



Living with COVID-19 & Workers' Compensation – a national view

Workers' Compensation has not been greatly impacted by COVID-19 to date, but what does it mean that we are about to enter a new phase of the COVID-19 pandemic – “living with COVID-19”? In this COVID-19 d'finitive we look at projected infection case numbers following opening up, and then delve into what it means for both workers and Workers' Compensation insurers. The statistics presented below are at a national level, however these could easily be refocussed to equivalent numbers specific to state, specialised or self-insurer.

A COVID-19 diagnosis can lead to very different health and recovery outcomes for patients, but what is very clear is how important vaccination is in reducing the likelihood of serious illness after infection. While there is only limited experience on the longer-term effects of COVID-19 to date, the evidence definitely points to a proportion of cases continuing to have serious symptoms well after the usual time it takes for full recovery (so called 'long-COVID').

When the economy opens up the Doherty modelling suggests there will be **hundreds of thousands of COVID-19 cases across Australia in the next 6-12 months**, many of whom will be workers and therefore eligible for workers' compensation if the circumstances allow. This raises the possibility of there being a significant surge in claims that could overwhelm insurer claims acceptance processes. Assuming such a scenario actually plays out, the cost of paying for respiratory ward and ICU stays, plus longer term weekly compensation, means the increased claims cost could be material.

The message is clear: get ready, and be prepared for these effects on your workforce and book of business.

The Australian story so far

Australian case numbers from local transmission have been very low by international standards, and have lagged peaks seen in the Northern hemisphere. Geographic isolation, closed international borders, successful test/trace/isolate/quarantine (TTIQ) arrangements and relatively strong public health responses (lockdowns) to small outbreaks have all contributed to this. Vaccination take up, while slow to get started, is now also contributing positively to limiting the infection and fatality numbers from what they would otherwise have been in our most recent Delta strain outbreaks in South Eastern states.

The first two peaks in Australia were solely the 'wild' original strain of COVID-19. More recently, the latest rise in cases, starting in June 2021, is due to the more infectious Delta strain. The daily peak is not yet clear, however, with increasing vaccination rates both the Victorian and New South Wales governments are enacting their plans for opening up.

As at the time of writing, Delta case numbers in this latest wave of the pandemic in NSW, ACT and Victoria were at approximately 100,000. Of these, approximately 10,000 were admitted to hospital. Allowing for a delay between symptom onset and hospitalisation of around 5 days¹ we estimate that the Delta strain is resulting in a 12-14% hospitalisation rate for unvaccinated people, with significant differences by age and vaccination status; this is around three times the hospitalisation rate that was seen in the original strain² of COVID-19.

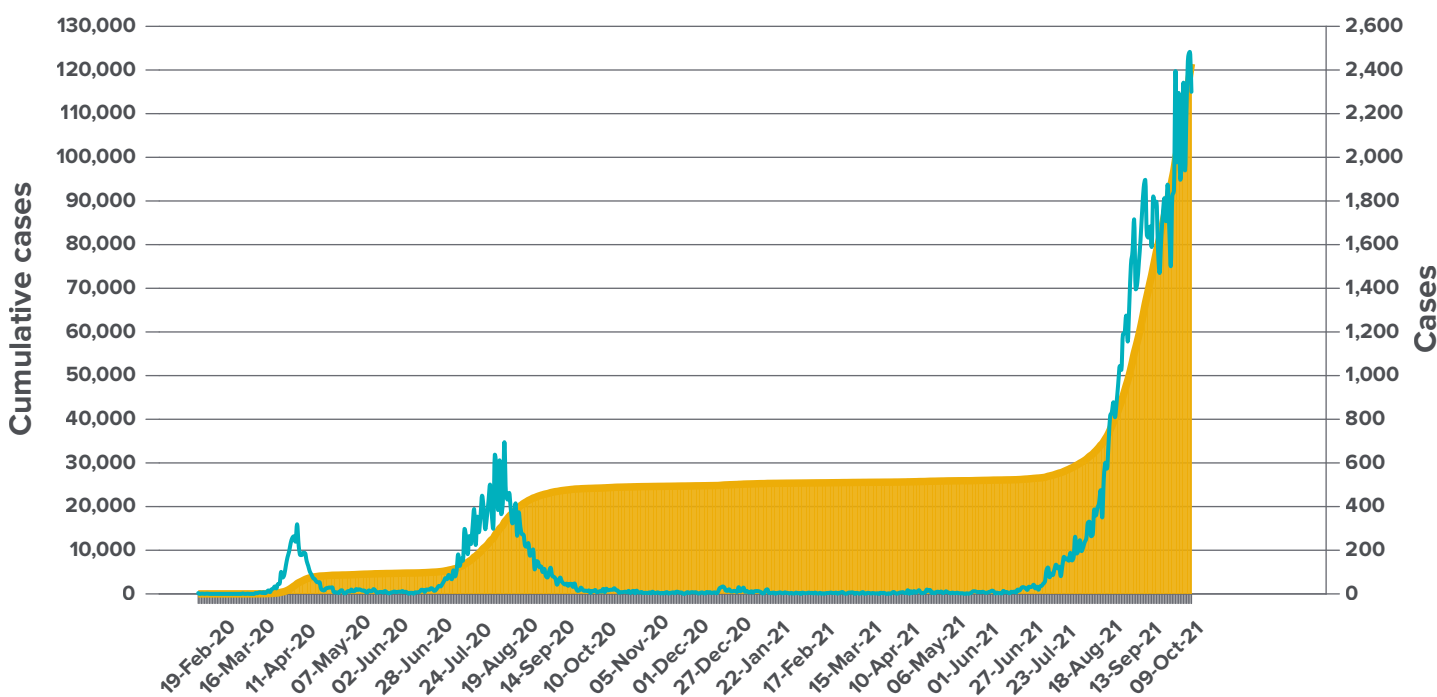


Figure 1 – Daily case numbers³

1 <https://www.health.nsw.gov.au/Infectious/covid-19/Documents/covid-19-surveillance-report-20210928.pdf>

2 [https://www.thelancet.com/journals/laninf/article/PIIS1473-3099\(20\)30243-7/fulltext](https://www.thelancet.com/journals/laninf/article/PIIS1473-3099(20)30243-7/fulltext)

3 <https://www.health.gov.au/news/health-alerts/novel-coronavirus-2019-ncov-health-alert/coronavirus-covid-19-case-numbers-and-statistics>

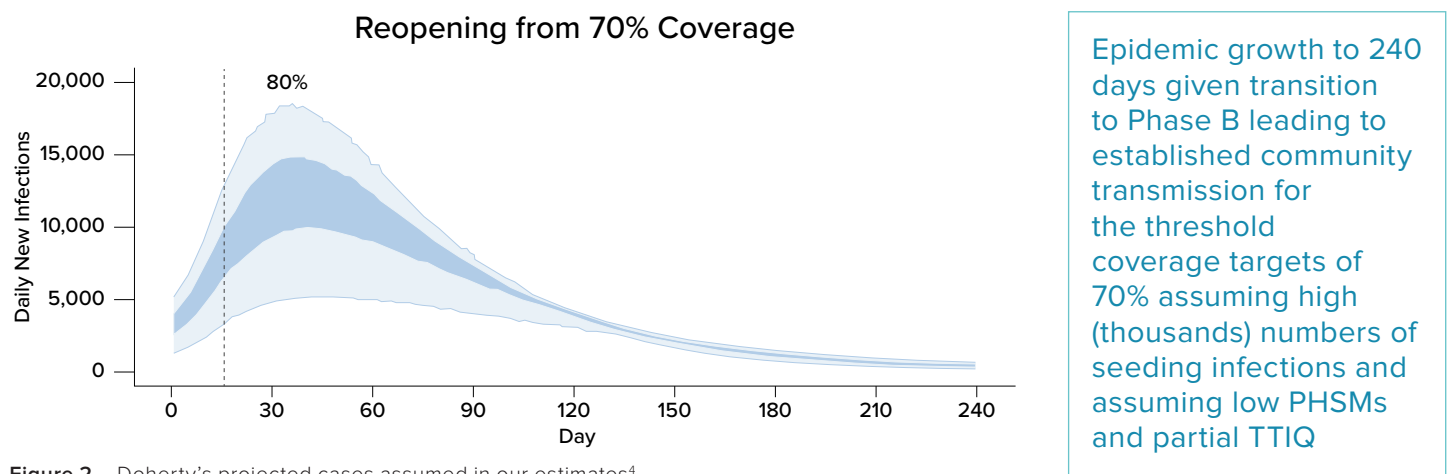
What opening up looks like – ‘the Doherty report’

To support the phased opening up plans, the Federal Government engaged the Doherty Institute to model projected case numbers, hospitalisations and deaths. They modelled a range of scenarios that considered different assumptions for low, medium and high seeding infection numbers on opening up and varying levels of Public Health and Social Measures (PHSMs) and effectiveness of TTIQ on transition to opening.

While the real world won't necessarily behave precisely as per Doherty, and noting that since June there have been Delta outbreaks in South Eastern Australia that have shown up cracks in Australia's TTIQ systems, the various Doherty scenarios help identify key drivers of different potential outcomes.

Doherty projections forecast 246,339 COVID-19 cases over a 180 day period would result after opening up at 70% vaccination (with vaccination then increasing to 80% and over soon after), under their “70% vaccination coverage, low PHSMs, partial TTIQ and high numbers of seeding infections” scenario. The announcements from NSW and Victoria seem to align with this scenario. Of these cases: around 9,700 would be hospitalised and 2,000 admitted to ICU; there would also be around 1,000 deaths.

It is important to note that the scenario we have described above is based on there still being ‘low’ Public Health and Social Measures (PHSMs) in place – meaning capacity restrictions would remain, but without ‘stay at home’ orders being in place. Doherty also includes a more pessimistic scenario where the PHSMs are reduced to ‘baseline’ level but other assumptions are unchanged (i.e. partial TTIQ and high seeding remain), leading to 900,000 cases (substantially higher than the 250,000 under the low PHSM scenario). While for the purposes of our assessment of the workers’ compensation risk we have not assumed cases go this high, it is the type of scenario that has played out in other countries where a ‘freedom day’ mentality has been adopted.



To date, cases and hospitalisations for fully vaccinated people have only been a fraction of the totals so far⁵. However, when the vast majority (80%+) of the population is fully vaccinated in coming months, then we can expect this will increase, with around 40% of the cases and 10% of the hospitalisations to come from those that are fully vaccinated. While this will represent higher numbers of vaccinated people being hospitalised than has been seen to date, it is important to realise that the *proportion* of vaccinated people being hospitalised is much lower than the proportion of unvaccinated people that are hospitalised (and this is particularly so for those still in the workforce, as vaccination appears less effective at preventing hospitalisation in the very old.)

‘Long COVID’

Long COVID refers to ongoing symptoms after the resolution of the initial infection. This is becoming a more salient topic as evidence emerges that a significant proportion of people infected with COVID-19 continue to experience some degree of symptoms months after the initial infection. Research^{6,7} suggests that 27% of those with a symptomatic infection and 50% of those who are hospitalised will still have a post-COVID-19 condition at 30 days. Of these, 45% will be working reduced hours 7 months after infection and a further 22% will not be working at all.

In an environment where ongoing weekly benefits are available for those with workplace based infections, these sorts of levels of ‘long COVID’ have the potential to be financially significant.

4 Doherty Modelling Interim Report to National Cabinet 17 September 2021 (pmc.gov.au)

5 <https://www.abc.net.au/news/2021-09-29/why-a-small-number-of-fully-vaccinated-people-have-died-of-covid/100497770>

6 A Detailed Study of Patients with Long-Haul COVID--An Analysis of Private Healthcare Claims--A FAIR Health White Paper.pdf

7 [https://www.thelancet.com/journals/eclinm/article/PIIS2589-5370\(21\)00299-6/fulltext](https://www.thelancet.com/journals/eclinm/article/PIIS2589-5370(21)00299-6/fulltext)

How will this play out for the working population?

Using UK data to inform assumptions around vaccination effectiveness at stopping infections⁸ and lowering the likelihood of hospitalisation if infected⁹, we have projected numbers of cases, hospitalisations, ICU and 'long COVID' for Australian workers consistent with the Doherty modelling.

In summary, our projections result in just over 100,000 COVID-19 infections in workers leading to around 10,000 hospitalisations, of which 700 are admitted to ICU. Up to (or perhaps even exceeding) 7,000 long COVID cases may develop who are fully off work, and twice as many again will still be on reduced work, 7 months later.

Vaccination changes the risk of infection and hospitalisation significantly. 42,000 COVID-19 cases are projected from the vaccinated workforce of 7.2 million workers. 64,000 COVID-19 cases are projected to come from unvaccinated workers (1.8 million workers).

Predicted COVID-19 outcomes in the vaccinated working population of Australia (7.2 million workers)

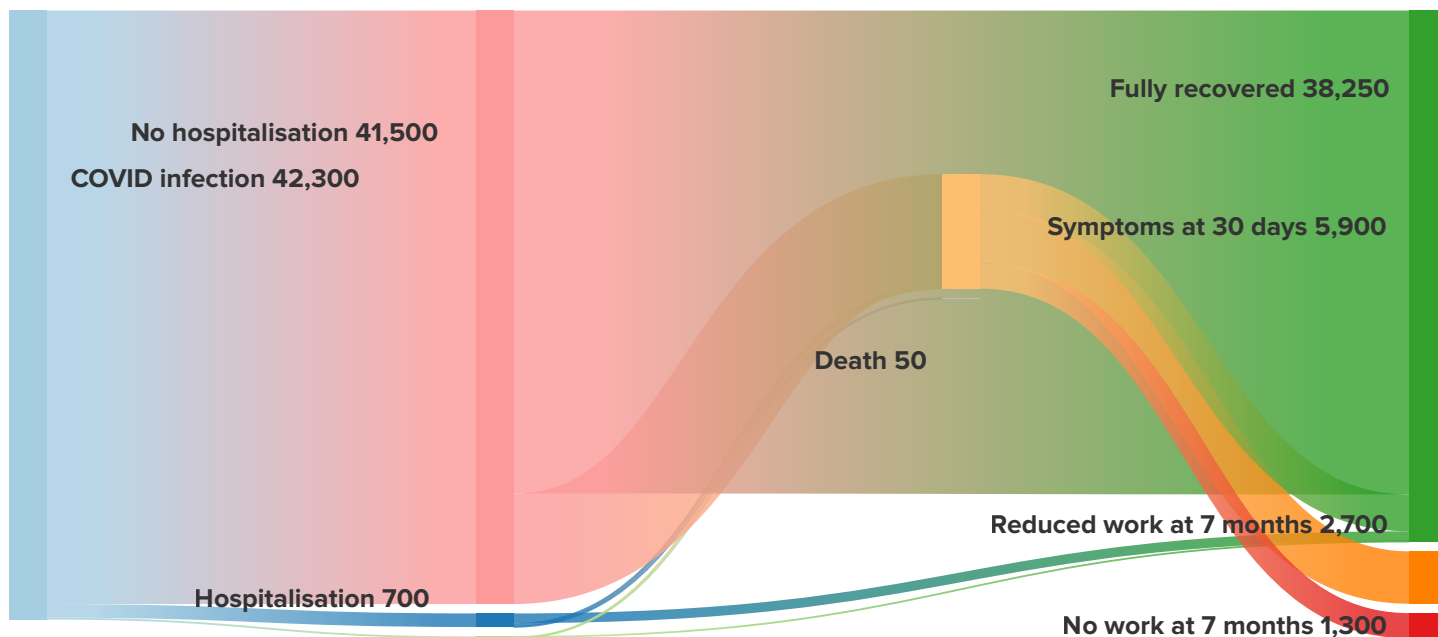


Figure 3 Estimated progression of COVID-19 cases from those in the vaccinated workforce¹⁰

Predicted COVID-19 outcomes in the unvaccinated working population of Australia (1.8 million workers)

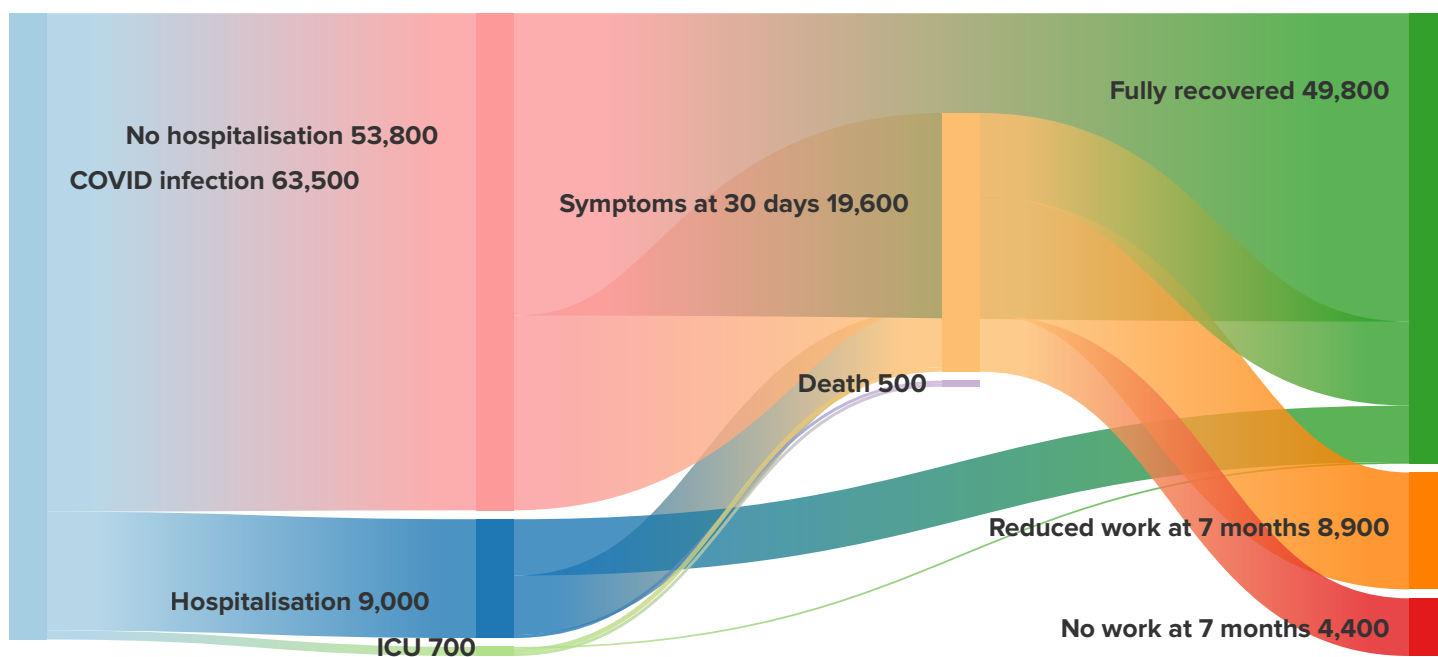


Figure 4 Estimated progression of COVID-19 cases from the unvaccinated workforce¹⁰

8 S1301_SPI-M-O_Summary_Roadmap_second_Step_4.2__1_.pdf (publishing.service.gov.uk)

9 COVID-19 vaccine surveillance report - week 37 (publishing.service.gov.uk)

10 Finitive analysis

How much is this all going to cost?

Over the duration of the outbreak after reopening we expect that the costs of initial COVID-19 treatment and lost income to be significant. How much of this cost is compensable by workers' compensation insurers will depend on how many of the infections can be linked back to work. The numbers presented below have been deliberately rounded, as our aim is to demonstrate the financial significance rather than provide precise estimates.

Hospital Costs

The median length of stay (LoS) in respiratory wards for COVID-19 patients that are admitted is around 7 days. For those that require ICU this is a little longer at 8 days. Both of these figures are based on hospitalisations in the first half of 2021 and Delta has a more severe impact.

If we assume that the average (not median) LoS is 10 days and that every day in hospital costs \$10,000 irrespective of ICU or ward, the 10,000 hospitalisations from COVID-19 positive workers equates to a national cost of \$1 billion.

Lost income (and potential weekly compensation)

Looking at those who were in ICU and those with long COVID who are not back at work at 7 months post diagnosis, as the group who will most likely have long term effects, this identifies between 700 and 6,000 people with significant loss of income. Using \$1,400 as an amount of weekly compensation (80% of AWE), the national lost income bill lies somewhere **between \$1m and \$8m per week** depending on how high the numbers of long COVID get to.

Long COVID Cases	700	6,000
Weekly (\$m)	\$1m	\$8m
6 months (\$)	\$25m	\$220m
12 months (\$)	\$51m	\$440m

Table 1 Estimated lost income from those unable to work

Deaths

Doherty projects around 1,000 deaths to occur within 6-9 months or so from opening up. The death rates we have adopted are based on UK Delta experience, and for workers amount to 500 deaths. If all of these deaths were compensable, then assuming around \$1 million per fatality would equate to **\$500 million**.

What if the infection numbers were even higher?

As noted earlier, the Doherty report also quantifies cases in a scenario of medium seeding and an 80% vaccine coverage, but **baseline** PHSMs and partial TTIQ. This scenario produces 914,000 cases and has been cited¹¹ by Dr Michael Lydeamore, Research Fellow in Infectious Diseases at Monash University, as the scenario that best correlates with the road maps that have been announced.

If this were to eventuate then we estimate the outcomes for workers and estimated costs would be roughly **four times** those shown above, as follows:

- Hospital ward: 36,000 hospital admissions over 180 days
- ICU: 2,700 admissions over 180 days
- Long COVID: 22,000 fully off work at 7 months
- Deaths: 1,900 fatalities.

Not all workers will claim on a workers' compensation policy

We estimate that approximately 90%¹² of those employed are covered by a Worker's Compensation policy, with the remaining 10% predominantly being self-employed. This would result in the following estimates of COVID-19 infections in people theoretically covered by Worker's Compensation.

	Best estimate	High scenario
Cases	95,200	353,300
Hospitalisations	8,700	32,400
ICU	700	2,500
Ventilation	300	1,100
Deaths	500	1,700
Long COVID (no work)	5,100	20,000

Table 2 Estimated workers covered by Workers' Compensation

¹¹ Australia COVID: Doherty reopening report: everything you wanted to know (smh.com.au)

¹² Safework NSW, Finitive estimate

Further, for an infection to be considered compensable it will need to meet the prescribed statutory test (which vary by state) to be regarded as having occurred 'out of or in the course of employment'. A considerable proportion of workers will not be able to meet this test, for example when it is known that they had a COVID-19 positive family member who they have been in close contact with, and where there is no such link through their work.

While we are not lawyers, we would expect that workers who undertake customer facing roles will likely have a higher chance of being able to establish the required links to their work, particularly if they do not have a close connection who has already tested positive. Rules around 'presumptive cover' are also important in this regard, as we discuss in the following section.

From an employer's perspective, the next few months will bring a number of difficult challenges, and potentially some significant legal obligations, when it comes to meeting their WHS obligations. Work Health and Safety requirements are absolute, and it would seemingly be an act of negligence for an employer to be in breach of their WHS requirements. The recent announcement that WorkSafe Victoria will be prosecuting the Victorian Department of Health in relation to breaches when it was responsible for Victoria's first hotel quarantine program demonstrate this point.

A note on presumptive legislation

In 2020, the NSW government made amendments to the Workers' Compensation Act 1987 that introduced a presumption that workers in "prescribed employment" who catch COVID-19 would be presumed to have caught it as part of their employment, unless the employer is able to demonstrate otherwise. This is likely to have a significant impact on the amount of COVID-19 related costs that are borne by NSW Workers' Compensation insurers.

Western Australia has a much more limited presumptive legislation covering healthcare workers only. While Western Australia has had relatively very few COVID-19 cases compared to NSW and Victoria, as the Doherty modelling forecasts all states should expect a ramp up in total cases and cases in workers as restrictions are unwound. There is currently no broad presumptive legislation in any other state or territory.

What else to look out for

There are many unknowns when considering the impact of COVID-19 on Workers' Compensation insurers and employers (some of which will be self insurers). A recent case involving a NSW man who spent over 4 months in ICU and subsequently died of COVID-19 while on a work trip in New York has seen a claim for medical expenses in excess of \$11 million¹³. We have also seen some indications that people who caught COVID-19 at work and passed it on to family members will try to seek to claim for the family members' illness as well¹⁴ (there is some comparable precedent for this in asbestos related claims by family members, although this is under liability cover rather than Workers' Compensation legislation).

Our estimates above have also not explicitly considered the potential for mental health related claims. It has been estimated that 1 in 5 people who become ill from COVID-19 will develop mental health symptoms¹⁵, and there is also the potential for workers distressed by their potential exposure to the disease, or changes to their work role arising from Public Health Orders, to claim for psychological conditions. The increase in demand for mental health services during the pandemic has been well documented. Recent Canadian surveys have indicated that high levels of anxiety and depression reported during the pandemic did not decrease as vaccination rates increased and restrictions were lifted. One in three Canadians reported in August 2021¹⁶ that decline in their mental health was impacting their ability to function, with 25% reporting they have been diagnosed with anxiety and/or depression, and 31% of health care workers diagnosed with depression. It may be that the mental health impact of the pandemic takes longer to play out through the Workers' Compensation system than the illness itself.

Please contact our COVID-19 and Workers' Compensation experts to see what all of this could mean for your specific circumstances.

13 Sara v G & S Sara Pty Ltd [2021] NSWPICT 286 Personal Injury Commission of New South Wales

14 <https://www.abc.net.au/news/2021-09-22/long-covid-compensation/100481274>

15 https://www.medscape.com/viewarticle/940922?nlid=138342_1842&src=WNL_mdplsfeat_201120_mscpedit_wir&uac=279103EX&spon=17&implD=2689315&faf=1

16 <https://www.mhrc.ca/findings-of-poll-8>

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