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

Submission to Peter Rozen QC

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Who we are

The Australian Lawyers Alliance (ALA) is a national association of lawyers, academics and other professionals dedicated to protecting and promoting justice, freedom and the rights of the individual.

We estimate that our 1,500 members represent up to 200,000 people each year in Australia. We promote access to justice and equality before the law for all individuals regardless of their wealth, position, gender, age, race or religious belief.

The ALA is represented in every state and territory in Australia. More information about us is available on our website.[1]

The ALA office is located on the land of the Gadigal of the Eora Nation.

[1] www.lawyersalliance.com.au.

Introduction

The ALA welcomes the opportunity to engage in this review.

We note the purpose of the review, as set out in the Discussion Paper[2]:

> *The Review will investigate the adequacy, suitability and effectiveness of the agent model in managing complex WorkCover claims under the Workplace Injury Rehabilitation and Compensation Act 2013 (WIRC Act). The Review will determine how and by whom complex claims should be managed to achieve optimal outcomes for injured workers, having regard to the need to maintain the financial viability of the scheme.*

We further note the compelling case for the review, as noted in the Discussion Paper[3]:

> *Despite making up only a small proportion of workers' compensation claims, complex claims are the basis for a relatively high number of complaints to WorkSafe and the Victorian Ombudsman about agent conduct and decisions. This high number of complaints led to the two investigations by the Victorian Ombudsman into the management of complex claims in 2016 and 2019.*

The outcomes of the Ombudsman's reports are described in the Discussion Paper[4] as follows:

> *The Ombudsman's 2019 report followed on from her initial investigation in 2016 into WorkSafe and its agents. Both the 2016 and 2019 reports highlighted several deficiencies that indicated a number of complex claims were being mishandled by agents including evidence of:*
>
> - *unreasonable decision-making by all five agents;*
> - *agents maintaining unreasonable decisions at conciliation, forcing workers to take the matter to court;*
> - *financial rewards encouraging agents to focus on rejecting or terminating entitlements; and*
> - *limited accountability or oversight mechanisms of agent decisions by WorkSafe.*

These finding reflect the experience of ALA members, and the clients they serve.

Following participation in the consultation process, and given that the Terms of Reference limit the review to only considering how *complex claims* are managed, there appear to be three courses of action available to this review:

- Option 1 – Retain the status quo, but rely on cultural change within WorkSafe to drive improvement.
- Option 2 - Retain the agent model, but require each agent to remove claims from general claims management at 130 weeks (or at whatever measurement of complexity is adopted). These would be handed to a dedicated unit within each of the current agencies with specialist skills in complex case management, and tailored incentives to reward good case management and quality decision making.

[2] https://engage.vic.gov.au/download_file/32038/4492; section 1.2, p.4

[3] Ibid; p.9

[4] Ibid; s.2.3, p.10

- Option 3 - Retain the agent model, but have a system where the cohort of complex claims go back to the Victorian WorkCover Authority for case management.

Of these options, the ALA supports Option 3.

We believe that Option 1 will merely see a perpetuation of the current, inadequate process. Cultural change is going to be central to any improvement in the management of complex cases, but we believe that change is required now – and waiting for cultural change to permeate the scheme will lead to more lost years.

While Option 2 is better, it does not address the core issue at the heart of the Discussion Paper, and in the Ombudsman's findings – that outsourced case management of complex claims by for-profit agencies leads to compromised decision making.

Option 3 provides the best chance of achieving real change within a reasonable time frame.

We note the Ombudsman's words, as reproduced in the Discussion Paper[5]:

> *Following her 2019 investigation, the Ombudsman concluded that in too many complex claims, the system fails to ensure that adequate compensation is paid to injured workers 'in the most socially and economically appropriate manner, as expeditiously as possible'. She considered that '[n]othing short of wholesale changes to the system will address the issues identified by both the 2016 investigation and the current one'.*

We strongly encourage this review to agree in its findings that 'nothing short of wholesale change' is acceptable. This may include a finding that further evidence collection is justified in establishing whether, in the long term, the agent model is an appropriate means for managing ***any*** workers compensation claim.

Our responses to the questions in the Discussion Paper appear below.

[5] Ibid; p.11

Background

1. For individuals, please explain your experience of the workers' compensation scheme if any.

N/A

2. For organisations, please describe your organisation.

We refer you to our above comments under the heading "Who we are".

Identifying and assessing complex claims

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

ALA recognise that the Review has been using '*those where the injured worker has received 130 weeks or more of weekly payments*' as a working definition of complex claims.

Whilst it may be a useful 'line in the sand' for the purposes of the review, it is not a good definition when looking at systemic adjustments.

ALA believe that there are other factors which should form part of any definition which seeks to delineate complexity. These may include:

- The type and nature of injury. For example, spinal injuries, psychological injuries, pain syndrome injuries, brain injuries, and some amputations will require long term engagement with the scheme, even if weekly payments are discontinued.

- The length of time an injured person is engaged with the scheme for reasons other than weekly payments. The type and nature of injuries as noted above may lead to ongoing connection with the scheme, even once weekly payments are discontinued, in order to access ongoing medical treatment and support services.

- The type and nature of surgery, and the number of surgeries can be an indicator of complexity.

- Whether someone has been found to have a serious injury at common law.

The relative complexity of these factors will differ depending on the personal circumstances of the claimant and the case. ALA believes that the introduction of a narrative type tests to define complex claims would a beneficial addition moving forward.

The current threshold for access to common law damages for injured workers is determined via the serious injury gateway. This is determined through an assessment of Whole Person Impairment (WPI) or the consequences of the injury, via a narrative test. Unfortunately, the current test to remain on weekly payment post 130 weeks sets the bar so high that it is unnecessarily difficult to meet the required standards.

The personalised, narrative test model is the best option for assessing what is and what is not a complex claim. It is important that such a test, however, does not set the bar so high that injured workers who need ongoing support miss out[6].

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

In terms of **how** claims should be assessed as complex, please refer to our response to question 3.

In terms of **at what stage** claims should be assessed as complex, we submit that this may differ depending on the type of injury.

For some injuries, the failure to react or respond quickly will determine the complexity. For example, many psychological injuries will become complex if not addressed early.

The ALA suggests a two-tiered approach to when a claim is identified as complex:

1. At initial lodgement. The type and nature of many injuries will enable an assessment of complexity from the outset. For example, if the claim involves multiple injuries, an assumption of complexity would be justified. As mentioned above, the nature of the injury will also provide an indication, upon lodgement, of the potential for escalation of complexity if immediate action is not taken.

2. Somewhere between 52 and 130 weeks, noting that the employer obligation period ceases after 52 weeks. This timeframe should be retained as a rule of thumb for when case complexity is reviewed.

Case management of complex claims

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

No

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

N/A

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

The ALA is of the opinion that the current system is **ineffective** in delivering and achieving positive health and recovery outcomes, including prompt, effective and proactive treatment and management of injuries.

[6] For more information on narrative tests, the Judicial College Manual on Serious Injury is a useful source of information: https://www.judicialcollege.vic.edu.au/eManuals/SIM/index.htm#54358.htm

The two reports produced by the Victorian Ombudsman contain numerous examples of poor performance and poor behaviours displayed under current case management practices. It is these behaviours which have led to this review.

The ALA believe there are two major shortcomings in the existing case management practices:

1. The need for tailored treatment.

The systems and processes of outsourced agents make injured people feel like a case number, rather than a client with unique needs. The Ombudsman identified that the current system lacks a personalised focus:

> *This is about people's lives. This is about human suffering, and what you see are references to numbers and files and claims.*[7]

The recent 4 Corners program[8] showed a number of claimants who described feeling like a case number under the Victorian and NSW agents models, rather than perceiving themselves as injured workers in need of support.

Decisions around cutting off payments are not the result of tailored treatment. They are the result of using an arbitrary threshold as a deadline.

The current model does not reward nor incentivise an individualised care model. On the contrary, it incentivises using one-size-fits-all timeframes as milestones for achieving acquittal targets and incentive payments.

2. The need for support based on biopsychosocial factors, individual circumstances and medical advice.

A recent ABC investigation[9] featured a case study who described her experience like this:

> *It was getting to the point where even though Chris's treating doctors … at well-known, reputable clinics who were recommending treatment, [they] were being ignored by the insurance company managing Chris's claim.*
>
> *Each time a treating practitioner provided a report, the insurance company got an independent medical report to say the contrary.*
>
> *At 130 weeks after the injury, Ms Iliopoulos's payments were terminated, even though her treating doctors said she was not well enough to go back to work.*
>
> *Ms Iliopoulos attempted suicide.*

The above case study is not unusual. It is broadly reflective of the experience of many of the ALA's members' clients. Our members report that, far from allowing expert medical advice to determine outcomes, the current case management model is typified by:

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[7] https://www.abc.net.au/news/2020-07-27/four-corners-workers-compensation-investigation/12477902

[8] https://iview.abc.net.au/show/four-corners, Episode "Immoral and Unethical"

[9] See under heading "Insurance agents 'gaming' the system for financial incentives"

https://www.abc.net.au/news/2020-07-27/four-corners-workers-compensation-investigation/12477902

- Purposefully seeking to delay decisions,
- Actively seeking to reduce payouts,
- A reliance on invasive and unnecessary surveillance to justify claim reductions,
- Ignoring the expert advice of treating health professionals
- Doctor shopping
- Inconsistency in decision making across agents
- Inconsistency in decision making within an individual case. Case managers change regularly, and there is often no consistency in the decisions of the old and new case manager.

The agents' attitude to case management has flow-on effects to other parts of the scheme. The adoption of one-size-fits-all decision making, along with an unwillingness to negotiate on supports and payments invariably leads to pressure on the conciliation process. This is currently under review, following findings that the process is slow and inefficient. The confounding behaviours of agents in the conciliation process has been shown to be a major factor in that inefficiency.

We submit that the above two shortcomings cannot be addressed by tweaking existing arrangements. The only way to stop the types of behaviours outlined in the Ombudsman's reports is to restore an in-house capacity to manage complex claims.

We believe that restoring an in-house capacity to manage complex claims would have the following beneficial results:

- The compromised motivation of the agency would be removed, enabling a 100% focus on the health and recovery of the injured workers (please see our response to question 8)
- It would provide an increased focus on evidence based decision making in relation to supports
- It would give the scheme the chance to reset its processes and expectations in relation to personalised treatment and support.

There are models of statutory compensation schemes where in-house management of complex claims does promote tailored treatment and evidence based support. These are discussed more in our response to question 23.

Financial incentives and agent decision making

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

The ALA submits that, in our experience, the current system enables compromised decision making by agents. One hundred per cent of their focus should be on the health and recovery of the injured workers, not on the achievement of incentives.

In general, it appears that *incentives are primarily linked to reductions in benefits*. This is not how the scheme should work. It means that any imperative placed on agents to ensure that an injured worker receives the benefits they need is compromised by the achievement of financial goals.

This compromised focus is typified by behaviours such as:

- Doctor shopping. It is our experience, and reflected in the findings of the Ombudsman's reports that agents will actively source medical evidence which supports their claim, and thus enables them to achieve their incentive deadlines.

- Agents are incentivised to obfuscate and confound proceedings, in order to achieve their goals – not the goals of the injured worker. Such delays are devastating for the injured workers and their families. Cases of psychological injury are particularly susceptible to delay, with agent processes not tailored to such claims.
- Agents feel that it is incumbent on them to haggle over every little payment. The focus appears to be on reducing benefits – not ensuring that the injured worker gets the right benefits.
- There is a clear and predictable pattern in their behaviour, which moves from rejection of the request, to then baulking at proper negotiation – knowing that the worker is powerless to progress the claim in any other way, and will be unable to afford delay.

There is a lack of transparency under current arrangements. We are unable to access the detail of the financial incentive schemes, we only know from the Ombudsman's reports that they exist. There is a lack of transparency in how these financial arrangements are set up, and that means there is a concurrent lack of scrutiny.

The ALA encourages the review to investigate the nature and requirements of incentives - along with the structure of retainers, management fees etc – and whether the focus on saving money is worth it.

The additional stress of poor and unfair process is actually creating health problems for injured workers, not fixing them.

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

No

10. If your answer to question 9 is yes, describe

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

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

N/A

11. If your answer to question 9 is no, describe

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

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

ALA members report that there is a general lack of responsiveness by the agents to communications from injured workers or their representatives. This is indicative of a system that does not incentivise the well being of injured workers.

ALA submits that incentives need to be framed around *benefit delivery*, not getting people off benefits. The success of agents should be based on how efficiently and promptly benefits are made available to the claimant.

To achieve this, the scheme needs broader data collection methods than just quantitative measures such as how many people are moved off benefits by 130 weeks.

To use Return to Work as an example, any incentives should focus on sustainable outcomes, rather than a three week evaluation, to ensure the long-term success of return to work interventions for an injured worker.

If a regime of incentivising benefit delivery (as opposed to benefit reduction) was introduced, it would incentivise such things as, for example, how quickly an application for surgery is approved.

Such incentives are based around the outcomes for the client – not the quantitative inputs or outputs of the process.[10]

The ALA submits that the solution does not lie in fixing the current arrangements. The only way to achieve prompt, effective and proactive outcomes for injured workers with complex claims is to remove any processes which incentivise anything other than the needs of the injured worker.

Adding more incentives to the existing model merely exacerbates the problems identified by the Ombudsman's investigations.

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

See above

Oversight of agents by WorkSafe

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

In relation to complex claims, no.

The Ombudsman noted in her 2019 report:

> *The investigation also identified deficiencies in WorkSafe's oversight of the scheme, particularly in relation to agent decision making on complex claims.*

If WorkSafe's processes for overseeing agents' management of claims were achieving prompt, effective and proactive outcomes for injured workers, neither this inquiry, or the inquiry into the ACCS would be necessary.

[10] The Inputs/Outputs/Outcomes/Impacts model is used frequently in government and agencies in calculating value and return on investment. See for example https://www.csiro.au/en/About/Our-impact/Our-impact-model.

The failure to ensure prompt, effective and proactive outcomes has led to an overwrought complaints and conciliation process, which in turn exacerbates the delay in achieving a fair outcome for the injured worker, and intensifies the frustration, stress and anxiety experienced by injured workers in the process.

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?

No.

15. If your answer to question 14 is yes, describe how.

N/A

16. If your answer to question 14 is no, describe why not.

The Ombudsman's report[11] tells us that:

> *WorkSafe has made a number of changes to its oversight mechanisms since 2016. However, the investigation found that WorkSafe is still not optimally using them to address unreasonable agent decision making on individual complex claims and to identify and respond to systemic issues.*

And that[12]:

> *…the investigation found that WorkSafe has not always held agents accountable for unsustainable decisions identified through the audits. In its 2017-18 audits, the investigation found instances where WorkSafe:*
>
> - *passed questionable decisions where the agent had only one piece of supporting evidence*
> - *re-assessed failed decisions as 'passes' when disputed by the agent, even if they would not hold up at court*
> - *did not require the agents to overturn most of the failed decisions.*

Central to issues surrounding WorkSafe's oversight of agent decision making is a lack of transparency. The terms of agents' relationship with and accountability to WorkSafe are not easily accessible.

The ALA believes that greater trust in the agent's role would be achieved if:

[11] https://www.ombudsman.vic.gov.au/our-impact/investigation-reports/worksafe2-follow-up-investigation-into-the-management-of-complex-workers-compensation-claims/#work-safes-oversight; para 38.

[12] Ibid; para 39.

- There was greater transparency in the oversight requirements of WorkSafe. (We note the list of processes for overseeing agent decision making on page 17 of the Discussion Paper, however we believe that granular detail as to how these are operationalised is lacking)
- There was greater transparency of the contractual expectations WorkSafe has of the agents
- There was greater transparency of the remuneration model that underpins the relationship
- There was greater transparency in how complaints against agents are handled
- There was greater transparency about what messages are being given to the agents by WorkSafe about their expectations

Limitations in oversight may also be a product of a disproportionate emphasis on scheme viability over benefit delivery.

The ALA wonders whether WorkSafe was surprised by the Ombudsman's findings in relation to Agent behaviours, or whether, like those who work in the field, the findings merely reinforced what had been known for a very long time.

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

As noted in our response to question 16, we believe that greater transparency in the accountability process would be useful.

It is evident, however, that scheme culture plays an important role. The Ombudsman's report tells us that[13]:

> *WorkSafe appears reluctant to adequately deal with unreasonable agent decision making when it is brought to their attention, which raises the troubling prospect that WorkSafe feels beholden to the agents and dependent on their participation to deliver a financially viable scheme.*

Evidently, WorkSafe needs to undergo a shift in its thinking away from prioritising scheme sustainability, to prioritising consumer-focused decision making. In other words, shifting the nature of the relationship with agents to being centred around ensuring that appropriate supports are provided to injured workers promptly and efficiently.

The ALA offers the following as potential enhancements to the existing oversight model:

i. We believe that a focus on sympathetic early engagement would assist workers in recovering better before they get to the 52 week mark. ALA expects that allocating resources to early management would lead to improved health and return to work outcomes for injured workers, and would reduce the amount of disputation between agents and workers.

ii. It is important for the worker to feel cared for. The current case management process where the worker has to keep having to prove injury does not achieve this.

[13] Ibid; para 42

iii. The current oversight mechanism appears to be quantitative. The addition of high level qualitative assessment of decisions by WorkSafe, with appropriate financial incentives and disincentives might result in much better decision making.

iv. The introduction of a randomised audit process would be beneficial. Such a qualitative assessment could either be done by way of a regular random file review, or when a worker has referred an agent decision to the Workers' Compensation Review Service. This would also make insurers far more accountable for how they approach conciliation at ACCS.

v. The quality of the staff engaged by Agents is an ongoing issue. It is essential that staff making decisions are appropriately qualified and experienced to make those decisions. It may be instructive for this Review to compare the quality of Workcover Agent staff with TAC or public liability insurers, where the quality appears to be significantly higher, and a significant number of staff have been recruited with allied health backgrounds.

vi. A revised process for complaints against the behaviours of agents. Currently, if we have problems with an agent's behaviour, WorkSafe's response is aloof and secretive. A more complainant-focused approach to responding to such issues would be advantageous. We find that WorkSafe's openness to feedback is not on a par with other schemes.

Evaluation measures

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 Worksafe Annual Report[14] lists Agent Performance Metrics as being based on:

i. <u>Return to Work Measures:</u>
- % of workers back at work at 26, 52 and 104 weeks

ii. <u>Service and processing</u>
- Worker levels of service
- Employer levels of service
- Number of valid complaints result
- Number of valid complaints per %10m billed premium
- Timeliness % of payments direct to injured workers:
    - Weekly payments paid within 7 days
    - Medical reimbursements paid within 11 days
    - Calendar days to pay 75% of employer reimbursements
- Timeliness of processing provider accounts:
    - % paid within 30 days of receipt of invoice
    - % paid within 70 days of service

iii. <u>Sustainability Measures</u>

[14] https://content.api.worksafe.vic.gov.au/sites/default/files/2019-10/ISBN-WorkSafe-annual-report-2019.pdf; p.142

- Second entitlement review
- Long tail claims management
- Complex care measure – recovery assistance program
- Complex care measure – transition support services
- Impairment resolution timeliness

iv. Variable measures:

- Co-funded – mobile case management
- Co-funded – agent innovation

The ALA makes the following observations about the above criteria:

- Many of the criteria listed above seek to measure success through the lens of scheme sustainability – not whether the injured worker got the supports they needed, when they needed them.
- Purely quantitative data collection rarely provides the true picture when it comes to assessments of satisfaction.
- Quantitative data based on inputs and outputs do not assess the impacts of poor decisions or poor process on injured workers
- "Service and processing" data is collected via survey. If the vast majority of claims are simple/non-complex, then those quantitative statistics will hide the true story of the impacts of poor user experience in complex matters.
- The success of a return to work intervention is based on whether the worker is still at work after three weeks. That is a very short period of time to assess the success or otherwise of agents' actions. This focus on short-term outcomes is problematic.

The findings by the Ombudsman in 2016 and 2019 surely indicate that current outcome measures are not working, especially when it comes to complex cases.

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

As described in our response to question 18, the current measurement methodology is focussed on measuring the impact of agent decisions on scheme sustainability – not the impacts of agent decisions on the well being of injured workers. It is based on collecting quantitative, short term information. It does not allow for nuance or for the voices of stakeholders to be heard.

In order to assess the quality of service provision, the quantitative data needs to be supported by long term, qualitative, attitudinal data. For example, our members are aware that many allied health professionals are reticent to take on Workcover work, purely because it takes so long to get invoices paid. Added to this, the likelihood that an allied health professional's expert opinion may be ignored in favour of a 'shopped' opinion impacts overall attitudes toward the scheme. Such valuable feedback will not come out in transactional, quantitative surveys.

As mentioned earlier, we believe that the current data collection processes should be augmented with random file audits. External audits – such as those completed by the Ombudsman – will show up more useful data than simplistic tick-box methodologies.

We urge the review to carefully analyse the statistics emerging from the Workers' Compensation Independent Review Service (WCIRS) as detailed in their monthly stakeholder reports.

Such information should be included in any assessment of Agent success, along with independent information on the behaviours of agents in conciliation hearings.

The need for a more nuanced approach to satisfaction is heightened when incentive payments are involved.

Any evaluation of scheme success should take into account the incidence of external audit and how the recommendations of those audits are responded to.

Above all, the current failures in data collection are a function of scheme and organisational culture. If Worksafe is serious about a client-focused approach, they will find ways to balance data collection which focuses on scheme sustainability, and data which places a higher priority on the impacts on injured workers.

The current agent model and alternative models

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

No

21. If your answer to question 20 is yes, to the extent you haven't addressed your response in answers to earlier questions, describe how the current agent model achieves prompt, effective and/or proactive management for injured workers with complex claims.

N/A

22. If your answer to question 20 is no, to the extent you haven't addressed your response in answers to earlier questions, describe:

a. the limitations of the current agent model,

b. how the current agent model could be improved to achieve better health and recovery outcomes for injured workers, and/or

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

As mentioned in the introduction, there appear to be three courses of action available to this review:

- Option 1 – Retain the status quo, but rely on cultural change within WorkSafe to drive improvement.

- Option 2 - Retain the agent model, but require each agent to remove claims from general claims management at 130 weeks (or at whatever measurement of complexity is adopted). These would be handed to a dedicated unit within each of the current agencies with specialist skills in complex case management, and tailored incentives to reward good case management and quality decision making.

- Option 3 - Retain the agent model, but have a system where the cohort of complex claims go back to the Victorian Workcover Authority for case management.

Of these options, the ALA supports Option 3.

We believe that Option 1 will merely see a perpetuation of the current, inadequate process. Cultural change is going to be central to any improvement in the management of complex cases, but we believe that change is required now – and waiting for cultural change to permeate the scheme will lead to more lost years.

If Option 1 is determined to be the best option:

- There will need to be major changes to improve accountability and monitoring. The Ombudsman's findings demonstrate that this is clearly inadequate.
- There will need to be a major rethink on what incentives actually incentivise. Incentives need to focus on the satisfaction of client-centred outcomes, not scheme-centred outcomes. The scheme needs to incentivise good decision making and sustainable outcomes, not benefit reductions.
- The scheme would need to reward good administrative systems.
- There scheme would need to re-prioritise stakeholder engagement, to encourage more allied health professionals to confidently participate in the scheme.
- There would need to be requirements which ensure that agents are appropriately skilled and experienced, preferably coming from a background in health or related industries. It is important that decision makers have appropriate skills and experience to understand the things they're making decisions on.
- The scheme may have to consider imposing a cap on agent profits[15].

While Option 2 is better, it does not address the core issue at the heart of the Discussion Paper, and in the Ombudsman's findings – that outsourced case management of complex claims by for-profit agencies leads to compromised decision making.

Option 3 provides the best chance of achieving real change within a reasonable time frame[16].

In response to the subsections of question 22:

a. the limitations of the current agent model

As noted elsewhere in this submission, the motivations which drive the behaviours of outsourced agents are compromised by profit motive and the achievement of incentive payments, at the expense of the best interests of the injured workers.

Any model which includes the outsourcing of case management of complex claims to agents will always experience this central conflict.

It is our position that complex cases **should not** be administered by outsourced agents.

[15] The Review might investigate the experiences of MAIC in Queensland as an example of this.

[16] Our assumption here is that a less narrow definition of 'complex claims' is engaged, with the effect of bringing in-house more substantive types of claims, not those currently under the narrow definition of 'complex'.

b. how the current agent model could be improved to achieve better health and recovery outcomes for injured workers

As mentioned elsewhere in this submission, we believe that the solution does not lie in fixing the current arrangements. The only way to achieve prompt, effective and proactive outcomes for injured workers with complex claims is to remove any processes which incentivise anything other than the needs of the injured worker.

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

As outlined above, our preferred alternative model is to retain the agent model, but have a system where the cohort of complex claims go back to the Victorian Workcover Authority for case management.

We believe this model provides the best chance of achieving real change within a reasonable time frame.

As mentioned elsewhere in this submission, we believe that restoring an in-house capacity to manage complex claims would have the following beneficial results:

- The compromised motivation of the agency would be removed, enabling a 100% focus on the health and recovery of the injured workers
- There would be consistency and predictability in case outcomes
- Issues of efficiency and responsiveness would be managed by one structure, rather than five.
- Removing the profit margin payable to outsourced agencies means that the scheme should be more cost effective.

The ongoing viability of the scheme is paramount. The ALA believes that reduced need for conciliation due to improper decision making will significant reduce the cost of the scheme. The focus of this review should be on producing a scheme that is viable today and tomorrow.

The scheme must play an educative role for employers – especially in relation to their duties in helping a worker return to work. Agents are not good at this. The impetus for this must be driven by the scheme itself. It would be easier for that to be administered internally.

Any alternative scheme must have a more advanced and proactive approach to stakeholder engagement. The scheme must be open to listening to and responding to the problems stakeholders are having with the scheme – such as allied health worker invoices not being paid in a timely manner. The scheme needs to be aware of any sense of harassment felt by medical practitioners, to make certain decisions. The current scheme is beholden to the business practices of the individual agencies. We urge this Review to consult with health providers about their experience with agents, and how this could be improved in an alternative model.

There are models of statutory compensation schemes where in-house management of complex claims does not lead to the poor outcomes outlined above. These are discussed more in our response to question 23.

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?

As noted above, there are models of statutory compensation schemes where in-house management of complex claims does not lead to the poor outcomes outlined above.

ALA recommends that the Review carefully examine the following parallel schemes, with the view to determining the criteria in which they are more successful in the handling of complex claims than current Workcover arrangements:

TAC

ALA members have significant experience representing both injured workers and injured motorists. Clients of our members have very different experiences depending on whether they are in the WorkCover or TAC scheme.

TAC never went down the path of outsourcing claims management to agents. Having these processes in-house means there is close monitoring of decision making and case manager behaviour.

The major difference between the two schemes appears cultural, driven top-down by management and the governance structures and incentives that appear to be about efficient benefit delivery. The scheme is based around an individualised care model – not a cookie-cutter approach. This is reflected in the CEO's words[17]:

> *By directing our unwavering focus to improving the support we provide, we aim to become the world's leading social insurer.*

The TAC systems and processes are a direct reflection of the governance and management culture described above. They foster a partnership arrangement with all stakeholders, including the injured person. There is a prevailing attitude that all stakeholders are partners with the scheme in achieving the appropriate supports and benefits for the client. It is a philosophy that is not based on competition or disputation.

It is worth noting a practice whereby WorkCover agents outsource the case management of catastrophically injured workers to the TAC. That seems to be an admission that the TAC is better equipped to manage those complex claims. We encourage this review to closely investigate that practice to understand what it reveals about the cultural and structural differences between the two schemes and the impact on service delivery to claimants.

Importantly, TAC is financially healthy. Current financial concerns are more due to environmental factors (such as investment returns) than inefficiencies or cost overruns.

Our members who work within the TAC scheme tell us that:

- Complex claims case managers genuinely listen to the expert opinion of health professionals. They have an evidence based approach to benefit provision – not an incentives based approach.

[17] https://www.tac.vic.gov.au/__data/assets/pdf_file/0009/192753/TAC_Strategy2020_UPDATE_WEB.pdf; p.3

- The trust/communications between TAC management and stakeholders is excellent. Management knows that stakeholders understand that scheme viability is essential. No-one benefits if the scheme become unviable.
- The introduction of a Joint Medical Examination (JME) model has meant there is no cherry-picking of health services or doctor shopping. It has led to a sizeable reduction in medical appointments and associated cost per case.
- Poor behaviour and compromised decision making within TAC is rare. Where it has been identified it has most commonly come from audits of the outsourced claims review process. (It is worth noting that often these claims review processes are outsourced to Workcover agents).

Importantly, TAC works in the same geographic locations as Vic Workcover. They serve the same citizens. We know that complex claims can be managed more successfully in–house for the same citizenry.

The ALA recognise that there are scale differences in the number of complex claims administered by TAC as compared to Workcover. We believe, however, that the cultural and attitudinal differences – along with the clarity of purpose in decision making – make it a model worth investigating.

The Ombudsman has found no need to conduct investigations into TAC's current processes for handling complex cases.

NDIS

The NDIS system is founded on a client-focused approach to individualised care. Philosophically, it is a fantastic example of empowering the beneficiary to drive support provision, through the adoption of the 'choice and control' mantra.

Practically, it is still maturing, and experiencing some significant issues in claims management – especially in complex claims.

The NDIS has been subject to more independent reports than most other statutory insurance schemes, each more damning than the last. Until the scheme has reached a more heightened state of maturity, we certainly wouldn't be recommending it as a model for claims handling.

NDIS is currently a poor example of in-house complex claim management. Our Members who work with the scheme tell us that:

- There are significant delays for clients in establishing eligibility
- There are significant delays for clients in having their plan finalised
- There are significant delays for clients in having a poor plan reviewed
- The external plan review process is traumatic for clients, and heavily skewed in favour of the NDIS
- Planners are dubious about (and sometimes antagonistic to) the input of health professionals
- There is no consequence to the NDIS for producing a bad plan. Whilst TAC and others are held to account for their decisions by courts, the NDIS is not[18].

[18] Many of these issues are reflected in the Interim Report of the Joint Standing Committee in the NDIS' inquiry into the planning process:

Once again, the scheme's relationship with its clients is a direct reflection of the culture and philosophies of its governance and leadership. In the case of the NDIS, this has been a function of a heavy focus on scheme viability (based on poor initial modelling) over the genuine needs of people with disability.

Those factors notwithstanding, the in-house nature of NDIS claims management means that transaction cost is low, and there are no perverse incentives for decision making.

Queensland's Workcover Scheme

The Queensland scheme is one of the cheapest, both in terms of premiums and running costs. It is certainly one of the most efficient schemes in the country. Its return to work rates are generally better than most others. In this context, it is worth considering as an alternative model.

Being a 'short-tail' scheme, its focus is on moving injured workers off a long drip-feed of benefits. It focuses on providing the worker with the financial support they need up front, and allowing them to make decisions about their own recovery.

Long tail schemes require a larger bureaucracy to administer them. The administration costs of the Queensland scheme are also worth examination by this review.

The trigger for exiting the scheme is stabilisation of condition. Stabilisation triggers access to a choice of (a) permanent impairment lump sum, or (b) common law. There are no WPI thresholds to accessing common law.

The scheme uses a statutory monopoly model, with Workcover Qld as the only agent. Our Queensland members who work within this scheme note the following advantages:

- There is no profit motivation, or commercial imperative for the agent, as the monopoly agent is not a for-profit entity.
- Monopoly providers only seek to break even, and remain solvent.
- Workcover Queensland has excellent solvency, allowing it to ride out difficult market conditions
- A monopoly provider has nothing to gain from delaying proceedings.
- The scheme offers psychological support to claimants during the process.
- The relationship between the provider and the regulator is excellent – there is clear alignment in the values and culture of both entities.

We believe that the oversight model used in Queensland demonstrates best practice as a means for better analysing scheme health.

https://parlinfo.aph.gov.au/parlInfo/download/committees/reportjnt/024350/toc_pdf/NDISPlanningInterimReport.pdf;fileType=application%2Fpdf

The NSW scheme's failings were bought into sharp focus by the recent 4 Corners program[19]. They found that the NSW scheme is a poor scheme, run badly. The ALA does not recommend the NSW scheme as a good model for the Review to consider.

We believe that whoever manages complex claims should be required to look to other schemes to ensure they are achieving best practice.

Victorian Ombudsman 2016 and 2019 reports

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.

Feedback from our members reflects the assessment of the Ombudsman, as outlined in her 2019 report, that no significant improvements in agent behaviours have been noticeable since the 2016 report. She wrote[20]:

> *In 2016 I tabled a report into WorkSafe agents' handling of complex claims, which concluded that while the whole system was not broken, the handling of complex claims – the most difficult and expensive – needed fundamental reform. The report was widely welcomed by many and WorkSafe accepted all 15 recommendations made to it, with the support of the responsible Minister.*
>
> *But did anything change?*
>
> *Complaints to the Ombudsman can be a good indicator. In the case of WorkSafe complaints, despite the implementation by WorkSafe of all 15 recommendations, the complaints have continued, raising the same themes: unreasonable decision making by agents, inadequate oversight by WorkSafe.*

The 2019 goes on to say[21]:

> *The Ombudsman made 15 recommendations to WorkSafe which included:*
>
> - *improving WorkSafe's oversight of complex claims and its use of information from complaints, stakeholder feedback and dispute outcomes to identify potential systemic issues*
> - *reviewing the financial reward and penalty measures to increase agents' focus on quality decisions and sustainable return to work outcomes for injured workers*
> - *providing training and additional guidance to agent staff.*
>
> *The Ombudsman made two recommendations to the State Government:*

[19] https://www.abc.net.au/news/2020-07-27/four-corners-workers-compensation-investigation/12477902

[20] https://www.ombudsman.vic.gov.au/our-impact/investigation-reports/worksafe2-follow-up-investigation-into-the-management-of-complex-workers-compensation-claims/#work-safes-oversight; p.4.

[21] Ibid; para 60-63

• review the process for injured workers to dispute claim decisions, which involves conciliation and then court, to ensure the process is fair and timely

• increase Conciliation Officers' powers to direct agents to overturn a decision

WorkSafe said it did not support these two recommendations. Although introducing an additional arbitration process following unsuccessful conciliation may produce more timely outcomes for workers (compared to court), WorkSafe said this would:

• 'add another layer of complexity and cost to the system'

• be 'contrary to the general objective of reducing the level of disputation'.

WorkSafe also said it did not support increasing Conciliation Officers' powers to direct because it would 'fundamentally and detrimentally' affect their 'capacity to mediate negotiated outcomes', and would make the process 'considerably more adversarial'

We note that the government has taken steps to address the two recommendations aimed at them.

While the ALA support the Ombudsman's view that none of the recommendations made to WorkSafe has been addressed, we believe it is also worth noting that none of those recommendations actually addressed the fundamental problem of conflicted decision making.

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

The ALA believes that the root problems identified by the Ombudsman in 2016 were:

- A scheme culture founded on scheme sustainability, rather than decision sustainability
- A scheme culture founded on minimising benefits, rather than the genuine needs of injured workers
- Conflicted decision making by agents, who are forced to choose between company profits and the wellbeing of injured workers

These were enabled by:

- A lack of transparency in the governance and financial arrangements which apply to outsourced agents.
- An incentives process that does not promote best practice, timely, sustainable and quality decision making by agents.
- A quantitative approach to data collection.
- An inefficient complaints handling system, which was not focused on continuous improvement.
- Inappropriately experienced or qualified staff, making decisions that were not based on evidence.

26. Do you think the implementation of the recommendations 3–9 in the 2019 Ombudsman report will address those root causes? If so, how will that occur?

No.

27. If you do not think the implementation of recommendations 3–9 in the 2019 Ombudsman report will address those causes, explain why not.

The ALA supports all 7 recommendations as worthy initiatives, but note that they will not address the root causes.

None of those 7 recommendations addresses:

- Scheme culture
- Agent culture
- Economic drivers of decision making

Further considerations

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

The ALA notes the following as potential avenues for examination by the Review, in responding to the Terms of Reference:

i. The Review should fully consider the cost/benefit implications of shifting to an in-house model of complex claim management. We believe that the benefits will outweigh the costs.

ii. We urge the review to consider the impact of the current claims process on the mental health of the injured workers. Much of the lack of dignity that workers feel in the process comes down to insurer behaviour. Delays and frustrations in processing claims can, in our experience, create or compound mental health issues for workers, rather than help rectify them.

iii. The review should consider the benefits of restorative justice models. Injured workers often feel anger toward their employer for the damage done to them. Employers play an essential role in return to work processes. There may be some elements of restorative justice processes that might help workers not feel so angry/damaged. It is important to provide employers with the help they need to make re-engagement with the workplace a positive experience for injured workers. Work is central to self concept. Restorative justice processes may help incentivise sustainable return to work as the right thing to do for most individuals.

iv. The current legislated limit that employers have to keep an RTW employee is 52 weeks. We encourage the Review to investigate whether this still represents best practice, and whether the scheme should incentivise employers keep injured staff for longer than the current 52 weeks.

The current inquiry is only focusing on the processing of complex claims. ALA's main submission is that complex claims should not be administered by outsourced agents. We believe, however, that as a separate piece of work, a further review may be required to consider whether *all claims* – not just complex claims – should be administered by outsourced agents.

We further believe that an additional review may be required to examine the degree to which the outsourced agent model impacts self-insurers.

Conclusion

ALA thanks you for the opportunity to have input into the review, and we would be pleased to elaborate on any of our submissions at a later stage if that would be of assistance.