MONASH University

Monday 21st September 2020

Mr Peter Rozen QC
Victorian Workers' Compensation Systems Independent Review
via email agentreview@justice.vic.gov.au

Dear Mr Rozen,

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

We are grateful for the opportunity to provide a written submission to the independent review. Our submission addresses a selection of the questions in your discussion paper.

We are happy for this submission to be quoted within a report to the Minister for Workplace Safety and to have this submission published on the Review website. We do not wish for the submission to be confidential.

Sincerely,

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Professor and Director

Ross Iles PhD
Senior Research Fellow

Insurance Work and Health Group
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Monash University

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Background

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

Professor Alex Collie

I am currently Professor in the School of Public Health and Preventive Medicine at Monash University, where I lead a group of researchers with a major focus on Australian workers' compensation schemes – the Insurance Work and Health Group. From 2009 to 2017 I was Chief Research Officer and then Chief Executive Officer of the Institute for Safety Compensation and Recovery Research, as research partnership of Monash University, WorkSafe Victoria and the Transport Accident Commission (TAC). From 2006 to 2009 I was a Senior Manager responsible for the health research program within the joint health services division of WorkSafe Victoria and the TAC.

My research interests include the determinants of health and return to work among injured and ill workers; interventions related to return to work; injured workers experiences of compensation claims processes; the interactions between injury compensation and healthcare systems; and evaluating the impact of policy change on injured workers and workers' compensation schemes.

There is more about the Insurance Work and Health Group at this website:

- https://www.monash.edu/medicine/sphpm/units/iwhgroup

My profile and research track record is available via this website:

- https://research.monash.edu/en/persons/alex-collie

Dr Ross Iles

I am currently a Senior Research Fellow in the School of Public Health and Preventive Medicine at Monash University, where I conduct research with a major focus on Australian workers' compensation schemes. I have completed international research training in the field of work disability prevention. I co-developed and appeared in the Early Intervention Physiotherapy Framework training program designed to improve the physiotherapy management of injured workers and Transport Accident Commission (TAC) clients.

My research interests include the reduction of unnecessary work disability through the introduction of evidence-based screening for risk of delayed return to work. I have led research projects in three Australian jurisdictions focused on early identification and intervention to help injured workers recover and return to work as soon as possible.

My profile and research track record is available via this website:

- https://research.monash.edu/en/persons/ross-iles

Identifying and assessing complex claims

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

As noted in your discussion paper, recovery from injury and disease is a complex biopsychosocial phenomenon in which various factors across the domains of personal, workplace, health and insurance systems influence both worker outcomes and experiences.

The Sherbrooke Model of Work Disability is a variant of the biopsychosocial model developed specifically for the field of return to work and workers' compensation and is highly regarded internationally (1). The model groups individual predictors of return to work into four domains that reflect the key participants in Australian workers' compensation schemes:

- Personal domain (the claimant/worker)
- Workplace domain (the employer)
- Health Care domain (the health care provider)
- Legislative and Insurance domain (agents, insurers and regulators)

The model also recognises that contextual or environmental factors can play a role in claim complexity and return to work (for example achieving return to work is more challenging in a labour market with high unemployment).

Return to work, or failure to return to work, is influenced by the complex interplay of multiple factors across these domains. In some cases complexity may arise from a single characteristic (e.g., a severe injury or illness) but it is common that an individual worker will have a complex claim that arises from a combination of factors across multiple domains. In short, there are many potential risk factors for a complex claim, and complexity is a product of both their presence and their interaction.

In a recent international literature review completed for Safe Work Australia to support development of the National RTW Strategy, we identified 33 factors as having moderate to strong evidence that they had an impact on return to work outcomes (2). These factors were distributed across the four domains of the Sherbooke model. Our review rated these factors according to whether they are modifiable or not modifiable. Some factors that influence claim complexity cannot be modified such as worker age and pre-injury income. Others are more easily modifiable, such as the speed of claims decision making, or whether an employer makes an offer to accommodate the injured worker with different working hours or duties. Based on this evidence review we concluded that major opportunities to improve return to work, and thus reduce the risk of a workers claim becoming complex, include addressing modifiable factors in the compensation/insurance domain (claims management practices) and the workplace domain.

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

The risk factors and characteristics that contribute to claim complexity are not necessarily static. Rather they change over time, reflecting the dynamic nature of injury/disease and recovery. For example, some workers will develop mental health problems during the course of their claim, presenting a barrier to return to work. The level of family and social support for an injured worker may change during their claim, affecting their recovery. In summary the risk factors for complexity change over time, with some workers developing characteristics that increase the 'risk' of experiencing a complex claim as the claim progresses. This means that it is important that risk assessment is conducted periodically through the course of a compensation claim.

The IWHG at Monash, working with WorkCover Queensland, has developed a best practice statement on risk factor identification that describes an evidence-based approach to identifying and acting on factors that can influence claim outcome, and is designed for a workers' compensation setting (3). This statement proposes that risk factor identification should occur throughout the course of a workers' claim. This document also describes the balance between the

timing of information availability and the ability to influence outcomes when identifying the complexity of a claim. The longer work disability persists, the easier it is to identify the complexities involved. However, the longer a worker is absent from work, the chances of ever returning to work decrease. We have demonstrated that the information needed to identify complexity can be collected with two weeks of a claim being accepted in NSW (4), and within four weeks in Queensland (https://www.worksafe.qld.gov.au/about-us/workcover-queensland-research-initiatives/recovery-blueprint). The most important aspect regarding the timing of identifying complexity is to do it within a timeframe to enable proactive intervention to prevent unnecessary time away from work.

Financial incentives and agent decision making

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

Greater transparency in the operation and performance of the scheme, and the performance of scheme agents, would provide a mechanism that would encourage improvements in quality. In our view there is a lack of publicly available and up-to-date data assessing the outcomes and experiences of injured workers in the Victorian scheme. To our knowledge, the main data sources currently collated include:

1. Administrative claims data. This is made available to external researchers on request. This is valuable for understanding claims trends and outcomes and scheme operations, but provides little insight into worker health or experience.
2. A regular worker experience survey conducted by a commercial research organisation on behalf of WorkSafe Victoria. To our knowledge this is not made available to external parties and only high-level outcomes are published.
3. The National RTW Survey. A small group of injured Victorian workers participate in this national survey. Data is available upon request, and includes substantial health and experiential data, but is collected irregularly.

None of these data sources are made available to the public, except in highly aggregated and summary format. For example, the WorkSafe Victoria claims statistical report available via the Victorian government open data platform is limited to aggregate claim counts by industry, occupation, nature of injury etc and provides no insight into claims processing or outcomes.

It is becoming more common for public agencies to adopt open data platforms, and there is opportunity, using the existing data sources, to make data available in a way that would enable comparison of agent performance. For example, using similar data sources, we have published a number of comparative studies demonstrating that on average, the duration of claims in the Victorian scheme is longer than that in other Australian workers' compensation schemes and that more Victorian workers have durations exceeding 2 years than in other schemes (5). We have also published data showing that injured workers in Victoria were statistically less likely to report positive claims experiences than workers in some other Australian jurisdictions (6). Similar approaches could be taken comparing outcomes and experiences between scheme agents, if data were more available.

Evaluation measures

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

Please also refer to our response to question 12 regarding transparency and open data. Some of the current measurements (e.g., the injured worker survey) are not made available outside the regulator and so it is not possible to comment on their appropriateness or accuracy.

The other outcome measures have multiple limitations. There is a heavy reliance on administrative claim data, which does not accurately capture health status and has limited return to work data, focussing instead on a proxy of return to work (benefit payment periods). Administrative data also provides little insight into many of the leading indicators of return to work such as factors in the employer, personal/worker or healthcare domains that influence claim complexity and outcomes.

While the National RTW survey does provide this information, this survey also enrols a unique sample that does not cover the spectrum of injured workers in the state. For example, it does not collect data from people with very long-term claims, such as those you have defined as being complex. Also data collection for the National RTW survey is irregular, being conducted only bi-annually, and thus not useful for the purposes of more regular performance evaluation or for use in ongoing scheme management (noting that this is also not its intended purpose).

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

We believe that a best-practice approach to outcome measurement in workers' compensation would supplement the routine data collected via claims management systems with regular collection of data directly from injured workers involved in the scheme, and those who have left the scheme. This should be conducted in a representative sample of workers and sufficiently often that trends in outcomes can be monitored on at least a quarterly basis. This should include data from across the spectrum of biopsychosocial factors that affect worker outcomes, including their experiences during their claim and return to work process, as well as information on the health state and return to work outcomes.

In Victoria, in order to explore the outcomes of workers with long-duration claims (e.g., those that go beyond 130 weeks), it is also necessary to collect data from these workers once their income benefits have ceased. One measure of scheme effectiveness is the longer-term (i.e., post-claim) health and employment outcomes of these workers, who have had a high degree of exposure to the scheme during their time as claimants. To our knowledge this data is not currently collected.

We also believe that it would be highly advantageous to make de-identified data available in an open access platform, to enable external scrutiny of scheme performance, and development of new methods of using data to provide insights into scheme performance.

It is important that scheme data sources measure not only outcomes (lagging indicators of performance) but also inputs or leading indicators of performance. This level of insight is required so that action can be taken on the determinants of outcomes. For example, multiple studies now show a link between the time taken to process claims, and the duration of time off work, with longer processing times linked to longer durations and greater disability (7) (8). Claim processing times are modifiable through policy and practice change, and thus are a target for interventions to improve return to work and other scheme outcomes.

It is also possible to draw greater value from existing data sources. For example, the IWHG is developing a set of metrics, using claim payment data, to assess the quality of healthcare provision to injured workers. This is a work in progress but we have, for example, been able to apply a measure of the continuity of care (9) to claim payment data including data from Victoria, and have shown that continuity of care is linked to duration of time off work.

The current agent model and alternative models

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

We draw your attention to a model pioneered in the Washington State workers' compensation scheme over the past two decades, the Centres for Occupational Health and Education (COHE). Washington State is one of few US states to operate a state fund workers' compensation scheme, and thus is similar in many respects to the Victorian scheme, at a macro level.

COHE's are geographically based partnerships between the workers' compensation regulator and local community health sector organisations, that aim to deliver best practice care and occupational rehabilitation to injured workers making claims through the state workers' compensation fund.

The COHE's differ in many respects to the current Victorian agent model, or indeed to any model currently in place within Australian injury compensation schemes. They are community-based approaches that are embedded within, and led from, local healthcare services. They are 'evidence-led' collaboratives that work together to develop and deliver programs that improve the quality, cost effectiveness and consistency of care provided to injured workers in the local community. They have educational and practice improvement activities that work closely with local employers and healthcare providers. In summary, they are a localised health system-led response to the problem of work injury rehabilitation, compared with the centralised insurance-led response currently in place within Victoria.

Independent evaluations have demonstrated that the COHE model is associated with a significant decrease in the duration workers spend off work and a reduction in the costs of income replacement. Compared with workers enrolled in a comparison group receiving 'usual care' through the Washington State system, the relative risk of being off work and receiving income replacement at 1 year post injury was 21% lower for all workers enrolled in COHE and 37% lower for workers with back pain enrolled in COHE (10).

We have cited a number of studies in the reference list that describe the COHEs, and there is more information available via the COHE website at www.gocohe.com

We also draw your attention to a proposal for a similar alternative model, a Community Focussed Health and Work Service (HWS) that extends the COHE model. This proposal was produced by global experts in the rehabilitation of injured workers (11).

Victorian Ombudsman 2016 and 2019 reports

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

In our view the root cause of the problems identified by the Ombudsman lies in the implementation of the so-called 'insurance model' of compensation, coupled with the privatisation of scheme delivery to for-profit organisations and the requirement to deliver legislation that was designed in the mid 1980's based on a biomedical model of injury recovery.

This approach places a heavy emphasis on the financial aspects of providing care and support to injured worker, and has meant there is an under emphasis on the critical psychological and social factors that influence recovery and return to work. These aspects manifest in multiple ways in workers' compensation schemes. Health and social care is viewed as a 'cost' to the scheme rather than as investment in achieving an outcome for injured workers. Influence over the nature and timing of care delivered is withdrawn from care givers (e.g., healthcare providers) and care receivers (injured people), with access to services and benefits determined by personnel working for organisations with financial objectives (i.e., agents). Processes and procedures are introduced to ensure claimants meet criterion for benefits that are based on biomedical concepts of 'injury' and 'severity' rather than on more contemporary concepts of work disability and function. Innovation diffusion is slowed and siloed within individual agents to enable commercial advantage, rather than being distributed across the scheme for the benefit of a greater number of workers. And as reported by the Ombudsman, financial incentives intended to support positive outcomes can have unintended negative consequences.

These issues are not isolated to Victoria – they exist to varying degrees in insurance-based compensation schemes globally. There is a substantial global evidence base demonstrating that insurance-based models of injury compensation contribute to poor health and return to work outcomes for injured workers (12) (13).

Ultimately, we believe that work injury rehabilitation and return to work are public health problems that should be approached via a public health model, rather than an insurance model. We believe that a fundamental re-thinking of scheme design and delivery is required and that a public health approach to workers' compensation should be implemented. As described earlier in our response, many of the factors that influence return to work are related to the worker and their local environment (e.g., their family and social circumstances, their workplace). A public health model would recognise the importance of these factors and would develop and deliver responses that address those issues. Other features of a public health model would include: embedding assessment of service quality and quality improvement initiatives; regular collection and disclosure of data related to the experiences and outcomes of the participants in the scheme; investment in training and education and skills development for front-line workers; funding a broader range of supports and services that recognise the psychological and social influences on return to work; rigorous identification and removal/modification of harmful processes and practices ("first, do no harm"); involving participants in the design of scheme processes and practices; and perhaps most importantly, recognising that the return to work and health objectives of the compensation scheme are its primary objectives, with financial sustainability an important enabling concept but not the primary focus of scheme activities.

The COHE example we describe in response to question 23 is one example of a public health model.

<u>26. Do you think the implementation of the recommendations 3-9 in the 2019 Ombudsman report will address those root causes? If so how will that occur?</u>

The recommendations of the Ombudsman may go some way towards improving the experiences and outcomes of injured workers in the Victorian scheme, but they do not address the root cause of the problems. The recommendations require agents and WorkSafe to pay more attention to complex claims and to take additional actions with respect to dispute resolution, complaints etc., but they do not fundamentally challenge the insurance model of workers compensation that is

currently in place, the current legislative design or the current delegation of scheme delivery to for-profit organisations.

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

Please refer to our answer to question 25.

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