Australian Industry Group

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

Submission to Independent Reviewer in response to Discussion Paper and issues raised during consultation forums

SEPTEMBER 2020

Ai GROUP

VICTORIAN WORKERS' COMPENSATION SYSTEM:

INDEPENDENT REVIEW INTO THE AGENT MODEL AND THE MANAGEMENT OF COMPLEX CLAIMS

SUBMISSION TO INDEPENDENT REVIEWER IN RESPONSE TO DISCUSSION PAPER AND ISSUES RAISED DURING CONSULTATION FORUMS

INTRODUCTION

The Australian Industry Group (Ai Group) is a peak industry association and has been acting for business for more than 140 years. Along with our affiliates, we represent the interests of businesses employing more than one million staff. Our longstanding involvement with diverse industry sectors including manufacturing, construction, transport, labour hire, mining services, defence, airlines and ICT means we are genuinely representative of Australian industry.

Our vision is for ***thriving industry and a prosperous community*.**

We have ongoing contact and engagement with employers across Australia on the broad range of issues related to the operation of their businesses, informing them of regulatory changes, discussing proposed regulatory change, discussing industry experiences and practices and providing advice, consulting and training services.

We also interact with and provide regulators and scheme managers across all Australian jurisdictions with employer views and experience on WHS/OHS and workers' compensation.

We have a significant number of large organisations within our membership. However, around three quarters of our members employ fewer than 50 employees and half employ fewer than 20 employees.

CONTRIBUTING TO THIS REVIEW

Ai Group welcomes the opportunity to provide input into the Independent Review of the Agent Model and the Management of Complex Claims (the Review).

The information we are providing is largely based on feedback received from employers during the provision of training and consulting services and when member companies contact our Workplace Advice Line, or our specialist workers' compensation advisers, to discuss difficulties they are experiencing within the scheme. We have also asked members to provide us with information specifically associated with this review.

We have encouraged members to share their first-hand experiences by making their own submissions to the review. However, we highlight that there are a number of barriers to them doing so, particularly: a lack of time to allocate to this type of activity; a general view that workers' compensation will always be difficult to deal with and there is little value in providing feedback; and concerns that detailed feedback about their experiences with a claim may lead to the identification of individual claimants and breach their privacy and confidentiality obligations.

CONTEXT OF THE REVIEW

A focus on "complex claims"

This Review follows on from, and is related to, the Victorian Ombudsman's investigations into the management of complex claims in 2016 and 2019.

In the foreword to the 2016 Report, Deborah Glass, Ombudsman stated, on page 4:

> *The vast majority of claims are neither complex not contentious: these are rarely the subject of complaint and WorkSafe's own surveys show a high level of customer satisfaction. But in the area of complex claims the current system has failed some particularly vulnerable people.*

Further, on page 5:

> *The system needs a better safety net for the vulnerable. Action must be taken to address the complex end of the system where terminations are rewarded. WorkSafe needs to examine its incentives – and the use of IMEs – to ensure that the system rewards sustainable decisions and to target its oversight accordingly. The process for resolving disputes also demands careful reconsideration – it is in the interests of workers, employers and the public at large that the resolution of claims should be both timely and fair.*

The 2016 investigation included a detailed review of 65 complex claims across all five agents (page 6).

In the foreword to the 2019 Report, at page 5, Deborah Glass, Ombudsman stated:

> *I said in 2016 that the system needs a better safety net for the vulnerable. In 2019 we need it more than ever. If the problems are persisting despite the adoption of my previous recommendations, the reforms were plainly not fundamental enough.*
>
> *The financial viability of the scheme is imperative; but the balance between financial sustainability and fairness for injured workers has tilted too far away from the latter*

The 2019 investigation reviewed 102 complex claim files in depth, and WorkSafe's handling of 51 complaints received in 2017-18 about agent decisions and Independent Medical Examiners. (page 7)

We note that this Independent Review has been established in line with Recommendation 1 of the Ombudsman's WorkSafe 2 Report 2019:

> *Commission an independent review of the agent model to determine how and by whom complex claims should be managed, taking into account:*
>
> *(a)* The need to ensure appropriate compensation is provided to workers, as well as the financial viability of the scheme
>
> *(b)* The experience of other accident compensation schemes, including Victoria's transport accident scheme (managed by the Transport Accident Commission) and other national and international workers compensation jurisdictions.

Claims and Return to Work Outcomes – Overview

Complex claims were described at page 6 of the 2019 Report as claims that "involve workers who were unable to work long term and/ or required long term medical treatment … these workers are likely to have complex health conditions and represent a substantial and disproportionately high cost to the scheme and broader society." The report acknowledges that these "are not the majority of the claims".

WorkSafe Victoria's Annual Reports for 2017/8 and 2018/19 provide a good "snapshot" of claims experience:

- each year there are approximately 27,000 "standard claims" (those that exceed the employer excess of 10 days weekly compensation and a medical excess that is currently $735, indexed annually).
- Around 77% of claimants (20,790) are back at work within 6 months:
  - approximately 80% of those with physical injuries; and
  - approximately 50% of those with mental injuries.

At page 9 of the Discussion Paper it is stated the scheme has "around 90 per cent of injured workers returning to work in less than 52 weeks." Based on this information, it would be expected that there are about 2,700 claims per year that are on their way to becoming a complex claim, with no return to work at 52 weeks; and 24,300 that are not.

It is important to acknowledge this data in the context of this review. It is crucial that the implementation of any recommendations of the review do not create unintended consequences for the 90% of workers, and their employers, that have achieved a return to work in less than 52 weeks.

The importance of Scheme Credibility

Scheme credibility is important for all of those within the scheme and those looking in from outside.

Workers who have an injury or illness which entitles them to compensation must be confident of appropriate treatment and strong recovery and return to work support.

Employers must be confident that workers will only receive compensation for injury and illness that genuinely meet eligibility criteria, as the acceptance of a claim creates a number of obligations and has potential premium impacts. Employers need to be supported in their efforts to assist a worker in recovery and return to work within the context of the other demands in their business, including situations when the claim relates to interpersonal conflict with others in the organisation who also need appropriate support and fair treatment.

Other workers and the general public must view the system as fair and equitable and available only to those with an injury or illness that entitles them to compensation, and only for the time that is reasonable.

Workers with long term workers' compensation claims are done a major disservice if the general public believe that it is "too easy" to be on workers' compensation.

THE QUESTIONS IN THE DISCUSSION PAPER

Identifying and assessing complex claims

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

The Discussion Paper identifies that the Ombudsman "characterised claims that progress beyond 130 weeks as 'complex claims'" (page 9). 130 weeks of compensation is a crucial time in the claim, as it is the point where entitlement to weekly benefits will continue or be terminated, based on a determination as to whether the worker has *a current work capacity* or *no current work capacity.*

However, a claim does not become complex at 130 weeks. The claim gets to 130 weeks because it is complex.

Complexity can occur for several reasons:

- the nature or severity of the injury or illness;
- specific features of some mental injuries, compared to physical injuries;
- inappropriate response by employers when the injury is first reported and/or when the claim is first lodged;
- Circumstances of the employer that make RTW difficult, e.g. size and, in the present situation, COVID impacts;
- Personal circumstances or mindset of the individual; and/or
- Agents making bad decisions and/or badly communicating decisions

It should be noted that WorkSafe Victoria already has arrangements in place for the Transport Accident Commission (TAC) to manage catastrophic claims, given their unique nature.

How, and at what stage, should claims for workers' compensation be assessed as being complex, or at risk of becoming complex?

An employer has 10 days to lodge a claim with their agent if the claim has any lost time, exceeds the threshold for medical expenses, or if the employer wishes to have the claim investigated.

Any claim that involves the employer wanting to have the claim investigated has the potential to become a complex claim and appropriate interventions should occur to minimise any negative impact on the employment relationship to be damaged.

In all other circumstances a key requirement of claim management should be at least an initial assessment on claim lodgement about the potential for the claim to become complex, particularly if the worker has not returned to work.

Data from research and from WorkSafe's extensive claims database should assist in identifying any factors associated with the employer, the claimant or the injury that may lead to a claim becoming complex.

Artificial intelligence systems should not be the only source of such an assessment, but they can identify those claims that have critical characteristics that may lead to complexity, to enable rapid assessment of the need for intervention.

Al other claims should be assessed for potential complexity once a worker has been away from work for 4 weeks.

Case management of complex claims

Are current case management practices able to support and treat the individual needs of injured workers with complex claims? How? What needs to change?

As an external organisation that supports employers who have concerns and complaints about the employer interaction with the agent, the difficulties experienced have not changed over recent years. They generally include: frustration with multiple and changing claims officer; lack of communication and explanation about claims decisions; and a lack of support when having difficulties with return to work.

It is not clear from our interactions whether the cause is the claims practices, staff turnover, high caseloads, or other facets of the case management practices.

Other issues associated with the management of claims

The employer's response to an injury can be a significant indicator of how the claim will progress, particularly in relation to injuries that do not involve a traumatic injury. These are the claims that often commence with a phone call to the employer where the worker says, "I hurt my back last week, I have gone to the doctor and I won't be at work for 2 weeks".

An employer who has never experienced a WorkCover claim is likely to go the WorkSafe website for advice and guidance. Therefore, it would be reasonable to anticipate that the website would be designed to give an employer good advice on how to support the worker in those first few days, in order to maintain contact and start planning for return to work.

Instead, as outlined in Figure 1, when clicking on the "make a claim" button on the home page and choosing the employer option, the information provided to the employer is not about contacting the worker and providing support for return to work. Instead it is about the forms that need to be filled in and submitted. The way the information is presented also has the risk of implying that the important time frames relate to claim lodgement and the employer doesn't have to do anything more until the agent advises about acceptance of the claim.

Figure 1: WorkSafe advice to employers when an injury occurs

The first advice is to report a notifiable incident.
This is reasonable advice as failing to do so would make the employer in breach of the law.

The employer is then advised to fill in the injury register.

The next steps are represented by three blocks which are mostly likely to be read sequentially across the page: submit your employee's claim; after completing employer's documents; and plan your worker's return to work.

Submit your employee's claim:

Step 1. Your worker must complete an injured worker's claim form
Step 2. You must complete the employer's claim report

Employers must act fast

You have 10 calendar days to lodge the claim with your WorkSafe agent from the time you receive the worker's injury claim form from your worker. There can be penalties for failing to meet this timeframe. Your WorkSafe agent has 28 days to assess the claim and let you know the outcome.

Step 3. Working with a Circumstance Investigator

After completing employer's documents:

Your WorkSafe agent will tell you if your claim has been accepted within 28 days

Get your worker back to work
Step 1. Understand what tasks your worker can do
Step 2. Start planning for their return to work
[in this section there is no reference to talking to the worker]

Plan your worker's return to work:

Begin by talking to your worker

https://www.worksafe.vic.gov.au/your-employee-submits-claim

Although this Review is focused on the agent role in managing complex claims, WorkSafe should also review communications and information provided to employers to ensure that it sends a consistent message about: the importance of early employer engagement with injured workers, including provision of tools to help them do it well; the employer obligation to commence planning return to work as soon as they become aware of the injury (even before they fill in the paperwork); and the capacity to seek assistance from the agent whilst the claim is being processed.

Financial incentives and agent decision making

What role does the current financial incentives for agents have in the agent's management of complex claims?

Financial incentives for agents is a crucial part of the scheme management. In years long gone insurers and agents worked in a model where their remuneration was determined by the level of premium they collected. Premiums were determined by the cost of claims. Increased costs meant increased premium, even if the insurer/agent was the reason for the increased claims costs. It would not be appropriate to return to such a model.

Similarly, if agents are awarded five-year contracts with no opportunity to increase their payments through good performance, or have penalties applied due to poor performance, what incentive is there to strive towards improved outcomes within their portfolio, or to contribute to improvements to the scheme?

The challenge is to establish well-balanced KPIs that drive the correct response by agents, in the best interests of workers, employers and the viability of the scheme.

Do the current financial incentives for agents support prompt, effective and proactive outcomes for injured workers with complex claims? How? What needs to change? Any different or additional measurements which could be linked to financial incentives to promote quality decision making by agents.

Each year members of WorkSafe's consultative forum, the Rehabilitation and Compensation Working Group (RCWG) are provided with an update on the Annual Performance Adjustment (APA) measure applied to agent Remuneration.

We note that the 2020/21 APA includes a very strong focus on Back@Work Measures:

- 26% upside incentive, which is more than 50% of the total upside payments available; and
- -5.25% downside remuneration reduction, which is 50% of the downside that can be applied.

This is a significant change from the 2019/20 APA, as reported in the Annual Report that had 13% of upside allocated to Back@Work measures. We welcome this strong focus on return to work. If it achieves better outcomes it will be of benefit to injured workers, employers and the scheme.

We do have some concern about the removal of the relatively small amount of upside and downside measures associated with second entitlement reviews and long tail claims management. At the most recent RCWG we were advised that these were removed in response to the OV concerns about incentives for "disentitlement".

It is our view that such a response creates a risk that agents will not give the necessary focus to making appropriate decisions about termination of claims at the correct times. We have been assured by WorkSafe that there are a number of controls and oversights to manage the second entitlement review, which is a legislative requirement that requires appropriate rigour.

It is important that these controls and oversights are applied, and outcomes reported to stakeholders.

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

The most significant non-financial drivers for agents to making quality decisions is to know that they will be held to account for making poor decisions. The challenge is how to strike an appropriate balance between oversight and micromanagement, in a scheme that has been structured around agent decision making and an oversight process by WorkSafe.

If WorkSafe become too involved in the day to day management of agent processes, it would logically raise a question about the value of the agent model across the scheme in total.

Audits of claims by WorkSafe are a vital measure; the predominant focus should be "key decisions" and "claims management processes". It is essential that the audit process is well-balanced, particularly in relation to "quality decision making" (QDM).

One of the concerns raised by employers in response to the recommendations of the OV and the implementation of the recommendations by WorkSafe is "the easiest way for an agent to avoid scrutiny of their adverse decisions is to only make decisions in favour of claimants."

To ensure both the integrity of the scheme, and the perception of integrity, it is important that QDM audits involve selecting an equal number of favourable and adverse decisions to ensure that agents do not overcompensate in order to avoid future criticism.

Oversight of agents by WorkSafe

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

Ai Group does not have sufficient line of sight to assess WorkSafe's oversight of agent activities. However, as an organisation that assists employers to navigate the workers' compensation system, we do know that there continues to be frustration amongst employers in managing their relationship with agents. These frustrations include: a perception that their views have not been considered when a claim has been determined; and difficulties in getting timely support from agent staff, including issues associated with staff changes and turnover.

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? Describe why, or why not.

The new mechanisms have the potential to improve WorkSafe's oversight of agent decision making.

Quality Decision Making Audits and Health Checks

It is Ai Group's view that WorkSafe needs to proactively assess the effectiveness of approaches such as the *Sustainability of Decision-making Framework (SDMF)* to ensure they are achieving the expected outcomes. Mechanisms should be established to provide meaningful feedback and discussion with stakeholders in relation to the findings and learnings from WorkSafe's Quality Decision Making (QDM) audits and health checks of agent decisions.

It is important that the sample of claims considered in these audits and health checks provide a balance of decisions that are beneficial and adverse. This will ensure that agents do not default to a culture of avoiding valid adverse decisions.

Workers' Compensation Independent Review Service

In response to Recommendation 3 of the 2019 Ombudsman's Report the Workers' Compensation Independent Review Service (WCIRS) has been operating since 30 April 2020. The WCIRS can review *genuine dispute* outcomes that relating to an agent decision that was made on or after 3 December 2020. It is our understanding that WCIRS can direct agents to make a new decision. However, this does not stop an agent from making a later, different decision, based on further assessment of the facts.

Ai Group has been provided with the following information about the operation of the Review Service by the head of the WCIRS.

- The role of WCIRS is to scrutinise the decision made by the agent. Therefore, their interaction is with the agent and there is no role for an employer to play in direct engagement with the Review Officer.
- When the WCIRS receives an application from a worker they advise the agent who made the disputed decision. A standard letter has been developed by WorkSafe Victoria for the agents to send to the employer advising of the WCIRS application.
- The WCIRS review the agent's claims files and have the capacity to upload any new information received onto the electronic case file. The agent is advised of updates and encouraged to engage with the employer if there is new information which would be relevant for the employer to consider and provide feedback.

Ai Group is concerned about the exclusion of the employer from the direct processes of the WCIRS. We are also concerned that the role of the Accident Compensation Conciliation Service (ACCS) is undermined by the WCIRS and may lead to conciliators being reluctant to issue genuine dispute certificates in circumstances where they are warranted.

Employers are encouraged to participate in the conciliation conference, which precedes a WCIRS review. This gives the employer an opportunity to provide additional information to a conciliator to aid decisions. It also means that they can respond to any additional information that is provided by the worker. This is particularly important in relation to claims for mental injury that have been rejected on the basis of reasonable management action.

If a conciliator has taken this verbal information during a conference into account when deciding to issue a genuine dispute certificate, it is not clear how this will be reflected in claims files and other information provided to the WCIRS.

We also believe that the reliance on the agent to communicate new information with the employer and the employer's response back to the WCIRS officer, runs the risk of important information not being considered.

In short, the WCIRS is relying on agents to undertake a key role in this process, when the ability of agents to manage claims effectively is under scrutiny and many of the recommendations of the ombudsman are related to increasing agent oversight.

To date, we have received feedback from one employer who has a worker who has utilised the service. They received verbal advice from the agent that an application had been lodged (not the standard letter developed by WorkSafe). Their next communication from the agent was that WCIRS had directed them to change their decision.

Ai Group has recently been added to the circulation of monthly reports from WCIRS. We will be watching the outcomes closely and are seeking feedback from members about their experience with the service.

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

Evaluation measures

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 prompts, effective and proactive outcomes for injured workers?

The increased emphasis on Back@Work measures in the 2020/21 APA has the potential to achieve a greater focus on applying resources and intellectual energy to achieve better return to work outcomes.

The service measures continue to be a key part of the APA, but none of these measures relate to the experience of the employer. That experience is easily dismissed by saying that employers have the choice of agent and can "vote with their feet" if they are not receiving appropriate support to navigate the system and facilitate return to work.

However, most employers do not have a lot of claims, so their first claim may be the first time they have to assess the agent experience, and at that point it is not appropriate to change agents. When the claim is finished, they breathe a sigh of relief and hope that never happens again.

Those employers who do have a large number of claims employ internal experts to manage claims, who are often resigned to "it's just the scheme and changing agents won't change the outcome".

WorkSafe provide agent Performance data in their annual reports. Appendix 2 of the 2018/19 Report (starting at page 137) illustrates that the variation between agents in reported performance data is not significant.

The *employer service levels* range from 84.8% to 89.5%. If an employer is experiencing bad service with any of the agents, they are likely to look at these ratings and determine that there really isn't much difference; and the agent I am dealing with has obviously been incorrectly rated.

The *Back@Work rate* also has a small range in outcomes for % returned to work within 6 months – from 75.98% to 78.34%. An employer is unlikely to make an objective decision to change agents, based on these figures.

Ai Group is very concerned about evaluation measures that are focused on reducing disputes and complaints. All workers' compensation schemes, that are managed effectively in line with legislative provisions that create rules for eligibility and ongoing entitlements will have disputes and complaints. In a scheme where disputes can only be initiated by workers, not employers, the disputes and most of the complaints will be initiated where agents have made adverse decisions in relation to a claimant.

The easiest way to reduce disputes and complaints is to not make any adverse decisions. This is not a good outcome for the scheme, nor for workers who have a genuine entitlement to compensation.

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

In the context of complex claims, a key measure may be the actions taken towards achieving better outcomes for workers. They may not always be successful, but their application should be acknowledged and encouraged. A current example is the implementation of *facilitated discussions* for mental injuries that involve interpersonal conflict. Whilst they will not be successful in all situations, the identification of appropriate claims to intervene with this service might be measured; the ability for agents to then learn from the successful and unsuccessful use of this intervention could also be measured.

The current agent model and alternatives

Does the current agent model achieve prompt, effective and proactive management for injured workers with complex claims? If yes, describe how. If not, what are the limitations of the current agent model and how could the model be improved to achieve better outcomes and/or any alternatives models that would be more effective. Consider the impact of the financial viability of the scheme with any alternative model.

In responding to this question, it depends on how the "current agent model" is defined. In its ordinary meaning, it is the model that involves agents appointed to manage claims on behalf of WorkSafe Victoria. In this context, there is no reason why the current agent model cannot achieve prompt, effective and proactive management for injured workers with complex claims.

However, the model can also be viewed more broadly, taking into account all the contractual arrangements, WorkSafe oversight, KPIs and incentives, claims officer skills, agent structures and industry turnover. From this perspective the answer becomes more difficult.

During consultative forums with the Independent Reviewer, three possible models were proposed for consideration: status quo; establishing a specialist unit within agents; or transferring complex claims to WorkSafe.

Status quo.

It is Ai Group's view that a version of status quo could be considered as the key starting point. As outlined earlier in this submission, complex claims are the manifestation of many varied circumstances. However, it is widely recognised that early supportive contact between the employer and worker, and the agent as necessary, is a major contributor to achieving better claim outcomes. This needs to occur as early in the claim as possible, in order to reduce the risk of a claim becoming complex. This means that the first contact with the Agent should result in meaningful contact with the employer and worker that supports the maintenance of good relationships. This cannot be achieved by establishing specialised units; it can only be achieved by every front-line staff member knowing that their first priority is to achieve meaningful early contact.

A specialist unit within the agents

The claim segmentation model, which was implemented many years ago, already has a version of this approach. How the segments are intended to operate are outlined in Appendix A. Rather than establish a "new" complex claims approach, it would be valuable to identify what is, and is not, occurring in each of the segments. Are they operating as intended? If not, why not? Consideration should also be given as to whether the first segment (0 to 78 weeks is too long, given that most claims achieve a return to work by 52 weeks).

A specialist unit to manage these claims within WorkSafe

Ai Group is concerned that this could have a range of unintended consequences, including:

- Claims officers within agents being nothing more than paper processors, further depleting expertise;
- Highly skilled staff leaving the agents' recruitment pool as they lose any opportunity of career advancement;
- Agents deciding not to deal with difficulties at the start of a claim as they know that once it reaches a predetermined milestone it will be transferred to WorkSafe;
- A conflict of interest between WorkSafe as the organisation overseeing Agent performance whilst also taking on responsibility for managing the more difficult claims within the scheme; and
- Negative impacts on the wellbeing of injured workers when the agent "gives up on them" because they are too complex and have decided to transfer the claim to WorkSafe.

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

Workers' compensation schemes are unique in their operation due to the ongoing involvement of the employer, unlike transport accident and personal injury claims. Subsequently, we do not see much value in comparing the scheme to anything other than workers' compensation schemes.

When it comes to workers' compensation schemes it is very difficult to compare the management of complex claims between schemes due to the variation in benefit structures.

Victorian Ombudsman 2016 and 2019 reports

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.

Anecdotal feedback from members has indicated a greater reluctance by agents to reject mental injury claims on the grounds of "reasonable management action".

RCWG receives an annual update on the outcome of various types of decisions within the scheme, through what is referred to as Decision Trees. The most recent update was in June 2020, showing data for claims lodged in 2016, 2017 and 2018. As an overall figure, the initial eligibility decisions on mental injury claims has not varied much over that time.

Rejected time loss claims for mental injuries claims were:

2016 – 48.9%; 2017 – 45.7%; 2018 – 47.2%.

However, these reports do not differentiate between claims that are rejected on "reasonable management grounds" and those rejected for other reasons.

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

Ai Group does not believe that an external organisation such as ours can identify the root causes of the problems outlined in the 2016 report, or the 2019 report for that matter. We can make assumptions and judgments, but they are not really helpful.

Do you think implementation of recommendations 3 – 9 in the 2019 Ombudsman report will address those root causes? How and/or why?

Ai Group is mostly comfortable with the recommendations and their potential to address the identified issues. However, we continue to be concerned that implementation of the recommendations could result in an aversion by agents and WorkSafe Victoria to the making of necessary and appropriate adverse decisions.

By way of example, recommendation 7 says:

> *Increase WorkSafe's oversight of the following claims management activities by agents, through targeted 'health checks' or audits:*
>
> *a. agents' use of surveillance*
> *b. mental injury claims rejected under section 40(1) of the WIRC Act (reasonable management ground)*
> *c. return to work non-compliance notices*
> *d. termination of 'top up' weekly payments provided under section 195 of the WIRC Act (or section 93CD of the Accident Compensation Act).*

The focus of this recommendation is on actions that the ombudsman believed should be reduced. If WorkSafe were to implement this recommendation without also auditing situations when these "negative" decisions were not made then an unacceptable culture, averse to making difficult decisions would emerge.

The credibility of the scheme relies on a balanced approach to implementing the recommendations.

Any evaluation of the work undertaken by WorkSafe to implement these recommendations must include an assessment of the safeguards that have been applied to ensure that the scheme is effectively managed in line with legislative provisions for both entitlement and disentitlement.

Further considerations

Are there any other matters the Review should consider in meeting the Terms of Reference?

Workers and Employers at the centre of the scheme

Workers' compensation schemes must recognise that, in most cases, the key to successful return to work outcomes is reliant on the injured worker and their employer being able to work successfully together to achieve effective outcomes.

The role of agents and scheme managers if firstly to implement processes that help to support these two key players to achieve those outcomes. If this fails the role of the agent and scheme managers is to have processes and interventions in place to achieve the best outcome for the injured worker, within the bounds of legislation and entitlements.

The importance of placing the worker and the employer at the centre of workers' compensation management is reflected in the National Return to Work Strategy, developed by Safe Work Australia in consultation with all jurisdictions, and representatives of employers and workers.

In outlining the scope of the Strategy it is highlighted that In recognition of the significance of the relationship between workers and their employers in the return to work process, they are the central focus of the Strategy around which the vision, strategic outcomes, guiding principles and action areas are designed.

Communication with employers

Prior to claim determination

Employers are not usually provided with the opportunity to respond to information provided by the claimant during a circumstance investigation. This can lead to a level of suspicion in relation to the process and may not allow a full consideration of the circumstances of the claim.

We have been told of situations where a claimant has lodged their mental injury claim arising out of a disciplinary process. During the circumstance investigation the worker makes accusations of bullying and the employer has no opportunity to respond to those issues as part of claim determination, nor to take any preventative steps that are required under OHS and other laws. This is not an outcome that is fair and reasonable for all; and may result in a further claim from the alleged bully who was not afforded a right to respond.

In these circumstances, a successful return to work is very unlikely.

Once the claim has been determined.

Workers' compensation schemes are complex and eligibility decisions do not always align with an employer's view of what is fair. If an employer feels that a decision to accept a claim is unjust, they are less likely to have a positive approach to supporting the worker which will ultimately reduce the likelihood of a successful return to work.

It is important that agents take the appropriate time to explain decisions to employers to help them to understand why a claim has been accepted.

When an employer is dissatisfied with a decision, we often recommend that they utilise section 78 of the WIRC Act to seek reasons for the decision. In some cases, once the employer receives that written response, they have a clearer understanding of the rationale for acceptance and can move on more effectively in managing the claim. It may also help the employer to identify corrective actions that need to be undertaken in the workplace, particularly if the claim related to mental injury.

There is no reason, other than the time taken to write the reasons, for an agent not to initiate this level of information provision to an employer at a much earlier stage in the process.

The importance of this review considering the role of employers, and the impact that poor claims management has on their attitude to return to work

We understand that this review is focused on achieving positive outcomes for injured workers, especially those with complex claims.

However, it is important that the outcome of this review also recognises that employers are crucial participants in the scheme. They also deserve fair and equitable outcomes. Employer confidence in the scheme is essential to ensuring there is an increased chance that injured workers will have a successful return to work with their pre-injury employer.

Appendix A – Current documented approach to managing claims

As outlined in section 2.6.3 of WorkSafe Victoria's online Claims Manual, the management of claims is currently *documented* as outlined below.

> *Accepted claims for weekly payments are managed in either the 0-78 weeks, 78-130 weeks or the 130+ weeks segment. When managing claims in any of these segments, agents are required to:*
>
> - *develop a claim summary with a case management strategy and*
> - *manage a claim using a multidisciplinary approach.*
>
> ***Multidisciplinary approach***
>
> *The objectives of the multidisciplinary approach are to:*
>
> - *evaluate the worker's capacity to return to work based on information obtained:*
>   - *no current work capacity (including catastrophic claims)*
> - *a significantly reduced work capacity*
> - *a current work capacity but with no suitable employment identified or*
> - *a current work capacity with suitable employment identified*
> - *identify return to work barriers and goals*
> - *assess the appropriateness of current entitlements, treatment and services*
> - *identify potential entitlements such as impairment benefit and*
> - *develop strategies to manage the claim.*
>
> ***Objective of the 0–78 weeks segment***
>
> *The main objective is to ensure that claims management is based on a high and consistent level of medical, legal and case management expertise to maximise the early, safe and sustainable return to work of workers.*
>
> ***Objective of the 78–130 weeks segment***
>
> *In addition to the aim of the 0-78 weeks segment, the main objective of the Tail segment is the timely and appropriate application of the Capacity Test at the end of the second entitlement period.*
>
> ***Objective of the 130+ weeks segment***
>
> *The main objective of the Long Tail segment is to regularly review a claim to ensure that the worker receives their correct entitlement to weekly payments after the second entitlement period.*