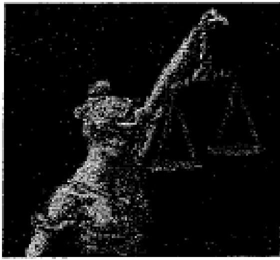

SUBMISSION TO THE INQUIRY INTO ASPECTS OF WORKERS COMPENSATION

"A MONITORING SYSTEM"

Time is running out for our leaders to provide us with a solution for our Insurance crisis.Indeed, the solution must be multifactorial.Contrary to what the insurance bashers would have you believe,there must be a restoration of the RISK – REWARD equilibrium for insurance companies.
In their two part review of negligence law the Ipp committee has made over 60 Recommendations.
Recommendation number 32 , is that which looks at contributory negligence and proportionate liability.It states that a magistrate can consider a plaintiff 100% responsible for their actions,when appropriating liability,(this was a maximum 90%).

A natioinal database identifying features of negligence claims had been recommended at last year's Australian Health Ministers Conference.Initial reports from this initiative just released , refute repeated claims by plaintiff lawyers that litigation has not risen.(page 2 AUSDOC,4/10/02,"GP litigation rates soar").

Taking a much needed extra step in data accumulation , is obtaining data on fraudulent and/ or exaggerated personal health claims(whether from medical negligence,workers comp,national CTP,income protection or even the inappropriate overuse of MEDICARE) , here everyone that is an employee has an employer,every employer , an employee and every employer must have w/comp insurance.
A lot of public displeasure has been created by media blurring the margin between claims from irresponsible acts and those claims perceived to be trivial.
Our health system is in the process of improving safety and buffer mechanisms to look after the catastrophically injured ; we have also introduced the concept of thresholds to hopefully deal with those trivial "slips and trips" and "staged" motor accidents.

It is dealing with an intelligent hunch suggesting that the level of fraud Involved at all levels of insurance is increasing , and it is that which will form the basis of the reasons for my recommendations.

It is for this reason that I introduce a "data acquisition tool" that looks at picking up fraud before it occurs , and not after the event ,such as data currently available to us , reflects.

The cost of insurance fraud in the United States is estimated to be

US $ 100 billion per annum.Bodily injury claims account for over 50% of these. They were generally as the result of either 'staged" motor vehicle accidents or "slip and fall" accidents in commercial premises . . . Insurance fraud is second only to tax fraud in the USA.("trends and issues in cime and crim. Justice,no 66, Feb 1997,AIC,Tony Baldock)

This system , has general practitioners (the primary health care providers) As the centrepiece.It assumes their subjective interpretation of patient (employee) behaviour as being reasonably likely to be correct.They are independent from employee – employer influences that may be present at the workplace.This may come in the form of belligerrent occ health officers and supervisors or suspicious work colleagues, OR, these parties may actually be complicit and facilitate or conspire with a colleague when he/she makes a claim.As such claims are made against the worker's comp insurer,the employer may even add to this facilitation.This last point may depend on the person in charge and how ethical he/she is.

Once a "train of claim" is commenced, it is difficult to reign in – especially after "the injured" sees a sympathetic doctor.(w/comp consults are worth much more in dollar terms than medicare).It would therefore be a good rule to have w/comp cases present Initially, to any other doctor apart from their regular GP.

It is for this reason , that I believe our general practitioners are best placed to independently supply the data that may reflect fraud and/or exaggerated claims, in workplace incidents.

In assuming that every consult with a GP has a secondary gain, we can arrive at four groups reflecting the different permutations formed by two parameters (volition and tangibility) that describe the secondary gain. These are :

1)Voluntary tangible group
2)Voluntary intangible group,
3)Involuntary tangible group and
4)Involuntary intangible group.

(The scope of the presentation will be limited to data acquisition reflecting the first two groups only – that which may be perceived as fraudulent or inconsistent with desirable behaviour designed and known to give optimal and most efficient outcome. This data tool has many other potential uses , that may become the subject of discussion with bodies such as the fraud division of the HIC,and divisions within the same body responsible for improved health outcomes per health dollar spent.)

Essential elements are care and honesty from the provider, and the capacity to document patient behaviour without being judgemental. This raises a fine line for doctors when patients access their notes. Doctors are less likely to

be subjected to litigation if they refrain from making a judgmental comment on a patient's statements and/or behaviour, and confine themselves to keeping a true and correct record.This database is not an attempt to undermine the power and role of a magistrate but,may assist when one is seeking as much information as possible to prove something beyond reasonable doubt,as may occur in certain court cases.

The categories of permutation, are listed below. The motivation can be seen as the secondary gain and the method seen as the instrument used to achieve it:

Group One UPB - Voluntary tangible gains	
Voluntary Tangible Gains could raise suspicion of fraudulent behaviour, a crime that is obviously punishable.	
Motivation	**Method**
Money	False medical negligence ,W/comp,Public liability,CTP,Income protection ... claims.
Days off	False illness behaviour seeking medical certificates
Pills	False information used to obtain drugs of addiction - often sold and/or over used on the streets.Also looks at a market where people obtain drugs under the PBS and sell / send them overseas or to third parties.

GroupTwo UPB - Voluntary intangible gains	
Voluntary Intangible Gains should also be classed as fraudulent. Examples in this class usually start off as a legitimate hypothetical concern but often largely continue on fraudulently.This group could be of great interest to A) HIC ,when looking at evidence based medicine ,health outcomes and overuse of medicare... B} Insurance companies assessing risk of each client B) Magistrates when now quantifying and qualifying contributory negligence And proportionate liability.	
Motivation	**Method**
Testing of a doctor's specific medical knowledge	Pre-consultation research
Attempt to mislead the practitioner	Arguing against doctors opinion due to preconceived self-diagnosis, despite having little knowledge of the medical principles at hand
Create obstacles to correct diagnosis or management	A patient not having the money for a bus to go for an x-ray or blood test.
	Too busy to go for the second opinion you think they need ASAP, often opting to request an unsatisfactory compromise that obviously put the patient at risk medically and doctor at risk of negligence
	Purely uncooperative behaviour like refusing to take advice for various reasons, an alarming example of this would be Doctor A advises patient A that by not taking tablets may lead to death, as time passes patient A relocates, sees Doctor B for similar complaint, Doctor B omits some advice assumed given in the past; now consider a negative outcome, patient A then sues Doctor B for not providing enough informed consent.
	Unreasonable demands not consistent with good medical practice, eg. requests for a referral from a patient that you have never seen before, who wishes not to discuss the reason for it ,other examples include shopping list presenters who are happy to spend 1½ hrs to get health problems out of the way , patients becoming violent or abusive when they don't get their way,"while we are all here you may as well look at all the

	children,people insisting to have their BP measured every month and the best one is when a disgrunteled employee asks you can he/she have a certificate for stress leave after an obvious work related incident.

The following two groups (3 and 4) are beyond the scope of this submission However,should be of interest to the Health Insurance Commission when looking at illness data and possibly redirect medical resources to more needy areas.

<table>
<tr><th colspan="2">Group Three UPB - Involuntary tangible gains</th></tr>
<tr><td colspan="2">Involuntary tangible gains are those when real gains are justified . We can subcategorise acute and chronic illnesses into the well known groups such as infective(viral,bacterial,fungal),neoplastic(lung,bowel,renal,breast,endocrine),traumatic,autoimmune,iatrogenic(Surgeon,physician,gp,naturopath,iridologist,masseuse,neglect/abuse etc etc).....</td></tr>
<tr><td>Motivation</td><td>Method</td></tr>
<tr><td rowspan="4">Accidental(indep of pt)</td><td>Justified medical negligence claims for injury suffered</td></tr>
<tr><td>Days off justified for being sick</td></tr>
<tr><td>Workers compensation for injury suffered at work</td></tr>
<tr><td>Our own pharmaceutical benefits scheme</td></tr>
<tr><td colspan="2">This section can be used by the profession to monitor performance of colleagues ,hospitals ,nursing homes, and other health care providers, as another quality assurance measure.It is apparent that medical mistakes are causing unnecessary morbidity and mortality that we would do well to minimise. This last point alludes to the possibly unfortunate label, that our doctors are also policing the system that they work in ,and ,there may be problems here when a body of professionals are asked to scrutinize their own colleagues ,but ,fortunately we already have a system that punishes provider misbehaviour.</td></tr>
</table>

Group Four UPB - Involuntary intangible gains	
Involuntary intangible gains are obtained when people behave in abnormal ways.This could be used as a screening tool for psychological disorders.A tool recommended by many in the past.	
Motivation	**Method**
Relief of psychological conflicts	Irrational behaviour
	Unsubstantiated irritability
	Abnormal effect
	Disordered thought processes
	Agitation (and many more)

We have now classified four groups of undesirable patient behaviour (UPB) using two parameters; tangibility and volition. Each consultation would have a UPB group designated.

As the system does not label or judge patient behaviour, it merely documents features of behaviour indicative of patterns consistent with undesirable behaviour patterns,this information can be used to qualify and quantify medical negligence claims as well as assist the court in qualifying and quantifying contributory negligence.

The advantages of having a register , with full access restricted to magistrates and police investigators are obvious.From the USA experience in 1976 Florida became one of the first American states to pass legislation that specifically targeted Insurance fraud.From the latest information available 35 American states now specifically recognise insurance fraud as an offence.The majority of those states also specifically provide for the granting of immunity from civil action to any person who furnishes information related to suspected insurance fraud. In 1992 the National Insurance Crime Bureau (NICB) was formed.The greatest achievement of this was undoubtedly the formation of its insurance fraud database – NICB EyeQ.This database contains in excess 350 million insurance claim and vehicle related records provided by the over 1000 member body comprising mainly insurance companies.

Sophisticated search formulae can use a number of search criteria such as :
1) NAME

APPENDIX

Fair go mate pty ltd will assume that:

a) Desirable patient behaviour in consultations would be defined as one where the patient behaves such that a doctor's advice is appropriate and optimal and that the patient appreciates and takes the doctor's advice gladly.Obviously ,undesirable behaviour would occur when the above situation breaks down.

b) That a doctor's documentation and interpretation of patient behaviour is Appropriate and accepted and without bias or malice.

c) This database is not perfect because there will be situations where Undesirable patient behaviour may not be an efficient use of health dollar ,but appropriate for the individuals' needs.

d) Full access to the database be restricted to the courts;
Access for patients be restricted to the data cumulated by their presentations to all practitioners;
Access to doctors be restricted to data cumulated by consultations provided by themselves only.(for example it would be impossible for doctor A to see what doctor B had for the same patient)

2) ADDRESS,
3) NATIONALITY or PLACE OF ORIGIN
4) SOCIAL SECURITY NUMBER AND TAX FILE NUMBER
5) DRIVERS LICENCE NUMBER
6) MEDICARE NUMBER
7) TREATING MEDICAL PRACTITIONERS PROVIDER NUMBER(S)
8) THE PLAINTIFF LAWYER or FIRM LICENCE NUMBER(S)
9) WORKCOVER RECORD REFERANCE NUMBER
10) INSOLVENCY AND TRUSTEE SERVICES RECORD NUMBER
11) CREDIT REFERANCE ASSOCIATION NUMBER
12) PAST EMPLOYER OR INDUSTRY GROUP IDENTIFICATION NUMBER
13) CRIMINAL RECORD IDENTIFIER ,INCLUDING INTERPOL AND OVERSEAS CRIMINAL RECORDS,
14) PROFESSION or OCCUPATION
15) INSURANCE CLAIM HISTORY(INSURANCE REFERANCE ASSOCIATION)
16) INDEPENDENT AUDITOR REGISTRATION NUMBER
17) AUSTRALIAN COMPANY NUMBER AND AUSTRALIAN BUSINESS NUMBER
18) A TIME GRID LINKING ALL OF THE ABOVE

Yours sincerely

Dr William Marchione Medical director

Fair Go Mate