SCRUTINY OF FINANCIAL ADVICE

Submission to Senate Standing Committee on Economics

15 April 2016
# CONTENTS

SCRUTINY OF FINANCIAL ADVICE ........................................................................................................... 1  
WHO WE ARE ......................................................................................................................................... 3  
INTRODUCTION ....................................................................................................................................... 4  
  HISTORY OF WORK IN THIS INDUSTRY ............................................................................................... 4  
NEED FOR REFORM ................................................................................................................................. 4  
1. IDENTIFY AND PUBLICISE INSTANCES OF THE INSURANCE SECTOR SEEKING TO AVOID ITS RESPONSIBILITIES BY EMPLOYING DUBIOUS AND UNETHICAL TACTICS ........................................... 6  
  1.1 Unethical behaviour by insurance providers .................................................................................. 6  
  1.2 Conditions that increase the likelihood of unethical behaviour and lead to the sale of inappropriate life insurance products .................................................................................................................. 7  
  1.2.1 Vertical Integration ...................................................................................................................... 7  
  1.2.2 Shelf-space fees ............................................................................................................................ 11  
  1.2.3 Inducements .................................................................................................................................. 11  
  1.3 Concerns regarding current superannuation-owned group insurance contracts ................................ 12  
  1.3.1 Capacity: unlikely vs incapable ................................................................................................... 14  
  1.3.2 Retraining clauses .......................................................................................................................... 15  
  1.3.3 Ongoing care ................................................................................................................................. 16  
  1.3.4 Coverage exclusion ....................................................................................................................... 16  
2. CLARIFY AND STRENGTHEN THE MINIMUM STANDARDS THAT INSURANCE POLICIES SHOULD MEET, PARTICULARLY IN RELATION TO TPD AND DEATH POLICIES PROVIDED VIA SUPERANNUATION FUNDS ......................................................................................................................... 17  
3. ENCOURAGE AND ENFORCE HIGHER STANDARDS OF BEHAVIOUR AND CONDUCT WITHIN THE SECTOR ................................................................................................................................................. 19  
RECOMMENDATIONS: .............................................................................................................................. 21  
  Vertical Integration .................................................................................................................................. 21  
  Shelf space fees ....................................................................................................................................... 21  
  Inducements ............................................................................................................................................ 21  
  Current insurance contracts ....................................................................................................................... 22  
  Code of Practice ....................................................................................................................................... 22  
  Royal Commission .................................................................................................................................... 22
WHO WE ARE

The Australian Lawyers Alliance (‘the ALA’) is a national association of lawyers, academics and other professionals dedicated to protecting and promoting justice, freedom and the rights of the individual.

We estimate that our 1,500 members represent up to 200,000 people each year in Australia. We promote access to justice and equality before the law for all individuals regardless of their wealth, position, gender, age, race or religious belief.

The ALA started in 1994 as the Australian Plaintiff Lawyers Association, when a small group of personal injury lawyers decided to pool their knowledge and resources to secure better outcomes for their clients – victims of negligence.

The ALA is represented in every state and territory in Australia. More information about us is available on our website.¹

¹ www.lawyersalliance.com.au
INTRODUCTION

1. The Australian Lawyers Alliance (‘the ALA) welcomes the opportunity to have input into the issues raised by the terms of reference of Senate Standing Committee on Economics’ Inquiry into the Scrutiny of Financial Advice. This submission makes comments on all of the Terms of Reference.

HISTORY OF WORK IN THIS INDUSTRY

2. The ALA has been advocating for our members and their clients engaged in the life insurance and superannuation industry for a generation. Our members often represent clients in actions against life insurance providers and superannuation funds, both before and during the formal claims process. Some of the concerns which have been highlighted in the recent media coverage of the life insurance industry are well known to our members. We have seen the tactics and outrageous behaviour of this industry, as revealed in the media, all too often. Some of the recent work we have done on this issue includes responding to proposed changes to industry regulation in Queensland\(^2\) and a submission to the Inquiry into Schedule 2 of the Veterans’ Affairs Legislation Amendment (2015 Budget Measures) Bill 2015.\(^3\)

NEED FOR REFORM

3. The ALA commends the addition of terms of reference announced on 2 March 2016 adding investigation of the insurance industry to the ongoing Senate Inquiry into


\(^3\) http://www.aph.gov.au/DocumentStore.ashx?id=1b1d89c4-c57d-42ea-bc75-018955387a82&subId=401977
financial advice. This submission responds to all five terms of reference added on that date.

4. On 8 March 2016, the ALA issued a media release in response to a media investigation into the insurance sector. That investigation alleged that insurers are avoiding policy obligations to their clients through the use of definition changes, avoidance clauses and delays and disputation of claims. This is the latest in a long line of scandals involving the insurance and superannuation industries, as described below.

5. The ALA is recommending a three-part reform for the insurance sector, in particular addressing total permanent disability (TPD) claims. In this submission we provide substantive recommendations as to the nature of the reforms that are needed to ensure that this industry is best meeting the needs of some of the most vulnerable members of our society.

6. We have publicly called for a Royal Commission or an Inquiry with the powers of a Royal Commission to properly investigate the industry and make further recommendations.

7. Specifically, the ALA is advocating for reforms that:
   a. Identify and publicise instances of the insurance sector seeking to avoid its responsibilities by employing dubious and unethical tactics;
   b. Clarify and strengthen the minimum standards that insurance policies should meet, particularly in relation to TPD and Death policies provided via superannuation funds; and
   c. Encourage and enforce higher standards of behaviour and conduct within the sector.

8. More detail of this three-part reform proposal is set out below.
1. IDENTIFY AND PUBLICISE INSTANCES OF THE INSURANCE SECTOR SEEKING TO AVOID ITS RESPONSIBILITIES BY EMPLOYING DUBIOUS AND UNETHICAL TACTICS

1.1 Unethical behaviour by insurance providers

9. The unethical practices employed by some insurance companies make headlines all too often in the Australian media. The ALA is concerned that the media often appears to have greater will and capacity to investigate troubling behaviour than the government agencies or industry organisations tasked with regulating the industry.

10. Most recently, revelations regarding unethical behaviour by CommInsure came out of a joint Fairfax – ABC *Four Corners* investigation. Examples included disputing claims using out-of-date medical definitions, and delay-tactics to avoid claims. A Prior to this, fraud on the part of financial advisers was uncovered in relation to the National Australia Bank and the Commonwealth Bank of Australia. The responses by both banks to these frauds were inadequate, perpetuating risk for policy holders and potential policy holders.

11. As well as hiding behind dubious interpretations of their obligations, some insurers have acted unethically in seeking to encourage claimants to withdraw claims. Insurance claimants have been intimidated by insurance companies, including being threatened with being charged with a criminal fraud offence to encourage them to

---


withdraw valid claims. See for example the media coverage on the treatment of injured NSW police officers by their former group life insurer, MetLife. \(^6\) Claimants have faced unreasonable delays and rude and aggressive behaviour on the part of insurance company representatives or investigators. Being sent to an unreasonable number of the insurer’s preferred doctors (including multiple doctors of the same discipline) until the insurer gets the opinion it wants is not uncommon.

12. The behaviours outlined in this submission are only a selection of the cases of impropriety in the insurance and banking sector in recent years. The ALA is particularly concerned that many of these allegations have only come to light following media investigations. As such, we question whether existing regulatory bodies are sufficiently equipped to be able to ensure financial services providers comply with their legal obligations and act ethically in all circumstances.

1.2 Conditions that increase the likelihood of unethical behaviour and lead to the sale of inappropriate life insurance products

1.2.1 Vertical Integration

13. Vertically-integrated advice is where an adviser recommends purchase of a financial product (including life insurance) from entities with which they are associated. This is often to the exclusion of more suitable non-affiliated products. This has been and remains a root cause of poor advice outcomes.

---

14. ASIC has described the vertically-integrated advice model as being inherently conflicted, and lacking in customer transparency. For example, ASIC’s submission of December 2014 to the Scrutiny of Financial Advice Inquiry noted:

The inherent conflict of interest created by vertical integration may not be readily apparent to clients, particularly if the product manufacturer and advice parts of the business operate under separate licences and business names. Roy Morgan Research found that 55% of surveyed consumers receiving financial advice from an entity owned by a large financial institution, but operating under a different brand name, considered it to be independent—in contrast, only 14% of consumers considered financial planners working under the brand of the same financial institution to be independent. This was also an issue identified by the Financial System Inquiry, which recommended that advisers be required to disclose ownership structures of the advice firm to consumers.7

15. The vertically-integrated players are predominantly owned and controlled by the big four banks, AMP (including AXA) and Macquarie Bank. These dealer groups collectively account for around half of the total market share in the financial advice sector, and their stake is increasing.

16. Dealer groups utilising a vertical integration model are not obliged to have any retail life risk insurance product on their Approved Product List (‘APL’) other than their own affiliated product.

17. This inherent conflict has given rise to much litigation in recent years,8 the most notable case being Commonwealth Financial Planning Ltd v Couper.9 In Couper, the late Mr Stevens was advised by a CBA adviser to cancel his existing Westpac life

---

7 Submission No. 88, at [245].

8 See also Swansson v Harrison & Ors [2014] VSC 118.

9 [2013] NSWCA 444.
insurance policy and replace it with a vertically-integrated CommInsure product, which he did. The subsequent claim made by his Estate for his life insurance benefit was declined and the policy avoided on the basis of non-disclosure under section 29 of the Insurance Contracts Act.10 The Court of Appeal found that the financial advisor was negligent and engaged in misleading and deceptive conduct. The Court noted that while the Statement of Advice did disclose the risk of avoidance for non-disclosure, it failed to disclose the ‘three year rule’, namely that:

- because his Westpac policy had been on foot for more than three years, it could not be avoided by the insurer except by proving fraud; and
- the CommInsure policy could be avoided for ‘innocent non-disclosure’ within the first three years from inception, and was therefore an inferior product.

18. The three year rule was, in the adviser’s words “news to me”.

19. These inherent conflicts were highlighted by Roy Morgan research which stated that over a three year period, these dealer groups allocated an average of over 70 per cent of their sales to their own products.11

20. Because the big vertically-integrated players have such vast distribution channels to sell their ‘in-house’ products, they do not rely on other advice firms to do it for them. That means they are disinclined to take the lead on product design, which in turn leads to inappropriate or defective products being paid for by the client, and often results in the insurer denying liability because of those defects.

10 1984 (Cth).

21. Recent controversies have exposed stark examples of this, such as CommInsure’s retail Trauma policies, which contained medically-obsolete ‘heart attack’ and ‘severe rheumatoid arthritis’ definitions. Despite knowing the definitional flaws, CommInsure relied upon them to decline claims. It took the media expose described above to prompt CommInsure to update its obsolete clauses.12

22. It is apparent that action is needed now to deal with the vertically-integrated sales model, which remains rife in the advice industry. Yet the draft Corporations Amendment (Life Insurance Remuneration Arrangements) Bill 2015 (“the Bill”) does not propose any substantive reform on this issue. It instead entrusts the industry with “responsibility for widening Approved Product Lists through the development of a new Industry standard”. Given the advice industry’s poor track record of self-regulation, and its manifest commercial interest in continuing to sell ‘in-house’ products, such an approach is troubling.

23. The vertical integration conflict can be addressed best by requiring financial advisers to demonstrate that they consider and recommend both affiliated and non-affiliated products. That could be achieved by making the following improvements:

a. Requiring that APLs include a balance of affiliated and non-affiliated products, and/or a minimum proportion of non-affiliated products.

b. Requiring that if a Statement of Advice produced for a customer recommends an affiliated product, that affiliation should be disclosed, and the Statement of Advice should show a comparison with one or more

comparable non-affiliated products to demonstrate that the affiliated product is more appropriate.

24. These measures would provide prescriptive requirements to support compliance with the best interest test established by the Future of Financial Advice reforms. These measures are also directed towards achieving the recommendation of John Trowbridge that APLs be reformed to “ensure competitive access and choice for all advisers and their clients.”

1.2.2 Shelf-space fees

25. These are levies paid by insurers to advisers to have their product listed on the adviser’s APL.

26. Some insurers have themselves called for a ban on these payments, with the ClearView Managing Director Simon Swanson reportedly stating that “customers are often recommended a product not because it’s the most suitable and appropriate, but because of an insurance company’s willingness and ability to pay shelf space fees”.13

27. Despite these concerns, and as with vertical integration, the Government continues to allow the industry to self-regulate on this issue.

1.2.3 Inducements

28. In 2015, the big banks were revealed as offering unethical inducements to employers to join their superannuation funds. Inducements included discounted banking products, sporting tickets and iPads. These inducements appeared to be in

---
contravention of the Superannuation Industry (Supervision) Act 1993 (Cth), which prohibits the offering or giving of allowances or discounts in exchange for employees becoming members of the fund: section 68A(1). Ultimately these inducements mean that individuals might be joining substandard superannuation schemes as their employers make decisions based on self-interest rather than the most appropriate fund.

1.3 Concerns regarding current superannuation-owned group insurance contracts

29. Increasingly, many of the problems that our members see stem from product design, particularly around default total and permanent disability (‘TPD’) insurance provided through members’ superannuation funds.

30. Default TPD in superannuation is a critically important resource for superannuation fund members. It is the means by which a disabled member can top up the shortfall in their superannuation retirement savings caused by the premature end to their career. This resource is of greater importance than ever given the significant underinsurance problem in Australia, and the toughening of Centrelink disability entitlements and Workers’ Compensation regimes.

31. The SIS Act allows for early release of a funds in a members’ retirement saving account in limited circumstances including ‘Permanent Incapacity’, which is defined as follows:

   if a trustee of the fund is reasonably satisfied that the member’s ill-health (whether physical or mental) makes it unlikely that the member will engage in gainful

---

employment for which the member is reasonably qualified by education, training or experience.\(^\text{15}\)

32. Any TPD insurance definition must be ‘consistent’ with that condition of release,\(^\text{16}\) however the industry interprets that to mean it cannot be less onerous, and has, in recent years provided TPD definitions that depart substantially from the ‘Permanent Incapacity’ requirement. This can lead to claimants receiving their account balances from the fund for ‘Permanent Incapacity’ but then having to face a dispute with the insurer for their insured TPD benefit at a time when they are most vulnerable, having ceased work due to disability.

33. We call for amendment to the SIS regime, including section 68AA of the SIS Act, to require the insurance TPD definition within superannuation to be no more onerous than the early release requirement for ‘Permanent Incapacity’.

34. Insurance law in Australia already has standard cover for some types of insurance such as home and contents, motor vehicle and travel insurance. Under that law, an insurer must provide minimum types of benefits and can only deviate from that cover if they "clearly inform" an insured of the changes.

35. However, standard cover does not currently apply to life insurance.

36. Life insurance policies can be very complex and hard to understand. As will be seen below, the deviations that are commonly seen from definitions found in legislation and regulations can have serious consequences for policy holders, of which they are often unaware until they need to make a claim on their policies. Accordingly, there is an overwhelming case that standard cover should apply to death and TPD insurance

\(^{15}\) SIS Regulations, reg 1.03C [emphasis added].

\(^{16}\) SIS Regulations, reg 4.07D
to reflect regulated definitions of what constitutes a heart attack, cancer, a stroke or a disability.

37. Insurers would still be free to market different types of life insurance but they would have to clearly explain to individual customers deviations from the standard cover without burying non-standard terms in the fine print, so they understand what they are covered for.

38. These reforms would address product design concerns and ensure continuity and consistency in the two tests.

39. Below we provide some extracts from currently used insurance contracts. These illustrate the extent to which various funds and group life insurers’ depart from TPD definitions which were traditionally in line with the ‘Permanent Incapacity’.

1.3.1 Capacity: unlikely vs incapable

40. From 1 November 2014, AustralianSuper/TAL, which has over two million members, changed its TPD definition to remove the word “unlikely”. It now requires claimants to demonstrate that they are “incapable of ever engaging in any occupation for which [they are] or may become reasonably suited by education, training or experience”.

41. The industry generally considers that the threshold “incapable of ever engaging” is much higher than “unlikely” as found in the regulations, hence their policy change to limit their liability to pay claims. Further, the standard of work that is considered appropriate is lower than that provided for in the Regulations. Ultimately this means that claimants can have claims rejected, even if it is unlikely that they will engage in employment similar to that which they were performing before the accident.
42. The NSW Court of Appeal\textsuperscript{17} recently considered the “unlikely” TPD test and found that “A real chance that a person will return to relevant work, even if it is less than 50%, will preclude an Insured Person being unlikely ever to return to relevant work.” It is submitted that such a test is sufficiently onerous.

43. It is pleasing to see that some funds, such as CBUS have resisted pressure from insurers to depart from the ‘Permanent Incapacity’ test and have kept the “unlikely” definition. The fact that such definitions are being retained by some confirms the viability for doing so across all insurers.

1.3.2 Retraining clauses

44. The current AustraliaSuper contract makes the following provisions regarding retraining:

In forming our opinion we will have regard to factors including but not limited to:

i. Any retraining, re-skilling, work or voluntary work that has been undertaken by the time we form our opinion;

ii. Any retraining, re-skilling that could reasonably be expected to be undertaken by the insured member within a reasonable time period;

iii. Any rehabilitation that has been undertaken by the time we form our opinion, or could reasonably be expected to be undertaken by the insured member within a reasonable time period;

iv. All evidence available to us for the period up to the time we form our opinion.

45. It is not clear who would pay for the retraining or re-skilling envisaged at ii. Further, if the cost of the retraining is greater than the prospective insurance benefit, what happens? Finally, if the Fund Member withdraws their account balance under the SIS total permanent incapacity grounds, will the Trustees continue to help a non-

\textsuperscript{17} TAL Life Ltd v Shuetrim; MetLife Insurance Ltd v Shuetrim [2016] NSWCA 68 at [89].
member retrain or rehabilitate? Policy holders deserve clear answers to these questions.

1.3.3 Ongoing care

46. The current MTAA/Metlife policy contains the following definition for regular and ongoing care. It means the person:
   a. Is under the regular and ongoing care of a medical practitioner who has given a clear prognosis that the Injury or Illness will continue throughout the life of the Covered Person (including after the expiry of the cover and the commencement of retirement) without any prospect of an improvement which would lead to a return to work (whether or not for reward) in any capacity; and
   b. Is complying with reasonable medical advice and treatment; and
   c. Has, in our opinion reached the maximum level of medical improvement possible for that Covered Person based on their Injury or Illness.

47. This is perhaps the most severe departure from the SIS Regulations and is arguably a form of ‘junk insurance’.

48. The definition of gainful employment in the SIS Regulations is as follows: “employed or self-employed for gain or reward in any business, trade, profession, vocation, calling, occupation or employment”. By allowing a return to work that would not be for reward, this policy provides a lower level of coverage than that provided for in the Regulations.

1.3.4 Coverage exclusion

49. The current NGS Super/CommInsure policy contains the following exclusion clause: Excluded Member Means a Member to whom any of the following applies:

18 SIS Regulations, reg 1.03 [emphasis added].
(a) A terminal illness, total and permanent disablement, trauma or similar benefit has been paid or is payable or can be claimed in respect of the Member under any insurance policy, whether that policy be owned by the Member or another person (including the Fund or another superannuation scheme);

(b) the Member has received, or is eligible to receive, a benefit, or has had a claim for a benefit admitted, from:
   i. the Fund; or
   ii. another superannuation scheme;

   on the basis the fund or scheme has found the Member to suffer from ‘permanent incapacity’ or a ‘terminal medical condition’ under the Superannuation Industry (Supervision) legislation or any legislation which replaces it; or

(c) the Member has or was eligible to have cover under any group life policy issued to the Fund and the Member:
   i. opted out of being covered; or
   ii. cancelled the cover; or
   iii. ceased being a member of the Fund.

50. As at June 2010, there were around 33 million superannuation accounts in Australia, being approximately three accounts for every Australian worker. Therefore, it is possible that most of the holders of these policies can get no benefit from their cover, regardless of whether a member’s other fund has any insurance. It is unclear why they should be paying premiums if it is possible that no benefit would be payable.

2. CLARIFY AND STRENGTHEN THE MINIMUM STANDARDS THAT INSURANCE POLICIES SHOULD MEET, PARTICULARLY IN RELATION TO TPD AND DEATH POLICIES PROVIDED VIA SUPERANNUATION FUNDS

51. The ALA believes the above concerns point to a need for an enforceable Code of Practice (Code) to be developed to regulate the conduct of the insurance and
superannuation industries. The above examples clearly indicate that a self-regulated code will be insufficient, and will represent a wasted opportunity to effect genuine change in the industry.

52. This proposed Code should ensure that these industries operate in an ethical and fair manner. It should be developed through an open and transparent process, involving genuine consultation with both community representatives and industry groups.

53. ASIC is the appropriate regulator. ASIC’s resources need to be increased to ensure they are capable of providing genuine and effective oversight. At a minimum, ASIC supervision should cover superannuation TPD, income protection, salary continuance, terminal illness, death and other claims. The ALA is in the process of preparing a draft Code of Practice that we would be happy to share with the Committee once completed.

54. The Code should ensure that the objectives of the SIS Act and the *Insurance Contracts Act 1984* (Cth) are met. ASIC’s Regulatory Guide 165 regarding time limits for internal dispute resolution should also be reflected in the Code. The definition of Permanent Incapacity should reflect that found in the *Superannuation Insurance (Supervision) Regulations 1994* (Cth), extracted above.

55. The Code should regulate conduct of insurance companies and regulators in assessing claims. It should agree to the fair and reasonable exchange of documentation relied upon in assessing claims. Claims should be assessed in a timely manner and avoid excessive delays. Any delays in assessing claims due to their complexity should be agreed between the parties. Any claim that is not assessed within a reasonable period of time after an internal complaint is lodged should be assessed in line with ASIC Regulatory Guide 165.
56. In terms of rehabilitation and return to work, claimants should be informed of the rehabilitation program proposed, including the basis for considering that that program is likely to lead to medical improvement and an opportunity given for the claimant to respond to it.

57. Where there is an urgent financial need and the claim has reasonable prospects of success, the assessment should be fast-tracked. If appropriate, a without-prejudice advanced payment should be available to alleviate immediate hardship for the claimant.

58. Any complaints should be responded to in a fair, transparent and timely manner. Claimants should be kept informed as to the progress of their complaint and given an opportunity to provide further information. Disputes as to assessment should also be handled expeditiously in the most appropriate forum to resolve it. Claimants should be provided reasons for the assessment made and be informed of appeal avenues. Any requests for medical reports should be made expeditiously and only reasonably necessary reports should be requested.

3. ENCOURAGE AND ENFORCE HIGHER STANDARDS OF BEHAVIOUR AND CONDUCT WITHIN THE SECTOR

59. Equally important, although more amorphous, is the industry culture that allows scandal after scandal.
60. The ALA is particularly concerned about many of the problems outlined above, which have featured repeatedly in the media in recent years. Of particular concern are the following:

- Inappropriate pressure exerted on medical officers by claim staff to seek to reduce the severity of the diagnosis and accordingly the entitlements of claimants. This was seen clearly in the CommInsure revelations of March this year.

- Surveillance and investigation of claims being used as a bullying tactic to encourage genuine claimants to withdraw claims. Some claimants have even been threatened with prosecution for fraud in making genuine claims under their policies.

- The practice of ‘doctor shopping’. ALA members are aware of unrepresented claimants being sent to up to six doctors, until one of them provided the diagnoses that the insurance company wanted.

61. A Royal Commission, or an Inquiry with the powers of a Royal Commission, is the appropriate process to investigate the depth of the problem and the appropriate government response to protect vulnerable clients. It could also explore these cultural problems in depth and provide recommendations regarding how they might be remedied.

---

RECOMMENDATIONS:

The Australian Lawyers Alliance makes the following recommendations:

**Vertical Integration**

- Financial advisers should be required to demonstrate that they consider and recommend both affiliated and non-affiliated products. That could be achieved by making the following improvements:
  
  - APLs should be required to include a balance of affiliated and non-affiliated products, and/or a minimum proportion of non-affiliated products;
  
  - If a Statement of Advice produced for a customer recommends an affiliated product, that affiliation should be required to be disclosed, and the Statement of Advice should show a comparison with one or more non-affiliated products to demonstrate that the affiliated product is more appropriate.

**Shelf space fees**

- The use of shelf space fees should be either banned or properly regulated by ASIC to ensure robust disclosure obligations, and that it does not cause a conflict that may result in the recommended product not being in the consumer’s best interests.

**Inducements**

- All allegation of the use of inducements that contravene the SIS Act should be investigated and, if the allegations prove to be true, adequately punished by ASIC.
Current insurance contracts

- The SIS regime should be amended, including section 68AA of the SIS Act, to require the insurance TPD definition within superannuation to be no more onerous than the early release requirement for ‘Permanent Incapacity’ under that Act.

- Standard cover should apply to death and TPD insurance to reflect regulated definitions of what constitutes a heart attack, cancer, a stroke or a disability.

Code of Practice

- An enforceable Code of Practice should be developed through an open and transparent process, involving genuine consultation with both community representatives and industry groups, to ensure that these industries operate in an ethical and fair manner.

- ASIC should be the regulator for the Code of Practice, and its resources should be adequately increased to be able to perform this regulation effectively.

Royal Commission

- A Royal Commission, or an Inquiry with the powers of a Royal Commission, should be established to investigate the depth of the problem in the insurance and superannuation industries, and the appropriate government response to protect vulnerable clients. It could also explore cultural problems in depth and provide recommendations regarding how they might be remedied.