Inquiry into the Scrutiny of Financial Advice
(Life Insurance Industry)

14 April 2016

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Senate Economics References Committee
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Canberra ACT 2600

Submission by email: economics.sen@aph.gov.au

Dear Dr Dermody,

Inquiry into the Scrutiny of Financial Advice – life insurance industry

Thank you for the opportunity to provide feedback to the inquiry into the Scrutiny of Financial Advice (Life Insurance). The terms of reference for the present inquiry include:

a) the need for further reform and improved oversight of the life insurance industry;
b) whether entities are engaging in unethical practices to avoid meeting claims;
c) whether a life insurance industry code of conduct is required;
d) the role the Australian Securities and Investments Commission in reform and oversight of the industry; and
e) any related matters.

By way of background, I am a medical practitioner with 20 years of clinical experience and have an interest in musculoskeletal injuries and critical care. I have a postgraduate qualification in psychology and I am currently pursuing a degree in law. I also have a doctorate from the Faculty of Business, University of Technology Sydney, and I am presently an honorary associate there.

My professional and academic background gives me a good theoretical and practical understanding of life insurance and this has assisted in my roles within the industry. I have worked within life insurers as the chief medical officer and have previously independently consulted for independent financial advisors (IFAs) and a rating house.

I am familiar with issues of life insurance medical definitions in product design, education of medical product benefits to financial and risk advisors, underwriting of medical risks and statistical risk stratification, assessment of life insurance claims, and helping clarify the medical issues within the contractual policy terms to the Financial Ombudsman Services (FOS) and the Superannuation Complaints Tribunal (SCT).

1.0 *Statutory Landscape*

1.1 The life insurance contract is governed primarily by the *Insurance Contracts Act 1984* (Cth) and inherent in every insurance contract is a statutory obligation to act with the utmost good faith. The insurance product is also classified as a financial service product and is granted exemptions from laws prohibiting unfair contractual terms and insurers have the power to discriminate. Such discrimination must, however, be based upon:

- actuarial or statistical data on which it is reasonable for the discriminator to rely; and

- reasonable having regard to the matter of the data and other relevant factors; or
- in a case where no such actuarial or statistical data is available, and cannot reasonably be obtained, reasonable having regard to any other relevant factors.

1.2 The present statutory position thus offers a privileged position to insurers and the insured consumers often lack the resource or legislative safeguards to challenge the insurer.

1.3 Democratic countries such as Australia are founded on the rule of law. In essence, no single individual or organisation is given unrestricted or absolute power. The rule dictates that those given much power and privilege by the public must also bear greater responsibilities and are held to a higher standard of conduct towards society.

1.4 Financial institutions and insurers operate under a social license for which the public has given up their liberties in exchange for conduct by organisations that is not just legal, but also fair, just, reasonable and conscionable. The following discussion will show how this may presently be lacking in life insurance.

2.0 *Product Design*

2.1 Life insurance policies include many different products and are distributed through the retail (financial advisor), wholesale (superannuation) and direct platforms. The products include a benefit in the event of death (life cover) or disability (living benefit). Life cover may sometimes have a Terminal Illness benefit. The living benefits include: income protection (IP) for ongoing monthly benefits for as long as a medical disability persists; a lump sum payment for a list of defined critical or traumatic medical condition (Trauma); and a lump sum payment when there is total and permanent disability (TPD).

2.2 Whilst a Trauma benefit is not available within superannuation, how the medical conditions are defined within the superannuation TPD benefit is often similar to that found in the Trauma policies. As such, any discussion on medical definitions would be applicable to all distribution platforms.

2.3 The rapid advancement of medical science means that our understanding, and therefore definition, of various clinical conditions continue to evolve. The insurance policy is, unfortunately, a legal contract and a policy that is meant to last a person 40 years[1] would quickly be not fit for purpose if the policy terms were outdated.

2.4 There is also a triple jeopardy effect that occurs in some instances where there are stepped premiums. Stepped premiums are the most widely used in the risk insurance industry and may represent almost 70% of all policies written. A stepped premium is such that the premium is recalculated at each policy renewal and usually goes up the longer a policy is held (due to increasing age).

2.5 The first jeopardy for an insured occurs because the longer an insured holds a policy, the more premiums is paid each year because of increasing age. But the increase in age means that the insured has a greater statistical probability of needing to claim for

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[1] Assuming it is purchased at age 25 and held until age 65.
[2] KordaMentha (2014) *Blowing the whistle: Protection for whistleblowers in Australia.*

a medical condition. This is the second jeopardy. The recognition of these two jeopardies has been consciously priced into actuarial calculations. What is often not factored into actuarial consideration, and is to the consumer's detriment, is when medical definitions are outdated. This is the third and crucial jeopardy.

2.6 Most insurers update some parts of their medical definitions annually but not all "pass back" the benefit of the updated definitions to existing policyholders, choosing only to benefit new customers. Outdated definitions mean that the longer the policy is held, the less likely the insured will fulfill the medical definition in the policy.

2.7 An outdated definition for heart attack, for example, would mean that a person suffering the same heart attack would be unsuccessful in an insurance claim in 2016, and successful in 2003. This is despite that the unsuccessful claimant would have paid a larger annual premium and having paid greater absolute premiums for the number of years the policy was held.

2.8 It was mentioned that most insurers update their definitions annually. Despite this, most updates tend to be minor tweaks with minimal real world impact. The current definitions in the market are severely out of step with contemporary medicine. By way of only a few examples (there are many more):

- the use of CK-MB in the definition of heart attack is pointless since the test has not been in clinical use for at least 15 years;
- the absolute level threshold of troponin for heart attack is at least 10 years out of date;
- the present definition of multiple sclerosis excludes up to 15% of patients with very severe disease;
- the use of Breslow and Clark criteria for melanoma unfairly excludes patients with skin cancers in difficult anatomical locations amenable only to shave biopsies;
- the exclusion for stroke on the basis of Reversible Ischemic Neurological Deficit is irrational since the term has not been used in clinical practice since the 1970s;
- the exclusion for stroke on the basis of Transient Ischemic Attack (TIA) in a patient with confirmation of diagnosis on CT scan or MRI is problematic since the international scientific consensus statement on this issue in 2009;
- the draconian criteria for rheumatoid arthritis has not reflected clinical reality for at least 15 years or more.
- the requirement of electrocardiogram (ECG) evidence for an Out-of-Hospital cardiac arrest benefit makes little practical sense because when such events occur outside of the hospital an ECG is often unavailable; and when it occurs in the hospital and documented on ECG it is ineligible because it was not out-of-hospital.

2.9 The discussion of outdated and unrealistic medical definitions is cogent in the context of the present legislative context. In this writer's opinion, insurers should not be able to rely on the terms of the policy where those terms are unfair. In the context of outdated and impractical medical definitions, there is no legitimate business interest in having the term and it disadvantages the consumer. Such definitions have the effect of making the insurance of low or no value ("junk policy"). Relevantly, the legal requirement of utmost good faith seems to operate in the real world only to assist insurers in the context of non-disclosures by the insured and not to protect consumers against outdated product definitions, unfair medical terms and junk policies.

2.10 It is also relevant to note that the Australian Consumer Law includes a regime of consumer guarantees that applies to consumer goods and services. These include, amongst other things, a guarantee that goods are of an acceptable quality and that they are fit for a disclosed purpose. If these rules are applied to life insurance products with outdated medical definitions and unrealistic terms, a reasonable argument would be that the life insurance policy is not fit for purpose when the details of the policy, the outdated medical definitions and the strict requirements to meet definitional terms means that it cannot be relied upon when someone experiences that insurable medical event.

2.11 Comminsure has recently announced that they have updated the definition of heart attack and rheumatoid arthritis but they will only apply for events occurring on or after the 11 May 2014. This is a welcome update for new consumers especially since this writer's almost two years of agitation from within the company were faced with resistance from senior management because of profit concerns. In this writer's opinion, the backdate to 11 May 2014 is not fair or conscionable since the previous definition for heart attack is almost 10 years out of date, and that for rheumatoid arthritis has not been reflective of clinical reality and not been fit for purpose for almost 15 years. The lack of practical value for the consumer in regards to the definitions of the other medical benefits remains. In this writer's view, any pass back should include up to and including when the medical definitions were not suited for the designated role or purpose for which the product was sold to the consumer. There should be a wider revamp to include all low or no value medical definitions.

2.12 It is this writer's view that putting customers first would require that life insurance product manufacturers and distributors must have certain statutory obligations to ensure that products are broadly fit for customer purpose at all times. The Australian Securities and Investments Commission (ASIC) should have a new power to amend or ban an insurance product that causes consumer detriment and to impose substantial penalties on insurers that fail to meet their obligations towards consumers.

2.13 Because life insurance products are complex and highly technical, the legislative privilege given to life insurers demands that product manufacturers and distributors should also have a duty to explain the deficiencies of their products to customers in order that an informed choice is made. This would be consistent with a similar duty to warn a patient of material risks as occurs in the clinical context as set out in the Australian High Court's decision in *Rogers v Whitaker* (1992) 175 CLR 479. This requirement to inform potential clients would not be onerous on life insurers because such risks and deficiencies have already been considered during pricing and product design and compliance of this requirement can be monitored by the Australian Prudential Regulation Authority (APRA).

3.0 *Underwriting Application*

3.1 Medical underwriting exists for retail life insurance and some wholesale products. When there are no pre-existing medical conditions in new applicants, these are considered "clean skins" and the insured is charged a standard premium. When one or more medical condition exists, these are assessed on its merits and the applicant is either charged a higher premium to reflect the increased risk (loading), is given a limiting term on the policy for that specific medical condition (exclusion), or the application is rejected (declination). Underwriting is thus in essence a discrimination process and the fundamental of risk products. For example, a premium loading of 100% for a medical condition assumes that there is a 100% increase in risk for the applicant to

claim for that medical condition in the future as compared to another applicant without that condition; the higher premium charged is reflective of that increased risk.

3.2 As stated previously, in order that the underwriting processes conform to the laws on anti-discrimination exemptions, the loading, exclusion or declination needs to be based on actuarial or statistical data. In most instances, insurance underwriters rely on reinsurer manuals provided. It is assumed that these manuals are based on robust, contemporary and evidence-based actuarial or statistical data. Unfortunately, there is a lack of transparency of the actuarial or statistical data behind these reinsurer guides to confirm if the assumption is valid.

3.3 From experience, the lack of transparency creates issues when an applicant files an anti-discrimination complaint against an underwriting decision. When such complaints arise, underwriting and medical staff within insurers often find it hard to access the underlying actuarial or statistical data from the reinsurers to help support their decisions. This is also not helped by the fact that a discrepancy of the statistical risk found in contemporary medical research against some of the recommendations in the reinsurer manual often exists.

3.4 Although meant only to be guides, the reinsurer manuals in real world application are followed prescriptively and without flexibility by most underwriters. Some insurers also have corporate rules that in practical effect dictate that underwriters must follow the reinsurer guides to the black letter law. Unfortunately the listed medical conditions in the reinsurer manuals are not exhaustive and often does not account for multiple inter-related comorbid issues or the risk-reduction effect of treatment. The guide is also insensitive to specific clinical nuances of an applicant.

3.5 This writer was previously informed of a class action case on matters in relation to mental health discrimination and the issues intimated above were the same concerns raised by the arbitrator. Previous suggestions to the insurer by this writer to gather the required data in anticipation of future legal challenges were ignored.

3.6 This writer is also aware of many instances where the exclusions placed on applicants' policies as stipulated are too broad, extravagant and unconscionable when compared to the greatest loss that could have possibly followed from the pre-existing medical condition. Often the exclusion clause stipulated acts as a penalty for a medical condition that is broader than what ought to have been excluded. As a very simple example, a "back exclusion" is often applied to new applicants with a pre-existing low back pain. Low back pain (or ache) is very common in Australia and the vast majority of cases are benign in nature. A generic and broad reaching back exclusion precludes the insured from the insurance benefit should, for example, a spinal cord injury occurs as a result of a traumatic event such as a motor vehicle accident.

3.7 In this writer's view, in order that insurers are exercising their statutory privilege with care, whenever an application is discriminated by a loading, exclusion or declination there must be a compulsory obligation on the insurer to also provide to the applicant the actuarial or statistical data together with that decision. That data must be specific to the applicant's circumstance and not based on data that is generic in nature. This is to ensure that any underwriting decision made is based on data that is reliable, specific and valid to the individual being discriminated and the specific medical condition being discriminated against. This measure thus imports the duty for insurers to exercise due care and skill in exercising their anti-discrimination exemption privilege.

Inquiry into the Scrutiny of Financial Advice
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4.0 *Claims Assessment*

4.1 How a medical claim is assessed is dependent on the life insurance product in question.

4.2 Trauma policies are assessed using fixed medical definitions for specific conditions. The issue of outdated definitions has previously been described.

4.3 For living benefits such as TPD and IP, the assessment is often based on functional capacity. Terminal illness benefits are based on prognostic factors. The problem with the policy terms for these functional and prognostic factors is that there is often a broad interpretation of how it should be applied and an insured is at the mercy of the crafty wordsmithery and ethical inclination of the claims assessor. For example:

- Should an insured with end-stage organ failure be deemed terminal but for an organ transplant that may never occur?
- Should the prognosis of 12 months survival of 70% for a cancer be deemed eligible for the terminal illness benefit but 60% is not? What is the percentage value threshold and why?
- Should a person with quadriplegia who is totally disabled but may potentially receive a yet unapproved stem cell treatment from overseas and in the future be deemed not suffering from a permanent condition or deemed not to have received maximum medical intervention (MMI) to qualify for a TPD benefit? Or,
- Should a manual, low and semi-skilled worker who has worked exclusively in the same job in a rural area for decades be denied an insurance benefit after an injury because the worker's education, training and experience (ETE) means s/he is still able to be hired in a hypothetical job in a different geographical location across the country?

4.4 The courts dealing with cases on policy interpretation such as TPD have been inconsistent in their decisions. The concerns of medical statistics on prognosis and issues of self-determination of medical treatment have also been raised by judges in related cases but left unanswered. The present mischief thus creates uncertainty for the insured that often have little financial (or health) capacity and literacy to challenge the decision of insurers.

4.5 The imbalance of power, and the statutory privilege conferred by society through responsible governments upon insurers demands a better solution to the problem. At the minimum, a binding code of conduct for life insurers is needed and the standard needs to exceed the legislative requirement.

4.6 Amongst other factors, such a code should include a duty to assess claims promptly and not delay paying claims without proper cause. It should be noted also that any delay in claim admittance might confer financial advantage to the insurer. There should thus be laws to impose substantial financial penalties on cases that have been delayed without reasonable cause in order to deter such conduct.

4.7 It is not uncommon for claimants to be made to attend multiple Independent Medical Examinations (IME) by medical providers selectively picked by the insurer. The reasonable perception is that the insurer is seeking to validate a pre-formed view (usually uninformed by the clinical facts) and will keep sending the claimant for IME reviews until the opinion that the insurer wants is received.

4.8 Sometimes, lessons learnt from early IME opinions help formulate later IME referrals by selectively withholding or carefully positioning of clinical information such that the clinical opinion received from the new IME is more predictable. Furthermore, a paramedical opinion (e.g. psychologist) may be preferred if that of a medical practitioner (e.g. psychiatrist) is deemed comparatively less favourable for the insurer. Sometimes, a general physician's opinion from a singular claimant clinical review is used to override that of a specialist-treating doctor who has been attending to the care of the patient for many years.

4.9 If insurers continue to resist a code of conduct that has practical value or persistently fail to act fairly or conscionably, one solution might be to have a truly independent body that assesses all life insurance claims. The body will be an independent organisation that has medical, legal, accounting and other relevant professionals. It will be funded from a percentage of the premiums paid to insurers for the insurance policies, the money currently paid by industry to the Financial Ombudsman Service (FOS), and the money from the government used to fund the Superannuation Complaints Tribunal (SCT).

4.10 After an insured has filed a claim, the insurer can submit their points of defence for cases they feel are fraudulent or do not meet terms of the policy. If the insurer makes no defences within a determined time, the body will make judgment. The judgment by the body will then rely only on information it has received from the claimant and interpreted against policy terms.

4.11 The advantage of the proposed independent system is that there will be a consistency of claims assessment across all companies, the timeline for a decision is known to claimants via a service level expectation of the body, and the professionals working in the body are bound by their respective professional registration code of conduct that will explicitly not be in conflict with their assessments of claims.

4.12 Finally, the body might also be designated as the final arbitrator for all claims decisions made and binding on all parties. The finality and certainty of decisions will circumvent issues of insurer delays through appeals; strategic delays that may cause further health detriments to sick and dying policyholders.

4.13 Another advantage of an independent claims assessment body is that the functions of FOS and the SCT, each with their respective limitations, can be combined.

4.14 The same claimant with the same medical issue with multiple life insurance policies (super, retail, direct) and with multiple companies will be assessed in the same and consistent manner. This will help resolve the practical difficulties currently faced by an insured who may have had their claim for a medical condition accepted by one claims assessor but rejected by another assessor from a different insurer or different platform team within the same insurer.

5.0 *Rehabilitation*

5.1 Prior to 1st July 2015 a general prohibition was created by s 118-1 of the *Private Health Insurance Act* (2007) (PHI). This part of the PHI was subsequently repealed and incorporated into s 10 of the *Private Health Insurance (Prudential Supervision) Act* (2015). Under these legislations, it is an offence for a company to carry on a health insurance business if they are not a registered private health insurer. The offence included the payment for hospital and general (medical) treatment by life insurers that

is intended to manage or prevent a disease, injury or condition. In short, life insurers are prohibited from offering benefits that resemble general insurance or private health insurance, or to render a service for which Medicare benefit is payable.

5.2 Despite the prohibitions, most life insurers currently pay for "rehabilitation" and various medical services, blood tests and radiological investigations as part of their assessment and management of claims.

5.3 In the recent Financial Services Inquiry (2014-2015), life insurers have argued that legislation should be changed to expressly allow life insurers to provide ancillary benefits or "riders" to consumers where only general or health insurers can currently provide those benefits.

5.4 From one perspective, explicitly allowing life insurers to pay for various medical treatments could be useful in helping sick or injured claimants recover. There are, however, several counter arguments for allowing this. Firstly from a policy perspective, the purpose of the life insurance living benefits is not intended to cover for the medical aspect of an insured's detriment per se. Rather, it is to assist with the social aspect of their life during a medical event, for example, paying of bills and other life's incidentals. Health insurance and Medicare would be the more appropriate instruments for addressing specific health issues.

5.5 Secondly, the strict motivation for providing rehabilitation services is in order to get insured patients off IP claims and/or to make claimants ineligible for TPD benefits under a strict interpretation of the terms of the policy definitions. In other words, payment of rehabilitation services is not for the health outcome of the insured but rather to limit the insurer's liability through definitional technicalities. In an environment where there is no ethical governance or an insurance code of conduct for the management of claims, the allowance for life insurers to dictate and pay for medical services may potentially be abused and cause health detriment to claimants.

5.6 Life Insurers rely on an army of "independent" rehabilitation service providers in the market. In most instances, these independent providers act for life insurers, are paid for by the life insurers, and the clinical management of claimants are directly or indirectly dictated by non-medical claims managers in the life insurers.

5.7 Despite alleged success of returning claimants back to work (RTW), and therefore terminating the insurance benefit, as reported by the rehabilitation services and life insurers, these testimonials have never been properly and scientifically validated. Many of such reported successes tend to be based on self-reported results by the rehabilitation providers or life insurers themselves (with inherent self-interests), rely on very small-scale patient samples, on highly biased and questionable research methodology, and adverse outcomes are never reported.

5.8 Should life insurers' miraculous rehabilitation success be true, perhaps it is an area that the clinical world should pay greater attention to since the reported success in the life insurance industry has never been matched in the clinical context by the best rehabilitation centres around the world.

5.9 It is cogent to note that in an internal audit of all mental-health related claims within one insurer, no such benefit of RTW was found. Whether rehabilitation on a claimant was done did not affect the outcome of how long a claimant was on a life insurance living benefit. The audit was based on scientifically validated methodology, statistically robust analysis, full sampling and covers across all living benefit claimants

from the direct, wholesale and retail policy platforms. The audit showed that the only determination of whether a rehabilitation policy was imposed on claimants was the size of their insurance benefit. In other words, only the financial size of the insurance payout determines whether rehabilitation is foisted upon claimants.

5.10 There is concern by many medical providers that the imposition of rehabilitation by life insurers has the potential to cause harm to patients. The issue is particularly concerning for psychiatric diseases. This is especially since the primary purpose of the rehabilitation is to terminate a claim rather than for the improvement of health of the claimant. Additionally, if the ultimate outcome of how long a claim goes on for is unchanged regardless of the rehabilitation status imposed, such actions dictated by untutored and medically unqualified claims assessors have the potential to cause great harm with no benefit to the insured nor the insurer. There is also the question of whether the provision of such general (medical) treatment is consistent with the law.

5.11 In this writer's view, the legality of rehabilitation benefits provided (or imposed upon) by life insurers should be better clarified and carefully scrutinised. Should such services by life insurers be deemed legally permissible, there must also be a strict duty of care condition attached, especially in the context of a lack of a suitable insurance code of conduct.

5.12 In the presence of an obvious conflict of interest where rehabilitation services are not truly independent and act primarily for the life insurers' and their own economic benefit and not the injured or sick claimant's wellness, life insurers and rehabilitation providers must provide evidence-based data that is founded on scientifically validated and clinically peer-reviewed results to show that there is clinical value in any such rehabilitation programmes. There must also be mandatory adverse result reporting when harm occurs. The definition of such harms must be broadly encompassing.

6.0 *Whistleblowing Policies*

6.1 A recent report by KordaMentha[2] cites a study to show that over 42% of uncovered frauds in an organisation were detected by whistleblowers and is by far the most prevalent way for fraud to be detected. Despite the value to Australia, current whistleblowing provisions in this country remain inadequate.

6.2 Under the present arrangement, ASIC provides protection under the *Corporations Act 2001* (Cth) to whistleblowers that report misconduct or dishonest or illegal activity that has occurred within an organisation.

6.3 Where a whistleblower's employment in a private corporation is terminated because of a disclosure made under s 1317AB of the *Corporations Act 2001* (Cth), the whistleblower can request a court order to be reinstated in either their original position or in another position at a comparable level.

6.4 Academic research on the issue of whistleblowing provides evidence to show that whilst the reasons and circumstances of why an employee may blow the whistle are varied, the response of the employer is largely consistent: termination of the whistleblower. Often such terminations are based on farcical reasons.

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[2] KordaMentha (2014) *Blowing the whistle: Protection for whistleblowers in Australia. Publication No. 14-05*

6.5 The practical issue of the present legislation is that employees that embark on asserting their protected disclosure rights often face enormous financial and emotional strain in challenging the company and thus may not be a viable option for many.

6.6 Additionally, recent examples in Australia have shown how whistleblowers are subjected to a concerted effort by their former employers to publicly discredit them (smear campaign). The employees are usually helpless against the economic might and media clout that the organisation possesses. As such, even if the employee is successful in his legal proceedings, being reinstated in the company or working in another company within the industry is fraught with issues.

6.7 The overall effect of the present deficiencies within private corporations is in reality a career-limiting endeavour for any employee who chooses to do the right thing and blow the whistle. As such, these concerns would weigh heavily in the minds of employees who have witnessed illegal or unethical conduct and would be factors the employee would consider before choosing whether to cross the Rubicon into the perishing world of the whistleblower.

6.8 Another form of protection available for whistleblowers is through the *Public Interest Disclosure Act 2013* (Cth) ('PID Act'). This Act offers protection to public officials who make a disclosure about suspected wrongdoing in an Australian Government department, executive and statutory agency, or a wide range of other entities associated with the Australian Government.

6.9 Amongst the various protections that the PID Act confers, it makes it a criminal offence to retaliate (or threaten to retaliate by means of discriminatory treatment, termination of employment or injury) against a whistleblower because they made a disclosure. The offence occurs if the reason, or part of the reason, for the termination of the employee is because the officer believes or suspects that the employee made, may have made or proposes to make a protected disclosure. The PID Act does not apply to private corporations.

6.10 There is presently a debate on the merits of compensation for whistleblowers. This writer will make no comment on this matter. This writer does believe, however, that there is merit in extending the imposition of a criminal offence found in the PID Act on private companies. The criminal offence should also extend to public relation officers and various individuals that are involved in smear campaigns against whistleblowers.

6.11 The criminal offence could act as a useful deterrent to ensure that all private companies, their senior managers and their agents act fairly and conscionably towards their employees. There is no logical reason why protection for the private sector should be considerably weaker than in the public sector.

6.12 Should lawmakers choose to enact legislation to criminalise the abovementioned (intentional or inadvertent) anti-whistleblowing behaviours by private companies and its agents, it may choose to make such laws retrospective. Such enactment would be consistent with being socially just and serve to reinforce and clarify the corporate citizenship requirements and social licenses already in existence either implied or expressed in statute and in society's expectations.

6.13 Having retrospective effect of new criminal laws is unusual but this will address the concerns raised by many in the public and also by several members of parliament. These concerns relate to how government action that stem from any parliamentary inquiry would ultimately fail to bring about restitution to the way whistleblowers have

been mistreated to date. It is for this reason that the broad powers and mandate of a Royal Commission into banks and the financial services sector would be preferred, necessary and be more effective than any enhanced powers conferred by parliament to the regulators ASIC and/or APRA.

6.14 Finally, there should be greater protections in ensuring the confidentiality surrounding the process of protected disclosures. For example, a manager should not be permitted to conduct surveillance or to access all of an employee's emails in order to uncover the contents that may include protected disclosure information. Such actions should be considered criminal offences similar to perverting the course of justice.

7.0 *Closing Remarks*

7.1 Responsible governments have a duty to uphold not just what is popular and the status quo, but to promote what is right and good for the whole of society. It has to show moral leadership and make laws for peace and order and to ensure justice and equity occur for all of its citizens and not simply favouring big corporations. If the financial services industry is given much privilege through legislation, it is fit and proper that governments must ensure that industry is held to greater account.

7.2 This writer understands that a Royal Commission is a possible outcome after the federal election. Should the recommendations made in this submission not be adopted, it is hoped that the issues raised would assist in the formulation of the terms of reference in the Royal Commission inquiry.

Yours sincerely,

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MBBS MMed MPsy PhD