

The Accident Insurance Act – a desirable reform or market madness?

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On July 1 1999, New Zealand's workers' compensation system was privatised. Was this a desirable reform or market madness?

Early last year, we reviewed national occupational health practice in the Journal,¹ concluded that the standard was poor and identified contributory factors. We recommended strategies common to successful workers' compensation systems.² Unfortunately, I do not believe the Accident Insurance Act I (AIA) is the legislative solution to these problems and I do not accept the argument that market forces will correct problems in system access, performance and cost.

No data from a comparative workers' compensation system exists to show that privatisation, *per se*, results in improved cost efficacy. Indeed, the general experience is that costs and premiums increase. Premium increases are often disproportionately great because insurance companies frequently purchase a large market share at the introduction of privatisation by quoting rates that are much lower than the traditional costs of workers' compensation for the organisations involved. This was certainly the case in New Zealand. The increased costs are due to factors such as legal and medical reports about entitlement, and are not just due to profit taking. For example, Western Australia (WA) has a similar system to that now in place in New Zealand. During a workshop held at the 1999 annual scientific meeting of the

Royal Australasian College of Physicians in Perth, data were presented by the responsible WA authority to show that some companies, which did not have a single work-injury claim in the previous 2 years, were still subject to a trebling of premiums.³

Insurance companies usually control the cost of privatised workers' compensation systems by regulating the level of entitlement. Where that is not possible, as is the case locally, the common response is to deny entitlement. Given that there is nothing in the AIA that will facilitate better occupational health practice (in comparison to the accredited employers scheme that existed under the previous legislation),^{1,4} the latter is the almost inevitable response here. Anecdotally, this is occurring and is manifest by many general practitioners not having their invoices paid by the insurance company on the basis that a "work injury has not been established". The legal profession has been quick to recognise the emergence of an "entitlement industry". Most large legal firms have established workers' compensation divisions or groups, and, in the case of one Dunedin law firm, have written to local general practitioners advertising their ability to advise any of their patients who have been disentitled by ACC.

Such a denial of entitlement is not difficult here because of the following observations: any potential claimant has to establish entitlement; entitlement is based on cause and not diagnosis; and mental trauma as a cause of disability is

excluded. General practitioners have already noticed a consequent and significant increase in required information on claim forms. This process is not designed to facilitate entitlement.

Consider the data available for upper limb pain syndromes as an example.⁵⁻⁷ With the exception of a complex regional pain syndrome (reflex sympathetic dystrophy) complicating a traumatic arm injury or perhaps a fibromyalgia syndrome after a whiplash neck injury at work, there are no objective data to show that mechanical work process alone can cause any of the chronic pain syndromes. Even when less problematic conditions such as rotator cuff tendonitis and epicondylitis are considered, again, there are no objective data to establish a causal relationship for most occupations, in the absence of some discrete violent injury. A common condition such as a carpal tunnel syndrome is more related to recent weight gain than work process, the exceptions being for jobs that involve vibrating tools and others that have considerable physical stress such as meat boners, meat and fish packers and fish filleters. It is hard to imagine a keyboard worker "passing" such an objective test of cause for any of the conditions that result in sustained upper limb pain. Indeed, current epidemiological data show that while such keyboard workers have an increased prevalence of neck, shoulder and elbow pain, there is no dose-relationship between this pain and their work process and they do not have an increased prevalence of any discrete musculoskeletal disorder. The end result is a group of patients who will be "in limbo" - neither acceptable to the ACC as a domestic, recreational, or motor vehicle accident, nor able to prove to the insurance company concerned that a mechanical work process has caused their problem. This is the group of patients that will fuel the "entitlement industry". The ACC has recently lost a considerable number of experienced case managers, presumably in the belief that they will experience a 25 to 30% reduction in claims (the approximate number of work-related claims). This is probably naive, as it is inevitable that ACC will become embroiled in the consequent debate of just who, if anyone is responsible for the ongoing costs of the "limbo" group.

The other major limitations in the AIA are not due to privatisation. Although we recognised in our 1999 review¹ that general practitioners were a major factor in the poor national standard of occupational health practice, any system that bypasses the family doctor is almost certain to be expensive and inefficient. Given that they are often the only people who are aware of the patient's (claimant's) overall health, any workers' compensation system should be designed to assist and not by-pass the family doctor.

To illustrate this concept, consider a typical New Zealand organisation I have audited. Work injury and illness costs are only about 15% of total "sickness" absence costs. Consequently, what is needed is a management plan for "sickness" absence of any form, and not a concentration on work injuries and illnesses. Second, analysis of absenteeism shows that once a worker has been absent for 5 days, the chance of them having a problem that will cause sustained invalidity and absence is high. This is the time for intervention. Such intervention should consist of an early human resources contact and an "expert" assessment after 5 days by a medical practitioner that has no interest in the outcome or in managing the patient. The subsequent report

on diagnosis, cause, entitlement to compensation, management and rehabilitation should be given to the family doctor and employer for ongoing care. This system achieves the following: the patient receives an early expert assessment before negative factors such as de-conditioning and illness belief become established; treatment is likely to be appropriate; any workplace factors are quickly identified and corrected; the employer is primarily responsible for a reactive workplace health and safety system; and the general practitioner remains the central care giver, is up-skilled by the process and is not put in the position of having to argue with, and possibly lose their patient, over issues of entitlement and work-fitness.

The AIA does not facilitate this type of cost- and outcome-effective program for at least 3 reasons. First, splitting the funding for work-related from non-work, related health problems inhibits any holistic management of absenteeism. Second, unlike the previous accredited employers' scheme in which the employer was clearly the primary risk taker, the primary risk taker now is an insurance company. Employer responsibility is actually diminished. Third and most important, the AIA enables injured workers to present initially to a wide range of therapists - despite the poor efficacy of the majority of these therapies for most patient complaints.^{8,9} The general practitioner can be by-passed. Initial contact is with a therapist and not a diagnostician. By the time a general practitioner is seen (presumably because therapy has failed to maintain work fitness and time off work is desired), the diagnosis will often not be apparent (and may have been modified) and a (frequently inappropriate) physical injury illness belief will be well established. The general practitioner will be placed in a position of having to accept a historical diagnosis from a non-medically trained therapist or enter into a no-win argument with their patient. This is a recipe for great cost, as well as for poor health care. The origins of the latter aspect of the AIA are mysterious, especially given recent initiatives to regulate the amount of physical therapy ordered by general practitioners. The expansion of first-contact health professionals should only be to occupational health nurses in industrial settings and to dentists for oral injuries.

It was generally agreed that the Accident Rehabilitation Compensation and Insurance Act 1992⁴ was in need of reform. In that context, privatisation is not a proven method of delivering workers' compensation. The problem in New Zealand's worker's compensation law is that it is still based on cause, which is frequently not known, and not on disability. The AIA is not good workers' compensation law and is likely to benefit only the insurance industry and the legal profession.

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