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

sda VICTORIA
THE UNION FOR WORKERS IN RETAIL.FAST FOOD. WAREHOUSING.

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UNITED AND STRONG

Authorised by Michael Donovan, State Secretary, Shop, Distributive and Allied Employees' Association, Victorian Branch

1. The SDA

The Shop Distributive and Allied Employees' Association Victorian Branch is a registered trade union, consisting of approximately 50,000 members. The SDA serves a diverse range of members across the retail, fast food, warehousing, pharmaceutical and beauty industries, and advocates for better pay and conditions for these members, on a variety of platforms and on both the individual and collective levels.

The Victorian Branch's Industrial department also consists of a dedicated Work Cover unit, which operates to assist injured SDA members in navigating their Work Cover claims, provide assistance with return to work issues, and represent injured workers in industrial or workplace matters. One of the primary functions of the Work Cover team is advocating for SDA members at the Accident Compensation and Conciliation Service (ACCS) in disputes over their entitlements to medical treatment and weekly compensation payments. In carrying out these functions, the SDA is frequently involved in consultations with plaintiff lawyers in workplace injury claims and conversations with Work Safe Victoria agents, claims managers and self-insurer representatives.

It is the SDA's experience in this area that forms the basis for the submissions to this review, and the avenue through which the union and its members have come to understand the significant shortfalls in Work Safe's 'Agent-Model' and its capacity to appropriately manage complex claims. A sample of SDA members who underwent the conciliation process in the first half of 2020 has demonstrated the following:

- The average age of these claimants is 45 years old.
- 69% of these claimants are female SDA members.
- 31% of these claimants are female SDA members over the age of 50.
- 41% of these claimants are female SDA members over the age of 40

While this breakdown does not strictly distinguish between claimants who had 'complex' claims or otherwise, it nonetheless highlights some significant vulnerabilities in regards to our membership base, and in particular, our female members in the 50-plus age range. The prevalence of this demographic in the SDA's Work Cover caseload is indicative of the limitations in career mobility for older female members in the industries for which the union has coverage.

The result is that these members perform in more physically demanding roles, at lower-paid classifications, for longer periods of time. Consequent vulnerabilities include

difficulties in distinguishing gradual process workplace injuries from degenerative conditions, as well as concerns arising from the prospect of termination of employment, and the well-known difficulties for this demographic in re-joining the labour market. These factors magnify the 'complexity' of our members' claims and can often lead to claims for secondary psychological injury, and other negative impacts on mental wellbeing.

In providing our response to the Review, the SDA has taken note of the Discussion Paper and Consultation Guide provided by the Independent Reviewer as well as the 2016 Victorian Ombudsman's Work Safe Report and its 2019 follow up. While we have not provided direct responses to all questions listed in the Consultation Guide, we have framed our responses to incorporate these questions under a number of headings below. The SDA's response to the Review hopes to provide a more detailed picture of the issues faced by our members in their specific industries. Much of that response will be aligned with submissions presented by other plaintiff and employee representatives, insofar that it is underpinned by an uncontroversial position: That the Agent-Model and its financial incentives scheme is wholly inconsistent with achieving satisfactory outcomes for injured workers with 'complex' claims.

2. Classification of Complex Claims

It is noted in the Attorney General's Terms of Reference that the definition of 'complex' claims is 'those [claims] where the injured worker has received 130 weeks or more of weekly payments'. It is the SDA's position that the current definition of 'complex' claims is arbitrary and inadequate in identifying the nuances of individual circumstances and their relevant complexities. While those claims where weekly payments are required beyond 130 weeks are indeed complex in their own right, this definition precludes other markers of 'complexity' which ought to be taken into account.

To ensure the propriety of the Agent-Model, and to avoid the exclusion of many complex matters from better claim management processes, it is pivotal that the classification of complex claims occurs at the earliest possible stage, and even throughout the life of a claim. In many instances, this will be possible from the outset. Below are a number of circumstances which the SDA believes warrant immediate classification as a "complex claim".

All Psychological Injury Claims

Claims for psychological injury are complex by their very nature, and require classification as such from the outset of any claim for compensation. These matters are complicated a medical sense, as they require the consideration of a variety of psychosocial, circumstantial and biological factors. However, they are also difficult to determine in a factual sense, and decisions surrounding these claims are often the result of unscrupulous circumstance reports or unreasonable evidentiary requirements. Moreover, the consequences for mismanagement of psychological injury claims are highly significant and include the risk of suicide. Despite these risks, many agents continue to handle psychological injury claims in an irresponsible and harmful manner.

The SDA notes the account of a claimant's experience at p.120 of the 2019 Ombudsman's Report, as illuminating the experience of many of our own members making psychological injury claims:

> "The litigation process related to psychological injury claims has been suggested by our members to be equally or more stressful than the injury itself. Many claimants…who are involved in psychological injury claims will accept less compensation or abandon their claim to avoid these stressors. [It is believed] that the process of rejecting these cases is in the hope that members run out of leave, benefits, or money, so that they give-up, resign, or return to work and forget about the claim."

All Claims with Multiple or Secondary Injuries

It is the SDA's position that all claims where employees sustain multiple injuries in one event, or where secondary injuries occur (including aggravations and exacerbations of previous injuries), ought to be classified as complex, for the below reasons:

- Claims where multiple injuries have occurred may require different areas of medical expertise and more tailored treatment responses.
- Claims where an employee aggravates a previous workplace injury may be indicative of mismanagement of the worker's return to work programme, poor employer supervision or inaccurate medical diagnoses or capacity assessments.

- Claims where employees have secondary injuries or aggravations can often create pressure, discontent or tension in a workplace. This can lead to deterioration in employment relationships and negative impacts on mental wellbeing.

Spinal Injuries and Injuries Requiring Surgery

Where a worker sustains an injury which has reasonable prospects of requiring surgical intervention, classification as a complex claim is warranted. The prospect of surgery can be daunting for claimants and have significant impacts on their mental wellbeing. Poor mental health outcomes are also seen in cases where claimants have their requests for such surgery rejected, as such decisions raise anxiety and uncertainty over a claimant's prospects of recovery and access to pain relief. Moreover, in instances where medical treatment sought by claimants may be more complex, costly or risky, the conflict between the scheme's priorities – financial viability and injured worker outcomes – becomes more apparent.

Naturally, a decision to reject expensive surgical treatment represents a significant saving in terms of claims management. While not all requests for surgery may be reasonable or necessary, creating a financial incentive for their rejection remains extremely fraught. Agent decisions surrounding requests for treatment have formed the basis for much of the criticism levelled at the scheme by the Victorian Ombudsman. Reasons for this include practices engaged in by agents, such as "doctor shopping" for favourable report outcomes, or maintaining unreasonable decisions at conciliation, in the hope that an injured worker will accept an insufficient offer under recommendation.

Injuries with Poor Prognosis for Recovery

Where claims relate to injuries that are known to have a poor prognosis for an injured worker's recovery, they ought to be classified as 'complex' at the earliest possible stage. Much of the reasoning for these classifications is the same as that which applies to spinal injuries or injuries requiring surgery. Claims where a worker's treating health practitioners note limited prospects of recovery, or of a worker returning to their full, pre-injury capacity often mean that a worker faces significant stressors in relation to impending unemployment, financial and familial distress, as well as the physical implications of their injuries. Frequently, the impending end of the 52 week employer obligation period serves

to compound these stressors.

3. Issues with Agent Model

The SDA's issue with the current 'Agent Model' comprises of two distinct but directly related elements. The first of these are the performance measures and financial incentives used to guide agent decision making, while the second is the conduct of the agents themselves, both in the conciliation process and throughout the management of our members' claims.

While it is understood that the imposition of performance measures may broadly be seen as an incentive to effectively manage claims, administer benefits and promote financial viability, the SDA has concern both with the measures themselves, and the manner in which these measures are assessed. In forming its criticisms, the SDA has had regard to the metrics and Agent Performance Results contained in the 2019 'Work Safe Victoria Annual Report' and the 2019 Ombudsman's Report.

The Performance Measures

Notwithstanding that there are significant transparency issues in regards to the performance measures and their financial incentives themselves, the SDA has issue with their operation in practice, and their impact on the wellbeing of its members. These measures are broadly distinguished as 'Return to Work' or 'Sustainability' measures.

One such example is the '26 week return to work measure'. This metric rewards the achievement of a base target for having injured workers return to work (including part-time) within six months, and staying at work for a minimum of three weeks. At surface level, providing incentives to agents to assist workers to return to work in a timely manner seems appropriate. However, such measures are only valuable insofar as they are meaningful. In this example, some obvious questions arise regarding the 3 week minimum period. What if the worker aggravates or exacerbates their injury after this time? What if the worker's employment is terminated after this point? What if a worker previously working 38-hour weeks returns to work, performing only a small fraction of their previous hours? In all these circumstances, it is difficult to see how a 'return to work' has occurred in any significant sense. As such, it also seems inappropriate to provide financial rewards for the achievement of such arbitrary measures.

An example of a 'sustainability' measure is the '134-week weekly payments measure'. This metric sets a base performance level of 2%, ostensibly incentivising agents to ensure that claimants engage with their return to work obligations, receive appropriate treatment and cease reliance on compensation payments. In reality, this is a blunt measure that encourages agents to unreasonably terminate entitlements to payments, to achieve artificial or arbitrary targets for financial gain.

Another example of a 'sustainability' measure is the 'injured worker service measure'. This metric is based upon responses to surveys provided to injured workers, assessing their satisfaction with their claim's management. The 2019 Work Safe report indicates that the base performance level for this metric was 81%. While this appears to be a relatively high standard for claimant satisfaction, it must be considered in light of the fact that the overwhelming majority of Work Cover claims are uncomplicated.

Indeed, most claimants return to work within weeks, for injuries that are relatively simple. As a consequence, it is unsurprising that the experience of these claimants with the Work Cover scheme is uncontroversial. Given the sheer volume of such claimants, it is natural that their survey responses overshadow the experience of claimants with more complex matters. Put simply, it is not appropriate to rely on the reviews of a claimant with a sprained ankle, to assess the overall performance of agents in the management of claims for injuries such as an adjustment disorder or spinal complications. Such reviews do not accurately reflect the experiences of those with 'complex claims'.

Conduct of Agents

The SDA understands that the administration of a complex scheme such as a worker's compensation scheme will likely need to rely on certain performance measures and indicia to assess its impacts and efficiency. Even if such measures may be unavoidable, it is the conduct of agents in achieving these measures that has been the area of most significant concern. The SDA has witnessed this conduct both first hand through communication with agents at conciliation conferences, as well as though conversations with our members about their experiences. Such practices are detailed below:

Unreasonable Conduct at Conciliation

Frequently, agents engage in the conciliation process with little appreciation for the principles of good-faith negotiation. The SDA has attended many conferences where

agents have attempted to maintain decisions that they know would not stand up in court, in the hope that claimants will abandon their disputes. Examples include:

- Refusals to negotiate over inexpensive or minor medical entitlements in attempts to force claimants to seek a Genuine Dispute. In these instances, agents know that the prohibitive costs of any such dispute far exceed the value of treatment sought – thereby rendering a Genuine Dispute ineffective.
- Refusals to implement a direction issued by the ACCS, where agents have been found to have no arguable case. In this instance, the financial penalty for this breach was lower than the costs of making payments to the injured worker.
- Failing to pay for or provide reports for an upcoming conference at the ACCS. Agents frequently fail to respond to requests for payment by medical practitioners and to provide medical reports to claimants and their representatives until the last minute. This causes claimants significant distress, as well as serving to prejudice the proceedings at the ACCS by not allowing claimants time to properly prepare for conciliation.

Poor and Misleading Communication with Claimants

The SDA has received many complaints from injured members regarding the communication styles and practices of claims agents. These complaints frequently include:

- Being unable to contact their case managers when seeking information on their obligations and entitlements.
- Being contacted by phone, despite requests to be contacted via email or through an authorised representative.
- Contacting an injured worker's medical practitioners in an attempt to influence the certification of the worker's capacity.
- Having their case managers changed without warning.
- Case managers affecting an overly friendly or familiar tone with injured workers when trying to influence their decisions – potentially for financial gain.
- A general reliance on an injured worker's ignorance of or unfamiliarity with the Work Cover scheme.

Reliance on Surveillance Reports

In many claims relating to psychological injuries, agents have unreasonably relied on circumstance reports, surveillance materials and investigations conducted by both internal Human Resources departments, and third-party providers. Frequently, these have been dubiously obtained, contain selective information and present one-sided or biased versions of events.

These materials are particularly prevalent when psychological injuries are claimed to have resulted from bullying and harassment, perpetrated by management or other senior workplace figures. Reliance on this kind of evidence is essential in engineering a finding that any such conduct by management constituted 'reasonable management action', in accordance with the provisions of 789FD of the Fair Work Act. The SDA has encountered many examples where the obtaining of, or reliance on such materials has been unfair, unreasonable and unethical. These include:

- Surveillance of a psychologically injured worker while getting a haircut: The insurer later claimed that this behaviour was inconsistent with the employee's medically certified inability to attend work.
- Deceptively obtaining a statement from an intellectually disabled and autistic employee, and including the statement in a completed circumstance report, despite the refusal of the injured employee to sign it.
- Witnesses to alleged events in the workplace being casually questioned about these circumstances, and later finding out that their responses had been twisted, misinterpreted or misused to substantiate or dismiss a certain finding, and effect certain disciplinary action.
- Claims agents collaborating with HR departments to ensure consistent narratives in psychological injury claims involving workplace bullying and harassment allegations.

Independent Medical Examiners and Responding to Requests for Treatment

A significant problem reported by SDA members has been the adversarial approach undertaken by agents in responding to worker requests for treatment. It appears that it is a prevalent tactic to continually delay, obfuscate and confuse claimants as to their entitlements, and the most effective way to access them.

Even where an injured worker has a claim that is accepted and uncomplicated, many agents appear to feel that they are entitled to demand justification for each and every treatment request. Often, this approach leads to required attendance at an IME, and

frequently, agents refer these claims to the same medical practitioners to ensure the same results.

IME reports that are obtained for one purpose, are then mined for potentially advantageous information and used to justify further refusals for treatment and the termination of entitlements. For many SDA members, the life of a Work Cover claim is frequently punctuated by an exhausting and debilitating series of small battles related to accessing their entitlements.

The culmination of all the conduct described above has a number of serious negative impacts. Of course, the primary impact is on the health and wellbeing of already vulnerable individuals. The mismanagement of complex claims jeopardises the effective recovery of claimants from workplace injury, as well as their mental health and wellbeing. Claimants frequently feel as though new obstacles are being placed in their way, preventing their progress and leading to feelings of anger, isolation, depression and despair. They understand that their claims are treated as a series of numbers and targets, unrelated to their individual circumstances, and the conduct of the agents does little to dissuade them of this notion.

These negative outcomes are compounded by the fact that the conduct of claims agents also serves to act as a deterrent for medical practitioners and treatment providers to engage in the Work Cover and return to work processes. The SDA has had many reports from members who have been refused by multiple doctors for requests to assist them in workplace injury matters. This is unsurprising given the previously mentioned difficulty for these practitioners in obtaining payment for completing time consuming and detailed medical reports. As a consequence, it often appears to be the case that insurers are able to obtain detailed reports from IMEs more easily than workers are able to obtain reports of a similar standard, and this serves to unfairly skew the evidentiary balance in an insurer's favour.

4. Self-Insurers

It is of note that a very large proportion of claims for compensation made by SDA members are managed by Self-Insurers, some of which are among the largest employers in Australia, and the most prominent entities in their respective industries. While the SDA understands that the scope of this review pertains to the outsourced agent model, it has

become evident that much of the conduct outlined in the 2016 and 2019 Ombudsman's reports is also prevalent among these Self-Insurers.

The SDAs position is that Self-Insurers are ill-equipped to manage complex claims, that their ability to do so is incompatible with an inherent profit motive, and that this conflict is irreconcilable. This incongruity is particularly relevant in the context of claims for psychological injuries relating to bullying and harassment matters; where Self-Insurers frequently act to dispel any potentially negative imputations regarding their workplace culture or practices.

While saving on costs to business by terminating, refusing or limiting access to entitlements is the most obvious manifestation of this problem, Self-Insurers are also motivated by a number of other concerns. These include desires to resolve their conflicts internally, retain an ability enforce their own codes of conduct and policies and protect their public images. While these may be natural motivations for any business, they appear to be inconsistent with ensuring that complex claims are managed with appropriate care and transparency.

5. Reform of Complex Claims Management

The SDA is supportive of all possible reforms to the management of complex claims that serve to prioritise employee welfare. While the mechanics of any incentive-based scheme are important to consider, it is more significant that such schemes effectively cater to the individual needs of injured workers and are capable of identifying and appropriately addressing claimant vulnerabilities.

While the SDA believes that the demand for this review indicates a need to consider the 'agent model' in its entirety, it is not principally opposed to the presence of incentive based schemes as an effective claims management tool, and recognises the need for effective performance measures, given the gravity of complex claims.

Again, such performance measures are only valuable insofar as they gauge tangible outcomes for injured workers. While a 'return to work measure' is already in place, its assessment is arbitrary and the measure itself provides little insight into injured worker outcomes.

Any revised 'return to work' incentive ought to have significantly more regard to the depth and breadth of a worker's re-engagement with employment and a more holistic

approach to worker recovery. Such an incentive should consider the extent to which injured workers have returned to their pre-injury duties and hours and the mitigation of the mental health impacts of workplace injuries and return to work processes.

The SDA believes that the most significant performance measure ought to be the 'injured worker service measure', and that its construction is ineffective in assessing agent management of complex claims. An injured worker's experience and review ought to be at the forefront of assessing claims management, and complex claims, once classified as such, should be assessed distinctly and on separate criteria from non-complex claims.

In considering overall agent performance in light of injured worker surveys, the responses from workers with complex claims should be given significantly more weight than other claims. The SDA believes that any scheme that considers it appropriate to award agents for satisfactory performance should also be equipped to demand greater accountability from these agents, and if necessary impose punitive performance measures or disciplinary action where the proper standards are not upheld.

While incentives are a tool to encourage and monitor agent performance, the SDA is of the view that incentives may also be useful for employers in achieving positive injured worker outcomes. Of course, any such incentive would need to align with the desired outcomes described above. That is, a focus on meaningful return to work measures and steps in recovery, as well as an increased focus on mental wellbeing.

Injured workers with complex claims are frequently facing challenges on two fronts. At the same time that they are attempting to navigate the intricacies of the Work Cover system, they also face significant questions over their ongoing employment. This is often compounded by managerial pressure and unnecessary or invasive requests for medical information. The SDA understands that many large employers incentivise managers to minimise claims for compensation at the store level. Ostensibly, such aims are achieved by creating safer workplaces. In practice however, they are achieved by discouraging employees from making claims, pressuring employees to return to work before they are ready or terminating their employment. The SDA believes this issue is magnified in regards to Self-Insurers.

The SDA believes that an extension of the 52 week employer obligation period would be of significant value to the scheme, and would give more peace of mind to those at their most vulnerable. Frequently, Work Cover entitlements are withdrawn, and termination of employment follows soon after, compounding injured workers' distress and confusion.

The SDA also believes that there ought to be greater oversight of the terminations of injured workers, where liability for injuries remains in dispute. Where claims have been rejected or the insurer decides that they are no longer liable for an injury, duties are often withdrawn before the 52 week obligation period. This can lead to situations where injured workers feel pressured to obtain clearances for full duties, despite being medically unfit to do so. Additionally, in can lead to procedural unfairness. In situations where the question of liability is subject to an ongoing dispute, employers often see this as a window to terminate employment. Case law on the matter says they are entitled to do so on the basis of the information before them. In situations where an employer's liability is later established, there is little recourse for terminated workers.

The SDA is aware that contributors to this review are in support of a model that is akin to that in the Traffic Accident Commission. While the SDA is not involved in cases at the TAC, it is aware that claims in this jurisdiction are not outsourced to agents, and as such are not subject to the same incentive schemes or workplace culture. The SDA believes that this is a positive distinction, and broadly supports the imposition of an in-house model. Additionally, the SDA is aware that the Queensland Government administers its worker's compensation scheme in-house, with greater oversight of agent decision making and little of the metrics used in the outsourced system. Again, the SDA believes that this is an appropriate avenue to explore.

The SDA is aware of some call for a hybrid approach, which retains the agent-model, but through more effective triaging processes, refers complex claims to be managed in an in-house environment, such as those described above at the TAC or in Queensland. The SDA is broadly supportive of this approach and understands that retaining the agent model in some capacity may assist in maintaining the scheme's financial viability. However, if it is considered – in line with the above submissions – that the agent-model is inappropriate and ineffective to manage complex claims, a question arises as to why such a model is necessary at all. If those claims that are not considered complex, are indeed simple, then there is no reason why they too should not be able to be efficiently managed in an in-house model. Additionally, if these are simple injuries that require minimal medical intervention, minimal time off work and minimal agent oversight, then surely it is not appropriate to disproportionately reward agents just for doing their job.

6. Summary

The SDA is aware of many aspects of complex claims management that are due for significant overhaul. As a union we believe that reforms to this area are crucial to enhancing the safety and welfare of Victorian workers, in promoting the long term viability of the worker's compensation scheme and in improving injury outcomes for businesses.

While there will no doubt be many different approaches suggested for implementing such reform, it remains imperative to remember that the current deficiencies in claims management cannot be remedied by simply tweaking agent performance measures and incentives. Rather, the experiences of the SDA's members, as well as the reports of the Victorian Ombudsman indicate the need for wholesale cultural change. Whether this is possible to achieve in the context of a profit-motivated organisation will ultimately be up to the Independent Reviewer to decide on.

Nonetheless, the SDA reiterates that reform to complex claims management should begin with redrawing the definitions of complex claims themselves. Any such redefinition should be expanded to include psychological injuries, secondary or multiple injuries and injuries related to the spine, requiring surgery or having low prospects for meaningful recovery.

Further, the SDA believes that any performance measures used to assess an agent's claims management need to be recalibrated, to ensure that real outcomes for injured workers are the primary goalposts for any incentive scheme. While the incentives employed thus far have been undoubtedly problematic, it is the conduct of agents that has been most distressing. These problems are amplified in regards to Self-Insurers.

It is the SDA's position that agents ought to have more accountability to injured workers, and that more oversight of their conduct and communication is required to ensure greater trust in the scheme. The service reviews of claimants with complex matters ought to be at the forefront of consideration when considering the potential reward or remuneration of any agent.

The SDA is supportive of all measures that advance the interests and wellbeing of its members and welcomes the review into the management of complex claims. While the agent-model has caused irreparable damage to many of our members, we hope to advocate for reform that prevents this from recurring and protects the interests of injured Victorian workers for many years to come.