

Professor Alex Collie

[REDACTED]
[REDACTED]
[REDACTED]

CTP Review
State Insurance Regulatory Authority
Level 25
580 George Street
Sydney NSW 2000

Friday 22nd April 2016

Re: Options for reforming Green Slip insurance in New South Wales

To whom it may concern,

Please accept this comment on the CTP Options Paper. Specifically I am responding to questions one and two.

I am contributing this submission in my capacity as a private citizen and researcher with interest in this field. The views and opinions expressed in this submission are mine and do not necessarily reflect those of the partners in the Institute for Safety Compensation and Recovery Research.

Sincerely,

[REDACTED]

Professor Alex Collie

Question 1. What should be the most important features in any scheme reform?

The CTP Options Paper states that any changes to the NSW CTP scheme should seek to achieve four objectives, specifically:

- Increase the proportion of benefits provided to the most seriously injured road users
- Reduce the time it takes to resolve a claim
- Reduce opportunities for claims fraud and exaggeration
- Reduce the cost of green slip reforms

These are all important considerations in revising scheme design and operation. However I would argue that these are procedural objectives and do not reflect what should be the critical public policy objectives of scheme reform.

Injury compensation schemes such as the NSW CTP scheme can and should play a critical role in injury prevention and rehabilitation. Motor vehicle accidents are a substantial cause of death and disability in society. CTP schemes are the primary means via which government has determined to address the problem of vehicle related trauma, and its effects on society. Thus it is important that any scheme reform reflect this critical role that CTP schemes play in ensuring the health and well-being of the motoring public.

A more appropriate and contemporary set of objectives for scheme reform would focus on (a) maximising the recovery of those injured in transport accidents as quickly as possible at the least possible cost to society; (b) maximising the function and the ability to live independently in people with serious life-long injuries; and (c) contributing to the prevention of injury and to transport safety.

These public health and social policy objectives should be at the centre of scheme design, and should be the focus of any reform of the current scheme.

There is now substantial evidence that scheme design has a significant impact on injury recovery and injury prevention. There are now multiple published studies demonstrating that changes in injury compensation scheme design can lead to changes in these objectives. The evidence base around the elements of scheme design that positively impact on these public health objectives has grown enormously in the past decade, and there are numerous experts within Australia with detailed knowledge of this evidence. This information should be considered as part of the scheme reform process.

Question 2. On balance, which option or combination of options do you believe best addresses the priorities for improving the scheme and why?

It is clear from the existing evidence base that injury compensation systems that are able to deliver early access to healthcare and other benefits produce superior outcomes in terms of injury recovery. Studies in international motor vehicle accident compensation systems have demonstrated that changing to no-fault, statutory benefits schemes improve recovery outcomes for those injured (for example Cassidy et al, 2000). Studies in Australian workers' compensation systems show that, even within no-fault schemes, those schemes that inhibit early treatment via an extended employer excess period, have poorer performance in terms of return to work outcomes than schemes without such excess period or with shorter excess periods (Collie et al, 2016).

It is also clear that engagement in dispute processes such as those that often arise during claims settlement contribute to negative health outcomes for the injured person, and greater costs to the scheme. Some specific scheme processes that are often used during disputes (such as Independent Medical Examinations) have also been shown to contribute to the onset of secondary mental health conditions, thus complicating recovery and increasing claims costs (for example Kilgour et al, 2015). There is also now evidence that systems that provide early access to benefits are perceived to be fairer by injured people, that such systems produce fewer disputes involving legal engagement in the

first twelve months, and that this is associated with improved recovery at 12 months post injury (Elbers et al, 2015).

Of the options presented in the CTP Options Paper, those that best address the critical public health objectives of injury compensation system are options 3 and 4. If implemented appropriately, these sorts of systems enable the provision of healthcare and other benefits very early post injury, and can thus reduce the perceived need for engagement in dispute processes which can hinder recovery.

It is also clear that while scheme design is a critical consideration, scheme implementation and management is equally important for ensuring health outcomes are achieved. I have attached below a transcript of a speech given by myself to the John Walsh Centre for Rehabilitation Research in July 2015 that addresses this issue.

Cited References

Cassidy JD, Carroll LJ, Côté P, Lemstra M, Berglund A, Nygren A. Effect of eliminating compensation for pain and suffering on the outcome of insurance claims for whiplash injury. *New England Journal of Medicine*. 2000 Apr 20;342(16):1179-86.

Collie A, Lane T, Hassani-Mahmoei B, Thompson J, McLeod C. Does workers' compensation system policy influence return to work following injury? A comparative effectiveness study. *BMJ Open* (in press). Accepted for publication 11 April 2016.

Elbers N, Collie A, Cameron I. The fairness of compensation schemes and the effect on claimants' recovery. 2015. Actuaries Institute. Injury Scheme Seminar.
<http://www.actuaries.asn.au/Library/Events/ACS/2015/ElbersCompensationSynopsis.pdf>

Kilgour E, Kosny A, Akkermans A, Collie A. Procedural Justice and the Use of Independent Medical Evaluations in Workers' Compensation. *Psychological Injury and Law*. 2015 Jun; 8(2): 153-168.

Attachment

Transcript of speech entitled “Achieving Public Health Objectives Within An Insurance Model of Injury Compensation: Ten Principles For Change”

Transcript of a presentation given at the John Walsh Centre for Rehabilitation Research, Kolling Institute, University of Sydney on 27th July 2015 by Professor Alex Collie, Chief Executive Officer, Institute for Safety, Compensation and Recovery Research, Monash University; and Adjunct Professor (Research), School of Public Health and Preventive Medicine, Monash University, Melbourne, Australia.

Professor Collie:

“Thank you to the John Walsh Centre for asking me to come and speak today. It is a great pleasure and an honour to be here amongst colleagues whose work I respect and that I have been following for a long period of time.

I am going to pick up a few themes from the first couple of presentations that John Walsh was talking about, and then I want to talk a bit about the tension that John described in this insurance model between costs and outcomes. That is really going to be the main theme of my presentation.

I think John also mentioned the challenge in implementing research in policy and the need for an evidence or research base for what we do in this sector. This is something that I am quite passionate about and for which ISCRRR was established to achieve.

For those of you who do not know much about ISCRRR, we are a little bit like the John Walsh Centre here. We are a partnership between Monash University, the Transport Accident Commission and WorkSafe Victoria, and our goal is to produce relevant research evidence, have it used by the Victorian injury schemes in order to have a positive impact on injured people in Victoria and on the schemes.

Before I begin, I would like to dedicate this presentation to Gary Fulcher. I am not sure if many people in the room knew Gary. Gary died about 10 days ago in hospital from complications resulting from severe burns he suffered in a motor vehicle accident about 19 years ago. He was a psychologist and a researcher who continued to work in the field after his injury. Those of you that knew Gary will realise how amazing it was that Gary made such a contribution to the field for 19 years following his injury. I think he had a pretty interesting and very fulfilling life. Gary gave his time a couple of times to come down to Melbourne and speak about his experiences and expertise. His loss is a big blow to the field, and so this one is for Gary.

When Ashley (Professor Ashley Craig) rang me a couple of months ago and asked me to come and speak, I thought I would take the opportunity to try to draw together various threads that I have been working on for the last 10 years. And that is my goal for today, I want to try and bring together what is hopefully a fairly cohesive narrative and link together a range of research evidence, in an attempt to answer the question, “How can we achieve a greater focus on public health in our injury schemes?”

The starting point, that hopefully you will all accept, is that injury is a major health and economic issue for society. In Australia, unlike in many other countries, the way in which we have chosen to address that big issue is through our compensation schemes. There are 20 major motor vehicle accident and workers compensation systems in this country. These injury schemes are the primary means by which we have chosen as a society to address this issue of injury rehabilitation and recovery. We have adopted an approach which John (Walsh) described as the insurance model and which I will talk about in a second. I think it is important to know that that approach is quite different to the way that some other comparable countries choose to address the same issue of work and transport injury. We do things in a unique way in Australia with some unique consequences.

The insurance model and 'short-termism'

The insurance model, as John (Walsh) was saying this morning, seeks to achieve a balance between the cost to the community of providing compensation and benefits to the community in terms of participation and recovery. As a public health researcher, I tend to think of the benefits in terms of rehabilitation, return to work and other markers of injury recovery, in addition to productivity and economic participation.

The way in which we think about our injury schemes is critically important. I have come to the position over the years that the dominant paradigm in this sector is a financial paradigm. We tend to focus much of our effort in the schemes on cost containment and liability control. This does not occur to the exclusion of all of other objectives, but certainly finances are the dominant objectives in injury schemes.

Of course we also recognise the public health objectives of injury schemes as things such as recovery and return to work being expressed in scheme KPIs, and in funding research such as that which occurs here through the John Walsh Centre. But the financial paradigm is dominant.

In my view, when it comes to the crunch, sometimes scheme financial objectives trump public health objectives in a scheme. We do not have to look too far to see examples of that.

This insurance paradigm is a hungry beast. It takes most of the resources within a scheme to manage a compensation system using an insurance paradigm. We tend to devote huge effort to doing things like responding to actuarial evaluations, to developing and implementing programs to address the latest area of cost increase. I have heard this described as a bit like the game, 'whack a mole', where a cost pops up in one area and you have to bang it down, and another one comes up over here and you have to whack it down. We are constantly putting out fires, and this doesn't leave much time to think about the long-term public health objectives of injury schemes.

I am very thankful to have a role that requires me to think about the long-term. There are also some people in the schemes who have similar responsibility.

But this lack of balance between short term and long-term thinking creates a critical risk. I would like recommend to you a document that was published in the UK a couple of years ago by Sir George Cox. (http://www.yourbritain.org.uk/uploads/editor/files/Overcoming_Short-termism.pdf). Sir George was asked by the UK government to review the UK financial system, the business sector, and his main conclusion was one about 'short-termism'.

Sir George described short termism as being the major risk to the future to the British business sector. He described it as the "...pressure to maintain financial sustainability over the short-term which occurs to the potential detriment of long-term objectives". Sir George further described some features, some consequences of short termism, including that it "... curtails ambition, inhibits long-term thinking, provides a disincentive to invest in research, products, training, recruitment and skills" ... and, from time-to-time ... "results in cost-cutting when financial results fail to meet expectations". And I think we see these features in our injury schemes in Australia.

From my point of view, although we have an insurance model that seeks to balance community cost with outcomes, maintaining the financial sustainability over the short- to medium-term has become the primary focus of injury scheme regulators. As a consequence the critical public health objectives of schemes, from time-to-time, are sacrificed. And this means that by default the public health objectives have become an important but a secondary focus for our injury schemes.

So, in my view we don't have the balance between short and long-term right.

This prompted me to ask the questions, “What would a public health model of injury compensation look like” and “What would you do differently if you were truly seeking to achieve public health outcomes as your primary objective in one of these injury schemes?”.

From my point of view...

- Although we have an insurance model that seeks to balance community cost with outcomes.....
- Maintaining financial sustainability over the short to medium term has become the primary focus of government and scheme managers.
- Public health objectives have, by default, become an important but secondary focus.
- We do not have the balance right.
- What would a public health model of injury compensation look like?

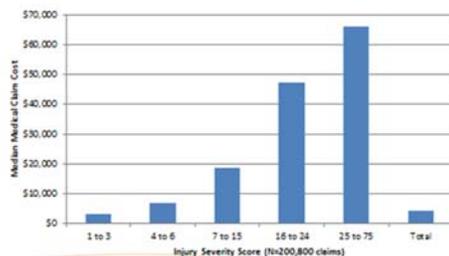


In thinking about these questions I came up with 10 ideas. I called them ‘principles’ to begin with but as I have been putting this presentation together some others have occurred to me, so I have downgraded them to ideas. I am sure you will all have other ideas that come to mind as I am speaking or that you have already thought of. I don’t pretend that these are a panacea to solve all of our problems, but they are things that I think can realistically be achieved within an insurance model to achieve a greater focus on public health. And importantly, they are all evidence-based. So here goes...

Principle 1. Improving health should be the primary scheme objective

This slide summaries the main findings from a study by Dr Jean Seers in Washington State workers compensation system. This is a state-fund scheme, of which there are only 3 or 4 in the US. Amongst the USA workers’ compensation systems, the state fund schemes look most like our workers’ compensation systems here in Australia.

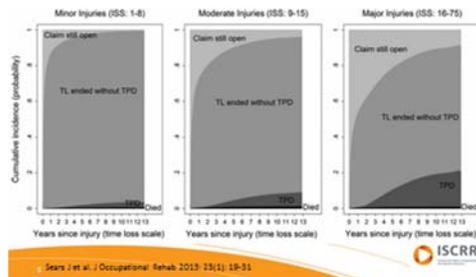
Association between injury severity and claim cost



This slide shows the association between injury severity and claim cost. We see very similar data in the Australian compensation schemes. The more severely injured you are, the higher the cost to the scheme. Pretty straightforward really.

This study is based on about 200,000 accepted workers’ compensation claims in Washington State. I am sure we have all seen similar data in the Australian schemes. And this second slide is from the same study, showing the association between injury severity and claim outcome. The outcome is presented in terms of whether or not the claim has closed with an award of total permanent disability, whether the worker is still receiving time loss payments or income replacement without total permanent disability, or whether the claim is still open.

Association between injury severity and claim outcome



And you can see the more severely injured people are more likely to have a claim still open over the 13 year follow up period, they are more likely to have an award of total permanent disability, and they are less likely to be on time loss.

This data is essentially demonstrating the very strong link between injury severity and claim cost. This is a commonly accepted association yet we do not follow this finding through to its logical conclusion.

The first, and most important, principle should be that improving health should be our primary objective in injury schemes. This is because very clearly, there is a direct link between the level of ill health or the burden of disability in our schemes and the cost to our schemes.

And we also know that the opposite does not hold true. The health services literature clearly demonstrates that changes in cost do not necessarily lead to changes in health. Paying more for a service doesn't necessarily lead to better health outcomes. Paying less doesn't necessarily lead to worse health outcomes.

But, if you have more illness and disability in your scheme, it will cost the scheme more.

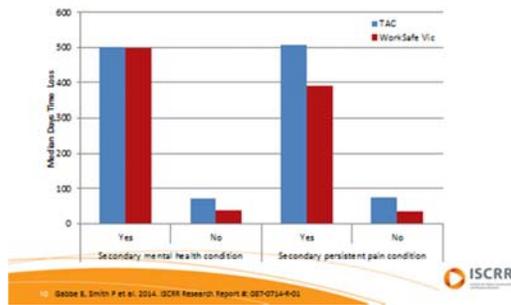
This means that our pathway towards long-term financial sustainability in these schemes should be to reduce the level of ill health in the schemes. Further I think that injury schemes should explicitly adopt health focus objectives as their primary goal, recognising that financial success should follow. And it should be explicit that the main avenue for achieving financial objectives is by focussing on improving health and reducing the level of disability on the scheme, and not by short-term cost containment measures. So that is my first proposition for today.

Principle 2. Prevention, Prevention, Prevention.

Now let's move onto the second principle. This slide shows data from a study that we have run over the last couple of years in Victoria, looking at both the motor accident and worker's compensation schemes. We have attempted to characterise groups of people with mental health and persistent pain conditions that occur secondary to their reason for entering the scheme, which was a physical injury.

This slide shows the median days of paid time loss after injury in both schemes for people who have secondary mental health conditions and people who don't. The blue bars represent the TAC (Transport Accident Commission), and the red bars WorkSafe Victoria. We observe that while only a small proportion of all claims in the schemes have secondary conditions, using the pretty conservative definition that we chose, there is a 15-20-fold increase in the total duration of compensated time away from work in these groups. In other words, these secondary conditions are having a huge impact on the costs in the scheme and a huge impact on the amount of time people are spending away from work.

Association between secondary conditions and scheme relevant outcomes

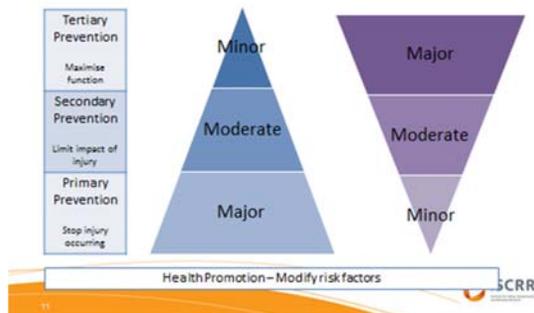


This study demonstrates the importance of preventing these secondary conditions from occurring. So my second idea is about prevention.

One of the fundamental concepts in most public health initiatives relates to primary, secondary and tertiary prevention. We see it all the time in the public health model. Usually we state that effective primary prevention will have the biggest health impact, secondary prevention the next biggest impact, and tertiary prevention strategies the next biggest impact. And that is true when you are dealing with health at a societal level.

But when you think about what an injury scheme can do, you might actually flip that around the other way. This is because in injury compensation schemes we do not often know about an injury until it has occurred. Our ability to have effective primary prevention interventions is limited. We can have effective secondary prevention strategies in partnership with other organisations, and I will have a bit to say about partnership later on. But there is very little we can do as injury schemes to prevent the secondary consequences of injuries from occurring, acting by ourselves. Because of the long-tail nature of many injury schemes, you might actually argue that the biggest opportunity within an injury scheme is tertiary prevention. That is, maximising function or minimising disability.

2. Prevention, Prevention, Prevention



More recently, and particularly in the workers' compensation area, we are seeing a growing focus on workplace health promotion. These initiatives to try and modify risk factors for injury and injury recovery. We should put these into the public health toolkit as well.

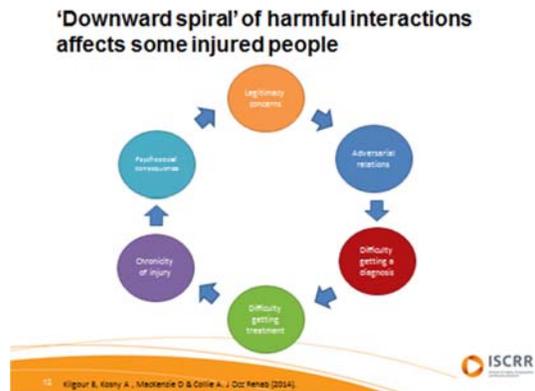
In summary, I think a public health approach to injury compensation would have at its core a prevention strategy that articulates specific initiatives at each one of these levels: primary, secondary and tertiary prevention.

Maybe I am not looking hard enough, but I do not see any such strategies in Australia. I do not see any public documents describing approaches to primary, secondary and tertiary prevention amongst

our injury schemes in this country. I rarely hear it discussed at conferences like this, and I think we have to put greater focus on that.

Principle 3. Do No Harm

Recently, one of my PhD students, who was fortunate enough to have Ashley mark her PhD thesis recently, and it passed, so thank you Ashley, conducted a systematic review of all of the qualitative research literature describing injured persons' experience in workers' compensation systems. And having read, digested and synthesised all of that research, she described how some injured people tend to fall into a downward spiral of harmful interactions with the compensation system. This spiral can start at any one of the points shown on this figure.



It can start with adversarial interactions, which can lead to difficulty getting a diagnosis from a health care provider. If the person does not get an accurate diagnosis, it is difficult to get appropriate treatment. If you cannot get appropriate treatment, it can lead to the injury becoming more chronic, which can exacerbate psychosocial factors, which in turn can lead to questions about the legitimacy of the injury, and this can lead to adversarial relations.

And the end result is this cycle, a downward spiral of things getting worse and worse. This does not occur in everyone, in fact it only affects a small proportion of people that in our injury schemes, but it is definitely there. And we see very similar results reading the qualitative literature from motor vehicle accident compensation schemes, of which there are quite a few.

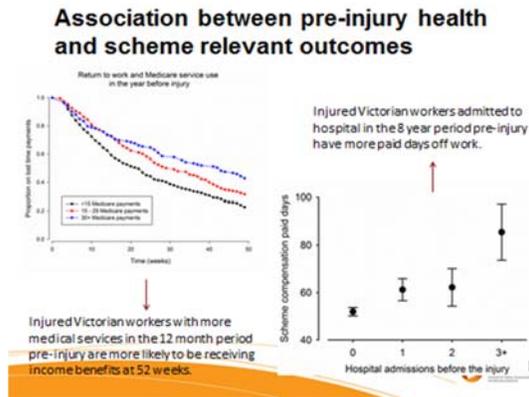
What we are observing here is the system itself, the interaction of the person with the system, generating additional disability, additional ill health beyond that which they bring into the scheme. This is the notion of system generated disability.

So the third principle we should have explicitly state in our schemes is the principle of doing no harm. We know that compensation is associated with slower recovery, not in everyone, but in some people, and we know what a lot of the risk factors are. There are some policies, processes and practices within our schemes that exacerbate poor health or lead to the onset of poor health, particularly mental health conditions. We do not need to look too far in the research evidence to see this. In a public health model we would actively identify and try to remove or minimise the impact of these scheme policies and practices. We are attempting to do some of that now in Victoria with some things I am happy to talk about.

Principle 4. Treat the whole person. Not just the compensable parts.

Another two studies we have run over the last couple of years are linking scheme data in Victoria to health system data, either hospital data, Medicare data or pharmaceutical benefit scheme data, prior to the injury occurring.

The graph on the left is from a study where we linked about 1,000 claims to Medicare payments 12 months prior to the injury and 12 months afterwards. Essentially what this demonstrates is that injured people who have more medical services in the 12 month period pre-injury are more likely to be receiving income replacement and still be off work 12 months post-injury. The graph on the right shows that injured people who are admitted to hospital in the 8 year period pre-injury have a much longer duration of time away from work post-injury.

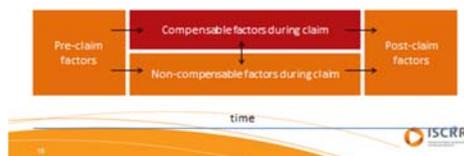


The impact of pre-injury health and comorbidities in this image is obvious and it is substantial. But, ask yourself, do we record people's pre-injury health when they enter the scheme? Do we ask the question about comorbidities in a routine way? Do we do anything about them? Do we treat people's comorbidities? Are we allowed to treat people's comorbidities in our injury compensation schemes?

So the fourth principle is to treat the whole person and not just the compensable bits. We know that many factors influence injury recovery. And only some of these are we able to compensate within the boundaries of the legislation we have established in our injury schemes. So, if all we are doing is dealing with the injury related parts, then we are missing most of the picture. We have to identify and address people's pre-existing health conditions, comorbidities, and health conditions that arise subsequent to the injury. Things like diabetes and cardiovascular disease among many others, are very important, because they all have a big impact on the costs in our scheme and on the health of people long-term.

4. Treat the whole person. Not just the compensable parts.

- Many factors influence injury recovery.
- Only some are compensable.



Principle 5. Take a systems approach

Sometimes I think science has a lot to answer for. The dominant paradigm in science over the last couple of centuries has been one of what I will call reductionism. The reductionist approach assumes that if we can understand things at ever more micro levels, we will be able to develop interventions that effectively address the conditions that we observe. The reductionist approach is being challenged now in science by complexity science.

Reductionism can lead to unintended consequences and can lead us down the wrong path from time-to-time. And we see this in our injury schemes. We tend to put in place, and I think we do this more often than we realise, quite simple lines of thought that can have unintended effects. Here are some examples.

Some unintended consequences of reductionism / linear thinking

Compensable cases on average have poorer recovery and return to work than matched non-compensable cases (Harris I et al. JAMA 2005; 293(13):1644-52)

Processes designed to ration healthcare resources (e.g., medical assessments) contribute to negative health impacts, increasing the requirement for healthcare (Lippel K. Int J Law Psychiatr 2007;30(4-5):427-43)

Experience rating premiums can lead to claims suppression, excluding some injured workers from system benefits (Tompa E, et al. Pol Prac HealthSafety, 2012;10(1):117-37)

Practices designed to enable GP to be healthcare 'gatekeeper' (e.g., sickness certification) are sufficiently cumbersome for some GPs to opt out of system participation (Brijnath B, et al. Submitted for publication).



A good one is that experience rating, which is used a lot in workers' compensation systems particularly in Australia and Canada, and is intended to provide an incentive for employers to improve health and safety in a workplace so they have fewer claims, can lead to claim suppression. Research is now showing that the way in which some employers address the experience rating issue can be by choosing not to submit claims through the workers' compensation system, in order to keep the premium down. And the consequence of this practice is that it excludes those injured people from the benefits the system has to offer. There is good evidence emerging about this now.

We also see things like processes designed to ration the health care resources, like independent medical assessments can have unintended effects. These IMEs are there because we want to figure out whether a person requires treatment or whether they are eligible for certain benefits. But we now know, from a number of studies, that they can contribute to the exacerbation of mental health conditions in some people. This actually increases the requirement for health care in those people. So IMEs may have the opposite effect of what was intended.

There are lots of these unintended consequences of reductionism or linear thinking in our injury schemes. These are one hallmark of what now are becoming commonly accepted or commonly termed, complex dynamic systems. There are many other features of complex dynamic systems and our injury compensation schemes display pretty much all of them.

One example is this concept of dynamic complexity. We often acknowledge in these schemes the idea of what I will "combinatorial complexity". This is basically that there are a lot of parties involved. There are lawyers, health care providers, injured people, case managers, etc – lots of different combinations. What we do not talk about very often is that the interactions between those parties change over time and they are dynamic. They change. This introduces an additional number of degrees of complexity. I do not have time to describe the very interesting area of complexity science in detail, and what it means for those that design and manage injury schemes, but it does mean some pretty substantial things.

It means, for example, that these schemes cannot be managed by a single authority. Schemes cannot be 'managed' by a regulator. The implication of complexity science is that regulators have to work in partnership with others as influencers rather than in command and control type relationships. All of the other parties in the scheme have to be involved in the process of managing the scheme in order for it to work effectively. It also means that our systems are in a constant state of disequilibrium, something is changing all of the time. The implication of this is that we should not over-react to short-term changes. We should analyse changes to determine what is really going on. We have seen a lot

of reaction to what I would call short-term changes in Australia in the last few years, and relatively little focussed analyses of longer-term structural changes.

Reductionist approaches such as that I have described in the last slide will have unintended consequences. These may not be immediately obvious and may take some time to emerge. An implication of this is that we need to measure the outcomes of scheme initiatives over the long-term, in order to identify what those consequences are.

The fifth principle is to take a systems approach. Or at least do not take a reductionist approach to managing an injury scheme.

Principle 6. Ensure fairness in processes and procedures.

Very recently, we have completed a study comparing perceptions of fairness of injured people in our Victorian and New South Wales motor vehicle accident compensation schemes. This was a study lead by Dr Nieke Elbers, in collaboration between the group here at the John Walsh Centre and ISCRR, and involving the Transport Accident Commission and the Motor Accident Authority.

As you will know, these two systems are very different in their design. We have a no fault, statutory benefits system in Victoria, and we have a lump sum, common law system here in New South Wales. In this study we asked people to fill out a validated procedural justice questionnaire about 12 months post-injury. We observed that there were large difference in the perception of fairness in the Victorian and New South Wales schemes, and more importantly, those differences were associated with, or were a significant predictor of post-injury health.

Perceived fairness of two MVA compensation schemes.

- Motorists with mild to moderate injury at 12 months post injury.
- Perceived fairness was a significant predictor of post-injury health.

Question	NSW (N=48)	VIC (N=42)	Chi Square	P value
It is easy to fill out forms	46%	78%	17.7	<0.001
It is easy to support claim	52%	85%	23.0	<0.001
Claim duration is acceptable	46%	85%	27.1	<0.001
Compensation received so far is fair	46%	74%	15.0	<0.001
Overall claim process is fair	45%	84%	30.0	<0.001
Pre-injury health (good - excellent)	92%	98%	3.0	0.06
Post-injury health (good - excellent)	47%	67%	7.1	<0.01



This study tells us that the perception of people, whether they think the scheme is treating them fairly, is having an impact on their health. And so, the sixth idea is that we should ensure that our procedures and process are fair and equitable.

If you work in a system, or have been involved with one for any length of time, you will understand how process- and procedure-driven they are. It is important that we think carefully about these processes and whether they treat the injured person fairly.

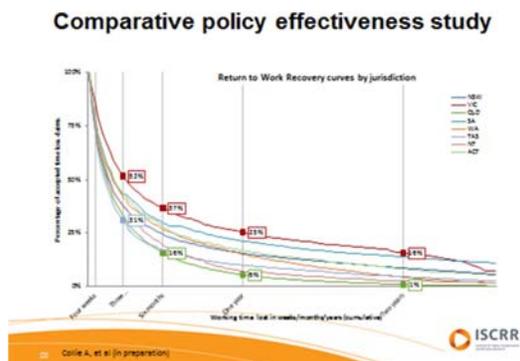
There is a great review that I will refer you to by Professor Michael Sullivan from Canada. This study reviews all of the literature in this area. It describes a relationship between perceived justice and adverse recovery outcomes, including poorer physical and mental health and lack of treatment response. He describes a range of cognitive and emotional behavioural and social processes that link perceptions of injustice to poorer health outcomes, not in injury schemes, but generally amongst people with pain. He also makes the observation that interventions that seek to reduce perceived injustice should have as a consequence an improvement in health too.

Again, if we are truly operating in these schemes using a public health model we would identify and minimise processes that are perceived to be unjust or unfair.

Principle 7. Enhance use and usability of data.

We have a huge amount of data in our injury schemes. There is loads of data going back decades, for thirty odd years in most states and territories. Recently, we have started a study out of Victoria, but involving 8 of the 10 workers' compensation systems in the country, using the national dataset of workers' compensation-based statistics compiled by SafeWork Australia. What we are trying to do is to tease apart the impact of scheme design and scheme management, or policy and practice for want of a better term, on recovery. We are using time on income replacement benefits as our proxy measure of recovery.

We are only a few months into this project but our analysis so far indicates that there is huge variation in compensated time off work between the 8 states and territories in Australia. That is what this graph essentially shows. These are recovery curves of all 8 states and territories, showing the proportion of injured workers who are still receiving income replacement benefits at 4 weeks, 3 months, 6 months, 1 year and 2 years post-injury. If you look at 1 year post-injury, we have Queensland down the bottom here at 6%, Victoria at 25%, and that is a huge difference. And this is after we have tried to remove some features of the schemes that actually make them quite different, such as the 10 day employer excess period in Victoria.



Subsequently, we have run some analysis that shows that much of this difference is actually attributable to the way the schemes are designed and managed. So when you factor in things like age, injury type, gender, occupation, industry, socioeconomic status, this difference between the schemes does not disappear, it is still there. This suggests strongly that scheme policy and scheme practice is having a huge impact on people's recovery post-injury.

To my knowledge, this is the first large study like this that sought to take advantage of the differences in scheme design that we have in Australia. Our aim is to use the data in clever ways to identify positive and negative policy and practice settings. There is huge potential to do this. Our schemes are data rich, but we do not make the most of that data.

There have been some good presentations here today using scheme data. Given the right conditions, we can do all sorts of fascinating things with the scheme data. I showed you earlier a data linkage study where we link scheme data to health care information. I just showed you a comparative effectiveness study where we are using the differences between the schemes to tease apart the policy and practice variations. We are also doing data mining and forecasting studies, where we are getting the boffins in the various faculties at Monash University to help us with some advanced forecasting of future scenarios.

This work is an extension of what we started 6 years ago at ISCRR where we embarked on a program of research to make much greater use of the administrative data, with the support of TAC and WorkSafe. This program has grown into what we now call our "3D" program. The first "D" in the

3D program stands for data management and provision, which we have been doing for 6 years. We have a data base and we provide it to academics for use in research studies. The second “D” is “data linkage”. I showed you a data linkage study earlier. We think there is huge potential to understand what goes on in these schemes by looking at linking data to other sources as well. And the third “D” is “data mining and analytics” which we are getting into now.

Our next major initiatives are going to include efforts to establish new datasets to give us different views of how the schemes are functioning. There is a lack of “outside-in” views in this sector. There are very few well-established studies, reported publicly, that report how the schemes are functioning from the injured person’s perspective, from the employer’s perspective, the health care provider or others.

In a public health model we would exploit the data we have, and we would seek to add additional datasets that give us a different view of the way the schemes are functioning.

Principle 8. Invest in the frontline workforce

Since I have been involved in this area, one of the things that has fascinated me is what happens at the frontline. What do case managers, or claims managers do and what impact do their actions have? There is actually very little academic research about claims management in injury schemes. I have come to view claims management as a mix of art and science.

There are some people in our injury schemes with a lot of experience and who understand the magic ingredients for a good claims management model. I am not one of them, but when I look for research evidence, there is very little about what works and what does not for injury claims management.

At ISCRR we have started some projects that try to understand what case managers think of their jobs, and their interactions with injured workers, employer and healthcare providers. We have now run 2 qualitative studies where we have interviewed over 50 case managers across 3 different compensation schemes in Australia. The dominant theme emerging from those studies is how complex the role is. Case managers are at the intersection of all sorts of competing expectations and they need to be very skilled to navigate those and achieve a positive outcome. Another issue is that outcome is defined differently by the various parties in the scheme as well.

Qualitative studies describe some of the challenges facing front-line staff.

- “Much of what the front line staff think, say and do reflects their positioning at the intersection of ... competing expectations.” (Eakin J et al, 2009. Institute for Work & Health).
- Factors emerging from interviews with 21 Australian case managers (Newnam S, et al, 2015. ISCRR)
 - Extra-role expectations
 - Emotional control
 - Stress
 - Conflict induced emotions



These studies also demonstrate that system complexity seems to have a negative impact on case managers emotionally. This may be one reason that we see such a high turnover of frontline staff in the schemes. It is just a very hard job. In one of our studies case managers across three different schemes reported that they feel like they are asked to go above and beyond all the time. They report that they do not have much emotional control. They experience a lot of conflict dealing with competing interests. And stress was the overriding theme that came through.

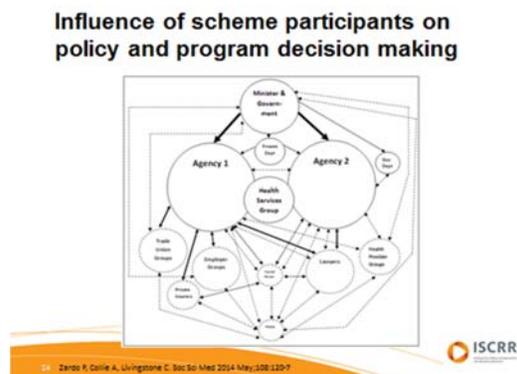
I am sure you would all agree that case management is a critical role in injury schemes. There is some evidence, including some studies from the group here at the John Walsh Centre, that changes

in case handling can have a positive impact on client health. But there are also many challenges, some of which I have just mentioned.

A principle that is common in other areas of public health is that you need to invest in the frontline workforce. I would go so far as to say that in this sector we need to provide case managers with health-promoting tools, more skills that address the health issues that occur amongst those injured. I think that would be a positive thing.

Principle 9. Engage the affected community.

Heading towards the end now. One of my doctoral students published a paper last year as part of her PhD where she mapped the input of different scheme participants in the Victorian schemes to policy and program decision-making. The study was based on 33 interviews with senior managers from the Victorian injury schemes. We used Bourdieu's field theory to map the influence of different participants, where the size of the bubble and the thickness of the arrows in this diagram indicates the degree of influence on policy and program decision-making, and the arrows indicate the direction of influence.



It is a pretty complex “field” as you can see. The message I want you to take away from this is that a relatively small number of participants in the schemes have a huge impact on policy and program decision-making. The agencies themselves, and not surprisingly the Government, have the largest impact. I guess, more surprising is that some other parties that are central to these schemes have very little influence over policy and practice. This is particularly true for injured people. The media, thankfully, are also a less influential group. Almost the least influential group in this sector are the people who are there to benefit from the schemes (injured people).

In a public health model, I would propose to you that we want to enhance the voice of some of these other participants in the scheme, beyond government. This is to give them a greater influence on the policy and program decision-making. We need to engage those other parts of our systems that are not having much of an influence at the moment.

There are many community participants in these schemes and there is good evidence now that if you invite those people to participate actively in program design that it leads to positive outcomes. It has benefits in terms of enabling service delivery, it allows you to meet community needs, enhancing the community's ability to identify its own needs, which can be difficult at times. It can also enhance our understanding of what the community's needs are.

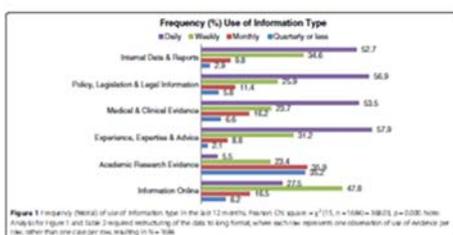
Some State Governments around Australia have frameworks for helping us to think about this, in Queensland and Tasmania, and they typically describe a spectrum of engagement from passive information provision, through consultation to more active participatory approaches. I think we probably need to ask ourselves: What do we do in injury schemes? What is the mode of information provision? We see a bit of consultation, particularly when there are scheme reviews going on. There is not a lot of active participatory involvement in the design and delivery of programs and policy in our injury schemes.

In a public health model we would seek to have more engagement with end-users, and not just injured people. When I say end-users, I am talking about the spectrum of end-users – health care providers, lawyers, injured people, employers, all of the above.

Principle 10. Grow and use the evidence base.

Finally, I had to finish on a principle about use of research and research evidence. This slide shows the results of a survey of over 300 people who work in injury schemes in Australia. It was published early this year in BMC Public Health. The purpose of the survey was to determine what sort of information they used in their day-to-day work, as well as the frequency and the purpose of the use of that information.

Use of information by two Australian injury schemes



We found, not to my great surprise, that academic research evidence was the least often used form of information in the scheme. It was used less often than ‘Dr Google’ unfortunately. Other forms of information dominated decision-making in the scheme. Internal data, policy and legislation, internal medical and clinical evidence, and experience, expertise and advice were used most often. Academic research was used less often. It was used much less frequently and more likely to be used monthly or quarterly than daily, whereas these top four were used daily.

Academic research was also used for a different purpose. It was more likely to be used to inform the thinking of people than to be used to direct policy and program decision-making. This study paints the challenge that John Walsh talked about earlier about getting research evidence used in policy and practice. It is a big challenge, there is a long way to go, and we have to shift academic research to look more like one of these other forms of information.

So the final principle is to grow and use the evidence base. There is a rapidly growing evidence base in this field, thanks to group like the John Walsh Centre here and others around the country, and we have a big challenge in using that effectively and translating it.

Conclusion

These are my 10 ideas. These are 10 things I think we can achieve. Not all of them are easy. Most of them are pretty difficult. But if we wanted to place a greater focus on a health objective, and to begin to get that balance a bit closer to where it should be, then these are some practical actions.

10 ideas for a public health approach to injury compensation

1. Improving health should be the primary objective.
2. Prevention, Prevention, Prevention.
3. Do No Harm.
4. Treat the whole person. Not just the compensable bits.
5. Take a systems approach.
6. Ensure fairness and equity in procedures.
7. Enhance use and useability of data.
8. Invest in the frontline workforce.
9. Engage the affected community.
10. Grow and use the evidence base.



I want to end by leaving you with one final message. This is really the premise behind my talk. I think we are faced with a choice when it comes to injury scheme financial management. We can manage scheme finances by focussing on cost containment, which we do a lot of now. Or, we can manage scheme finances by focussing on improving health. I think one of these is a relatively short-term way of managing a scheme. One of them is a long-term way of managing a scheme, and I know which one I would be choosing.

Thank you very much.”

ENDS