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Committee Secretary
Standing Committee on Employment and Workplace Relations
House of Representatives
Parliament House
CANBERRA ACT 2600

IAG
Insurance
Australia
Group

Dear Mr Selth,

Re: Inquiry into aspects of Australian workers' compensation schemes

Insurance Australia Group (IAG) welcomes the opportunity to comment on Australian workers' compensation schemes focussing on issues of fraud, rehabilitation and employer obligations.

IAG is Australia and New Zealand's largest general insurer with more than four million customers. The company is also Australia's largest workers compensation insurer with a leading role in every scheme open to the private sector, either as an underwriter or an agent for state authorities. As such, it brings a uniquely national perspective to the issues currently before the Committee.

The company and its representatives are available to expand upon the contents of this submission should the Committee require further information, in that instance please contact Noelene Palmer on ph: 02 9292 3832.

Yours sincerely,

Douglas R. Pearce

DOUGLAS R. PEARCE
Group Executive
Personal Injury, Health & Commercial Insurance

Introduction

IAG views many of the problems in workers' compensation schemes as largely systemic. That is, the problems within workers' compensation are a result of the inherent structures and procedures of the schemes themselves.

This submission will firstly consider the instance of fraud in workers' compensation and secondly the other factors that lead to differences within and between industries with regard to safety and the claims process.

What is fraud in workers' compensation?

One of the significant issues in this area is the lack of consensus for a definition of fraud in workers' compensation, as distinct from exaggeration and behaviours typical of an adversarial system.

For the purposes of personal injury insurance the IAG definition of fraud is the making of a statement, either orally or in writing, by a person who knows the statement to be false, with the intention of obtaining a financial advantage for themselves or another. Or, the making of a document that is false and then using the document to obtain a financial advantage for themselves or another knowing the document to be false. This is distinct from exaggeration, where the claimant may honestly believe that they are ill, but in fact, it is not as serious as they believed. This is discussed in this submission under the section on claimants incentives and state of mind.

Types of fraud include:

- Workers engaged in employment when they have made statutory declarations that they are not working (for example social security fraud).
- Workers supplying false or misleading documents in support of their workers' compensation claim (false medical certificates).
- Employers providing a statement of wages and employee numbers which are false by under estimating their true position (premium base fraud).

- Workers making a false statement concerning how they received their alleged injury (for example injury received from sporting incident but claimed as workplace incident).
- Service providers submitting false invoices for services not actually provided.
- Self-employed people using a claim as a form of ongoing income whilst there is a dispute over the level of incapacity.

The incidence and costs of fraudulent claims and conduct by employees and employers and structural factors which encourage such behaviour.

It is difficult to establish the incidence of fraud by employees and employers as IAG's current reporting mechanisms are not able to determine this, outside the SGIO portfolio in WA. The workers' compensation systems used by IAG are those that were acquired in the purchase of the HIH workers' compensation portfolio, where there was essentially a reactive and ad hoc approach to fraud investigation. One explanation for the history of low investment in the past for this area, is the lack of incentive to insurers in non-risk States to identify fraud and to work with employers to reduce the instance of fraudulent activity. We have little information on the number of instances where fraud was detected, and where prosecutions were initiated.

IAG recognises the importance of detecting and eliminating fraud and has a great deal of experience in this area through our other personal injury portfolios, in particular CTP. We are currently in the process of applying this understanding and experience to our workers' compensation portfolio. Specifically, we are undertaking an Internal Investigator Pilot in NSW to investigate suspected instances of fraud. Under this pilot the costs associated with the investigator are charged back to Work Cover.

Costs

IAG has seen estimates that between five and ten percent of all claims are fraudulent, however the company has no method of validation for this estimate. In the 2000/2001 financial year there were 12,820 NSW workers' compensation claims, which if this estimate is correct, equates to 641 to 1,282 potentially fraudulent claims. These

percentage estimates increase considerably depending upon the type of injury and/or employment sectors. In dollar terms, this potentially equates to $46.25m to $92.5m.

Structural issues

IAG believes that the instance of fraud is a systemic problem. As such, it is imperative that workers' compensation schemes have provisions for managing and deterring fraud.

Recommendation:

This should include statutory provisions that:

- ***require a fraud investigations capacity be mandatory,***
- ***require an employer to produce employment documents relevant to the person suspected of committing fraud (eg. Section 174 in NSW legislation),***
- ***require an employer to declare the injury within 48 hours,***
- ***require an employer to provide detailed lists of employees biannually,***
- ***require treating medical practitioners to provide a standard Work Cover medical certificate to the Authority.***

Insurers' time constraints

Another structural issue that impacts on fraud is the timeframe given to insurers to investigate. All workers' compensation schemes require a determination of liability by the insurer between 10 (NT) and 28 days (NSW) from claims lodgement and we support short timeframes to encourage early notification as an essential requirement of effective injury management. However it does create some difficulty in allowing for an effective investigation of potential fraud.

Recommendation:

The provisional liability be offered for a three-month period during which liability will be assessed (as per NSW CTP. There are similar provisions in workers' compensation if provisional liability is accepted within seven days).

Further to this, there are currently limited data sharing provisions available to insurers undertaking fraud investigations. Information from government agencies such as the Australian Tax Office, CentreLink and Customs would significantly enhance and streamline fraud investigations. While the issue of information sharing has traditionally been contentious between State and Commonwealth agencies, this should not preclude the consideration of future information sharing arrangements.

The methods used and costs incurred by workers' compensation schemes to detect and eliminate:

(a) fraudulent claims.

In April 2002, following IAG's acquisition of HIH's workers' compensation business, a fraud investigation presence was established within the NSW Workers' Compensation portfolio. This capacity is considered cost neutral.

Fraud training is provided to claims staff and has been delivered in-conjunction with the WorkCover Fraud Investigations and Referral Unit. Within the NSW Workers' Compensation claims division, the NRMA Insurance Limited Personal Injury Fraud Investigations Unit also work closely with the internal training department to develop fraud detection skills among staff.

Fraud is detected proactively (via claims staff checking claims against fraud indicator lists) and reactively (informant information). The fraud investigation service is closely aligned to claims management as well as being integrated within the NSW WorkCover process. IAG's workers' compensation business has a dedicated fraud response comprising an analyst and investigator. NSW WorkCover Authority has a **Compliance and Improvement Branch**, within this branch there are only three dedicated Fraud investigators, IAG believes this is inadequate. Further please note the current discussion on this issue between the NSW Minister for Industrial Relations and the NSW Shadow Minister regarding the balance between the number of WorkCover inspectors monitoring employer compliance and the number of investigators monitoring employees.[1]

[1] Media Release: Mike Gallacher MLC, Shadow Minister for Industrial Relations 14 August 2002

Methodology

Briefly, once a fraud is detected a multi-discipline approach is adopted. This involves the development of an investigations strategy with claims staff, a fraud investigator and a fraud analyst. There is a clear delineation of roles in the management of this claim from this point. Claims staff maintain the day-to-day management and overall responsibility of the claim whilst investigations staff conduct investigations. Importantly, both communicate their actions on a regular basis. Once the investigation is completed the information and evidence collected is assessed to determine a possible litigation strategy. The company's approach is to refer claims to WorkCover as soon as possible. This uses a global method of early intervention and results in increased communication and focus between the regulator and the insurer while considering bottom line costs to ensure efficiency and effectiveness.

(b) the failure of employers to pay the required workers' compensation premiums or otherwise fail to comply with their obligations.

A review on this issue has recently been undertaken in NSW. The ICA response to this study is attached.

IAG agrees that premium avoidance by employers is a significant systemic issue. The opportunity for fraud generally arises at the time of the employer's estimation of wages, and is perpetuated through, unquestioned, insurer acceptance of the estimation. To prevent this happening it is important that insurers have the ability to conduct an independent audit of an employer's payroll. It is also important to deter premium avoidance, using penalties from regulators. At present strict penalties are available, however they are rarely enforced.

Factors that lead to different safety records and claims profiles from industry to industry, and the adequacy, appropriateness and practicability of rehabilitation programs and their benefits.

There can be vast differences in regards to workers' compensation claims profiles and safety records within and between industries. There are a variety of reasons for this, which will be considered in this section.

Risk Rating

There are several methods of risk rating that impact on an employers workers' compensation premium. These methods are discussed here with reference to the impact that they have on an employers' risk mitigation and safety activities, and ultimately their claims profile.

ANZSIC (Australia and New Zealand Standard Industry Code)

The ANZSIC code is the widely used measure for premium rating between industries. However, it was designed to differentiate on an economic basis between industries, and not specifically for the purpose of risk rating for the calculation of premiums. Where it is used as a proxy for workers' compensation risk identification, there is an inherent problem in that it does not adequately differentiate well between various risks within the same industry. The roles and occupations within a single industry can be wide ranging, and have extremely diverse risks associated with them. As such, the ANZSIC code is a good starting point. However it needs to be refined.

The preferred way to calculate premiums is to consider it from a risk-based perspective. This involves looking within an industry at discrete risk-based categories, perhaps most appropriately defined by *occupational characteristics*. The reasons that this method hasn't been adopted universally are because of the differing views about the rating for such characteristics and the difficulty of collecting relevant, detailed data.

In July 2001 the ANZSIC code was replaced in NSW with the WorkCover Industry Classification System (WICS). This has removed many of the issues under the previous ANZSIC system. WICS provides many more categories than previously available, meaning that most organisations can be appropriately assigned a category. The significant issue with this method, is the lack of information available in each category, which can mean that the rating assigned to a category may not always be appropriate. However, WICS is a much more effective system than ANZSIC, as it was specifically designed for workers' compensation classification.

Experience Rating

Another method used for the rating of premiums, often in conjunction with ANZSIC-based rating, is experience rating. Experience rating approaches may be split into two groups:

1. *Objective:* This approach is usually used by State monopolies. For example, claims experience over a three year period is considered and used as a base for the majority of the risk premium for a large employer.
2. *Subjective*: This approach is common with private insurers. It involves considering the individual company's risk and claims experience, and rating it as is done in most other commercial risk rating.

In both cases there is difficulty distinguishing between large and small employers within the same category. It is easier to rate large employers on their individual risk than it is for smaller employers. Smaller employers tend to be grouped with similar organisations of the same size, which does not take account of their individual risk mitigation activities.

Collection of data

Better collection of detailed data about actual claims experience is needed. This would allow a proper analysis of the instances giving rise to claims. At present each State compiles their own data, however it is difficult to compare this between States due to differences in reporting methods.

In many jurisdictions data is scattered among a large number of public and private organisations with large differences in recording and reporting standards. It is extremely difficult if possible at all to establish meaningful national benchmarks and performance standards to identify and monitor emerging trends at the national level.

To overcome the lack of uniformity in data collection the National Data Set (NDS) was developed for compensation-based statistics. The objective of the NDS is to *"assist in the prevention of occupational injury and disease by the production of uniform national, and nationally comparable, indicators of occupational health and safety performance and experience"* (National Data Set for Compensation-based Statistics 3rd Edition, May 2001). The NDS provides a high level of data in a format that can be compared within and across industries on a national scale. This is a positive step towards enabling accurate risk rating based on individual organisations.

Recommendation

A system be established to develop, collect and coordinate data needed for more accurate risk rating of individual organisations, taking into consideration any risk-reducing measures or activities that the organisation has undertaken.

Incentives

One important area of concern is that of incentives to all stakeholders in the workers' compensation systems. This includes employers, claimants and insurers. The current incentives, or lack thereof, to these stakeholders encourages institutionalisation into the workers' compensations system instead of encouraging rehabilitation, return to work and ultimately to normal duties as soon as possible.

- Employers

In regard to workers' compensation employers, need incentives in several areas to ensure that the schemes work effectively and to enable employees to make a full recovery and return to work.

Initially, employers need incentives to take safety precautions and reduce risk in the workplace. As the schemes currently exist there is little incentive for employers to undertake risk-reducing activities as these are generally not taken into consideration in their risk rating, which determines their premiums (as discussed above).

NSW WorkerCover operates a "Premium Discount Scheme" which is a financial incentive for employers to implement best practice OH&S and injury management procedures. NRMA Insurance targets poor performers with regard to OH&S and injury management systems allowing them to work with our risk management specialists to identify and reduce risks at their workplace. Employers have been receptive to this because of the incentives offered.

Secondly, employers need incentives to notify their insurer quickly of potential claims. Early notification of workers' compensation claims is vital to ensuring that claims are managed as quickly and efficiently as possible. It should be mandatory and supported by legislative and compliance requirements. This both reduces the instance of fraud and ultimately leads to an expeditious return to work for the claimant.

This has been seen in NSW under the WorkCover scheme. This scheme requires employers to lodge claims within seven days of the incident occurring. Under this initiative WorkCover is able to impose fines on employers who do not notify the authority of claims quickly. However, to date the authority has not imposed any fines and it does not appear that they have any processes in place to do so.

Further to this, under provisional liability provisions in NSW, notification of injury can be done either by the employer or the employee. The aim of this provision is to encourage early notification by employers. The incentive is that through early notification, employers will have greater control over the claims, rehabilitation and return to work processes than they would have had their employee notified the insurer of their injury.

In July 2002, the ACT scheme implemented a similar policy whereby employers must notify their insurer of a claim within three days of an injury.

At present there is no data available on the impact of the early notification provisions, however anecdotal evidence suggests that it has led to a reduction in claims costs and faster return to work for the claimant.

Workers' compensation provisions in Victoria state that the employer pays the first ten days of compensation and a set amount of medical expenses. These provisions were intended to encourage early notification by employers. However, it is in fact an impediment to early notification, as there is no real incentive to do so. This causes further problems in that employer, while they may mean well, do not have expertise in rehabilitation and as such may cause more damage than if the employee was immediately referred to the workers' compensation insurer.

Currently the investigation of fraud incurs costs against the claim, this means that the employer will be charged a cost for any investigation which is incorporated within their premium and their yearly claims cost. This acts as a disincentive for employers to pursue fraudulent claimants. Further to this, in some States employers have to contribute financially to the cost of a claim against their policy where an award has been made under common law. For example in NSW an employer will contribute up to $150,000 by virtue of increases premiums over the three years following the accident date year.

Recommendation:

That the relevant scheme legislation include financial and structural incentives for pursuing fraudulent claimants.

Incentives are also needed for employers to encourage them to provide an environment that enables return to work at reduced duties for injured workers. Most large employers are receptive to considering alternative return to work options, as they are aware of the costs associated with not rehabilitating and bringing an employee back to work.

However, this awareness is only developed as a result of having a claims history. As such, many smaller employees who do not have a claim history are not aware of the financial impacts of having injured employees. Subsequently, they tend to be unmotivated to rehabilitate their injured workers, or provide suitable duties upon return to work. Further education is required to ensure that all employers are aware of the financial incentives associated with rehabilitation programs and return to work.

Similar issues arise in workplaces in regional and rural areas and where older and manual labourers are injured. In these situations it is less likely that there are suitable, reduced duties options available to enable the employee to return to work. As such, these employees need to be retrained or they are likely to remain in the workers' compensation system for extended periods. Provision needs to be made for these workers to ensure that they do not become institutionalised in the scheme.

The majority of employers, whether insured under a State based or private insurer, consider workers' compensation premiums to be a tax. This is due to its compulsory nature, combined with the fact that for most employers claim incidence is infrequent. This reduces the motivation to manage risk which claims experience can generate. As a result insurance does not act as an incentive to most employers to be proactive about mitigating their risk by putting safety measures in place, particularly in the case of small employers.

- Claimants

Claimants need an incentive to rehabilitate and return to work in full capacity as quickly as possible. Under the current workers' compensation schemes there is not enough incentive to apply best practice injury management (the following section considers this in more detail). These schemes encourage employees to remain ill or incapacitated. Many claimants think that their claim is not believed by the insurer, and as such they risk developing an *"I'll show them I'm really sick"* mentality, which can cause further illness or prevent recovery.

Further to this there is anecdotal evidence that some claimants are encouraged by lawyers to remain on benefits longer than may otherwise be necessary to establish a case for receiving a lump sum commutation.

A report by the **Australasian Faculty of Occupational Medicine and the Royal Australasian College of Physicians** *(Compensable Injuries and Health Outcomes*, 2001*)* found "people with compensable injuries have poorer health outcomes than do those with similar but non-compensable injuries."

This report confirms what many others have also concluded - that a person's state of mind is critical to better health outcomes. In other words, insurance claims that encourage a person to appear injured so they can be awarded more favourable compensation is unlikely to produce a state of mind focused on recovery.

As a new entrant to the workers' compensation environment, IAG has observed a different claims management culture from that in the CTP scheme which appears to have evolved from the different incentive arrangements.

The impact of different cultures is well illustrated by the comparative costs of motor vehicle accident claims managed through the workers' compensation system, with recovery from NRMA Insurance CTP, and other claims involving economic loss that are directly managed by NRMA Insurance. The following table illustrates this.

	Workers' Comp Involved	**Workers' Comp Not Involved**
Average Medical Cost	$6,384	$2,144
Average Future Medical Cost	$2,311	$1,849
Average Rehab Cost	$58	$113
Average Eco Loss Cost	$7,547	$3,132
Average Future Eco Loss Cost	$11,078	$6,726
Average Cost Overall	**$27,377**	**$13,964**

From this it can be seen that the cost of a workers' compensation claim can be more that twice the cost of an injury not handled through a workers' compensation scheme, for example, CTP.

- Insurers

The issue of incentives to insurers is particularly relevant in State monopolies. In this situation the insurers are used as process areas for the claims of the State workers' compensation authority. The insurers act as agents but have no underwriting exposure, and as such no direct financial interest in the scheme. As such, the insurers do not have the same incentive to develop best practice systems, as they would in a fully commercial environment.

Injury and Claims Management

Further to this, is the issue of early notification by insurers to injury management specialists. While there is now a significant emphasis on early notification by employers to insurers, however there also needs to be protocols in place to encourage insurers to minimise the timeframe between notification and rehabilitation.

In the handling of injury and claims management it is important to use a multi-disciplinary approach. This should balance the commercial interests of the insurer, recognition of the community responsibility inherent in participation in a statutory compensation scheme and the critical objective of ensuring the optimum health outcome for the injured person.

All aspects of handling a workers' compensation claim should be dealt with as promptly as possible. In IAG's experience, there is a clear and direct correlation between the duration of a claim and the finalised costs. A reduction in average duration has an immediate and substantial impact on outstanding claims results.

It has been widely recognised that rehabilitation, or more correctly injury management, is the key to an effective and efficient workers' compensation scheme. Early notification of claims and referral to an injury management specialist is vital to

ensuring that claimants are successfully rehabilitated and returned to work as soon as possible.

The adequacy of injury management is defined by:

- how quickly after the injury it commences – early notification is vital,
- the real opportunities for recovery effected by the injury. This is impacted by:
    - the claimants bio-medical capacity,
    - the claimants opportunity for employment,
    - the level of commitment the employer has to get the claimant back to work, and
    - the capacity and willingness of the medical practitioner to cooperate in the return to work process

The success of a injury management program is also dependant on a combination of the preparedness of employers to pay for value in injury management and the capacity of the injury management providers to give value. This has been an issue in the Victoria workers' compensation scheme, which is regulated by the VWA.
Under this scheme the VWA paid low rates to injury management providers, which lead to the withdrawal of services by high quality providers and the entry of lower quality providers. These new providers were commercial operators and tended to over-service. This practice was all but encouraged by the absence of monitoring by the VWA, that is, it was a direct result of inadequacies in the scheme at that time.

Accountability of health care providers

Another significant issue in the injury management process is the lack of accountability of General Practitioners. There are legislative requirements for doctors to remain active in the injury management process; for example they must return phone calls and follow up on any outstanding matters, however to date there has been minimal enforcement of this requirement. Many GPs are also reluctant to sign off on injury management programs due to the current state of the medical indemnity insurance market. As such, injury management providers are unable to give treatment, which delays the injury management process and may in turn lead to all the issues associated with delayed treatment as outline above.

Objective medical assessment

Many workers' compensation injuries tend to be non-demonstrable, that is, there are no obvious signs of the injury, for example soft tissue injuries. These injuries are typically cited in fraudulent workers' compensation claims as the extent of the injury is more difficult to prove or to disprove in an adversarial system.

Recommendation:

That a binding objective medical assessment and evidence-based medicine of impairment process (eg NSW Workers' Compensation scheme) be introduced to mitigate against the pursuit of a fraudulent claim.

Safety standards

It is common for there to be significant differences in safety standards between industries. This can be due to a variety of reasons including necessity, active industry bodies or economics.

Necessity

Some industries must focus on their safety record as a matter of necessity. For example some industries that have a typically high incident level and as such, through necessity, have developed high levels of safety. Common examples of this are in the construction and manufacturing industries.

Industry bodies

Industry bodies and associations in some industries are significantly more active than others. This means that the organisations in these industries may have a higher level of safety standards as a result of more active or influential industry association.

Further to this some organisations may not belong to an industry body. This significantly reduces their ability to lobby for industry wide changes to safety regulations. For example the construction industry successfully lobbied cement manufacturers for a decrease in size of cement bags from 40kgs to 20kgs. Now labourers picking up bags of cement are far less likely to injure themselves as a result of heaving lifting. It would have been almost impossible for a single employer to successfully lobby for such a change.

Economics

The economic situation of an employer or an industry can have a significant impact on the safety standards employed. An example of the extremes that can occur as a result of economics is typified in the textile and footwear industry. This industry has been severely impacted by tariff reductions. The result of this has been a significant decrease in the revenue created in the industry. With less funds available generally, organisations tend to consider safety issues only when they are 'forced' to through legislation etc. In contrast to this is the meat industry where a lot of money is spent on increasing health and safety as it is seen as a competitive advantage.

Safety performance monitoring

Some industries, in particular the construction and manufacturing industry, use Lost Time Injury Frequency Ratios (LTIFR) as a measure for safety performance. LTIFRs are often used as evidence of safety performance when an organisation tenders for a job or enters into a contract.

While this initiative promotes high safety standards, it also encourages under reporting of incidents, not allowing an injured employee time to recover, harassment and in some cases activities to reduce "down time" as a result of an injury. In one extreme case, an organisation was found to be setting up computers at their injured employees' hospital bedside to ensure that the injury did not impact on the LTIFR. Such undesirable activities also impact on the rehabilitation process by reducing the instance of early notification.

This behaviour is a result of reliance on this measurement tool while ignoring other equally important factors, for example injury frequency and claims costs. Some organisations pay management bonuses based on LTIFR in isolation of other safety measurements.

There is evidence that claims frequency is decreasing as a result of improved safety standards. However at the same time, the severity (claims cost and lost time) is increasing. The severity of an incident is a product of the workers' compensation scheme, while the claims frequency is a product of the employer. That is, the factors that affect the claims costs and lost time of an incident are directly attributable to the scheme and are beyond the control of the employer. As such, increase severity of incidents is not related to the safety measures initiated by the employer, but rather to inadequacies in the scheme.

Claims Profiles

There can be vast difference in claims profiles between industries, primarily due to the inherent variations in the underlying risk of different industries as well as the differences in safety standards adopted. For example the construction industry will have a much more frequent and severe claims profile than an office environment.

Conclusion

IAG believes that there are many systemic issues in the workers' compensation schemes across Australia and that fraud is a symptom of these issues. The incentives offered to employers, claimants and insurers need to be realigned to achieve the desired outcome, that is, fraud free workers' compensation schemes.