Dr Arthur Chesterfield-Evans, 2020

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Summary

This submission is written from the perspective of a Nominated Treating Doctor with experience in occupational health, surgery, public and preventive health, and legislative process.

iCare's behaviour has concentrated on cost-saving rather than service delivery and has rejected or delayed many treatments at huge human cost. It is not a cost-effective scheme and has spent far too much effort on its financial base and too little on its core business of treating injured workers and compensating their wages. It has been desultory in assessing their Pre-Accident Average Weekly Earnings (PIAWE) and underpaid many. At the corporate level, it has over-rewarded executives who have neither looked after the people that the organisation exists to serve nor followed reasonable public service standards in their governance.

SIRA has been a totally inadequate regulator belatedly realising after its parallel regulators were shown up in the Hayne Royal Commission that it is doing at least as poorly as they. SIRA does not have the mechanisms to supervise insurers adequately, and collects KPI data that does not get to the heart of the case management problems.

Insurers must have less influence on SIRA, which must take a much harder audit and policing role than it has to date.

The emphasis on the financial performance of the WC scheme has distorted its priorities, and the salaries and focus of its executives. The terms of reference and staffing of this inquiry reflect these distorted priorities and create a significant danger that the limitations will persist in the Inquiry Report and the future changes of any system rebirth.

If Medicare were a functional system that doctors could use, this could do the treatments and supplementing this with an income guarantee insurance scheme could allow the system to be abolished. In the absence of this aspects of the WC could be tagged on to existing Medicare or Private Health insurance schemes with income guarantee insurance picking up the Compensation payments and the WC scheme as it is abolished with likely big savings. The efficiency of the scheme must be judged in terms of what percentage of the premium income is returned to injured workers of spent on their reasonable treatment. There is no particular need for a large sum to fund all ongoing liabilities and different funding models should be considered that simply pay for treatments and wages on an annual basis.

The AMA must be involved to set and control medical fees, and the Colleges must set protocols for treatment, and lists of doctors able to provide services. If NTDs and specialists follow these guidelines insurers should not be able to refuse to pay. College panels could decide if treatments are necessary if there are disputes.

Patients should have formal funded support networks and advocacy inputs to SIRA and whatever replaces iCare and a seat on their Boards.

Medical treatment should be peer reviewed and ideally treatments followed as an ongoing research project to improve treatment outcomes.

Biographical Note

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

The author graduated in medicine from Sydney University in 1975, and studied surgery for 6 years in Australia and the UK, getting an FRCS in England. He was struck by the huge amount of tobacco-caused illness and tried to get government action to achieve a smoke-free society. This did not pay, so he worked at Sydney Water assessing workers compensation claims. At that time the doctors ran the compensation system in a self-insurance framework. He was responsible for monitoring a large number of long-term back injuries who were on restricted duties and for negotiating suitable duties for injured people. This was prior to the Workers Compensation and Rehabilitation sections being established. He was responsible for the management of large numbers of RSI cases which came with increased use of keyed in data entry, and developed a number of preventive and health promotion strategies in that workforce.

He did a Master's degree in Applied Science in Occupational Health and Safety, won a Public Service Fellowship to study Workplace absence and wrote his thesis on the Relationship between Health and Workplace Absence.

He had advocated for political action to achieve a smoke-free society and he went into private practice as an Occupational Health and Safety Physician before entering the NSW Parliament for 9 years with the Australian Democrats, where he took an interest in workplace and CTP legislation. On leaving parliament he went farming for 5 years, but returned to medicine and is principally working in treatment of Workers Compensation and CTP injuries. He has written submissions to the Hayne Royal Commission and Dore inquiries into Workplace and CTP insurance.

Part A: Contextual Preamble.

iCare is a government monopoly insurer in Workers Compensation. Both it and the CTP scheme are under the SICG Act but it is noted that only workers compensation is the subject of this report. It seems that the object of the SICG Act was to learn from the private sector, manage the insurance better and cut the premiums.

iCare was keen to use computer algorithms from Guidewire rather than staff to cut costs. This strategy has been stubbornly pursued long after it could have been considered to have failed. Whether it has failed due to bad programming, poor implementation or a conceptual failure is hard to assess from outside iCare, but certainly the doggedness of iCare Management in assuming that it would come right in time has allowed an appalling situation to continue. The political support to iCare management seems to have encompassed the same values[1,2], and it also seems that as financial considerations appear to be paramount in the SICG legislation, the management utterances of CEO John Nagle at the Parliamentary inquiry[3] and the reasons for the media interest in iCare[4]. One can only conclude that the primary function of iCare, to look after injured workers has been totally neglected.

SIRA was set up by insurers to regulate the insurers and it seems that their major focus was to ensure that no injured person could possibly be overpaid. There was no serious attempt at fairness as the assumption of the SICG Act was that these insurances were a financial problem and that costs needed to be controlled. The fact that it was under Treasury underlined this aspect.

In actual fact the two key ways to cut Workers Compensation costs is to prevent accidents and then to treat people quickly. Neither of these has had much attention in the finance-driven model of the SICG Act and its implementation by iCare, SIRA, Treasury and the private insurers of the CTP system.

Worksafe got such bad publicity from its bullying culture[5] and its sacking of expertise, that it renamed itself Safework, got rid of its working teams in Dust Noise, Chemicals, Radiation, and Safety and moved to 'tick box' system with generic and less trained generalist safety officers reacting to complaints and having intermittent projects based on what seemed important to Management at the time. The scandal of silicosis from kitchen benchtop dust[6] and the deaths from poor scaffolding[7] directly relate to the emasculation of the inspectorate, with belated blitzes showing the extent of the problems[8]. The improvement in statistics[9] probably relates to the deindustrialisation of NSW

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[1] www.smh.com.au/politics/nsw/department-warned-icare-had-direct-line-to-the-treasurer-20200811-p55klv.html

[2] www.smh.com.au/national/nsw/employment-of-icare-staffers-in-treasurer-s-office-unlawful-hearing-20200909-p55tyq.html

[3] Transcript of Law and Justice Committee Inquiry into Workers Compensation 3/8/20 www.parliament.nsw.gov.au/lcdocs/transcripts/2380/Hearing Schedule - 03 Aug 2020.pdf

[4] www.smh.com.au/business/workplace/multimillion-dollar-icare-contracts-were-awarded-in-sham-tender-20201031-p56ae1.html

[5] www.parliament.nsw.gov.au/committees/inquiries/Pages/inquiry-details.aspx?pk=1629

[6] www.smh.com.au/national/nsw/deadly-upswing-in-nsw-silicosis-dust-disease-cases-20200211-p53zn9.html

[7] www.safework.nsw.gov.au/news/safework-media-releases/safework-attends-tragic-incident-in-macquarie-park-after-scaffolding-collapses

[8] www.abc.net.au/news/2019-10-01/almost-half-of-nsw-building-sites-have-dodgy-scaffolding-report/11562850

[9] www.safeworkaustralia.gov.au/statistics-and-research/statistics/fatalities/fatality-statistics-stateterritory

and also the poor collection of statistics, but considerable investigation would be needed to quantify this situation more accurately.

Dominance of Finance is a Danger

Neither prevention nor medical treatment are primarily financial issues; they rely on experts from other fields, who are largely neglected by iCare SIRA and Treasury. Once the primacy of money becomes the dominant paradigm, those who know about money are assumed to be the experts and managers to have in charge. But in fact those who understand prevention and treatment could make the decisions that will save money, but currently are not even asked or noticed, and are even absent in the terms of reference, except in as far as they cast themselves in the managerial role and rhetoric. The injured workers/patients are not even mentioned, yet lack of attention to their needs and wants is why the system is in its current farcical state. Would you ask an insurance manager to advise you on a neurosurgical problem? No. So why do you ask Boston Consulting group to advise on thousands of such decisions? Those who currently make the decisions have no expertise in either prevention or treatment, so really should not be making the decisions, staffing the inquiry or setting the terms of reference. But they are doing all three. It is better to have the right strategy and to implement it suboptimally than to have the wrong strategy and implement it well. Sadly, the Emperors are naked. Current management has the wrong strategy and have not even implemented it well. The author wrote a submission to the Dore inquiry criticising the dominance of the existing establishment in the terms of reference (Appendix 5). Her conclusions were reasonable but her judgments very euphemistic and her solutions very tepid.

The financial dominance remains very active in this inquiry. The terms of reference speak in very managerial terms and do not mention medical treatment or patients and seem not to have any focus on the injured victims and those who might treat them. I note that the Department responsible remains the Treasury and that they will staff the inquiry.

A Cautionary Tale

A parallel might be drawn here with inquiries into another failed system- DoCS and Child Protection. The author was responsible for the NSW Parliamentary inquiry into DOCS in 2002, which resulted in the sacking of the Minister, Fay Lo Po and the head of DoCS, Carmel Niland and a considerable increase in DoCS funding. It did not, however result in a change of culture in DoCS, which had had its middle management expertise gutted in the 1990s, and continued to rely on a model of management of files by upper levels and allocation of these to lower level staff with poor prevention and continuity. Funding was increased after the 2002 inquiry, but not much changed and there was another inquiry into Child Protection by DOCS by Justice James Wood conducted in 2008[10]. The Wood Inquiry was staffed by DoCS and much weight was given to the stress placed on DoCS workers by the Children's Court. The Children's Court chief magistrate was Scott Mitchell, who tried to get the Act implemented with reasonable plans for the children at risk. As DoCS rarely had such plans, he was their only quality control mechanism. Naturally this was very stressful for the front-line workers who had often been allocated the cases only a few days before their Court appearance. The solution therefore was to pass legislation that only a Supreme Court judge could run the Children's

[10] http://ngolearning.com.au/files/face2face-courses/KTS-info-session/the-wood-report---summary-recommendations.pdf

Court, which effectively sacked Mitchell. But the new appointee had no expertise in child protection matters and took the advice of the DoCS staff with their threadbare plans. Unsurprisingly the situation did not improve. A key issue in both the 2002 and 2008 reports was 'mandatory reporting' which just wasted immense resources due to multiple notifications of the same case. Although Wood stated that only 13% of reports resulted in a home visit, which either meant that there was a huge percentage of multiple reports or that DoCS was not seeing significant cases. This was not changed. DoCS continued to be a problem, and there was yet another Parliamentary inquiry in 2017 which found systemic failure[11]. The reason for this anecdote is that if the same people continue doing the same thing, the result will stay the same. And if those who caused the problem set the terms of reference and staff the inquiry, even a good judicial officer may be unable to make recommendations to improve the situation. In Wood's case it was DoCS, in this case it is Treasury.

The Primary Purpose of the Scheme

The two major functions of the Workers Compensation system are to pay for the medical system to treat the injuries and return the injured worker to work, and to replace his or her wages. The wages loss depends very largely on the success of the medical and rehabilitation system in returning the patient to health. Some would see that the whole Workers Compensation and CTP systems pre-date Medicare and exist to provide the medical care for injured people. In that Medicare has been allowed to wither to just over half its previous payment level and few doctors will use it for elective surgery, the private health insurance system now functions in a pre-Medicare mode, being necessary for non-urgent medical interventions. The WC and CTP systems thus have their primary function as paying for treatment, and if they do not pay, patients cannot get elective treatment that is not done in public hospitals and requires more than bulk-billed GP visits.

Patient Perspectives.

Most patients are keen to return to work. There is always some degree of financial penalty for being on workers compensation, and there is also a question of the respect within the family and society of being at work. Added to this, there is some incidence of an understatement of income by employers or underpayment by insurers that leaves patient's worse off. The writer is not in a position to quantify this, but it would be an interesting exercise to have an outside person compare Pre-Injury Average Weekly Earnings (PIAWE) and Workers Compensation Payments (WCP) and to see how much the insurers meet their obligations. Patient anecdotes suggest that they often do not, and it would be a worthwhile endeavour of the inquiry to look at these type of functions of the system as it is not clear that SIRA will do this. SIRA ought to do this as part of their monitoring of iCare and insurers. SIRA seems reluctant to get its hands dirty by actually looking at what is done. It sets some KPIs, but does not look at case management in detail, and never punishes insurers for callous behaviour or unjustified treatment refusals. Naturally these do not show up in KPIs.

Insurer Perspective

The insurer perspective seems to be that people are fit for work, but linger complaining of incomplete recovery, taking their gullible NTDs with them writing needless certificates of unfitness. There is a fundamental distrust of NTDs by insurers, who attempt to supplant their role and dictate treatments.

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[11] www.smh.com.au/national/nsw/nsw-parliamentary-inquiry-finds-child-protection-system-in-crisis-20170316-guzc20.html

Rehabilitation professionals can help in negotiation of partial fitness which involves changing who does what in a workplace. This ideally requires that the rehabilitation professional acts in the interest of the patient. Some employers are unaware of the possibilities of reorganising their task allocations, and state that the patient cannot return until they can do the job exactly as they did it before, which may make return to work delayed or even impossible.

Insurers also like to think that if a patient is working that their problems are over. This is not necessarily the case, and they should be allowed to complete treatments even if they RTW.

SIRA provides guidelines for some treatments, but the worry is that these guidelines are skewed by those who wrote them For example, if one were writing guidelines for Whiplash, one would expect that at the initial management stage, there should be major input from emergency physicians and neurosurgeons. In fact there are neither of these[12]. There are 3 regulatory reps, 2 insurers, an epidemiologist, a Psychologist, a Chiropractor, a physio, a Rehab expert, Disability/Rehab, Rehab/Pain, and a GP. This is not to criticise the expertise of these professionals, merely to question whether they are the optimum people to assess the acute situation, which is where the insurers accept or reject treatments most frequently. It seems that insurers have far too much input to the workings of iCare and SIRA.

Investigators

Use of investigators seems rife, and usually escapes attention. The amount of this can presumably be judged by how much money is spent on it and it needs some investigation by the committee. The writer's perspective is that people are forced to do certain things by economic necessity, then photographed in the wrong context, accused of fraud and them refused treatment of compensation. It seems that strenuous efforts are made by this method to deny compensation of treatment. The 'success rate' of investigations should be looked at systematically as a treatment would be, and there should also be some external evaluation of the conclusions reached and implemented. Persons denied on the basis of such footage should have the right to know why their claims are denied and to have access to the relevant footage unedited to respond to it.

Insurer-written Contracts with Employers dictate others' Treatments

Insurers are bound by contracts to provide services. They write these and offer them to employers. But it is the injured people who are paid or not paid. They are unaware of these contracts, and if the contracts have 'wriggle room' to allow insurers not to pay, the injured party does not discover this until they are denied treatments or compensation. Ideally there should be a standard contract put out by SIRA, which would be fair and have minimal 'wriggle room' to avoid payment and insurers would compete to provide services on this basis. Failing that the contracts of all insurers should be made public on the SIRA website or other platforms that would make comparison easy, so that there would be some consumer pressure for a better deal.

Specialists

Many specialists will not do Workers Compensation or CTP cases because of the problems created by insurers. Of those who do, many are totally frustrated by delays and refusals. These folk generally do not give submissions to inquiries such as this. The inquiry should reach out to a sample

[12] www.sira.nsw.gov.au/resources-library/motor-accident-resources/publications/for-professionals/whiplash-resources/SIRA08104-Whiplash-Guidelines-1117-396479.pdf page 1

of specialists and get their input as to how the system works. The author is able to identify some specialists who would have such insights if requested.

SIRA

SIRA seems under the impression that it needs to educate GPs. The NTD perspective is that GPs need to educate both SIRA and the claims clerks of the insurers. Claims clerks need to meet the patients and SIRA needs to start calling them patients rather than 'customers'. The word 'customer' suggests that the patients are there voluntarily and the they are part of a money making process. They are but that should not be the objective.

SIRA seems to have no idea how many claims are refused, or accepted in theory but with so many treatments not approved that the claim is almost useless from a treatment point of view. Insurance 'case managers', (which is a fancy title for the disempowered, high-turnover clerks on the front line of unjustified treatment refusals), need to be educated that the people that they are refusing are generally not frauds. Perhaps a better solution is to change the composition of the workforce, so that a significant percentage have a medical background so that there are sensible and timely approvals of reasonable treatments. 'Reasonable' treatment needs to be clearly defined as standard medical practice. The attempt to hijack this definition to mean 'value medicine' in the Boston Consulting Group definition which seeks to make each treatment be proved as cost-effective by some sort of accounting research must be resisted. The medical research profession does far better research to improve treatments than the dilettantes of the accounting consulting world, and all that happens if this absurd model is pursued is more disputes, delays, non-treatments and lives ruined.

Part B: The Workers Compensation System in Practice

Macroscopic Issues

1. The government has been captured by industry lobbyists and rhetoric about costs and 'bludgers', with the social objectives of paying for the treatment of people injured at work and in accidents subordinated to cost considerations.
2. Workers Compensation in NSW under the State Insurance and Care Governance Act 2015 was set up by insurers with the principal concern being cost-control.
3. iCare has dispensed with the social obligation of being the main agent to pay for those injured at work, and has sought to minimise its costs by denying liability for such accidents and given increasing emphasis to forcing patients back to work, denying that they are injured, or trying to prove that their injuries were pre-existing, unrelated to their workplace and hence the insurer is not liable. Indeed, iCare CEO Nagle wanted to re-define the end point of iCare's obligation to pay as being fit to Return To Work (RTW), rather than having actually done so. This meant that workers could be defined as fit by certain doctors and then left without job, treatment or income, but it was very convenient for iCare's financial performance.
4. This has been hugely to the detriment of injured workers and their medical treatment.
5. This has happened in a number of ways:
    a. The State Insurance and Care Governance Act 2015 has empowered insurers and undermined the funding of reasonable medical care. The NSW Nurses Association argued that this Act was because employers had been reluctant to offer restricted duties and that costs were falling back on the State WC insurer[13]. They further argued that the schemes were intended to transfer the costs of injury from State schemes to the Federal welfare system. This would seem to be the case.
    b. The establishment of iCare which supposedly regulates insurers and SIRA (State Insurance Regulatory Agency) which supposedly regulates iCare have been set up and overseen by highly pro-insurance executives from Allianz[14].
    c. The protocols and even the form designs of these organisations have been created in an insurance model, so that they act to control insurance costs rather than to arbitrate fair behaviour by insurers in the patients' interests.
6. There is effectively regulatory capture of SIRA and iCare by insurance interests.
7. The insurers' corporate behaviour is far worse than the Banks, as insurers can either pretend that all the claimants are false, or that they have to take large amounts of time, money and effort to exclude this possibility. The overheads of the system are hugely higher than private health insurers at about 12%, or Medicare at 4.5%.
8. A case has been made that there is systemic fraud by insurers in their standard practices in NSW WC and CTP[15]. This writer is of the opinion that fraud by patients is relatively uncommon of the order of 1%, whereas the denial of reasonable treatment is routine, so at least 95% of the fraudulent behaviour in the system is perpetrated by the insurers.

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[13] http://www.nswnma.asn.au/wp-content/uploads/2013/09/Current-issues-submission-joint-select-committee-nsw-workers-comp-scheme-attachment-NSWNA-Submission.pdf

[14] www.allianz.com.au/media/news/2017/allianz-selected-to-help-icare-transition-to-single-agent-nsw-workers-compensation-scheme

[15] Submission by Chesterfield-Evans to the Haynes Royal Commission June 2018

9. No data of the refusal rates of treatment that would allow monitoring of the insurers' behaviour exists as SIRA does not collect it[16]. Hence whenever a mismanaged case is cited, the insurers can pretend that it is a 'one off' when in fact it is common and systemic.
10. Workcover was emasculated into Safework and had all of its doctors and most of it hygienists made redundant. It now does few inspections, writes letters about policies and seems to keep few real injury statistics. The entirely predictable rise in silicosis[17] would seem to be an illustration of this dysfunction. It would be desirable for SIRA to provide statistics for Safework to act on and inspect workplaces to prevent accidents and diseases. This does not happen nearly as well as it did.
11. The WC and CTP systems seem heavily influenced by US precedents of insurers dictating to treating practitioners and it would appear that this is a workshop and training area for insurers to test protocols and boundaries to 'manage cases' in Australia. Insurers already claim that they are the 'case managers'. It would appear to be a concerted campaign to undermine the position of the Nominated Treating Doctors (NTDs), who are GPs. Rehab professionals are used as proxy NTDs to liaise with patient, families, employers and specialists to coordinate cases and by-pass GPs in the interest of insurers.
12. There was also an attempt by iCare to built a new monopoly insurance system based on computer algorithms and management flow diagrams. There were not even any case managers until a problem occurred. When EML, which had only 15% of the cases was asked to take over all the cases it is likely that iCare management believed that since 80% of the cases are simple, only 20% need managing so that EML could stretch to this. In fact, if EML were managing 15% of all cases, but only 20% of these were complex, then logically EML had only 3% complex cases and were being asked to upgrade to 20%- almost a sevenfold increase in their complex case load. It is matter of record that unmanaged cases caused huge delays and EML were incapable of taking on the number of cases that they had. The key problem was the incredible management arrogance that all medical case management could be simplified into a computer algorithm.
13. The NTD (Nominated Treating Doctors) are continually and systematically undermined by the insurers, who wish to take this role to minimise their costs. NTDs are frequently not informed of the results of IME (Independent Medical Examinations), tests or surveillance which are used to deny treatments. Often only the patient or the solicitor is informed, or the specialist. SIRA will not act to make informing the NTD mandatory, and seem happy to let NTDs position be undermined. In their denials, insurers often state that they are using 'SIRA guidelines'; a meaningless assertion.
14. SIRA seems totally pro-insurer in that they at first insisted that the internal appeal mechanisms of the insurers be used, before they would accept a complaint. NRMA, (the worst of the insurers[18]), had 3 appeal levels, to the case manager, the team leader and the State manager before their procedures were exhausted. Most insurers have a dispute review procedure, but these uphold the original decision in about 80% of cases. The author is unsure if there are any hard statistics available on this number- (naturally there ought to

[16] Chesterfield-Evans Submission op.cit. Appendices 2 and 4.
[17] www.abc.net.au/news/2018-10-10/stone-cutting-for-kitchen-benchtops-sparks-silicosis-crisis/10357342
[18] See figures from Chesterfield-Evans Appendix 4 to submission to Hayne Royal Commission, from both his practice and another larger sample.

be). The 'internal review' process merely serves to waste time, and discourage appeals directly to SIRA.

15. Complaints to SIRA about insurers are merely forwarded to the insurers for a response, and that response seems to be very largely accepted and passed back to the complainant. Any request that SIRA act that is in the complaint is also passed to the insurer, so naturally reflects immediately on the complainant most of whom are very fearful of the insurers.

Day to Day Practical Issues

1. Rehab providers can in theory be chosen by patients, but in practice insurers offer unknowing patients either no choice or a choice of three that the insurers have already selected.
2. Because most of the rehab professionals get all their work from insurers, they become agents, even spies for the insurers. They attend surgery visits and report back to insurers frequently breaching medical confidentiality. They also do 'Work Capacity Assessments' which are used to force patients back to work. They see the insurers as their clients, rather than the patients, which is of course a professional conflict of interest. This can be seen by looking at their websites, which usually market themselves as cost-savers to insurers or employers rather than helpers for patients or doctors.
3. Doctors are bullied into certifying patients as fit to work.
4. Patients have treatments refused and then have low incomes so are forced back to work.
5. When patients work they are deemed fit and treatments are refused.
6. Many doctors will not see WC and /or CTP patients as they feel bullied, even though the pay rates are higher. There seems no research to assess the prevalence of this or the reasons for it.
7. The form for Workers Comp has been written as if by insurers. It is a 'Certificate of Capacity' which emphasises what a patient can do, not that they are unfit. If they are unfit, there is a space to state when they will be fit, even if this cannot be known. There is a small space for the Diagnosis, which suggests a single diagnosis only is necessary. Yet if a second or third diagnosis is missed on the original certificate, insurers try to deny it was present at the time of the original injury.
8. If a patient is 'partially fit', this is used to lessen their compensation payouts, even if it is unlikely that they will ever get a job. Make-work, totally non-cost-effective jobs are created to achieve this. Patients do a few months in meaningless work, are deemed partially fit which lessens their payout; the employer then declines further work and the insurer pays out less as they are not completely unfit.
9. It might be noted that very few of those long-term injured patients taken off Workers' Compensation in 2017 by the 2012 legislation either found a job or were successful in getting the Disability Support Pension. The Federal government had taken a pride in how few people that had made this commitment to[19][20]. It seems that there has been no interest in these people from the NSW Government. It seems that their fates have not even been quantified.

[19] www.theguardian.com/australia-news/2015/jul/16/newstart-becomes-de-facto-disability-pension-for-25-of-claimants
[20] www.yourlifechoices.com.au/news/14423/20150714/dsp-approval-rates-hit-new-low

10. When treatments are refused, doctors try to get their patients treatment through private health insurance, Medicare or the patients paying. In many cases the insurers never have to pay for this and if they do the payment is delayed, or is much less as the Medicare amount is about a third of the WC rate, so insurers are rewarded for refusals or delays. SIRA has never prosecuted an insurer for this, so there is no downside to treatment refusal. It is like being a shoplifter where the worst penalty is having to put back half of it.
11. Insurers have 10 working days to make a decision on a treatment. All treatments are delayed by this, costing patients huge amounts of time, particularly as treatments are sequential. Many insurance staff are part-time working 2 days a week, so patients wait in pain and at their cost to save insurers money, while insurers boast that they are 'flexible workplaces.
12. Recently insurers have taken to refusing to pay consultants who charge above the AMA rates, telling the GPs to find another specialist. It is another step in undermining the role of NTDs and dictating treatments. Yet neither insurers nor SIRA keep potentially helpful lists of who do specialist operations, which might help NTDs find good specialists. There is obviously potential for research into the effectiveness of treatments such as spinal operations, but this has never even been suggested, much less implemented.
13. Cost control by insurers seems poor. MRIs can be obtained for about $250, yet insurers pay up to $1,700 or refuse the entire investigation.
14. Many cases do not have case managers. It seems that when the diagnosis is given, a computer algorithm is used, and if investigations requested correspond to the flow path of the algorithm they are approved, and if no, not. Only when there is a dispute does a claims consultant come into play, and this causes further delays. In practice, one wonders if refusal is the default.
15. 'Claims managers' (clerks) have little power and simply follow protocols, which are designed to ensure that no extra money could possibly be paid. Clerks defend these are being 'what they have to do', as they are abused for unreasonable delays. So the delays are directly caused by those at the top of the insurers' hierarchies. The turnover of these lower level clerks ('claims managers') is very high because they take the abuse for bad decisions that they did not even make.
16. Some aspects of protocols, like checking previous records for any symptom or sign that would allow an insurer to claim a pre-existing injury lead to very long delays as old records are sought and treatments are delayed or refused until this is met.
17. Though it is well known that radiological features correlate poorly with clinical pain, minor degenerative changes on radiographs are used to prove previous pathology and deny that the new injury is responsible for the inability to work, even if the patient was working up to the injury and is unable to work after it.
18. SIRA has declined to affirm the 'eggshell skull' principle in that if a person had some pathology but was able to work prior to the injury and is unable to work after it, that the incident caused the problem. The old Workers Compensation paid for any incident that 'caused or exacerbated' an injury. It seems that the 'exacerbate' has been dropped either in law or in practice of it.
19. Some medical guidelines, such as the ones for 'Whiplash Injuries' are very conservative and were created by two rehab physicians, a physio, a Chiropractor, a psychologist, an

epidemiologist, a GP, a disability researcher , a fellow to write it up and two insurance industry reps. It would seem insurers had huge say in their drafting and use them to delay treatments. They were not worked out by those who should have worked them out such as ED physicians, orthopaedic surgeons and neurosurgeons[21].

20. The use of surveillance is frequent, but it is not quantified and subjects have no opportunity to respond to the allegations made. Often patients are effectively starved into working by having their monies cut and have to work no matter how much pain they are in. The fact that they worked is then used as proof that they can, and they are classified as fit by insurers who then ignore NTDs assessment to the contrary and deny further treatments or referrals.
21. Specialists are played off against GPs by rehab professionals who ask each whether the patient is fit, and take the most convenient answer for the insurer.
22. GPs are often paid for their services, but have no investigations or referrals approved[22]. Effectively they merely write certificates until the insurer or rehab person bullies them into certifying a patient fit for work, and then once they start, the injury is considered minor or cured and no further significant treatment is approved.
23. Specialists have many of their treatments refused outright, even if there is good scan evidence of pathology that warrants intervention. Surveys of relevant specialities would be needed to discover the extent of this. (SIRA does not do any).
24. Medical confidentiality is totally undermined as insurers subpoena the total record and records are not designed to be culled, edited or censored. Computer records are particularly like this. Insurers find it cheaper to demand a computer record or photocopies than to get a report. A GP who had paper records and asked to be paid to sort out non-compensable from compensable material was refused.
25. IMEs are abused, often being brought from interstate or being hired by agencies, who naturally have a vested interest in having a result that pleases insurers.
26. The legal profession has priced itself out of resolving medical disputes. The AMA Guide for the Assessment of Permanent Impairment' is used, which does not take pain into account, which is logically absurd in that pain is the major thing that stops people working. The AMA Guidelines were worked out by the American Medical Association in order for doctors to decide the degree of impairment as the legal system was too expensive to be able to do this. As pain cannot be quantified it uses proxies, such as the range of movement of a joint. It make no distinction between impairment and disability, which is absurd as some impairments need not be disabilities in some occupations, but may be catastrophic in others. The bottom line is that a person may be only a few percent impaired in the AMA Whole Person Impairment (WPI), but be 100% unemployable. Insures only pay by the WPI, so the person's life is destroyed with minimal compensation. Ideally a better way of assessing disability would be found.
27. Insurers often refuse to pay for treatments or delay their payments. This means that many specialist insist on payments up front and the injured patients often do not have the oney for this, which makes it very hard to get them asssessments even if the insurers approve.

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[21] www.sira.nsw.gov.au/resources-library/motor-accident-resources/publications/for-professionals/whiplash-resources/SIRA08104-Whiplash-Guidelines-1117-396479.pdf page 1

[22] Chesterfield-Evans A. Submission to Hayne Royal Commission Appendix 4 Confidential- Radiology Request denials by insurers.

Many doctors will not do WC or CTP for this reason, yeet there has been no study as to the incidence or reasons for this. SIRA does not monitor the payment practices of iCare or the other insurers. Presumably this is 'commercial in confidence'. See Comment below[23].

28. Disputes over treatment usually result from IMEs working for insurers and giving opinions that treatments are not necessary, or that pre-existing pathology existed. These disputes are referred to the Medical Assessment Service, (MAS). MAS doctors then have the final say and cannot be appealed. Plaintiff solicitors are often reluctant to use the MAS as they so often find no treatment is necessary. It seems that when MAS doctors are selected, a criterion is that they have written opinions for insurers. Since few doctors have done this, it is as if the insurers are choosing the arbiters for the disputes that they have created. This is quite against the patients' interests.
29. It is in the interests of insurers that patients do not have major surgery such as backs because the 'AMA Guide to the Assessment of Permanent Impairment' gives a higher percentage to people who have had surgery. The percentage impairment largely determines the compensation. Therefore if the person is not scanned, not diagnosed, does not see a neurosurgeon and does not have an operation, the seriousness of their injury can be questioned and their payout will be lessened. So delay is the friend of insurers. Plaintiff solicitors are paid when a settlement is achieved, and usually have to wait until then to get any money. So there is financial incentive for them to settle quickly. It is a frequent occurrence that the desperate patient settles for a relatively small sum and then has either to pay a considerable amount to get the surgery that they should have had before settlement, or wait for Medicare, which often takes over a year from when they are listed. Some patients on 457 visas, foreign students, tourists or refugees do not even have Medicare.

[23] Large corporations often delay payment to small ones. It might be noted that Franklin's stores had a model where all suppliers waited 3 months for payment. Franklins thus sold the good quickly at retail, but had 3 months to repay at wholesale prices, so effectively they had the use of other people's money for 3 months, while their suppliers may have had to borrow to provide that money. No regulatory body looked at the issue, so delay or non-payment of bills may be considered 'normal' business conduct. If SIRA is acting in the public interest, however, it should monitor payment delays and denials as a KPI of insurer performance.

Part C: Fraud within the WC (and CTP) systems

It is assumed by insurers that there is a large amount of fraud by claimants in the WC (and CTP) systems. This is also a view that is publicly promoted enthusiastically, which has a very negative effect on public perceptions of injured people.

This translates into doctors having excellence as being defined as their ability to detect fraud in patients, and by their excellence in this regard to diagnose feigned illness and allow insurers to refuse payments. Doctors who accept patients as they claim to be are then portrayed as naïve or less competent. The author started working within this ethos in 1983, and has examined a very large number of people since then. He estimates that deliberate and contrived fraud is less than 1% of cases presenting, and is usually not difficult to detect. There are other features which could be considered, but these are much less relevant or frequent that one might reasonably expect. These are that under current awards, if one is sick one may only have a few weeks sick pay, whereas if one is injured at work, one may have years of compensation. The author had one case where a man with a bad heart tried to exaggerate his back pain but this is one case in 37 years. One might also expect that if one cannot afford an operation, one would try to get under WC. This is surprisingly uncommon, presumably as many people still think that they can treatment under Medicare, (which in terms of elective surgery is very difficult with long waits). However the literature and modelling from the US, where health services are very dependent on insurance status may have a far higher incidence of fraud than there is in Australia.

Since doctors are so amply rewarded for finding fraud and denying the veracity of patients there is a huge incentive for them to become IMEs for insurers, thus to become wealthy and give themselves the status of being able to diagnoses fraud that escapes lesser doctors. It is interesting that in the patient feedback websites, such as www.ratemds.com, some doctors are highly rated when they treat their own patients but very poorly rated when assessing insurance cases. This might be termed Dr Jekyll and Dr Hyde syndrome and may reflect the doctor's social and political attitude to patients claiming injury as much as their physical findings. It is the author's experience that patients who are accused of faking symptoms behave as if their symptoms are genuine. They do not improve without the treatments that were originally suggested and whether they are awarded compensation or not, long-term follow up shows that they do not get better without such treatment. All that is certain is that insurers will refuse to pay them and their life will be made miserable at best, or destroyed at worst. The insurer IMEs simply pocket their fees and seem to have no interest or concern in the medium term outcome.

Insurers frequently deny treatments and if challenged use IMEs to justify their refusals. Often they do not give reasons for the denials, but at other times they state that the treatment was not 'reasonable and necessary' or they cite SIRA guidelines or similar, rarely stating which clause they are basing this on. Most NTDs do not challenge the ruling, or even ask for an internal review, 80% of which will confirm the original decision. SIRA did have an appeal system by which the insurers' internal mechanism had to be exhausted before they could be appealed to and some insurers had a number of levels of appeals. NRMA had three. At that time SIRA boasted that only 0.1% of claims led to a complaint. The author had a rate of about 50%, so clearly SIRA's protocol was totally ineffective. SIRA now accepts complaints. However, they usually forward the whole complaint

letter to the insurer, including any requests that the complainant makes for action by SIRA (See Appendix 6 for a recent example). They do not investigate the management of the case, but merely relay the insurer's response. In a number of conversations with SIRA complaints staff there is an almost pathetic need by them to find out information about what actually happens, as it seems that they have no reality contact in the process, let alone the patients. How would they? They are clerks in isolated offices following insurance-industry-written protocols.

Non-payment by insurers is endemic. SIRA was set up by insurance interests and does not actually know what is going on. Insurers are running a massive rort. When the premiums were set for CTP the insurers estimated their costs. It is well known that they have paid out far less than they budgeted to do, so they made supernormal profits, which the government then clawed back and distributed as a 'rebate' on CTP insurance to people who registered their cars in the year before the last state election, claiming that it was their wonderful management that enabled this largesse. Realistically it was because the insurers managed to withhold payments from injured people beyond their wildest dreams, and many people were left untreated to achieve that surplus. This in the author's experience has also been the case with WC, but this has been hidden by other factors[24] such as the fall in the RTW rate, the general downturn in the economy and fall in the stockmarket, the apparently deliberate effort to misclassify people to reduce their PIAWE[25] and the general political fuss over bad contracts[26], nepotism , obscene executive salaries and funding religious political minders from the USA[27].

It is the author's opinion that the non-payment for reasonable treatment is so endemic in the WC and CTP systems as to constitute systemic fraud, and that over 95% of the fraud in the WC and CTP systems is insurers not paying those who should be paid. It seems that the government is happy to turn a blind eye to this in order to lower premiums. This why only SIRA has the authority to prosecute and they never do so. So the law is effectively unenforced with a huge incentive not to pay for 'reasonable and necessary' treatment. If challenged, insurers can paint each case as a 'one off' when it is no such thing, but no collated figures of behaviour exist. It is a matter of definition when a bad scheme becomes a rip-off and progresses from a scam to systematic fraud of criminal dimensions but it is the author's opinion that the last is the situation. In that the regulatory framework has been so lax, decisions so little challenged and so few standards, a criminal prosecution is unlikely to be successful, though it is possible a class action in a civil suit might do better. The insurance system in NSW is far worse than the Banks were shown to be in the Hayne Royal Commission and SIRA is probably a worse regulator than ASIC and APRA were shown to be.

Investigations. We assume that these are usually done by private detective agencies, though the system is so opaque that outsiders have little knowledge of what is done or how. Video surveillance is used, shown to insurers and the case is refused or not, usually with no explanation given. So no overall data is publicly available and only anecdotal evidence can be offered. The author has

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[24] www.smh.com.au/topic/icare-investigation-1nii
[25] www.smh.com.au/business/companies/snouts-in-the-trough-circle-australia-s-60b-workers-comp-system-20200726-p55fiu.html
[26] www.smh.com.au/business/workplace/multimillion-dollar-icare-contracts-were-awarded-in-sham-tender-20201031-p56ae1.html
[27] www.smh.com.au/politics/nsw/icac-needs-to-look-at-treasurer-s-office-icare-salary-scandal-20200808-p55jud.html

experience with 2 recent cases [28]which lead to the conclusion that surveillance footage is being misused and leads to wrong conclusions. The fact that the injured person may have no knowledge of what has been done and no opportunity to reply is extremely unfair. Indeed, it is not satisfactory that a decision is made that is grossly against the patient's interest and they are able to response many months later possibly get the decision reversed. A lot of harm may be done by then.

It should be mandated that if surveillance footage is used this should be notified to the person subject to it and if it is used in the decision-making process the footage and any reports from it should be made available to the plaintiff, their solicitor, and the NTD.

Transparency and the Adversarial Framework

It seems that insurers want transparency in terms of getting the NTD's notes, visiting the patient's home and workplace, but will give none of their own. There is no scrutiny of their notes or decision-making process. They also want a consensual framework when helping to choose the doctors and treatment protocols in SIRA that will decide the cases in which they have created the disputes. They want a consensual framework for the regulator, but to work in a highly adversarial framework in terms of trying not to pay or treat the injured patients.

It is generally assumed by the legal profession that they must uphold the rights of people by access to the Courts. This is true. Ants may fight elephants. But currently the government is reluctant to allow the ants to have lawyers, and a far cheaper system would be for there to be better control of the elephant so that fewer ants get stepped on. SIRA needs to be run by an auditor or a policeman

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[28] Case 1 was a young Korean man with poor English who had come to study. He was allowed only a little work, and was working moving furniture for cash. The van in which he was a passenger had an MVA and he suffered a bad whiplash with pain radiation to his arms. He should have been Workers Comp, but his employer had no insurance and persuaded him just to be CTP. A scan showed that he needed a cervical discectomy, and a neurosurgeon confirmed this and wanted to operate. (This was in the old legislation, prior to Dec 2017 when there was some income introduced for CTP). He had no Medicare and no income. His boss, who felt bad for what had happened let him drive the truck, as he was able to do this with quite a lot of pain and had no choice in order to survive. He was sent to a IME for the insurer and followed by an investigator, who filmed him driving the van and his treatment was suspended, as he was supposedly faking his illness.

Case 2 was an obese Samoan man, who was an ex-Rugby player, brought up in a Christian mission. He got casual work with a Labour Hire company and was unloading frigs from containers. He alleges that he had an altercation with the foreman as his workmate was the subject of a racial slur. The forklift driver was also involved in the altercation. He alleges that the forklift driver drove the forklift into him inside the container deliberately crushing him against the frig, and causing him bad back pain. The CCTV footage was examined and reported as showing that he did not have an injury. Unusually, it was provided to the patient. It showed no such thing. It showed an altercation, then him going into the container, then a little while later the forklift going into the container. The forklift came out of the container without a frig, and stopped just outside it. The driver appeared to be speaking into the container and the patient came out walking very slowly and left the workplace. After some argument he went to an emergency dept where the doctors were concerned that he had internal injuries and scanned him to exclude them. Three IMEs for the insurer accepted the report that stated that the CCTV footage showed no injury, a psychiatrist, an orthopaedic surgeon and on occupational health physician who 'reviewed the file'. The orthopaedic surgeon also opined that as he had had previous back problems this would not have caused more than a temporary exacerbation, which had passed and therefore any back problem he had was unrelated to this injury. Against the odds, his experienced solicitor has managed to retain insurer payments for some of his treatments, though the nature of these is still being argued. As his PIAWE was iCare-assessed as low, he is in financial trouble.

and insurers' notes need to be able to examined as the medical notes are and their management commented on. If they unjustly refuse payments they need to be fined much more than they saved by the treatment or payment refusals otherwise the law is effectively unenforced and there are huge financial incentives for insurers to deny treatments and benefits.

Part D: Data to Substantiate Opinions Offered

It is the view of the author that statements must be backed up with evidence, particularly if the evidence is damning and contradicts the dominant paradigm.

The author has been working in the current system for some years and has assembled evidence for the Hayne Royal Commission into Banking and Financial Service. This required a great deal of time to collate information from large number of patient records that were not written for that purpose. This could be repeated, but only at the cost of a large amount of time. It is the author's opinion that the situation has not changed substantially, but only by repeating the research could a more recent set of data be provided. Many of the patients cited are still having ongoing problems or live much diminished lives.

That said, **Appendix 1** cites 83 cases of Insurer Misdeeds that have involved insurers taking action that is against the patients' interest. Each has a summary. The patients are de-identified and have not given specific permission for their cases to be used. But a large percentage would be willing and able to testify if asked, as are a considerable number since.

Appendix 2 was a 2 week diary of all patients who came to the surgery with the percentages of them that had significant treatment denied. 15 out of 25 WC cases had had significant treatment denials (60%), and 34 of 39 CTP cases (87%). This is consistent with the general view of GPs that WC and CTP are similar but CTP is slightly worse.

Appendix 3 is the author's experience with insurers' not paying GPs. This was not done by individual insurers, though it could and should have been. The author has continued to treat patients based on their need and continued to bill insurers after they had refused to pay rather than do what is common, to transfer the costs to the patient, private health insurance or Medicare, the last being commonest due to the financial circumstance of the patients. In the 2016-7 financial year 17.5% of this GPs bills were not paid and in the half-year period July-December 2017 14% were not paid.

Appendix 4 looks at the denials of Radiology Requests by insurers. It does not distinguish between WC and CTP cases, but rather compares insurers. The first table refers to my own experience. The larger later sample is from another source that wishes to remain confidential, so I have requested that this Appendix remain confidential. It illustrates that there are considerable differences between insurers, with some more ruthless than others. If the government wishes to use competition to improve insurer performance, this would certainly be possible but would require SIRA to produce these figures and make them public. Currently they are not collected.

. The evidence cited here shows that:

1. Many people are very badly affected by insurer denials, delays and interference in treatments

2. GP treatment, which is usually the most basic is denied at between 14 and 17% of what is required.
3. Radiology referrals, which may lead to referrals and more expensive treatments are denied at a much higher rate by some insurers, with NRMA at 61%.
4. This (3) means that any denials of specialist treatments are in addition to those who did not even make it to get the investigation that would lead to a referral. The author has no figures of specialist denials and believes that such figures do not exist, but obviously should.
5. The denials are of such significant magnitude as to constitute systematic fraud.

Part E Comments on Terms of Reference Not Covered Elsewhere in the Submission

Please note. The author will not comment on all aspects of the terms of reference- Items commented on in order of the TOR.

A comment on **iCare's Response to the Dore report**[29]

It would be hard to find a better example of management PR gobbledegook than this. The response is a flurry of empty management clichés, claims of recent improvements and undefined supposed improvements. Look at some of the list of words and phrases in the jumble of rhetoric:

efficiency, effectiveness, focus, stakeholders, engage meaningfully, consult, feedback, delivery, accountability, customer quality, improving service, scheme accountability, work outcomes, compliance activities, data quality, direct involvement, active case management, ongoing improvements.

All these and more just in the first half page. And this in an organisation that cannot manage claims, underpays endemically, always delays and often refuses treatments, and is getting a shocking result in RTW. Why would one bother picking their way through their claims? A broom needs to go through the organisation. A completely new start is needed.

The **21 Point plan** to fix the Dore Report's problems is nearly as fatuous.

Rather than have SIRA supervise iCare at a respectful distance, the two CEOs are going to have pleasant lunches together. The blowout in treatment costs is being addressed by an auditor, rather than a medical taskforce where cooperation might be useful. SIRA is going to educate the doctors in the Health Benefits of Good Work as if they do not know these. The pamphlets come attached to iCare's letters of treatment refusal with no irony noted. What is needed is the doctors to educate

[29] www.icare.nsw.gov.au/-/media/icare/unique-media/about-us/publications/files/icares-response-to-the-first-quarterly-claim-file-review-of-the-nominal-insurer.pdf

SIRA and iCare, not vice versa. Much of the rest of it is just management clichés. If everything were done well it would be well done. Who can argue with that?

It is a generic management and financial solution to a medical management problem. As such it will fail and it is frankly worrying that this sort of non-strategic thinking is being touted when the problems are finally identified. If this is allowed to be the answer there will be a re-run of this fiasco in another 5 years.

Matters In Scope for the Review

1.d. Culture

The Culture of iCare seems to be a preoccupation with money at the top, seeing the whole organisation as a money making venture. Protocols are set up to minimise losses and those at the bottom follow these with no concept of their effect on real people. The people ate the bottom then take the criticism from this callousness and have a high turnover. There is a lack of respect for treating doctors opinions and even unequivocal scan results. Delays and refusals, the lack of case managers, the flexible hours among the insurance staff, which naturally means that the claims decisions are delayed, and the number and nature of treatment refusals all pass unnoticed by the iCare management and SIRA, yet are highly relevant to the low RTW rate. The use of rehab professionals to bully doctors into certifying people as fit, and the use of agencies to ensure that professionals do the bidding of the agency that wish**es** to please the insurer all add up to a cynical and adversarial framework in iCare that SIRA does not even notice.

The culture of SIRA would seem to be guileless public servants following insurer-designed protocols to measure anything that costs money, but measuring no real human performance other than RTW. They act as a not very astute senior insurance clerk rather than a fair referee between insurer greed and good treatment. It seems that they have little idea of either. The rhetoric of transparency seems there for the medical records which can be subpoenaed on a whim. Yet the insurers' refusals and use of investigators seems to lack any scrutiny. SIRA merely passes on complaints and asks for comment. Where is the open examination of insurer records, or are they more precious because they relate to money?

Governance in iCare seems to be an extreme example of what has bedevilled Western society for some decades. The idea that all that matters is the profit of an organisation and that Management have special insight and ability that all others lack has led to a cult-like following of the notion that only a few people can have this brilliance and that they are entitled to huge rewards and immune to the constraints that other mortals have. They swagger around, and are supposedly head hunted on merit rather than nepotism, citing the 'world market' that supposedly sets their salaries. Either their peers or their cowed inferiors agree to the salaries, bonuses and perquisites of this subclass. So it was with the heads of iCare. They awarded themselves net salaries far above normal public service grades by sophistry. They had nothing but contempt for normal public service notions of tendering or transparency and seemed to regard it as rather generous that they would stoop to work for the public service at all.

But beneath the bombast, the Emperors have no clothes. Competent people on modest and incremental public service salaries, particularly if guaranteed tenure, have worked hard and well for many years and built the country. It is time the bluff was called, and the nonsense of the neo-liberal management elite, who recognise no expertise but their own was exposed. The lack of respect for knowledge has led to the idea that a messianic figure at the top will set a protocol

which lesser beings follow depowers those who actually can make the decisions that add up to a competent corporate culture. It belittles their knowledge because it assumes that those who set the protocol know more about each and every situation than those working at the coal face. In the case of iCare, the decisions were supposedly made to save money, but they did not do so. In the case of SIRA, they were not really supervising the insurers at all as they floundered around worrying about whether their computers could capture and process KPIs in time for next year's parliamentary questions. They did not actually know what the insurers were doing, and they still do not. It seems that they are scared to ask. (See Appendix 5)

Executive remuneration needs to be at a reasonable public service level. If the value of the corporation were not inflated so hugely by having to manage a large amount of capital to fund the system everlastingly there would not be the distorting feature of the money to manage, which also takes the executive focus away from the human task that the organisation actually exists for. It also means that the executive recruitment is distorted by the need to choose executives to manage that capital. But simple greed at the top must simply be called out. There is quite good research that shows that many people work for things other than very high salaries, such as stability, respect and the idea that they are doing something worthwhile. This concept is often ridiculed by the bombastic ones who regard this as an impediment to their stratospheric salaries being refused, but it merely a question of standing firm and making sensible decisions about the competence of those at the top.

g. Board effectiveness and accountability

Boards must be effective and at some distance from the CEOs. They need expertise in the human aspects of the job. There seemed very few people who had ever worked in human services, and more a groups of old mates from the insurance sector. A Board should be broadly based with a preponderance of those with expertise in the key task of the operation, and expertise in other areas that are relevant. In the case of WC organisations, this is paying for treatment and replacing wages with compensation.

h. Procurement practices

Procurement generally should be by tender, but very many mistakes are made in specialist areas such as IT, or even medicine where those with the most knowledge are not good at having their reasons heard. It requires a culture of respect for knowledge to allow those with power to listen to knowledge. One of the other features of the rise of management bombast has been the increasing gap between power and knowledge, with a knowledge of how to make money in the short-term being hugely over-rated and distorting decision-making.

i. **Management of probity matters such as gifts, travel, & conflict of interests** should follow public service or even Parliamentary guidelines.

j. **The relationship with the State Insurance Regulatory Authority (SIRA)** is that SIRA is the regulator and iCare is working in a supervised framework. It books should be available for a forensic analysis, as all their decisions should be transparent within statutory guidelines. Currently, insurers demand medical records with the threat of subpoena guaranteeing that his will be met. Medical records are not usually kept with a separate part for compensable and non-compensable matters, and the computer systems do not even allow for partial deletions. SIRA simply passes on complaints to the insurers and asks them to respond, rather than actually examining the insurers records (See Appendix 5 for sample SIRA letter), in the interests of 'transparency'. It seems that everyone is transparent except the insurers. Their books and case

notes must be open to forensic examination by auditors or SIRA regulators. It would seem that this is not the case now at least in practice. The author is unsure of the law in this area but insurers, either owned by the State such as iCare, or subcontracted to the state as accredited agents must meet public service standards of transparency and accountability, and their case records must be open to regulatory scrutiny and GIPA requests.

4. b. **Financial stability and management of the workers compensation schemes**

The fact that this is term of reference in a sense assumes that the current model of a self-funding scheme with huge reserves will continue. That it is a term of reference in this context is just another illustration of the point that existing financial interests have set the terms of reference and the idea of a scheme funded in a 'pay as you go' way of funding health insurance and wages lost is not considered nor to be considered. The distorting effect of this on the structure, priorities and remuneration of iCare executives has been dealt with elsewhere in this submission. Hopefully it will not deter consideration of this by the Review.

c. The SICG Act must be amended to strengthen the obligation of any insurance scheme to discharge its key functions of funding the treatment and wages compensation of injured people. This mentioned in the Act but seems forgotten after its token mention, and certainly in the implementation of the SICG Act.

d. The Workers Compensation Act 1987 (WC Act) or Workplace Injury Management and Workers Compensation Act 1989 (WIM Act) used to stress that workers could be compensated if an incident 'caused or exacerbated' an injury and resulted in an inability to work. This is in essence the 'eggshell skull' principle. If a worker is vulnerable due to age changes or problems, but was working satisfactorily prior to the accident and is reasonably unable to after the accident the accident must be deemed to have caused the incapacity. Insurers now look for indicators of prior disease on scans or in the patient's history, then claim a pre-existing pathology, even if there was no previous history of the same. IMEs then claim that any exacerbation that might have occurred would have passed in a few weeks, so that any ongoing incapacity does not relate to the injury. This is nonsense, as the person was working before and is unable to work after the incident. The author has written to SIRA and asked specifically that they reaffirm the 'eggshell skull' principle and the concept of an incident 'causing or exacerbating' an injury, but they have replied that every case must be judged on its 'own merit', which is simply a way of avoiding the issue and allowing insurers to continue their venal denials. The concept of eggshell skull and exacerbating an existing situation must be clearly stated in the legislation, and enforced by the regulator. The insurers take the premiums from a workforce as they find them. Doctors have to treat patients as they find them and insurers must pay for injured people as they find them. There is no public benefit in these cost-shifting activities and there is huge detriment to injured people.

Review approach

Focus

It is heart-warming that **the Review will be an inquisitorial rather than adversarial process** and that **the Review will be carried out on the assumption of complete cooperation and full disclosure from the parties involved**.

While the rhetoric of transparency and a non-adversarial approach is touted, it is more noted in the breach than the observance. Letters of treatment denial end with the cheerful slogan, 'We are here to help you' without a trace of irony. SIRA may wish to be non-adversarial as they simply send on

complaints to insurers and faithfully recount their fob offs but the insurers never seem to have to open their files and are never held to account for callous and unjust decisions that they make. It would be nice to think that this inquiry would have an open book from them. But the devil is in the detail. Without seeing the callousness of the way individuals are treated, it is impossible to judge the small decisions which add up to the immense social harm that the scheme is doing or to gauge the extent of what the author believes is systemic fraud. The key problem has been that the KPIs do not reflect what is actually happening and a macroscopic overview will not see any wood in the trees. It is concern that the terms of reference excludes an examination of individuals, as only by looking at a sample of these in a forensic way will the inquiry be able to see what is actually happening. This submission attempts to give such an overview from collated case data and a number of anecdotes, but the Inquiry needs to hear individual stories, even if it cannot act on individual cases. The author urges it to do so and to have public hearings for this. How transparent insurers will be when their individual records are examined will be interesting. If it happens it is likely to be a new experience for them.

The author is encouraged to note that the Review **seeking and considering feedback obtained through a targeted stakeholder consultation and public consultation (including a call for submissions based on the Terms of Reference)**, and hopes that this is quite a large part of its activities, though it is rated low on the list in the terms of reference. .

It is encouraging that **the Independent Reviewer will determine the level of support he requires. He will have available to him:**

- **a Review Team comprised of staff from NSW Treasury and the Department of Customer Service**
- **additional support and resources as requested by him, such as assisting legal counsel and external expert advisors.**

The author is concerned as stated above that the dominance of Treasury and insurance interests in the drafting of the Terms of Reference and the staffing of the inquiry is likely to distort its priorities, methods and conclusions and urges the Independent Reviewer to get external help and information to counterbalance these influences

Part F: Discussion of Solutions for the WC system

Prevention of Accidents, Injuries and Industrial Diseases

There needs to far more emphasis on prevention of injuries. Safework needs to rehire experts and form ongoing project teams as it had formerly abolished. It needs to conduct inspections, both after significant accidents, and also at random. There needs to be a separate safety education agency. It must be separate, or industries will be reluctant to call it, fearing inspection and punishment.

There must be better communication between SIRA and Safework so that injuries are reported and secondary prevention (of recurrences) can occur.

Need for the Scheme

There are two elements to Workers Compensation, payment for medical treatment and workplace rehabilitation, and replacement of wages.

Alternative Payment Systems for Treatment

Given that the WC scheme is an extraordinarily inefficient way to deliver health services, the question is whether it is necessary at all. If Medicare were to function as a credible health system, the combination of public hospital Emergency Depts for acute care and Medicare for GP and later elective specialist care would be quite workable. The WC schemes evolved in a pre-Medicare time when some people did not get timely treatment under the ‘Honorary system’ where doctors did public patients for free in return for access to public hospital beds for their paying patients. Briefly Medicare paid doctors at 85% of the AMA fee, and specialists were willing to work at that level. Now that governments have let the Medicare rebate fall with inflation to 46% of the AMA fee, specialists are not willing to work for Medicare, so the WC and CTP systems are necessary. If the Federal government would again make Medicare a credible alternative, these inefficient private schemes would not be needed. However, this is unlikely, so the only alternative is to try to make the WC (and CTP) schemes less inefficient.

It is noted that in the USA, health insurance is paid by employers. In that workplace injuries are a small part of the total health requirements even of full time workers, employers might be able to make an arrangement with Health Funds or with Medicare to pay a premium that had no gap and no waiting time for accidents or injuries that were certified to have happened at work. A check system involving employers, doctors or Safework might certify an injury/illness as work-caused to enable payment under this system. It may be a lot cheaper to administer than the current system. Employers would not be liable for non-work-related conditions.

Alternative Wages Replacement

It is notable that some unions pay for Income Guarantee Insurance for their members while the WC scheme processes the claims. (It is mute testimony to the inefficiency of the scheme that another scheme exists just to pay for its delays!) If the treatment were taken care of by another medical payment system, the wages replacement could be through Income Guarantee Insurance unrelated

to Workers Compensation. It is likely that a Health insurance for work injury and an income guarantee insurance would be cheaper than the existing system.

Assumptions in the Current WC scheme

The assumption of the current scheme is that it must be long-term self sustainable leads to the accumulation of huge amounts of capital to fund future liabilities. The management of that capital then becomes more of a preoccupation of the Board and Management than the core business of treating injuries and replacing wages, as has been seem in the current fiasco. In that the pay-outs do not vary hugely from year to year, it would be possible merely to budget a certain amount annually based on recent experience with a surplus in case of a bad year. This would take the stress from the management as they could concentrate on what should be their core business without worrying about stockmarket returns or other distractions. The WC system could return to its real role as part of the funding of health treatments and a guarantee of wages to inured people and families. The salaries of CEOs might also become more realistic.

Treatment under the Scheme

The problem with the scheme is that unqualified insurers interfere in reasonable treatments in order to try to minimise the cost of claims. If this role were given to medical professionals there could be discussion based on medical outcomes. After successful prevention, optimal medical outcomes are the key to reducing costs of injuries. Doctors would have to justify the treatments within a medically agreed framework that the Colleges could supervise in a transparent way. The fees also would have to be agreed and adhered to. If some practitioner wanted to insist on far higher fees (which is currently the case sometimes), a list of doctors qualified and willing to do the work could be assembled. Ideally all treatments done within the scheme would go into an ongoing medical research and assessment programme that would allow monitoring of both individual excellence in participating doctors and the relative success of types of interventions.

The coordination of treatment should be by NTDs who are GPs and the protocols for treatment of injury be worked out by the RACGP, or by specialist colleges for their areas. Treatments within the RACGP/specialist college guidelines shall be considered 'reasonable and necessary' and insurers should be obliged to pay them at a negotiated rate. Arguments over treatment should be referred to the RACGP or other appropriate colleges, with appeal to WIRO. There should be no arbitrary refusal of treatments by insurers allowed, as currently happens.

The rate of pay of doctors should be worked out by negotiations with the AMA, but also with the proviso that there be one item number for each significant procedure.

Having worked as a surgical registrar and put people on coronary bypass for $12.50 per hour, the author is amazed at the current quotes for surgery. The author is able with some goodwill to get MRIs for $250 each for patients denied such by insurers, yet sees approvals for lumbar MRIs at $1700. One can only note that a large Sydney radiological practice recently changed hands for a large sum with the existing staff simply continuing to work under their same arrangements[30], though the consideration was not stated. The author understands that there is some difference between

[30] www.permira.com/news-views/news/i-med-radiology-network-to-acquire-alfred-medical-imaging/

the fee schedules of the AMA and the Orthopaedic Association, and that some specialists do not adhere to either of these rates preferring a 'market' solution. There is often a large premium for WC and CTP cases as there is a risk of not being paid, having detailed reports required later or even court appearances which are immensely detrimental to work scheduling. That said, there are cases where the fees are higher than would seem to be justified and some practitioners quote multiple item numbers when the procedure was intended to have one item number and the number of similar ones were intended to be there for similar but separate operative procedures. From a GP or NTD perspective the decision of what specialist to use is usually made by experience of the service and results that the specialist obtains, with almost no consideration of the fees charged by the surgeons or the hospitals. Indeed, the NTD rarely has access to any of this information. Occasionally insurers simply refuse to pay more than a certain amount and instruct the NTD to find another specialist. There is no public information to help with this, so it just appears as another example of dictatorial insurer behaviour. As may be discerned from this submission, the author does not have a great deal of sympathy for insurers, but the medical profession and the Colleges must take responsibility for this issue and work out a solution, so that competent investigation and treatment can be had at a fair price.

Governance

SIRA should accept the fact that it is an auditing and policing role. As such it should be willing and able to examine the management of claims in a systematic fashion, checking all complaints and a random sample of files. The checks should be for fairness and timeliness with penalties, as the lack of penalties and the lack of 'hands on' assessments has led to completely ineffective regulation. A major culture change at SIRA is needed with more auditors and ex-police in the workforce.

SIRA should uphold the decision-making by NTDs, and mandate that they are given all information about the patients that they are managing in real time.

SIRA should monitor that iCare is paying the correct amounts in relation to PIAWEs, and randomly check iCare files for compliance, and all files that create complaints. SIRA should not merely rely on KPIs supplied. This should apply to all insurers supervised by SIRA.

SIRA should produce a standard contract in simple language and let insurers work to it, so that there cannot be 'wriggle room' to get out of paying. Failing this all contracts should be on the web and available to all.

Insurer records should be in a format that allows easy monitoring of the time that requests are received, the time taken for approvals or denials of treatment and by whom. This should be monitored as a KPI by SIRA. Collated data should be made public and individuals should be traced when there are complaints or in random audits. If insurers can inspect medical records at will, their records should be subject to the same scrutiny.

It is likely that the current efforts to reduce payments at every level by insurers are generating more costs than they save.

Use of Allied Health Professionals

Rehabilitation practitioners should be chosen by patients in consultation with their NTDs, and not by insurers, so that the primary loyalty of the Rehab professional remains to the patients. If some doctors are unaware of the roles that Rehab practitioners can play, this can be addressed by the Rehab professional marketing to the doctors rather than the insurers.

Use of Investigators and Surveillance

The records of surveillance used and the raw footage of any electronic material produced should be made available to the patient at the time it is used to deny their treatments, so that there is a chance for them to respond to the allegation, which is effectively unseen and unchallenged in making an insurer's decision. All surveillance should be overseen by SIRA who must ensure that it is not overused and that it is cost-effective.

Research

SIRA should appoint universities, the National Health and Medical Research Council or other appropriate bodies to supervise quality control and run ongoing studies of the effectiveness of treatments in areas such as spinal surgery where the treatment protocols may not be clear.

Injured patients

Injured workers are no t 'Customers' as there is nothing elective in their situation. The ability to ignore their situation has been a major factor in the problems of iCare and SIRA. There needs to be a formal and funded support network, which must be allowed an advocacy function within SIRA and iCare. As the organisations exists for their benefit they should have a seat on the Boards.

Part H: Recommendations

1. There needs to be far better prevention. Safework needs to hire better trained people, organised in teams who and have and continually develop expertise in their own areas and continually monitor these in the field. Safework needs to get injury cases and statistics from insurers and inspect significant incidents and monitor workplaces regularly and at random.
2. Abolish the inefficient WC Scheme and have alternative payment systems for the treatment and the compensation systems separately. Possibilities of paying include:
    a. Fix Medicare to pay doctors 85% of the AMA rate as it was when Medicare began. Doctors would then be willing to use it. The premiums equivalent would offset part of the extra Medicare costs. (The author recognises that this is unlikely as it is a Federal government issue).
    b. Use Medicare's computers to keep track of the treatment records, but keep an independent record of the workplace or CTP injuries and pay them at least double the Medicare rate, so doctors would be willing to use the system.
    c. Let employers pay for private health insurance that only covered their employee's workplace injuries.
    d. Compensation payments could be made by Income Guarantee Insurance, perhaps paid as part of payroll tax.
3. Pay the cost of the scheme on an annual basis and do not attempt to have a huge sum that covers the whole cost of the scheme and distracts from the core task.
4. The key performance indication for the scheme as a whole should be the percentage of premium income that is paid in treatment and compensation payments to injured people, and should be compared to Medicare, Private Health insurance and payrolls.
5. Have guidelines with treatment pathways worked out by the medical colleges and have insurers obliged to pay for treatments that fall within the guidelines. Appeals would go to college panels.
6. Strengthen the position of GPs as Nominated Treating Doctors (NTDs), insisting that they are informed of all investigations, referrals, approvals or denials that they are not immediately responsible for.
7. Ensure that all rehabilitation and allied health providers are chosen by the patients and their NTDs so that these health professional are not placed in conflict of interest positions by insurers or hiring agencies.
8. SIRA must be reformed to have an audit and policing role. It cannot assume that insurers will do the right thing, and must be clearly separate from insurers to guard against regulatory capture.

9. SIRA must be able to access insurers' files and examine them forensically after complaints or as random samples.

10. Insurers who unreasonably refuse treatments or compensation must be fined considerably more than the benefit that the denial would have brought them to discourage this fraudulent behaviour.

11. SIRA must collect figures of insurer delays and denials and make these figures public. If there is competition this must be done to show the difference between companies.

12. Medical fees must be set in negotiation with the AMA, who should be involved in fee disputes.

13. SIRA should produce a list of doctors willing to do procedures in cooperation with the Colleges for use by NTDs

14. Insurers must not have input into the selection of IMEs used in MAS or DRS medical panels and all IME reports must be subject to College overview and peer review, with SIRA responsible for regular long-term follow up with feedback to the relevant practitioners.

15. SIRA should work with colleges and relevant medical research bodies to compile registers of operations/treatments with their success independently monitored, perhaps by NTDs. These should be part of ongoing trials and their findings used to improve treatment protocols.

16. Surveillance must be notified to the subject after it is done and if it is used to make any adverse decision it must be provided to the subject, the NTD and the solicitors to give them an opportunity to respond to any conclusions drawn.

17. Any protocols or surveillance exercises that are supposedly for fraud prevention should be subject to scrutiny and strict cost-benefit analysis.

18. The RACGP must set up a training programme for insurance staff with help from the Ethics Centre[31].

19. iCare must have all its appointments done in transparent processes, as used to occur in the public sector.

20. The RACGP should set up training programmes for SIRA and iCare staff.

21. Injured workers should have funded support groups formal representation within the structure of SIRA and iCare and a seat on the Board.

[31] www.ethics.org.au