**ARPA Supplementary Information Relating to:**
**"The Role of Private Insurers in Workers Compensation Schemes"**

As a result of further enquiries from the Commission, ARPA provides the following information as explanation of our view of the benefits and dis-benefits of various scheme control models used in Australia. Rather than confining our views to the role of private insurers, each of the common scheme approaches are considered. It is probably safe to say that each approach has some positive and negative impacts on the provision of rehabilitation services, and that it is the degree to which three important tenets of sound rehabilitation are met that influences rehabilitation outcomes and scheme results. Having said that, in the absence of counter influences, it is ARPA's experience that each control model has an inherent tendency toward a specific approach to rehabilitation services.

The three basic tenets of best practice rehabilitation service delivery considered here are "early intervention", "workplace based", and "professional autonomy". These tenets are related to each of four scheme control models used widely in Australia. The scheme control models considered are "State Underwritten and Administered", "State Underwritten / Agent Administered", "Insurer Underwritten and Administered", and "Self Insured". We have included Comcare as self insured as it is closer aligned with this than other categories.

As well as the specific tendencies of each scheme it should also be noted that a bureaucratic approach can negatively impact any scheme form. As one of many current national examples, in Western Australia the process used to initiate referrals to rehabilitation requires the approval of three parties; the injured worker, the employer, and the treating medical expert. The mean delay from date of injury to rehabilitation intervention in that State is currently 285 days! These types of issues add significant cost and are not restricted to any scheme control model.

## STATE UNDERWRITTEN AND ADMINISTERED

Early Intervention

While these schemes generally agree with the need for early intervention they are usually the slowest at claim determination and therefore *the slowest at referral to rehabilitation serv*ices. There are many reasons that early claim determination and referral to rehabilitation are important to scheme outcomes and these are described more fully in the previous Submission.

Workplace Based

State scheme administrators generally espouse the value of workplace based rehabilitation although the reality often does not match the rhetoric. There are regular shifts of focus to clinical approaches, together with financial disincentives (such as lesser fees for travel to and from worksites) that are driven often by an individual administrator without regard for contra-evidence.

Overall these schemes are *reasonable at delivering rehabilitation services at the workplace*.

Professional Autonomy

These schemes can be constraining and administratively focussed at a system level, however they *generally are more likely to allow a degree of professional discretion* in rehabilitation service delivery that on average is only second to self insured schemes.

**STATE UNDERWRITTEN / AGENT ADMINISTERED**

Early Intervention

These schemes are reasonably quick at claim determination which can allow for early rehabilitation intervention. In reality Agents will often "triage" claims in house which adds a delay to intervention times. Some use in house rehabilitation for this function which could be considered a form of early intervention, others use less qualified and experienced people for this role resulting in slow or inappropriate rehabilitation service delivery.

On average *this scheme form achieves reasonable intervention times*.

Workplace Based

Agents are generally closer to employers and their needs than State based schemes are so they can understand the value of rehabilitation services provided at the worksite. This is often counterbalanced by the insurance cultural focus on cost control and compliance rather than recovery and restoration, which can lead to a limited style of service delivery being acceptable to them.

On average *this scheme form achieves reasonable levels of workplace based intervention*.

Professional Autonomy

In these types of schemes, Agents are often under pressure from the Scheme underwriter to deliver in narrow areas for very small profit margins. In this environment Agents will often micro-manage inputs and process allowing *little or no professional discretion*. This is particularly true in environments where there are few Agents.

There is also a perception by some injured workers and their doctors that rehabilitation professionals in these schemes are aligned to the Agent.

**INSURER UNDERWRITTEN AND ADMINISTERED**

Early Intervention

These schemes are also reasonably quick at claim determination which can allow for early rehabilitation intervention. They are also often ambivalent to the value of rehabilitation to the scheme so are more likely to delay referral. *It is only where time standards are built into these schemes that early intervention is achieved*.

Workplace Based

Insurers have a supplier / customer relationship with employers and so have a focus on delivering services at the worksite. Their ambivalence about the value of rehabilitation and the potential for rehabilitation to impact their relationship with their customers can lead to very tight controls on the style of service delivered. Clinical based services are often seen as a way of controlling inputs to customers and are used despite poorer outcome delivery.

On average *this scheme form achieves reasonable levels of workplace based intervention*.

Professional Autonomy

In these types of schemes Insurers will often do whatever they can to control the impact of service delivery on their customers so will *allow very little professional discretion*.

**SELF INSURED**

Early Intervention

Self Insurers often have in house rehabilitation providers that know about the injury before the claim is determined. A notable exception is Comcare that uses strict standards to ensure early intervention. *Self Insurers achieve the best levels of early intervention*. This level of early intervention is difficult to achieve in any other way and may not be translatable to other schemes.

Workplace Based

*Self insured rehabilitation is almost exclusively workplace based*. This scheme form understands the value of retaining a focus on the workplace if return to work is the primary outcome expectation of a scheme. It is often easier for self insured employers to understand the importance of training supervisors and managers to support injured workers in their recovery and return to work.

Professional Autonomy

There are varying levels of professional discretion allowed amongst self insurers and it is not universally accepted by these large employers whether it is best to focus on cost control and compliance, or to focus on recovery and restoration. While the former, the risk management approach, can sometimes cost the scheme less financially, employers using the rehabilitation approach often claim the same direct financial benefits together with greater workplace satisfaction, motivation and productivity, lesser accident rates, and less of a focus by injured workers on waiting for an offer to leave.

On average *this scheme approach delivers reasonable levels of professional discretion*.

There is also a perception by injured workers and treating medical experts that rehabilitation professionals in these types of schemes are too closely aligned with employers needs rather than those of the injured worker.

## CONCLUSION

From a rehabilitation perspective there is no obvious best form of scheme that can be translated to a national model. It is interesting to note that the Comcare scheme performs well when compared to State models but is far from the best performer of the self insured schemes.

No matter what scheme approach is adopted it is important to ensure that there are requirements to deliver “early intervention”, “workplace based”, and “professionally autonomous” rehabilitation services. Each approach requires systems that guarantee this best practise.