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SIRA consultation – Regulatory requirements for health care arrangements

Ensuring best outcomes for injured people

It is not clear whether injured people in the schemes are all receiving evidence-based care, or that clinical guidance and evidence-based practice is always followed.

Do you think that injured people are receiving high quality, evidence-based health care in the personal injury schemes (workers' compensation and motor accidents schemes)?

No, ARPA believes that is clearly not the case in either scheme.

People with injuries need varying degrees of medical and treatment care. Some very little and others with more complex presentations, much more. Those same people with injuries who require more medical and treatment support, are those that have historically been the ones that are referred to rehabilitation providers. In doing so, the medical and treatment is coordinated, goal driven, evidence-based and timely, therefore ensuring care and spend is effective. That is one of the roles of rehabilitation providers in the scheme.

In CTP, there level of engagement between case managers and people injured in MVA's remains incredibly low. At the same time, engagement of rehabilitation services to support early recovery, access to the right treatment and support for restoration of independence is also negligible. The opportunity to improve injury management practices in the CTP environment is enormous and aligns closely with the opportunities outlined in this paper with respect to workers' insurance.

In workers' insurance, with the implementation of an alternate icare model of case management, triage and attempts to automate claims management, the volume of referrals to rehabilitation providers has plummeted. It is no coincidence, that with the reduction in rehabilitation spend, there has been an inordinate expansion of costs in medical and treatment spend. More medical costs clearly do not reflect high quality, nor evidence-based health care, as there is a corresponding deterioration of return to work outcomes and worker experience. The growth in medical and treatment spend of over $72,000,000 over the 12 months from 2017/18 to 2018/19 swamps the savings in rehabilitation spend over the same time and will have continued to grow unabated. Combine this with the increasing cost of benefits due to the decline in RTW rates, the attempted savings from the reduction in workplace rehabilitation has been a very costly exercise indeed.

Those workers with injuries requiring additional care and support are being left to doctors and treatment providers with little to no knowledge of the workers' compensation scheme, no accountability to outcomes, no incentive for outcomes and an open slate for prolonged service provision. Simultaneously, workers in these situations readily develop dependencies on treatment and medical providers that further prolong treatment. This sustains a cycle of disempowerment, desperation and aimlessness. In the absence of WRP involvement, questions must be asked such as:

- Who is directing workers with injuries towards independence?
- Who is support them to get the right treatment?
- Who is asking their clinicians to be accountable and work towards a common goal?
- Who is supporting their recovery and return to work?
- Who is activating work, as a key treatment modality, with their employer?

While rehabilitation spend has plummeted, return to work outcomes for workers in the first 13 weeks has fallen off a cliff. It is most recently quoted by SIRA at 57%. This is a travesty, letting down people with injuries and the employers funding the scheme. It also clearly highlights that without rehabilitation support, those people most in need will be over serviced, under supported and are the emerging tail of despondent, disengaged members of society.

The correlation between these factors is obvious, clear and direct. Unfortunately, there remains either a direct lack of acknowledgement, understanding or action to rectify.

All workplace rehabilitation providers in NSW are governed by the HWCA Nationally consistent approval framework for workplace rehabilitation providers (WRPs), which is designed to ensure minimum standards are consistently met in the delivery of services to workers and employers.

In addition, rehabilitation consultants are each required to maintain their own registration with their relevant authorities. This includes mandatory professional development to accrue CPD points which would include courses to access updated research and EB guidelines.

ARPA NSW believes that this framework (and the upcoming HWCA Principles of Practice for WRPs which replace it) ensures that all providers of workplace rehabilitation services in NSW provide high quality and evidence-based services.

The escalation in medical costs in the NSW Workers Compensation scheme is a result of a combination of factors, but what cannot be in dispute is that a lack of knowledge of the appropriate, evidence-based approach for the management of injuries by insurer case managers, is resulting in a significant escalation of costs and poor case for those that need it. As there is no accountability on treatment or return to work outcomes, no peer reviewed discussions and negotiations on the effectiveness of treatment, and no regular assessment of treatment efficacy, costs blow out. Treatment and medical providers apply economic rationale and deliver more services with a negative impact on costs and return to work.

Which issues need to be addressed to ensure injured people receive high quality, evidence-based health care?

Lack of early intervention and infrequent use of rehabilitation providers is central to the deterioration in evidence-based healthcare. SIRA has found that increased (medical) service utilisation is a driver for burgeoning medical and treatment costs. So to, a reduction in workplace rehabilitation is also a driver for burgeoning medical and treatment costs. Medical and treatment providers have consistently demonstrated a lack of contemporary knowledge of the mechanisms operating within personal injury schemes. That is not to impart blame, but merely underscores the fact that workers' compensation and personal injury components of caseloads for health professionals and doctors is a smaller component over their overall workload profile. Without the oversight, support, review and collaboration with accredited rehabilitation providers' consultants, medical and treatment providers' quality and evidence base is severely eroded.

Key factors that need to be addressed for people with injuries to receive high quality care include:

- coordination of worker return to work goals
- coordination of worker recovery and return to work timeframes
- coordination of treatment providers
- alignment of treatment outcomes to work capacity
- accountability on the efficacy of treatment.

More consistent use of workplace rehabilitation for those who need it, coupled with early referral, will significantly enhance the quality and efficacy of medical and treatment provision within personal injury schemes. This ensures people with injuries receive the best and most effective care.

As insurer case managers are not required to be tertiary allied health qualified, are not subject to professional health standards, are not routinely audited and monitored and are not required to have knowledge of, or to even reference, evidence-based strategies for the provision of health care, there can be no doubt that not all people with injuries are receiving high quality or evidence-based healthcare.

With reference to quality of care, ARPA notes there has been an emergence of non-accredited providers of various guises providing services within the workers' compensation scheme. This includes social prescribing, career coaching and well-being agencies who have been allowed by the Nominal Insurer to provide programs to workers with an injury to help get them 'work ready'. There is no transparency on the skills, qualifications, care or capability of these organisations or their staff to work with workers who are vulnerable due to injury or illness.

Whilst WRPs are:

- accredited and meet strict approval criteria (including the mandatory requirement to employ registered allied health professionals for delivery of services)
- required to meet auditing requirements to maintain approval
- are cost controlled and outcome measured,

new entrants are not.

There is a new burgeoning, costly and unregulated marketplace for social prescribing, career coaching, well-being services that are charged at daily rates that swamp WRP fees for full programs and whose efficacy is not measured. There is no accountability to the scheme funders (employers), no measures of return to work outcomes nor is there any recognition that the scheme already possesses the qualified skills, accreditation and expertise to get workers with an injury job ready through evidence-based, best practice approaches (via WRPs). In addition, these service providers may not be equipped to deal with the vulnerable and psychologically impacted worker who requires trained and experienced personnel to ensure they are providing best practice treatment.

Many of these programs are selected based on clever marketing campaigns rather than evidence-based decision-making. Further, they target a very small portion of claimants, typically long-term job-detached, with measures of success not including return to work, yet including subjective, non-validated questionnaires measuring feelings and emotions.

The Nominal Insurer should stop funding service providers of this nature and engage WRPs for such services, as the technical experts in the field of supporting workers with injuries. More support should be provided to both workers and employers in early stages to prevent long-term worklessness.

How can SIRA, insurers and providers help injured workers and motorists access the best outcomes?

Ensuring the best outcomes, more consistently, is neither complex nor a distant pipedream.

SIRA can mandate insurers to complete the screening and identification of workers and motorists with injuries who:

- have complex injury presentations
- are likely to have more than two weeks of incapacity or four weeks of partial capacity
- present with psychosocial risks.

These workers and motorists represent the highest risk of prolonged treatment and recovery. As such they should be routinely referred to experts (rehabilitation providers) whose role it is to coordinate, manage, support, orientate and activate medical, treatment and return to work. Noting that work is a key factor and indeed a treatment modality considered of key importance in ensuring recovery and restoration of independence, this component of intervention is critical to recovery, health outcomes and cost effectiveness.

ARPA believes it critical that there is a clear, evidence-based, best practice approach to early intervention for new claims and that there is proactive and early engagement of workplace rehabilitation to facilitate early and sustainable return to work. As previously outlined, to facilitate the early engagement of workplace rehabilitation icare should:

1. Allow an automatic approval and funding for employer or treating doctor directed rehabilitation referrals in recognition of the employer's commitment to facilitating recovery at work.
2. Mandate early referral for workplace rehabilitation at 2 weeks (where the worker is likely to be off work for greater than 4 weeks).
3. Direct scheme insurers and agents to immediately approve referrals from employers, workers or treating doctors.
4. Ensure that training manuals, information and support available to agents and their team of case managers accurately represents early intervention and the benefits of same.
5. Train case managers on the effective use of workplace rehabilitation services, in particular on the benefits of early referral to workplace rehabilitation.

ARPA support SIRA building on the provision of data that is clear and consistent – to all WRPs and the scheme more broadly, and that the source and accuracy of that data is verified by an independent party, so as to provide confidence to all stakeholders and the NSW community that results are being achieved. It is ARPA members experience that data provided by icare, in particular with respect to NPS outcomes, is often inaccurate.

ARPA believes there a significant problem with the current model that is not being made clear to the public and that are therefore delaying the urgent actions required for these problems to be solved. These problems cannot be solved by icare, its agents or SIRA alone – they require the collective engagement of all stakeholders including employers, brokers, workers and WRPs to get the scheme back on track. Our belief is that all stakeholders are willing, and collectively improvements can be achieved.

People with injuries who return to work sooner are less likely to have long-term disability or become disengaged, will not draw down on weekly benefit entitlements beyond the duration of necessary support and achieve more sustainable recovery outcomes.

Objective criteria should be applied to remove any subjective decision making in respect of access to WRP intervention. The employer and the worker are entitled to and need the quality health support that only comes from an accredited WRP and the Nominal Insurer should be engaging WRP more often and earlier in the life of a claim. ARPA have made a case for mandatory referral to WRP which will deliver value from investment for the scheme and improve the experience for workers and employers.

Australasian and international empirical evidence shows that good work is beneficial to people's health and wellbeing. Conversely, long-term work absence, work disability and unemployment have a negative impact on a person's health and can exacerbate underlying mental health conditions.

The risks to long-term scheme viability by reluctance, refusal, inability or inaction to engage WRPs in early intervention support of workers and employers are real and evident in the independent (SIRA) statistics. ARPA NSW recommends that the Nominal Insurer be made to mandate referral to workplace rehabilitation for workers not anticipated to completely return to work within four weeks.

Previous workers' compensation scheme reviews have identified the need for the employer to increase their literacy and capability in managing RTW following injury. This has been poorly interpreted as an opportunity to shift the responsibility to the employer to manage all aspects of RTW when clearly this is not within the capability for most employers within NSW, considering most businesses in NSW are small to medium enterprises.

Conversely, the scheme, the employer and the worker all benefit from the unique health intervention and education that comes from WRP intervention which is what is intended in the legislation. The Nominal Insurer should not be given the authority to randomly or selectively allow access to WRP benefits to some workers and employers, and not others, as a short-term measure to reduce scheme spend. The evidence is overwhelmingly clear that this is a false economy based on invalid assumptions. The facts demonstrate that with reduced workplace rehabilitation spend, return to work rates have plummeted and remain in freefall, while medical costs have exploded and continue to grow. To ensure workers and motorists with injuries access the best outcomes, allied health professionals whose role is to actively manage those outcomes must be engaged.

WRP intervention is a prescribed benefit under the legislation and should not be subject to arbitrary application under the guise of what is 'reasonable and necessary'. Objective criteria should be applied to remove any subjective decision making in respect of access to WRP intervention, including what, if any, in-house resource and capability exists within the employer.

For most employers and workers, a claim is a rare occurrence and, as such, it is extremely difficult and unrealistic to expect an employer to have the capability and experience to manage the return to work of their injured worker appropriately. This often leads to frustration, confusion and tension between the employer and worker as they simply do not know what to do. The employer and the worker are entitled to and need the quality health support that only comes from an accredited WRP. WRP provide a crucial role in providing education and information to both the employer and worker on the scheme and helping to navigate it smoothly. ARPA have made a case for mandatory referral to WRP which will deliver value from investment for the scheme and improve the experience for workers and employers. The Nominal Insurer should be engaging WRP more often and earlier in the life of a claim.

In addition, there need to be clear transparency and communication to a worker with an injury and their employer regarding a choice of WRP as per legislation where the hierarchy of choice is:

1. The worker can nominate their own WRP (via their own research, recommendation by a treating party, or labour union).
2. The employer can in absence of a WRP nominated by the injured worker nominate a WRP.
3. The insurer engages a WRP in absence of a nomination of WRP by the employer or worker.

Early referral will minimise delay to support; delays of return to work and the associated wages recorded on the claim. Further, it will significantly improve the employer's experience and the worker's experience by allowing the worker to return to work earlier, stay engaged with work and recover at work. The impact of delays can also contribute to a breakdown in the relationship between the worker and the employer and the heightened development of secondary psychosocial factors that directly impact on an individual's recovery timeframes.

From your observation what are some of the reasons for the increase in service utilisation (i.e. the increase in the amount of services each injured person is receiving)?

The increase in service utilisation for medical and treatment is due to changes in the way workers' compensation is managed in NSW. There is a direct correlation to these changes and the associated lack of accountability, and the spend increase. The specific factors impacting reasons for increase in service utilisation include:

- an injury management system that does not effectively triage / screen people with injuries and their psychosocial risk profile
- nominal insurer instructions and training to agent case managers that contradict science and evidence-based best practice for injury management
- insurer / agent representatives and case managers that lack the education, training and skills to hold treatment and medical providers accountable to outcomes
- insurer / agent representatives and case managers that lack knowledge on evidence-based interventions to support recovery from the broad spectrum of injuries they are overseeing
- insurer / agent representatives and case managers that cannot either comprehend or apply the critical psychosocial approaches to mitigate longer term disability and therefore use of treatment and medical services
- a lack of people accountable for establishing SMART goals and gaining the endorsement of people with injuries, treatment and medical providers to ensure progress and achievement of these goals
- a directly correlated reduction in rehabilitation spend, which prevents rehabilitation providers from executing the above tasks.
- the deterioration in RTW rates, especially in 0-13 weeks post injury, results in over medicalisation rather than engagement through a biopsychosocial model of intervention.

The Nominal Insurer has chosen to spend less on workplace rehabilitation services, and subsequently celebrated this reduction as an apparent win for the scheme, workers and employers. What has transpired since this time is absolutely crystal clear:

- workers are having more treatment and medical services than ever before. An increase in over $72,000,000 over a 12-month period that will continue to grow
- workers are not returning to work at anywhere near the same frequency (now recorded at 57% in the first 13 weeks)
- scheme liabilities are increasing
- the funding ratio has deteriorated
- the scheme incurred a substantial loss, this time of ($876,000,000), a number that is certain to increase in the years ahead without significant intervention.

Since the second year of the inception of icare, ARPA NSW members have all recorded an enormous decrease in their referrals for workplace rehabilitation services. That this is celebrated by icare reflects a complete absence of understanding of the role of workplace rehabilitation in the overcoming of barriers to recovery, the mitigation of unnecessary medical and treatment costs and the access to evidence-based interventions that actually achieve outcomes.

Setting and indexing of health practitioner fees

How can fee-setting and indexation be better used to improve outcomes in the schemes?

ARPA is focusing this response on the application of fee indexation and gazetting for the workplace rehabilitation industry. This relates specifically to the rates charged by allied health and medical professionals, as WRPs directly employ these professionals in accordance with the national approval framework.

Since the Nominal Insurer took over WRP service contracts with Agents under one single Deed, rates have not been renegotiated nor indexed and are held at 2016/17 levels. This has occurred at a time when there is significantly increasing demand for health professionals, mostly due to the introduction of the NDIS. Health professionals within WRP have higher demands and expectations placed upon them in comparison to other health sectors and as such a premium is required in wages to attract and retain staff. Conversely, the service rates have actually declined and now fallen below other health sectors. For example, the NDIS which is the largest consumer of allied health services nationally outside of the state health systems, have published rates for an occupational therapist that are 7.7% higher than NSW workers' insurance. The published rate from the NDIS for a psychologist is 16.7% higher than NSW workers' insurance. The Nominal Insurer demands the best and brightest from the health sector to meet the stringent demands of workers' insurance however the service rates have now fallen from a leading position, to a trailing position within the market. NSW workers' insurance runs the risk of not being able to maintain quality allied health personnel as WRP cannot compete with wages and conditions of employment elsewhere. For the first time ever WRP are reporting losing allied health staff to the aged care sector which was previously at the lower end of the scale for wages with less challenging professional demands on qualified professionals. The NDIS has published material regarding the risk of critical market failure nationally within the allied health sector and has moved to increase service rates in an effort to attract resources in direct competition to traditional market sectors such as NSW workers' insurance.

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Unlike other areas of the health sector, service rates for workplace rehabilitation are actually below market rates rather than above market rates. Simple analysis demonstrates that rates within the workplace rehabilitation sector have barely kept pace with inflation and have actually fallen below realistic market rates, contrary to scheme experience for other areas within the health sector.

Currently some jurisdictions use MBS rates while others use AMA rates to set fees for doctors and for coding and billing purposes.

How can rates best be set for doctors? Are there other options available to set rates?

N/A

Should NSW use MBS item numbers and billing rules to classify and report services instead of the AMA's? Are there other options available?

N/A

How could SIRA appropriately set and index private and public hospital fees with the aim of better outcomes?

N/A

How could SIRA appropriately set and index allied health fees with the aim of better outcomes?

As noted above, the NDIS has identified the need to increase fees in order to attract and retain high quality staff. As such, it is recommended that SIRA look to the NDIS and acknowledge the need for highly specialised individuals to undertake the WRP work.

An alternate consideration, although more complex to consider, is that within WRPs there are levels of technical aptitude and experience. There is no recognition of levels of experience and skills of WRP consultants in rates of payment. In a mature professional payment environment, this should be considered in order to ensure experienced talent is kept within the market and not lost to other jurisdictions.

Should consideration be given to the schemes having fee setting mechanisms for additional health practitioners? If so, which ones, and why?

There does need to be an assessment of the health practitioners that are working within these schemes. The technical and specialised requirements of working with injured workers who are suffering complex trauma, for example, need to be seen by practitioners who are appropriately trained with a fee to reflect this.

Furthermore, the knowledge of psychosocial risk factors influencing recovery is critical to any health professional treatment in a compensable scheme setting. It is globally known that these factors, if not managed, pose a far greater risk to long-term disability and dependency on treatment, than does the injury pathology itself.

Physiotherapists for example who undergo further training to attain titled membership such as a Sports Physiotherapists or musculo-skeletal Physiotherapist have no distinct fee structure. For example a GP fee vs a specialist fee reflects the additional investment in study and specialization. Similarly, a distinction needs to be applied to Allied Health professional who attract a titled membership within their respective organisations. This will in turn ensure experienced clinicians remain in the workforce.

Improving processes and compliance

What could help improve administrative processes – including reducing paperwork and leakage – for providers, insurers and other scheme participants?

As previously outlined, mandating the effective triage of people with injuries is a foundation piece from which all positive changes in medical, treatment and rehabilitation flow. This is customer centric. This is a social heart with a commercial mind. This is evidence-based practice.

For WRPs there is a need to streamline the administrative processes and an alignment throughout schemes. There are too many variations of the same thing requested by agents within the same scheme. This aspect of WRP is both time consuming and costly, adding no real value to outcomes.

Scope and contract creep have been enormous. By way of example, the demands on Vocational Assessments have altered enormously yet no adjustments have been made for the additional requirements of the reporting. Not least of which is the need for 3 employer calls per 3 labour market options, which alone requires a minimum of 3 hours and typically 4 hours to successfully complete. By adding vocational face to face, testing, analysis and result synthesis plus reporting time, the time taken for a vocational assessment has expanded by at least 50%. Yet the same time allocation and low hourly rates are provided. Insurers and agents request more and more information to be included in reports without change to fees or time allocation.

In addition, monthly spreadsheets need to be simplified to the Nominal Insurer. Key points can be recorded monthly, with the aim that this could be done electronically rather than the current manual task of excel spreadsheets. Overall, there is a need to ensure both deed and non-deed providers are reporting in the same manner. All templates need to be provided to the industry, irrespective of whether they are a deed/non-deed provider.

Approval of services in a timely manner needs to be ensured. The lack of communication from insurers regarding an outcome of a treatment of other request is often a burden borne by the WRP who is required to navigate barriers with the injured worker and employer.

What enhancements to claims administration requirements would help ensure scheme sustainability and improve understanding of the outcomes being achieved?

ARPA has no comment on how this applies to medical and treatment providers.

What improvements to monitoring, data collection and reporting would help ensure scheme sustainability and improve understanding of the outcomes that are being achieved?

Above all, data inconsistency remains the most destructive aspect for information and understanding. Presently there is no clear indication on who is the authority in respect of data. We feel for transparency and consistency, SIRA should hold accountability and authority for scheme data.

All providers (deed and non-deed) need to be reporting in the same manner with the same statistics. There needs to be a roll out of a simplified data collection spreadsheet/online form that is explained to all providers. All data needs to be consistent i.e. It is vital that all providers are coding outcomes in the same manner (e.g. ensuring that a OR01 service is accurately coded for single services only, not a range of single services that are provided to the one worker).

Implementing value-based care

The concept of 'value-based care' was developed to help health purchasers move from paying for the volume of individual services, towards payment based on value – i.e. performance and patient outcome.

What opportunities does a value-based care approach present for the personal injury schemes? How could these be implemented?

Whilst this sounds appropriate theoretically, it is open to misuse, misinterpretation and scope creep by stakeholders.

The performance data is yet to be statistically correct, so to assign work to those deemed to be high performers may not be appropriate at this stage. Data needs to be collected from all stakeholders and allowances made for providers who may specialise in complex psychological claims versus those who may predominately work with simple and minor injuries. A weighting scale needs to be applied to ensure fairness and equity when making such decisions. What we have seen over the past three years is a focus on minimising costs, yet the outcomes have decreased. What needs to be reinforced is the early intervention at the start of a claim and focus on reducing long-term costs accordingly. A specialised early intervention program (with a set fee) could be the first step of ensuring appropriate and reasonable care is provided to all claims. Once the early intervention is completed, it may be reviewed by all parties to determine if ongoing support is required and what services are required at this point.

In terms of moving to a performance-based / outcome-based payment system, ARPA NSW strongly disagrees with this. Such models are fraught with danger and pose significant risk to both the scheme and WRPs due to confusion, misuse, scope creep, and financial hardship. We are unaware of any evidence to support such a model and we not aware of any successful implementation of such a model anywhere internationally. Allied health within workers' compensation has an image problem amongst the broader health sector already without further impacting on the industry reputation through the introduction of a model that has no evidentiary foundation, is administratively burdensome and is questionable ethically. To suggest that health care is only rewarded for those that recover and that those most in need are not deserving of funding for intervention is contrary to the code of ethics for all health professions. A medical doctor has a Hippocratic oath to ensure everyone will receive treatment. In Law everyone is entitled to a defence. Equally, access to rehabilitation is a prescribed benefit within the legislation rather than an arbitrary intervention that is only funded should you actually return to work.

There is a real risk with outcome-based models in that it can cause a behavioural shift of service providers and agents, i.e. 'creaming and parking' clients, resulting in only those claims that can be reasonably guaranteed of an outcome being given appropriate service.

This type of model has been tried previously without success across various jurisdictions. For example, the QBE NSW outcome-based model (several years ago) was extremely poorly designed and implemented. It did not result in improved RTW outcomes, but rather resulted in significant scope creep, confusion and misuse. Whilst we understand QBE reported decrease in rehab spend, reports from providers included QBE claims managers forcing WRP to 'close' a case simply to avoid having to pay an outcome. Many WRPs suffered significant financial hardship as a result and the model was eventually discarded.

Other jurisdictions have also not had success with such models. The Victorian workers' compensation scheme has struggled and continues with poor RTW outcomes despite using a fixed-fee / outcome-based model.

What options are there to better understand and influence the health outcomes and patient experiences within the personal injury schemes?

Regular feedback forums or other mechanisms for all stakeholders provides an opportunity to gain valuable insights and understanding. We note that improving the social outcomes for the people of NSW is a scheme objective however this has not yet been measured. While this is an admirable goal, focus needs to be retained on the basics for the scheme presently as broad satisfaction firstly comes with competent management and there is a number of opportunities for improvement that could be targeted with immediate results.

Any other issues

Are there any other issues you want to raise or comments you would like to make?

ARPA supports diversity within the health sector to achieve the greatest level of continuous improvement and innovation. Presently within NSW not all providers are given the same information by the Nominal Insurer. We encourage a focus on ensuring all SIRA accredited providers are be treated, trained and assessed equally with the same access to information.