinions on have been beyond the levels of their expertise. The second criterion about the 5 years equivalent relevant clinical experience including the treatment/management of work-related injuries' should be retained. An extra criterion needs to be added that the IMC should have experience in the area in which he/she is asked to adjudicate. GPs or AFOEMs sometimes lack expertise in neurosurgical matters or other less common conditions. The standard should be raised, not merely set at a minimal level.
8. **Knowledge of the Workers Compensation system**: is a worthy objective. If SIRA wants doctors to know about this, it could provide training in the area, of at least resources to be digested. Courses in these type of topics are often either too mundane and obvious or too concerned with technical detail and often very time consuming and dull from a participants point of view. There is also a tendency with both professional colleges and bureaucracies to have very detailed criteria for exclusion while doing nothing towards helping people meet the criteria.
9. **Communication/negotiation skills**: This is the same point as the one above about Medication/Negotiation in the Re-approval process. My understanding is that IMC means Independent Medical Consultant. These often do Independent Medical Examinations. In

practice these are either for plaintiff solicitors to gain evidence for insurers in disputed cases, or for insurers to get opinions that they frequently use to deny treatments or force patients back to work. IMCs frequently call and say things like, 'Yes doctor I agree that Mr X will always have pain as you state, but you have to admit that he has to face this fact and get on with his life and if he doesn't return to work, he will soon run out of compo, so you do agree that he should be phased back. How many hours do you think, or if not now, how soon?' The IMC has been co-opted like the Rehab professional into bullying the GP/NTD to returning the patient to work. If SIRA is unaware of this use of rehab and IMCs, it is sadly uninformed. It appears that SIRA wants to further strengthen insurers' tools to pressure NTDs. My view is that it is the job of SIRA to support NTDs as patient advocates. The reason given that the IMC requires high level negotiation 'to overcome barriers to recovery at work' suggests that the problem is seen as a question of persuading reluctant workers or NTDs to agree to return to work. It would seem that SIRA's understanding of the situation on the ground and the roles needed to change this not correct.

10. **Complaint history**: It is good that SIRA now at least intends to take complaint history into account, but the idea that this is limited to certain bodies of whom patients may not be aware, or may be unable or frightened to complain to is not enough. SIRA has had a very bad record of accessibility to complainants. This reached high farce in a presentation by Cameron Player on 13/11/17 at the Wentworth Hotel where an audience of about 150, principally doctors involved in the system, more or less shouted him down as he claimed that only 0.01% of claims led to complaints and that therefore the system worked well. In fact there was no complaints form on the website, and the literature said that insurers must be complained to first according to their protocols. NRMA for example, needed 3 complaints to their internal procedures; the Claim manager, the Team leader and the head of CTP, before their processes were exhausted. It would have been surprising if more than 0.01% of people went this far. In practice most patients are scared to upset the insurers and so do not complain at all, never mind 3 times. So SIRA sat behind this fence said it was doing well. Player is gone, but I am unsure that SIRA has yet got the message about patient feedback and vulnerability. There needs to active surveys of patients, and monitoring of sites like www.ratemd.com not merely passive waiting for complaints that have to navigate unfriendly websites. It might be noted that there are still many people who are not computer literate, and this is particularly in disadvantaged and non-English-speaking groups who are the most injury-prone.
11. **Re-approval criteria regarding performance and behaviour**: I note that 6 separate criteria have been withdrawn and a more general statement replaces this. There need to be criteria or there will be a problem if SIRA is challenged in the AAT. I am concerned that treating patients with respect and allowing NTDs to be the principal agents deciding treatment will not be relevant- but should be.
12. **Activity in the IMC role**: I do think it matters how often the IMC roles is done except to SIRA who do not want to have too many people to supervise. It is more important that the IMCs are in active practice in the area on which they are making decisions, and not venturing into areas where they lack expertise, particularly if they are involved in treatment denials.

13. **Reasons for revocation**: As for Re-approval above. Making criteria more vague may give more grounds for revocation, but these need to be patient-focused, and actually used. If more vague criteria will make any action SIRA takes more subject to appeal and harder to defend in the AAT, this needs to be considered carefully. I live in hope that SIRA will act in the patients' interest rather than simply watch insurers minimise the costs of the scheme to the patient's detriment. Part of this is to reinforce patients'' rights and NTDs' treatment and to stop the abuse of IMCs and rehab consultants by insurers. IMCs must have a countervailing pressure to the financial incentives and blandishments of insurers.
14. **Performance Monitoring and Quality Assurance**: This is clearly a step in the right direction. I hope that it actually happens.

I hope that this submission is of use. I am happy to provide further details if required and you are welcome to meet those of my patients who are willing and see for yourself the veracity of my claims.

Yours sincerely

Arthur Chesterfield-Evans