



Report:

**Review of Health Care Infrastructure:
SA WorkCover Corporation**

By

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EXECUTIVE SUMMARY

SECTION ONE: CONTEXT OF THE REVIEW

The new Board and CEO of WorkCover have identified significantly improved return to work rates and recovery times for injured workers as critical to managing a financially sustainable system which rehabilitates, compensates and returns injured workers to independence. There is good evidence that people who are injured and claim compensation have poorer health outcomes than people who have a similar injury, but do not claim compensation. There are, therefore, both ethical and economic imperatives to develop sound, evidence based strategies to improve health recovery and return to work for compensated injured workers.

Strategies which support health care providers to provide services in line with evidence of best practice are fundamental to achieving the desired outcomes. Embedding evidence into the everyday practice of health care providers is a challenge in health care, generally and there is no doubt that it is further complicated by the issues pertinent to compensated injuries. However, there is good evidence about what kinds of strategies are effective.¹

Compensation schemes in other jurisdictions have had significant success in reducing costs of care, improving recovery and return to work and reducing the longer term liability of the scheme through a strong focus on improving provider performance. The Victorian WorkCover Authority has established a Medical and Rehabilitation Division. The Accident Compensation Corporation in New Zealand (ACCNZ) has established a division known as “Healthwise” which has a similar function to the Victorian Medical and Rehabilitation Division. The success of Healthwise can be seen in the results. The “tail” cases are down from 30,000 to 14,000 and liability has decreased from \$11 billion to \$7 billion. The duration of compensation is down from an average of 56 days to an average of 35 days, but claimant satisfaction is up at an all time high of 86%. The ACCNZ is operating at a surplus of \$554 million.

The Motor Accident Commission in South Australia has developed a submission to Cabinet to establish a Centre for Trauma and Injury Recovery whose objectives are entirely consistent with the Board’s strategy. Given South Australia’s relatively small and fragile health workforce, it would be counter-productive if two separate approaches evolve to deal with best practice management of the same injuries by, essentially, the same group of providers. Some discussion of this is included in this Report.

The predominance of soft tissue injury with prolonged certification provides an opportunity for substantial improvement in management to occur with the associated benefits to the injured worker’s health, the liability, and to health care and compensation costs.

¹ Grol, R. and Grimshaw, J. (2003) “From evidence to best practice: effective implementation of change in patients’ care.” *Lancet* 362: 1225-30.

SECTION TWO: TERMS OF REFERENCE

The specific terms of reference for the review were as follows:

Using a multi-disciplinary approach that enables engagement from our key health care stakeholders:

1. Critically review the quality and effectiveness of current operations, strategy and structure of the Health Care Operations Unit (the Unit). Specific attention to be given to;
 - 1.1. Engagement strategies for interacting, communicating and consulting with health care professionals towards continuous quality improvement.
 - 1.2. The framework for and alignment of the benchmarking and regulation of fees to medical and allied health professionals.
 - 1.3. Monitoring and evaluation of health care provider performance and cost control outcomes.
 - 1.4. Access for injured workers both directly and through WorkCover claims agents and self insured employers to timely and appropriate health care.
 - 1.5. Education, training and consultancy services offered by WorkCover to health care providers.
 - 1.6. Administrative processes relating to the capture, collection and maintenance of information about health care providers in the system, payment of invoices and complaint management.
 - 1.7. Capacity for research and development in the area of health care provision and better clinical outcomes for injured workers.
 - 1.8. Formulation of WorkCover policy and guidelines regarding health care treatment products and services (for example to the use of Independent Medical Examiners).
 - 1.9. Change Leadership and structure requirements.
 - 1.10. Alignment and contribution to WorkCover's strategic directions and critical success indicators.
2. Recommend future strategy and opportunities for process and system improvements as identified in the course of the review.

SECTION THREE: THE REVIEW METHOD

1. Interviews were conducted with;
 - Staff of the Health Care Operations Unit. This included all the program managers.
 - Other staff of WorkCover who had experience or a history in Health Care Operations.
 - Other staff of WorkCover who necessarily interacted with the Unit's functions.

- The professional advisors for medicine and allied health and the claims managers of the insurance agents who provide the claims management function for WorkCover.
 - A range of health care providers and representatives of various health care provider associations.
 - Representatives from other similar organizations.
 - Researchers who undertake clinical costing and pricing studies.
2. Forums were convened including;
 - General Practitioners.
 - Medical Specialists (Orthopaedic surgeons, occupational physicians, rehabilitation physicians, psychiatrists, neurologist).
 - Allied health care providers (physiotherapists, occupational therapists, psychologists, chiropractor).
 - Non medical therapy providers (nursing, gym and physical support, rehabilitation, remedial massage providers).
 3. Various WorkCover documents were reviewed.
 4. Articles and publications pertinent to health care of compensation patients were reviewed.
 5. Websites of the Victorian WorkCover Authority, WorkCover Authority of NSW and the Accident Compensation Corporation of New Zealand were searched to determine the services and information available to providers and to consumers from other similar schemes.
 6. WorkCover data on health care utilization was analyzed.

SECTION FOUR: FINDINGS

Scope Limits:

Although case management was not within the scope of the Review, it has been necessary to make some observations and recommendations in relation to its improvement and on the nature of the contracting process with Agents, since it is the interface between WorkCover, the health care providers and their patients.

Current Role of the Health Care Operations Unit

Provision of Education Services

Undergraduate and Post Graduate Education

A key determinant of behaviour change towards best practice health care is education. The undergraduate education courses provided by the Unit for physiotherapy and medical students are highly valued by the Universities of South Australia and Adelaide. Agreement has been reached with the Flinders University for the Unit to provide input to the undergraduate medical course. Preliminary evaluation of the outcomes of the physiotherapy course would indicate a level of success in influencing the practice of newly graduated physiotherapists.² The undergraduate education strategy already in place is, therefore, worth continuing.

High quality educational resources, developed by the Unit, have not been strongly embedded into provider culture or practice in South Australia. The resources available for developing post graduate education on best practice compensation health care are out of step with the emphasis on development of best practice in other organizations with which WorkCover might benchmark. A re-allocation of resources to enhance this function might be considered.

Education for Case Managers

The education program for case managers reflects a process driven contract rather than a focus on best practice in health care and improved outcomes. If the contractual requirements of the Agents were based in the objective to improve recovery and health outcomes, it is questionable whether WorkCover should be responsible for providing the education program for case managers or, simply, for reviewing and contributing to the education programs run by the Agents themselves. It may be appropriate to review this function following improved contractual arrangements for case management.

Developing Best Practice

Developing Best Practice Case/Claims Management

There are serious deficiencies in the current case/claims management arrangements. Reports that satisfaction surveys conducted by the Agents have yielded patient

² Although the results are preliminary, a review of a strategy to educate undergraduate physiotherapists about issues pertinent to compensation patients has shown that those physiotherapists who participated in the program have lower levels of service provision and lower recovery times for the same type of injury compared to their post graduate counterparts who did not participate in the education program. This was in spite of their relative junior status. The difference in costs of service utilization for the same injury type was \$250,000 allocated over 11 physiotherapists.

satisfaction scores of 70% are very disturbing. The experience that a health care provider or an injured worker has with “WorkCover” may differ depending on the approach the Agent takes to case management. This means that WorkCover’s image and reputation amongst health care providers and injured workers is out of the control of WorkCover.

The current contracts with Agents inadvertently provide an incentive for the Agents to recruit lower cost junior staff and address any knowledge or experiential deficiencies by employing professional consultants or independent medical examiners to provide advice or intervention on complex cases. These extra resources are then recharged to WorkCover.

There is a fundamental paradigm clash between health care providers who see that their goal is to treat and care for their patient in the best way they can, and claims agents and employers who see that their goal is to ensure that the claim is legitimate and that the cost is minimized. Claims management activities aimed at checking the legitimacy of a claim are often seen as unnecessary and even counter productive by providers. They have described it as “busy work.” They report that case managers can drive activities which the scheme is ultimately paying for and which have the capacity to delay and even prevent recovery, thereby increasing the liability. A case management focus on improving health recovery times, return to work or community, as well as patient and employer and provider satisfaction would ensure that the clash of paradigms is addressed.

Industrial relations issues (including conflict in the work place and stigmatization following the injury) or lack of access to appropriate retraining can be serious obstacles to returning an injured worker to work. Despite this, the current criteria for compensation do not include payment for mediation services or expanded retraining services.

Best practice models of case management should be developed with input from the Unit, the Agents, the consumers and the provider associations with the focus being on accountability for outcomes as well as process. The contract with the Agents should be based in a philosophy of partnership and gain sharing. It should ensure that incentives are aligned to best practice in relation to service provision and recovery and return to work and community. It should include agreement about collaboration on strategies to improve provider performance and recovery outcomes in major injury groups.

Developing Best Practice Health Care

Most health care providers consulted are aware that WorkCover has the right to review their service data and to call people to account for abnormal service patterns. However, there are a range of views about the approach currently taken, with some people viewing the process as intimidating. Although the existing process is relatively useful in supporting practice change amongst health care providers whose patterns are outside the norm, there is broad agreement that a more pro-active focus on developing and disseminating evidence on effective treatment and facilitating and supporting provider peer review and education, both through the existing professional associations and through the Unit itself, is required in South Australia.

A number of specialist providers consider the current performance review process as problematic. It is outside the standard quality processes of the various professional bodies. Models of quality review and practice improvement, which are based in the existing quality processes of the various provider associations, divisions of general practice and colleges, could be further developed.

The independent medical examination has very little credibility amongst providers and is regarded as “busy work” by many. There is a need for review of policy and procedures for its use.

The Unit’s work to establish skill and knowledge standards for various professional groups in the area of compensation health care has been a useful way to engage the professions in the issues as well as to ensure the longer term capacity of the professions to respond to the issues pertinent to compensated health care. This activity should be continued.

Some very useful projects to support best practice have been discontinued or not properly resourced. It is important to select a small number of high yielding projects and to stick with them, evaluating continuously, developing and enhancing the programs on the basis of the evaluation and informing stakeholders of progress.

General practitioners and medical specialists in South Australia point out that the credibility of evidence and guidelines for practice in relation to compensation health care would be enhanced by its independence. There is an inherent difficulty with WorkCover or the claims agents being seen to be controlling this activity since they have a vested interest (in keeping costs and the liability down) which may be at odds with the best care.

It is important for the staff of the Unit to be a part of mainstream health care and to be abreast of the various quality initiatives across the nation and internationally.

Remuneration of Health Care Providers

There are significant problems with the existing process for determining remuneration for health care providers. For almost all provider groups, there is no agreement about the base line, no agreed parameters for measuring price and no defined period within which the discussions will be resolved. Furthermore, there is disagreement by the providers about the data and the various interpretations used by WorkCover to reach conclusions about fees. The process is unduly long with at least six layers of approval required after the Unit completes a fee review and develops a proposal.

Health care providers complain that WorkCover has a “bullying” attitude in that the legislation only requires WorkCover to consult, not to negotiate. The only power the provider groups have is to withdraw service. The processes around caring for compensation cases are generally complex and time consuming. Since health care providers are not remunerated in accordance with that complexity, some provider groups are no longer taking compensation referrals, leading to the creation of a second tier of access, with injured workers significantly disadvantaged. The impact of this lack of access is to increase the time to recovery and to increase the compensation paid.

Remuneration is a key strategy in providing incentives for best practice care. Yet it is not used strategically to control outcomes and reduce the overall costs to WorkCover. Health care provider associations in South Australia are very keen to explore the potential for performance based incentives. However, they point out that they are now so underpaid for basic service that they are not prepared to discuss more refined models until the base payment issue has been addressed. A short term strategy to address the current access issues is required. However, a longer term strategy which develops the full potential of remuneration as a key strategy in reducing overall costs to WorkCover is also required.

The nature of the expertise required to study costs, model incentive options and develop the proposals for fee structures is outside that of the staff of the Unit and more in keeping with those of health care financing experts. Whilst it is essential for those staff who are knowledgeable about best practice to contribute to funding policy discussions and decisions, it may be more cost effective for WorkCover to commission a collaborative study using health financing experts to undertake periodic remuneration studies.

Information Management and Payment of Accounts

The provider payment system provides a database of services provided and their cost for each claimant. There are staff concerns about the quality of the data entered by the Agents. This has been corroborated by health care providers who have received duplicate payments or no payment at all. Furthermore, the system is inefficient, requiring double entry of some of the data to ensure appropriate payment.

A requirement to undertake effective quality management of the data should be incorporated in the contracting arrangements for Agents. The accuracy of the data and the ongoing review processes should be a major priority for audit and risk management functions within WorkCover.

If WorkCover is to develop a stronger focus on improving health care outcomes and return to work status through improving the quality of the care of providers and the management of claims, a sound evaluative framework will be required. More information is required about the provider (eg demographics of the provider, nature of education or resources used or undertaken, quality activities undertaken, etc) as well as the claimant (health outcomes, functionality, return to work). The existing system will require modification or enhancement to achieve this.

Other Roles to be Developed

Research and Development

It makes economic sense to analyze the effectiveness of some therapies, technologies and models of service provision or case management before there is agreement to expand their use. An enhanced capacity for research and evaluation is, therefore, required within the Unit.

Public Communication and Consumer Information

There is now very good evidence in mainstream health care that the more informed a patient is about his/her illness and treatment processes, the more appropriate his/her expectations and participation in care which, in turn, has a positive impact on health outcomes and satisfaction levels. Consumer information has been a major strategy to promote optimum health in almost all spheres of health care. A stronger focus on public and consumer information is required to heighten knowledge about the WorkCover process and about the injuries, their treatment and self care opportunities.

Structure to support improved health recovery

Observations on issues regarding organizational and structural issues in relation to health provider support and systems are provided in a supplementary report to WorkCover.

SECTION FIVE: ORGANIZATIONAL AND STRUCTURAL ISSUES

A Supplementary report has been provided to the Management of WorkCover. The Report makes observations and recommendations regarding the structural and organizational arrangements required to support the improvements recommended in this Report

SECTION SIX: CONCLUSION

A strong focus on improving health care provider performance in caring for injured workers has the potential to yield significant improvements in the liability as well as in the care and experience of patients and providers. These improvements are already being experienced in other jurisdictions. WorkCover would be well advised to seek assistance from these areas in developing the strategies outlined above. National forums and processes to share information and approaches would advance progress by reducing the potential to re-invent wheels within the Corporation. For example, a study of fee relativities is already being undertaken in Queensland. The study might be expanded to incorporate South Australia.

The staff of the Unit have expertise and experience which should not be lost to this area. They have fully cooperated in the process of this Review and support the broad directions outlined. They require effective organizational support, clarity in relation to the key issues to pursue and strong sustained leadership over two to three years to make a long term difference.

SUMMARY OF RECOMMENDATIONS

Recommendations: Improving Education

1. Continue with the investment in undergraduate education and continue to evaluate the performance of graduates in relation to their knowledge of the system, and their compliance with best practice, their service patterns and outcomes, their participation in relevant post graduate education.
2. Increase the resources available for post graduate education. A flexible budget would be more appropriate than increasing the existing sessions. This enables the purchase of particular expertise for particular projects as required and acknowledges that projects may be of differing durations and that some of the required expertise may be additional to that already available in the Unit.
3. Establish a multi-disciplinary Education Advisory Group comprising representatives of provider groups to provide advice on strategies and approaches to education, provision of information and ways to improve access to education.
4. Develop an education strategy to raise awareness and skills of providers in the treatment and rehabilitation of injuries which are known to provide the largest opportunity for improvement. Components of the strategy should include the development of materials, seminars, information links and web based materials, workshops, sponsorships etc consistent with the objectives of improving practice in those high yielding areas.
5. Increase the profile of WorkCover priorities for injury management improvement by liaison with the provider associations, development of public relations material, provision of sponsorship for seminars etc.
6. Review the current provision of education for claims managers and the potential to shift to regularly reviewing agent education programs. Consider re-allocating the resources currently engaged in education for claims managers to professional education. (See recommendations relating to improving case management below.)

Recommendations: Improving Case Management

1. Over the next 6 months, initiate a study, with the participation of case managers, Agents, relevant providers, employer and consumer representatives, which;
 - Analyses the current case management processes and identifies the major obstacles to effective and efficient care for injured workers who have injuries known to provide the largest opportunity for improvement.
 - Develops re-engineered options for case management which can facilitate improved health care treatment and recovery times, as well as satisfaction for

- those injuries known to provide the greatest opportunity for improvement in recovery time and health outcome.
- Identifies the organizational supports required for the options for case managers (eg seniority of case managers, roles of consultants, role of WorkCover, role of providers, HR strategies including recruitment and selection strategies and training and development processes etc).
2. Jointly develop an outline for the training of case managers in keeping with models to be used by the Agents.
 3. On the basis of the results of the study, develop pilots and agreements with Agents to implement the models;
 - Agree on the kinds of supports required to increase the effectiveness of the models (eg seniority of case managers, roles of consultants, roles of WorkCover, role of providers, HR strategies including recruitment and selection strategies as well as training and development processes etc).
 - Agree on an evaluative framework and information requirements to monitor progress.
 - Agree on a quality framework and a process for continuously evaluating outcomes including return to work, recovery, satisfaction of both providers and injured workers, satisfaction of case managers etc.
 - Agree on processes to improve communication and partnership between the Agents and WorkCover.
 - Develop and model options for gain sharing (based on improving health outcomes and recovery times) to be built into the contract financial arrangements.
 4. Build these agreements into the contract ensuring that the incentives are aligned to improvements in outcomes as well as best practice process.
 5. Once models of case management and associated supports are agreed and contracted, review the current provision of education for claims managers and assess the potential to shift to regularly reviewing agent education programs in keeping with the agreed evaluation framework.

Recommendations: Improving Health Care

1. Establish a multi-disciplinary quality advisory group with representation from professional associations and colleges. The Group's role would be to advise on the quality improvement program, on the ways to improve the participation of relevant health provider groups in developing strategies to improve injury management and to facilitate liaison between the program and the various professional association and college programs.
2. Identify those areas of injury management which have the greatest potential for improvement.
3. In collaboration with the relevant provider organizations;

- Identify whether there are existing evidence based guidelines around the priorities and consult on their appropriateness amongst the relevant provider groups. Where there are none, undertake literature reviews to identify what evidence is available about treatment and outcomes.
 - Draft or review evidence based guidelines and consult amongst provider groups.
 - Identify the information required to monitor and evaluate the application and effectiveness of the guidelines and determine the best methods to collect and monitor the information.
 - Develop an education program to increase knowledge of the guidelines. This should be part of the recommended post graduate education program.
 - Develop an evaluation program to continuously monitor the effectiveness of the strategies.
4. In collaboration with the relevant health care provider organizations, establish and/or support the operations of special interest groups and peer review programs specifically aimed at improving treatment and care of compensated injuries;
 - Agree on the information required to support the program, (eg service utilization and outcome profiles for all participating providers, information on patient profiles for each participating health care provider).
 - Agree on the approach to review (ie case discussions, open disclosure in interest groups etc).
 - Agree on the approach to individual support (mentoring, education sessions etc).
 - Agree on frequency and process for engaging providers.
 - Agree on the roles of the health care organizations vis a vis the role of WorkCover.
 5. In collaboration with provider organizations, establish a panel of allied health experts, consistent with those established in Victoria, NSW and New Zealand, to review and assist those providers whose health care is considered to require particular improvement.
 6. Establish an on-line quality consultation service to provide advice to health care providers who have enquiries about injury management. This would require increased specialist consultant time and would expand the telephone consultation service already available.
 7. Establish on-line educational material on best practice models of care and treatment.
 8. In collaboration with relevant provider organizations, establish “flags” to assist case managers to identify, as early as possible, those providers who might need assistance. Ensure that the protocols for contacting and supporting providers who have been identified are appropriate and non confrontational.
 9. In collaboration with relevant provider organizations, establish policy and procedures for identifying, supporting and addressing over-charging or over-servicing behaviour. Establish a process to continually review the process.
 10. Undertake a review of cases to determine how many longer term compensation claims are related to industrial relations issues rather than quality of care issues and

identify cost effective models of intervention. This should be undertaken in partnership with employer, union, and consumer stakeholder representatives.

Recommendations: Improving the Payment System and Information Management

1. Undertake an urgent audit of the accounts payable process including that part of the process for which the insurance agents are responsible. The audit should identify the risk points and determine risk management strategies to ensure that the information system and payment process is accurate and timely. Risk management requirements and data quality processes should be incorporated into the contracting arrangements for Agents. Following the audit, consideration might be given to relocating the administration and maintenance of the provider payment system to the funding and revenue group.
2. Establish an evaluation framework which outlines the information required to effectively evaluate the quality, education and consumer information strategies implemented to improve provider performance in terms of recovery and return to work or the community.
3. Using the evaluation framework as the basis for review, identify the existing data sources and any deficiencies or gaps in the information already available.
4. Establish a project to enhance the existing information systems, either through modification or the development of additional tools, to ensure effective input to recommended quality and evaluation processes and to ensure efficiency of the system.

Recommendations: Improving the remuneration strategy

1. Advise the Ministerial Advisory Committee on Worker's Compensation and Rehabilitation on the issues outlined and begin discussions with the Minister in relation to the inadequacy of the current legislation relating to fees (Section 32 of the Act) and the need for immediate remedial steps to prevent withdrawal of access to services by some key providers.
2. Develop a proposal for a short term agreement to raise fees for those organizations which are threatening to withdraw services and those whose fees will need to be reviewed over the next 12 months.
3. Establish a high level communication channel between health care providers and Senior Management of WorkCover with a view to;
 - Understanding the position of the providers.

- Developing some agreement about the way forward in both the short term and long term.
4. Commission a program of independent studies to establish service items, costs and potential policy options to ensure that funding is aligned to best practice. These studies should be conducted by credible independent consultants, appropriately experienced and skilled in health care financial analysis and modeling. Each should be managed by a steering group comprising WorkCover officers and credible provider representatives who can ensure that the quality of the data and the methods of review are appropriate. The studies should address;
 - The nature of the service items known to be associated with best practice in the major areas of injury addressed by WorkCover.
 - The nature of the items of service provided to WorkCover patients currently.
 - The extent to which the current funding schedules provide for these services (eg through appropriate categorization and through the adequacy of payment).
 - The cost of providing these services (using agreed benchmarking and clinical costing techniques).
 - Trends in cost increases for the services over previous years (to assist with discussions on indexation).
 - Approaches to funding arrangements which maximize best practice service provision.
 5. Establish a rolling program of fee reviews over a five year period which includes all provider groups. The program should be managed by the General Manager responsible for the Workplace Injury Group or the General Manager responsible for policy and strategy with input from the Chief Financial Officer and the Unit. This reflects the key role of remuneration in strategy and ensures the alignment of the process with the strategic directions of WorkCover. It ensures that the focus of the Health Care Operations Unit is on best practice development rather than fee negotiations.
 6. Undertake fee reviews which should include;
 - Evaluating the impact of previous fee structures and agreements on health care provision.
 - Modeling policy options in relation to fees for each provider group based on best practice using the outcomes of the study (as outlined above) as a baseline.
 - Modeling indexation options for a 3-5 year period.
 - Developing draft fee proposals (consistent with the baseline study, the best practice incentives required, the indexation for the next 3-5 years) for negotiation with each provider group.

Recommendations: Improving Research and Development

1. Develop a policy on research and development consistent with strategic priorities and allocate a research and development budget, part of which should be allocated to health provider support.

2. Establish a multi-disciplinary Research and Development Advisory Group comprised of provider representatives, employer representatives, employee representatives, and consumer representatives who have experience and expertise in research. The group should;
 - Advise on the development of a research and development plan which is in keeping with the strategic plan of WorkCover.
 - Advise on processes for inviting submissions from staff of WorkCover and, where appropriate, from external organizations capable of undertaking the required research or developmental work.
 - Advise on the process for application and selection of research and development projects, ensuring that the process addresses criteria relating to expertise of the researchers to undertake the work, appropriateness and ethics of the method, potential to address priority questions to improve the health outcomes for injured workers, and maximum participation by relevant stakeholders.
 - Review applications and select projects in keeping with the policy and plan.
 - Monitor the progress of the research projects.
 - Receive reports on research outcomes and advise on ways to ensure that information about research results are disseminated to appropriate stakeholders.

3. Appoint a Research and Development Team Leader (from within existing EFT) with expertise in research and grants administration to;
 - Undertake the work as outlined above and support the activities of the Research and Development Group.
 - Identify sources of funds which could be tapped to enhance the funding available for research and development in line with strategic priorities.
 - Liaise with staff, providers, case managers and employers.
 - Educate and support staff in relation to developing appropriate proposals for research and development funding.
 - Report on the progress in implementing the research and development plan.
 - Undertake developmental and evaluation projects relevant to the questions and issues pertinent to improving provider performance and injury recovery.

Recommendations: Improving Consumer and Public Information

1. Establish a Consumer and Community Advisory Group with representation from appropriate consumer advocacy organizations, community health organizations with expertise in dealing with relevant cultural groups, consumer representatives and worker representatives to;
 - Provide advice on consumer information requirements in relation to worker's compensation.
 - Ensure that all injury priorities for WorkCover have relevant educational information available for injured workers.
 - Provide advice in relation to the requirements of the community generally about injury and evidence.
 - Provide advice in relation to style and media most appropriate to reach the audiences.

- Assist with reviewing draft information and other personal education and information strategies.
2. Appoint a Communications Team Leader (from existing EFT) who is experienced in developing health promotion materials and public information strategies, to work within the Unit. This person would be responsible for ensuring the quality and accessibility of educational and information material, appropriate methods for dissemination of material and continuous review, and improvement of the materials available for both professionals and injured workers.

SECTION ONE:

Context of the Review: The Case for Health Care Management

In an economic environment of an increasing compensation liability and increasing health care (and other) costs, the new Board and CEO of WorkCover Corporation have reviewed the Corporation's mission, vision and critical success factors. It has identified significant improvement of return to work rates and recovery times for injured workers as critical to fulfilling its role as a manager of a financially sustainable system which rehabilitates, compensates and returns injured workers to independence.

The economics and the ethics of this direction are sound. Provider costs have increased across all groups. Medical service costs have increased by 7.4%, allied health service costs by 12.8% and "other" service costs by 22% over the last three years (to 2004/5). A 63% increase in rehabilitation services is the subject of a separate review project. These cost increases do not appear to be associated with major improvements in return to work or recovery times. Furthermore, there is good evidence that people who are injured and claim compensation have poorer health outcomes than people who have a similar injury, but do not claim compensation.

1.1. The Evidence

Attempts to ensure that health care is based in evidence of best practice will reap benefits both to WorkCover and the injured worker, particularly if the focus is on those injuries where there is greatest variation between care for compensated and non compensated patients, despite predictability in the course of treatment and outcome.

There is no single cause of poorer health outcomes for compensable cases. Research has identified some of the causes, starting with the injured person themselves and extending to the work and care environment and still further to the legal and social environment (eg the psychosocial environment of the injured person at the time of the injury and after the injury, his/her psychological, educational and socio-economic profile, the initial response to the claimant by the employer and then the insurance agent, the management of the treatment, the handling of the case management, the impact of legal activities, and time away from work and its psychological impact.) It is likely that a complex interaction of these factors leads to poorer health outcomes.³ Multi-faceted strategies are therefore required to address all the issues.

Embedding evidence based protocols or guidelines into the everyday practice of health care providers is a major challenge in health care, generally and it is further complicated by the issues pertinent to compensated injuries. However, there is good evidence about

³ A good summary of the relevant literature is contained in "Compensable Injuries and Health Outcomes" published by the Australasian Faculty of Occupational Medicine, the Royal Australasian College of Physicians, Health Policy Unit, Sydney 2001.

what kinds of strategies work.⁴ The literature surrounding the impacts of “managed care” in the United States⁵ and of quality improvement initiatives in hospitals in Australia and overseas demonstrates that it is possible to substantially alter care in line with evidence of best practice. These initiatives have significantly reduced unnecessary service utilization and associated costs as well as improved recovery rates and times. There is also evidence from WorkCover in South Australia of success in influencing physiotherapists’ behaviour in line with best practice for soft tissue injury.⁶ Lessons learned from the Commonwealth Department of Health Coordinated Care Trials and from a range of disability management programs⁷ would indicate that improved care coordination for complex patients who require regular care from specialists, allied health care providers and their GPs has the potential to improve health outcomes, reduce hospitalization and its associated costs, and improve the satisfaction of the patients.

1.2. Some Benchmarks

Injury compensation schemes in other jurisdictions have had significant success in reducing costs of care, improving recovery and return to work and reducing the longer term liability of the scheme through a strong focus on provider performance improvement. The Victorian WorkCover Authority has established a Medical and Rehabilitation Division whose main role is to improve the performance of health care providers. Its focus, in its first phase of action, is on allied health service provision in long term cases. A “Clinical Framework for the Delivery of Services to Injured Workers” has been established. The Framework, setting out the principles and the approach expected of allied health care workers, forms the basis of review, monitoring and service improvement strategies. The strategy has been developed with maximum participation from the provider groups and is supported by them. In 12 months, physiotherapy utilization has reduced by 24% using this approach.

The Accident Compensation Corporation in New Zealand (ACCNZ) has established a division known as “Healthwise” which has a similar function to the Victorian Medical and Rehabilitation Division. Its role is to; develop relations with health service providers, define service delivery models, develop service specifications and standards, construct purchasing frameworks, plan and support the implementation of frameworks, identify and encourage best practice, monitor delivery patterns and variance and identify optimizations in purchasing frameworks. The strategy has contributed to a reduction in the “tail” cases from 30,000 to 14,000 and a decrease in the liability from \$11 billion to

⁴ Grol, R. and Grimshaw, J. (2003) “From evidence to best practice: effective implementation of change in patients’ care.” *Lancet* 362: 1225-30.

⁵ Steiner, A. Robinson, R (1998) *Managed Health Care*. Open University Press.

⁶ Although the results are preliminary, a review of a strategy to educate undergraduate physiotherapists about issues pertinent to compensation patients has shown that those physiotherapists who participated in the program have lower levels of service provision and lower recovery times for the same type of injury compared to their post graduate counterparts who did not participate in the education program. This was in spite of their relative junior status. A preliminary estimate of the difference in costs of service utilization for the same injury type was \$250,000 allocated over 11 physiotherapists.

⁷ Eg Harder, H. and Potts, L. (2003) *Disability Management: The Insurance Corporation of British Columbia Experience*. *Pain Res Manage* Vol 8 No2 Summer. See also “Compensable Injuries and Health Outcomes” published by the Australasian Faculty of Occupational Medicine, the Royal Australasian College of Physicians, Health Policy Unit, Sydney 2001.

\$7 billion. The duration of compensation is down from an average of 56 days to an average of 35 days, but claimant satisfaction is at an all time high of 86%. The ACCNZ is operating at a surplus of \$554 million.

1.3. The Opportunity for South Australia

Clearly a strong focus on improving health care and recovery can have a significant impact on reducing liability and decreasing costs to the scheme in South Australia. A study commissioned by the South Australian Motor Accident Commission (MAC) concluded that at least 5% could be saved from the total amount of MAC claims for soft tissue injury and was confident that 10%-12% savings would be possible in the longer term.⁸

A review of injuries treated by practitioners who managed 50 or more claims in 2001-2002 undertaken by professional consultants of WorkCover in 2004 found that 78% of all WorkCover claimants who were provided with certification for absence from work were still receiving certification 6 weeks later and 57% were still receiving it 13 weeks later. This is despite the fact that 73% of all WorkCover claims were for soft tissue injury which is known, generally, to have a maximum healing time of 6 weeks. The predominance of soft tissue injury with prolonged certification provides an opportunity for substantial improvement in management to occur with the associated benefits to the injured worker's health and to health care and compensation costs.

A further review of a selected group of soft tissue injury claims occurring in 2002 would indicate that an effort to bring certification into line with what is known about general recovery rates for this injury group has the potential to yield savings of up to 20% of income maintenance claims. The review found that the 40 general practitioners with the highest WorkCover case load (and therefore presumed to be more familiar with the injury types and their management) provided certificates for 29% of their patients compared with other general practitioners who had a certification rate of 37%. Of these 40 "more experienced" practitioners, the highest rate of certification of their patients was 86% while the lowest was 14%. It is impossible to conceive that differences of this magnitude are a result of different case mix. The conclusion is that there is a huge potential to reduce this variation by improving the knowledge and performance of general practitioners.

The evidence, as outlined above, makes it clear that the Board's decision to focus on managing health care more closely is a sound strategic priority for WorkCover.

⁸ Motor Accident Commission Medical Management Project Final Report (2003), University of South Australia, Division of Health Sciences, and the Adelaide University Department of General Practice.

SECTION TWO:

Terms of Reference

The specific terms of reference for the review were as follows:

Using a multi-disciplinary approach that enables engagement from our key health care stakeholders:

1. Critically review the quality and effectiveness of current operations, strategy and structure of the Health Care Operations Unit (also known as the Provider Systems Unit). Specific attention to be given to;
 - 1.1. Engagement strategies for interacting, communicating and consulting with health care professionals towards continuous quality improvement.
 - 1.2. The framework for and alignment of the benchmarking and regulation of fees to medical and allied health professionals.
 - 1.3. Monitoring and evaluation of health care provider performance and cost control outcomes.
 - 1.4. Access for injured workers both directly and through WorkCover claims agents and self insured employers to timely and appropriate health care.
 - 1.5. Education, training and consultancy services offered by WorkCover to health care providers.
 - 1.6. Administrative processes relating to the capture collection and maintenance of information about health care providers in the system, payment of invoices and complaint management.
 - 1.7. Capacity for research and development in the area of health care provision and better clinical outcomes for injured workers.
 - 1.8. Formulation of WorkCover policy and guidelines regarding health care treatment products and services (for example to the use of Independent Medical Examiners).
 - 1.9. Change Leadership and structure requirements.
 - 1.10. Alignment and contribution to WorkCover's strategic directions and critical success indicators.
2. Recommend future strategy and opportunities for process and system improvements as identified in the course of the review.

SECTION THREE:

The Review Method

1. The central questions addressed have been;
 - What role is currently undertaken by WorkCover to improve provider best practice and the earliest possible recovery and return to work or the community?
 - What resources are used?
 - What issues facilitate or inhibit maximum effectiveness and efficiency in performing the role?
 - What role/s should be undertaken?
 - What strategies are essential to support provider best practice and the earliest possible recovery and return to work or the community?
 - What resources are required?
 - How should they be organized?

2. Interviews were conducted with a particular focus on the questions outlined above. The interview schedule included;
 - Staff of the Health Care Operations Unit. This included all the program managers.
 - Other staff of WorkCover who had experience or a history in Health Care Operations.
 - Other staff of WorkCover who necessarily interacted with the Unit's functions.
 - The professional advisors for medicine and allied health and the State Managers of the insurance agents who provide the claims management function for WorkCover.
 - A range of health care providers and representatives of various health care provider associations: These included;
 - The Physiotherapy Association
 - The Australian Medical Association (SA Branch)
 - The Institute of Private Practicing Psychologists
 - Occupational Therapy Australia (SA Branch)
 - Remedial Massage Therapists
 - Gymnasium and Hydrotherapy Providers
 - Rehabilitation Providers
 - Private Hospitals Association (SA)
 - SA Divisions of General Practice
 - Independent Medical Examiners Group
 - Department of Health SA
 - Orthopaedic surgeons
 - Psychiatrists
 - Neurologists
 - Occupational physicians
 - Rehabilitation physicians
 - Representatives from other similar organizations such as;
 - The Victorian WorkCover Authority Health Provider Division
 - The WorkCover Authority of NSW

- Accident Compensation Corporation of New Zealand
 - Representatives from the South Australian Motor Accident Commission Medical Management Project
 - Representatives of health insurance companies
 - Representatives of the Self Insurers of South Australia
 - Researchers who undertake clinical costing and pricing studies.
7. Forums were convened including;
 - General Practitioners.
 - Medical Specialists (Orthopaedic surgeons, occupational physicians, rehabilitation physicians, psychiatrists, neurologist).
 - Allied health care providers (physiotherapists, occupational therapists, psychologists, chiropractor).
 - Non medical therapy providers (nursing, gym and physical support, rehabilitation, remedial massage providers).
 8. Various WorkCover documents were reviewed including reviews undertaken in the past three years.
 9. Articles and publications pertinent to health care of compensation patients were reviewed.
 10. Websites of the Victorian Workcover Authority, Workcover Authority of NSW and the Accident Compensation Corporation of New Zealand were searched to determine the services and information available to providers and to injured workers from other similar schemes.
 11. WorkCover data on health care utilization was analyzed.

SECTION FOUR:

Findings

4.1. Preliminary Comments

4.1.1 *Scope limits: case management and rehabilitation coordinators*

Although a focus on case management was not originally within the scope of the Review, it has been necessary to make some observations and recommendations in relation to its improvement and on the nature of the contracting process with Agents. It is the case manager who is the interface between WorkCover, the health care providers and their patients. It is not possible to improve support to providers without the Agents and case managers involved and engaged as active partners in the strategies.

Rehabilitation services are the subject of another review and not within the scope of this Review. However, rehabilitation coordinators have been identified, by almost all health care providers, as causing confusion in the process of care and possibly prolonging the processes of recovery. It is important to ensure that a focus on the role of rehabilitation providers is not lost by the recent decision to move responsibility for the management of the Rehabilitation contracts from the Unit. The fact that the responsibility for the Rehabilitation contracts rests with the General Manager for Workplace Injury, who is also responsible for the Unit, is acknowledged.

4.1.2 *Participation structures*

A common claim by external people was that WorkCover works in isolation from the groups who are most affected by its policies and procedures. A style of project development, which relies on early workup by the Unit and consultation amongst other stakeholders after the fact, is not sufficient to ensure that strategies can be accepted and implemented by those most able to influence health care outcomes. Provider groups appreciate the partnership approach to working, which the Unit uses to develop education materials and processes. To facilitate improved recovery time and return to work or the community for injured workers, the Unit will need to influence the behaviour of claims agents, of employers, of health care providers and injured workers. It can only do this by using a collaborative and participative style similar to the approach it has taken in developing its educational programs.

A number of providers have referred to the effectiveness of “advisory groups” which had been in place some years ago, but which have not been convened for many years now. They reported that such groups facilitated mutual learning and improved relationships across WorkCover and other key provider groups. The recommendations of this Review have included the establishment of “advisory” groups to assist in the development of

strategies and even in the implementation of strategies. These advisory groups may be formed for early development and then convened less frequently to assist with ongoing review and improvement.

4.1.3 Potential for collaboration at National and State levels

The issues identified by this Review are not uncommon to other areas of compensation health care. Many of the recommendations might be implemented in collaboration with other compensation schemes in Australia. The development of effective information and evaluation frameworks, the development of effective remuneration strategies to better control quality and cost of care, and the development of education packages for providers and consumers are all relevant to all jurisdictions of compensated health care provision in Australia. Efficiencies might be gained by sharing projects across jurisdictions. The CEO may choose to raise these issues at national forums of compensation schemes.

In South Australia, the Motor Accident Commission (MAC) has proposed the development of a separately incorporated Centre for Trauma and Injury Recovery which will undertake activities aimed at improving recovery and return to work or the community for people injured in motor accidents. MAC argues that these quality and health improvement functions are more cost effective when they are conducted at arms length from the insurer and are separated out from both the medico-political and policy issues concerning fee negotiation and associated matters and from provider contract management functions. Many of the issues the Centre will be addressing are the same as those identified in this Review. It will be appropriate for WorkCover Management to consider the best option for ensuring collaboration with MAC. Within South Australia, with its relatively small and fragile health workforce, it would be counter-productive if two separate approaches evolve to deal with best practice management of the same injuries by, essentially, the same group of providers. Some discussion of this is included in this Report.

This section briefly describes the health provider support functions, as they are currently performed and outlines the consultant's observations in relation to the critical success factor of improving recovery times and return to work. Following presentation of these observations, recommendations to improve the function are outlined.

4.2 Current Role of the Health Care Operations Unit

The current Unit functions are, essentially; to establish fees for the various services provided to injured workers; to educate health care professionals (both graduate and undergraduate), claims managers and employers in relation to compensation injury issues and best practice; to monitor health service provision and investigate patterns of service provision which are "outliers" in relation to what is known is required for various injury types; to manage relationships and communicate effectively with health care providers about WorkCover and compensated injury issues and; to improve the quality of service provision in line with best practice. This latter function involves assessing procedures

and therapies for potential payment and developing and evaluating models of care, guidelines, and a range of strategies to assist in their utilization by health care providers. The Unit also accredits and contracts some providers (eg Rehabilitation service providers and Independent Medical Examiners) and investigates complaints about providers.

On the surface it could be argued that the roles outlined above are exactly what is required to be effective in improving health care provider performance. However there are a number of issues which detract from the success of the Unit in fulfilling these roles which will be discussed in detail following a description of how the Unit approaches the tasks.

4.2.1 Provision of Education Services

Until recently, the Unit has included an Education Team comprising a full time Program Manager, 2 FTE Training Officers and an Education Support Officer. Its role has been to develop and deliver an education program to claims managers employed by the Agents contracted by WorkCover to provide a claims management service and to support the development and implementation of professional education programs developed by the Allied Health and the Medical Teams. Professional education programs include post graduate seminars and courses developed in collaboration with various provider associations as well as undergraduate education for physiotherapists at the University of South Australia and for medical students at the University of Adelaide.

Following the most recent restructure, the two education officers, primarily responsible for the claims management education function, have been structurally realigned to the section of the Workplace Injury Division which deals directly with the Agents. Some observations in relation to all education functions are outlined below.

4.2.1.1 *Well regarded undergraduate education*

The undergraduate education courses for physiotherapy and medical students are highly valued by the Universities. The Unit contributes to medical education at the University of Adelaide in 1st, 3rd, 4th and 6th year of undergraduate training as well as in the registrar training program. Agreement has also been reached with the Flinders University to have input on worker's compensation health care for its medical undergraduate students. This is exemplary and provides the potential to significantly impact all future South Australian trained doctors.

Whilst it could be argued that the return on the investment in undergraduate professional education is slow, preliminary evaluation of the outcomes for physiotherapists who have participated in undergraduate education on worker's compensation health care would indicate a level of success in influencing the practice of newly graduated physiotherapists.⁹ The evidence from evaluations of efforts to change the practice of

⁹ Although the results are preliminary, a review of a strategy to educate undergraduate physiotherapists about issues pertinent to compensation patients has shown that those physiotherapists who participated in the program have lower levels of service provision and lower recovery times for the same type of injury

medical specialists in hospitals has demonstrated that it is much easier to develop compliance with best practice protocols amongst younger doctors than amongst the consultants who have been practicing in their own pattern for a longer time. Therefore the undergraduate education strategy already in place is worth continuing and, if possible, enhancing.

4.2.1.2 *Insufficient resources for post graduate and continuing education*

The role of the Unit in developing and delivering post graduate education is more complex. WorkCover works collaboratively with health provider associations to develop content for the associations' existing continuing education programs, where the associations have identified compensation health care as a priority. These collaborative projects have included seminars for physiotherapists, support for the Occupational Therapy Association's program on upper limb injuries and ergonomic design in the workplace and home. It is possible that a more pro-active approach from WorkCover (eg the sponsorship of special interest groups within the associations, sponsorship of seminars, development of fact sheets etc) would increase the Associations' perceived priority of the issues.

Other materials developed to educate and support providers have included the Workplace Injury training modules for use by the Royal Australian College of General Practitioners, the guidelines for Independent Medical Examiners, programs to educate medical practitioners in the use of electronic prescribed medical certification and the Allied Health Reference Guide designed to assist health care providers to understand and use the worker's compensation and WorkCover systems.

In addition to these specific projects, a number of communication mechanisms are in place to keep providers up to date with issues as they arise. These include the "Newslink" which goes out to all registered medical providers twice a year and briefing notes which are sent out to all case managers and allied health care providers to provide information on new policies and issues. It would appear that these activities have not been formally evaluated and are not particularly well resourced. Providers indicate that they would appreciate more information, in accessible formats, about dealing with WorkCover patients, what the Act means, what the procedures are, where to get help etc. Collaboration with the various provider associations in continuous review and improvement of the strategies would ensure ongoing effective use of the resources.

Best practice guidelines already developed include the management of occupational stress, pain and lower back injury. Educational backup to assist in implementing these guidelines into practice in South Australia was provided in collaboration with the AMA and was rolled out through Divisions of General Practice and General Practice Groups. Despite this good start, it has been a number of years since the Unit has facilitated education programs amongst providers to support guidelines on best practice.

compared to their post graduate counterparts who did not participate in the education program. This was in spite of their relative junior status. The preliminary estimate of difference in costs of service utilization for the same injury type was \$250,000 allocated over 11 physiotherapists.

A key determinant of provider behaviour change towards best practice is education. However, the resources available for developing post graduate education on best practice guidelines are insufficient and out of step with the emphasis on development of best practice in other organizations with which WorkCover should be benchmarking. The health provider consultants who are employed in the Unit spend a large component of their time in the discussions on fees, the review of cases referred by the case managers, the performance review of providers and responding to internal and ministerial requirements. Aside from the consultants, there are only 2 FTE available to develop and implement all the educational programs including the case management education program.

4.2.1.3 *Education for case managers*

The input from the Unit in relation to claims management is currently limited to education of claims managers. It would appear that there is a degree of dissatisfaction on the part of the insurance agents, who are responsible for the claims management process, with the education program for claims managers provided by the Unit. The Agents dislike having to pay for education which is compulsory and over which they feel they have little control.

Some insurance representatives suggested that a more interactive and less didactic process would improve the product. This would increase the opportunity to share best practice in relation to claims management and create a greater focus on intelligent relationship management and getting the best outcomes. They point out that there is currently no contractual requirement to focus on improving health outcomes. Staff of the Unit agree that the education for case managers is not conducive to improving outcomes and that the contractual requirements focus on process. The education program reflects this reality.

A much stronger contractual focus on outcomes would change the nature of education. If the contract required adherence to best practice models of case management, the education programs would need to support those models. It is questionable whether, if the contractual requirements were appropriate, WorkCover should be responsible for providing the education program or simply reviewing and contributing to the education programs run by the Agents themselves. This case management education function would therefore require review.

4.2.1.4 *Recommendations: Improving Education*

1. Continue with the investment in undergraduate education and continue to evaluate the performance of graduates in relation to their knowledge of the system, their compliance with best practice, their service patterns and outcomes, and their participation in relevant post graduate education. Broadening the subject matter to incorporate the practice of health care in compensation domains would enable cost sharing with MAC for this endeavour. Explore the potential of the existing programs

to be multi-disciplinary to ensure similar input to the education of all key allied health providers.

2. Increase the resources available for post graduate education. A flexible budget would be more appropriate than increasing the existing sessions. This enables the purchase of particular expertise for particular projects as required and acknowledges that projects may be of differing durations and that some of the required expertise may be additional to that already available in the Unit.
3. Establish a multi-disciplinary Education Advisory Group comprising representatives of provider groups to provide advice on strategies and approaches to education, provision of information and ways to improve access to education.
4. Develop an education strategy to raise awareness and skills of providers in the treatment and rehabilitation of injuries which are known to provide the largest opportunity for improvement, as identified through the strategic plan. Components of the strategy should include the development of materials, seminars, information links and web based materials, workshops, sponsorships etc consistent with the objectives of improving practice in those high yielding areas.
5. Increase the profile of WorkCover priorities for injury management improvement by liaison with the provider associations, development of public relations material, provision of sponsorship for seminars etc.
6. Review the current provision of education for claims managers and assess the potential to shift to regularly reviewing agent contracts and associated education programs to ensure their consistency with what is known about best practice. Consider re-allocating sufficient resources to professional education to implement the recommendations as outlined above. (See also recommendations on improving case management on page 17)

4.2.2 Developing Best Practice Claims Management

Claims management and the relationship with the Agents are fundamentally important in determining the nature of the relationship with the injured worker and the health care provider. Inadequate knowledge about particular injury types can lead to inappropriate responses to claims, including inappropriate use of independent medical examinations or inadequate or inappropriate intervention when healthcare utilization is higher than what is considered to be reasonable. These responses can lead to higher costs.

The expertise of case managers is central to effective monitoring and intervention with health care patterns. The ACCNZ *Healthwise* branch has a strong focus on developing best practice models of case management and supporting case managers to work within them. It is not possible to ensure best practice services and conduct successful relationships with health care providers without including case managers as a key part of the strategy. It has not been part of the responsibility of the Unit to relate to claims management or to contribute to issues relating to the Agent contracts. This is very problematic.

There are serious deficiencies in the current case/claims management arrangements. Indeed the object of the activity itself is unclear. Some stakeholders believe it should be “case” management which denotes a focus on the case or the patient. Others believe it should be “claims” management, which denotes a focus on the claim and its assessment and processing. This difference in perspective is the hub of a fundamental paradigm clash between health care providers who see that their goal is to treat and care for their patient in the best way they can, and claims agents and employers who see that their goal is to ensure that the claim is legitimate and that the cost is minimized.

It is important not to blame very hardworking case/claims managers for what is essentially a systemic problem. The overwhelming evidence from all people consulted, whether it be staff, providers, injured workers or indeed employers,¹⁰ is that the case management process needs a major overhaul.

4.2.2.1 Un-aligned incentives

Currently the agents are contracted and audited in the delivery of processes rather than outcomes. There is no in-built incentive to improve recovery and return to work rates. Furthermore, the contract inadvertently provides a potential incentive for the Agents to recruit junior staff and address any knowledge or experiential deficiencies by employing medical and allied health consultants, or independent examiners, to assess other doctors’ treating patterns and claims. Both of these activities are paid for by WorkCover.

Some rehabilitation providers point to the fact that they are often requested to do work which is really the role of claims managers if the latter are too busy or too inexperienced to do it. This, too, is an extra cost to WorkCover.

“Garden variety rehab coordinators are basically subcontracted to do the work of case managers whose caseloads are too high. This incurs rehab costs which are really case management costs.” (rehabilitation coordinator)

All health care providers consulted raised the issue of “busy work” created by the existing case management process. They point out that case managers can drive activities which the scheme is ultimately paying for and which has the capacity to delay and even prevent recovery and increase the liability. This “busy work” includes requests for reports and independent medical examinations. General Practitioners and medical specialists report increasing numbers of requests for reports and data supports the view that independent medical examinations are increasing (along with the associated costs). there appear to be no consistent standards or criteria for ordering independent medical examinations.

Paradoxically, this “busy work” is viewed by the claims agents as necessary to ensure eligibility and appropriateness of care. Yet its increasing frequency would appear to be

¹⁰ See “Gender, Workplace Injury and Return to Work: A South Australian Perspective” Working Women’s Centre 2004. The report outlines the results of a survey of stakeholders including injured workers.

out of proportion to the amount of fraud that might be expected in the system. Consequently, the process is described by providers as being confrontational and stressful and leads to more disputes and litigation than appears necessary. Health care providers report that there seems to be very little understanding by the case managers about the particular issues confronting very disadvantaged groups such as those from non English speaking backgrounds and there appears to be very little support for providers who have these kinds of patients. These kinds of patients seem to attract large numbers of requests for reports. It would appear that the clash of paradigms is compounded by inexperienced case managers.

A gain sharing contractual approach is required so that if outcomes are improved (as agreed with all stakeholders) then the Agents and WorkCover both win. An economic benefit for insurance agents from improving health recovery times, return to work or community as well as patient and employer and provider satisfaction would ensure that the clash of paradigms is addressed.

4.2.2.2 *Lack of collaboration between Agents and the Unit*

There have been a number of attempts to align claims management to support best practice protocols but Unit staff report that Agents have refused to monitor provider compliance. A case management model which separated complex care from non complex care was not implemented because the Agents wouldn't change their structure and process to fit the different approaches needed.

This apparent lack of cooperation may be due to the contractual requirements and the perverse incentives currently in place (as outlined above). It may also be because WorkCover (not necessarily through staff of the Unit) has initiated proposals for changes to case management largely in isolation from the claims agents, relying on consultation after the fact rather than participation in the early stages. Agents point out that a number of the models proposed by WorkCover were inconsistent with the human resource realities of the industry in that it is just not possible to recruit and retain the number of experienced and qualified case managers which would be required to support them.

Clearly it would be more appropriate to develop models of best practice case management in collaboration with the Agents and this means direct participation in the planning stage rather than consultation after the fact.

4.2.2.3 *Limited communication between key players in the care of injured workers*

Basic communication between case managers, injured workers and health care providers is flawed. There are standardized communication processes and templates which are confusing to providers and patients, potentially threatening and which provide very little assistance in the management of the process. Furthermore, many of the standard requests for information from providers are not what are needed to assist the claims manager. Doctors report, for example, that it is not unusual to hear from their patients that an

Independent Medical Examination has been required by a case manager. There is no communication with the doctor before seeking such a report. Nor does the doctor see a copy of the report from the Independent Medical Examiner. This is completely outside any of the norms of polite human interaction. It creates a defensive attitude from the provider and the patient, increases the cost of service utilization and provides nothing in the way of quality improvement.

“Case managers will send a letter requiring a report that takes hours to prepare and is not remunerated properly. Having got the report, he or she gets another report from someone else who has not met the patient but simply reviews my report. The patient feels out of control and intimidated and gets angry. I get angry. This happens far too many times to be truly needed. The case manager has set an unnecessary process in motion simply because they don’t know enough about care or don’t understand the cultural or social issues surrounding a case. Their focus is on trying not to pay for things.” (General Practitioner)

“The best way to communicate is to actually talk. Having regular case conferences seems to clear up a lot of issues and prevent unnecessary reports etc.” (General Practitioner)

4.2.2.4 Resources allocated to meet obligations of the case manager rather than the needs of the injured workers

The mandated allocation of rehabilitation coordinators to all claimants may be contributing to inappropriate care. Category A standards require that a worker be allocated a rehab coordinator even when there is no reason for anyone to believe that the worker will not be back at work within 3 months. This is a process driven rather than patient driven requirement. It wastes resources and is out of step with efficient and appropriate service provision models.

Rehabilitation plans are criticized by health care professionals, including the Rehabilitation coordinators, for being excessively bureaucratic and not particularly helpful for care. Medical specialists and general medical practitioners agree that there is a place for rehabilitation coordination but not all cases require it. Unnecessary intervention or requirements of service are not necessarily benign.

“Anything that increases the confusion and stress of the patient has the potential to interfere with recovery and lengthen the period for return to work. I have seen many cases where the rehabilitation coordinator is not recommending return to work even when everyone else is. They seem to just pounce all over the process.” (Medical specialist)

4.2.2.5 The public image of WorkCover is “outsourced”

The experience that a health care provider or an injured worker has with “WorkCover” may differ depending on the approach of their case manager. This means that

WorkCover's image and reputation amongst health care providers and injured workers is completely out of the control of WorkCover. Injured workers have a very low level of satisfaction with the system. Reports that satisfaction surveys conducted by the Agents have yielded results of 70% satisfaction are very disturbing. The literature relating to patient satisfaction surveys would indicate that, in health care, any result less than 90% can be considered problematic.¹¹ This is because there are social and psychological pressures to be satisfied with public services (the gratitude effect) compounded by fear of retribution and compromised care. This effect would be even greater where there is dependence on the worker's compensation system to cover costs.

More recent studies in the field of patient satisfaction would suggest that the best way to assess the patient experience of care is to focus survey questions on their experience rather than to ask them to rate their satisfaction. Methods to continually assess the experience of the injured worker are important to consider when assessing and improving the quality of the process.

4.2.2.6 *Limited access to services which could improve return to work rates*

All providers consulted identified that industrial relations issues (including conflict in the work place and stigmatization following the injury) can be serious obstacles to returning a worker to his/her workplace. Yet there is no access to mediation services which could support both the worker and the employer to develop strategies to address and work through the conflict (unless the employer is prepared to pay.) When conflict is recognized as a major cause of secondary depression hindering return to work and there is no willingness by the employer to pay for mediation, WorkCover's compensation costs increase. It would be more cost effective to provide mediation.

Health care providers report that they also find it very difficult to get support from claims managers to fund reasonable retraining programs. They identify that the training appears to be limited to computing skills development which is not suitable for the majority of their patients. Assistance with re-thinking employment, career options, and more intensive training for alternative employment is almost impossible to access despite the fact that it may assist in a resolution.

Consideration might be given to the cost of compensation of those cases where there are issues not directly associated with the injury but which have a potential to prevent the worker from returning to work. Having determined the extent of these problems it would be appropriate to consider broadening the range of services available to address them.

¹¹ See "The Role of Patient Satisfaction Surveys in a National Approach to Hospital Quality Management" Mary Draper and Sophie Hill. AGPS 1995.

4.2.2.7 Redesign the system of case management

The case management system is clearly not working. Injured workers are dissatisfied,¹² health care providers are dissatisfied with dealing with people they regard as inexperienced. The turnover amongst case managers is very high, indicating that they are also dissatisfied with their work. It would appear that caseloads are very high, that triage of complex cases is not occurring, that rehabilitation coordination is being used inappropriately and that independent medical examinations are also being used inappropriately. The system is driving health care utilization costs but not improving outcomes. It needs major overhaul.

Agents are aware of the gap between the current “claims management” approach and the required “care management” approach. They have changed their recruitment processes to attract case managers with a health care background and have indicated their willingness to participate in developing best practice models of case management. These models must be developed with input from the Unit, the Agents, the consumers and the provider associations with the clear focus being on accountability for outcomes in addition to process. Outcomes should include the satisfaction with the process by the various stakeholders.

The contract with the Agents should be based in a philosophy of partnership and meaningful gain sharing. It should ensure that incentives are aligned to best practice in relation to service provision and recovery and return to work and community. It should include agreement about collaboration on strategies to improve provider performance and recovery outcomes in major injury groups. These strategies would include developing models of case management, recruitment, education and ongoing review processes which can support the implementation of the best practice models.

4.2.2.8 Recommendations: Improving Case Management

1. Over the next 6 months, initiate a study, with the participation of case managers, relevant providers, employer and consumer representatives, which;
 - Analyses the current case management processes and identifies the major obstacles to effective and efficient care for injured workers who have injuries known to provide the largest opportunity for improvement in recovery times.
 - Develops re-engineered options for case management which can facilitate improved health care treatment and recovery times, as well as satisfaction for those injuries known to provide the greatest opportunity for improvement in recovery time.
 - Identifies the organizational supports required for the options for case managers (eg seniority of case managers, roles of consultants, role of WorkCover, role of

¹⁴ See “Gender, Workplace Injury and Return to Work: A South Australian Perspective” Working Women’s Centre 2004. The report outlines the results of a survey of stakeholders including injured workers.

- providers, HR strategies including recruitment and selection strategies and training and development processes etc).
2. Jointly develop an outline for the training of case managers in keeping with models to be used by the Agents.
 3. On the basis of the results of the study, develop pilots and agreements with Agents to implement the models;
 - Agree on the kinds of supports required to increase the effectiveness of the models (eg seniority of case managers, roles of consultants, roles of WorkCover, role of providers, HR strategies including recruitment and selection strategies as well as training and development processes etc).
 - Agree on an evaluative framework and information requirements to monitor progress.
 - Agree on a quality framework and a process for continuously evaluating outcomes including return to work, recovery, satisfaction of both providers and injured workers, satisfaction of case managers etc.
 - Agree on processes to improve communication and partnership between the Agents and WorkCover.
 - Develop and model options for gain sharing (based on improving health outcomes and recovery times) to be built into the contract financial arrangements.
 4. Build these agreements into the contract ensuring that the incentives are aligned to improvements in outcomes as well as best practice process.
 5. Withdraw from direct provision of education for claims managers, but regularly review Agent education programs in keeping with the agreed evaluation framework and allocate sufficient of the resources to implement the recommendations relating to provider education.

4.2.3 Developing Best practice Health Care

The Unit undertakes provider reviews on a biannual basis. This involves identifying those providers whose number of services per patient are 20% over the median number of services across the whole scheme and reviewing the details. If the return to work rates are lower than average, they receive a letter from the Unit providing them with their statistics in relation to their peers. This is quite often all that is required to produce a change in the service pattern for future patients. If there is no improvement and extreme differences from peers are demonstrated, both in service patterns and in return to work rates, the provider receives both a letter and a visit by a professional consultant to discuss why their service pattern is different. Service patterns have normalized for most providers who have participated in this process. Whilst it is an unpopular strategy with some providers, it is effective in changing provider service patterns.

Where there is dispute over quality issues and service patterns, an independent medical examination may be required either by the case manager or by WorkCover. An independent medical examiner is chosen from a list of examiners who are credentialed by

WorkCover. There is no credentialed list of independent allied health examiners in South Australia.

4.2.3.1 *Monitor performance against evidence*

Most health care providers are aware that WorkCover has the right to review their service data and to call people to account for service patterns that are out of the norm. However there are a range of views about the approach taken with some people viewing the process as intimidating. Service review is most effective when it is based in evidence of best practice in relation to the specific injury type, and when it includes meaningful discussion of why a provider's practice might not comply with that evidence. The Unit has developed a number of guidelines and resources which appear to be of very high quality and which are also appreciated by the health care providers. More resources are required to implement evidence based guidelines to support more meaningful review of practice. "Just in time" support is known to be a more effective approach to quality improvement. A more rigorous and timely process for flagging providers who may need assistance is required. If recognized guidelines were endorsed and widely available and used and if Agents were aware of them and working cooperatively with WorkCover, it would be possible to intervene in a timely and collegial way once claims managers identify a service pattern inconsistent with the guidelines, rather than through "after the fact" reviews.

Some general practitioners, who were asked to attend a review interview, complained that the WorkCover consultants seemed not to appreciate the differences in care required for very disadvantaged groups (eg refugee and non English speaking background groups). A focus on these groups' requirements is important when assessing provider performance against guidelines.

Although recognized and professionally endorsed guidelines would assist discussions about service patterns, providers would be concerned if they were used to assess performance without an understanding of the needs of different population groups or the particular social and cultural circumstances of some patients. Successfully implementing guidelines would require that they do not become rigidly applied.

4.2.3.2 *Incorporate quality review into existing culturally accepted systems*

The fact that the quality review process is currently outside the standard quality processes of the various professional bodies is considered problematic by a number of providers. Medical specialists, for example, do not appreciate their practice being questioned by general medical practitioners, who they view as lacking the specialty credibility to conduct the reviews.

Most professionals agree that the best approach to quality improvement would be through peer review. Models of quality review and practice improvement which are based in the existing quality processes of the various provider associations, Divisions of General Practice and colleges could be further developed. WorkCover's role would be to support

these established peer review processes rather than to control them. This approach is consistent with that used by the ACCNZ which launches a new set of guidelines every 6 months. Practice profiles are developed by ACCNZ, for every medical provider, against the profile that would be expected given the evidence. Arrangements are in place with the Divisions of General Practice and the Royal College to ensure that peer review takes place. The professional associations report their behaviour change outcomes to the ACCNZ. Providers in South Australia also indicate a level of comfort with developing peer review processes under the auspices of WorkCover.

Evidence from various pilot projects funded by the ACCNZ (but conducted by three of the New Zealand Divisions of General Practice) would indicate that a range of interconnected strategies are required to improve compliance with best practice service patterns. There was a 23% decrease in service utilization with improved health outcomes within the general practice division which provided best practice guidelines and service profiles, facilitated discussion amongst peers and facilitated mentoring for extreme outliers. This compared to a 12% decrease within the division which provided best practice guidelines and service profiles and facilitated discussion with peers. There was no change within the division which provided best practice guidelines only. Clearly peer review processes which use a range of strategies will be most successful.

Although the existing performance review process is relatively useful in supporting practice change amongst health care providers, all staff agree that a much stronger focus on developing and disseminating evidence about effective treatment and care, on facilitating and on supporting provider service review, both through the existing professional associations and through the Unit itself is required in South Australia. A focus on those professionals who are extreme outliers and not able to be assisted to change their practice by their own professional associations or through in-house quality processes would still be required of WorkCover. However, it is anticipated that this would be a small number of reviews.

4.2.3.3 *Improve the credibility of “independent” review*

As outlined above (see Developing Best Practice Case/Claims Management, page 12) the independent medical examination has very little credibility amongst providers. The credibility of the examiners themselves is often questioned by providers (eg some providers report that the only people who have time to provide the service are those who are retired and perhaps not up to date with modern practice, or who cannot get other work). In South Australia, although WorkCover credentials examiners, there is no process to review an independent medical examiner’s performance and continued status as a credentialled provider. Health care providers report that many examiners are known to be aligned either to the insurer/employer or to the employees and are used in a dispute to counteract each other’s arguments. All of this activity increases the cost to WorkCover with very little impact on the quality of care provided to injured workers. The process is outside the norms of quality in health care.

Independent Medical Examiners point out that, because there is no therapeutic relationship if there is no agreement between the doctor and the patient about the

diagnosis, there are social incentives for a doctor to simply rubberstamp the self diagnosis of his or her patient. An independent medical examiner doesn't necessarily believe the patient and is just looking at the facts. Medical examiners argue that the independent examination and report provides a more effective analysis of the quality of diagnosis and prognosis.

There is no process in place to provide independent advice in relation to allied health practitioners in South Australia. Other jurisdictions (Eg. Victoria and New Zealand) rely on "expert panels" of practicing allied health providers paid to overview and discuss cases and to provide mentorship for those where the panel agrees there is need for a planned approach to quality improvement. The panel membership changes over time. A very comprehensive recruitment and selection process and appropriate remuneration is used to ensure that panel members are credible amongst their peers. This has been more acceptable to the providers and, in New Zealand, where the process has been in place for some time, has had some very positive influence on their behaviour. Consideration should be given to the development of "expert panels" to provide advice in relation to the practice of both medical and allied health care providers in South Australia.

4.2.3.4 *Develop professional standards*

Allied health provider associations have appreciated the collaborative approach taken by the Unit to develop competency standards and accreditation processes for allied health providers. Working in partnership to establish the skill and knowledge requirements of professionals providing care for injured workers has been a useful way to engage the professions in the issues, as well as to ensure the longer term capacity of the professions to respond to the issues pertinent to compensated health care. Unfortunately, there are insufficient resources available to support this activity effectively. Projects are slow to be developed and implemented and backup for ongoing education and dissemination is not available.

4.2.3.5 *Align the quality improvement plan to strategic issues*

Quality initiatives in hospital and health care settings have required a long lead time before success is evident. Culture change is an important aspect in behaviour change and this takes time. Staff of the Unit report that they feel drawn between too many isolated projects with insufficient time available to fully implement the projects once developed. This is consistent with observations about the relatively small allocation of the existing resources available for quality projects. It is important to select a small number of high yielding projects and to stick with them, evaluating continuously, developing and enhancing the programs on the basis of the evaluation and informing stakeholders of progress. Quality improvement plans should be developed around those injuries known to provide the greatest opportunity for improvement in recovery time for cost reduction.

4.2.3.6 *Quality improvement milieu is crucial to success*

An organizational milieu which supports health research, quality improvement, provider support, evaluation and open collaboration and liaison across health care is required to support those activities known to be successful in improving health care outcomes. The organizational culture of WorkCover has undermined the objectives of the Unit and distracted it from the most important activities. The culture is not conducive to the health care improvement culture of the Unit. Mainstream health services have identified that cost containment occurs as a result of improved quality. An exclusive focus on cost containment does not engage providers in best practice and, paradoxically, has not produced significant reduction in costs of care.

General practitioners and medical specialists in South Australia support the view that the credibility of evidence and guidelines for practice in relation to compensation health care would be enhanced by its independence¹³. There is an inherent difficulty with WorkCover or the claims agents being seen to be controlling the development of guidelines for best practice since they have a vested interest (in keeping costs and the liability down) which may be at odds with the best care. In New Zealand, the guidelines for practice and referrals are all developed with the participation of the professional colleges and associations and, until recently, Healthwise, now a division of ACCNZ, was an independent company. The fact that peer review and quality improvement initiatives are also implemented in collaboration with the professional colleges and associations strengthens the credibility of the process. This has clearly been associated with major success in reduction of service costs and with reductions in the liability resulting from improved health outcomes.

It is important for the staff of the Unit to be a part of mainstream health care and to be abreast of the various quality initiatives across the nation and internationally. Staff report feeling “out of the loop” of health care provision and yet their major function is to support health care providers and advocate for this function within WorkCover. This could be addressed by establishing provider advisory groups to provide comment on and participate in the quality improvement programs and supporting staff participation in various conferences and seminars conducted within mainstream health care.

4.2.3.7 *Recommendations: Improving the Quality of Health Care*

1. Establish a multi-disciplinary Quality Advisory Group with representation from professional associations and colleges. The Group’s role would be to advise on the quality improvement program, on the ways to improve the participation of relevant health provider groups in developing strategies to improve injury management and to facilitate liaison between the program and the various professional association and college programs.
2. In collaboration with the relevant provider organizations;
 - Identify whether there are existing evidence based guidelines for multi-disciplinary providers within the South Australian primary health care setting which have the potential to improve practice for the areas of injury management

¹³ As reported by the Medical Management Project of the Motor Accident Commission following consultation with General Practitioners and other provider associations

- which have the greatest potential for improvement. Consult on their appropriateness amongst the relevant provider groups. Where there are no guidelines, undertake literature reviews to identify what evidence is available about treatment and outcomes.
- Draft or review evidence based guidelines and consult amongst provider groups.
 - Identify the information required to monitor and evaluate the application and effectiveness of the guidelines and determine the best methods to collect and monitor the information.
 - Develop an education program to increase knowledge of the guidelines. This should be part of the recommended post graduate education program outlined in Section Four, Recommendations on the Education Role, page 11.
 - Develop an evaluation program to continuously monitor the effectiveness of the strategies.
3. In collaboration with the relevant health care provider organizations, establish and/or support the operations of special interest groups and peer review programs specifically aimed at improving treatment and care of compensated injuries;
 - Agree on the information required to support the program (eg service utilization and outcome profiles for all participating providers, information on patient profiles for each participating health care provider).
 - Agree on the approach to review (ie case discussions, open disclosure in interest groups etc).
 - Agree on the approach to individual support (mentoring, education sessions etc).
 - Agree on frequency and process for engaging providers.
 - Agree on the roles of the health care organizations vis a vis the role of WorkCover.
 4. In collaboration with provider organizations, establish a panel of allied health experts, consistent with those established in Victoria, NSW and New Zealand, to review and assist those providers whose health care is considered to require particular improvement.
 5. Establish an on-line quality consultation service to provide advice to health care providers who have enquiries about injury management. This would require increased specialist consultant time and would expand the telephone consultation service already available.
 6. Establish on-line educational material on best practice models of care and treatment.
 7. In collaboration with relevant provider organizations, establish “flags” to assist case managers to identify, as early as possible, those providers who might need assistance. Ensure that the protocols for contacting and supporting providers who have been identified are appropriate and non confrontational.
 8. In collaboration with relevant provider organizations, establish policy and procedures for identifying, supporting and addressing over-charging or over-servicing behaviour. Establish a process to continually review the process.

9. Undertake a review of cases to determine how many longer term compensation claims are related to industrial relations issues rather than quality of care issues and identify cost effective models of intervention. This should be undertaken in partnership with employer, union, and consumer stakeholder representatives.

4.2.4 Information Management and Payment of Accounts

The Unit administers a claims database. All service companies and professionals who provide services to injured workers have details keyed into the database. The information is used to make payments to providers, monitor provider service patterns and costs, and contribute to strategy and planning.

The system's potential to contribute to evaluating service patterns, compliance with best practice approaches, and outcomes of injury management, has not been reached. Concerns about the database and the payment of accounts have been raised by staff and claims management agents.

4.2.4.1 Accuracy of data and payment

Staff are concerned about the accuracy of the data and point to the need for ongoing audit and improvement of the quality and timeliness of data entry by the Agents. The final quality test on the data entry has been with WorkCover staff. They have noticed major problems with data entry by Agents. However, the resources available for them to ensure quality are minimal. Only 2 FTE are available to administer a system of accounts payable which has grown past the point of a reasonable workload. A requirement to undertake effective quality management of the data should be incorporated in the contracting arrangements for Agents. Furthermore, the system is inefficient, requiring double entry of some of the data to ensure appropriate payment. Clearly, there are insufficient resources available to operate the system at the level of quality that staff would prefer. Staff are concerned that the credibility of WorkCover with providers is undermined by the difficulties with the payment system. They also report having to track down payments for providers who have not received payments and who are bounced between Agents and WorkCover in their attempts to seek payment.

The accuracy of the data and the ongoing review processes should be a major priority for audit and risk management functions within WorkCover since there is a risk of duplicate payments. Concern by staff has been corroborated by a number of providers who have reported that duplicate payments are "quite a regular occurrence." Their response has been to "charge less next time." Providers also report having to constantly track payments which they have not received and where there has been no communication from the Agents about why. Clearly, relying on the good nature and honesty of providers is not the best method to ensure accuracy of payment.

Agents point out that the system does not support case managers enough in that there are no "red flags" that facilitate awareness of potential inappropriate servicing. It is, therefore, necessary to rely on the experience and memory of the claims managers. Staff have highlighted that there are red flags but that they are not used effectively by the

claims managers. A more rigorous system of flagging those doctors who have aberrant charging or servicing patterns is required.

4.2.4.2 Information for effective evaluation

Information systems are required in any organization to facilitate monitoring and analysis of progress against strategic goals. Key outcomes sought are the early achievement of sustainable function and return to work or the community, greater consistency in the number and type of claims for particular injury types and efficiency in claims management administration. Although staff can determine what type of services have been provided to an injured worker (providing that the data has been provided and entered accurately) the database does not provide WorkCover management with sufficient information to assess performance against the key outcomes of interest. The information system relating to health care providers focuses almost exclusively on the cost outcomes arising from a claim or injury.

If WorkCover is to develop a stronger focus on improving health care outcomes and return to work status through improving the quality of the care of providers and the management of claims, a sound evaluative framework will be required. More information is required about the provider (eg demographics of the provider, nature of education or resources used or undertaken, quality activities undertaken, etc) as well as the claimant. Some of this information could be provided through a single database but other information might be provided through supplementary tools. Analysis and research expertise is also required to use the data effectively and to provide meaningful reports to management on progress against strategic goals.

The Motor Accident Commission (MAC) in South Australia is currently developing a proposal to improve recovery times and return to work and the community for patients compensated by Compulsory Third Party Insurance. As part of the proposal, it has outlined an evaluation framework which includes an approach to information collection and review. Since it would be useful to compare different outcomes and processes for different types of compensated patients within the same state, it would be appropriate for WorkCover to collaborate with MAC on this project and to ensure that databases are comparable.

At a broader level, there are national efforts to link health care utilization data. The Australian Institute of Health and Welfare and World Health Organization are proposing to incorporate an International Classification for Functioning (ICF) into the International Classification of Disease (ICD) when the review of the ICD Version 10 is undertaken in the near future. These new classifications will replace the disability fields currently incorporated into the ICD Version 10. The Commonwealth, States and other providers (such as WorkCover) will need to sign off to a strategy of collaboration over 5-10 years. This new classification system will give WorkCover the opportunity to compare its data with mainstream health service utilization for similar patients and will provide greater information and power in quality development activities. It will be necessary for WorkCover to be an active partner in these developments.

Clearly, health information expertise will be required within the Unit to ensure that WorkCover contributes to and makes use of these developments. A recent decision by

the Executive of WorkCover to centralize the information and analysis functions across WorkCover has a number of advantages. However, there is a need to ensure sufficient expertise and familiarity with health care information management. Effective collaboration is required within this new structure to ensure that sufficient resources are made available to the Unit to undertake the development and analysis required to properly plan and evaluate its activities.

It could be argued that the management of the accounts payment function is more in line with the roles and responsibility of that part of the Corporation which deals with funding and revenue. As long as the data is accurate and available to be used effectively in research and evaluation by the Unit, it is not necessary for it to be managed in the Unit.

4.2.4.3 *Recommendations: Improving the Payment System and Information Management*

1. Undertake an urgent audit of the accounts payable process including that part of the process for which the insurance agents are responsible. The audit should identify the risk points and determine risk management strategies to ensure that the information system and payment process is accurate and timely. Risk management requirements and data quality processes should be incorporated into the contracting arrangements for Agents. Following the audit, consideration might be given to relocating the administration and maintenance of the provider payment system to the funding and revenue group.
2. Establish an evaluation framework which outlines the information required to effectively evaluate the quality, education and consumer information strategies implemented to improve provider performance in terms of recovery and return to work or the community.
3. Using the evaluation framework as the basis for review, identify the existing data sources and any deficiencies or gaps in the information already available.
4. Establish a project to enhance the existing information systems, either through modification or the development of additional tools, to ensure effective input to recommended quality and evaluation processes and to ensure efficiency of the system. Ensure appropriate links with National and State initiatives in health information management.

4.2.5 *Establishing Fees for Provider Groups*

Although there is no Board approved schedule of fee reviews, there is informal agreement between the Unit and the professional associations of some of the important provider groups about the timing for reviews. A review is initiated when the provider associations submit a proposal for a fee increase to the Unit.

The fee determination process is a complex and time consuming task involving surveying private practices to determine private patient fees (in order to ensure compliance with

Section 32 (12) of the Workers Rehabilitation and Compensation Act 1986 which requires that payments be “based on” the private practice rate) consultation with the relevant professional associations (as required by Section 32 (13) of the Act) and consultation with other key stakeholders (who may include employer stakeholders, employee stakeholders, self insurers and the Motor Accident Commission).

Although relatively robust information is available relating to the private practice fees paid by health insurance funds and the fees paid by the Commonwealth Health Insurance Commission (HIC), information on gap payments required by allied health, hospital and medical providers is not always mutually agreed between the Unit and the various provider associations. Furthermore, there are a number of items of both medical and allied health service which are specific to WorkCover patients and which are, therefore, outside any existing private practice fee structure. Both the method by which these items are priced and the final price generally need to be agreed with the relevant provider associations, of which there are many (eg allied health providers include physiotherapists, rehabilitation providers, occupational therapists, psychologists, chiropractors, speech pathologists, and other therapies such as massage, gymnasium, etc). In addition to individual health care providers, WorkCover must establish fees for public hospitals. It could be argued that this is less difficult since the Department of Health funds hospitals for all services provided without any gap.

Following finalization of a fee package, each package must then proceed through a series of further consultations and approvals, including the Board, the Minister, Cabinet and the Parliament, before being implemented.

4.2.5.1 *Problems with the process*

The need for an agreed baseline:

The overall process used by WorkCover to determine its response to the various provider fee submissions is not agreed with provider associations and has been the cause of much irritation on both sides. The Unit sees that it is required to comply with Section 32 of the Worker’s Compensation Act in determining fees. However, there is no agreement by both providers and WorkCover on determining private practice rates. For almost all provider groups, there is no agreement about the base line, no agreed parameters for measuring price and no defined period within which the discussions will be resolved. Furthermore, there is disagreement about the data used by WorkCover to reach conclusions about fees and the interpretation of that data.

Process unnecessarily long:

Both staff of WorkCover and the providers report that the process is unduly long. After completing fee reviews and developing a proposal at the Unit level, there are at least six more layers of approval, including the Manager of the Unit, the General Manager of the Division, the CEO, the Board, the Minister and the Cabinet, all of whom can disallow the proposal.

One health care provider who has been integrally involved with the fee discussions, summed up provider feelings as follows;

“It’s like being on a merri-go-round without ever getting off.”

4.2.5.2 Perception that the approach is “bullying”

Providers complain that WorkCover has a “bullying” attitude in that the legislation only requires them to consult, not to negotiate. The only power the provider associations have is to withdraw their service or go directly to the Minister. This practice has the potential to create an escalation amongst other providers. Providers are quick to defend the Unit staff who they believe are compromised in their attempts to reach agreement by the multi-layered approval process.

“What starts off as a good process at the Unit level, becomes adversarial as we go through the rest of the layers.”

It will be important to establish a more collaborative and participative process to establish appropriate baselines, understand how existing funding arrangements impact on care and review funding models which might provide incentives for best practice. Health care providers point out that the credibility and the independence of the studies will be important signals of WorkCover’s willingness to improve their relationships with providers, which many believe are at an all time low.

4.2.5.3 Excessive resources are required

Since there is no “program” of fee review activities in place, all program managers within the Unit are engaged in fee setting projects all the time. Staff report that at least 25% of the time of the allied health staff is spent in fee review activities. Clearly, the ideal allocation of time would be more balanced towards service and quality improvement.

The fact that staff are not health funding experts compounds the problem. There are organizations which specialize almost exclusively in this kind of task. It may be far more cost effective for WorkCover to commission these experts on a periodic basis to study service items provided, their relative values and costs rather than to attempt to do it for all providers using its own resources. The current process interferes with staff’s ability to relate effectively with providers on quality and service improvement initiatives.

4.2.5.4 Inadequate remuneration contributes to reduction of access

The processes around caring for compensation cases are generally complex and time consuming. Since providers are not remunerated in accordance with that complexity, some provider groups are no longer taking compensation referrals, leading to the creation

of a second tier of access, with injured workers significantly disadvantaged. Psychiatrists, Neurologists, Orthopaedic Surgeons and Neurosurgeons are in short supply in the community generally. They have sufficient work, appropriately remunerated, to withdraw their services to compensated patients with little or no consequence to their financial position.

Neurosurgeons now have such little trust in WorkCover that their services have significantly reduced already. They view attempts by WorkCover to survey their fees with suspicion and refuse to participate in the process. This situation requires remedial attention immediately since, with Orthopaedic Surgeons tending to opt out of spinal surgery and into sports type injuries, it is highly likely that all spinal surgery will be done by Neurosurgeons in the future.

The Australian Private Hospitals Association is also at the point where there is a very real threat to access. Access for rural injured workers is a particular problem since almost all professional groups are in short supply in rural areas.

General practitioners report delays of three months and longer for their Worker's Compensation patients to access some specialties. Clearly, there is a need to study the impact of reduced access on compensation costs. Whilst a short term strategy of delaying fee increases may seem to be an effective cost containment strategy, it will be having a negative impact on the liability when injured workers are waiting longer for their treatment and suffering reduced recovery times.

4.2.5.5 *Inadequate remuneration model may be driving poorer quality and higher costs*

Some providers have not had fee increases for over 10 years. This cannot be considered reasonable and fair under any circumstances. In almost all other health care funding there is at least indexation to increase funding in line with CPI and cost increases in the health care economy. There is also regular review (eg 5 yearly) of baselines for items of service and costs.

The perception amongst providers that WorkCover refuses to set realistic rates may be driving a change towards more costly service patterns. There has been a steady increase in general practice level C consultations (longer than 20 minutes) and level D consultations (longer than 40 minutes) with no apparent change in the case mix since 2002 with no apparent improvement in recovery times.

4.2.5.6 *Impact on relationships between providers and WorkCover*

The fee setting process is so difficult and convoluted that meetings about fees are now virtually the only regular meetings between WorkCover and health care provider associations. This is particularly problematic in an environment where a trusting and mutually respectful relationship between providers and WorkCover Corporation staff is required to develop new initiatives in best practice. The task of determining fees has compromised the credibility of staff and their relationships with the providers generally.

Providers who participate in the discussions with WorkCover do so in their own time and are “burned out” by the process.

Whilst it is essential for those staff who are knowledgeable about best practice to contribute to funding policy discussions and decisions, it could be argued that they should not manage the process of fee determination and negotiation. The nature of the expertise required to study costs, model options and develop the proposals for fee structures is outside that of the staff of the Unit and more in keeping with those of health care financing experts.

WorkCover payments are now so out of step with the market that the increases required are potentially beyond what can be paid in one period. Denial of fee increases, as a short term cost minimization strategy, has very real long term disadvantages both in terms of the size of the cost increase required to get back to some reasonable level of payment and in terms of the access to care by injured workers.

4.2.5.7 Fees not related to best practice

Remuneration is a key strategy in providing incentives for best practice care. Yet it is not used strategically to control outcomes and reduce the overall costs of WorkCover. There was a program of “value added” fees established several years ago but it was discontinued. Compensation schemes in other jurisdictions are using performance based bonuses to align practitioners to best practice and ensure that payment is based in the realities of the private practice environment in an attempt to ensure access to high quality services.

Health care provider associations in South Australia are very keen to explore the potential for performance based incentives. However, they point out that they are now so underpaid for basic service that they are not prepared to discuss more refined models until the base payment issue has been addressed. A short term strategy to address the current access issues is required. However, a longer term strategy which develops the full potential of remuneration as a key strategy in reducing overall costs to WorkCover is also required.

4.2.5.8 Recommendations: Improving Remuneration Policy and Practice

1. Advise the Ministerial Advisory Committee on Worker’s Compensation and Rehabilitation on the issues outlined above and begin discussions with the Minister in relation to the inadequacy of the current legislation relating to fees (Section 32 of the Act) and the need for immediate remedial steps to prevent withdrawal of access to services by some key providers.
2. Develop a proposal for a short term agreement to raise fees for those providers who are threatening to withdraw services and those whose fees will need to be reviewed over the next 12 months.

3. Establish a high level communication channel between health care providers and Senior Management of WorkCover with a view to;
 - Understanding the position of the providers.
 - Developing some agreement about the way forward in both the short term and long term.

4. Commission a program of independent studies to establish service items, costs and potential policy options to ensure that funding is aligned to best practice. These studies should be conducted by credible independent consultants, appropriately experienced and skilled in health care financial analysis and modeling. Each should be managed by a steering group comprising WorkCover officers and credible provider representatives who can ensure that the quality of the data and the methods of review are appropriate. The studies should address;
 - The nature of the service items known to be associated with best practice in the major areas of injury addressed by WorkCover.
 - The nature of the items of service provided to WorkCover patients currently.
 - The extent to which the current funding schedules provide for these services (eg through appropriate categorization and through the adequacy of payment).
 - The cost of providing these services (using agreed benchmarking and clinical costing techniques).
 - Trends in cost increases for the services over previous years (to assist with discussions on indexation).
 - Approaches to funding arrangements which maximize best practice service provision.

5. Establish a rolling program of fee reviews over a five year period which includes all provider groups. The program should be managed by the General Manager responsible for Workplace Injury or the General Manager responsible for policy and strategy with input from the Chief Financial Officer and the Unit. This reflects the key role of remuneration in strategy, ensures the alignment of the process with the strategic directions of WorkCover and ensures that the focus of the Unit is on best practice development rather than fee negotiations with all its associated relationship issues.

6. Undertake fee reviews which should include;
 - Evaluating the impact of previous fee structures and agreements on health care provision.
 - Modeling policy options in relation to fees for each provider group based on best practice using the outcomes of the study (as outlined above) as a baseline.
 - Modeling indexation options for a 3-5 year period.
 - Developing draft fee proposals (consistent with the baseline study, the best practice incentives required, the indexation for the next 3-5 years) for negotiation with each provider group.

4.3 Roles for Further Development

4.3.1 Research and Development

The Unit has responsibility for assessing evidence in relation to new therapeutic interventions and technologies, researching evidence in relation to best practice models of treatment and service provision, and evaluating health care models and interventions. However, staff report that there is very little time available to undertake any of these activities. There is no dedicated resource available for these tasks.

Staff have applied for funds to undertake some evaluation and research projects from the existing WorkCover Grants Scheme. However, they report that they have not been successful in their attempts to do so and have been advised that the grants are available only to external applicants. This is out of step with WorkCover in NSW, Victoria and New Zealand, where projects have been undertaken in collaboration with other “expert” groups and funded through designated research and development budgets. ACCNZ has an entire division focused on research and development.

It makes economic sense to analyze the effectiveness of some therapies, technologies and models of service provision or case management before there is agreement to roll them out. Some capacity for research and evaluation is therefore required.

4.3.2 Recommendations to Improve Research and Development

1. Develop a policy on research and development consistent with strategic priorities and allocate a research and development budget, part of which should be allocated to health provider support.
2. Establish a multi-disciplinary research and development group comprised of provider representatives, employer representatives, employee representatives, and consumer representatives who have experience and expertise in research. The group should;
 - Advise on the development of a research and development plan which is in keeping with the strategic plan of WorkCover.
 - Advise on processes for inviting submissions from staff of WorkCover and, where appropriate, from external organizations capable of undertaking the required research or developmental work.
 - Advise on the process for application and selection of research and development projects, ensuring that the process addresses criteria relating to expertise of the researchers to undertake the work, appropriateness and ethics of the method, potential to address priority questions to improve the health outcomes for injured workers, and maximum participation by relevant stakeholders.
 - Review applications and select projects in keeping with the policy and plan.
 - Monitor the progress of the research projects.

- Receive reports on research outcomes and advise on ways to ensure that information about research results are disseminated to appropriate stakeholders.
3. Appoint a Research and Development Manager with expertise in research and grants administration to;
- Undertake the work as outlined above and support the activities of the Research and Development Group.
 - Identify sources of funds which could be tapped to enhance the funding available for research and development in line with strategic priorities.
 - Liaise with staff, providers, case managers and employers.
 - Educate and support staff in relation to developing appropriate proposals for research and development funding.
 - Report on the progress in implementing the research and development plan.
 - Undertake developmental and evaluation projects relevant to the questions and issues pertinent to improving provider performance

4.3.3 Public Communication and Consumer Information

A very small number of projects have focused on the provision of information to injured workers and the general public. These include a very high quality brochure on lower back pain and its management and a brochure on Independent Medical Examinations for workers. Apparently, providing consumer information about injuries and treatment has not been considered the role of the Unit. Given the existing resources it would be unlikely that the Unit could have developed more information even if it were considered its role. All provider groups have identified the need for more consumer specific information.

There is now very good evidence in mainstream health care that the more informed a patient is about their illness and the treatment processes, the more appropriate their expectations and participation in their own care which, in turn, has a positive impact on health outcomes and satisfaction levels. Consumer information has been a major strategy in almost all spheres of health care.

It could be argued that consumer health information is available to patients through their health care providers. However, there are quite specific aspects of the compensation health care process which are very different from the processes for health care without compensation.

If patients knew the broader role of WorkCover and the issues it faces, the processes it must use which are different from what they would normally have expected, they may be less confused and stressed by the process. Injured workers should also know what their own rights are in the process, what the limits of Worker's Compensation are, what litigation means, the legal process and what outcome patterns there are in relation to litigation. More factual information on these issues may lead to less litigation and more willingness to engage in mediation and dispute resolution and even less disputes overall. Patients should also know how to provide feedback on their care or their case management.

It is also important for patients to know about their injury or illness, how it is usually treated, how best to care for it and what the evidence says about potential recovery times and prognosis. Such information ensures that patients have realistic expectations of their treatment, can ask meaningful questions of their health care providers and participate effectively in their own health care and recovery¹⁴.

Information should be made available in culturally appropriate ways. Many people who may be at high risk of injury or whose recovery is at risk, may not be able to read their own language. Use of appropriately trained interpreters and existing cultural networks should be used to assist the broader community and individual workers to understand the issues.

4.3.4 Recommendations on Consumer and Public Information

1. Establish a Consumer and Community Information Advisory Group with representation from appropriate consumer advocacy organizations, community health organizations with expertise with relevant cultural groups, consumer representatives and worker representatives to;
 - Provide advice on consumer information requirements in relation to worker's compensation.
 - Ensure that all injury priorities for WorkCover have relevant educational information available for injured workers.
 - Provide advice in relation to the requirements of the community generally about injury and evidence.
 - Provide advice in relation to style and media most appropriate to reach the audiences.
 - Assist with reviewing draft information and other personal education and information strategies.
2. Appoint a Team Leader (within existing EFT) who is experienced in developing health promotion materials and public information strategies, to work within the Unit. This person would be responsible for ensuring the quality and accessibility of educational and information material, appropriate methods for dissemination of material and continuous review, and improvement of the materials available for both professionals and injured workers.

¹⁴ A five year follow-up of patients with lower back pain, treated with light mobilization and information, indicated higher return to work rates than patients not provided with such information. See Indahl, A. Haldorsen, E., Holm, S., Reikeras, O. and Usun, o. (1998) Spine, Volume 23, No. 23, pp 2625-2630.

SECTION FIVE:

Organizational and Structural Issues

Observations and recommendations regarding WorkCover's organizational and structural arrangements for Health Care Operations Unit have been provided in a supplementary report to WorkCover.

SECTION SIX:

Conclusion

A strong focus on improving health care provider performance in caring for injured workers has the potential to yield significant improvements in the liability as well as in the care and experience of patients and providers. These improvements are already being experienced in other jurisdictions. WorkCover would be well advised to seek assistance from these areas in developing the strategies outlined above. National forums and processes to share information and approaches would advance progress by reducing the potential to re-invent wheels within the Corporation. For example, a study of fee relativities is already being undertaken in Queensland. The study might be expanded to incorporate South Australia.

The staff of the Unit have expertise and experience which should not be lost to this area. They have fully cooperated in the process of this Review and support the broad directions outlined. They require effective organizational support, clarity in relation to the key issues to pursue, and strong sustained leadership over two to three years to make a long term difference.