CHAPTER 2:

MEDICAL COMPLAINTS: NOT YET?

Introduction

2.1 This chapter examines the arguments that were put to the committee in support of the contention that medical complaints should be excluded from the jurisdiction of the Tribunal. Chapter 3 examines the arguments for the inclusion of medical matters in the Tribunal's jurisdiction.

2.2. The Insurance and Superannuation Commission (ISC) contended that:

> (i) the assessment of medical evidence is a highly complex function and does not rest easily with the tribunal process, which is informal, economical and quick. It rests better in a court process where dealing with that type of disagreement is well established;[9]
>
> (ii) the cost of disability benefits falls on other members of the fund. These high costs could make small or medium funds insolvent unless the fund was able to recover the provision through insurance;[10] and
>
> (iii) if a disability benefit is an extra $100 000, a large number of disability claimants would choose to go to the Tribunal,[11] a 'floodgate' could open.

2.3 These contentions raise two general categories of argument against the inclusion of medical complaints in the Tribunal's jurisdiction:

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[9] Duval, Evidence, p 111

[10] Duval, Evidence, p 112

[11] Duval, Evidence, pp 113-114

(i) that a floodgate of complaints could open; and

(ii) that the Tribunal does not have the relevant expertise to hear matters involving medical evidence.

Opening a 'floodgate'?

2.4 The ISC posed the rhetorical question: 'What is the point of accepting an adverse decision of the trustee?'.[12] The Commission went on to postulate that disability claimants, the majority of whom the Commission has 'no doubt' are sick, would go to the Tribunal in large numbers 'given the amount of money they might get if they did get a claim up'.[13] These contentions were made by way of speculation, although the committee did seek to elicit more substantial material on the issue, but with little or no success.

2.5 The evidence of Association of Superannuation Funds of Australia in the ninth inquiry of the committee was that disability claims would potentially overwhelm the Tribunal so that the Tribunal's time would be taken up in dealing with those matters rather than the other sorts of matters which would come before the Tribunal.[14] The committee has received no evidence in support of this contention in the course of this inquiry. The committee has been provided with evidence that refutes the floodgate argument. After examining all of the evidence, the committee does not accept that a caseload of unmanageable proportions will be created as a result of the inclusion of medical complaints in the Tribunal's jurisdiction.

Or a pinhole?

2.6 In response to the floodgate argument put to the committee, a number of witnesses raised compelling counter-arguments.

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[12] Duval, Evidence, p 113

[13] Duval, Evidence, p 114

[14] Senate Select Committee on Superannuation, *Super Supervision Bills*, October 1993, p 82

2.7 In the committee's Ninth Report, evidence that disputes over medical evidence comprise a minority of disputes was provided.[15] This contention has been supported by the evidence received in this inquiry. The committee has received evidence on the types of disputes that arise with disability claims. Generally, they do not involve the assessment, evaluation or consideration of medical evidence, opinion or reports, but are disputes involving procedural fairness. These are discussed further at paragraph 3.9 below.

2.8 In the course of this inquiry, the committee has received substantial evidence on the pressure that matters involving medical evidence place on the workloads of other tribunals that deal with these sorts of matters. In particular, the committee received evidence on the Life Insurance Complaints Board (LICB), the Social Security Appeals Tribunal (SSAT), the Administrative Appeals Tribunal (AAT), the Defence Force Retirement and Death Benefits Authority (DFRDBA) and the Veterans' Review Board (VRB).

2.9 In the period 1 July 1992 to 31 December 1993, the proportion of disability complaints made to the LICB represented 11 per cent of total complaints in that period. The most recent LICB data indicates a slight reduction in complaints re disability policies. [16] Although some predict that the **number** of complaints will increase, there has not been any evidence submitted that the **proportion** of medical complaints will increase.

2.10 SSAT data demonstrates a similar trend, showing 9.5 per cent of persons denied the disability pension have appealed to the SSAT.[17]

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[15] Senate Select Committee on Superannuation, *Super Supervision Bills*, October 1993, p 84

[16] Attorney General's Department, SISREG Sub No 14

[17] ACA, SISREG, Sub No 1 (Supplementary)
AFCO, SISREG Sub No 18
Drake, Evidence, p 24

Half of these appeals have been successful. The statistics are set out at Figure 1 below.[18]

Figure 1:

Statistics on the Social Security Appeals Tribunal

Applications for disability pension		108,000
Rejections by DSS		38,000
Appeals to SSAT	non-medical cases	600
	medical cases	3,000
Of the 3,000 medical appeals to SSAT:		
	original decision varied	1,450
	original decision not varied	1,550

Statistics for 1992/93 (rounded)
Source: DSS Statistics office; Geoff Hall, Operations Manager of the SSAT and former SSAT member

2.11 Ms Prudence Ford of the Attorney-General's Department submitted that at the time of the establishment of the SSAT, there had been a great deal of concern about vexatious complaints and difficult medical cases. In relation to the problems of backlogs, the SSAT has managed by changing procedures and appointments.[19]

2.12 The potential for a relatively large number of persons to seek a merits review of decisions under a specific decision-making power does not justify

[18] SISREG Sub No 1 (Supplementary)

[19] Evidence, p 79

excluding those decisions from merits review.[20] This has been the consistent argument of the Administrative Review Council (ARC), established under the *Administrative Appeals Tribunal Act 1975* to advise the government as to the classes of administrative decisions that should be the subject of review by a court, tribunal or other body and the appropriate court, tribunal or other body to make that review.[21] The ARC's view on the relevance of potential numbers using a jurisdiction was endorsed by the Australian Consumers Association (ACA) which submitted that options for review of medical complaints are needed regardless of the number of cases involved.[22]

2.13 As a precaution against any opening of a floodgate, it was put to the committee that the position of the Tribunal could be reviewed in 12 months so as to assess the impact of medical complaints. This would allow hard evidence to be available in relation to the volume and complexity of medical complaints.[23]

Tribunal expertise and resources

2.14 The submission that the assessment, evaluation or consideration of medical evidence would be too difficult for the Tribunal, was made by the ISC as set out at paragraph 2.2 above.

Response to the 'too hard' argument

2.15 The committee questioned the argument that trustees are better qualified than the Tribunal to make the decision on disability,[24] as did other witnesses before the committee.

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[20] ARC, SISREG Sub No 22

[21] Section 51, *Adminstrative Appeals Tribunal Act 1975*

[22] Drake, Evidence, p 30, p 34

[23] Drake, Evidence, p 33

[24] Evidence, p 117

2.16 ACA submitted that trustees are unlikely to have expertise in medical matters. Similarly, courts that rely on medical evidence to make determinations do not have medical expertise. Furthermore, primary decision-makers, such as the Commonwealth Superannuation Board of Trustees and the trustees of private superannuation funds are often involved in the assessment of medical evidence.[25]

2.17 The ARC also expressed concern that the basis for the exclusion of medical complaints, as identified in the committee's Ninth Report, is that conflicts in medical opinion could only be adequately determined by a court and that there could be a flood of work in the area of medical complaints. The ARC has argued that the Tribunal would be as well placed as a court to determine complaints involving medical evidence.

2.18 There is strong evidence that other tribunals handle cases involving medical evidence in a 'reasonably efficient way'.[26] The AAT, the SSAT and the VRB are examples of alternative dispute resolution mechanisms that resolve disability cases involving medical evidence.[27]

2.19 In response to 'the inference that tribunals really do not have the competence to deal with the assessment of medical evidence', committee member, Senator Woodley, informed other members of the committee, and put on public record, that he had been a member of the SSAT in Brisbane. Senator Woodley stated that it was not his experience that tribunals were incompetent in making a judgement in disputes involving medical evidence.[28] Mr White, of Disabled Peoples International, gave evidence that he had been a member of the Defence Force Retirement and Death Benefits Authority and that all the matters before that body involved the

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[25] ACA, SISREG Sub No 1 (Supplementary)

[26] Evidence, p 78

[27] ACA, SISREG Sub No 1 (Supplementary)
AFCO, SISREG Sub No 8
ARC, SISREG Sub No 22

[28] Evidence, p 31

assessment of medical evidence. Mr White agreed with Senator Woodley that, in his experience, tribunals are competent to deal with medical evidence.[29]

The role of the insurance company in the payment of death and disability benefit

2.20 It was put to the committee that the ability of a fund to recover a disability payment from its insurer is a paramount factor in the determination of disability claims. Maurice Blackburn & Co., a law firm with a superannuation disability claim practice of approximately 500 active cases, submitted that in its experience 80-90 per cent of claims are initially rejected, particularly in non-government superannuation funds. It stated that 'the claims process is substantially influenced by the role played by underwriting insurers', some of whom adopt an adversarial attitude to claims.[30]

2.21 LIFA outlined to the committee the role of insurance in the superannuation industry. LIFA stated that there are two players: the trustee, that determines the benefits payable to an individual; and the insurance company, that provides cover on the policy.[31] However, the committee also received evidence that, in a number of cases, trustees use the same assessors as the insurance companies, to the extent that trustees have in the past undertaken no assessment at all other than consulting the insurance company's assessors.[32] Funds take out insurance with a life insurance company that covers both the eventuality of death and total and permanent disability.[33] Throughout the inquiry the committee was told that there is a significant problem with inconsistencies between the definitions of disability in the insurance policy and the trust deed. This evidence is canvassed at paragraph 3.9.

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[29] Evidence, p 31

[30] SISREG Sub No 24

[31] Robinson, Evidence, p 101

[32] Duval, Evidence, p 121

[33] Drake, Evidence, p 35

2.22 The committee acknowledges that these discrepancies create difficulties for superannuation funds where an underwriting insurer refuses to accept a claim. However, it has been submitted that such problems can be overcome by superannuation funds renegotiating the decision-making process in group insurance policies and, in particular, binding the insurers to determinations made by the Tribunal. The argument is that, given the competitive insurance market, such modifications could be negotiated.[34]

2.23 The ISC submitted that the inclusion of medical complaints in the jurisdiction of the Tribunal is likely to cause funds 'to tighten the definition so that it is abundantly clear what is covered and what is not'.[35] In view of the plethora of evidence that the committee received on the discrepancies and uncertainties surrounding these definitions, the committee agrees with the ISC that such a move 'is quite significant'.[36]

2.24 A number of funds have now given members the right to choose whether they want this sort of cover and if so, at what level. It was put to the committee that it is very important that this choice be mandatory as there are people who have this type of cover elsewhere or for whom such cover is a waste of money.[37]

Prudential impact

2.25 The Attorney-General's Department has noted that the review of decisions involving medical evidence could possibly have a prudential impact on funds, that is, funds that have to make payments outside their insured cover will be at risk. The Department further noted that there appears to be no information available to gauge the possible prudential impact.[38]

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[34] Maurice Blackburn & Co., SISREG Sub No. 26, see also Duval, Evidence, p 123

[35] Duval, Evidence, pp 115-116

[36] Duval, Evidence, p 115

[37] Drake, Evidence, p 35

[38] SISREG Sub No 14

2.26 The distinction between the prudential impact of a court's judgement and a tribunal's decision has not been demonstrated to the committee. Medical cases decided by a court also have a prudential impact.[39] If 'prudential impact' is the reason for limiting the Tribunal's jurisdiction, there needs to be some very significant data collection, research and actuarial analysis to demonstrate and assess those impacts. Prudential reasons should be tested very rigorously so it can be determined whether they are an overriding consideration.[40]

2.27 In commenting upon the LICB's decision to allow the panel to deal with medical complaints up to the investigation and conciliation phases, Ms Ford stated that the Board, in coming to this decision, took account of some of the prudential implications. The committee understands that the Board will review this position in two years. In view of the life industry's initiative in this regard, the committee is very concerned that a federal tribunal is lagging behind industry-based justice initiatives. It is particularly concerned that the needs of consumers, as identified by industry, for an alternative disputes resolution system in the area of medical complaints has not been addressed in the current environment of improving access to justice.

2.28 The committee received a further submission from LIFA dated 24 August 1994 expressing a concern that 'if the assumptions underlying premiums rates can be over-ridden by other non-judicial decisions, then the integrity of insurance products will be in jeopardy. In this situation, the solvency of some life companies could, ultimately, be at risk.' The committee did not receive any supporting data and did not have the opportunity to test such statements with other witnesses.

Government employees

2.29 It was argued that, as the right to merits review at the AAT was withdrawn from public servants in the transition from the Commonwealth Superannuation Scheme to the Public Sector Superannuation Scheme, it would be inequitable to provide for merits review of disability decisions for members of non-public sector schemes. The committee understands that

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[39] Ford, Evidence, p 85

[40] Ford, Evidence, pp 84-85

both public sector scheme members and non public sector scheme members will have the same rights of review under SIS if they are members of a regulated fund. Both groups will have access to the Superannuation Complaints Tribunal. Indeed, following amendments debated in the Senate on 25 August 1994, it is likely that some state public sector superannuation funds, who have not elected to come under the SIS legislation, will be able to use the services of the Tribunal.

2.30 This argument is no longer relevant to the debate.