

**Submission  
No 165**

## **INQUIRY INTO NSW WORKERS COMPENSATION SCHEME**

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# ***Submission to the NSW Government Inquiry into the performance of the Workers Compensation system***

This submission addresses the performance of the Scheme in the key objectives of promoting better health outcomes and return to work outcomes for injured workers. Firstly I will outline my background and qualifications in making this submission before suggesting pertinent perspectives on how the system is failing. Finally I will make recommendations about how the scheme could better address the needs of injured workers and to reduce the excessive costs of minor injuries which proceed to major claims.

## ***My background***

My research concerns Australian rehabilitation provision associated with statutory personal injury compensation systems. My PhD was awarded on the basis of an eight year study investigating the dynamic interplay between health professionals and 'claimants' whose main barrier to return to work is chronic pain (Wales 2011). In 2010, in the international journal "WORK", we published a comprehensive review of published literature and policy documents to examine the models underlying current practice within Australian Workers' Compensation and Motor Accidents compensation systems, particularly in relation to 'medically unexplained pain' (Wales, Matthews et al. 2010). As part of the [SquareCogs Project](#) I teach health professionals the neurophysiology of chronic pain and the models used to explain pain, although for over a decade I worked within the NSW WorkCover system as a pain educator and counsellor in a return to work environment.

I am also the President of [Chronic Pain Australia](#), a community based not-for-profit incorporated association which advocates for broader community understanding about the phenomenon of chronic pain, its impact on the lives of Australians and the de-stigmatisation of people living with chronic pain.

The next section will overview the difference between 'acute' and 'chronic' pain and suggest that assumptions of the biomedical model form a context within the system which effectively escalates the progression from acute to chronic pain and increases disability in NSW workers.

## ***The current situation***

In Australia the annual cost of chronic pain to work productivity is estimated to be AUD 5.1 billion, a sum that includes absenteeism and reduced effectiveness at work due to pain (Cousins, Nicholas et al. 2006). In New South Wales (NSW) those soft tissue injury workers' compensation claims which resulted in permanent impairment were estimated to cost AUD109 million in 2007 (WorkCover NSW 2008). However, the full extent of the economic impact of reduced work effectiveness due to pain is uncertain (Cousins, Nicholas et al. 2006) and the total cost of persistent pain across all Australian compensation jurisdictions remains difficult to quantify.

In the NSW WorkCover system, rehabilitation professionals work within accredited rehabilitation organisations to provide rehabilitation assistance to workers, many of whom experience minor injuries. It is notable that many of these workers go on to experience long term disability due to pain. How can this occur? In many respects the answer is much bigger than the NSW WorkCover scheme, and can partly be revealed by how we, as a broad community, explain pain.

Most people understand pain that is associated with an injury and which goes away once the injury heals. This is called 'acute' pain. However, if pain persists beyond the time expected for normal healing ('chronic pain'), it is likely that other physiological processes are occurring. In particular, the nervous, endocrine and immune systems are now understood to be critical in the production of long term pain (Gracely, Petzke et al. 2002; Dantzer and Kelley 2007; Chapman, Tuckett et al. 2008). There is increasing understanding that acute pain related to a minor injury may become chronic pain in the presence of overwhelming threat (Lyon, Cohen et al. 2011). Many of these workers have had investigations that reveal little or no pathology to explain their pain. This is called 'medically unexplained pain' and in my experience, many of these workers find themselves being treated quite differently to those whose pain is distinctly explained by ongoing injury, for example orthopaedic injuries. Indeed they often find their pain is disbelieved by claims and health professional personnel. For many workers this is quite threatening – experiencing pain which people don't believe and which leads to arguments about one's veracity can be quite threatening on many levels: threat to future income and employment, threat to integrity, threat to life purpose, threat to enjoyment, even threat to ongoing marital harmony and survival. The 'invisibility' of pain leads to negative responses by case managers, health professionals, co-workers and even family members who expect the pain to go away. Many respond with disbelief and argument, and this becomes a part of the problem. Based on current understanding about the physiology, pain in these circumstances can be expected to escalate.

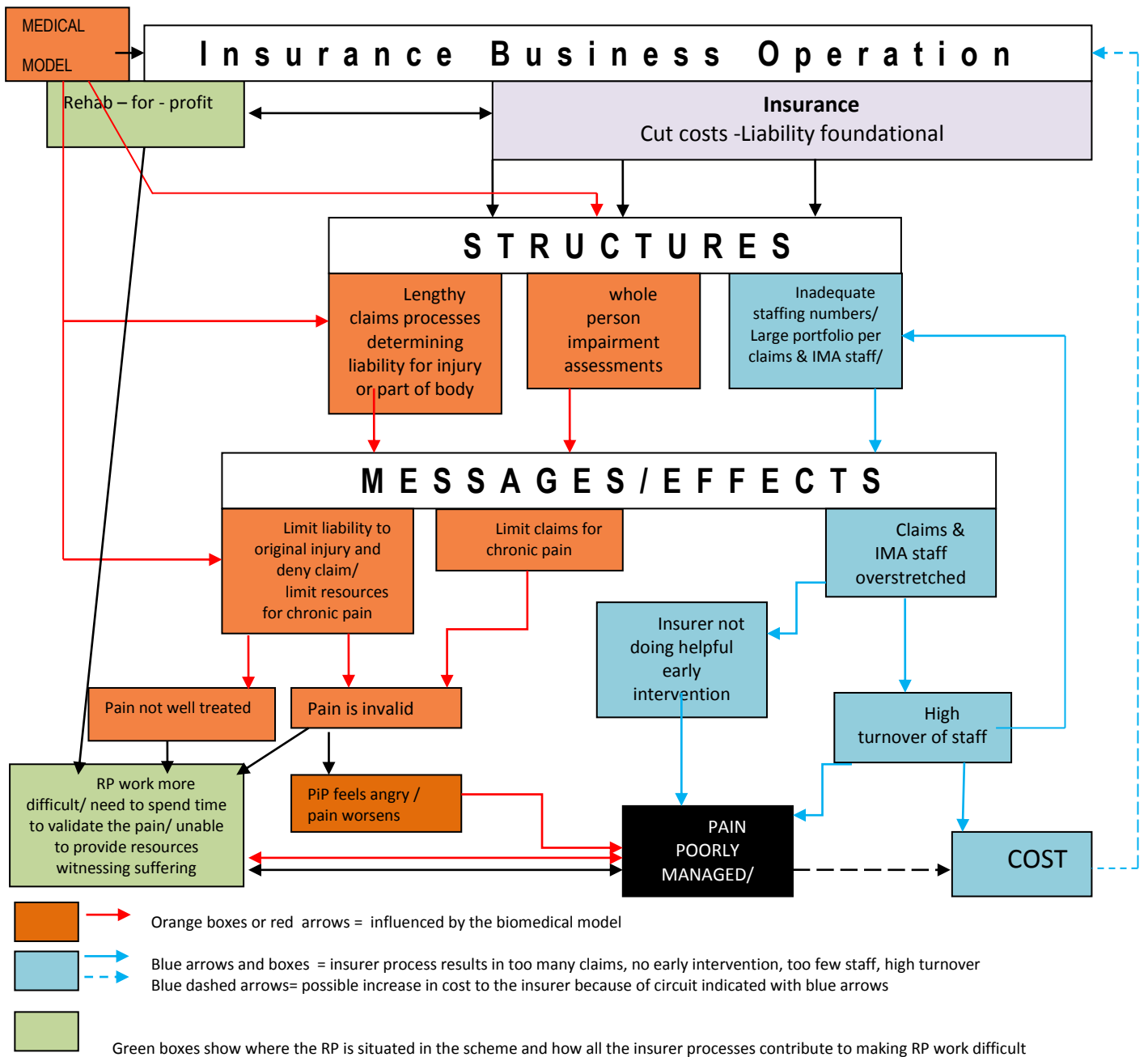
At the same time, I have observed that claims staff spend significant time and energy trying to 'prove' that the worker is somehow magnifying their pain. We now understand that over time, chronic pain can be increasingly experienced in parts of the body other than the site of the original injury. A pain that started in the elbow can, over time, progress to the shoulder, the neck, the back

and the other side of the body (Lyon, Cohen et al. 2011). This then brings on issues of liability and more argument. The effect of this considerable time and expenditure is to actually make pain worse.

The underlying problem here is that most people use an 'acute' pain model to explain chronic pain. Models that explain pain this way are fundamental to the 'biomedical' framework which posits that where there is pain there is injury (Quintner, Cohen et al. 2008). In my work with people in pain I have witnessed many whose beliefs are consistent with those of the broad community: pain is always directly related to injury, in other words, a biomedical model for pain. People with chronic pain frequently end up on a treadmill or 'medical roundabout' looking for a 'cure' for their pain. As time goes on, this search for a cure is associated with increasing distress and fear that there may be a sinister cause for their pain, not yet found by the medical profession. Out-of-date models of pain widely subscribed to by the community are grossly unhelpful in perpetuating pain related disability.

To illustrate the way the current NSW Workcover Insurer process makes pain worse and claims more expensive, please refer to Figure 1 (Wales 2011). Here we see how the business processes used by the insurer rely on structures which are underpinned by assumptions of the biomedical model of pain. The commercial link between the insurer and the rehabilitation organisation is shown at the top of Figure 1. Mechanisms employed by insurance organisations operating as a business include lengthy claims processes to determine liability based on a medical diagnosis and the whole person impairment system. Each of these mechanisms attempt to limit claims for chronic pain. These mechanisms are aligned with the biomedical model of pain (shown in orange, with red arrows indicating its direct influence). There are frequently too few staff, too much work with little time to achieve what needs to be done in insurance business processes. It would appear that there is a negative feedback loop whereby inadequate staffing numbers, too much work, high staff turnover and increased costs puts pressure on these insurance business processes to reduce costs and the cycle continues as shown in Figure 1 by the relevant pathways in blue (Wales 2011).

One of the outcomes of this process is that pain is often poorly managed particularly when the business operation is so closely aligned with the biomedical model of pain. It is an assumption of the biomedical model of pain that if pain is not related to an assessable physical impairment then it is not valid. The interaction between the insurance business processes and the biomedical model of pain sustains and exacerbates disability due to pain. This contributes to the costs being borne by the insurer notwithstanding attempts to further invalidate pain through medical assessments.



**FIGURE 1: Insurance based system affecting rehabilitation**

## ***Recommendations for change***

This brief overview of some of the systemic problems of the NSW WorkCover scheme – in relation to dealing with the problem of chronic pain - raises some clear recommendations for change. If all parties have a better understanding of the effects of using out-dated models to explain pain, we can go some way to reducing the negative spiral of increasing disability and cost associated with poorly managed chronic pain.

Public education programs are highly recommended. For example, campaigns addressing community attitudes about chronic pain and campaigns to publicise examples of people who were able to return to meaningful activities despite pain are required rather than examples of fraud which are currently widely disseminated in the media. These campaigns about chronic pain have good evidence in the Australian context, reducing the burden on the health system and reducing long term disability (Buchbinder, Jolley et al. 2001). These recommendations are consistent with the National Pain Strategy (Australian and New Zealand College of Anaesthetists, Faculty of Pain Medicine et al. 2010) which was the result of over 12 months of development and consensus building among a wide ranging group of stakeholders including consumer representatives and their families, medical and allied health personnel, and peak bodies for consumers, health, business and employer organisations.

Other recommendations are at a system level and include education programs to address knowledge deficits about chronic pain. Targets for such programs include people experiencing pain, claims staff, doctors, rehabilitation professionals as well as lawyers and other stakeholders. There is strong evidence that such education reduces fear and disability related to pain (Moseley 2004; Moseley, Nicholas et al. 2004).

Other system changes recommended include the elimination of whole person impairment assessments which systematically invalidate chronic pain despite the evidence that pain can cause significant disability in the absence of assessable impairment. This recommendation is not new, as suggested by Quintner (2004):

*Some of the issues that need to be addressed include the practice of assessing disability using impairment ratings, misguided attempts to compensate people for pain and suffering rather than for their inability to work ... and the apparent failure to recognise that assessment systems themselves can add to the humiliation of the people whom they were originally designed to serve (Quintner 2004, p. 56).*

Facilitating rehabilitation consultants to be able to spend valuable time with the client in pain in order to validate their experience and build trust is recommended as best practice (Quintner, Cohen et al. 2008; Wales 2011). It is important to be able to apprehend the whole person using appropriate programs which address the barriers presented by chronic pain (Hayes and Hodson 2011). These

recommendations counteract the strong current of stigmatisation that is effective not only in delegitimising the experience of chronic pain, but also in increasing pain related disability and claims cost. The relationship between the professional and the person in pain is the pivot on which successful rehabilitation depends. The professional training that teaches health professionals to respond empathically to the suffering of people in pain is often discouraged by the culture of NSW WorkCover where rehabilitation consultants are told to avoid advocacy, and yet this is the cornerstone of health provision. This lack of advocacy flies in the face of what many consider to be the role of the rehabilitation professional (Layne, Hohenshil et al. 2004; Egan 2007) and is particularly unhelpful in light of the influence of the professional and the person in pain on each other's health in the therapeutic encounter (Adler 2002; Quintner, Cohen et al. 2008) Herein lies significant conflict for the rehabilitation professional and a direct link between the experience of the therapeutic encounter and failure in rehabilitation.

To restore this therapeutic relationship, our recommendation is to extend opportunities for health professionals to undertake training which not only apprehends the complex physiological basis of chronic pain, but reaffirms their role as agents of rehabilitation. Thus trust and knowledge can be shared and true partnership between health professional and person in pain can be established. It is this interpersonal therapeutic relationship in which true healing can occur (Institute of Medicine 2001).

In summary, in this submission I suggest that we need to start thinking about minor injuries differently. We need to increase the awareness of ALL stakeholders of the risk of acute pain becoming chronic, and the circumstances in which this is likely to occur. Ongoing arguments and the application of out-dated models to explain pain will continue to compromise the health and wellbeing of the scheme and all its stakeholders. Major recommendations include public education campaigns to increase awareness in the community about how to manage acute pain so that the risk of progression to chronic pain is reduced. Other recommendations include providing comprehensive and tailored education and awareness programs about chronic pain, not only for injured workers but particularly for the claims and health professional staff who serve them. Only then will we start to see real health and wellbeing outcomes not only for this group of NSW workers but for the scheme as well.

Respectfully

Dr Coralie Wales

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