Parliament of New South Wales
Legislative Council
Standing Committee on Law and Justice

Inquiry into Workers' Compensation System New South Wales

Response to Parliamentary Inquiry

Prepared : 4th June 2012

by

The Australian Medical Association (NSW) Limited

Response to Parliamentary Inquiry

We refer to evidence provided by AMA NSW on Monday 28 May 2012 and the questions on notice put to the AMA. With regard to the questions on notice, we make the following further submissions.

Causation

As requested, we enclose a small sample of information about the potential patients assessed by Dr Michael Glickman. As noted in his evidence and the AMA NSW submission, we believe there would be benefits to the scheme if the process for establishing causation was matched to the criteria and medical input of the Motor Accidents Scheme.

Single Scheme Agent

We have taken further advice on the experiences in South Australia. We understand that the jurisdiction is reconsidering the reliance on one scheme agent. However, we maintain that scheme agents whether as the single agent or as one of a number of agents, should be required to prioritise the safe, timely and appropriate return to work of the patient.
We would be happy to provide further advice or submissions as required.

Response to the Submissions of the Civil Contractors Federation

In the limited time available, we have consulted with our membership with regard to the proposal put forward by the Civil Contractors Federation. While we recognise and support the desire to return employees to work as soon as possible, we believe the submission fails to consider a range of important issues.

As a preliminary comment injured workers do have access to high quality medical care in NSW and in comparison to other states access to medical care for injured workers is equitable to patients with private health insurance. This principle of access should be maintained for patients injured as a workplace injury in NSW.

Our members have identified a range of systematic factors that we believe to be of greater significance in the delaying of the return to work than the potential conflicts in the role of the GP as treating doctor and assessor. Instead, we suggest an initial focus on establishing a clear system for developing a prompt decision as to whether the injury is work related All too often patients are treated for months with therapies such as physiotherapy and medication only to have the situation reversed when it is decided that more costly treatment is recommended. This causes significant distress to the patient, confusion and setup a situation for future treatment failure and medico legal dispute. In many cases the decision appears to be made arbitrarily.

We would recommend that the decision as to whether the injury or presenting problem is work related needs to be made early in the patients treatment. This would mean that once the decision is made that subsequent treatments could be approved quickly and efficiently which would also improve patient outcomes.

Currently approval for treatment, particularly for surgical intervention, takes too long and the decision making process is very poor. The whole system appears designed to delay treatment and extend the period over which the process of effective treatment is delivered. Once the treating doctor requests approval for surgery or a treatment, there is usually three weeks for the insurance provider to respond. This is often in the form of a request for more information. The information requested has often already been provided in the original letter/report. The supplementary report attracts a charge. Thus there's duplication, waste and delay.

The decision is then reviewed by case workers who have essentially no clinical training or experience. While they have no clinical experience or expertise they question the recommendations of the treating doctor/specialist often inappropriately. While the decision should be justified there may be better ways of efficiently reviewing and approving treatments. Many can be driven by clinical protocols and evidence which are often at the core of clinical decision making in any case.

The frequency with which the case managers for individual patients change is far too high. Communication between patients and case managers is poor. This causes delays, inefficiencies and increases costs. It also adds to the antipathy that builds between the insurance provider and the patient.

Insurance providers for individual workers often change mid treatment. Injured workers are sometimes treated and traded between providers as commodities. This means that the case managers suddenly change mid treatment and the case is reviewed. In some cases liability may then be denied even though they have been undergoing approved treatment for their work related injury.

With regard to the specific proposal of the Civil Contractors Federation that any patient requiring more than 3 days of time off work is referred for a workplace capacity assessment, we specifically note;

- Three days is a brief and arbitrary period of absence from work. The GPs we have consulted indicate that there would be considerable increase to the cost and complexity for the scheme if this timeframe were adopted.

- GPs indicated that one of the main difficulties they encounter (aside from the delays with scheme agents) is receiving accurate, comprehensive information about nature of the pre-injury position description. While obviously, many larger employers will manage this process well; this is often a cause of considerable difficulty, particularly in rural and regional areas. This is an area that should be considered as a matter of urgency.

- Doctors from rural and regional areas noted the workforce difficulties of attracting either GPs or other health professionals to undertake the work of workplace capacity assessment in the manner recommended.

- There is a concern about the variety of training and expertise of other health practitioners who may be considered as able to provide workplace capacity assessments. Our members are concerned that their experiences suggest the potential for increased dispute and cost if it is unclear who holds the primary responsibility for the care and safe return to work of the patient.

We recognise the difficulties in the current system where a patient is seen to depart from expected return to work timeframes. These patients are extremely difficult for the nominated treating doctor, the employer and the scheme. We would accordingly propose the following;

- As noted above, there is early decision making about whether an injury is work related, what the expected treatment processes are to be.

- That treating doctors are able refer patients to work place capacity assessment by appropriate health professionals. This may include occupational therapists, physiotherapists, other medical practitioners or as determined. This would provide the access to the necessary technical expertise to undertake the workplace capacity assessment while also ensuring that the treating doctor remained engaged in the care of the patient. By working with and facilitating the active referral model, rather than mandating the separation of the treating doctor and capacity assessment role, we believe there will be increased resources working towards the expedited return to work of the patient.

- That the AMA and relevant colleges undertake further work with Workcover on education treatment guidelines and other systems and resources to identify most effective treatment approach and systems to identify patients who may require additional intervention of either a medical, counselling or career based approach to manage the return to work process.

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