Submission No 10

INQUIRY INTO NSW WORKERS COMPENSATION SCHEME

Organisation: Professional Health Partners P/L

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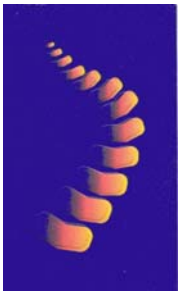

Professional Health Partners Pty. Ltd

We look after your Business whilst you look after Yourself

Joint Select Committee on the NSW Workers Compensation Scheme.

The Legislative Council

Parliament House

Sydney NSW 2000.

Submission

This submission has been prepared by Tony L Hennessy, a Physio-therapist with almost 40 years of experience. I currently work in NSW as a contract Physiotherapist.

My current work address is

My registration number is

My Provider Number is

My NSW Workcover number is

I have worked in Victoria, Tasmania, New South Wales, Queensland and the Northern Territory.

I have worked in Public Hospitals, Private Hospitals and Private Practice.

The NSW Workers Compensation Scheme:

General Overview:

The current scheme is unwieldy, expensive, inefficient and not meeting the needs of the employers or the injured workers.

It does not meet the needs of the medical professionals trying to restore injured workers to good health and to provide an expeditious return to the work-place.

The Scheme currently has many Insurance Companies working under the umbrella of Workcover.

Each Insurance Company has its own bureaucracy, from Boards of Management to frontline office staff. They work through Case Managers (who typically have no formal medical training) and return to work coordinators. These typically work for a third party Company, and also seldom have any formal medical training.

The Case Managers, employed by the Insurer, and the Return to Work Coordinators have the right to withhold treatment recommended by specialists, or to over-rule evidence based treatment based on thorough medical knowledge.

The problem becomes more absurd in that the Insurer, Case Manager or Return to Work Coordinators often change, without notice. The Insurance Company changes with amalgamations and take-overs, or when employers change Insurers, the Case Managers seem to change within Companies without reason and it would appear that if the Return to Work Coordinator works too diligently on behalf of the injured worker then the Insurance Company replaces them with someone who works more in accord with the wish of the Insurer.

Advice from the most senior Medical Staff in the country can be over-ruled by Case Managers, and often Orthopaedic or Neurosurgery is delayed or never done on the whim of a Case Manager “who decides that it is not necessary.”

Insurers regularly use Medical Advisers that are known to provide reports favourable to the Insurer. These appear to be used to prevent reasonable care to injured workers, especially if the injury is complex, or has been ongoing for a significant period. They are often flown in to an area from afar, see a large number of people in a short period of time and then leave the region. Alternatively patients are directed to travel inordinate distances for a consultation, with all reports and radiology. They are usually advised “I am performing this examination on behalf of the Insurer and I am unable to discuss any of my findings with you.”

In the event of an adverse report this does not allow the injured worker to contest the statements effectively.

It would appear that many medium sized businesses choose to pay the fees for injured workers themselves, rather than transferring the cost to the Insurance Company because the long-term penalty to the Company’s premium is much more than meeting the cost themselves. This seems to be a ridiculous situation, but certainly it would fit with the Workcover objective of cost containment.

Insurance Case Managers and Return to Work Coordinators have a policy of returning injured workers to a work-place, even when it is impractical. A person who works as a heavy labourer in a sawmill or a coal mine is unlikely to be able to be gainfully employed in those positions with a serious injury, yet that is exactly what is attempted. When this fails, there is often a statement in relation to retraining. But the retraining is often unrealistic. A hard working saw-miller is unlikely to be able to cope with retraining as a computer technician or as an office worker but these seem to be the first options considered.

I have been notified twice in the last fortnight that injured workers have been advised that they should seek retraining at their own expense and that on commencement of retraining they will be transferred to Centrelink payments, and their compensation would cease. This is hardly motivation for an injured worker to attempt rehabilitation along a new career path.

Physiotherapy Specific Concerns:

One Client that attends the Clinic that I now service has an ongoing injury that has three different Insurers, three Case Managers and three back to work coordinators, including a self-funded Insurance Office within the employer Company, all arguing over who is responsible for specific treatment. This results in a huge amount of paperwork and common argument by the Insurers in relation to liability. The visiting Medical Specialist to the employer has issued a continuing certificate for impairment, but the Insurer for that specific area of concern has notified the Clinic that the case has been closed and finalised. The worker has not been advised, and quite rightly says that he has just has a further medical investigation and he has been advised to continue having treatment.

It must be pointed out that there is never a problem with the employer and the self-insurance system; the concerns always involve the previous two Insurance Companies.

Concerns with the Physiotherapy Management Plan:

The following demonstrates the process under which an injured worker receives Physiotherapy services. It is indicative of the complexity and frustration across the medical sector in relation to the current system of health delivery to injured workers.

The current system requires a “Physiotherapy Management Plan” to be submitted for each 8 treatments. These have to be approved and returned before the therapist is allowed to provide ongoing treatment. The “Plan” is often not returned, and often the Insurer claims to have not received the Plan, despite the fax receipt showing Day, Date and Time received. When Case Managers go on leave there is seldom a system in place to ensure these “Plan” documents are dealt with.

The option to send these via email (with guaranteed evidence of receipt) was rejected on the basis that the Insurance Company’s system does not allow this to be stored properly. This does not make sense in that the Document would be scanned at the consulting room and could be printed out in the Insurer’s office in exactly the same format as the one delivered by fax.

Most galling is that these “Plans” have to be approved by people with no medical training, and in many cases with very limited experience. There appears to be a high turnover in Case Managers in most Insurance Offices. This results in the often statement “I will need to talk to a supervisor as I am not sure of my responsibilities in this matter”. Most of these Case Managers would appear to be junior Staff in the first few years of employment.

A recent case (May 7th) has the following curious twist.

A PLAN was submitted to the Insurer and returned promptly, approved and signed off.

The request was to allow a worker to follow a rehabilitation exercise program in a very high quality gymnasium, as he was not progressing with standard treatment. A phone call from the Case Manager requested a letter in relation to the Gymnasium costs. This was forwarded and the Clinic was advised that it appeared to be reasonable.

On that basis and the signed PLAN the program was commenced.

Two weeks later the Clinic was advised that the Case Manager had been shifted and the new Case Manager did not approve of the program. At this stage there is some doubt that the sessions will be paid for, or that the gymnasium will be paid.

Logically, this Physiotherapist asks what is the significance of the Plan process if a PLAN can be approved and then removed after completion.

This is a Physiotherapy specific concern but the difficulty of compliance with paperwork seems to cut right across the medical arena. Some GP's choose to not act as the Nominated Treating Doctor (NTD) under Workcover because of the difficulty of compliance. One major Physiotherapy group advertises that all patients are treated as Private Patients. The group does not provide a service to Workcover, RTA or Veterans Affairs because the paperwork is untenable.

<u>In Summary:</u>

- Workcover is fragmented across many Insurance Companies, each one required by their shareholders to make a profit.
- Each Insurance Company has its own bureaucracy that adds major costs to the process.
- The profit driven motive of the Insurers ensures that most injuries of significance end up in the hands of lawyers, with resultant delays, angst and significant cost increases. This is best exemplified by media advertising from Law Firms that promise "We will get you more." In most cases, the Law firm gets more and the injured worker gets more frustration, depression and ostracism.

- The most common complaint from employers is that there is never a delay from the Insurance Company when the premium is due, but there are interminable delays and impediments when the worker is injured. Of course the second shock occurs when a claim is processed and the employer finds that the premium rises by amounts that are sometimes more than the claim made.
- Workers are required to submit Medical Certificates to the employer but unless these are forwarded to the Insurance Company, the worker is threatened with loss of wages. Many injured workers find the only option is to copy the Certificate themselves to the Insurer.
- Medical personnel must report to, and live by the decisions of unqualified clerks in Insurance Offices even when medically it is obvious that the decision of the clerk is not in the best interest of the injured worker. There is no right of appeal in any real sense because the Insurer simply refuses to meet the cost.

The Solution:

Workcover as it now operates must be dismantled.

It is failing to support injured workers; it is failings the medical personnel delivering treatment to injured workers and it is failing NSW in that it is not meeting its obligation to provide this service at an economic cost.

A new authority based on the Motor Accident Insurance Board of Tasmania should be used as a template for Workers Compensation Insurance.

The MAIB is the only insurer for Third Party insurance in the State of Tasmania. It is a statutory authority that is run by a Board at arms-length from the Government.

MAIB provides immediate care to people injured on the road. It does not have to determine who “was in the right” and it looks after all injured people without argument. It has strict cost limits in relation to those drivers breaking the law but this does not stop medical support to those people whilst overcoming the injuries. Illegal behaviour, such as drink-driving, drugs, unregistered vehicle, does impact on final settlements where injuries result in permanent loss of function. However innocent victims of such behaviour are not disadvantaged and all people, including the offenders, have the medical costs covered promptly and without duress.

- Because of the humane approach to care, there is a dramatic reduction in legal costs, with most people not needing to obtain legal counsel at all. Final settlements are usually provided by the generous schedule and again often are done without legal advice and the substantial associated costs.

The MAIB in Tasmania has a substantial investment fund that has helped it weather some major cost increases in recent times, although the biggest drain on its potential surplus remains the State Government “dividend”, which is simply a tax by which the State Government takes a large amount of money for other purposes from road users in the State.

Even with the “dividend” to the Government, the MAIB fee is considerably cheaper than the Greenslip in NSW and Victoria. It must be noted that the NSW method of providing Third Party Insurance for motor vehicle accidents follows the same template as NSW Workcover, with multiple Insurers competing to provide the Insurance cover. This also provides a second rate, and very expensive program that becomes a feeding station for Law firms.

The Benefits of a Statutory Body to provide Workcover:

- There is only one bureaucracy, with one paid Board of Management and one set of rules for providers to adhere to.
- There is only one set of Offices, with reduced rent and overheads when compared to the current fragmented process.
- There would not be a need to make a profit, unless the State Government decided it also required a “dividend”.
- There would not be a revolving door of Insurers adding complexity to service delivery.
- Claims Officers and Return to Work Coordinators could be provided with proper medical training, and preferably be people with University training in appropriate areas of Medicine, or related University qualifications.
- A proper process could be put in place that would allow an easy appeal system when decisions taken by Case Managers were viewed by medical providers as being inappropriate.
- By developing a fast response and humane approach to Work Injuries, much of the legal involvement would be made unnecessary.
- Those habitual abusers of the system who makes claims with every employer they work for would be quickly found because there will be only one Insurer and one Database.
- The argument that multiple Insurers guarantee a lower cost structure because of competition does not stand up to serious review. The added structural costs, and the profit driven raison d’etre for Insurance Companies to be involved with Workers Compensation makes the current system unworkable and very expensive.

The simple MAIB system provides cost effective, high quality care that is respected by the medical profession and those people unfortunate enough to be injured on the roads of Tasmania.

Tony Hennessy. Physiotherapist