SUBMISSION FROM ALAN CLAYTON

Peter Rozen QC
Independent Reviewer
Independent Review into the Agent Model and the Management of Complex Claims

Dear Peter Rozen,

I am pleased to make this submission to the Independent Review into the Agent Model and the Management of Complex Claims (the Review). I have had a long experience with the Victorian scheme, even prior to the seminal 1985 changes. This has been in Government, with the Victorian WorkCover Authority and as a consultant and adjunct academic. As a consultant I have conducted reviews of, or major aspects of, eight of Australia's eleven major workers' compensation systems as well as the Dust Diseases regime in New South Wales. This experience has also extended to significant involvement with many overseas schemes.

I have chosen to structure my comments to the Review under the headings of the key questions for the Review set out in section 3 of the Discussion Paper. Over my four decades involvement in this field I have produced over a hundred research, consultancy, conference and other papers.

I am happy to speak to the Review in relation to this submission and with respect to any other matters that fall within its purview.

1. Introduction

The first of the key questions for the review (in section 3 of the Discussion Paper) is that of the effectiveness of the agent model in delivering positive outcomes.

There may be an assumption that the agent model is a standard and established approach in international workers' compensation structures and practice. It is not. If one surveys the international scene, in terms of the nature of workers' compensation arrangements, there is, outside of the agent model that exists in Victoria, New South Wales and South Australia, only one extant example of a similar arrangement. It arose after the introduction of the Australian agent model and has, from its inception, been mired in a culture of endemic corruption. There is also one transitory example of a similar form in South America which no longer exists. Thus, in terms of the taxonomy of workers' compensation arrangements, the agency model stands as a mutant genus that has no recognised progenitor. It was the product of political compromise in the mid 1980s. Rather than being a brief transitional arrangement towards some more established (and tested, in terms of effectiveness) workers' compensation arrangement, the agency model has limped on, for three and a half decades, as a totally sub-optimal vehicle for serving the needs of injured workers and employers in the workers' compensation system.

While the product of political compromise, I have viewed, with increasing bewilderment, an emerging, or, perhaps now more correctly, emergent, narrative that the agent model reflects some form of sophisticated public policy initiative which harnesses, on the one hand, the stability of central underwriting with, on the other, a market-driven ongoing increase in service quality, to both workers

and employers, from agents competing to gain and retain employer business. In the context of the real world, only one of these propositions is true.

Over the last three decades I have conducted numerous reviews of various Australian workers' compensation schemes, commissioned by either government or the scheme regulator. Where relevant to the subject matter of the review, I have highlighted aspects of the principal-agent problem which, in my view, undermines the attainment of quality outcomes in schemes structured on an agency model. In discussions with senior officers within government or with the relevant workers' compensation regulator about why the agency model persists, despite its demonstrated shortcomings and perverse outcomes, the general response has been that the transition costs of moving to a different system are too high and the disruption effects too great. However, more recently, I have noted a shift to a of normalised acceptance of this arrangement as being the natural order and even a belief that it is, in fact, the best of all worlds. This was strikingly illustrated to me in a conversation with a number of senior WorkSafe Victoria officials where a very senior officer of that agency earnestly stated that rather than the agent model being bedevilled by the principal-agent problem, it indeed represented the 'principal-agent opportunity'.

In my view, the ongoing entrenchment of the agency model in three of the major Australian workers' compensation schemes has had a pernicious impact upon the quality of outcomes of those schemes to the detriment of both injured workers and employers in those schemes. This has been dramatically highlighted in the extremely disturbing findings of the Victorian Ombudsman's 2016 and 2019 reports. It is front and centre to the train wreck of the current New South Wales iCare scheme.[1] Although there would be transitional costs in moving to a different form of system, these costs, I believe, pale into insignificance compared with the ongoing social and economic costs of maintaining the present dysfunctional system and the benefits that would flow from moving to a well-managed scheme structured according to better (if not best) practice arrangements internationally.

2. Background to the structure of the Victorian workers' compensation system

2.1 Longer view

In historical terms, workers' compensation systems represent a response to the carnage of the late Industrial Revolution and the inability of then current legal system to deal with the phenomenon of mass injury. In terms of this response, there are two main models. First, Bismarck's Imperial German Accident Law of 1884, taking effect from 1 October 1885, and secondly, the English Workmen's Compensation Acts of 1897 and 1906. These represent two polar models of workers' compensation design which have profoundly influenced the arrangements adopted in most other countries.

The 'German model', in the form of the statutes of 1884 and 1900, was able to draw upon the traditions and institutions of the guild structure which, due largely to the late flowering of large-scale industrial activity in Germany, had managed to survive from the Middle Ages into the nineteenth century.

[1] Among a litany of egregious examples, the action of the single iCare agent, Employers Mutual, between 11 February 2020 and 11 June 2020 in conducting over 39,000 case reviews on more than 17,000 claims with the express aim of removing claimants from benefits; a result that appears to have been successful in 7,274 cases: https://www.parliament nsw.gov.au/lcdocs/other/13571/Corro%20-%20Ms%20C%20Donnelly%20-%20Clarification%20to%20evidence.pdf

Following this tradition, the German arrangements, in the form of the statutes of 1884 and 1900, and institutionally, through the autonomous industry insurance institutes (Berufsgenossenschaften), went beyond a simple concern with compensation to encompass accident prevention (particularly through the inspectorial role vested with the insurance institutes and their ability to levy a 'danger tariff' upon firms with particularly bad accident records) and rehabilitation (an area not narrowly confined to industrial rehabilitation but extending to social rehabilitation of injured workers to a state of 'social health' (soziale Gesundung)). These German arrangements provided the model for workers' compensation developments in a number of other European states, beginning with Austria-Hungary in 1887 and Norway in 1894.

By contrast, the schema of English workers' compensation arrangements embodied in the 1897 legislation was the product of a political environment heavily imbued with the spirit of Manchester liberalism, the dominant economic and social force in late nineteenth century Britain. It was an environment in which a driving tenet was that social relations, as well as those in the economic sphere, should be the subject of minimal state intrusion. However, the effect of a triad of judicially created defences, which have become known as the 'unholy trinity', was to essentially preclude an injured worker receiving compensation payments as the result of occupational injury. After the relative ineffectiveness of successive amendments to Employers' Liability legislation to change this situation, Joseph Chamberlain, the somewhat unorthodox Tory, changed the perspective from further salami slicing the impediments to tort recovery in favour of a limited no-fault alternative.

This was the model of workers' compensation which was adopted in Australasia by the various Australian jurisdictions and in New Zealand. It was also the dominant model in the United States and was the basis for Canadian arrangements prior to 1914. As well as, initially, only being concerned with limited income support, this model was underwritten by private insurance except for those employers granted self insurance status. The integration of occupational rehabilitation into system operations is a development which largely stems from the late 1970s while, in most schemes, the issue of aligning scheme operations to have anything more than an incidental effect upon injury and illness prevention is still at a quite basic stage.

In terms of financing arrangements, the schemes adopted the English system of private insurer underwriting with the ability of enterprises being able to 'contract out' as self-insurers according to certain criteria. Unlike the English system, the requirement to insure was generally made mandatory and most jurisdictions, often at the time of enacting their workers' compensation legislation, also created a state-owned insurer which competed in the market with private insurers. The state-owned insurer also tended to have the functional role of an insurer of last resort and thus serve a role which in the United States is often that of the residual market. Thus, in United States terms, the typical Australian scheme was a three-way system of private insurers, a competitive state insurer and self insurance. The significant exception was the state of Queensland which, in 1916, under the radical T J Ryan Government, moved to oust private insurers from workers' compensation and established a monopoly state scheme, without any provision for self insurance.

2.2 Medium-term view

The current structure of workers' compensation in Victoria is essentially the product of the reforms enacted in 1985. In a medium-term perspective, this outcome was largely the product of the behaviour of the general insurance market, and particularly in the workers' compensation segment of that market, which was exhibited from the mid-1970s. This experience appears to have resulted from the conjunction of a number of factors. First, there was the influence of the federal Insurance Act 1973

which regulated the prudential operations of insurers. A number of insurers were faced with problems in regard to financing the solvency requirements laid down under the Act within their existing capital structure; the result was a flight of premium through companies rejecting workers' compensation business in an attempt to meet the solvency margins. However, many of these companies managed to secure the requisite prudential buffers and margins after a couple of years and were ready to buy back a position and market share in the workers' compensation market through heavy discounting.

Secondly, the fallout from the Australian Woodhouse inquiry and report. Had the Whitlam government remained in office and the proposals of the Woodhouse report been implemented the insurance industry would have faced the catastrophic blow of losing all personal injury business, not simply workers' compensation but compulsory third party motor vehicle injury insurance and some other areas of liability insurance which involved a personal injury component as well. Given that coverage would have been given to the self-employed there would have been significant loss of private disability business as well. Faced with the prospect of being ousted from personal injury lines completely and the running out of the claims tail from existing reserves, the industry regarded itself as significantly underfunded and consequently premiums were raised in the prospect of the run off involved. The quarantining of the Woodhouse legislation in the Senate Legal and Constitutional Committee and the subsequent fall of the Whitlam government removed this threat and contributed to the vigorous price cutting war which followed.

Thirdly, according to evidence from brokers to the Cooney Committee, the mid-1970s coincided with an unusual over-capacity in the international re-insurance market. One of the results was fierce competition for the premium dollar, and this was reflected in heavy discounting in Australia. Thus, these features combined to produce, from around 1975, a cut-throat price cutting war in the workers' compensation market, particularly in respect of larger accounts. As interest rates were at historically high levels, part of this war for market share and premium income represented an element of cash flow underwriting to secure funds which could be invested to take advantage of the prevailing high interest rates. This situation was also exacerbated by the entry into the market of some new aggressive underwriters such as C E Heath and the American International Group who didn't have the claims tail of established market players. These new entrants were targeting the larger employer accounts and the competition in this sector was particularly intense.

The immediate impetus which largely led to the demise of private underwriting in Victoria was the dramatic attempt by insurers to suddenly regain much of the ground lost during the period of ferocious rate-cutting. The huge increase in premium rates which occurred in the period 1981/82 to 1982/83 had the effect of completely alienating the business community and making that community amenable to other solutions.

A membership survey by the Victorian Employers' Federation in November 1982 had revealed that a majority of respondents had experienced premium increases in excess of 50 per cent in the previous 12 months and some reported increases of 200 per cent and 300 per cent between 1981 and 1982 despite declining or static claims rates. The Metal Trades Industry Association of Australia reported on the experience of its membership which showed dramatically escalating premiums, unrelated to claims experience, of up to 500 per cent; one company had its premium increased by 184 per cent between 1980/81 and 1981/82 even though employment in this company had decreased by almost 17 per cent and it had had no claims for many years. The Victorian Small Business Development Corporation reported that premium increases for small business in the previous two years had ranged from 80 per cent to 400 per cent with individual cases of more than 700 per cent.

2.3 The emergence of the agent model

In response to this crisis, and also as a result of representations from the trade union movement about the inordinate delays in hearing matters (sometimes up to twelve months) at the then Workers Compensation Board, the Cain Labor Government, in July 1983, announced the appointment of the Committee of Enquiry into the Victorian Workers Compensation, generally known as the Cooney Committee after its chairman, the late Barney Cooney, a barrister and later Victorian Labor Senator. The other four members reflected major stakeholder interests.

While the Cooney Committee report proved to be a very useful source document in terms of detailing the ills of the system, as a vehicle for change it was hampered by the fact that its membership reflected the interests of the existing system and, consequently on important issues these members voted to support the interests of the constituency from which they were drawn. The analysis within the report provided a damning indictment of the operation of the then current system and of its failures in both economic and social terms; however, when it came to recommendations and solutions the Committee largely divided upon interest group lines.

On a number of important issues the Committee divided 3-2 in its decisions. The recommendation that lump sum redemptions should be removed from the compensation system on the grounds of being destructive of the successful operation of a rehabilitation-oriented compensation system was adopted by this margin. Similarly, the recommendations that there should be a continuance of private underwriting and not a move to a central fund and limiting lump sums, apart from Table of Maims payments, to highly circumscribed situations were adopted by this thin majority.

The Cooney report thus represented a comprehensive review of a system in crisis but little unanimity in terms of solutions in respect of major issues. However, during the period of the Committee's operation, Bill Landeryou had resigned as Minister for Labour and Industry and, in a reallocation of departmental functions, the administration of workers' compensation was transferred to the Department of Management and Budget (DMB) and consequent ministerial responsibility rested with the Treasurer. This proved to be a crucial development.

The new Department of Management and Budget, under Dr Peter Sheehan as Director-General, was an interventionist powerhouse for transforming the Victorian economy. As a vehicle for technocratic revolution it resembled some of the initiatives of Massachusetts Governor Michael Dukakis in the days of the 'Massachusetts miracle'. The Department was the major architect of the Government's economic strategy for Victoria which was released in April 1984. A document entitled 'The Next Step Forward' outlined issues concerning the development of the Victorian economy over the next decade. It was followed by a series of economic strategy statements giving a detailed outline of proposed initiatives in individual sectors. It is significant, but not surprising, that the outline of the new WorkCare scheme was detailed in one of these economic strategy statements. It was fifth publication in this series following detailed statements on state and regional industry policies, the Government's energy policy, the Portland aluminium smelter and the tourism strategy.

Initially it had been proposed that the new Accident Compensation Commission would operate as single fund on the Queensland Workers Compensation Board and New Zealand Accident Compensation Corporation model, in which it would discharge the claims handling, premium collection and other functions involved in the running of a workers' compensation system. It was envisaged that, at least for an interim period, some or all of the claims functions would be handled by the State Insurance Office and that of premium collection could be undertaken, again at least for a period, by the State Taxation Office which was the vehicle for the collection of payroll tax. Again, there were New Zealand analogues for such interim action.

The decision to move to a system of claims administration agents was a strategic and pragmatic decision by the Government, particularly to assist the passage of the proposed legislation in the Legislative Council in which the Government did not have a majority. Some elements of the business community were concerned that a government monopoly would become overly bureaucratic and inefficient and made their price of supporting the removal of private insurers and the move to such a monopoly contingent upon having private sector involvement in the administration of the scheme. As well, the Insurance Employees Union was concerned at the prospect of significant redundancies among its members as a result of the move to a monopoly state fund. The Government statement justified this change as being one to "ensure minimum insurance industry disruption, increased business opportunities and maximum efficiency".

2.4 Comparator arrangements

As already noted, the agent model was the result of a political compromise at a time of very vigorous political debate where it was uncertain as to whether the proposed new workers' compensation statute, and the radically different arrangements which it would bring into being, would in fact pass the Legislative Council. It was not a preferred design feature of the Cain Government.

The only examples that have any passing similarities with this Australian variant, both occurred later in time than this Australian development. These relate to transitional aspects of the system relating to the compensation for occupational injury and illness in Colombia in South America and to Managed Care Organisations (MCOs) in the Ohio workers' compensation system in the United States.

In 1993, in a process of neo-liberal opening up of the social security system in Columbia, the Government ended the monopoly of the public Social Security Institute (ISS) and has moved to a system where in various areas of social security (including age pensions, healthcare and compensation for work-related injury and illness) there is competition between a state body and private sector bodies. This process concluded with the final closure of the ISS in 2012. Since 2012, in respect of work-related injury and illness compensation there is competition between a state life insurance company, Positiva, and private sector agencies. It appears that, in the initial stage of this transition process, the system was still underwritten by the ISS but significant areas of service provision was discharged by private companies, Aseguradoras de Riesgos Profesionales (ARPs). Subsequently these bodies were able to compete with the ISS in terms of underwriting as well.

The system of managed care organisations (MCO) in the Ohio workers' compensation system dates from 1997 as the result of a Health Partnership Program. Ohio is one of the few remaining monopoly state fund jurisdictions in the United States and the MCO initiative was introduced on an assumption that private companies would be able to manage workers' compensation claims more efficiently than the monopoly state provider. Every employer covered by the Ohio workers' compensation system either chooses one of the authorised MCOs or, in default, is assigned to one of these MCOs. While the issue of claims liability is still determined by the Bureau of Workers Compensation (BWC), the MCO manages the medical aspects of the claim and coordinates the return to work activities. They are paid an activity-based payment and also receive an incentive payment based on return-to-work results. The number of MCOs has been dropping over the years, from 58 at the inception of the system in 1997 to 38 in 2000, 15 in 2015 and 11 today.

The system has been widely criticised. Some of this criticism has been levied at the regulator, the BWC, in terms of lax oversight of the activities of the MCOs, in which a culture of endemic corruption, including widespread resort to kickbacks, and payment of hundreds of thousands of dollars to politicians in return for privileged treatment, has flourished. This was exposed in a Pulitzer Prize winning series

of articles by the *Toledo Blade* newspaper in 2006 which profiled these scandals, along with other corrupt practices within the Ohio workers' compensation system.[2] These problems have persisted over the years.[3]

3. Effectiveness of the agent model in delivering positive outcomes

3.1 The Review's proposed approach to analysis of this issue

The Review's information paper sets out its criteria for judging positive health and recovery outcomes as encompassing:

- sustainable return to work outcomes;
- WorkSafe Victoria's annual survey results of injured workers' experiences with the scheme;
- quantitative data and qualitative research; and
- consultation with injured workers, healthcare providers and others with direct experience of, or involvement in the WorkCover scheme.

With respect to agents' responsibilities to workers and employers, the Review will draw heavily upon the comprehensive reviews by the Victorian Ombudsman and on qualitative studies such as *Victorian Injured Workers Outcome Study*.

I agree that this is a good and robust approach to exploration of these issues. With respect to research, both quantitative and qualitative, Australia is very fortunate in having a body of researchers whose work, in terms of methodological rigour and sophistication, is at the forefront of international research. In this regard, I think that it would be very worthwhile and productive for the work of the Review to have contact with:

- Professor Alex Collie, Director of the Insurance Work and Health Research Group in the School of Public Health and Preventive Medicine at Monash University. Alex has a national and international reputation in applied public health perspective to the consequences of injury and illness in a range of compensation settings. He and his group have conducted a number of impressive studies using large data sets at a jurisdictional and national level.

- Associate Professor Genevieve Grant, Director of the Australian Centre for Justice Innovation at Monash University. Genevieve brings the unique perspectives of being both an epidemiologist and a lawyer, with extensive experience in both realms. She helped shape the research field in relation to the connection between personal injury compensation processes with adverse health outcomes and continues to break new ground with conceptual and empirical studies in this and related areas.

- Dr Elizabeth (Beth) Kilgour, a Senior Researcher at the Australian Centre for Justice Innovation at Monash University. Beth is internationally recognised as one of the most sophisticated qualitative researchers, particularly in respect of interactions between various parties in

[2] https://www.toledoblade.com/news/state/2006/12/18/BWC-scandal-riles-claimants-injured-workers-see-millions-lost-as-they-fight-for-help/stories/200612180002

[3] For instance https://www.cantonrep.com/article/20081214/NEWS/312149899; https://www.cleveland.com/cuyahoga-county/2012/06/cuyahoga_county_cancels_relationship_with_company_mentioned_in_corruption_probe.html

accident compensation schemes. She was the central figure in the *Victorian Injured Workers Outcome Study* which the Review has signalled it will draw upon in relation to agents' responsibilities to workers and employers. Beth is also a highly experienced clinician with extensive experience in working with injured workers.

- Professor Anthony (Tony) LaMontagne, Professor of Work, Health & Wellbeing at Deakin University. Tony brings the perspectives of a highly knowledgeable and respected epidemiologist to area of work injury and illness. He has done a lot of ground-breaking work in relation to the impact of injury and disease within various settings including that related to psychological injury and musculoskeletal injuries.
- Dr Mary Wyatt, one of Australia's leading occupational physicians. As well as having over twenty years professional experience, Mary has a very strong research interest and great expertise in the translation of research findings into practice. Mary is the ex-chair of the Australasian Faculty of Occupational and Environmental Medicine (AFOEM) Policy and Advisory Committee and was the driving force behind the AFOEM's Health Benefits of Good Work initiative.

3.2 The twin issues militating against positive scheme outcomes

At the macro level I believe that there are two issues that militate against the agent model being an effective arrangement in workers' compensation practice. The first is the 'principal-agent problem'. The adoption of the agency model as the vehicle for scheme operations has entrenched the tension and moral hazard that is inherent to this model within the Victorian workers' compensation scheme for some three and a half decades. What has been witnessed has been rampant rent-seeking behaviour on the part of agents which been to the detriment of positive and effective scheme outcomes.

The second issue, which is not unrelated to the first, is the inherent failure of the agency model, in any of the three Australian jurisdictions in which it has been adopted, to develop – let alone sustain – the requisite level of operational capability and capacity to produce, with any level of consistency, quality outcomes in the services they deliver, particularly to injured workers, but also to employers. This situation has been exacerbated, and the level of non-performance sustained, by the endemic situation of extremely high staff turnover within the agency system.

3.2.1 Principal-agent problem

The 'principal-agent problem' concerns the issue in economic theory concerning how a body ('the principal') can structure incentives so that entities ('agents') who are placed in control of resources that are not their own – with a contractual obligation to use these resources in the interests of some other person or group of people – will actually perform this obligation as agreed, instead of using their delegated authority over these resources to advance their own interests rather than the interests of the principal.

The alignment of agent performance with the intentions and expectations of the principal is primarily attempted through the use of incentives, usually some combination of moral, material and coercive incentives. Moral incentives, in the sense that the agent aligns its behaviour with the principal's goals from a sense that it is the correct or proper thing to do is, of course, the most effective basis for alignment. However, in a world of self-maximising actors it represents a relatively rare element and not one that has been widely evidenced in the operation of the agent model in Australian workers' compensation.

The matter of the influence of financial incentives on agent decision making is one of the topics identified in the Review's Discussion Paper for comment. The response in this submission with respect to issues pertaining to the other incentives – material and coercive - is set out at section 5 below.

3.2.2 Agent capability and capacity

What constitutes organisational capability and capacity is a complex and multi-dimensional issue. However, almost any attempt to conceptualise and concretise this notion puts talent - *we are good at attracting, motivating, and retaining competent and committed people*[4] - at the top of necessary requirements.

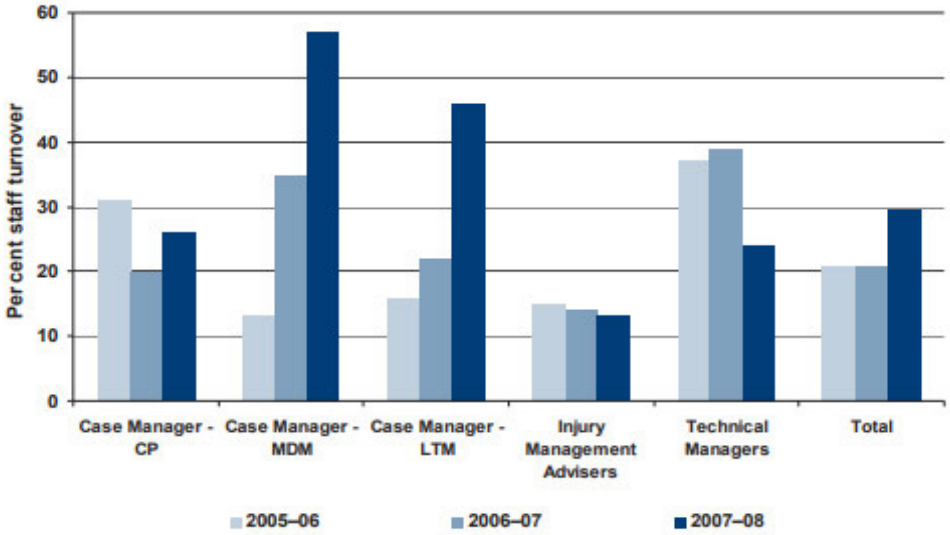
When one looks at the outsourced claims management model, as it has operated in Australia, two striking features emerge. The first relates to the comparatively low level of capability and capacity (in terms of skill levels and experience) of claims managers within these systems. The second concerns the extremely high level of staff turnover in the system. These two features are, of course, inextricably linked as high levels of turnover mean that there is little retained capability and capacity remaining within the system.

I was a technical adviser to the Victorian Auditor General in relation to both the 2001 and 2009 performance reviews by VAGO of claims management within the Victorian system. The 2009 review found a disturbing lack of experience among a wide range of claims staff, with significant numbers not meeting the VWA's stipulated minimum requirements. For instance, at GIO, some 70 percent of the claims processing (CP) case managers and all five of the long-term management (LTM) case managers had less than two years experience in a statutory benefits scheme. At CGU 34 percent of the LTM case managers fell into this category as did 47 percent of CP case managers at Gallagher Bassett. There were variants of this situation at other agents. At most agents claims managers were overwhelmingly in their twenties and rarely had been at their present organisation for more than a few years.

The second feature of the outsourced claims management schemes relates to the extremely high level of staff turnover in the system. The 2009 VAGO review found that at GIO during 2006, 2007 and 2008 the level of turnover among multidisciplinary management (MDM) case managers was at 80 percent, 35 percent and 42 percent, respectively. The turnover was even higher for the other two classes of claims manager. Similar high levels of turnover were experienced by other agents as can be seen from the following Figure from that 2009 report.

[4] Norm Smallwood and Dave Ulrich, Capitalising on Capabilities, 82(6) *Harvard Business Review*, 119-127 (June 2004) at p. 120.

Figure 4C
Staff turnover rates for MDT positions, 2005–06 to 2007–08



Note: Claims Processing (CP) Case Managers manage low-risk claims, whereas Multidisciplinary Management (MDM) and Long Term Management (LTM) Case Managers manage high-risk claims.

Source: Victorian WorkCover Authority.

This situation of relatively limited experience and high turnover is also found in the New South Wales and South Australian forms of the outsourced claims management model. When I conducted a review of the framework for rehabilitation in the South Australian WorkCover system in mid-2005, I found that the claims managers in the multi agent system that was then in operation were often provided with a minimal level of induction training before having to take on a sizeable caseload. As well, there was little ongoing training and skill development. With the move to a single agent, Employers Mutual, there was a hiring of many new claims managers, many of whom had never worked in the workers' compensation industry before. There was a higher level of training and, at least initially, lower case loads.

However, the move to a single agent had little impact upon the level of case manager turnover. In South Australia, as in New South Wales, this has consistently been at an average rate of between 20 and 30 percent per annum with much higher churn rates experienced by individual agents at particular times. This has been the case in South Australia under both the multi agent and single agent scenarios. In the half year to June 2008, the turnover rate at Employers Mutual rose to nearly 40 percent of case managers before returning to around the 20 to 25 percent level with a low point of around 16 percent

The workers' compensation scheme in British Columbia, managed by the Workers' Compensation Board of British Columbia (WCBBC), is recognised as one of, if not the, premier performing workers' compensation system in North America. Consequently, during the 2009 VAGO review, I enquired from my friend and colleague, Terry Bogyo, who was then Director of Corporate Planning and Research at WCBBC, as to the age and experience profile of claims staff in that scheme. The response was broken down in relation to case managers and vocational rehabilitation consultants who play an important role in the British Columbia scheme:

	Case Manager	Vocational Rehabilitation Consultant
Average age	46.5 years[5]	46.5 years
Average number of years in the position	8.1 years	6.7 years
Average number of years with WCBBC	13.3 years	8.6 years

In terms of turnover, the annual attrition rate (encompassing both groups) was 3.84 percent.

I recognise that this encapsulated summary of agent capability and capacity relates to a situation existing in Victoria and the other two agent jurisdictions some time ago. I have not had access to more recent information that could illuminate the current situation. I hope that there would be some incremental improvement, but suspect that, in fundamental aspects, the situation has not radically changed. I would urge the Review to seek this information from WorkSafe Victoria in order for it to present a profile of the current situation concerning this very important, nay imperative, area upon which the achievement of positive scheme outcomes is so crucially dependent.

4. Targeted case management practices for complex claims

4.1 Introduction

The original workers' compensation schemes were devised in a different era at a time when the dominant injury issue was that of traumatic injury, in the form of amputations, fractures, burns and the like, primarily in the context of an industrial enterprise. These are still not insignificant conditions in a modern workers' compensation scheme, but dealing with matters unheeded in the early schemes, such as psychological injury, are very significant issues in contemporary schemes.

Similarly, our understanding of the dynamics of the injury and recovery process is becoming increasingly sophisticated as the result of an accumulating body of research evidence. This has led to the development of better approaches to the diagnosis, treatment and support of workers with particular injuries and illnesses.

The result is that workers' compensation scheme regulators are dealing with a more complex work/injury environment with a concomitant responsibility to guide and assist all players in these schemes to act in a more nuanced and sophisticated manner in order to achieve the best outcomes for injured and ill workers.

In terms of effective claims management, there is one central issue that confronts the operation of every workers' compensation scheme (and other compensation arrangements as well). The nub of this issue can be stated quite simply. Without any significant intervention (apart from medical treatment) the vast majority of claimants will be able make either a full recovery or one that, although leaving them with a

[5] I queried whether the fact that the average age of both groups was in fact the case rather than as the result of a typographical error. It was confirmed that both figures were in fact correct.

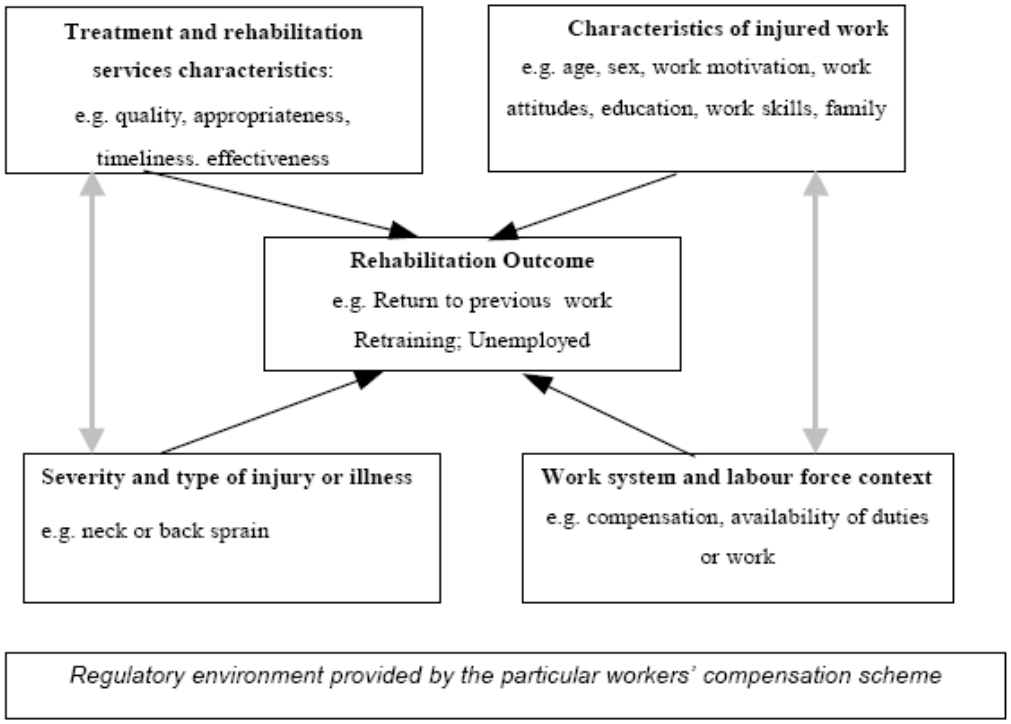
residual degree of incapacity, does not preclude them from returning to their previous employment. Where there is a more significant degree of incapacity the return to work may have to involve alternative or modified duties, sometimes assisted by rehabilitation and allied interventions (such as workplace modification). However, there is a group of injured claimants who, looking simply at their injury condition/s, should have achieved a quite unproblematic return to work but whose cases become complex, long duration claims.

4.2 Why is this all so difficult?

At an intelligent lay level of understanding the issue should be relatively simple. The first task should be to gain a good appreciation of the nature of a worker's injury or illness. Secondly, having done this, to then implement an optimal healing and (physical and /or psychological) restoration regime in order to achieve maximum medical improvement in the most feasibly expeditious time. At this level there is a beguiling promise that a process based upon a nuanced understanding of injury characteristics and severity could provide a finessed guide for action. Indeed, there is an instrument in the form of the MDGuidelines from ReedGroup (formerly Dr Presley Reed's *The Medical Disability Advisor*) which sets out information on the minimum, optimum and maximum duration expectancy figures for almost any injury or illness type.

However, researchers and many scheme regulators have, for a number of decades, known that a proper understanding of the dynamics of occupational injury and illness and return to work cannot adequately be understood from such a biomedical perspective. Rather, it is now appreciated that these conditions, and the web of processes surrounding them, are permeated by complex psychological and social elements.

A more complex framework or model of understanding - that of a biopsychosocial model of health - has emerged to provide a more adequate understanding of the various elements at play. It is a framework that sees health status as being influenced by a complex set of interactions between an individual's biological system, their psychological makeup and the environmental context, including the social context, in which they operate and interpret their health. Some of the dynamics associated with the biopsychosocial model as may relate to rehabilitation and return-to-work outcomes are presented in the Figure immediately below.



Source: P Foreman and H. Swerissen. *Occupational rehabilitation service market structure and policy options*, Latrobe University, 2001

4.3 What does the research tell us?

There have been efforts by medical researchers and others to understand the dynamics of the work environment and the elements of that environment that complicate the return to work process since at least the 1990s. However, there have been earlier efforts, going back to the mid-1930s, to look at approaches that could assist in return to work.[6]

4.3.1 Cohort studies

One of the early approaches was to try and tease out the major factors relating to long absence following work injury or illness by looking at a large cohort of workers and, through regression analysis, attempting to find the major correlates for extended duration of work disability. An Australian example of this approach was the study undertaken by Dianna Kenny of 3041 injured workers in New South Wales.[7] It found that the variability in time lost following injury was more significantly related to variables such as the age of the worker, their gender, family responsibilities, job remuneration and occupation than to the nature or cause of the injury.

There are a number of North American studies that are to similar effect. One of these is that undertaken by Arthur Oleinick and associates of a cohort of 8,628 Michigan workers with compensable back injuries.[8] This study attempted to distinguish the factors that predicted continued work disability during

[6] N.Eckleberry. The injured workman: methods of handling to get him back on the job. *Ind Med*. (1936) 5:557–60.
[7] D. Kenny. Determinants of time lost from workplace injury: the impact of the injury, the injured, the industry, the intervention and the insurer. *International Journal of Rehabilitation Research* (1994) 17(4): 333-342.
[8] A. Oleinick, JV Gluck and K Guire. Factors affecting first return to work following a compensable occupational back injury. *American Journal of Industrial Medicine*. (1996) 30(5):540-55.

the acute (defined in terms of absence up to 8 weeks) and chronic disability (defined in terms of more than 8 weeks absence) periods. In the acute phase the statistically significant predictors were gender, age, number of dependants, industry (construction), occupation and type of work. In the chronic phase the major correlate with duration of work disability was establishment size and, to a lesser extent, wage compensation rate.

Since then there have been numerous other studies conducted, with respect to highly diverse cohorts of injured workers in equally diverse industrial and national settings.[9] The overall message from these various studies is that injury type and the extent of injury is not a good predictor of the amount of time off work following occupational injury or illness.

4.3.2 Muskuloskeletal Disease studies

Musculoskeletal disease conditions, and particularly low-back pain, have been an ongoing concern for researchers and workers' compensation administrators as constituting a leading cause of work disability in the industrialised world. It is an area that has also attracted the attention of a remarkable group of occupational physicians including Alf Nachemson in Sweden, Gordon Waddell and Kim Burton in the United Kingdom, Rick Deyo in the United States and Mary Wyatt in Australia. These physicians were instrumental in bringing about a significant change in the recognised treatment regimes for low-back pain[10]. As well, detailed population-based studies that they undertook revealed that duration of work disability as a result of low-back pain was not reliably correlated to the anatomical and physiological features of the condition.

An early supporter of work undertaken by low-back pain researchers to develop a better prognostic understanding of this condition was the Accident Compensation Corporation (ACC) in New Zealand and, in work supported by the ACC, a number of these researchers, including Steven Linton, Nick Kendall and Christopher Main, developed the notion of 'yellow flags' This was a conscious allusion to the notion of 'red flags', that had been developed around 1994, concerning the warning signs of serious pathology in patients that required further medical investigation. The idea of 'yellow flags' was to encapsulate the psychosocial and workplace factors that contribute to back disability after pain onset. This was presented in a publication published by the ACC in 1997, titled *Assessing yellow flags in acute low back pain: risk factors for long-term disability and work loss*.

Since then, and particularly from around 2000, there has been a mini epidemic of flags, with the recognition of orange (psychiatric symptoms), blue (perceptions about the relationship between work and health) and black (system or contextual constraints).

4.3.3 Misuse of the ‘flags’ research

There has been a downside to this ‘battle of the flags’ It has excited the attention of a number of commercial software vendors, particularly from the United States, who have moved to develop triage products that incorporate in their ‘risk factors’ a smorgasbord of these elements and features. While in theory this may be fine, in practice it has been disastrous. One of the factors contributing to the current morass of the New South Wales iCare scheme has been the almost evangelical belief of the single scheme agent in the efficacy of algorithmic-led claims triage. In practice this belief has run up against an almost an iron law of triage tool design that increasing the number and complexity of the risk factor

[9] A perusal of the volumes of the *Journal of Occupational Rehabilitation* will bring to light a host of these studies.
[10] Some of this journey is chronicled in Gordon Waddell's book *The Back Pain Revolution*, New York: Churchill Livingstone, 2004

elements has a rebounding effect in expanding the number of false positives and false negatives generated by the tool in practice.

A little reflection would indicate that this result is to be expected. One of the first lessons from Epidemiology 101 is that statements that can be made with considerable certainty at a population level are unable to be prognostically applied with such certainty to an individual member of that population. Perhaps the major besetting sin relating to the development and use of triage tools lies in the level of expectation as to what they can achieve. Not surprisingly, vendors of commercial products wish to project an aura (cloaked in the mantle of artificial intelligence) that such tools are something of a silver bullet, able to greatly enhance the efficiency of claims management teams. That this turns out not to be the case is not surprising since such tools are largely applied in abstraction from the individual case, even though there is some individualised information generated from a claim form, medical certificate or similar paper source that is matched to the checklist of risk factors or passed through the algorithms of an electronic version of the tool. However, the point remains that the amount of individualised information is both relatively limited and, in qualitative terms, quite low grade. Added to this difficulty is the compounding limitation of the sheer volume of claims.

An associated besetting sin, related to the silver bullet phenomenon, is the tendency to ascribe the 'value add' of the triage tool to the tool itself rather than to the operator. Indeed, one of the selling points relating to triage tools is that they encapsulate the accumulated wisdom of the field in relation to claim risk factors and that this wisdom can empower quite junior (in terms of both age and experience) claims/ case managers with this embodied knowledge and wisdom. In fact, the best and most effective triage tool is an experienced and empathic case/ claims manager who is fully informed about the circumstances of the individual case and claimant. This has been the case in the past and will almost certainly be the situation in the future regardless of any developments in the sophistication of triage frameworks and tools. This is not to say that a very well-designed triage tool cannot be an extremely useful instrument in the tool box of an experienced and wise claims / case manager. However, in mature, well-performing, schemes there should be no mistaking which is master and which is servant.

4.3.4 Role of the accident compensation system itself in relation to health outcomes

A number of excellent studies have focused upon the overall impact of the operations of accident compensation systems on the lives, health and well-being of injured and ill workers. Some of the earlier studies with respect to workers' compensation schemes emanated from Canada. The late Terry Ison, an iconoclastic Canadian legal scholar who, as chief executive of the British Columbia Workers Compensation Board, helped mould that scheme into the pre-eminent place that it has enjoyed among Canadian schemes, paved the way more than three decades ago.[11] This was followed by Katherine Lippel, a prominent Canadian socio-legal scholar whose cultural and linguistic background has enabled highly nuanced studies illuminating the dynamics of Anglophonic jurisdictions and that pertaining in the culturally distinct system in Quebec.[12]

---

[11] Terence G Ison, The Therapeutic Significance of Compensation Structures, (1986) 64 *Canadian Bar Review* 605. Terry Ison's early seminal work, *The Forensic Lottery* (London: Staples Press, 1967) in draft form had a significant influence upon the nature of New Zealand's iconic no fault accident compensation scheme.

[12] This has included Katherine Lippel, Therapeutic and Anti-Therapeutic Consequences of Workers Compensation, (1999) 22 *International Journal of Law and Psychiatry*, 521; and on the Quebec workers' compensation system (CSST) Katherine Lippel, Workers Describe the Effects of the Workers' Compensation Process on Their Health: A Quebec Study, (2007) 30 *International Journal of Law and Psychiatry*, 427 and Katherine Lippel, Marie-Claire Lefebvre, Chantal Schmidt and Joseph Caron, *Managing Claims or Caring for Claimants: The Effects of the Compensation Process on the Health of Injured Workers*. University of Quebec at Montreal, 2007.

In Australia, much of the early work on the impact of accident compensation schemes came from medical practitioners who were struck by the finding that people with injuries who claimed compensation for those injures had poorer outcomes than people with similar injuries but who were not involved in the processes of the compensation system. In an influential report, *Compensable Injuries and Health Outcomes*,[13] that explored the existing literature, the Australasian Faculty of Occupational Medicine and the Royal Australasian College of Physicians found that there was "good quality evidence" in support of that association.[14]

More recently, there has been detailed quantitative and qualitative studies from Australian researchers (often in partnership with Canadian researchers)[15] that has provided more methodologically sophisticated analyses of overall system impacts[16] and those relating to particular interactions (eg with insurers[17] or health professionals[18]) within that system.

5. Influences of financial incentives on agent decision making and WorkSafe oversight of agents

5.1 The issue encapsulated

I have decided to combine the discussion of these two issues as they are highly interconnected. The persistence of rent-seeking initiatives by agents with distorted decision making impelled by the gain from financial incentives, is integrally related to failures in WorkSafe oversight of agent operations. This point is perhaps made most strikingly by the Victorian Ombudsman in the Foreword to her December 2019 report. It is worth quoting the opening paragraphs at length:[19]

> Does anything change after an Ombudsman investigation?
>
> In almost every case I have dealt with in my five years in the role the answer is yes, and meaningfully so: unfair laws, policies and procedures have been replaced, new systems have been introduced, in some cases thousands of dollars have been paid to people wrongfully disentitled.
>
> 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?

---

[13] Published by the Royal Australasian College of Physicians in 2001.

[14] An unpicking of some of the methodological issues is undertaken in Genevieve Grant and David M. Studdert, Poisoned Chalice? A critical analysis of the evidence linking personal injury compensation processes with adverse health outcomes. (2009) 33 *University of Melbourne Law Review*, 865

[15] Perhaps the most fruitful partnership has been between the Insurance Work and Health Group at Monash University with the Institute for Work and Health in Canada.

[16] Alex Collie, Luke Sheehan, Tyler J Lane, Shannon Gray and Genevieve Grant, Injured worker experiences of insurance claim processes and return to work: a national, cross-sectional study, *BMC Public Health*, (2019) 19:927

[17] Elizabeth Kilgour, Agnieska Konsny, Donna McKenzie and Alex Collie, Interactions Between Injured Workers and Insurers in Workers' Compensation Systems: A Systematic Review of Qualitative Research Literature, *Journal of Occupational Rehabilitation* (2015) 25(1): 160

[18] Elizabeth Kilgour, Agnieska Konsny, Donna McKenzie and Alex Collie, Healing or harming? Healthcare provider interactions with injured workers and insurers in workers' compensation systems, *Journal of Occupational Rehabilitation* (2015) 25(1): 220

[19] Victorian Ombudsman, *WorkSafe 2: Follow-up investigation into the management of complex workers' compensation claims* (December 2019) at p.4.

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.

While I monitor the implementation of all my recommendations, this is the first time I have launched a fresh investigation into the same issue. All Ombudsman complaints involve people's individual stories, but the WorkSafe complaints were and are particularly painful. I said in 2016 these cases involve people's lives, and the human cost should never be forgotten; that human cost continues to this day.

I launched this second investigation in May 2018 on the back of a continued influx of complaints and anecdotal evidence that not enough had changed. Sadly, that has proven to be true.

Agents are still unreasonably terminating complex claims: cherry picking evidence, doctor shopping, relying on Independent Medical Examiners (IMEs) over treating doctors even when evidence is unclear, contradictory or inconclusive – or ignoring it if it didn't support termination.

If anything, the evidence strongly suggests that much of the impact of my 2016 report has been to drive these practices underground. Agent staff were told to be careful what they put in writing – in case the Ombudsman sees it. Staff were advised to use words like 'entitlement reviews' in their emails rather than 'termination'.

But while this meant less overt evidence of decisions being made for financial incentives, this was the only logical explanation for some of them: agents who came to conciliation not prepared to conciliate beyond a derisory sum; maintaining those decisions knowing they would be overturned by a court, on the basis that many workers would simply give up.

From the evidence in this report, it would appear that my 2016 investigation only scratched the surface. New issues were also identified in the files we reviewed, and confirmed in interviews, including the use of surveillance without adequate justification. Such an invasion of people's privacy is only permitted if there is some evidence of worker dishonesty, but we found numerous examples of surveillance being used without a shred of evidence to justify it.

5.2 The principal-agent problem revisited

While the principal-agent problem, as introduced at section 3.2.1 above, may appear to be just a theoretical construct in economic theory, these powerful remarks from the Victorian Ombudsman illuminate its operation in a real-world setting. As mentioned earlier, at the heart of the principal-agent problem is the ability of the principal to ensure that the agent will direct its attention to performing its actions to the benefit of the principal rather than that of the agent's own interests.

The main instruments at the disposal of the principal in attempting to secure such alignment are incentives, usually described as moral, material and coercive. As mentioned at section 3.2.1 the moral incentives, at least in this setting, appear to be both in short supply, and of limited utility, in all three Australian workers' compensation that operate on this model.

That leaves the material and coercive sanctions. These were explained to me some years ago by a former senior WorkSafe manager as, alliteratively, being in the form of 'bluff, biff and bribery'[20]. The history of the WorkCare and WorkCover schemes, at least in relation to the operation of scheme claims management functions, has been an exercise in ever-changing experiments in the use of this tripartite armory of regulatory weapons. It has been a gamekeeper-poacher issue as that same history is one of numerous, premeditated, efforts by agents to game the system.

[20] The term 'bribery' was used for alliterative effect and referenced the various payments, including incentive payments, under the agent contract and not to a more nefarious type of reward.

5.2.1 Incentive payments

The remuneration system for WorkSafe agents falls into two major parts. The first is a base annual fee that is directed towards meeting the costs of the agent's core functions. The second is the incentive payments set out in a measure called the 'Annual Performance Ajustment' (APA) which, according to WorkSafe, attempts to "[a]lign agent performance with WorkSafe's goals of delivering improvements in return to work and service, while driving quality case management and ensuring the overall sustainability of the Scheme"[21] The APA is adjusted annual and involves measures that fall into three broad categories; return to work, sustainability (financial sustainability of the scheme) and service quality (the level of service provided to injured workers and the quality of agent decision making).[22] Each measure includes a target base performance level; performance above this base level can bring with it a reward payment and that below this level can be visited with a penalty sum. There are differential weightings accorded to the various measures.

The initial framework for the APA incentives arrangements dates from 2002. It followed a review of the Victorian claims management model by the international management consulting firm, McKinsey & Co, after concerns about continuing poor claims performance and mounting scheme liabilities.

The McKinsey review argued for a far more active regulatory stance and oversight by the VWA. It proposed that the VWA should bring the notification and assignment of claims in-house so as to enable the VWA to control the first classification of claims in terms of risk. This recommendation was not taken up. However, most of the other McKinsey recommendations were adopted including a variant of their proposed approach at claims segmentation according to risk characteristics; recommending five segments - Simple, Complex, Long Term Care, Catastrophic and Long-Term Return to Work.

The introduction of the APA was an attempt to use market mechanisms to align agent behaviour with scheme goals. The annual adjustment to the nature and weighting of the elements of the APA represents an attempt to calibrate more precisely the incentive mix in the light of emerging knowledge of scheme trends and agent activities. As well, the issues of agent risk tolerance and agent responsiveness to incentives have been important aspects of the incremental development of the incentive system. For instance, the change in 2004 to remove the 50 percent discount from the lump sum and pay the value of the lump sum at the two year (rather than four year) payment date was made in an attempt to achieve greater buy in and engagement by agents.

A major issue with the structure of the incentive payments regime is that they had been designed primarily to reward actions that lead to reduced claim costs; for instance the rewarding of claim termination at or before the 130 week mark of claim duration. It was not until the 2016 Victorian Ombudsman's report that there was a reweighting this regime of incentive payments to increase the available reward for quality service. This was achieved by a reduction of the incentives for terminating claims, increasing those incentives for quality decision making and introducing a long-term return to work measure.

[21] Victorian Ombudsman (2019), para 461.

[22] The elements of the APA for the 2017-18 for the main category components is set out in Victorian Ombudsman's 2019 report at p. 144. This Table does not include the measures relating to impairment benefits claims, premium collection and processing sustainability.

5.2.2 Financial penalties

The agent remuneration arrangements allow for the reduction of agent fees upon the occurrence of an event such as a failure to meet performance criteria. Over the years, this provision has been invoked on a number of occasions,[23] including:

- in 2007-08 Gallagher Bassett incurred a remuneration reduction of $320 000 for failure to maintain effective internal quality controls relating to the integrity of data used to measure continuance rates;
- in that same financial year, QBE incurred remuneration reductions totalling $546,000 for failure to maintain effective internal quality controls relating to the management of its privacy obligations and unsatisfactory performance on key liability measures (continuance rates and paramedical growth) and failure to comply with the VWA requirements relating to the processing of Access to Information Requests;
- in 2008-09 CGU incurred a remuneration reduction of $1M for the failure to maintain effective internal quality controls relating to the integrity of data used to measure impairment benefits;
- in 2010-11 CGU incurred a remuneration reduction of $2.8M. This was comprised of:
  - $891,000 for the failure to meet minimum processing standards in respect of the payment of service provider accounts;
  - $1,912,111 for the failure to maintain effective internal quality controls in relation to accounts management which resulted in the occurrence of the manipulation of data used to determine performance on remunerated performance measures.
  CGU were also required to reimburse WorkSafe $1.5M in incentive payments paid, or penalties avoided due to the manipulation of data;
- in 2013-14 Allianz incurred a remuneration reduction of $155,311 for failure to maintain effective internal controls in relation to the employer liability calculation;
- in 2015-16 CGU incurred a remuneration reduction of $444,527 for data manipulation relating to the payment of weekly compensation.

5.4 Oversight by WorkSafe

The nature, quality and intensity of the regulatory oversight of the agency relationship by the relevant regulators in the three jurisdictions where this model has existed – Victoria, New South Wales and South Australia – was, particularly for the first decade and a half of operations, very poor. This was especially so in New South Wales. At least in terms of a capacity to monitor the activities of agents, Victoria was well ahead of New South Wales with its introduction of a centralised transaction processing system with which all scheme agents interfaced. As a result, Victorian WorkCover Authority (VWA) had access to the full transactional information record and was able to subject this to review and analysis. By contrast, in New South Wales each agent operated their own systems and provided monthly data extracts to WorkCover NSW. This greatly increased the opportunity for gaming behaviour.

The oversight within the Victorian scheme moved from one of very light touch regulation to a more interventionist and intensive engagement with agents from around 2002, following the McKinsey report. The VWA instituted a significant change management process to develop and implement the new claims management model and structures, systems and processes to support this new model. It

[23] These examples have been accessed from the Victorian WorkCover Authority's Annual Report covering the relevant period.

established a Program Management Office to oversee the activities of 13 implementation teams. This effort was to ensure the smooth transition to the new system from 1 July 2002.

Before the 2002 contracts there had been ten Agents. On 22 April 2002, the VWA announced the new Agent panel. Five of the previous insurers were not reappointed[24] under the new contracts and a new panel of seven entities was appointed.[25] There was a deliberate effort to move from a purely insurer panel to one that included organisations with a claims processing background as third party administrators.

This set the stage for a framework for the organization and oversight of claims agent that is still largely in place today. The major instruments of WorkSafe oversight of agents are four-fold: auditing the quality of agent decisions; handling complaints about agents; surveying injured workers about agent service delivery and undertaking targeted 'health checks' of claims management issues.

The 2016 and 2019 reports by the Victorian Ombudsman raise important issues about the robustness of this oversight regime. In relation to the system of audit of the quality of agent decisions, this has been progressively expanded[26] and made more stringent[27] since the 2016 Ombudsman's report. However, while these changes appear to herald a much more rigorous system of oversight, in practice this rigour seems more illusory. The Ombudsman found instances of questionable passes, questionable decisions to change audit outcomes, failure to reinstate worker entitlements following an audit decision that the worker had been 'wrongly disentitled' and failure to follow up actions identified through audits.

Some of the dynamics that are at play in this process are concerning. Agents are able to dispute a WorkSafe audit finding through a review process. This is fine, and indeed important from a natural justice perspective. However, the Ombudsman found that, in relation to the 880 weekly payments terminations that WorkSafe audited in 2017-18, it failed 37 of these decisions. Agents requested a review in 33 of these cases. On reassessment by WorkSafe it reversed its stand in 24 cases (almost three quarters of the reviews) to recognise them as passes, including a situation where WorkSafe still held that the quality of the decision remained 'questionable'.[28] It is not clear as to the basis or reasons for this high rate of reversal. On one interpretation, it could point to the abysmally poor quality of the original WorkSafe decision making. More likely it shows an entrenched degree of agent veto power or even regulatory capture.

5.5 What is happening here?

Following the 2002 recasting of the agency framework in Victoria, the VWA/ WorkSafe has embarked on the most extensive and intensive journey of trying to operationalise the agency model of any of the three jurisdictions that employ it. In terms of sophistication, it was light years ahead of what was in place in New South Wales and South Australia. A major architect of this framework was Len Boehm who, for many years, held positions at the Executive Director level at the VWA. He is widely regarded as one of the (if not the) most talented and lateral-thinking administrators in Australian accident

[24] Catholic Church Insurances Ltd, GIO Workers Compensation, Guild Insurance Ltd, Royal & Sun Alliance Workers Compensation Ltd and Zurich Workers Compensation Victoria Pty Ltd.
[25] Allianz Australia Workers Compensation Victoria Ltd, Cambridge Australia, CGU Workers Compensation Victoria, JLTA Workers Compensation Services Pty Ltd, NRMA Workers Compensation Ltd, QBE Mercantile Mutual Workers Compensation and Wyatt Gallagher & Bassett
[26] Increasing the sample size from under 700 to over 1,700
[27] Increasing the frequency of audit from twice yearly to monthly and incrementally increasing the pass rate from 80 per cent to 90 per cent.
[28] Victorian Ombudsman (2019), paras 541-544.

compensation, having worked previously at a senior level at the TAC and then moving to head up the Motor Accident Commission in South Australia. He developed around him a team of analysts and statisticians (assisted by two in-house actuaries) to assist in monitoring trends in scheme activity.

So why, given this level of intellectual and other investment has this attempt at regulation failed?

One of the most damning indictments of the current situation that was revealed in the 2019 Victorian Ombudsman's report is not necessarily contained in the content of the report but, as she observed in the Foreword to report, cited above, is that three years after the 2016 report, *she was compelled to revisit this terrain once again.*

The unkindest observation would be to repeat the remark of Tallyrand, on the restored Bourbon dynasty after the abdication of Napoleon, that "They had learned nothing and forgotten nothing". I do not think that this is the case. There are many very fine and talented people at work with WorkSafe doing their very best, within the environment that they find themselves, to do the right thing. The problem I believe is overwhelmingly structural rather than personal. With New South Wales iCare it is probably both.

5.5.1 Who is master, who is servant?

Near the very end of her 2019 report, I believe that the Victorian Ombudsman makes a very important observation:[29]

> WorkSafe has implemented a number of initiatives to improve workers' experience of the scheme since the 2016 investigation, and this work will continue with the delivery of its 2030 strategy. However, the investigation has shown that workers' experience of the scheme is most significantly affected by unreasonable agent decision making. WorkSafe appears reluctant to adequately deal with this when it is brought to their attention, based on its view that agents have delegated authority to manage claims and that conciliation and the courts are the appropriate mechanisms to ensure workers are appropriately compensated. It begs the question whether WorkSafe feels beholden to the agents, dependent on their participation to deliver a financially viable scheme.

The expectation of the public is that the regulator of a system will hold the ring and maintain the probity and fairness of the rules and protect the interests of those for whom the system is set up to serve. One of the problems (potential and actual) confronting any regulatory system is that of regulatory capture. At its most venal this what is referred to as materialist or financial capture. However, a more subtle and perhaps more insidious issue is what is referred to as non-materialist or cognitive or culture capture; the situation where regulator takes on the stance and mindset of regulated entities.

I mentioned, in the introductory section of this submission, the shift that I have observed over three decades in relation to the agency model: from a recognition that this was a political expedient, to a belief that it was sophisticated product of public policy, to now one that regards it as the natural order and perhaps even the best of all worlds.

In his May 2011 report, *Investigation into record keeping failures by WorkSafe agents*, the Victorian Ombudsman, along with other failings in this regard, highlighted the manipulation of the WorkSafe incentive scheme by agents. This report pointed to the substantial financial incentives or bonuses that were then available to the scheme agents for achieving various performance targets, with agents being paid a total of $30.3 million in incentive payments in 2009-10. One of the incentive measures related to the timely payment of invoices by agents. One of the agents - CGU - had benefitted by $2.5 million on this measure, chiefly because of the practices of CGU staff which included, during 2010, hiding some 10,000 invoices in a locked cupboard, thus artificially inflating their performance on this measure.

[29] Victorian Ombudsman (2019), para 768.

This practice went undetected for around nine months.[30] Subsequently WorkSafe Victoria fined CGU $2.8 million and CGU made restitution of the $2.5 million payment[31] received under this performance measure.

Two years earlier CGU had incurred a remuneration reduction of $1 million for other data integrity issues. Thus, over a three period, CGU had incurred penalties and repayments totalling either $4.3 or $5.3 million[32] for data manipulation to achieve a financial benefit. One might have thought that this would have, if nothing else, had a required deterrent effect to prevent similar behaviour in the future. Wrong. A further two years later, CGU – in 2015-16 – incurred another remuneration reduction of $444,527 for data manipulation relating to the payment of weekly compensation.

It is difficult to contemplate what type and level of premeditated gaming behaviour would be necessary for an agent in the situation of CGU to be removed as an agent. It may perhaps be related to the fact that CGU has historically been the agent with the largest market share (between a quarter and a third of the market). There may have been consideration that the disruptive impact of removing it and having to allocate its employer portfolio to other agents and/or bring in another claims agent. A possible case of too big to be removed.

These penalties relate to serious breaches that were, first, detected and then deemed of sufficient magnitude for the VWA to move to penalise. It is not known what prevalence and intensity of gaming behaviour within the system was not detected or, if detected, was not, forever reason, visited with a penalty. As well, there must be considerable doubt as to the deterrent effect of the VWA compliance regime. One agent, CGU, historically the agent with the largest market share (between a quarter and a third of the market), having incurred penalties and repayments totalling $5.3 million over a three year period for data manipulation to achieve a financial benefit, was still engaging in such behaviour four years after having received such a significant financial sanction.

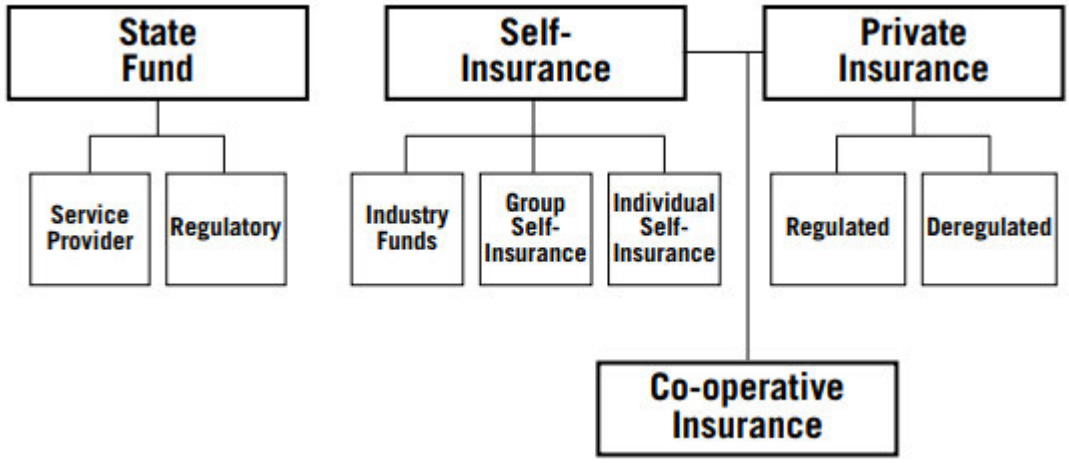
[30] Victorian Ombudsman, Investigation into record keeping failures by WorkSafe agents (May 2011) at p.4
[31] In the 2011 WorkSafe Victoria annual report, the restitution amount is expressed as $1.5 million.
[32] See previous footnote.

6. Alternatives to the agent model

6.1 Introduction

The Review's Discussion Paper notes that it will consider a range of alternative compensation and insurance frameworks to inform consideration of the potential benefits and limits of any proposed changes to the current agent model.

Almost a quarter of a century ago, I attempted to portray in a single diagram the various alternative arrangements for schemes dealing with compensation for occupational injuries and diseases around the world in terms of their financing structure.[33] This is set out immediately below:



Some examples of these forms are:

State Fund

Service provider: TAC, WorkCover Queensland, ACC (NZ)
Regulatory: Agency model in Victoria, NSW and South Australia

Self Insurance

Industry Fund: German Berufsgenossenschaften
Group Self Insurance: Local government Association Workers Compensation Scheme, S.A.
Individual Self Insurance: Self insurers under the various State and Territory schemes and Comcare

Cooperative Insurance: No Fault Labour Market Insurance (AFA Försäkring) scheme, Sweden

Private Insurance

Regulated: Western Australia workers compensation system
Deregulated: South Dakota workers compensation system

It should be noted that many, if not most, schemes do not represent a single pure model as they have elements from more than one of these forms. In particular, it is especially common for schemes to have provision for self insurance alongside other underwriting forms.

[33] Alan Clayton, Workers Compensation – the Third Way, *Safety Science Monitor* (1997) 1(1) 1 at p.3

Given the nature and history of evolution of workers' compensation in the Antipodes, I think that the Review is right, as flagged in its Discussion Paper, to concentrate its focus on what it has identified as the three main models (service provider state fund, private insurance and agency), supplemented by lessons that can be learned in relation to the management of complex claims from self insurers and the NDIS. However, there are important insights for effective scheme management that can be gained from some of the exemplary international scheme performers that are based on a different model, such as the German Berufsgenossenschaften.

6.2 State Fund vs Private Insurance

I think that it is abundantly clear from the previous sections that, in my view, the agency model is a completely flawed approach. It is one that, because of the inherent tensions associated with the principal-agent problem, is probably not capable of being effectively managed into being a viable vehicle for quality scheme operations.

With respect to the choice between a state fund which is also the service deliverer (eg TAC, ACC) and a privately underwritten workers' compensation scheme, I believe that there is a similarly sharp choice and divide. To adequately argue and document this proposition would require a submission that would be at least double to length of this one. Accordingly, I will proceed by some judgments and observations, with some accompanying information in relation to each judgment and/or observation. I am happy to discuss any or all of these with the Review if further evidence or documentation is wanted.

6.2.1 The role of private insurance in international workers' compensation

As mentioned above (section 2.2), in broad historical terms, there are two polar models of workers' compensation. The first is the ***public*** 'German model' which, from the very beginning, had embedded into its practices a focus on rehabilitation and injury prevention. The second is the English ***'private insurance'*** model which was adopted throughout the then British Empire. It was the dominant Australian model until the mid-1980s. The only significant exception was in Queensland where, in 1916, the T J Ryan Labor Government moved to a monopoly state scheme due to a number of scandals in respect to the practices of private insurers. It was also the model in New Zealand until 1974 and the introduction of the comprehensive ACC scheme.

Within the British Empire, the major move from the private insurance model was in Canada. The catalyst was the action of the Ontario government, in response to a lack of adequate funding for injured workers and a slow, inequitable, court system, appointing, in 1910, a prominent judge and later Chief Justice of Ontario, Sir William Meredith, to head a Royal Commission into the workers' compensation system. Sir William Meredith produced a number of interim reports and his final report was handed down in 1913. In these reports he excoriated the then current model as primitive and barbarous and recommended a new approach, based on five concepts now known as the 'Meredith principles'. The Ontario legislature enacted a new workers' compensation statute, that encompassed these principles that came into force on 1 January 1915. This model was subsequently adopted by all other Canadian provinces. One of the key Meredith principles is that of 'state administration'; that the state (province) assumes sole responsibility for the collection of premiums and the management of claims. The Meredith principles, including state administration, have remained as almost unassailable precepts in debates within Canada over reform of workers' compensation.

While there have been numerous examples of jurisdictions moving from private underwriting to a state fund (for instance, twelve Canadian jurisdictions, four in Australia and New Zealand) I am only aware of two instance (both in the United States) where there has been a move away from a monopoly state fund.[34] The only major country where private underwriting is a significant major force in workers' compensation insurance underwriting is the United States. However, even here, in 20 states there is a competitive state fund arrangement (that is a state-owned insurer that competes on even terms with private insurers) that is usually a major and sometimes the dominant insurer in a particular jurisdiction (eg SAIF Corporation in Oregon). As well, in most jurisdictions, a very considerable segment of the workers' compensation market is covered by self-insurance arrangements (both individual and group self insurance).

6.2.2 In no international jurisdiction is private insurance a deliverer of exemplary services and outcomes

Perhaps not unsurprisingly, in terms of effectiveness and performance, the distribution of schemes, internationally, conforms to that of the bell curve, albeit a somewhat skewed bell curve.[35] A quite small number of schemes are exemplary performers, most schemes sit in the middle and another group (larger than that of the exemplary performers) are characterised by poor to abject performance. Internationally, in terms of the management of work injury, the small group of exemplary performers would include the German Berufsgenossenschaften and Unfallkassen, the CRAM (now CARSAT) in France, the Labour Market No Fault Liability Insurance (AFA) scheme in Sweden and, in the Anglophonic world, very good performers include WorkSafe British Columbia, the Washington State workers' compensation scheme in the United States, the ACC in New Zealand and the TAC in Victoria.

There is no jurisdiction whose workers' compensation arrangements are set up on the basis of private insurance underwriting, which can show anything approaching exemplary service and outcome. Such service and outcomes require a long-term, consistent, investment in building and sustaining organisational and scheme capability and capacity. The Caisse Nationale d'Assurance Maladie has its own tertiary education institutes for developing management skills for public sector administrators and professionals in environmental and occupational health. The DGUV, the regulator of German Social Accident Insurance has more than a dozen research institutes which provide world leading research and training in a wide variety of fields. These include accident prevention and product safety (Institute for Occupational Safety and Health in Sankt Augustin), occupational psychology and work organization (Institute for Work and Health in Dresden) and epidemiology and toxicology (Institute for Prevention and Occupational Medicine in Bochum. The AFA scheme in Sweden is the foremost funder of research into the prevention of occupational injury and illness in Sweden.

The achievement of such a level of organizational and scheme capability and capacity is not possible under a privately underwritten system. It requires a commitment and a high level of investment over many decades. The perspective of private insurers is to provide an adequate, plain vanilla, service that will retain their existing client base and probably provide for some incremental market growth. The regulator will often stipulate some minimum standards; however these are as much or more directed to

[34] Nevada and West Virginia. In both these jurisdictions almost as many workers are covered by self insurance plans as are covered by private insurers.

[35] In terms of what are the attributes of exemplary service and outcomes, my two major criteria in arriving at a judgment about schemes and where they sit in terms of a bell curve distribution are (a) effectiveness in managing complex and catastrophic claims and (b) having a injury and illness prevention focus and achieving effective outcomes in this area.

financial/prudential issues as provisioning for outstanding claims liability as they are to service quality. It is not by accident that perhaps the best performing Australian workers' compensation insurer is the state monopoly fund, WorkCover Queensland, which has been a state-owned and operated entity for more than a century.

7. Concluding Observations – the need for 'critical coherence'

The challenge for any accident compensation system is to have the capacity and capacity to manage all aspects of its operations to a high level of competency and professionalism in a consistent manner over long periods of time. While there are always times when systems face challenges – particularly from shocks from the external environment in which they operate such as the current COVID-19 pandemic – there needs to be sufficient system-wide capability and capacity and resilience for the scheme to absorb those shocks without compromising the standards that a civilised society expects of its public and quasi-public institutions.

I have been involved in whole of system reviews of accident compensation schemes, both in Australia and overseas for almost four decades. This activity has been primary involved with workers' compensation schemes and the dynamics of their arrangements, but has also extended to schemes dealing with the compensation arrangements following motor vehicle injury and those involving patient injury. Over the course of this history, I have had cause to reflect upon the attributes of those schemes that have demonstrated consistent and ongoing exemplary and superior performance.

In an encapsulated sense, I believe that the distinguishing characteristics of high performing and exemplary schemes, compared to the average and poor performers, comes down to a bundled set of features that I would refer to as "critical coherence". Such critical coherence is not primarily about staff numbers, although there is obviously a minimum requirement in this regard. It is more fundamentally about the quality of staff (particularly in terms of technical skills but also in terms of professionalism and an ability to communicate) and an environment (including senior managerial support) that allows these staff to be effective in their roles.

This is a state of being that takes time to develop and a continuing need for strong leadership and managerial support to maintain and, incrementally over time, continue to improve. The element of leadership is crucially important. The rise of the Washington State workers' compensation scheme in the United States to undisputed pre-eminence in the US, in terms of quality service delivery and effectiveness of outcomes, was in considerable part due to the strong and inspiring leadership of Joe Dear, one of the most capable workers' compensation administrators that I have encountered in nearly four decades of involvement in the field, that propelled the Washington State workers' compensation system to the preeminent position that it enjoys in the United States. It is the ability to engage, nurture and retain good and experienced managers that has been a key element of the success of the Transport Accident scheme.

As well, there needs to be a strongly entrenched, and continually reinforced, commitment to strong ethical standards and commitment to the public good. These are features that are in the DNA of the small group of international exemplary performers such as the German Berufsgenossenschaften, the Caisse Regionale d'Assurance Maladie in France and the Labour Market No Fault Liability Insurance (AFA) scheme in Sweden. The antithesis to this can be seen in many workers' compensation schemes in the United States and, unfortunately, in the iCare scheme in New South Wales.

Then, fundamentally and crucially, there needs to be the institutional capacity to deliver the necessary service at a competent and professional level to provide effective outcomes. This is particularly the

case with the management of complex claims. In this respect there is a stark contrast between the WorkSafe system and the management of claims within the Transport Accident Commission (TAC) scheme. The TAC, along with the ACC in New Zealand, has an international reputation for the quality and effectiveness of its management of claims for persons having sustained catastrophic injury. Indeed, the TAC manages the catastrophic injury claims from occupational injury on behalf of WorkSafe.

The Victorian Ombudsman, in one of the recommendations of her 2019 report, recommended that there be a review that, within its purview, included looking at the experience of the TAC scheme and those in other accident compensation schemes nationally and internationally. This recommendation has found its way into the terms of reference of this Review.

Unlike the TAC scheme, the present WorkSafe system is not able to provide a sophisticated and professional framework for targeted case management practices, particularly for complex claims, because there is not the capability and capacity within the current – and I suspect any potential future – agent structure to do so. The basis and reasons for this have been canvassed at section 3.2 above. I am not confident that this is a redeemable situation within the present structural framework.

An effective remedy would require very serious effort as it is not a quick fix or easy process. Such a path was taken in the Accident Compensation Commission in New Zealand in the late 1990s to increase the professionalism and competency of its case management staff. Today almost all ACC case managers have some form of tertiary qualification and experience in a professional field. In its recruitment procedures for filling case manager positions, the ACC seeks staff with strong communication skills and who are able to demonstrate professional judgment. It has for some time used psychological testing and targeted interviewing techniques to enhance the recruitment of persons with these qualities.

In terms of training, the ACC instituted a national induction programme (StartUp) consisting of a number of core modules (such as using the information system) together with specialised modules (such as caseload management). The six week programme involved structured activities mainly supervised by a team manager, and supported by a 'buddy' system. Within the first 12 weeks of their employment, all new recruits attended a one-day orientation workshop at the ACC's head office which provided a strategic overview of ACC's role and functions, together with its history and operational philosophy. There were also ongoing, self-directed, learning modules supported by written material.

The ACC established a formal staff training programme known as TeamUp involving workshops, self-directed learning modules and team-based training sessions. The training workshops covered communication modules, skills in negotiation, and interview room safety. The self-directed learning modules included customer care, entitlements, rehabilitation, and the review process. The team-based training sessions, of an hour's duration, were scheduled three times a month in each ACC branch. These included a focus on new policies and initiatives and the reinforcement of specific training needs as they arose. The knowledge and skills learned during the training sessions were supported through coaching by team managers. This coaching component was considered to have contributed to a reduction in case manager turnover. As well, the ACC used external management training to improve branch leadership and communication. The ACC also encouraged case managers to further their professional development through attending courses and conference and obtaining higher qualifications.

The level of turnover among ACC case managers after these processes were fully implemented was eight percent annually with a range (across branches) of between two and twelve percent. However a large proportion of these case manager departures were to take up positions elsewhere in the ACC.

By 2005, the effect of this investment was credited as a major factor behind a fall in the average duration of ACC lost time compensation claims from 56 days to 35 days concomitant with a rise in the claimant satisfaction rating to a figure of 86 percent.

It is a commitment of this magnitude that is required. I do not see that it is possible within the current Victorian agent system. I believe that it is imperative, in the interests of both Victorian workers and employers that there is a move back to the original intentions of the designers of the WorkCare system; namely a provider state fund along the lines of WorkCover Queensland, the TAC or the New Zealand ACC.