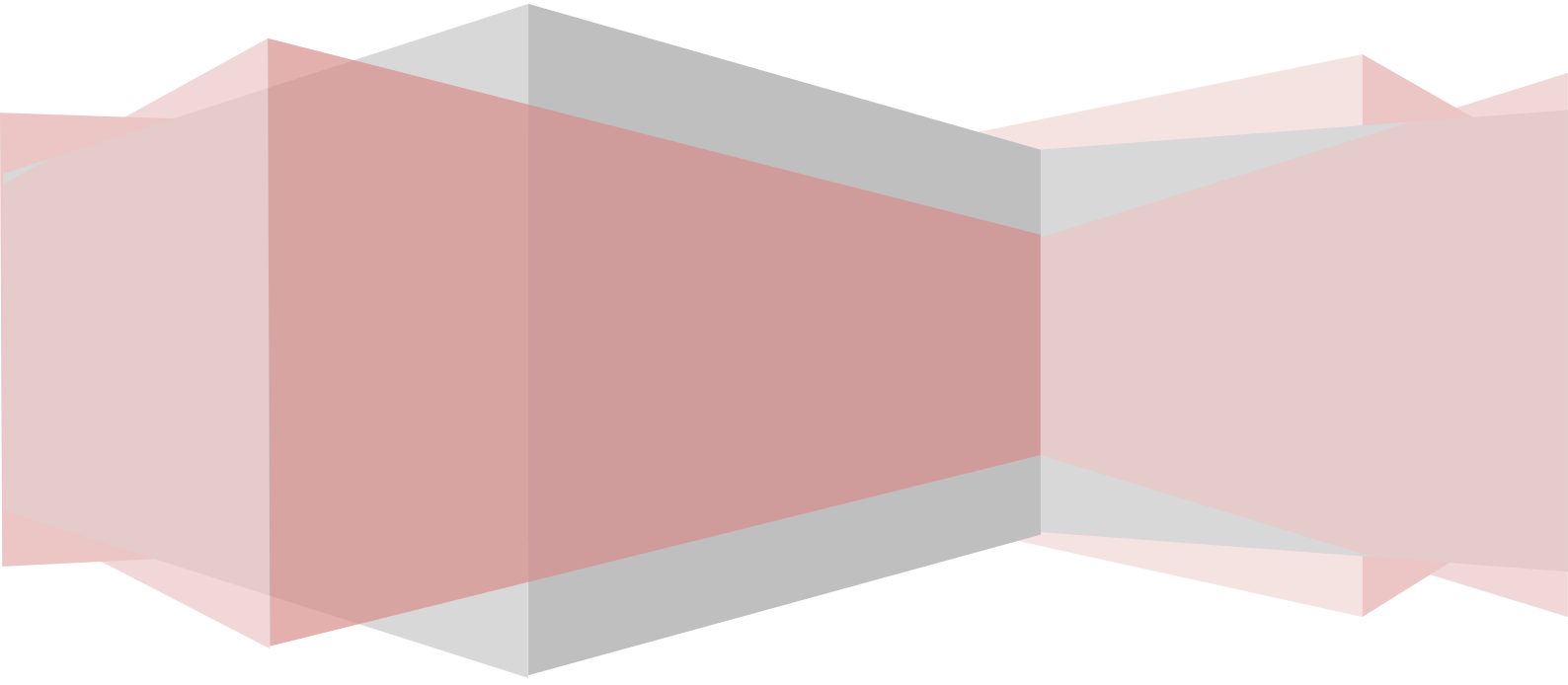
Insurers' Institute on Personal Injury

Dynamic in righteousness and reason

Annual report (2012)



A dynamic year

The year 2012 was a dynamic year for the personal injury industry. A lot happened, nearly too much to list here. I refer, for example to the new Code of Conduct for Handling Personal Injury Claims (GBL), which was presented to State Secretary Fred Teeven in November 2012.
The same State Secretary received in June the Medical Paragraph, which is part of the Code of Conduct.

Initiatives

The Dutch Association of Insurers published the new Collective Market Agreement 15. The agreement emphasizes the need that transparent information about the claim settlement process is provided to the victim by the insurer. This also applies if the victim avails of a legal representative.

Pivotal role

The PIV endorses the trend that many insurers measure how the victim has experienced the claims settlement. This ensures that the focus is on what the victim finds important and any possible improvement schemes that can enhance satisfaction levels. This way, the person who really matters is put at the heart of the claims settlement process.
This has put an end to the prevailing and age old notion (also on the side of insurers) that no communication about the claims settlement is permitted between the insurer and the victim when the latter is legally represented.
This is in total conflict with the victim's need for information about the current position and progress of his injury claim, on the one hand, and the insurer's requirement to be open about this, on the other hand. The contents of this new Market Agreement is therefore welcomed by `friend and foe' alike as self-evident.
Finally there were the 'Recommendations to prevent and/or solve disputes in the personal injury process', which will be dealt with in more detail in Chapter 2 of this annual report.

No change, no progress

Claims handlers and claims-adjusters can sometimes be heard lamenting: "*Does it never stop*?". In all honesty, the answer must be `no'. The settlement of personal injuries is an area that is constantly in motion and subject to many innovations. That is how it should be, because we owe it to the victim. Here the proverb `No change, no progress' is relevant.

Victim's pivotal role

Audits, satisfaction surveys and quality certifications are such that insurers continually strive for improvement. It is of importance, though, that there is always a close correlation between these innovations, the criteria for the quality certification, and the victim's real requirements. A further enhancement of the criteria must not become a goal in itself. The needs and requirements of the victim must always prevail. Fortunately, extensive scientific research is carried out into these matters, especially by the Vrije Universiteit of Amsterdam.

Further steps in 2013 ...

In 2013 further steps will be made; maybe not so much in the field of market agreements and quality certifications, but certainly with regard to a number of heads of claims.
In addition to the question of whether the assessment of quantum for pain and suffering should be determined in a different manner, attention will be given in 2013 to the losses of persons other than the victim. I specifically refer to affection damage, loss of income by the caretaker partner/parent, and fatality claims.
Both the legislator and the industry are currently working on a number of initiatives, which will certainly occupy us in 2013.

Medical negligence cases

The settlement of injury cases resulting from medical malpractice is an issue that is currently receiving a lot of media and political attention. It must be concluded that the present regime is very burdensome for the victim, but perhaps also for the insurer.
Undoubtedly this year will see new initiatives to improve the position of victims of medical negligence cases.

Open eye and mind

The PIV will (inevitably) play an active role in all matters and initiatives that are occurring in 2013, not from a defensive position, but with an open eye and mind to adapt existing systems –but with due regard to the insurers' possibilities and the victims' needs.

With an eye for righteousness and reason!

1. Decrease in protracted traffic injury cases

The Code of Conduct for Handling Personal Injury Claims (GBL) sets a term of two years for the settlement of a personal injury claim resulting from a road traffic accident.
In 2010, Eiffel Consultants, on behalf of the Dutch Association of Insurers and the PIV, carried out a first study to find out what percentage of claims are really settled within this time frame. The study also served as a baseline measurement. A follow-up study, in which most motor insurers partook, was conducted in 2012. It transpired from this in-depth analysis, which was based on the Code of Conduct for Handling Personal Injury Claims (GBL), that 91.6% of all claims were settled with the victim within two years. All claims which were reported in the first quarter of 2010, and which were fully settled with the claimant on 1st April 2012, were examined. This took place by means of a fixed format, which was completed by a different claim handler than the one responsible for the file.

Outcome!
The good news is that the total percentage of personal injury claims that is not settled within two years has decreased from 10% in 2010 to 8.4% in 2012.

We also wanted to establish which claims constitute the core of these open cases.
The results were as follows:

- Whiplash/neck complaints (40%)
  It is not that surprising that neck complaints score so highly. The claim settlement of chronic neck complaints is generally a slow and difficult process, particularly when the causality between the complaints and the resulting impairments, on the one hand, and the accident, on the other hand, is at issue. Also to be considered is the question to what extent these limitations lead to an inability to work. Even the jurisprudence on the subject is divided.
- Fractures/orthopaedic injuries (29%)
  It might come as a surprise that orthopaedic injuries score high. The reason is that it generally concerns badly healed fractures, so that there is not a medical status quo after two years. Often, a further medical report from an orthopaedic medical expert must be obtained.

Delay

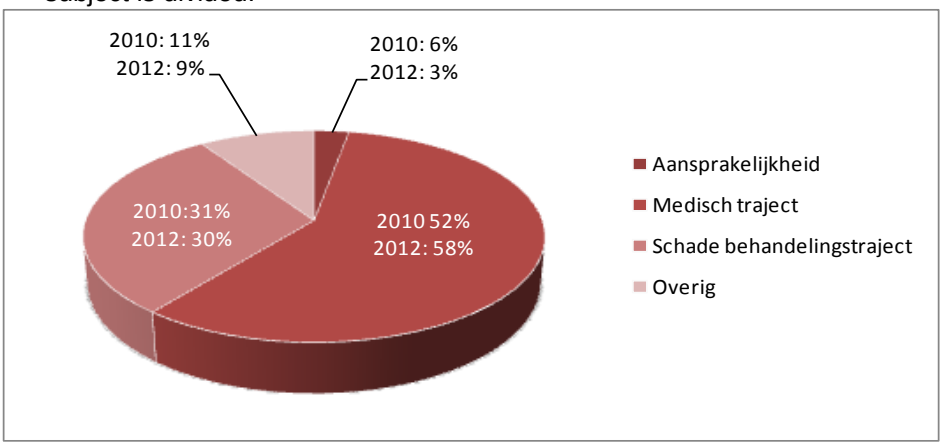
Another interesting item is the reason for the delay in the claims settlement.

Noteworthy!
Compared to the previous survey, the reasons for delay have not changed significantly. It transpires once more that discussions on the question of liability lead to a settlement duration longer than two years in only a small number of cases. And the 2012 figure has halved in comparison to 2010. Most discussions are about possible contributory negligence on the part of the injured party, often cyclists.
It is clear that the medical trajectory is still the main ‘culprit’; after two years there is still disparity about or within the medical trajectory in nearly 60% of the open claim files, i.e. in 5% of the total number of cases.

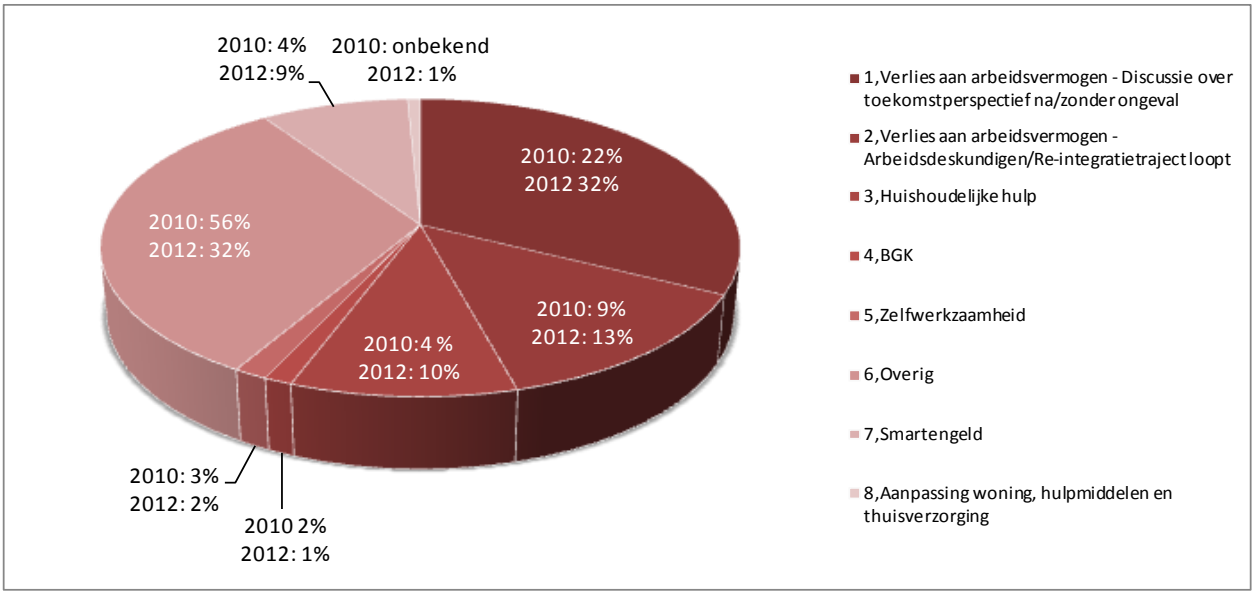
Significant detail; both with neck complaints and not fully healed fractures, the debate in most cases is about medical, respectively medico-legal issues.

Graph I demonstrates that 30% of the delay occurs during the assessment of the claim, especially the loss of earning capacity. The following graph, which sets out the discussion points within the claims settlement trajectory in more detail, underpins this.

In-house self-assessments carried out by various insurers, give the following picture:



(Graph I: Causes of delay during claims settlement)



(Graph II: discussion points within the claims settlement trajectory)

Detail: Discussions about legal costs (BGK) only rarely lead to delays in the settlement process.

Inroads!

Apart from the assessments carried out by the insurance companies themselves, Eiffel subjected 10% of the files (with a minimum of five claim files per insurer) to a random check. The consideration was whether or not the claim could, on hindsight, have been settled earlier. The answer was in the affirmative in 22% of the cases. The Eiffel auditor even came to a percentage of nearly 40%. The results of this survey demonstrate that great inroads can still be made.
Areas in need of improvement lie especially in the loss assessment phase, where a more proactive stance by the claims handler can definitively speed up the process, particularly in cases where the legal representative is less active and settlement orientated.

Positive influence

In approximately 7% of the cases that are not settled within two years, the delay is attributable to the legal representative and/or the victim. In these cases, the waiting has been for a reaction. A random check learned that once a reaction is not forthcoming, the claims handler also tends to become more passive. Little or no pressure is brought to bear on the legal representative. Contact by phone is reduced to a minimum and the claims handler will be satisfied with sending a standard reminder. The general public, and particularly the media, generally point the accusing finger at the insurer when there is a delay. There are points to be gained here by the insurance companies.
Other issues that can positively influence the loss assessment trajectory are:

- Guaranteeing a harmonious atmosphere, with sufficient attention for and input by the victim;
- Ensuring that adequate advance payments are made;
- Not waiting too long before a three way interview takes place, in which the claim handler should be more actively involved;
- Not being afraid to make a decision and not hesitant to make a generous offer.

Conclusions

The two most important conclusions from this in-depth analysis are:

- Firstly -regardless of how well insurers perform- the percentage of claims that is not settled within two years will never be nil. There will always be cases where, even after two years, the medical situation remains too uncertain (also for the victim) to come to a responsible final settlement. Of course insurers must continue to safeguard aspects such as advance payments, transparency and an informative attitude.
- Secondly, there will always remain cases that centre on a point of

principle, or in which the opinions of both parties lie so far apart that legal recourse (or an alternative form of dispute resolution) becomes unavoidable.

It is up to the judiciary in these cases to decide if the loss assessment is realistic. Jurisprudence shows that there are cases where the court decides that one party is over-asking and the other party is underbidding. The truth does not always lie in the middle. Legal representatives do not always have realistic expectations of the final indemnification. Thus years can pass by from the accident date if parties decide to litigate in two, let alone three instances.

The PIV is of the opinion that the percentage, established in 2012, of 8.4% of injury cases that are not settled within two years, can be reduced even further. At the same time, not too much must be made from the fact that most cases are settled within two years. This time scale of two years must not become a goal in itself. Every case must be dealt with as efficiently as possible. If a case is finalized within two years, but this could, on further analysis, have been done in six months, this certainly warrants attention.

2. What if prevention does not work?

The age-old dictum “prevention is better than healing” also applies to disputes in the settlement of injury cases. Disputes will unavoidably arise between the insurer and the victim and/or his legal representatives, for example about:

- points of principle that emerge in the course of the claims settlement
- the open standards that so often feature in our claims settlement legislation.
- diverging opinions on for example the career prospectives of the victim if the accident had not taken place.

The mere fact that conflicts might possibly arise is inherent to our system, which is after all not based on complete standardisation by means of tables and formulas. It is, however, important to recognise these divergent opinions as early as possible, to identify them and to subsequently start a dialogue about how to solve them.

Clarity and adequate action

- Differences of opinion can arise early in the claims settlement process, for instance in determining the question of liability or whether or not the victim should accept contributory negligence. As the further settlement of the claim is partly dependent on this, it is important to resolve these issues as quickly as possible.
  To this end, both parties must have at their disposal all relevant documents, such as witness statements. The fact that increasingly fewer police reports are filed is a hindrance to a smooth claims settlement process. The PIV has learned that this will in all likelihood be improved in the future.
- Disputes about the criteria for the compensation of household assistance or participation in a rehabilitation programme, often occur in the first year. The exact nature of the disagreement must be discerned from the reports of the claims adjuster, the correspondence with the legal representative or from a three-way interview. Adequate action is then called for.

Reference points in the claims settlement

Nowadays, a number of fixed reference points are used for dispute resolution.

The first reference point

This lies two years from the date of the accident, if the case has not been (fully) settled with the victim at that stage. Within the claims department of the liability insurer, a *second opinion* is obtained from another colleague/claims handler, the so-called ‘four eyes principle’.
The outcome of the second opinion must be communicated as swiftly as possible to the victim and his legal representative, preferably by means of a three party interview.
There are subsequently three scenarios:

1. Parties agree that there are valid reasons why the case could not be resolved. As indicated in chapter I, that will be the situation in approximately half of ongoing cases. Furthermore, there will not be a dispute situation in many of these cases. But that must not be a reason for the insurer to simply sit back and wait. The insurer will have to establish what must be done to come to a final settlement.
2. Parties agree that the case should have been fully settled or that this can be achieved within the short term and make specific agreements to that end.
3. Parties disagree. In that case, an analysis must map the points of divergence and their possible solutions. The partial dispute courts might then become an option, whereby a joint application by both parties would be most in line with the spirit of The Code of Conduct for Handling Personal Injury Claims (GBL). The Mediation Desk of The Injury Board (De Letselschade Raad) is also an option by way of consultation. Mediation could also be considered, especially when the differences are not solely of a legal nature.

The second reference point
The time band between two and three years constitutes the second reference point. In that phase existing instruments must be used, such as:

- periodic inter-company exchanges;
- the PIV Injury Plaza;
- submitting the file to an internal dispute commission -as is in existence at Achmea.

The third reference point
The third reference point is three years after the (traffic) accident. In the summer of 2012 the Dutch Association of Insurers published the report 'Recommendations to prevent and/or solve disputes in the personal injury process', which contains recommendations for insurers for cases in which victims express (and underpin) their belief that the insurer does not handle matters properly. This is in keeping with one of the recommendations from the report of the Association The Ombudsman, "The Code of Conduct for Handling Personal Injury Claims (GBL): *a well kept secret*?"
In these instances, the insurer proposes external dispute resolution, with mediation as the primary option. But if a victim is not in favour of mediation and prefers a different solution, the insurer must be open to this. One of the reasons for this preferred choice is because mediation has a very high success rate (approximately 90%) in the personal injury world. An additional argument is that most – successful- mediations take no more than one or two sessions.

The Dutch Association of Mediators in Injury Cases (LetMe!) is now incorporated in the Dutch Association of Mediators in the Insurance Industry (NVMV), which was founded some years ago. Finding competent mediators is thus relatively easy. The cost of mediation is borne by the insurer. The Dutch Association of Insurers advises insurers to send adequately mandated personnel to a mediation session, in order not to lose the momentum.
These recommendations are part of a three year pilot project and relate to (traffic) injury files in which the three year period will lapse in July 2013. In injury cases resulting from industrial accidents or in medical negligence cases, the three year period commences when policy cover and liability have been established.

Protracted injury cases
There have to exist very extraordinary and compelling reasons to justify that the settlement of a traffic injury claim lasts much longer than three years; it might happen, for instance, in cases involving children.
The choice for a structured settlement might also be a reason for a prolonged settlement duration.
In all other cases, in which parties have not reached agreement after this three years period has lapsed, or in which mediation was unsuccessful, it is better to litigate. Submitting a case to the courts is more effective than for parties to continue arguing with each other – sometimes against their better judgement – for a number of years.

The fourth reference point
The fourth reference point is when the deed of Settlement is signed; this should ideally be not too long after the third reference point – the three year period. It is not without reason that the motto of the 2013 PIV Annual Conference is "*From tomahawk to peace pipe*". It is better to smoke a peace pipe than to "burn one's hands".

High expectations
The PIV has backed these recommendations and has high expectations for them.
The evaluation, which will take place in three years' time, will mainly centre on the following topics:
- early availability of mediators;
- the possibility to discuss the choice of the mediator;
- the duration and cost of mediation;
- the success rate.

It goes without saying that the PIV will be involved in this evaluation.

3. Liability and legal assistance insurers; an odd couple

Legal aid insurers are responsible for a major part of the representation of victims in personal injury cases.
It is therefore important that there exists a good relationship between the various liability and legal assistance insurers, both in the individual claim files and at the macro level.

Improving relationship
A good relationship was sometimes lacking in the past, sometimes for no explicable reason. Mutual distrust and a lack of respect for each other's position (on the one hand both insurers, on the other hand one also acting as a legal representative) are perhaps the underlying reasons for this.
In order to improve this relationship, a Steering Committee was formed through the PIV and the Dutch Association of Insurers, in which both camps were represented.

The introduction of the GBL and the report "The Code of Conduct for Handling Personal Injury Claims (GBL): a well kept secret?" by the Association The Ombudsman from March 2011, was the main incentive for this initiative, because legal aid insurers are the only group of legal representatives who have collectively signed the GBL. Furthermore, both liability insurers and legal aid insurers are represented in the Sector Board General Insurance of the Dutch Association of Insurers; these aspects make it appealing and logical to agree to closer working arrangements, without compromising the legal aid insurers' position as legal representatives.
An added advantage is that the legal assistance insurers adhere to the PIV-scale in as far as their legal costs are concerned, so that their remuneration cannot give raise to discussion.

Projects
In 2011 the Steering Committee initiated two sub-projects: a project Minor Injuries and a project Severe Injuries.
The 2009 'Market Agreement Costs of Legal Assistance for Injury Cases', to which both liability and legal assistance insurers could sign up, already contained a 'Minor Injuries Scheme' for an efficient and swift settlement of injury cases with a value not exceeding Euro 3,000 and/or a convalescence period of the victim up to six months. Both parties concluded in 2011, however, that not all eligible cases were being dealt with under this programme. The question arose if this was due to unfamiliarity with the scheme (which was perhaps overshadowed by The Code of Conduct for Handling Personal Injury Claims (GBL), or as a result of the aforementioned sometimes strained relationship between these different insurers.

Minor Injuries

The aim of the project 'Minor Injuries' was to create an extra impetus for an optimal application of the existing programme through a predefined fixed process and a minimum of contact moments. The essence of the scheme is that, once the liability insurer has established policy cover and liability, the legal assistance insurer can settle the claim directly with its insured. With this project, interim discussions with the liability insurers have become a thing of the past. The ceiling amount was also increased to € 5,000.

Win-win situation!
With this scheme, a win-win situation is created. Both insurers not only save on transaction costs, but they can also count on a higher satisfaction score. Statistical data indicate that this programme can be applied every year to more than 10,000 cases.
The predefined fixed process 'Minor Injuries' comprises important elements, such as:

a. A swift intake by phone between the legal assistance insurer and its insured. This new claim notification is then promptly relayed to the liability insurer;
b. Communication by e-mail about the question of liability;
c. In principle no medical records are sent, respectively requested;
d. After four months, an evaluation takes place of cases which have not been settled to determine if settlement can take place within the next six months; and
e. Deliberation by phone about the payments, to be made directly by the liability insurer to the victim.

A good beginning …
At the end of 2012 a questionnaire was sent to members of both parties, the results of which were presented during a meeting in February 2013. The initial feedback is promising, but it remains necessary to constantly remind the claims handlers from both insurers of (the advantages of) the scheme.
The project 'Severe Injuries'
The project 'Severe Injuries' relates to personal injury cases to which the GBL applies. It is a challenge to make further working arrangements which are based on the GBL, but which are simultaneously a harmonious mix of an efficient work process and a victim friendly attitude.
The project focuses on the first stages of the claims settlement process, because a smooth start-up generally creates a good basis for the subsequent settlement climate.
A study group has taken the first steps towards a structured procedure GBL, which prescribes strict deadlines for both sides.
Specific attention is paid to:

- detailed information to the victim
- the three party interview
- the first advance payment
- the medical trajectory
- digital action plans

Aspects that need further consideration:

- Three party interview
  If a three party interview is indicated, it is of importance that this is not hindered by logistic obstacles, such as capacity problems. The study group will draw up specific criteria for these three party interviews, particularly with

regard to those cases, which, at first appraisal, fall between the categories 'minor' and 'severe' injuries. There is also the question of whether a three party interview must always (immediately) take place, even if parties do not see a need for it.

- Mandate
  A contentious item the study group was confronted with, was the financial mandate that liability insurers give to their claims adjusters, both with regard to advance payments and agreeing final settlements. The subject has already been raised in a broader context by The Injury Board.
  If the mandate is insufficient and the insurer's claims handler must first be consulted, both victims and their legal representatives experience this as counter-productive. Instances where a payment recommended by the claims adjuster is later overruled, place a severe strain on the settlement climate.

Further steps in 2013
Regardless of the work of the study group, the subject has given rise to the PIV taking further steps in 2013. We will do so, among others, in cases where the insurer avails of external claims adjusters. The underlying reason is because the GBL expressly emphasises the need for an adequate financial mandate when conferring with the victim and/or his legal representative.

Vision for the future
When abiding by the predefined fixed process 'Severe Injuries', contact with all parties is, whenever possible, conducted by e-mail or by phone. It is investigated how a digital environment can be a useful tool for more efficient communication. This point will be examined in 2013 by the study group.

Challenge!
It will be a challenge in 2013 to come to the best possible work process between liability and legal assistance insurers on the basis of mutual trust. Such an approach can serve as an example for work processes with other legal representatives. In that regard liability and legal assistance insurers form 'an odd couple', also for the application of the GBL!

4. Figures don't lie

4.1 The strength of the PIV Personal Injury Statistics

"20% of the total claims burden is paid to legal representatives" – "the average running time of a whiplash case is 1.5 years"
Are these statements correct?
The PIV Personal Injury Statistics allows for these statements to be easily verified by means of a large database that has been accrued over the last number of years with the assistance of insurers. The number of participating insurers has remained constant in 2012 at eleven. The database increases rapidly: in June 2012, the database contained in excess of 64,000 claim files. This is thanks to the fact that the participating insurance companies represent a significant percentage share of the industry, and because a number of insurers supply data digitally.

Strength
The strength of the PIV Personal Injury Statistics is that data is supplied as soon as the personal injury claim has been concluded, even if the claim file is still open, for instance because there are still recovery claims to be settled. Only the actually paid personal losses are recorded. Of relevance are the following five heads of claim:

- general damages
- household assistance
- loss of earning capacity
- DIY compensation
- legal costs

The group of participating insurers is presently reviewing if a column 'total personal claim' will be added in due course.
In order to possibly gain insight into the effects of legal developments on, for instance, the claims burden of public liability claims or information about the average running time of whiplash claims, we also note the following details:

- the nature of the injuries
- the type of legal representative
- the type of claim
- the running time

Meeting
Twice yearly, a meeting of the participating insurers is arranged. At these meetings benchmark figures are discussed. It is also a means to compare the own results with the benchmark average. Participants are given the possibility to suggest additional requirements for the reporting format.
At the request of the member companies, the year 2012, for instance, saw the inclusion of the results of public liability claims per completion year, with a further subdivision into the number of claims and the average running time per claims category.

Additional advantages
Partaking in the PIV Personal Injury Statistics also makes it viable for participating insurers to monitor the effects of changes in general policy on the running time and claims burden.
In addition, the achievements of individual claims handlers are visible, which can be used by managers to coach the teams.

In-depth Analysis 2012
The data of the PIV Personal Injury Statistics was used again for the (second) In-depth Analysis of the application of the Code of Conduct for Handling Personal Injury Claims (GBL).
Through the PIV Personal Injury Statistics, data about the division into injury categories is available. The In-depth Analysis GBL gives insight into the percentage that has been settled within two years per injury category.

In table III, the findings from both studies have been combined. This comparison allows, for instance, for the conclusion that with regard to the category 'fractures', the ratio has improved in relation to the first In-depth Analysis GBL.

	In-depth Analysis 2012		In-depth Analysis 2010	
	Breakdown settled claim files as per PIV Personal Injury Statistics	Division cases older than 2 years	Breakdown settled claim files as per PIV Personal Injury Statistics	Division cases older than 2 years
Amputation	0%	0%	0%	1%
Psychological Damages	1%	3%	0%	3%
Head/cerebral	5%	6%	4%	7%
Fractures	13%	29%	11%	33%
Contusions/Abrasions	29%	11%	30%	10%
Scarring/burns	3%	1%	2%	0%
Whiplash/Neck Complaints	31%	40%	36%	36%
Back injuries	5%	7%	5%	6%
Fatalities	0%	0%	0%	1%
Paraplegia	0%	0%	0%	1%
Dental injuries	2%	2%	1%	2%
Other	11%	0%	11%	0%

(Table III Comparison In-depth Analysis 2012 with 2010)

4.2 PIV Satisfaction Survey – The perception by the victim is of paramount importance!

Liability insurers work hard at continually improving the claims settlement process and to place the victim in an even more central position.
Concrete examples of projects and initiatives are:

- the projects with one (joint) medical advisor;
- the predefined fixed process 'Minor Injuries';
- partaking in the PIV audit;
- the revised Collective Market Agreement 15 'Provision of Information in Injury Cases', which came into effect this summer;
- the recommendations by the Dutch Association of Insurers to prevent and/or solve disputes in the claims settlement process;
- the Code of Conduct for Handling Personal Injury Claims (GBL) 2012, which was introduced last November.

Perception by the victim

The quality of the claims settlement, however, is ultimately determined by how it is perceived by the victim. It is therefore necessary to find out how the victim has experienced the claims settlement. To this end the PIV, in collaboration with Q-Consult, has offered a satisfaction survey since 2005. Insurers participating in the survey send victims, immediately upon completion of their personal claim, a questionnaire. The satisfaction survey gives participants insight into the appreciation of the claims settlement process, both in terms of individual scores as well as overall benchmark results. By means of the scores of the satisfaction survey, insurers can monitor how improvements in the claims handling are appreciated by victims, and which aspects need further attention.

Important
An interesting detail is that the results of the satisfaction survey have in part contributed to the revision of the Collective Market Agreement 15.

Apart from scores on the various aspects of the injury claims settlement, the satisfaction survey gives information about what the victim perceives as important in the settlement process. In the first place features 'clear information about the claims settlement', followed in second place by 'showing empathy for the circumstances'. 'Regular updates about the progress of the claims settlement' is also deemed important by victims.

Table of priorities

Items	Total	Score
clarity of the information about the claims settlement	15,4%	7,4
empathy for the situation	13,8%	7,6
abiding by commitments	12,6%	7,9
regular contact about the progress of the claims handling	11,4%	6,9
total duration of the claim	10,4%	6,9
amount of the indemnification	9,8%	7,5
prompt payment of the agreed compensation	9,6%	7,7
professionalism of the claims handler	8,7%	7,8
professionalism of the claims adjuster	4,6%	7,6
(phone) accessibility	3,6%	7,6

(Table IV: Table of priorities 2012)

Table V lists the highest and lowest scores. Many of the lower scores can be positively influenced if a digital action plan was used. In that case the victim can monitor progress, see what activities the insurer deploys and who is next to take action. The renewed Collective Market Agreement 15 'Provision of Information in Injury Cases', offers the insurer the possibility to inform the victim directly about the process.

(February to August 2012)

Satisfactory Scores (February thru July 2012)

Highest scores:		Lowest scores:	
1. fulfilling commitments	7.91	1. total duration of claim settlement	6.90
2. professionalism claims handler	7.80	2. manner in which the victim is informed about the progress	6.94
3. prompt transfer of final payment	7.73	3. involvement in determining the amount of compensation	7.18
4. answering questions (asked by phone)	7.67	4. time lapsed between reporting claim and first contact	7.20
5. Accessibility by phone	7.61	5. Extent to which claim is proactively dealt with	7.22

(Table V: Results satisfaction survey)

Specifics

A participants' conference is held bi-annually. At this conference, the benchmark results, as well as wishes the participants might have and any possible improvements that need to be made to the survey, are discussed. Although the response figure of 23.7% for the first half of 2012 is a good result, this year more attention was paid to initiatives that positively influence the response rate.

At the participants' request, the results of the survey were also split into claims with a recovery period longer and shorter than one year. A further differentiation was made in claims with and without a legal representative. One of the conclusions was that victims who are legally represented, are less satisfied with the interim provision of information by the insurer. Thus there is scope for the insurance companies to inform victims even more actively about the progress of the settlement

process. This fits in seamlessly with the innovations of the Collective Market Agreement 15.

What can be improved?

In view of the outcome of the satisfaction survey, the participants have suggested the following points of improvement:

- discuss and clearly define the victim's requirements during interviews;
- During meetings with the claims adjuster, the progress and handling of the case must routinely be discussed (what goes well, what could be improved upon?);
- Managing the victim's expectations;
- Agreements made are confirmed in writing, with a clearly defined time span in which the victim can expect a reaction.

Quality Certification Customer orientated Insurance

As from 2011, conducting a satisfaction survey is mandatory in order to obtain the Quality Certification Customer orientated Insurance. When conducting the satisfaction survey, insurers must assess the satisfaction rating of a number of subjects.

The indicators for the satisfaction survey are:

- satisfaction about the total claims handling
- satisfaction about communication (showing empathy, transparency, written communication)
- satisfaction about provision of information (information about the handling of personal injury claims, clarity of information, interim progress reports)
- satisfaction about running time/speed (time lapsed between first notification/first contact, total duration settlement).

The reliability of the survey is of paramount importance. During the certification audits, particular attention is paid to if and how the management ensures that the questionnaires are sent out upon completion of the claim.

The Quality Certification Customer orientated Insurance has positively influenced the degree of participation in the PIV Satisfaction Survey. Fourteen insurance companies already partake. Two insurers, who presently carry out their own satisfaction survey, are currently reviewing how these can best interlink with the PIV Satisfaction Survey.

Pivotal role

The PIV endorses the trend that many insurers measure how the victim has experienced the claims settlement. This ensures that the focus is on what the victim finds important and on improvement schemes that can enhance satisfaction levels. This way, the person who really matters is put at the heart of the claims settlement process.

5. The PIV as Dynamic Knowledge Centre

5.1 – Twelfth PIV Annual Conference: 'A different tone in the personal injury settlement'

The twelfth PIV annual conference took place on 30th March 3012 in the Hotel Theater Figi in Zeist. With in excess of five hundred participants, all places were filled.
The theme of the conference was 'a different tone in the personal injury settlement'. Communication and the tenor in which it is conducted ran as a common thread through the day's programme, but various other subjects were also broached. Unique to this year's annual conference was that different tones could literally be heard: The 'PIV blues band', which had been specially formed for the day, provided swinging intermezzos between the speakers. The eight member band came from both insurers and legal representatives

Morning session

Jørgen Simons and the medical advisors **Angelique Reitsma** and **Wilco Blanken** presented their views on the new medical paragraph of the Code of Conduct for Handling Personal Injury Claims (GBL). Particular emphasis was placed on direct consultation between the medical advisors, as well as between medical advisors and claims adjusters.
Gerjo Strijker, Laurens Buisman and **Peter Sonder** shared their experiences with various pilot schemes in which one joint medical advisor is instructed. The first experiences were very positive.
Arno Akkermans, in his introduction, propounded that insurers can assist in the victim's recovery process by a proactive stance in the claims settlement. It is important to initiate the first contact, in which they lend a listening ear and empathise with the victim. The draft collective market agreement Provision of Information gives the insurer more scope to do so.
Bert de Hek – judge at the Court of Appeal in Leeuwarden – illustrated through two cases how important it is that the victim is always given recognition. His recommendations were to always show respect, avoid disputes about causation and to allow time for convalescence.

Afternoon session

The participants were given an opportunity to attend workshops on a variety of subjects, namely:

- privacy laws and personal injury settlement
- the experience of court judges with whiplash cases,
- employers' liability, mediation,
- the Social Support Act (Wmo),
- proportional liability and
- the social media in the personal injury settlement.

Finally **Eelco Wisman** – director-owner of *Outwise Personalia Improvement* – encouraged everyone present to let go of old habits, roles and patterns and to be amenable to new developments.

The **PIV Giraffe** is annually awarded to a person (or organization) who, through new initiatives, 'sticks out his neck' to improve the personal injury claim settlement. This year it was awarded to the District Court of The Hague for their initiative to always order a conciliation hearing before a full panel of judges in personal injury proceedings. The claimant himself is expressly involved in these hearings. The Giraffe was presented to **Sonja Hoekstra-Van Vliet** – one of the instigators of this initiative – by **Mark van Dijk**, director of Korevaar van Dijk Letselschade.

5.2 Ninth PIV Injury Plaza

The ninth PIV Injury Plaza took place on 10th May 2012. At these meetings, delegates from insurers and legal representatives meet informally and, if and where possible, discuss specific claim files. Contact, after all, (almost) always runs smoother if you know the person on the other side.
Some 100 people attended the Injury Plaza. It was once more perceived as useful and pleasant to meet each other in person. Over the last number of years there has been increasingly more emphasis on the positive influence of personal contact between insurers and legal representatives. Insurers – following the example of the Injury Plaza – regularly arrange inter-company meetings.
For those who did not have any claim files to discuss, there was ample opportunity to exchange thoughts in a relaxed atmosphere. In addition, Eva Deen – a lawyer at The Injury Board (DLR) – spoke about her work at the Mediation Desk.
The venue of the Injury Plaza is normally the Conference Centre De Roskam at Houten, but this year it was combined with the annual Raasveld Congress of Raasveld Expertises and the Support Trade Show and consequently held in the Jaarbeurs in Utrecht. The Support Trade Show is for and about people with a physical handicap, their families and/or those with a professional interest.

5.3 Back to school: Current Developments Lecture 2012

On 25th September 2012 and 4th October 2012, 131 people attended the Current Developments Lecture 2012.
Dr. Chris van Dijk of Kennedy Van der Laan Advocaten in Amsterdam, discussed and clarified the jurisprudence from October 2011 up to the day of the lecture.
Bart Neervoort – director of Medarba/chairman of the NVMV – dedicated his lecture to the deployment of mediation. He also discussed the 'Recommendations to prevent and/or solve disputes in the injury claims process', that were launched by the Dutch Association of Insurers in July 2012.
And last, but certainly not least, **Dr. Carolien van Weering** of LegalTree Solicitors, The Hague/mediator- explored and clarified the *ins and outs* of the Data Protection Act in relation to medical data.
Because the two courses are also open to candidates from 'non-insurers', we increasingly welcome more colleagues from legal representatives. There was ample opportunity to exchange experiences during the `ecumenical' drinks and extensive Italian buffet.
The Current Developments Lecture is organised each year as a refresher and enhancement course. Participants are former students of both the Training for advanced injury claims handlers and claim adjusters, and the Moderate Injuries Course (Mzl) by *OSR Juridische Opleidingen* and the Severe Injuries Course (Zwl) by NIBE-SVV.
If there are places left, colleagues from insurers and claims adjusters are welcome.

5.4 PIV-Bulletin

In 2012, eight editions of the PIV-Bulletin were published. The circulation initially rose to 2,750 and we are pleased to welcome increasingly more readers from among others the judiciairy and the medical science. We aspire, wherever possible – for reasons of cost reduction and sustainability – to distribute a digital copy of the magazine to staff members and employees of insurers. The number of hard copies will therefore eventually decrease.

6. Organisation

Staff
On 1st April 2012 J.J. Daniëls retired as advisor.

Board of Management
Th.J. Woudstra (Achmea Claims) withdrew in September 2012 as chairman and member of the Board of Management, and Dr. Ing. R. Van Gijzen (ASR Nederland) withdrew as vice-chairman and member of the Board in October 2012. Both positions are presently vacant.

Mrs. Dr. L.T. Suur (Unigarant) took the place of the late Dr. J.F.M. Hennekam.
The members of the Board of Management chose from the midst Dr. C.J.A.M. Schneijdenberg (Allianz Nederland Claims) as new chairman.

Advisory Board
Mrs. Dr. H.L.M. Hoekstra of Nationale-Nederlanden joined the Advisory Board in the middle of 2012.

Editorial Board
Mrs. Dr. C.P.W.M. Mathijssen withdrew in the spring of 2012.