Submission in response to the *Victorian Workers' Compensation System: Independent Review into the Agent Model and the Management of Complex Claims Discussion Paper – August 2020*

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Background

The Australian Centre for Justice Innovation (ACJI) was established in 2011 as a research centre in the Faculty of Law at Monash University. ACJI conducts high quality research and evaluation to support effective legal policy and practice innovation. ACJI's research provides an evidence base for effective improvements to law and justice systems and increased accessibility for system users and stakeholders. ACJI researchers have led research on a range aspects of injury compensation systems, including:

- dispute resolution systems and processes;
- the use of legal services by claimants;
- the health impacts of compensation claims processes on claimants;
- innovative approaches to independent medical assessment; and
- the experiences of injured workers with long-term compensation claims.

This submission is provided by Dr Elizabeth Kilgour and Associate Professor Genevieve Grant.

Associate Professor Grant is the ACJI Director and has an extensive track record of interdisciplinary research partnerships with government agencies, courts, compensation schemes, regulators and dispute resolution organisations. A/Prof Grant has a PhD in Public Health and Law from Melbourne University, and completed the Work Disability Prevention Strategic Training Program at the University of Toronto, Canada. Her experience includes academic roles in Public Health and work as personal injury litigation lawyer and in legal policy development. She teaches litigation and dispute resolution, legal ethics and company law at Monash Law School.

Dr Kilgour is a Senior Research Fellow at ACJI. She has a PhD in Public Health from Monash University and also completed the Work Disability Prevention Strategic Training Program at the University of Toronto, Canada. Dr Kilgour is a registered and endorsed Counselling Psychologist with over 20 years' experience of working with transport accident and workers' compensation clients. She was a member of the advisory panel that developed the Victorian WorkCover Authority's Clinical Framework for the Delivery of Psychology Services to Injured Workers (2006). Dr Kilgour's PhD focused on injured worker and health care provider experiences of workers'

compensation systems. It investigated injured worker experiences with Australian and international workers' compensation systems, and sought opinions from 53 psychologists regarding the Victorian WorkSafe system. Dr Kilgour was principal researcher and author of the *Victorian Injured Workers' Outcome Study 1 – A qualitative enquiry into outcomes for injured workers in Victoria who have longer term claims* (2018).

The Victorian Injured Workers' Outcome Study 1 Report 2018 (VIWOS 2018)

The VIWOS 2018 report elaborates on findings that are most relevant to the questions posed by this Review. A copy of the report can be accessed at https://research.iscrr.com.au/__data/assets/pdf_file/0009/2076570/146_REP_RES_VIWOS-Study-1_Report.pdf

The VIWOS 2018 report details the views and experiences of workers' compensation claimants and those who work with them. Thirty-six injured workers with complex and long-term claims (LTIWs) from across Victoria were interviewed. Sixteen LTIWs had claim duration of between 52-130 weeks, and 20 LTIWs had claim lengths between 131-312 weeks. Interviews were conducted with LTIWs from August to October 2016.

Sixteen professionals who worked with long term injured workers across all sectors of the workers' compensation system were interviewed between December 2015 and February 2016. These 'key informants' were drawn from a range of fields representing Health Care Providers, Insurance Agent staff (Claims managers, Injury Management Advisor and Team leaders), Independent Medical Examiners, Personal Injury Lawyers, Mediators (from WorkCover Assist, Union Assist, and the Accident Compensation Conciliation Service), and a large Employer in the health sector with services across Victoria.

While the VIWOS 2018 report has informed much of our response to the discussion paper, we also speak from our professional experience and on the basis of the research we have published. We are available to clarify any aspect of this submission or provide additional information if required. We confirm that our submission may be quoted in the report to the Minister for Workplace Safety and that our submission may be published on the Review website.

Identifying and assessing complex claims

Discussion Paper Question 3: What are the features of a claim for worker's compensation that make it complex, or at risk of being complex?

Complex workers' compensation claims have been characterized in the Review as those that progress beyond 130 weeks and "involve workers who were unable to work long term and/or required long term medical treatment" (Victorian Ombudsman, 2019, p. 6). However, the elements that contribute to claim complexity can exist and/or develop well before 130 weeks. The VIWOS 2018 study investigated claims from 52-312 weeks in an effort to understand what influences and maintains, as well as mediates, the development of complex and long-term claims.

There are multiple factors that contribute to claim complexity. Individual worker attributes and injury characteristics, claimants' experience with insurers and claims administration processes, rehabilitation and workplace factors, all interact to generate complexity in claims. Some of these factors are modifiable whilst others are not.

Individual factors that influence claim complexity include severity of injury, age, place of residence, attitudes towards recovery, lifestyle habits and health literacy. The severity of injury influences recovery outcomes, and older workers recover from injury more slowly. Access to rehabilitation services and return to work (RTW) opportunities are dependent upon place of residence. Rural locations have fewer medical services and more limited job opportunities. Factors such as injury severity and age are finite, and place of residence is not easily modified.

Personal attitudes of injured workers (IWs) that can influence speed and extent of recovery and RTW trajectory include viewing recovery chances as poor, and/or taking a passive role in managing injury and rehabilitation, and/or having a fear of re-injury. Fear of re-injury can mean injured workers are less engaged with rehabilitation programs and wary of RTW. Attitudes towards recovery, lifestyle habits and health literacy are individual factors that can be modified (with the assistance from skilled health care providers) to improve recovery outcomes. A slower recovery adds to claim complexity (Kilgour & Kosny, 2018, pp. 16-17).

Workplace factors that contribute to claim complexity include employers' response to the injured worker, administration of claims, and non-compliance with RTW obligations.

In the VIWOS 2018 study, a range of unhelpful actions by employers were reported by LTIWs as having a negative impact on their recovery and RTW, and often gave rise to disputes which then served to complicate and prolong claim duration. Such actions included:

- Employers discouraged LTIWs from making a claim, failed to lodge their claim, or incorrectly lodged a claim for medical services but not wage replacement.
- Employers did not provide appropriate pay records, effectively preventing LTIWs from meeting WorkSafe requirements to prove their pre-injury income. In some instances, LTIWs were without any income or medical treatment for weeks.
- Some employers pressured claims managers to deny, or pend and investigate claims.
- Negative response from employers towards LTIWs when delivering certificates of capacity for them to forward to WorkSafe insurer – LTIWs reported they were considered by employers to be a nuisance and administrative burden, as well as threatening the worksite harmony and costly to the business as they could be seen as an example for other workers to make a workers' compensation claim.
- No assistance with RTW or active discouragement of LTIWs' efforts to RTW by employers.
- Not retaining injured workers once the 52-week obligation period expired.

Employers can also have a positive influence and can prevent claims becoming complex or delaying RTW. Essentially, positive actions by employers can be summarised as being supportive of injured workers at time of injury and when lodging a claim, remaining in contact with them throughout their rehabilitation, and facilitating their RTW (Kilgour& Kosny, 2018, pp. 17-20).

Compensation system and processes

The interactions IWs have with compensation systems and associated administrative processes can influence the perceptions that IWs hold about themselves and the system that is responsible for their rehabilitation and recovery. Negative and stressful interactions can fuel adversarial relationships between IWs and insurers and thus increase claim complexity and impede IW recovery (Kilgour, Kosny, McKenzie, &

Collie, 2015) (Kilgour, Kosny, Akkermans, & Collie, 2015) (Grant, O'Donnell, Spittal, Creamer, & Studdert, 2014).

There are several aspects of the claims management process that are amenable to modification. Change in these areas could reduce claim complexity and duration whilst improving IW experience and recovery outcomes.

Deferred lodgement of claims

The lodgement of claims can be deferred by IWs and/or employers (as previously mentioned). Injured workers may be hesitant to make a claim because of stigma about having a workers' compensation claim and receiving compensation. Others fear they will not be believed, especially if the injury is not physically obvious or if it is psychological in nature. Some LTIWs only filed a claim once their own financial resources were depleted. They reported using sick leave and annual or long service leave entitlements, hoping they had only a minor injury and would recover and RTW quickly. (Kilgour & Kosny, 2018, p. 32)

Deferred lodgement of claims can result in injuries becoming entrenched and chronic before appropriate treatment is received, thus contributing to slower recovery and adding complexity to claims.

Investigation and pending of claims by agents

When claims are investigated, they are pended for 28 days (before the agent must meet legislative requirements to advise the worker of the claim determination decision). The VIWOS 2018 study found that pending and investigation of claims seemed to occur routinely for particular types of claims, such as mental disorder claims. A claims manager from one agent reported that while 94% of physical injury claims were immediately accepted, approximately 30% of psychological claims were accepted. The experience and injury-related knowledge of a claim manager was influential in whether or not pending and investigations of claims occurred.

Delays in claim acceptance added further worry for workers as it meant wage entitlements and medical treatment were also delayed. Investigating the worker and the circumstance of the claim can also foster an adversarial and distrustful atmosphere between the injured worker and their employer and insurer (Kilgour & Kosny, 2018, p. 33).

Claim manager turnover

The turnover of claim managers has a huge impact on IW recovery and the progress of the claim. Change in claim manager can mean knowledge of the claim is lost. Changes in claim manager can cause delays in approvals and provision of services which can give rise to disputes. The impact of personnel changes on claims management is discussed further in Question 7.

Disputes and delay in resolution of disputes

Many participants interviewed for the VIWOS 2018 study viewed the workers' compensation system as an adversarial system where claim management decisions were driven by cost containment concerns rather than facilitating IW recovery.

Medical services and income benefits can be terminated on the basis of limited medical evidence (Victorian Ombudsman, 2016, 2019) and the decisions may, or may not, then be appealed by IWs. Injured workers might need to navigate several processes in the course of appealing a decision. Navigating an appeal via an internal review, through conciliation, sometimes then via the medical panel and finally to a court hearing is a lengthy process that can take years. There are potential delays at each step in the appeal process.

Whilst the Victorian Ombudsman (2016) reported the high proportion of cases that are overturned at court (75% of 130-week terminations), and it is the IW who feels the impact of the disputes and the appeal process. Going without income support or medical treatment adds worry and stress, suspends IW recovery, and cripples claims progress with added complexity integral to the dispute process (Kilgour & Kosny, 2018, pp. 41-50).

Legal assistance

The engagement of a lawyer by a claimant is commonly seen as a marker of complexity in injury compensation systems. In reality, however, there a range of reasons why an injured worker might engage a lawyer and the pathways to lawyer use are not well understood. An emerging body of research has identified the need for and benefits of high-quality empirical analysis of trends in the use of lawyers in compensation schemes (Scollay, Berecki-Gisolf, & Grant, 2020, Scollay, Berecki-Gisolf, Batagol, & Grant, 2020).

The VIWOS 2018 report identified that LTIWs' primary reason for seeking legal assistance was to find out about their rights or locate an advocate to assist them to obtain entitlements. There were points in the life of a claim where LTIWs commonly sought legal advice and help:

- time of claim lodgment if experiencing difficulty with employers or insurers;
- close to the 52-week point (when the employer's obligation to re-employ the worker ends); and
- if income or medical benefits were terminated and disputes were unsatisfactorily resolved through internal reviews by agents or through conciliation.

Discussion Paper Question 4: How, and at what stage, should claims for worker's compensation be assessed as being complex, or at risk of becoming complex?

Complexity of claims (and potential risk) can be assessed at multiple times throughout a claim, as outlined below:

- At time of accident: Severe injuries should be managed differently from the beginning of the claim. Catastrophic injury (e.g. spinal or brain injury), or major psychological sequelae (e.g. life threatening with severe PTSD) should have some claim administration automated (e.g. less frequent medical certificates, automatic granting of serious injury certificate). Similar to the TAC model, claims could be classified by injury type instead of claim stage.
- At claim lodgment: Complexity increases if claim is pended or investigated, if employer disputes claim, and/or lawyer is engaged.
- When treatment commences, and when ongoing treatment is requested: Health care practitioners should screen biopsychosocial factors according to the Clinical Framework principles which help identify barriers to recovery.
- At regular intervals throughout the claim. Case management meetings (with the IW and all treating practitioners) should be conducted to review and refine a coordinated rehabilitation and RTW plan.

The repetitive use of IMEs should be avoided, however, when they are conducted the examiner should be asked to comment on contributing factors (and potential solutions) to claim complexity.

Case management of complex claims

Discussion Paper Question 5: Are current case management practices able to support and treat the individual needs of injured workers with complex claims?

Case management practices are not sufficiently individualized. This means some LTIWs miss out on needed services and others are forced to participate in programs or services that they consider unnecessary and find unhelpful (Kilgour & Kosny, 2018, pp. 51-52).

Discussion Paper Question 6: If your answer to question 5 is yes, describe how current case management practices respond to the individual needs of injured workers with complex claims.

Discussion Paper Question 7: If your answer to question 5 is no, describe what needs to change in the case management practices of complex claims so that injured workers are better supported and treated.

Reduce change in claim managers

Frequent changes in claims managers are a hallmark of the WorkSafe agents. Changes in claims managers occur at arbitrary stages of a claim (an effort to create stage expertise e.g. claims managers handle either lodgment phase or long-tail claims). These changes reduce job satisfaction for claim managers which, along with high case-load numbers, contributes to high staff turnover. Frequent changes in claims managers – both at different stages of claim and staff turnover during the stages – mean the history of claim is lost and approvals for services are delayed.

In the VIWOS 2018 study, LTIWs reported they were constantly required to repeat their history and needs to new claims managers. Repetition of injury details can be re-traumatizing for IWs, and also requires them to re-focus on accident events and painful memories rather than thinking about their future recovery and RTW.

Long term injured workers described how claims managers were hard to contact, and slow to return calls and/or email messages. They described feeling unsupported,

frustrated and confused, and hampered in their efforts to direct or participate in their rehabilitation. Lack of information and assistance also fostered disrespect and resentment from LTIWs towards insurers. The LTIWs perceived that claims managers were intentionally changed as a cost-containment measure: if agents prevented claims managers from developing a full understanding of the LTIW's circumstances, they were less likely to approve services to meet their needs (Kilgour & Kosny, 2018, pp. 23-26).

Streamline capacity for work certification and lodgment

For LTIWs with complex health conditions, or a projected 'long haul' recovery (for example, cases involving spinal surgery), being reviewed by a GP every month was considered both an expensive waste of the GP's time and demoralising for the injured worker. Although the length of time between medical certificates can be varied, health care providers and LTIWs reported that in practice, extension of certification periods happened infrequently. Repeatedly seeing doctors only for certification purposes could keep LTIWs focused on being unwell and reinforce the sick role, thus delaying recovery and prolonging claim duration (Kilgour & Kosny, 2018, p. 23).

Injured workers are required to provide their certificates of capacity to their employers who are responsible for lodgment. This requirement is inappropriate in cases where the relationship between IW and employer has deteriorated. Long term injured workers reported certificates and other paperwork frequently being lost by insurers. Allowing IWs to lodge documents electronically would address these concerns.

Whilst only GPs can provide initial certificates of capacity, Physiotherapists, Osteopaths and Chiropractors can provide continuing certificates of capacity for injured workers with physical injuries. Approval for Psychologists to provide continuing certificates of capacity for IWs with psychological claims (as allowed in NSW by SIRA) would save IWs from attending unnecessary repeat medical appointments, and reinforce the need for return-to-work focused discussions to be included in psychology treatment.

Financial incentives and agent decision making

Discussion Paper Question 8: What role do the current financial incentives for agents have in the agent's management of complex claims?

As the contracts between WorkSafe and agents are confidential and the remuneration structures are not publicly available, it is impossible for us to evaluate the role of financial incentives precisely. However, as noted by the Victorian Ombudsman (2016, 2019), financial incentives linked to claim termination have a negative impact on claim management as termination becomes a priority for agents.

Commentary on financial incentives linked to RTW across different stages of a claim indicates that it is more rewarding for agents if the IW remains off work at certain periods of the claim (Stipic, 2020). Incentives are payable to agents if a worker RTW at 13, 26, 52 and 134 weeks. If a worker has not RTW at 53 weeks, the agent will not receive a payment unless the IW remains off work until 134 weeks. This incentive structure provides little motivation to assist IW who have complex claims longer than 52 weeks, until closer to the potential claim termination date of 130 weeks.

Similarly, financial incentives linked to RTW outcomes can result in IWs being pressured to RTW before they feel ready, or to RTW to jobs they find unsuitable. Financial incentives linked to RTW mean LTIWs can be required to participate in Occupational Rehabilitation services that do not meet their vocational needs, for example, provision of Original Employer Services to LTIWs (often with work-related stress claims) who have no intention of RTW with the pre-injury employer (Kilgour & Kosny, 2018, pp. 27-31).

Discussion Paper Question 9: Do the current financial incentives for agents support prompt, effective and proactive outcomes for injured workers with complex claims?

Some claims management practices that are intended to achieve KPIs linked to financial incentives are harmful to IWs. The practice of 'doctor shopping' by agents via repeatedly sending IWs to IMEs to obtain opinions to support claim terminations has been identified as harmful to IWs by the Victorian Ombudsman (2016 & 2019).

Claims managers have also used the threat of sending LTIWs to an IME if they do not participate in Occupational Rehabilitation. Injured workers fear attending IMEs as they worry such assessments may unreasonably result in loss of income or medical

treatment (Kilgour & Kosny, 2018, pp. 42-45). The use of IMEs to challenge and deny medical services is not only also harmful to IWs, but also acts as deterrent to HCPs who become hesitant about continuing to provide services in the WorkSafe system (Kilgour, Kosny, Akkermans, & Collie, 2015). This has further consequences for recovery outcomes as it impacts adversely on the quality and timeliness of health care available to injured workers.

Discussion Paper Question 10: If your answer to question 9 is yes, describe

a. how the current financial incentives for agents maximise outcomes for injured workers with complex claims.

b. any different or additional measurements which could be linked to financial incentives to promote quality decision making by agents.

Discussion Paper Question 11: If your answer to question 9 is no, describe

a. the ways in which the current financial incentives for agents could be changed to maximise outcomes for injured workers with complex claims.

Rather than incentives being linked to terminations and inadequately defined sustainable RTW outcomes, financial incentives could be linked to timelines for quality service provision, for example:

- time taken to answer phone calls, provide information to IWs, resolve complaints, provide income support payments, provide medical services and to pay for medical services; and
- time RTW is sustained, with the level of the incentive increasing with the length of time the IW remains employed.

Similar initiatives could connect to the number and resolution of complaints and disputes. Care would need to be taken, however, to ensure that any such incentives were structured in such a way that complaints and disputes were not suppressed, given their potential for contributing to improved practice.

b. any different or additional measurements which could be linked to financial incentives to promote quality decision making by agents

Financial disincentives need to be added to discourage poor performance, for example, penalties if agents are found to breach specific performance measures, e.g. not complying with ACC, Medical Panel or Court rulings. The financial penalties should be sufficiently severe to outweigh the potential financial gains that agents can obtain by unconscionable actions.

Promoting quality in decision-making, improving oversight of agents by WorkSafe and evaluation measures and successful practices in other schemes (Discussion Paper Questions 12-19 and 23)

The Discussion Paper raises a number of questions about quality decision-making, oversight of agents and evaluation measures. We address these questions collectively, drawing on our accumulated experience undertaking research and evaluation work with a range of injury compensation, insurance and dispute resolution organisations. In doing this, we identify some successful practices in other schemes for the Review to consider.

Transparency, open data and independent evaluation

That it has taken two investigations by the Ombudsman – the second of which identified decisions and actions that were 'not only unjust, unreasonable and wrong', but 'downright immoral and unethical' (Victorian Ombudsman 2019, p 5) – to get to this Review is of great concern. Fundamentally, these investigations demonstrated a deep and underlying problem with transparency and accountability in the operation of the Victorian workers' compensation scheme. This is particularly so in light of the Ombudsman's findings that there was strong evidence that her 2016 review drove bad practice underground, rather than stopping it from happening (Victorian Ombudsman 2019, p 4).

To achieve better outcomes for injured workers and the Victorian community, including through quality decision-making, agent oversight and evaluation, a far greater commitment to transparency in the workers' compensation system is required. This would represent a significant change to current practice. There are however a number of easily achievable mechanisms to advance this objective. Chief

among these is making more data available about activity in the scheme on a real-time basis. A useful example of such an approach is the State Insurance Regulatory Authority's Workers Compensation System Dashboard, which provides a range of useful and interactive information about a number of aspects of the performance of the NSW workers' compensation scheme, including claims data, payments data and return to work rates. Crucially, this information is made available as open data to download without the need for permission from the regulator.

SIRA's practices are in contrast to the very limited amount of information on the WorkSafe Victoria Data and Statistics page, which provides a static annual claims statistical report and workplace fatalities report. Additionally, as at the date of this submission there were only 3 WorkSafe Victoria datasets published on the DataVic Victorian Government open data platform. We note that the first of the DataVic access policy principles stipulates that 'government data will be made available unless access is restricted for reasons of privacy, public safety, security and law enforcement, public health, and compliance with the law'. The example set by SIRA clearly shows that it is possible to do better with WorkSafe's data, and to do so would improve transparency about the operation of the scheme. Additionally, WorkSafe should consider implementing a Freedom of Information disclosure log, to promote greater transparency by making material that has been disclosed under the Freedom of Information Act (subject to some exclusions) available to the public. This is a step not required by law, but represents good practice. VicRoads is an example of a Victorian agency that has implemented such a log 'in the spirit of promoting greater openness and transparency in government' and 'to make it easier and quicker for the public and media to access material which has already been disclosed under the FOI Act': the VicRoads disclosure log is available here.

Independent and high-quality evaluation and research is another key mechanism for WorkSafe to employ in improving the transparency of its practices, especially as it continues to respond to the recommendations made by the Ombudsman. The results of this kind of work should be made public. As a rapid way to explore the extent of published evaluation research in the Victorian workers' compensation scheme since 2017, we conducted a search of Google Scholar, using each of the search phrases (1) 'WorkSafe Victoria' AND data AND evaluation and (2) 'Transport Accident Commission' AND data AND evaluation, for the period 2017 to 2020. This search

yielded n=372 records for WorkSafe Victoria, and n=562 for the Transport Accident Commission (that is, there were only two thirds the number of records for WorkSafe compared with the Transport Accident Commission). While this approach yields only an approximation of evaluation research finding its way into the public domain connected to the two organisations, it suggests that there is a greater contribution to the published evidence base being made by evaluation research in Victoria's transport accident scheme. We note that the Ombudsman's 2019 report identified a number of initiatives introduced by WorkSafe Victoria, but little evidence of formal and published independent evaluation of this work. The absence of rigorous evaluation limits the ability of WorkSafe, stakeholders and the community to understand the performance and effectiveness of initiatives introduced in response to the Ombudsman's recommendations.

Innovation relating to independent medical assessments

One of the persistent problems identified by the Ombudsman is the use of Independent Medical Examinations in the Victorian workers' compensation scheme. We note that a novel approach to medical assessment, the Joint Medical Examination (JME) process was introduced by the Transport Accident Commission in consultation with its key stakeholders in 2014 and refined in 2016. This initiative, unique to Victoria and its transport accident compensation system, has was intended to reduce the number of examinations that clients undergo, to speed facilitation of entitlements and improve client outcomes.

In 2019 ACJI produced an evaluation of the JME Process. The Review identified that there are substantial advantages associated with the JME process, particularly for clients. The JME process reduces the number of assessments clients undergo, resulting in decreased delays. Some clients and assessors report deriving benefit from their perception that assessors are jointly appointed rather than being appointed by one party or the other. Importantly, these perceptions help address and counteract some of the negative psychological impacts for clients, that may be associated with medical assessments as a mechanism for determining the provision of, and entitlement to, benefits. We would be pleased to make a copy of the JME Process evaluation report available for the Review.

Use of complaints data to drive quality decision-making

The Ombudsman's inquiries indicated that there is insufficient use of complaints data by WorkSafe as a resource to drive quality decision-making. Rather than separate and individual problems to be resolved, complaints represent a data resource for understanding what activities and decisions in a scheme are problematic, particularly where there are activities and decisions (and decision-makers) associated with greater volumes or types of complaints.

A significant body of research indicates that many people confronted with a legal problem will take no action in response to it (see, for example, Coumarelos et al, 2012). For that reason, where an injured worker has taken the step of complaining about their experience of the workers' compensation system, there are likely many more with a similar experience who do not come forward. WorkSafe should be encourage to take a dispute prevention approach by better utilising complaints to inform improved practice.

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