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ANMF (Vic Branch) Submission to Department of Justice and Community Services

Submission to Independent Review into the Agent Model and the Management of Complex Claims

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21 September 2020

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21 September 2020

Mr Peter Rozen QC
Reviewer
Independent Agent Review
Service Delivery Reform, Co-ordination and Workplace Safety
Department of Justice and Community Safety
Level 30 / 121 Exhibition Street
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Email: agentreview@justice.vic.gov.au

Dear Mr Rozen

Re: Victorian Workers' Compensation System: Independent Review into the Agent Model and the Management of Complex Claims

The Australian Nursing and Midwifery Federation (Victorian Branch) welcomes the opportunity to make a submission to the Victorian Workers' Compensation System: Independent Review into the Agent Model and the Management of Complex Claims.

As the union representing over 90,000 nurses, midwives and carers in Victoria, many of whom have been injured as a result of their work, we have significant experience of the current WorkCover system, and the interaction with the agents. We also have experience with how the system, as it is currently set up, not only often fails to assist in the recovery of our members who experience workplace injury, but in fact serves to further injure them in the process of dealing with the system in an attempt to access their entitlements.

ANMF (Vic Branch) supports the submission of Victorian Trades Hall Council, and the recommendations made therein. Our submission further draws on the direct experience of frontline Victorian nurses, midwives and carers whom we have assisted through their claim journey, and focusses on the potential areas of improvement, making recommendations to provide a system that focusses on the rehabilitation and recovery of workers injured at work through no fault of their own, to the best possible state.

I welcome the opportunity to discuss our submission further and invite you to contact me directly to arrange. I also urge your direct contact on any issues of relevance to our members that arise during your inquiry.

Yours sincerely

Lisa Fitzpatrick
Secretary
ANMF (Vic Branch)

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Introduction

Background: About the ANMF (Vic Branch)

The Australian Nursing and Midwifery Federation (ANMF) (Victorian Branch) is the peak professional and industrial body for nurses, midwives and personal care workers in Victoria. We have more than 91 000 members working in Victorian health services, including in hospitals, mental health services, aged care facilities, community health services, maternal and child health services, schools, alcohol and other drug services (AOD), medical clinics, home visiting services and prisons.

Our strong and unified membership has enabled us to make a real difference to the quality of nursing care in Victoria and to the health and wellbeing of Victorians. For example, it was the drive and commitment of our members that saw Victoria introduce the world's first mandated nurse/midwife to patient ratios in 2001. The ratios, which have since been improved and expanded, have been so successful in increasing the capacity of health services to provide quality care for patients/clients that they have now been enshrined in legislation through the Safe Patient Care Act 2015. Additionally, ANMF (Vic Branch) has a strong focus on occupational health and safety, and the prevention of injury and illness to our members. Pursuit of the implementation of No Lift programs and the development and roll out of the 10 Point Plan to end violence and aggression are two significant examples which have made a difference to the number of nurses, midwives and personal carers injured as a result of their work. However, we are also committed to supporting our members who suffer injury or illness resulting from their work.

ANMF (Vic Branch) has been representing our members in the workers compensation system for many years, and has experience from the initial injury process and making of the claim, right through to continuing to support members who may have been in the workers compensation system for many years, and are having to continually represent them at conciliation conferences where their entitlements are chipped away, piece by piece, by decisions made by 'those without a face'. Each decision in itself is insufficient in monetary value to take to court, however in combination serve to reduce the ability of our members to continue to participate in society and undertake any form of recovery.

The health care and social assistance industry, of which our members are a part, accounts for 14.7% of all claims, although it accounts for only 11.8% of all hours worked in Victoria1. In the 2019 calendar year, there were 941 mental injury claims reported as at 1 Jan 2020, and 3,446 physical injury claims for the same period2. Additionally, data presented at the June 2020 WorkSafe Stakeholder Reference Group identifies that the healthcare and social assistance industry has a higher number of claims than any other industry in Victoria. We further know that there is a significant reticence by our members to make a claim. Further,

[1] WorkSafe Victoria, Draft Compliance and Enforcement Priorities, provided 22 July 2020.
[2] Ibid.

we are aware that there are employers who provide 'Early Intervention Programs' which actively discourage members from making a claim when they are injured. Consequently, our members (and our organisation) have a significant experience of the workers compensation system.

The 'system' as it currently operates is an unwieldy beast, which appears to be less focussed on providing opportunities for recovery and return to work for workers injured through no fault of their own (although often through a fault of their employer) and is more focussed on 'functioning'.

We are strongly committed to a workers' compensation system that allows all Victorians requiring compensation to receive best practice, person-centred, recovery-focussed care through the health practitioner and facility that best achieves optimal outcomes for injured or ill workers.

Throughout this submission, in order to provide focus, reference is made to the questions contained within the Victorian Workers' Compensation System: Independent Review into the Agent Model and the Management of Complex Claims Discussion Paper August 2020.

Additionally, ANMF (Vic Branch) has provided a number of case studies throughout the submission which are real cases of our members in order to illustrate the effects of the system.

Identifying and assessing complex claims

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

Defining a claim as complex simply because it extends beyond 130 weeks is overly simplistic, and does not adequately consider the relevant aspects of claims, particularly the reference to individual circumstances of claimants. Additionally, it does not recognise that potentially this claim has only persisted to this point due to mismanagement in the earlier phases of an otherwise 'uncomplex' claim.

ANMF (Vic Branch) defines complex claims simply as 'those which require active and ongoing engagement and clinical interventions'. These claims will often languish and lack progress without such activity, which is required in a team-based approach by a number of parties, including the worker, employer, treating practitioners, and the managing 'agent'. These can be distinguished from the 'simple' claims, which are those whereby the benefits / medical and like payments are made, and the recovery is relatively simple.

Psychological claims are susceptible to becoming complex claims, due to the difficulties associated with contact and interventions. Working with workers with psychological claims requires a specific skill set in order to be able to appropriately communicate with workers at the right time, and ensure that they are receiving appropriate support and assistance. Many of the primary psychological claims our members experience are as a result of:

- Inappropriate workplace behaviours they have been subjected to, sometimes as a result of management action and others as a result of interpersonal interactions;
- Single incidents of occupational violence and aggression or other distressing incidents, causing anxiety and other psychological conditions in relation to returning to the workplace;
- Multiple distressing incidents over the course of their employment, resulting in anxiety, depression, post-traumatic stress disorder; or
- Stress and workload.

ANMF (Vic Branch) experience has shown that these claims can become particularly complex where there is a lack of acknowledgement of the cause of the initial injury or illness, as well as inappropriate contact from the employer in the initial injury / illness period. This may be in terms of perceived pressure from the employer to return to work prior the member being psychologically ready (and before they are medically certified), or a complete lack of contact, leaving the member feeling as though they are not supported. Further, much of the early contact from many of our members' employers is in trying to progress them through their 'early intervention process', and dissuading them from making a claim. However, those who do put in a claim feel an initial sense of betrayal to their employer. They are then forced through a circumstance investigation in order to assess their claim at a time when they are acutely unwell. Often they will opt not to participate in

this process due to the additional psychological stress that it causes. This will regularly result in the rejection of their claim, as the agent only considers the information provided by the employer, rather than the full circumstances surrounding the injury. This process further exacerbates the original psychological injury, with many of our members opting not to progress further in the dispute of their claim with the view to trying to get well. For those who do opt to progress, they must then prepare for and attend a conciliation, with the associated fear of facing their employer (who they believe has not supported them), inevitably to have their rejection maintained by the agent at conciliation, and therefore facing the prospect of taking the matter to court. This all results in exacerbating an injury that may have otherwise resolved. There is hope that the 'Provisional Payments Scheme for Emergency Workers Pilot' will identify the benefit in early treatment and access to medical services for these claims, with the view to extending this beyond emergency workers, and reduce the need for such adversarial situations. However, this scenario will remain, as the pilot and proposal covers only medical expenses, and therefore these members will still be subject to the injurious processes of the system to obtain weekly payments.

Claims that involve secondary psychological issues are often complex, because once the initial physical component of the claim has resolved, the full claim has not, and the individual worker remains unfit for work. In ANMF (Vic Branch)'s experience, there are three common factors that contribute to this:

a) The workplace has failed to acknowledge and address the cause of the original injury or illness, leading to an ongoing fear in the worker that if they return, they will experience the same or similar situation;
b) The workplace has failed to contact and provide support to the worker immediately after they become aware of the injury / illness or incident; and
c) The workplace has failed to communicate adequately with the injured / ill worker throughout the claims process

Many injuries and illnesses that developed over time also have characteristics that may indicate that they will become complex claims. Our members often make a claim after many years of exposure to conditions that have caused their injury, and therefore there is significant damage done, either physical or psychological. This can sometimes indicate that there will be substantial interventions required to address their condition (which will often be unlikely to resolve completely). This can also result in difficulties in relation to recovery and rehabilitation, as well as return to work.

Claims that extend up to and beyond 52 weeks immediately become complex claims due to the lack of employer obligation under the *Workplace Injury Rehabilitation and Compensation Act 2013* (Vic) to provide them with suitable duties in relation to their return to work. This regularly results in members who may be comfortably undertaking suitable duties, and progressing in their capacity, having these duties withdrawn, with the only way to reinstate them to take this down an industrial / equal opportunity / reasonable

adjustments pathway i.e. commencing further proceedings against their employer. Additionally, members whose treatment is still occurring coming up to the 52-week mark are often not given the opportunity to recover from the treatment and determine the capacity at that point. These members, and those with no capacity at 52 weeks, often face the termination of their employment. This results in a lack of opportunity for them to return to work in suitable duties (as their only option for suitable duties has been taken away), and therefore leaves them subject to the workers compensation system. The consequence of this is that when they are assessed at 130 weeks (or before) in relation to their capacity for work, they are found to have capacity for some work, which is often not suitable, nor takes into account their education and experience. These members are then lost to the health system more broadly but are also removed from the workers compensation system and are required to either draw down on superannuation, apply for disability benefits, or attempt to access their income protection insurance.

The further complicating factor at 52 weeks for our members is the significant drop in income that they experience due to the pre-injury average weekly earnings (PIAWE) no longer considering their shift penalties and overtime. Therefore, at 52 weeks our members potentially experience a loss of a significant amount of income, a loss of their job, and a loss of their sense of hope that they will be able to return to work in the future as their prospect of suitable duties has been removed.

Significant physical injuries can also become a complex claim due to the requirement for multiple specialities and treating practitioners to be involved in the treatment and rehabilitation of the worker. If there is a lack of coordination between the treatment team, with a clear point of reference (i.e. a proactive and knowledgeable general practitioner in many circumstances who is willing to advocate for their patient), the treatment can become piecemeal and reduce the effectiveness of each of the interventions.

Finally, the nature of employment of the injured worker can have a significant impact on whether their claim is likely to become complex. Workers who are employed in insecure work, or via agencies or internal staff banks are more likely to have difficulties in accessing suitable duties when they have a capacity for work, and also do not have the support processes of a workplace built in.

Case Study 1: Complex claim could have been identified

45 year old nurse working in a very specialised area of nursing at a major metropolitan hospital experienced a traumatic event in the workplace in 2018, and was not provided with the appropriate psychological supports. She subsequently suffered a panic attack in the course of her employment, after being exposed to the situation. She was undergoing desensitisation treatment with her psychiatrist, and there was a further plan to desensitize her to the environment, however there was interference from her manager in relation to the suitable duties, which meant they did not go ahead at the time. This process persisted, prolonging the return to work date on the basis that they were not comfortable that she

was fit for work. This occurred for most of the obligation period (the member had not sought any assistance prior), until the employer suggested that the member would be unable to return to work without a full clearance. Whilst this member has not as yet been terminated due to ANMF (Vic Branch) advocacy (although this has been threatened a number of times), she has also not returned to her pre-injury duties, and it is unclear if this will happen. The delays meant that the psychological distress that she experienced were exacerbated, and she also lost trust in her colleagues and management as a result. This also means that her specialist skills are not being appropriately utilised.

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

The view of the ANMF (Vic Branch) is that complex claims are defined inadequately. Claims that are 130 weeks or over are long term claims and not necessarily complex. Claims are often complex in their management well before they reach the 130-week mark, and many claims become "complex" due to being mismanaged along the way. This 130-week mark is far too late to start active management of complex claims. Such management should commence much earlier in the claims process.

There are some claims which can be identified as being at risk of being / becoming complex from the start. Incidents involving severe physical or psychological trauma should be treated as complex claims from the outset, as well as other claims which present with particular indicators as outlined in Question 3 (above). This would allow early intervention to ensure that injured workers are provided access to the treatment and rehabilitation they need at the earliest opportunity.

Ideally, a review should be carried out of each claim using a decision-making framework, at approximately the 13 week mark to determine whether a claim is likely to become complex. This framework would provide the basis for making such a decision, and could be carried out either by the Agent or by WorkSafe at that point. The framework must be such that the carrying out of the review would lead to consistent decision making irrespective of who undertook it.

Examples of such decision-making frameworks include The Nursing and Midwifery Board of Australia (NMBA) *Decision making framework for nursing and midwifery*[3] or the Nursing and Midwifery Board of Australia *Framework for assessing standards for practice for registered nurses, enrolled nurses and midwives*[4]. The purpose of the *Decision making framework for*

[3] 3 February 2020 *https://www.nursingmidwiferyboard.gov.au/documents/default.aspx?record=WD19%2f29157&dbid=AP&chksum=9LilUkdFvM5AJeKIaJZd1A%3d%3d*

[4] *https://www.nursingmidwiferyboard.gov.au/Codes-Guidelines-Statements/Frameworks/Framework-for-assessing-national-competency-standards.aspx*

nursing and midwifery[5] is to provide an "evidence-based contemporary document that is to be used in conjunction with standards for practice, policies, regulations and legislation"[6] and "to guide decision-making relating to scope of practice and delegation and to promote decision-making which is:

- consistent
- safe
- person-centred/woman-centred, and
- evidence-based. "[7]

This is precisely the type of decision making required in determining whether a claim has the propensity to become a complex claim. It must be consistent, safe, claimant-centred and evidence-based. Developing the decision-making framework must be undertaken in consultation with stakeholders and also having reference to evidence in relation to factors that contribute to making a claim 'complex' in its management.

A further review should occur at the 52 week and 130 week mark, or as requested by the injured worker (or otherwise required), using a further decision making framework to determine whether the claim has become, or is likely to become, complex (or is no longer complex). This provides for regular reviews of claim progress, treatment plans and needs, and should be conducted in consultation with the injured worker and their treating practitioner.

Case study 2: Employer 'early intervention programs' are different to 'early intervention'

A registered nurse sustained a workplace injury in November 2019. However, the employer steered the member to their 'injury assistance payments' and light duties for a few months. This is commonly known as their 'early intervention program' and is consistent across numerous health services. When the member had not recovered by July 2020, the employer advised that they could no longer offer light duties, and advised that the member was unable to return to work until a full medical clearance was provided. She was then required to submit a WorkCover claim, which was rejected, and is now forced to go through the process of appealing the decision.

[5] NMBA, 3 February 2020 *https://www.nursingmidwiferyboard.gov.au/documents/default.aspx?record=WD19%2f29157&dbid=AP&chksum=9LilUkdFvM5AJeKIaJZd1A%3d%3d*

[6] Ibid, page 1.

[7] Ibid.

Recommendation 1

That the definition of a complex claim be expanded to deal with factors beyond time frames, and incorporate factors associated with individual claims

Recommendation 2

That a decision-making framework be developed to assess claims to determine their status as a complex claim or otherwise

Recommendation 3

That claims are reviewed and assessed periodically (i.e. at 13 weeks, 52 weeks, 130 weeks, and at any other time as requested by the worker, or deemed necessary) throughout the life of the claim to determine whether their status as a complex claim may have changed. Review should be in consultation with the injured worker and their treating practitioner, and the 13 week review should include an assessment of psychological risk factors.

Case management of complex claims

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

Currently it is not apparent what is likely to change if a claim is considered complex in the case management practices. ANMF (Vic Branch)'s experience with claims that would likely be considered complex does not support that the current practices are able to treat the individual needs of workers, and as such these require a complete overhaul.

Question 7: Describe what needs to change in the case management practices of complex claims so that injured workers are better supported and treated?

To better support injured workers with complex claims, the relationship between the employers and the agent needs to be severed. It must be clear that the person managing the claim is working for the best outcomes for the injured worker and is not compromised by the pressure of the 'client' in the decision-making processes. ANMF (Vic Branch) recommends that this occur through complex claims being managed by WorkSafe Victoria, and removing agents from the equation. This removes the financial incentives associated with agents, and also addresses the conflict of interest scenario. It further requires that WorkSafe Victoria and the scheme be directly held accountable for the successes or failures of the system in relation to complex claims, rather than being able to keep these at arm's length from their own responsibility.

All workers with claims should also go through a review at 13 weeks, which should incorporate a review of psychological risk factors. This is due to the factors that occur at this period, whereby a worker has potentially been off work for a period of three months. Further, the step down of payments from 95 to 80% occurs at this time, and therefore a significant reduction in income, which can contribute to psychosocial stress factors because of the process, on top of the claimed injury. This would also ensure that appropriate treatment is sought and provided at an appropriate stage (if it had not occurred prior to this).

Additionally, the management of claims should be streamed by injury type to claims managers with expertise in the particular injuries / illnesses suffered by the workers, rather than by employer, which is simply convenient for the agent. This way injured workers would have people working with them on their recovery and rehabilitation who understood and were knowledgeable in the types of injury that they have experienced, and therefore would have more individualised plans, rather than feeling like a cog in a wheel. This would also provide more job satisfaction to those undertaking the work, as they would be able to affect the outcomes of workers in positive ways, and not be simply undertaking a check box

exercise. Consequently, it is anticipated that this would lead to more consistency in the claims managers with which injured workers would deal, and better continuity of care.

Importantly, the 52-week employer obligation period to provide suitable duties and maintain employment for injured workers needs to be extended for the life of the claim. This is critical to enable those with complex claims to recover and return to work that is to their capacity. Many ANMF (Vic Branch) members are still undergoing active treatment at 52 weeks, whether this is because the agent has delayed decision making on approval of applications, or because their claims are complex and require a longer period to resolve. Extending the 52-week obligation period to the life of the claim would mean that as the worker recovers, they are able to access suitable duties, and improve their work fitness, potentially returning to their pre-injury duties.

Many of our injured members work for large organisations, with huge numbers of employees and many different roles, with various psychological and physical requirements associated. However, when the 52-week obligation period ends, these employers will often terminate the injured worker as they 'cannot perform the inherent requirements of their position'. If these employers were obliged to look at long term return to work options beyond the immediate pre-injury position, they would benefit from the experience of the injured worker, as well as not losing the investment in these workers. The worker would of course benefit, as they would have a position that they could undertake, meeting their medical restrictions, and continuing to work. The scheme would benefit because these injured workers would continue to remain employed, rather than ending up on full benefits without any opportunity for return to work.

Furthermore, the use of Independent Medical Examiners (IME) must be reviewed. Agents regularly send injured workers to the agent's choice of IME, it seems for sport, which often results in an outcome which is unfavourable to the worker. There is often no clear justification of a need for the IME, nor particular question that is required to be answered. Subsequently, the agent then relies on the report of the IME (or even often only part of the report) to make a decision to terminate payments, without due consideration of the information and reports provided by the treating medical practitioners. The recent change whereby WorkSafe Victoria allocate the IME for mental claims is a significantly more independent and unbiased system, which should be implemented for all IMEs. In doing so however the use of IMEs should be considerably curtailed.

Finally, the use of surveillance in the claims management process needs to be significantly reviewed. The time, effort and cost associated with undertaking surveillance on injured workers could be better spent engaging with and speaking to injured workers, whilst achieving the objectives of the WIRC Act, including ensuring that suitable employment was provided to workers. Surveillance of injured workers has only limited relevance in a system that is intended to focus on recovery and rehabilitation, and only serves to ensure that the

system is adversarial in nature, rather than a partnership, with all working for the purpose of the best outcome of the injured worker.

Case Study 3: Terminated before rehabilitation completed

33 year old rehabilitation nurse working on a rehabilitation ward of a hospital. Nurse suffered a manual handling injury to her lower back when she reached out to prevent a patient from falling. Nurse attempted a return to work with a gradual increase in duties and hours, beginning approximately two months after the date of injury. Whilst the member was not deemed to have a permanent impairment, she required another 6-12 months of rehabilitation and graduated return to work. However, because at the 52-week mark the member was not certified fit to return to her full pre-injury duties, her employment was terminated by her employer as their obligation period had ceased. Had she been able to participate in additional graduated return to work, it is likely that she would have returned to close to full pre-injury duties. However due to her employment being terminated, and her compromised physical abilities, she is unlikely to return to work in a nursing role.

Case Study 4: Successful RTW post 52 weeks

40 year old mental health nurse working in the Crisis Assessment Team at a major metropolitan hospital sustained both physical and psychological injuries following a significant assault by a patient in the course of her role in September 2017. Member had surgery in March 2018 and returned to modified suitable duties in another area. Member experienced exacerbation of psychological scenario due to a number of workplace factors and had to cease work again in July 2018. Employer failed to investigate the incident, despite the member and ANMF (Vic Branch) requesting many times in the initial 52-week period. This caused further psychological distress to the member, who was unable to consider a return to work until she had been assured that her incident had been investigated, and controls put in place to ensure that the same scenario would not occur again. Secondary psychological claim accepted in December 2018. Eventually the hospital undertook an investigation with the input of the member, and she made a successful return to work at the end of 2019. The hospital accommodated her need for reasonable adjustments in order to assist her back to work, beyond the 52-week obligation period.

Case Study 5: Still receiving treatment at 52 weeks

58 year old enrolled nurse working at an aged care facility for seven years. Sustained a serious back injury when moving a resident. Secondary psychological injury resulted due to work-related stress, as a result of the poorly managed return to work process. At the 52 week mark, she was not working, due to the psychological effects of the RTW process. This also prolonged the physical recovery. Member was receiving physiotherapy, and had a steroid injection in June 2020. Further injection requested and referral to a surgeon,

however COVID-19 made access to treatment more difficult. Member received second injection at approximately 48 week mark, meaning that the full impact of the injection was not yet apparent at 52 weeks. The employer pushed for a full clearance at 52 weeks, which not able to be achieved at that point, and her employment was terminated at the start of September 2020. Whilst it is not clear whether the treatment will result in a full recovery, this member is now jobless, and even if a full recovery is achieved, her employment prospects are hindered.

Case study 6: How it could work if the obligation period was extended

Intensive care unit (ICU) nurse working in private hospital when she sustained a back injury. The nurse was unable to work for over 2.5 years. At the end of the 52-week obligation period, there was little prospect of a return to work in ICU due to the nature of the injury, but the employer continued to support her, beyond their statutory obligation. Return to work duties were provided with an alternative position. The member received the treatment necessary to manage the injury, including surgery and associated rehabilitation. Late last year the member was able to return to ICU work, and her pre-injury position was provided to her. Employer supported her with a graduated return to work, refresher training and buddy shifts to facilitate the process. Member is currently working in ICU with no further concerns.

Recommendation 4:

That agents are removed from the workers compensation system for complex claims management, and that WorkSafe Victoria commence the management of these claims.

Recommendation 5:

That claims be streamed by injury type and injured worker needs, rather than by employer, to specialist claims managers with experience in the types of injuries and rehabilitation required by the injured worker.

Recommendation 6:

That the 52-week obligation period for employers to provide suitable duties and access to pre-injury position be extended to cover the life of the claim.

Recommendation 7:

That consideration be given to extending the obligation for large employers to provide ongoing suitable employment to injured workers on a permanent basis.

Recommendation 8:

That all IME requests are reviewed by WorkSafe Victoria prior to allocation occurring by WorkSafe Victoria.

Recommendation 9:

That clear guidance is provided which requires agents to give preferential weight to the opinion of the treating practitioner, except in circumstances where there is clear evidence to adopt the alternative position.

Recommendation 10:

That the use of surveillance be reviewed to ensure the resources are being directed towards achieving the objectives of the WIRC Act to assist injured workers in their recovery and rehabilitation.

Financial incentives and agent decision making

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

The current agent model has inbuilt conflict of interest, with the agents 'for profit' companies whose basic premise is to make money, and not put injured workers first. This is their primary purpose.

They are also conflicted as the employer pays their premiums direct to the agent, and yet the agent is expected to work in the best interests of the worker. The employer is the client, and is able to unduly influence the agent in how determinations around workers' claims are made.

Furthermore, we know that not all workers who have a negative decision made in relation to their claim will take this to conciliation – there is a drop off. The drop off is further felt after conciliation in terms of taking matters to court due to the associated costs and difficulties. Consequently, agents can wage a relatively safe bet that many of the poor decisions made will never be appealed, and will therefore be upheld, increasing their financial outcomes. It is hoped that the drop off after conciliation will be somewhat addressed through the implementation of the Workers Compensation Independent Review Service (WCIRS), and also further through an arbitration mechanism when it is introduced, but neither of these will address the initial drop off after the agent makes the poor decision in the first place.

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

In short, no. The current financial incentives for agents do not provide any incentive for active management of those with long terms claims, except to remove them from the system, or reduce their benefits. Once the claim is a long-term claim, the return to work prospects of the worker are significantly reduced through the loss of their employment. It is then extremely difficult and time consuming for an agent to provide the intense assistance that the worker requires to enable them to recover to the fullest extent available to them, and also to begin the process of participating in work again. In a cost / benefit analysis for the agents, it seems that the cost of the effort required to have such a successful outcome is outweighed by the much simpler short-term benefit of having the worker's entitlements terminated. Often this is not undertaken in one fell swoop, but rather a 'death by one thousand cuts'. One may postulate that this is because if it was done at once, it would provide a clear, more significant decision that may be worth taking to court. However, when it is a reduction in home help, then a reduction in physiotherapy sessions, then a further reduction, each decision is required to be taken to a conciliation conference (where the agent inevitably maintains their decision), and individually these decisions are not

financially viable court cases. Further, the additional pressure and stress that this places upon the worker at every opportunity means that they are less likely to have the psychological mindset to be able to pursue a court case, let alone the financial means of doing so.

Additionally, as there is no known financial incentive, nor penalty, associated with the agents making timely decisions in relation to requests for further treatment, the worker will often languish for months awaiting a request for surgery or other treatment. The agent will often require an Independent Medical Examination (IME) before such treatment is provided, irrespective of the speciality of the requesting and treating practitioners, and the IME is not prioritised for the longer term claims. The IME appointments are prioritised for the claim determinations because there are clear timelines and consequences of not complying with these i.e. a claim will be deemed accepted. A similar system should apply when a worker applies for approval for a service / treatment or other – where the agent has not responded within 28 days, the request is deemed accepted. This would facilitate timely responses to the requests, as well as timely treatment being provided to the worker. If a worker's treating practitioners have applied for spinal surgery, having to wait for 6 months to receive an outcome from the agent (which is only forthcoming once a conciliation request is put in), then potentially required to be disputed through a conciliation process, and then to medical panel as it is a medical question, means that it has potentially taken almost 12 months for the worker to receive the treatment which was identified as being required 12 months ago. This affects not only the quick and timely recovery for the worker (who in the meantime has been suffering), but also affects their mental health. Just as importantly, it has also often eaten away at the 52-week obligation period that their employer has to provide suitable duties. Consequently, once the worker finally has the surgery that was identified earlier, the employer no longer has an obligation to provide them with suitable duties, and our members often experience being required to be back to pre-injury duties before they can return to the workplace (where they are fortunate), or having been terminated as they had no capacity to undertake their pre-injury employment (where they are less fortunate). This all results from the lack of timely decision making by the agent in relation to the seeking of treatment recommended by a treating medical practitioner.

Case Study 7: Agent failure to approve request for treatment

Nurse in mid-40's at the time of injury, who worked in a medical centre as a Practice Nurse. There was a significant incident of occupational violence and aggression against her in her workplace, which resulted in a psychological injury, as well as having been exposed to bloodborne viruses. Throughout the initial 52-week period of the claim, the nurse underwent psychiatric and psychological treatment and rehabilitation, however was unable to return to work because the agent refused to pay for a cognitive assessment. The nurse was psychologically ready, able and willing to return to work, but because the obligation period was close to ending, and the failure of the agent to seek and authorise a cognitive assessment, she was unable. Consequently, the obligation period expired, and the

employer withdrew the offer to provide suitable duties. The member's employment was subsequently terminated.

Case study 8: Agent's unreasonable decision given evidence at hand

Personal care worker with a private aged care facility (large employer). Worked at facility for 20+ years, although had been taken over by company a number of years prior. Worker had been subpoenaed to give evidence in a matter against the company, which began a 9-month period of activity undermining and discrediting the member for unreasonable and irrelevant actions. The action toward the member was targeted, and was not equally taken on others for similar circumstances. The member sought medical treatment in relation to the distress caused by this approximately 3-4 months after it began, which lasted a number of weeks. The activity continued, and after 9 months, she received a disciplinary letter inviting her to a meeting to discuss a number of allegations. This was the third letter over the period in relation to unfounded allegations, and included some which had already been dealt with. At this time, the member ceased work, and sought further medical treatment for her psychological condition. When she was coming to the end of her personal leave, she put in a WorkCover claim, as she was still unable to work. Unfortunately, she nominated the date she received the final letter as the date of injury (rather than indicating that it occurred over a period of time), was unable to participate in the circumstance investigation (due to her psychological condition) and on this basis her claim was rejected as a result of 'reasonable management action undertaken in a reasonable manner'. At conciliation the detail of the circumstances was provided to the agent, who maintained their decision. She received advice to make a new claim, indicating that the claim was as a result of the ongoing activity (rather than a single incident), and again was unable to participate in the circumstance investigation. Again her claim was rejected, and resulted in a further conciliation, where again the agent maintained their decision, although made a without admission of liability offer of 8 weeks compensation and partial coverage of medical expenses (the member had to cease much of her treatment as she was unable to afford it as a result of the lack of income). This second conciliation occurred some 15 months after she initially ceased work as a result of her condition. The agent unreasonably made and maintained their decision without seeking appropriate evidence to base it on. This matter is ongoing.

Question 11: Describe

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

ANMF (Vic Branch) recommends that the system include provision for deeming of worker requests, as for claims where determinations are not made in a timely manner i.e. if a decision is not made on a request within 28 days, that decision is deemed approved, so that the worker is able to continue in their recovery and rehabilitation process without being unnecessarily delayed.

ANMF (Vic Branch) recommend that agents are removed from the management of complex claims, and the claims management be brought inhouse to WorkSafe Victoria (see Recommendation 4). However, the below discussion relates to the alternative, in the event that an agent model for complex claims is maintained.

ANMF (Vic Branch) also recommends that additional incentives be provided to agents for assisting workers who are unable to return to their pre-injury roles to be retrained and find another long term, sustainable, suitable employment option. Many of our members are employees of large, multi-site health facilities, with a multitude of employment options for nurses and midwives with varying requirements. However, when they are injured and unable to return to their pre-injury duties, the employer will terminate them in preference to redeploying them elsewhere within their health service to a role that is suitable, where they can continue to contribute. Further, the agents will rarely make significant efforts to identify suitable employment options for our members. It becomes clear that there is a lack of knowledge / understanding of the role they are undertaking when occupational rehabilitation providers or IMEs recommend that they are capable of being a midwife (when they are a registered nurse) etc. It is also problematic that our members are identified as having significant transferrable skills and are therefore not deemed suitable for additional education or training. In order for our members to be able to undertake appropriate roles, they will often be required to undertake further training, and therefore providing agents additional incentives to identify and support this would significantly assist in our members returning to meaningful, sustainable work.

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

It would appear that thus far the financial incentives and penalties scheme by which agents are remunerated have not been successful in changing agent behaviour. The changes which occurred post the 2016 Ombudsman's report have made little difference to the behaviour of the agents, as was found in the 2019 report, and therefore making changes would seem to be 'tinkering around the edges of a broken system' somewhat. Further, given that the carrot approach has not been adequate to amend agent behaviour, there needs to be additional focus on the stick.

ANMF (Vic Branch) recommends that where a decision is overturned by either the WCIRS function, or at arbitration, or even at court, the agent should be penalised for the failure to make an appropriate decision initially.

Further, where it is identified that agents are regularly having their decisions overturned via either WCIRS or arbitration, there should be a scheme of additional penalties to disincentivise the ongoing poor decision making.

Additionally, ANMF (Vic Branch) considers that any time an agent does not make a decision within an appropriate timeframe (28 days is suggested), they are further financially penalised.

Moreover, ANMF (Vic Branch) recommends that where, due to an agent failing to make timely or quality decisions (i.e. those overturned at WCIRS or arbitration) a worker's 52-week obligation period is effectively curtailed, the worker be entitled to be back paid superannuation for that initial 52 week period. This could be determined by Independent Review / arbitration at the time that it occurs.

Question 12: Describe any non-financial mechanisms by which agents could be encouraged to promote quality decision making.

Since the introduction of the WCIRS, data has been circulated amongst stakeholders around the different outcomes in terms of decisions being overturned, broken down by agent. However, this data is not public. Making this data publicly available in order for workers (and the public more broadly) to see which agents were regularly having decisions overturned would incentivise quality decision making. It is likely that such data would be picked up by the media, and this would disincentivise making poor decisions. It would also potentially assist employers in their determination around their choice of agent.

Additionally, injured workers who have had experience with the agent should be able to provide feedback on a vote-type basis around this. It could be housed on the WorkSafe Victoria website, and the results publicly available. Whilst it is understood that WorkSafe regularly undertake to seek feedback from injured workers, this would be a more accessible system (on top of the existing means of feedback) that injured workers could provide some feedback. In order to ensure that it was the worker providing the feedback, each worker who had a claim within the 6 month period could be emailed / texted a link once every six months to complete a 'star rating', and an opportunity to request a more detailed feedback session to ensure that complaints could be appropriately dealt with. This would also give an additional source of information in terms of the performance of the agent overall.

A concern that is often raised by our members is that they feel as though they are treated like a car subject to a car insurance claim or the like. Whilst they may have dealings with particular claims managers at the agents (who regularly change), it is important that all of those involved in the business are more intimately familiar with the process an injured worker is required to go through. Consequently, to improve their empathy with injured workers, any time a complaint is made about an agent, a senior manager should be required to speak directly with the injured worker involved to hear and understand their experience, and assist with resolution of the complaint. There is a sense that agents become somewhat removed from the people at the centre of the decisions that are being made, and so this regular contact with injured workers may assist.

Recommendation 11:

That where a request is made by a worker for a service / treatment, if it is not responded to within 28 days, the request is deemed approved.

Recommendation 12:

That increased incentives be provided for agents and employers assisting workers who are unable to return to their pre-injury roles to be retrained and supported to find another long term, sustainable, suitable employment option.

Recommendation 13:

That where a decision is overturned by either the WCIRS function, or at arbitration, the agent be penalised for the failure to make an appropriate decision.

Recommendation 14:

That where it is identified that particular agents are regularly having their decisions overturned via either WCIRS or arbitration, a scheme of additional penalties to disincentivise the ongoing poor decision making be introduced.

Recommendation 15:

That any time an agent does not make a decision within an appropriate timeframe (28 days is suggested), they are further financially penalised.

Recommendation 16:

That where, due to an agent failing to make timely or quality decisions (i.e. those overturned at WCIRS or arbitration), a worker's 52-week obligation period is effectively curtailed, the worker be entitled to be back paid superannuation for that initial 52 week period. This could be determined as relevant by WCIRS / arbitration at the time that it occurs.

Recommendation 17:

That data from the WCIRS function is made publicly available, including details of which agents have had the most decisions overturned or upheld.

Recommendation 18:

That injured workers be provided an opportunity twice a year to provide a 'star rating' on the interactions that they have had with the agent managing their claim (and an opportunity to request a more detailed discussion), the consolidated data of which is made available publicly.

Recommendation 19:

That when complaints are made in relation to agents, senior managers be required to directly engage with the affected workers to understand their experience, and assist them in the resolution.

Oversight of agents by WorkSafe

Question 13: Are WorkSafe's processes for overseeing agents' management of claims achieving prompt, effective and proactive outcomes for injured workers?

In some circumstances, perhaps. However, the members who request assistance from ANMF (Vic Branch) have inevitably had issues with their claim, whether it be through an initial rejection of the claim, or a subsequent termination of weekly payments, or medical or like expenses. A significant number of the matters with which ANMF (Vic Branch) deals are a result of poor decisions by agents, which indicates that WorkSafe's processes must not be achieving prompt, effective and proactive outcomes for injured workers through oversight of agent's management of claims.

Case study 9: Agent manipulating the outcome of IME… with severe consequences for member but none for agent

58-year-old enrolled nurse employed at private aged care facility for 11 years. In December 2018 whilst rolling a resident in bed, member was injured, and made a WorkCover claim, which was accepted. In April 2019, member's entitlement to physiotherapy was terminated for unclear reasons. The GP opinion was clear that the member continued to suffer from the original injury, and that the symptoms were consistent with this. An Independent Medical Examination was conducted, with two supplementary reports provided. The initial report of September 2019 was supportive of the member's injury and treatment. Two further supplementary reports were sought by the agent, and the final supplementary report provided in November 2019 by the same doctor provided an opposite opinion. It advised that the condition was no longer work-related, and the diagnosis was changed from aggravation of a work injury (where there was no previous work injury) to pre-existent degenerative disease. The doctor had not undertaken any further examination of the member, however had been asked to provide supplementary reports by the agent a further two times after the initial examination, where the agent finally obtained the opinion they were looking for. There was no justification as to the altered opinion provided. The treating GP submitted a letter rebutting the IME opinions, which included that the member "is showing signs and symptoms of the onset of a depressive illness as a consequence of these actions." The GP further commented

> "The process of an injured worker returning to work after a relatively short period off work is commendable. It is in the spirit of workcover that we are supposed to provide assistance and support to such workers. Yet this case illustrates the subversive tactics of some insurers in their treatment of an injured worker who has done everything that an exemplary injured worker should do, and yet (the member) is being victimised because (the member) continues to suffer with ongoing symptoms – all of which is beyond (the member's) control."

This IME opinion led to the termination of this member's claim, which resulted in the loss of employment, as the employer advised that the member could not return to work, as they were no longer obliged to provide light duties.

Question 14: Do the new mechanisms implemented by WorkSafe in response to the Ombudsman's 2019 report address any limitations in WorkSafe's oversight of agent decision making?

Whilst it is still early days in relation to the implementation of new mechanisms, and is therefore difficult to know the full outcome, it is further unclear what all of these new mechanisms are.

Question 15: How? 16 Why not?

One of the most visible mechanisms involves the WCIRS for injured workers where there is a genuine dispute certificate following a conciliation conference. The outcomes of these reviews have thus far been promising, in that there is a clearer oversight of decisions which are taken to review, and results indicate that a significant number of agent decisions are being overturned by this function (with 50 valid applications received and determined, 34 resulted in the decision being overturned (either on direction or by the agent withdrawal), and 14 affirmed the decision of the agent[8]). However, this also indicates that the WorkSafe oversight is not occurring in a proactive manner, and is only assisting where a member is able to make the application for the WCIRS. Thus it is not addressing the issues of bad decisions being made to start with, although rectifying them in some circumstances. Of course, it is hoped that agents will start to make better decisions if they know that it is likely that their decision will be overturned. The numbers of genuine dispute results in the time of the existence of the WCIRS is unknown, and therefore it is unclear in terms of rates of decisions being overturned compared with the decisions made in the period.

Further, the WCIRS function relies on an injured worker not only having the strength and tenacity to appeal the decision to conciliation to begin with, but then further appeal the decision to the WCIRS. This again, does not deal with the root cause of the problem i.e. the poor decisions being made to start with, and the lack of oversight around this initial decision-making process.

Question 17: How could any limitations in WorkSafe's oversight of agent decision making be overcome?

See recommendation 4.

This removes the ability for

a) Agents to make decisions at all, as they are no longer part of the system; and

[8] Data provided via email from Mario Briffa, 11 September 2020.

b) Removes the need for WorkSafe to oversee the decision-making process of multiple third parties.

WorkSafe Victoria would be required to oversee their own decision-making, which is able to be more directly influenced. Further, it provides the opportunity to start afresh, without the hangover of the poor practices of agents and their behaviour trying to be addressed retrospectively. Moreover, it makes WorkSafe directly accountable for the behaviour of any people managing claims, with the direct associated corporate and social responsibility that comes with that.

Evaluation measures

Question 18: To what extent do current measurements of outcomes for injured workers, including return to work rates and worker surveys, accurately measure whether the agent model achieves prompt, effective and proactive outcomes for injured workers?

The current measurements do not measure outcomes for injured workers accurately. A sustained return to work should be required to extend beyond four weeks for it to be considered a 'successful return to work'. Often ANMF (Vic Branch) members will return to work earlier than recommended due to pressure from their employer, and will then suffer an exacerbation of the injury, meaning that they are then required to take additional time off.

Further, the worker surveys target a limited number of workers at any one time. Those who participate in the survey will be somewhat self-selected, as it will be those who have the psychological ability to participate in the process. Many of our injured members refuse to answer calls from unknown numbers, sometimes as a result of the experience they have had with the WorkCover system. Consequently, a randomly selected group of workers who are called will not ensure that those with this type of experience participate, thereby potentially leading to misleading measures.

Moreover, it is believed that there is nothing in the current measurements of outcomes which directly addresses prompt, effective and proactive outcomes for injured workers. There are no measurements related to prompt approval of requests for medical treatment or services, nothing reported of the effectiveness of occupational rehabilitation services or multi-disciplinary case management discussions, or the like. Given that there are few proactive actions undertaken, it is difficult to imagine how the current measurements could appropriately reflect these.

Question 19: Describe any additional or alternative methods of measuring outcomes for injured workers that should be considered?

Successful return to work should be measured in terms of a return to not only pre-injury hours, but also pre-injury duties for a continuous period of 6 months. This would then show that it is a sustained, safe and sustainable return to work. An additional definition should also be incorporated, which reflects a 'restricted' return to work i.e. that where a worker is working to their capacity, however not to their pre-injury duties and / or hours. In some claims, this will be as far as their return to work will be able to progress. This will better reflect whether injured workers are making substantive recoveries, or only recovering enough to return to limited duties and/or hours, and will better reflect the success or otherwise of the system.

In order to gauge a better understanding of worker satisfaction and experience, electronic surveys could be sent out to all workers, where they are able to more easily complete an online survey. This could be more accessible to those workers who are otherwise unlikely to engage in a phone survey.

Recommendation 20:

That WorkSafe Victoria change the definition of a successful return to work in measuring outcomes of injured workers to incorporate a sustained return to pre-injury hours and duties for a continuous period of 6 months.

Recommendation 21:

That WorkSafe Victoria introduce a further measurement around return to work that reflects where injured workers have returned to work, but not to pre-injury duties and/or hours. This could be known as a 'restricted' return to work.

Recommendation 22:

That WorkSafe Victoria introduce an electronic survey, in addition to the current worker surveys, to further gauge experience of injured workers (in conjunction with Recommendation 18).

Recommendation 23:

That WorkSafe Victoria introduce additional measures that reflect 'prompt, effective and proactive outcomes for injured workers', including time taken for approval of requests for medical treatment or services, effectiveness of agent interventions etc.

The current agent model and alternative models

Question 20: Does the current agent model achieve prompt, effective and proactive management for injured workers with complex claims?

The outsourced model does not achieve prompt, effective and proactive management for injured workers at all, but it is especially problematic for complex claims.

As previously discussed in questions 9 and 11, and recommendation 11, there are no legislated timeframes for agents making decisions relating to medical and like services and claim reinstatement. This results in services taking months to be approved and many require conciliations which means that recovery is hindered. The Government has introduced the Provisional Payment Pilot for mental health claims for emergency workers, which ensures that this group of injured workers receive timely treatment to manage their injuries, but this has not been expanded to all workers at this point. The fact that there are no timeframes to approve rehabilitation services for injured workers directly opposes this Government initiative. It is ANMF (Vic Branch)'s view that agents exploit this legislative shortfall.

Constant changes of case managers due to an unstable workforce within agents mean they are not across the injured worker's circumstances and when new case managers are appointed to the case, there is a tendency to again 'review' every worker's entitlements in order to justify their appointment, often resulting in benefits being terminated. This changing workforce also hinders the ability of a worker to have a therapeutic relationship with the claims manager, where they are able to call them to address questions or concerns, as each time they call, there is a new person allocated to their case, who is not familiar with the circumstances. This means that the agent is primarily available to assist the employer, but not the worker, where this should be their focus.

Additionally, agents have a lack of consideration of individual circumstances. They manage claims purely as a process and there is little or no consideration of injured workers' circumstances. This is very evident with approving services like home help/gardening; as soon as an injured worker advises there is someone who lives with them, the process says they can pick up the load and there is no consideration on their ability to do that. They also fail to understand that different people with the same injury may have different capacities, and a different recovery process. This is partially due to the lack of expertise of the claims managers in the clinical side of injuries, but also due to the 'process' that they implement, with scant regard to the individual.

Furthermore, agents tend to 'pick on' injured workers with complex claims, constantly reviewing their entitlements (and removing them) in a way which makes it very difficult to contest in court. The nature of these decisions is to remove the 'like' expenses (such as home help and gardening) bit by bit, making it financially unviable for injured workers to contest past conciliation due to the cost of court. This was very much the experience of the

Injured Nurses Support Group, and long term injured members, as every year ANMF (Vic Branch) and/or the member is required to argue their entitlement and need for these types of services.

Question 22: Describe

Questions 22a) and b) have been addressed in response to earlier questions.

c) Any alternative models to the current agent model that would be more effective in delivering positive health and recovery outcomes to injured workers

It is the strong view of the ANMF that claims which are defined as complex should be managed by WorkSafe directly and not the claims agents for the reasons previously detailed.

Whilst consideration has been given to a private third party to manage complex claims, ANMF (Vic Branch) considers that the consistent issue with this is that there would remain financial incentives which impact their ability to objectively support injured workers. ANMF (Vic Branch) strongly believe that WorkSafe Victoria should manage the claims, ensuring that the scheme remains financially viable and that injured workers are treated with dignity and respect, and without conflict in relation to their role and intent.

Question 23: Are there practices or procedures used by other compensation schemes, in Australia or overseas, that maximise outcomes for injured workers that the Review should examine?

ANMF (Vic Branch) will not be providing a response to this question.

Victorian Ombudsman 2016 and 2019 reports

Question 24: Have you observed any changes to (i) agent decision making and (ii) the oversight of agents by WorkSafe since the 2016 Ombudsman report? Please describe

ANMF (Vic Branch) have observed very few changes since the 2016 Ombudsman report. There was initially a flurry of activity by WorkSafe Victoria in order to respond, bringing together consultative forums and groups, however there was little visible, ongoing change.

One of the main changes in recent times has been the allocation of mental injury independent medical examinations by WorkSafe Victoria, rather than the agents. This has been an improvement, as there is a much more objective process in which the IME is chosen. It is recommended that a similar process be implemented for all IMEs to reduce the bias shown where agents regularly choose the same examiners (who tend to give them reports which provide for termination of worker entitlements) (see Recommendations 8 and 9 above).

Question 25: What are the root causes of the problems identified by the Ombudsman in her 2016 report?

ANMF (Vic Branch) assert that the root causes of the problems stem from a number of primary issues associated with the set up of the claims management scheme, being:

a) The use of 'for profit' companies, with a primary focus on making money, to manage a process which, by its very nature, is unlikely to provide the dividends desired, if done ethically;
b) The use of insurance agents, who treat dealing with injured workers as though they are dealing with a claim for car insurance, and have their internal KPIs and culture set up in this way;
c) The inherent conflict whereby the employer pays the premium, and is the 'client', and the agent is supposed to work in the best interests of the worker, which may be in direct conflict with the desires of the client;
d) The lack of individualised claims management for workers, which recognises their biopsychosocial factors as critical to the way their claim, recovery and rehabilitation will progress;
e) The management of injured workers claims by agents in a way that ensures convenience for their employer, rather than focussing on the recovery, rehabilitation and return to work for the injured worker;

f) The primary focus of the workers compensation scheme on collecting premiums, rather than supporting the recovery and rehabilitation of workers who are injured in the course of their employment.

Question 27: Do you think the implementation of the recommendation 3-9 in the 2019 Ombudsman report will address those causes, explain why not.

It is not expected that implementation of recommendations in the 2019 Ombudsman report will address the causes. Whilst there remain agents managing complex claims (in particular), injured workers will continue to suffer, and be left behind. The inherent conflict would remain.

Further, the focus remains on the convenience of the employer in having all of their injured worker claims managed together, rather than getting the best outcomes for the workers by having people with experience in the particular types of injuries managing cohorts of workers with similar injuries.

The agents have been provided with significant opportunities to address the poor behaviour and decision making, as well as culture, as a result of initially the 2016 report, and more recently the 2019 report. This has not borne out in the evidence, nor has there been a show of commitment to address this in any meaningful way. Hence, ANMF (Vic Branch) do not believe that the implementation of those recommendations will be enough to make the wholesale, comprehensive about-face required to address the identified issues.

Further considerations

Question 28: Other matters

Mental injuries v physical injuries

The difference within the WIRC Act in relation to the way physical injuries are treated in comparison with mental and psychological injuries is potentially directly discriminatory. There are two main areas that these differ a) the removal of the 'no fault' system in order to reject a claim on the basis of 'reasonable management action undertaken in a reasonable manner', as is provided under s40. This is particularly relevant in relation to the management of claims, and meeting the objectives of the WIRC Act. The objectives of the Act include to 'reduce the incidents of accidents and diseases'[9], and 'ensure appropriate compensation … is paid to injured workers in the most socially and economically appropriate manner, as expeditiously as possible'[10]. Therefore, having a provision which means that employers are not held accountable for inappropriate management action is counter to these objectives. This provision is enacted by agents in rejecting workers claims wherever there is even a hint of management action. There is rarely any consideration of whether the action was reasonable, nor whether it was undertaken in an appropriate manner. This group of workers are some of the least likely to seek assistance if their claim is rejected at the first hurdle, as they are already vulnerable. This provision requires significant review into the operation and necessity in a 'no fault' compensation scheme.

Further, requiring workers who have submitted a claim for a psychological injury, who are at their most vulnerable and are unwell, to go through a circumstance investigation (as a matter of course) and be subjected to IMEs to determine whether their claim is genuine is damaging and often injurious in itself. The differential treatment with these processes between physical and psychological treatments is marked and requires significant review.

The third stark difference is in the requirement for a lump sum claim to be made. For a physical claim, this threshold is a 5% whole person impairment, however to make a lump sum claim for a psychological injury, a worker has to reach a 30% whole person impairment. This difference in the way the lump sum process is treated, and the impacts on this for the rehabilitation and recovery of workers who have suffered a psychological injury are significant. They are unable to be compensated for what may well be a permanent psychological impairment due to this provision. This further impacts on meeting the initial objective of the Act, that of reducing harm done by work, because the financial imperative to employers to improve the psychological health and safety of their workplaces is not impacted in the same way as physical lump sum claims are able. Consequently, the effect of

[9] *Workplace Injury Rehabilitation and Compensation Act 2013* (Vic), s10(a).
[10] Ibid, s10(d).

this difference of treatment should be reviewed in the context of the broader compensation system.

Recommendation 24:

That a review consider the significant differences between the way physical and mental health claims are administered and managed, and the entitlements and benefits available to workers in each instance, and consider whether there is potentially a form of inherent discrimination.

Return to Work (RTW) Plans

The requirement for written RTW Plans was removed from the legislation some time ago. This has resulted in inconsistent and inadequate information exchange between injured workers, employers, treating practitioners, agents and anyone else involved in the claim. There is an ability for a lack of clear understanding of the role which is being proposed for RTW duties, as well as when this is not being met, and there is a failure to engage in RTW. Returning to a mandated system of preparing a written RTW Plan in consultation with the relevant stakeholders, and its exchange and agreement would significantly reduce the confusion and disputes in this area.

Recommendation 25:

That consideration of reintroducing the mandated requirement to prepare a written return to work plan in consultation with the injured worker and other stakeholders is undertaken.

Rejected claims

A potentially overlooked component of any review of the system is those whose claims have been rejected. Whilst it is anticipated that with significant changes and oversight to the system, there should be fewer workers whose claims are rejected unreasonably, there is still a proportion of claims rejected and not taken any further. These workers continue to experience injury or ill health, and without the support of the workers compensation system, many of these workers will fail to recover and rehabilitate. They may be unable to afford the medical treatment that they require or may not have access to the leave needed, or lack the support. Whilst the consideration of what happens to these workers more broadly would appear to be outside the scope of the Terms of Reference for this review, it is important that these workers are not forgotten.

Summary of Recommendations

Recommendation 1

That the definition of a complex claim be expanded to deal with factors beyond time frames, and incorporate factors associated with individual claims

Recommendation 2

That a decision-making framework be developed to assess claims to determine their status as a complex claim or otherwise

Recommendation 3

That claims are reviewed and assessed periodically (i.e. at 13 weeks, 52 weeks, 130 weeks, and at any other time as requested by the worker, or deemed necessary) throughout the life of the claim to determine whether their status as a complex claim may have changed. Review should be in consultation with the injured worker and their treating practitioner, and the 13 week review should include an assessment of psychological risk factors.

Recommendation 4:

That agents are removed from the workers compensation system for complex claims management, and that WorkSafe Victoria commence the management of these claims.

Recommendation 5:

That claims be streamed by injury type and injured worker needs, rather than by employer, to specialist claims managers with experience in the types of injuries and rehabilitation required by the injured worker.

Recommendation 6:

That the 52-week obligation period for employers to provide suitable duties and access to pre-injury position be extended to cover the life of the claim.

Recommendation 7:

That consideration be given to extending the obligation for large employers to provide ongoing suitable employment to injured workers on a permanent basis.

Recommendation 8:

That all IME requests are reviewed by WorkSafe Victoria prior to allocation occurring by WorkSafe Victoria.

Recommendation 9:

That clear guidance is provided which requires agents to give preferential weight to the opinion of the treating practitioner, except in circumstances where there is clear evidence to adopt the alternative position.

Recommendation 10:

That the use of surveillance be reviewed to ensure the resources are being directed towards achieving the objectives of the WIRC Act to assist injured workers in their recovery and rehabilitation.

Recommendation 11:

That where a request is made by a worker for a service / treatment, if it is not responded to within 28 days, the request is deemed approved.

Recommendation 12:

That increased incentives be provided for agents and employers assisting workers who are unable to return to their pre-injury roles to be retrained and supported to find another long term, sustainable, suitable employment option.

Recommendation 13:

That where a decision is overturned by either the WCIRS function, or at arbitration, the agent be penalised for the failure to make an appropriate decision.

Recommendation 14:

That where it is identified that particular agents are regularly having their decisions overturned via either WCIRS or arbitration, a scheme of additional penalties to disincentivise the ongoing poor decision making be introduced.

Recommendation 15:

That any time an agent does not make a decision within an appropriate timeframe (28 days is suggested), they are further financially penalised.

Recommendation 16:

That where, due to an agent failing to make timely or quality decisions (i.e. those overturned at WCIRS or arbitration), a worker's 52-week obligation period is effectively curtailed, the worker be entitled to be back paid superannuation for that initial 52 week period. This could be determined as relevant by WCIRS / arbitration at the time that it occurs.

Recommendation 17:

That data from the WCIRS function is made publicly available, including details of which agents have had the most decisions overturned or upheld.

Recommendation 18:

That injured workers be provided an opportunity twice a year to provide a 'star rating' on the interactions that they have had with the agent managing their claim (and an opportunity to request a more detailed discussion), the consolidated data of which is made available publicly.

Recommendation 19:

That when complaints are made in relation to agents, senior managers be required to directly engage with the affected workers to understand their experience, and assist them in the resolution.

Recommendation 20:

That WorkSafe Victoria change the definition of a successful return to work in measuring outcomes of injured workers to incorporate a sustained return to pre-injury hours and duties for a continuous period of 6 months.

Recommendation 21:

That WorkSafe Victoria introduce a further measurement around return to work that reflects where injured workers have returned to work, but not to pre-injury duties and/or hours. This could be known as a 'restricted' return to work.

Recommendation 22:

That WorkSafe Victoria introduce an electronic survey, in addition to the current worker surveys, to further gauge experience of injured workers (in conjunction with Recommendation 18).

Recommendation 23:

That WorkSafe Victoria introduce additional measures that reflect 'prompt, effective and proactive outcomes for injured workers', including time taken for approval of requests for medical treatment or services, effectiveness of agent interventions etc.

Recommendation 24:

That a review consider the significant differences between the way physical and mental health claims are administered and managed, and the entitlements and benefits available to workers in each instance, and consider whether there is potentially a form of inherent discrimination.

Recommendation 25:

That consideration of reintroducing the mandated requirement to prepare a written return to work plan in consultation with the injured worker and other stakeholders is undertaken.

Conclusion

ANMF (Vic Branch) believe that the current system with agents managing complex claims is broken, and needs a substantive and significant overhaul. By implementing an early identification process for complex claims, and ensuring that WorkSafe Victoria manage these claims in-house using targeted teams with expertise in relevant injuries, it will give injured workers the best chance of having a targeted, individualised experience to enable their recovery, rehabilitation and return to work. It will further the achievement of the objectives of the WIRC Act.