T R A N S C R I P T

LEGISLATIVE COUNCIL LEGAL AND SOCIAL ISSUES COMMITTEE

Inquiry into Claims Made through the Transport Accident Commission (TAC)

Melbourne – Wednesday 10 June 2026

MEMBERS

Joe McCracken – Chair
Michael Galea – Deputy Chair
Ryan Batchelor
Anasina Gray-Barberio
Renee Heath
Ann-Marie Hermans
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Lee Tarlamis

WITNESS

Mark Gibbins, President, Australasian Association of Medico-Legal Providers.

The CHAIR: Welcome back to the next session of the Legal and Social Issues Committee's inquiry into the TAC and claimants. I am Joe McCracken, Chair of the inquiry. We will go through and introduce our committee members. David Limbrick will be back in a moment, I can assure you.

Sheena WATT: Hi. I am Sheena Watt, Member for Northern Metropolitan Region.

Mark GIBBINS: Hi, Sheena.

Michael GALEA: G'day. Michael Galea, Member for South-Eastern Metropolitan Region and Deputy Chair.

Mark GIBBINS: Hi, Michael.

Renee HEATH: Renee Heath, Member for Eastern Victoria Region.

Mark GIBBINS: Nice to meet you, Renee.

Renee HEATH: Nice to meet you, too.

The CHAIR: We have got some online as well. I will go Anasina and then Ann-Marie.

Anasina GRAY-BARBERIO: Good morning. Anasina Gray-Barberio, Northern Metro.

Mark GIBBINS: Hi, Anasina. Nice to meet you.

Ann-Marie HERMANS: Good morning. I am Ann-Marie Hermans. I am also a Member for the South-Eastern Metropolitan Region.

Mark GIBBINS: Hi, Anne-Marie. Nice to meet you.

The CHAIR: Okay. All evidence taken is protected by parliamentary privilege as provided by the *Constitution Act 1975* and further subject to the provisions of the Legislative Council standing orders. Therefore the information you provide during the hearing is protected by law. You are protected against any action for what you say during the hearing, but if you go elsewhere and repeat the same things, those comments may not necessarily be protected by that privilege. Any deliberately false evidence or misleading of the committee may be considered a contempt of Parliament.

All evidence is being recorded. You will be provided with a proof version of the transcript, and ultimately that will be made public because it will be put on the committee's website.

Just for the Hansard record, are you able to say your name and the organisation that you are appearing on behalf of, please.

Mark GIBBINS: Yes. My name is Mark Gibbons, and I appear on behalf of the Australasian Association of Medico-Legal Providers.

The CHAIR: Perfect. Thank you and welcome, Mark. I appreciate you taking the time to be here today. We have probably got 8 or 10 minutes for you to have an opening, but as you have indicated, you may not need that. The floor is yours, Mark. Welcome, and over to you.

Mark GIBBINS: Thank you, Joe. First of all, thank you for having me here today. I appreciate the opportunity to present on behalf of the medico-legal association of Australia. It is always interesting to look at schemes all over Australia and in particular the TAC, which many of our members contribute to as providers. I will read now from my opening statement. I am very grateful to appear today and contribute to your inquiry. As I mentioned, I am appearing here as the President of the Australasian Association of Medico-Legal Providers. We are a member organisation that represents specialist medical practitioners and providers and organisations

that we refer to as MLPs, medico-legal providers, and we manage the assessments that are done for medico-legal reports on behalf of the specialist doctors. Our members provide services to 11 workers compensation schemes, eight motor accident schemes as well as life insurance, health insurance, NDIS disputes and defence. For the TAC scheme our members sit at the heart of the TAC's JME, joint medical examination, process and IME process, which is the independent medical examination process. We estimate our members provide around two in five JMEs to TAC clients. I have not been able to determine exactly the proportion of IMEs, but I hope to be able to provide that to you.

Firstly, I would just like to acknowledge that whilst I could not watch all of yesterday's evidence, I understand that it reflects stories of clients who have not had a good claims experience with the TAC. In a person-centric system I feel like it is important that we recognise that my evidence that I will provide today on behalf of our members is not intended to diminish in any way the experience that those people have had or the stories that they have told. We work in a very complex system both in Victoria and all over Australia. The stories are not uncommon when systems break down. I just want to put a caveat over the evidence that we are providing, given the severity of some of the stories that we heard yesterday and have heard in numerous inquiries and royal commissions since I have been involved in the industry.

The main thrust of our submission was to encourage greater levels of transparency and scheme reporting from the TAC. I note that the TAC's submission to this inquiry addresses a lot of the information gaps that were the motivation for our submission. The content of their submission is terrific. However, it is a once-off document triggered by this inquiry. What I would like to believe is true is that transparency is trust. Where there is transparency from the consumer point of view, from the provider point of view, from a government's point of view or other regulators that may be involved, then people can understand what is going on and whether or not things are systemic or whether they are operating broadly for the reasons for which insurance schemes are designed, which is to return people to their preinjury capacity, whether it be in a worker's compensation scheme, a life insurance scheme or in this sense a motor accident scheme.

It is the strong recommendation for this committee that the level of transparency that the TAC have provided with their submission be the standard moving forward as it is for many other schemes around Australia. The TAC after all is Australia's largest government-owned monopoly motor accident insurer. Unlike other agencies funded by appropriations it is funded through compulsory contributions on every Victorian motor registration. This dynamic should be a prompt for more public reporting not less. However, there is scant public data on TAC claims costs, outcomes and scheme trajectory. It is our view that broadly, not from an individual claimant's point of view, you have a well-operating scheme in comparison to other schemes in Australia in that you have your liabilities covered. The payouts are not small; they are considerable. You have got $1.8 billion that is going out. It is a profitable scheme in terms of its liabilities. Profit is not a term that you should probably use with insurance, but it is a scheme that is not going to go bankrupt any time soon and that is an indication of a well-funded scheme. That is our recommendation – that there is more transparency so that there is more trust in the scheme from a claimant's point of view, government's point of view or providers' point of view. The reason I speak on behalf of the providers in the scheme is that that is a lot of money going out of a scheme, $1.8 billion. Most of that is not going to individual people; it is going to support providers, bureaucracies, doctors, lawyers and the like. To get a view of that and how that operates is important.

That transparency that builds trust also indicates investment and innovation in a scheme. Whether it is a rehab provider, whether it is a doctor or a lawyer, the innovations in insurance schemes are predicated on transparency. If an investor is looking at coming into a scheme to provide innovations – and there are lots of innovations happening in claims management and rehabilitation and return-to-work outcomes – nobody can really understand what should be happening from an investment point of view. I know it is a bit blunt to say people are investing in health, where a doctor would probably say it is about care and compassion and those sorts of things, and that is true; however, we are moving into a different world. There are a lot of innovations occurring that the TAC could benefit from if there were greater transparency and ongoing reporting in the schemes, in my opinion. For example, in terms of other suggestions, there is a bypass payments aspect of the TAC scheme, which is a TAC protocol negotiated between the ALA, the Law Society of Victoria and the TAC. That bypass protocol is aimed to get people back functioning and not to have to go through the common-law process. I think it is an empathetic scheme that understands that when an injured person has to present their injuries and circumstances of their injuries over and over and over again to two doctors, that can be distressful and that can be difficult for that person.

The Vic scheme provides a $4000 payment to incentivise lawyers to forgo the common-law process, with the objective of settling a claim. In other jurisdictions it may be called a commutation, but certainly I am not aware that there is an incentive to the law firm in other jurisdictions to work with the TAC to bring about a quicker settlement for a claim – which I think is innovative; there is no other scheme in Australia that I am aware of where a commutation is incentivised like that.

Those sorts of innovations could be used in other schemes. When I come back to transparency and reporting, if other schemes are aware of the effectiveness of that protocol, then other parts of Australia and the other schemes can benefit from the knowledge of the performance of those protocols. I am just saying here that we do not know how often it occurs or on what justification, and it is just another aspect of the TAC that is opaque and could benefit from more transparency. When I say when I say 'benefit from more transparency', I do not mean that the TAC would benefit necessarily from the transparency, but it is the consumer that could benefit from transparency, and so could the rest of Australia benefit from the from the transparency, because it is a unique aspect of the scheme.

Thirdly, fee structures: fee changes for specialists to provide neuropsychology and psychiatric JME reports have materially reduced specialist availability. A lot of catastrophic claims and primary site claims will require those types of reports. The proposed neuropsychology rate sits well below the market, whilst the psychiatry rate is approximately 22 per cent below the publicly available medicolegal opinion. It is a lot greater for the clinical practice of private practice of psychiatrists, who are charging upwards of a thousand dollars an hour these days. Far be it from me to suggest that they are making too much money; however, that is the market rate for clinical practice. I think if we calculated what the neuropsych is getting in the scheme, it is about $350 an hour.

The Transport Accident Commission is rightfully a source of pride for the Victorian community. It is an excellent scheme that is more than adequately funded and offers, in general, good support for those whose lives are impacted by traffic accidents. I apologise that I have gone beyond the 3 minutes, and I have probably gone beyond the 8 minutes, which is when I started trying to cull this. Hopefully that was of interest.

The CHAIR: It is fine. I will go first, and we will go through. My question was really, and you did touch on it: what are the things that you want to know that you do not know already about the TAC that you want publicly reported? I know you talked about, for example, how effective some elements of the system are and how they might be able to help other schemes across the state. But what data do you want to be publicly available that is not?

Mark GIBBINS: I am just trying to refer to the TAC submission. Page 17 talks about the breakdown in spend, and there are some pretty high-level numbers. It would be helpful if the breakdown of the spend in all those areas was known so that you can do a compare and contrast with other schemes, and there is a benchmark for that: medical and like services, $782 million; income benefits, $200 million; dependency, $62 million; impairment payments, $101 million; and common law, $530 million. It would be good to know how that is spent. There are some high-level numbers that were not actually known prior to the submission, and it would be good to know how that money is spent. I am going outside of my area of expertise.

The CHAIR: I do not disagree with you. It would be good.

Mark GIBBINS: I am going outside of my area, but when you have got 40 new clients coming on every day and you have got 43 that are actively supported, that is a lot of people that are affected by a large part of the government's economy, if that is the way of expressing it. So those sorts of details are helpful to be able to do a compare and contrast. I am sure the TAC are doing that with other schemes and other providers and they have their own relationships. However, my premise is that transparency builds trust, and the greater transparency the greater the trust.

The CHAIR: That makes perfect sense.

Mark GIBBINS: Some of the innovations around early support and triage that the TAC have done – I know that they have moved away from having claims managers in hospitals, which was the case many, many years ago, so if you were in a catastrophic claim, you could be attended to by a TAC claims manager in a hospital. I know the TAC has moved away from that and it is more of a legal process now, but being able to understand what the impact on claimant behaviour is, that sort of information is critical to understanding how people behave in an adversarial system, because people do not like to be told what to do. They would prefer to be

invited to do something, and if you have got a claims manager that is assisting you to process your claim, you are starting off on the right foot in that you are not feeling like it is an adversarial system and someone is there to help you.

The CHAIR: And you get a better outcome in the end, hopefully.

Mark GIBBINS: And I would expect that you would get a better outcome – exactly.

The CHAIR: That makes perfect sense. I will hand over to Mr Galea now. My time has run out.

Mark GIBBINS: Okay. Thank you, Joe.

Michael GALEA: Thank you, Chair. Thank you, Mr Gibbins, for joining us today. Just to begin with, in your opening remarks you compared the TAC favourably to equivalent jurisdictions interstate. Was that primarily a financial sustainability comparison that you were making, or are there broader aspects into the client relationship that you were also referring to, and could you expand on that?

Mark GIBBINS: Look, I can only speak broadly in terms of the financial viability. I am not an expert in that area. I prefaced my original remarks by saying I am alluvial at best. However, looking at the other schemes, you are very well funded, and that is the critical point of a lot of schemes. So if you look at the New South Wales workers comp scheme, for example, that was very underfunded, and as a result it became a political object, I guess.

The CHAIR: Can I just pause? While we are in the middle of this, are you able to hand out, so we can have a look at them, your comments as well?

Sheena WATT: Some of the statistics you provided.

The CHAIR: Just your opening comments. That would be really awesome. Thanks.

Mark GIBBINS: Coming back to your question, Michael, about the financial stability, yes, that is the key aspect of any insurance scheme. If the scheme goes broke, nobody is going to get paid. I can refer to workers comp schemes in the US that have not been well funded, and they have been funded by captive insurance companies that have gone broke. That does not help anybody in the end. It is a real risk to schemes. Your premiums, for want of a better word, are indexed, which means every year they are going up by a small amount, adjusted for CPI. Very few other schemes have that direct indexing and are capped in other ways, so it means that the revenue side is at risk. Your scheme is always going to be a well-funded scheme. I had another point that I was going to make, but I will have to come back to it. Your other question was in relation to non-funding aspects of the scheme.

Michael GALEA: The client relationship, or the patient outcomes.

Mark GIBBINS: And the patient outcomes. The point I was going to make on that I am going to have to take on notice and respond to because I lost my train of thought, I apologise.

Michael GALEA: I am happy for you to come back to me on that one – no problem at all. Thank you, Mr Gibbins. Thank you, Chair.

The CHAIR: I will hand over to Mr Limbrick.

David LIMBRICK: Thank you. I apologise that I was not here to introduce myself before. Your submission mentioned something which I have considered as well. The TAC accident prevention component of what they do has fairly limited effect. They are fairly limited in what they can control. There are other things that control accidents, like vehicle technology, police enforcement, road design and maintenance and that sort of thing. Yet their reporting is heavily weighted towards crash statistics and road safety rather than financial issues around claims data, which they have significant control over. I would be interested in your thoughts on that, because it seems to me that surely they should be reporting more on the things that they have far more significant control over, rather than things that a lot of other aspects would be driving.

Mark GIBBINS: That was one of the points we made in our submission – that the reporting is just very thin and it is about the people that you are returning to their pre-injury capacity and their experiences – that client journey and what is happening there. The point that we are trying to make is that it is a well-operated, well-managed scheme broadly, notwithstanding the bad experiences that a lot of people have, and just provide some more information, because it is something to be proud of, not something to keep in a box secret to everybody else, because we can all learn.

David LIMBRICK: There were also some points made yesterday about the, I suppose you could call it, administrative inefficiency. Maybe this is because it is unknown, because it is maybe not reported very well, but there were concerns about the amount of money that was spent in delivering claims compared to the amount of money that was actually paid out for services for clients or to clients themselves. An example yesterday was that a client had a $110 claim for some dental work and it ended up costing $12,000 to manage that dispute. What do you think could be done better here to stop that sort of waste?

Mark GIBBINS: Thanks for the question, David. Our members are engaged with insurers doing what we call now API integrations. At the very basis of that, it is to prevent double data entry as a time-saver. It is also designed to prevent data from going missing and assist with communication between stakeholders in the scheme to prevent mistakes from happening and oversights from occurring, as is happening in other schemes where claims service providers are now integrating their claims service platforms with providers – whether it be GPs, whether it be lawyers or whether it be medicolegal providers or trustees that are administering settlement funds, the integration of those systems.

My members are going through a complete revolution with how disparate stakeholders engage with government entities, and that goes to compliance and regulation in a scheme which we are advocating for all over Australia. Increasingly we are not being seen as legal, we are being seen as health data managers, and the standards for managing health data is much higher than the standards for managing legal data. The opportunities exist now for the integration of those disparate systems. I think there was a note in the TAC submission that they are looking into innovations and they are welcoming innovations. That is a very simple innovation that goes on. If you are booking your plane on Webjet and you are trying to get access to multiple operators – notwithstanding the lack of competition in the Australian market, I digress – you can book your request from one system, and you do not have to go into multiple systems.

When you have multiple systems that do not talk to each other, it is an opportunity for bad things to happen. It is a risk that does not need to be taken these days. I am sure none of my suggestions will solve anybody's problems that have happened prior to today, but many of them are basic communication problems. They are oversight problems. Can you fix the people part? No. But you can certainly fix – and the government has the budgets to do those sorts of things – the compliance, the regulation and the technology that enable the exchange of data in a risky environment. We are all exposed to cybersecurity risk. Sending emails from doctors to lawyers to the TAC, I shudder. My insurance premiums are going up every six months around cybersecurity because the risks are real. Law firms are being hacked, and health providers; Medicare has been hacked. Everybody in our environment has been hacked. Data has been lost. API integrations are not the panacea for everything, but they can assist with the exchange of information between disparate stakeholders.

David LIMBRICK: Thank you.

The CHAIR: I am going to pass over to Dr Heath now.

Renee HEATH: Thank you so much, Mark. It has been a good conversation so far. Just a couple of questions. You speak about a lot of the lack of transparency. We keep hearing about how it is a complex system. Do you think that it is a lack of transparency that is making it complex?

Mark GIBBINS: Yes, yes. Transparency is trust. So if it is complex but I can see what is actually happening, I will engage with – I am not speaking on behalf of myself – the process.

Renee HEATH: Okay. That is interesting. Are you worried about the transparency about what has been happening with TAC's money? Is that something that I picked up or not?

Mark GIBBINS: No. I think it is a well-funded scheme. When you say 'what is happening with the money', the primary purpose of an insurance scheme is to pay out for injured people and return them to their

pre-injury capacity. I think the TAC does a fairly good job of paying out for minor and catastrophic claims. Most insurance schemes are weighted towards catastrophic claims and the support that those people require, and the TAC is no different to that. I would note that the liabilities in the TAC scheme are capped, which is not a great thing if you have got a catastrophic claim because the injuries are gazetted. However, in a system, it is not the worst thing that you can have that liabilities are actually capped. In fact in a negotiation settlement nobody is ever happy, right? But at least most people are going to be happy most of the time in this system.

Renee HEATH: The reason I ask this next question is because obviously you are medico-legal practitioners and the medical world and the legal world are very different – I am trying to bridge that gap, I guess. Is there an issue with the way medical records are taken that does not interact well with the TAC or the legal aspect of this?

Mark GIBBINS: I am not aware of the details of how medical records are retrieved and the onus on the injured person to be required to put in a freedom of information request.

Renee HEATH: I have got another question on that as well, but I have got 25 seconds.

Mark GIBBINS: In other jurisdictions a letter of authority is signed by the claimant to enable other third parties to act on their behalf and the medical records are released. I am no expert in the area. I know that the privacy issues may be different – I am no expert in that area. However, in other jurisdictions that providers operate in, the medical records seem to be able to be more easily obtained, and that goes back I guess to my premise of transparency.

The CHAIR: I am sorry, but your time has run out, Dr Heath. I am going to try and get through everyone before we finish. I will hand over to Ms Watt now.

Sheena WATT: Mr Gibbins, thank you very much for joining us today. I want to perhaps go to fee structures, which you spoke to in your opening remarks. Recently I had the good fortune of reading the federal budget, and I am particularly interested in the DVA scheme, for which I have seen an uplift in the federal budget of the fee structure. Yesterday we heard from multiple witnesses saying that medical professionals will not take them on because of the fee structure and the complexity of the system, so I particularly want to ask if you could speak to that. Particularly you cited a 22 per cent gap in rates, with particular reference to psychiatric assessments and some other health professionals – I cannot remember what the term was.

Mark GIBBINS: Neuropsychs.

Sheena WATT: Can you talk to us a little bit about what your members are saying with respect to the gap in the different systems that exist, and basically, you know, incentives to participate in TAC, because we want our TAC participants to get the very best medical care, and that is clearly not happening with their fee structures as they are.

Mark GIBBINS: It is always a difficult conversation when you talk about how much a doctor is being paid or how much a lawyer is being paid, because the community sees it as sometimes excessive. In saying that, the benchmarks for psychiatric assessments and how much a doctor can earn have materially increased post COVID. What has also happened is that telehealth assessments are becoming more prevalent, which means that a doctor living in Victoria can provide assessments into Queensland or Western Australia or South Australia.

Sheena WATT: Participants in other schemes.

Mark GIBBINS: In other schemes. Labour will move to wherever they are making the most money – not all the time, not everybody, but there has been a shift. I am sure people will deny that they do that, but we have seen the shift. Doctors will remove their availability from a low-paying scheme, as they did in the Victorian WorkSafe scheme until the rates increased. And then there was a flood of doctors coming back in and providing availability into the Vic WorkSafe scheme, so they are able to process claims much faster.

Sheena WATT: Yes. So seeing fee structures change for other schemes certainly will have an impact, then, in terms of labour force availability, just looking to, particularly our regional communities accessing –

Mark GIBBINS: Which will be able to be better served these days, from a psych point of view, because you can do more telehealth. The other point that I would like to make about the schemes is that the doctors that

are providing medicolegal opinions into TAC and WorkSafe these days are also at risk of their reputation being talked about on social media.

Sheena WATT: Could you talk about that, actually? That is very interesting.

Mark GIBBINS: Yes. You almost have to pay a supplementary payment, beyond the clinical fee, because a doctor will perform 1 hour or 45 minutes of psychiatric assessment in a clinical environment and their job is done. They write up their notes, and they go home. In the WorkSafe or TAC environment, if a claimant does not receive the outcome that they felt like they deserved, that doctor's reputation can be harmed in the public environment through social media. It is almost as if you have to pay more. And in fact different schemes in Australia, whether they are common law or they are statutory benefit schemes, do pay above what is considered a benchmark for that reason, because arguably, returning people to their pre-injury capacity – you should move the labour force into that environment because they cease being a productive member of the society, so the longer that goes on, it has a productivity impact on an economy.

Now, I know that is a big statement to make, but how do you incentivise doctors to do more work in the scheme? My argument is you have got to pay them more than what they are getting in clinical practice, not benchmarking it even at the 22 per cent, which was a conservative estimate in the medico-legal space, but benchmarking it then against their clinical practice and possibly paying more in recognition of the fact that their reputations are at risk.

Sheena WATT: Thank you. That is all of my time, and I will return it to the Chair. Thank you.

The CHAIR: Thank you. I will hand it over to Ms Gray-Barberio now.

Anasina GRAY-BARBERIO: Thank you very much, Chair, and thank you, Mr Gibbins, for being with us today.

Mark GIBBINS: Thank you for having me.

Anasina GRAY-BARBERIO: I want to start off by asking you: how often were you informed by your members of TAC using protocol payments to bypass claimants' access to independent medical opinion via JME processes?

Mark GIBBINS: We have a number of members that are providing assessments in the scheme, and I only found out just recently – and that is not any reflection on the TAC; that is just about my understanding of the scheme. I mentioned before, my knowledge is alluvial, but I am trying to provide a broader context. But I understand that it came in in July 2025; that was when that protocol was introduced. And whilst it may or may not have had an impact on my members, I am more interested in a balanced scheme and how effective that protocol is in returning people to their pre-injury capacity. So what I would really like to know is how many people access that protocol and benchmark it against previous years. That is the transparency and the sort of information that I think builds trust with providers and with the injured person.

Anasina GRAY-BARBERIO: Because I guess the risk with this happening is that having no specialists, or at least the incentive for specialists to participate, can cause delays in assessments and prolong the disputes for the claimants. So there is the other side of that when these protocol payments are bypassed. But you are very quick to say this is not on TAC, so what exactly are you saying?

Mark GIBBINS: But when you say that a protocol payment is bypassed, it is the payment –

Anasina GRAY-BARBERIO: Well, this was actually in your submission, so –

Mark GIBBINS: Yes. I am just getting to the definition of what we are talking about. So it is not that the protocol payment is bypassed, it is that the protocol is introduced as an incentive to bypass a JME so that we can get to the common-law aspect of a claim faster. In my opinion, that will aid the settlement of a dispute and not hold it up. You are actually getting to the end faster, rather than going through – I will get the exact legal term for that process. But there are two thresholds: there is the 11 per cent threshold test, which you need to do with the JME, and then you have to wait a period of time after that until the injury is further stabilised before you can go into the common-law process, so that might be another 12 months. What the protocol does is introduce a process by which you can get to the end faster.

Anasina GRAY-BARBERIO: Do I have time to ask one quick question?

The CHAIR: A quick one, if that is all right.

Anasina GRAY-BARBERIO: Thank you. I guess the reason why I raise this, Mr Gibbins, is because we heard yesterday witnesses talking about the advantages of using JME, that you have got joint medical examiners on the panel, because they have found that IME does not give that same level of fairness and impartiality. Do you have a response to that?

Mark GIBBINS: Yes. How long have you got?

The CHAIR: Ten seconds.

Mark GIBBINS: IMEs are used –

Anasina GRAY-BARBERIO: We probably do not have a lot of time, but whatever you can give us will be helpful, and anything on notice is also good.

Mark GIBBINS: IME is a general term for 'independent medical examination'. The substance of an IME is a function of the questions that are asked of the specialist. The term JME is 'joint medical examination' and the idea of it, as I understand it in the Victorian scheme, is to have one person responsible for the impairment assessment. An IME can also be used to provide treatment direction or to provide a work capacity insight as the client's return-to-work journey occurs. The JME I think in other jurisdictions, as a concept, is used to have a final arbitrator determine the level of impairment. In the TAC scheme, as I understand it, there are two occurrences for a JME to be used to get over – or not – the 11 per cent threshold and then it goes into a catastrophic claim. Where I think the TAC have been useful – but I do not know, because I have not got all the data – is moving the catastrophic claims, rather than going through the 11 per cent threshold and before you get to the 30 per cent threshold, to try to get to there quicker. That is why, in terms of a system approach, a JME using the protocol seems to be a sensible approach. The IME can be used throughout the scheme for different reasons, but they are both beneficial, in my opinion, where a treating practitioner may or may not be the best person to determine impairment where a financial pecuniary interest is involved.

The CHAIR: Thank you for that.

Anasina GRAY-BARBERIO: Thank you very much. Thanks, Chair.

The CHAIR: I just got a message from Mrs Hermans that she does not have any questions; thanks very much, Ann-Marie, we appreciate that. I know Dr Heath has one last question before we finish up.

Renee HEATH: You were speaking about how in other jurisdictions it seems to be easier to get your own medical records and your documents. Do you think the withholding of medical records and documents is (a) a breach of people's rights and (b) potentially a breach of the law?

Mark GIBBINS: I am not a lawyer. All I can do is explain what I see in other schemes. I think it is easier, from my experience, my understanding – I may be wrong – in other jurisdictions and other schemes to get medical records that relate to the claim for which you are a participant.

The CHAIR: Thank you. That brings this session to an end. Mark, thanks very much for your time today. We really appreciate it. I dare say there may be some questions on notice. If you are happy to respond to those, that would be awesome as well. Thank you very much.

Witness withdrew.