Health Care Benefits – Early Intervention and Rehabilitation

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Question 7

At this year’s FSC Life Insurance Conference, CEO John Brogden announced that:

“The FSC will … advocate for a change to the Private Health Insurance Act to allow insurers to fund medical treatment for claimants to return to work where possible. Research has consistently demonstrated that participation in work provides better health and general welfare outcomes for individuals. This will also help insurers work with the medical profession to enable people to return to work. Together these changes will deliver better outcomes for consumers and manage increasing claims costs for insurers.

Do you agree this change is desirable and how do you think it would create a better structure for disability claims management if companies were able to provide these kinds of benefits under policies? If you think there is a need for change, what are the issues that will need to be resolved and how do you think the industry should approach them? Are there other viable solutions the industry could consider? Your answer should be illustrated with appropriate references to relevant experience in other countries where different rules apply.

Introduction

Statistics show that individuals who are out of the workforce for any extended period of time are at greater risk of poor physical health, poor mental health, suicide, social isolation and overall reduced quality of life. Therefore, the speedy and effective return to work of individuals should be the central objective of claimants, medical practitioners and insurers alike.

There are multiple factors that need to be considered to facilitate a claimant’s successful recovery and sustainable return to work, all of which need to be well understood, and are required to work simultaneously in order for quality results to be achieved.

One factor that impacts the claim and duration management process is the accessibility and cost of medical treatment for claimants. Unlike life insurance industries abroad, the Private Health Insurance Act in Australia prevents insurers from funding medical treatment that is covered by Medicare and private health insurance policies. In the instances where claimants do not have appropriate private health cover, their insurance cover has lapsed, and they have to rely on the public health system, significant time delays are experienced before the claimant receives the necessary treatment. All too often, the treatment is too little, too late.

Receiving the right treatment, at the right time, in the right place, is crucial in achieving the best recovery. It sounds simple enough, but add to the process paper work, claim delays, hospital waiting lists, job loss, medical bills, mortgage repayments, children and credit card bills and the claimant’s focus is almost instantaneously removed from recovery and rehabilitation and directed towards looming financial hardship and the stress of the unknown.
If a change is made to the *Private Health Insurance Act* to allow insurers to fund medical treatment, will it actually improve the welfare of claimants and get them back to work quicker?

If it is done correctly, yes.

![Figure 1: Circles of Success](image)

**The right time...**

Research undeniably supports that early intervention from a medical and rehabilitation perspective produces the best return to work outcomes. Therefore, funding reasonably necessary treatment to claimants in the acute stage of their condition will more than likely increase the claimant’s chances of a good recovery.

Ideally, “early intervention” would almost precede the time the claimant suffers the condition. However, in the life insurance setting, with delayed notifications and waiting periods, early intervention is challenging and not always possible. This is where creative approaches need to be further explored. Proactive actions are better than a reactive approach, but preventative measures supersede them both.

*Prevention*: Preventative measures may include insurers funding more regular health checks for members, providing free health and well-being education sessions and ensuring greater promotion of the health benefits of work and staying active. Giving the members the fundamental knowledge around illness, injury and return to work may assist them with making the right decisions if they ever find themselves facing a potential claim.

*Proactive Management*: For larger group schemes, an insurer in the United Kingdom (UK) has a one week absence notification procedure in place. Once a “potential” claimant has one week off work, the employer then reports the absence to the insurer. The insurer then proceeds with completing an Initial Needs Assessment (INA) to determine if there is any assistance that they can provide on an ex gratia basis (no formal liability, with no effect on premium), allowing for the earliest intervention possible.
With other smaller schemes, the UK insurer is notified of any new claims at a minimum of half the waiting period and conducts the INA accordingly. The assistance that is provided by the insurer at this point includes basic medical treatment, Occupational Rehabilitation (OR), or simply directing the claimant towards the most appropriate medical services. This window of opportunity is when claimants need the most support and the time in which treatment and rehabilitation services can have the most positive impact.

Figure 2 below briefly illustrates various pathways a claimant may take to return to work and where the provision of medical services may be suitable:

![Figure 2. Return to Work Pathways](image)

**The Right Treatment...**

The most “common” health problems and injuries that account for about two-thirds of sickness absence and long-term incapacity are mild/moderate musculoskeletal injuries, mental health and cardio-respiratory conditions (Waddell & Aylward 2005).
Claimants with more severe conditions (cancer, stroke, chronic schizophrenia) receive the required treatment without the need for insurer involvement.

Only a small fraction of claimants need a highly coordinated level of care from treaters, employers and claims managers. Most claimants with “common” health problems can be helped to return to work by following a few basic principles of healthcare, positive support and independent problem solving (Iles, Wyatt & Pransky 2012).

**Musculoskeletal Conditions**

The focus of evaluation of musculoskeletal conditions must identify the injury, grade its severity and formulate a multidisciplinary management plan to return the patient to normal activity as soon as possible, if appropriate. A multidisciplinary management plan should be developed with the claimant, doctor and physical therapist as the core team members. Other health professionals (such as an exercise physiologist, psychologist, or occupational therapist) can then be recruited as required. This type of approach allows for clear goals to be set from the start, ensuring the claimant receives all the necessary support along the way.

**Mental Illness**

Different medical and psychological treatments for mental illness, including depression and anxiety, no doubt can improve symptoms and quality of life, but there is limited evidence to support that they increase a claimant’s ability to return to the workforce and sustain employment. However, the most promising approaches include treatment with a specific focus on return to work (Waddell, Burton & Kendall 2008).

The National Institute for Health and Clinical Excellence (NICE) in the UK has developed a Stepped Care Service Delivery model. The concept of the Stepped Care Model is to provide the least intrusive, most effective intervention first and have a clear outlined criterion which assists in determining when the next “step” should be taken, in the form of a treatment “pathway” (Bower & Gilbody 2005). This type of approach is ideal and assists insurer’s abroad to make decisions regarding claimant treatment options and guides overall claim duration management.

One of the UK’s largest insurers mostly limits their treatment funding to conservative Allied Health Services that specifically focus on return to work goals, with Cognitive Behavioural Therapy (CBT) and Physiotherapy being the two most common therapies provided.

**The right place... (the right environment, the right relationships)**

The causes of disability are not only due to a claimant’s personal symptoms (physical and/or psychological), but also stem from a claimants day-to-day surroundings and human interaction which include their workplace, employers, colleagues, family, the compensation system, the healthcare system and medical treaters. Therefore, not only do the actual symptoms need to be addressed in order for the claimant to recover, but so too does the claimant’s environment.

Butler, Johnson, and Côté (2007) conducted a study on employee relations and back pain. The principal result of this study was that employee’s satisfaction with their employers’ responses to their condition was the most important single influence on stability in employment subsequent to their condition. Butler, Johnson, and Côté (2007) concluded that “although satisfaction with health care is influential, it is a much less important influence on patterns of employment than is a worker’s perception of the actions of his employer.” This highlights the importance of a supportive workplace. Evidence also shows that the workplace is where the best rehabilitation results are achieved (Waddell & Burton 2004).
Need for change?

Australian life insurance currently takes a reactive approach to claims in comparison to its overseas counterparts. By the time active claims management is initiated, claimants have been off work for extended periods of time, have generally well exceeded the expected return to work timeframe for the condition, and have fallen into the sick role mentality.

There is undoubtedly a need for change. Medical treatment has a key role in claimant’s rehabilitation however evidence shows that treatment by itself has little impact on work outcomes. A multifaceted approach is required that engages all stakeholders.

In order to achieve successful outcomes all stakeholders (claimant, medical practitioner, employer and insurer) need to work together and act fast. More time and focus need to be placed on claims at conception. Conducting a thorough assessment and identifying risks, biopsychosocial factors and medical treatment requirements right from the onset, will direct the claim down the right path, saving time and potentially money in the long run.

In order to successfully introduce medical treatment funding in the life insurance industry in Australia the following needs to be considered:

Medical model versus social model: Currently, some insurers are steered by the Medical Disability Advisor Guidelines to determine expected return to work timeframes and treatment. Whilst these guidelines can be helpful for claims assessors to gain some insight into specific medical conditions, it can also make assessors medicalise a claimant, subsequently altering how they manage the claim.

There is no doubt that medicine is important and an essential part of treatment for specific conditions and injuries, however there is evidence to suggest that medicalisation of conditions can potentially increase disability. This is why it is vital to have the correct process and procedures in place if insurers are to start funding treatment.

Giving a health problem a specific medical diagnosis has its own pros and cons. Whilst a diagnosis may provide reassurance to the claimant and allow them to make the necessary steps towards recovery, if not handled correctly, a diagnosis can create fear, anxiety, stigmatisation, illness behaviours and a sickness mentality (Wessely 2002).

Once a condition is diagnosed, a medical model of disability tends to replace a social model. The medical model suggests that curing illness or disability revolves around identifying the illness or disability from purely a clinical perspective and is treated accordingly with medicine and clinically based treatment. In comparison, the social model is a more functional analysis of the claimant, addressing the individual on a holistic level, factoring in physical, sensory, intellectual and psychological dimensions. Holistic governance over all claims needs to be applied to ensure that the focus of treatment is always directed towards function, and that work should be viewed as part of therapy and not solely the goal of therapy.

Improve healthcare provider communications and relationships. Members of the healthcare system generally prefer to steer clear of the insurance/compensation world. It brings with it too much paper work and too many questions. Despite the abundance of evidence confirming that returning to work is good for claimants, some medical practitioners continue to have the philosophy that the only reason insurers encourage a prompt return to work is to get claimants off claim for financial reasons. If the insurer has the ability to assist with funding medical treatment, this may encourage other stakeholders to view the insurer as more of a “facilitator” in the return to work process.

Allied Health professionals and experienced Injury Management advisors need to be an essential part of all Life Insurance teams. In the UK, insurers have large teams of internal Medical Advisors and
Rehabilitation Consultants who conduct the INA’s and monitor medical management on claims from start to finish. Currently in Australia, most of these resources are outsourced. If the funding of treatment is to be launched, the introduction of permanent, easily accessible Chief Medical Officers, Medical Advisors and Allied Health Professionals would be paramount for each and every team.

Flexibility in claims management is key. As we have seen time and time again, what works for one claimant, will not work for another. Therefore, a blanket approach to claims management is not realistic. The ability to fund medical treatment will give insurers increased flexibility with how they manage claims from a duration perspective. Funding treatment will increase strategy options, however care needs to be taken to ensure that medical treatment doesn’t turn into the only solution for everything.

Claimant motivation: The most crucial part of the entire claims process is the claimant themselves. If the claimant does not have the motivation to get better and has no plans on returning to work, no insurer intervention will be viable. Therefore, treatment should only be funded where a claimant’s motivation is apparent.

To ensure that funding medical treatment will actually impact on reducing claim duration, there also needs to be an element of claimant responsibility added to the income protection structure. When treatment funding is agreed to, solid return to work expectations need to be set. If the claimant doesn’t follow the treatment plan as expected (without any reasonable explanation), then negative financial implications should take effect, whereby the cost of the treatment gets deducted from their ongoing benefits.

Employer incentives: The Australian life insurance industry should consider devising a scheme similar to that of the Victorian WorkCover Authority (VWA). The Worksafe Incentive Scheme for Employers (WISE) provides a financial incentive of up to $26,000 to an employer who offers an employee up to 15 hours of work per week. The scheme also protects employers from potential Workers Compensation claims if the claimant is to aggravate their injury at work.

Much of the variability in return to work outcomes is accounted for by what takes place in the workplace (Franche, Cullen, Clarke, Irvin, Sinclair, Frank, 2005). Currently, there is no reason for an employer to assist claimants with remaining in the workplace given the risks involved. If employers are provided with incentives to keep claimants at work, then there will unquestionably be more employers who would be willing to accommodate graduated return to work programs. In the Worker’s Compensation scheme, injured claimants who remain with their original employer have a much higher return to work rate in comparison to those who have to seek new employment. Therefore, keeping a claimant with their pre-injury employer should be one of the insurers top priorities.

Conclusion

Work absence due to illness and long-term incapacity are unlikely to be improved simply by providing healthcare alone. There needs to be a basic shift in treatment approaches, and employer management needs to be revolutionised.

If a change is made to the Private Health Insurance Act allowing insurers to fund medical treatment, the following must be implemented for it to be worthwhile:

- rapid access;
- individualised advice;
- correct assessment and treatment;
- focus on function and return to work; and
• regular communication between all stakeholders.

Funding medical treatment will only deliver better outcomes for claimants and manage increasing claims costs for insurers, if the right treatment is provided at the right time and in the right place.

References


