Submission No 75

FIRST REVIEW OF THE WORKERS COMPENSATION SCHEME

Organisation: Injured Workers Support Network

Date received: 9 October 2016

Submission to the Standing Committee on Law and Justice.

First Review of the Workers' Compensation Scheme

Addressing Terms of Reference:
1 (a) Workers' Compensation Scheme

Injured Workers Support Network

Return to Health

Injured Workers Support Network

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The injured workers support network would like to thank the numerous members and volunteers who have helped research and compile this submission. We would also like to thank those injured workers who have shared their stories with us to include in our submission.

Note: *All names and identifying information have been suppressed within this submission to protect the privacy of the people and families those stories belong to.*

07 October 2016

Injured Workers Support Network Submission to the Standing Committee on Law and Justice.
First Review of the Workers' Compensation Scheme

Addressing Terms of Reference: 1 (a) Workers' Compensation Scheme

The Injured Workers Support Network (IWSN) welcomes the opportunity to provide a submission to the Law and Justice Committee regarding the review of the Workers' Compensation System.
Established in 2011, The Injured Workers Support Network is a not-for-profit organisation whose prime purpose is to assist injured workers trying to navigate the adversarial NSW Workers' Compensation System by providing them with their rights, educating members and the public regarding the impact and consequences of the current system and advocating for change that enhances the lives and return to work prospects of injured workers in New South Wales.

Notes on our submission:

In our submission we have highlighted those areas of the Workers Compensation System that have the greatest impact on our members and on the injured workers of NSW. Our submission mirrors the journey taken by injured workers as the move through the system from the original claim to returning to work or being sent to the dole cues with an acquired disability.

To protect the privacy of our members and those people participating in our submission we have de-identified the quotes to the best of our abilities.

Invitation to the Law and Justice Committee.

The Injured workers Support Network is willing to make our Coordinator and a few willing members available for interview by the Law and Justice Committee if it wishes to take up the offer.

We would further offer and suggest that the committee travels to a regional area to hear from injured workers living in regional NSW about their lived experiences of the system as these are vastly difference than those living in the Sydney basin.

Anachronism used in this submission:

IWSN: The Injured Workers Support Network

WIRO: the WorkCover Independent Review Officer

The Regulator: the State Insurance Regulatory Authority.

iCare: Insurance & Care NSW

Contents:

Executive Summary

The Injured Workers Support Network believes that the problems with the workers compensation are significant and systemic. The impact is very personal. The most significant problem is the system places insufficient emphasis on a return to health of injured workers, placing too much influence on a return to work strategy, which, though important is only a part of a return to health which is of paramount concern to injured workers.

The problems stem from the system itself. From the overly complicated claims system to the lack of professional interest in the insurers. From the 21-day approval times which are too long to begin with to the stalling tactics employed by the insurers to extend this time.

The private investigators pervasively used to provide “medical evidence” against injured workers for Independent medical examiners and other guns for hire medical consultants and vocational assessment providers.

Anything good about the system is discharged inadequately by the insurers and others. The independent medical consultants, who should be there to assist nominated treating doctors in their planning and service provision are used to provide evidence to reduce or eliminate weekly benefits or medical services for the injured worker. Injury management plans, there to provide some assurance of service to the injured worker, are in practically a case list of administrative obligations the insurer makes the injured worker beholden to.

The independent umpires, both The Workcover Independent Review officer and The Workers Compensation Commission are hamstrung to provide the full range of independent assistance and over site the system need.

Within all of this is the worker injured while performing his or her duties for someone else to make a profit from. There are no constraints on the behavior of the Employers in the way they treat those workers injured by their systems or lack of systems. There is no real protection of service nor assistance to retrain or become employed again.

Change is desperately needed to ensure that those people who rely on workers compensation for their recovery from a workplace injury or illness and or adaption to an acquired disability.

The Impact of a workplace injury

"Sensitivity, stress, unbearable pain and depression is something that I deal with every day.

The worst is frustration and acceptance that from a healthy person I became a disabled person.

It is unbelievable what we injured workers have to go through, with the insurances not taking our condition seriously.

I do not really care about greedy insurances loosing 4 billion dollars through wrong investments, being in surplus now, only proves to all of us another big lie and it only shows how much in benefits injured workers lost since the changes have been made.

of course, we are just numbers in the system.

We are heavily mortgaged, with the husband about to lose his weekly benefits, due to the return to work capacity decision being made, that actually says that he is able to do the office receptionist work only, due to his back and hernia injury, but the insurance wants him back to work doing heavy lifting, twisting, bending …

Needless to say I am on 80 % of my pay, so we will basically either starve or lose our home.

Our credit rating is destroyed, our lives are destroyed. Our family is the only value that we still have.

cheers to all of you out there, do not stop fighting for our rights."

(website comment October 2014)

The Injured Workers Support Network is inundated with stories of hardship suffered by people after the impact of a workplace injury and involvement in the NSW Workers Compensation System. Since 2012 these stories have been told daily to the coordinators of the Injured Workers Support Network and if listed in full, would require more space than is available within this submission to recount. The stories of our members can be found on our website for anyone interested in reading them
http://www.injuredworkerssupport.org.au/your-stories.

The Injured Workers Support Network believes that there is a divergence between a person with an injury and one going through the workers compensation system it is important therefore to separate the impact of an injury from the impact of the workers compensation system to gain a true understanding of the issues surrounding the NSW Workers Compensation System.

An injury serious enough for the person who suffered it to have time off work or require medical intervention to overcome has a lasting effect.

In 1967 Drs Thomas Holmes and Richard Rahe researched and published a list of the top life stressors an average person can face.

As soon as someone has an injury at work (as opposed to injured outside of the workplace) serious enough for them to need workers compensation seven out of that list occur:

- personal injury (score of 53)
- Change in financial state (score of 38)
- Change in workplace responsibilities (score of 29)
- change in working hours (score of 20)
- Change in recreation (score of 19)
- Change in social activities (score of 18)
- Change in sleeping habits (score of 16) and
- Change in eating habits (score of 15)

According to those psychiatrists this gives the injured worker a potential immediate score approaching 293. A score of 300 means that person is at clinical risk of a serious illness due to stress. All it takes is one more stressor to crop up, and it will, and that person will exceed that clinical boarder and there are 16 others likely to happen once someone is injured and going through the workers compensation system these include: Divorce, Marital separation, Dismissal from work, Retirement, Change in health of family member, Business readjustment, Sexual difficulties, Change to different line of work, Change in frequency of arguments, Foreclosure of mortgage or loan, Spouse stops work, Change in living conditions, Trouble with the boss, Change in residence Applying for a small loan, Minor violation of a law.

One aspect that isn't mentioned by the psychiatrists in their evidence was the impact of isolation. Isolation is part and parcel of a work place injury. Even with the best of workplaces, the best of family support, the best medical support an injured person will feel isolated, and in a very practical sense an injured worker will be isolated, no one can overcome any serious injury without feeling isolated.

The second aspect which is rarely addressed by people talking about workers compensation is the acquired disability.

The legislation talks about "workers with high or highest needs" they compartmentalise injured workers through a total body impairment percentage impairment system and provide services based on this compartmentalisation regime. Professional stakeholders rarely discuss the impact of an acquired disability on an injured worker. The range of social and familial activities that the injured worker will no longer be able to participate in due to their acquired disability and the impact this has on the injured workers ongoing relationships and self-identity. The Injured worker becomes a body map on a wall with a doctor and insurance case manager using coloured stickers to work out liabilities and responsibilities. The person as a whole, as an active member of their society and family is given no consideration.

The Injured Workers Support Network provides assistance well beyond the scpe of the workers compensation system and legislation. We have helped numerous injured workers access emergency housing, bill assistance, financial counselling, marriage counselling and legal aid for divorces, parenting courses, anger management courses, emergency food services, shelters, drug addiction services, suicide prevention services and more. We have helped people access disability services and psychologists, pro-bono lawyers for foreclosures, Centerlink and welfare support agencies. The assistance we now provide goes well beyond the established aims of providing a voice for injured workers within the workers compensation system and takes up and increasing amount of our work time and phone calls.

This form of assistance is not being offered by any other service geared for workers in NSW and beyond. It is also unrecognised by the insurers and the government as being necessary.
The reason for this is as above; the emphasis for these agencies is on financial outcomes, not human outcomes.

It is the hope of the Injured Workers Support Network that this inquiry will not only lead to changes within the current system but will establish a future Upper House investigation into the impact on injured workers of the NSW Workers Compensation System, not just how effective the legislation is at fulfilling its stated roles but on how the system as an ecology surrounding the 3.5 million workers in NSW are assisted if they are injured at work.

The Impact Of Being On Worker's Compensation.

Since being injured at work in 2007, I have not only had to endure worsening pain and limited mobility, I have had to constantly deal with people who question my injury even though I have medical evidence that it is a reality. I have been isolated from some of my friends who are fed up with hearing about my woes with Workers Compensation and members of my family who have always been supportive, also get fed up with my complaints.

I was a happy, adventurous person who had an excellent job. I have travelled widely, had so many interests like painting portraits and making jewelry. I frequently went to Art Galleries, concerts and my big passion, movies. I used to have dinner parties and barbeques for my friends, I would go on drives and picnics on the weekends. Now my big entertainment is TV, because to go out means that the next day, I will have to lay down and recover from any activity.

I do not suffer loneliness as I still have close friends and a big family, but I cannot visit them as driving aggravates my injury; I am restricted to local driving. Housework is a real problem as I cannot kneel and as my shoulder also has limited range, I cannot reach up either. Due to my shoulder injury and my knee injury being on the right side, it is very difficult to use a walking stick as it causes pain (I am right handed). This has meant that several times I have fallen over, mostly on my front lawn when getting mail, so it has not hurt me, it is just embarrassing to get up as I can't. My husband is home with me and he helps me when this happens. Without him, I would be in a desperate situation. I still go shopping as it is a chance to socialise, but I use the shopping trollies as support and it is very embarrassing when I scream in pain if I move the wrong way. Other people either rush to help me or look at me strangely.
It has also affected me psychologically but I am loathe to admit that as I fear more judgment and I know secondary injuries are not acknowledged by the current system. I fear the phone ringing as case managers have claimed that they have tried to contact me and I was not there, even though most of the time I have been here and my husband is always here. I have told them I prefer e-mail but they always ring me at home.

I also now have a fear of going to doctors, not that my doctors have been anything but kind and helpful to me. I am required to see my treating doctor once a month and I am embarrassed about that. I feel like I am wasting their time as I never get any better and there is limited treatment they can give me. Consequently I have not addressed other medical issues I may have, except for my eye allergy, which affected my eye sight for nearly two years until I sought the help of a specialist. I was treated with genuine compassion and made to feel like a normal person because there was no 'legal' aspect to that illness.
Today I am not that happy person. I veer between despair and anger. I feel like I am constantly being pressured to have an operation, I feel like going to IMCs, case conferences, vocational assessments, functional assessments is my new job and there is zero satisfaction in that. I just want to be treated the same as anyone else with a disability. I just want to be a human being again.

Open letter to committee from member. included with permission

Return to Health

> **"Well after a long 19 months on this horrible ride dealing with workers comp, I have won and will receive my back operation. Everyone please stick it out because it is worth it."**
>
> **(website comment April 2016)**

Within the NSW Workers Compensation System the catchphrase on any information provided by the Government through its Regulator, The Insurers or WorkSafe NSW is "Return to Work". This catchphrase has become as close to a religious mantra as is possible within the current system. The Government's emphasis on Return to Work has become all-encompassing for the professionals working with injured workers, questions within medical assessments are phrased in such a way that the return to work mantra is either explicit or implied, but must be addressed by all medical professionals. Insurance KPI's and casework management are explicitly related to ensuring the injured worker "returns to work". Requirements on injured workers to maintain assistance throughout a recover is explicitly linked to requirements to return to work. Benefits can and are suspended because of an insurers perception that the injured worker is not adhering to the return to work case management strategy.

Medical support is also linked to the return to work processes, with medical care denied to workers if the result would not allow or move that injured worker closer to a return to work, even if it would allow that person to recover or maintain their health and/or functioning. Within the current workers compensation system returning to work is the one and only test of success for everyone involved.

> **"My last return to work plan in 2013 after violence in the workplace resulting in PTSD was I had to fight to go to a different workplace. 2 weeks after I commenced work my work plan consisted of working 9-5 with an hour for lunch and attend all medical appointments in my own time. I can tell you I never fully recovered and I was not allowed to talk about the incident in my new work place or to discuss my PTSD. Fast forward 2 years I have been on special leave for 8 months since that time I have had a stress heart attack amongst other things waiting to see when and if I am medically fit to return to work."**
>
> **(website comment October 2015)**

The Injured Workers Support Network firmly believes that this focus has so skewed the system that it is damaging to anyone unlucky enough to have been injured dues to an incident at their workplaces.

We have entitled our submission “return to health” because the Injured Workers Support Network strongly believes that as much emphasis on a return to health should be the true requirement for a workers compensation system. Returning to work is one part of this process but it should not become the bulls eye that it has become ensuring that any other positive intervention the workers compensation system can produce are ignored as are currently the case.

Placing Return to health as the goal of the NSW workers compensation system would lead to a systemic focus ensuring that a worker, injured because of a workplace incident, has the medical and supportive interventions required to recover from that injury and or adapt to an acquired disability and maintain a level of functioning equating to the capacity available to them in light of their physical or psychological injury, illness or disease.

Returning to work would be an important aspect of this, there is enough proof that a timely, secure and durable return to work is important to the recovery and or adaption from injury of an injured person but a quick and early medical assessment and treatment is even more important to the recovery and or adaption to an injury as**:**

a. the quicker the diagnosis and establishment of a treatment plan the quicker and more likely maximum recovery will be achieve
b. the quicker maximum recovery can be achieved the quicker an injured worker will be able to return to full duties or adapted duties matching the acquired disability will be achieved.
c. The less likely a secondary injury will occur due to a too early return to work while injured. Finally d. the cheaper the costs of the system will be over the lifetime of a workers injury.

The real tragedy inherent in the current Workers Compensation system is the sidelining of the health needs of injured workers. If the same emphasis and resources were employed to ensure an early diagnosis of an injured workers medical condition as is devoted to denying a claim, the treatment of such and the development of a recovery/adaption focused injury management plan would inevitably lead to a quicker return to health and work.

An early access medical model would also reduce the likelihood of secondary injury caused by the inadequate first instance medical care prevalent in the current system. It would also prevent the likelihood of re-occurrence at a later date due to deterioration.

It is the opinion of the Injured Workers Support Network that the current emphasis on return to work is preventing injured workers from truly recovering and or adapting from their workplace injury. A return to work is part of the true aim of a workers compensation system, it should not be the only goal less the system does what it is doing now, which is ignoring the medical and recovery needs of injured workers.

"I injured my arm/elbow back in October 2014, I reported the problem but didn't initially do a incident report by December that year I was really having trouble so reported it to my supervisor who told me to fill a incident report. I went to my gp who signed me off unfit for duties. I started physio in that same period it helped, about the beginning of January both my physio and doctor told me I'd be off for a least 4 to 5 weeks more before I'd be right for work, my caseworker came to my doctors appt in January 2015 and because the physio had said my arm seemed stronger and improved I was to go back to work full time the next day, I lasted a few weeks and ended up back on 5 hrs a day.

In the end my arm just got worse I couldn't really do anything right handed, the machine I was running I had to have someone setup for me as I couldn't, bug as time went on the pain was getting worse, I'd even told my doctor I'd had enough just cut my arm off. I was referred to a orthopedic surgeon, had MRI done which confirmed I needed surgery. I had been on and off work up your this point.

My arm was operated on mid 2015 the recovery time was 4 weeks off work with about 4 to 6 weeks for the pain to subside, then light duties for a further 14 weeks with regular physio sessions, my arm strength was getting better but once I started back at work the pain was going away and my arm strength dropped.

I ended back off work, back to surgeon I'd end up back at work change of tasks still no good. Ended up seeing a microsurgeon and then a pain management specialist turns out I have nerve damage now."

(website comment January 2016)

Recommendation:

- That the Committee recommends the system adopts are return to health strategy for the injured workers of NSW.

- That the committee adopts the philosophy within their recommendations that all aspects of the Workers compensation system should reflect a Return to health of the injured worker as its priority.

- That the Committee recommends the NSW Government renegotiate the KPI's and public reporting mechanisms for the insurers and others delivering a service to injured workers to ensure the recovery from injury and or adaption to an acquired disability is the main focus of their work.

- That the government incentivises insurers and others delivering a service to injured workers, rewarding achievement for the recovery, rehabilitation and adaption of injured workers to and from their workplace injury.

- That the government ensures all propaganda and written communication reflects the goal of returning to health rather than the current return to work.

Making a claim

"I'm on 3 full months since the injury and the insurance still hasn't accepted the claim they need more time to investigate the injury. I'm broke and really don't know how long can i go on like this, this is so wrong you think you have a permanent employment and you'll be looked after if need be, but you may as well be a criminal since you get treated the same way, soo wrong…."

(website comment March 2016)

"I injured myself at work in October 2014 and I'm still waiting for a reply from work cover, it is actually 2 injuries that happened in the space of 2 days and I have been of work since with no income, they are sending me to a IME and have given me a claim number and now we are trying to get my operations to be done asap,1 is on the leg and the other on my arm, now i broke my hand 20 years ago and they are trying to tell me that my hand didn't heal properly and that is why it got reinjured(after 20 years) what happens at these IME places and they also mentioned my doctor has not filled my certificate of capacity properly and that is why the claim has been denied so I must get the forms done and sent to them then they will reassess my claim."

(website comment January 2016)

The issues surrounding making a claim mirror issues in all other areas of the workers compensation system. The significant issues in making a claim come from:

- **a.** The pressure on injured workers not to make a claim in the first instance and
- **b.** The processes for making a claim.
- **c.** The insurers tactics in denying claims and
- **d.** The problems in making a claim for injured workers whose primary languages are other than English.

The pressure on injured workers to not make a claim

The Injured Workers Support Network receives regular calls from newly injured workers asking the question as to whether they should make a claim for their time off.

These can be classified into pressure from employers and pressure from society.

Pressure from employers

> **"My employer said they would cover all my costs as long as I don't make a claim. I don't know if I can trust them but I also don't want to make a claim if I can help it"**
>
> **(helpline caller May 2016)**

During the unions NSW Return to Work Inquiry which the Injured Workers Support Network participated in we heard stories of employers encouraging their staff to not make a claim. This encouragement can be direct:

Or, in more cases, hidden within an "early intervention program".

> **"Employers are circumventing the system by offering the physiotherapy services, and we don't get to see whether they are injured or not. It's not restricted to whether they [the employers] are large or small. The way they have done it is that they are offering physio therapy to anyone whether its work related or not. We know the reasons behind it, it's to circumvent the [workers compensation] system. The first person who sees them [the injured worker] is the physio not the doctor. What if the physio damages the person? Physiotherapists should not be diagnosing the person."**

Patricia Fernandez from the Australian Meat Industry Employees' Union told the inquiry that:

A member of The Shop Distributive and Allied Employees' Association Newcastle & Northern (SDA) when asked about the behaviour of Coles and Woolworths stated in their appearance:

> **"People are actively discouraged from pursuing their rights from the get go"**

One of their members stated:

> **"My manager sent me an email that he sent to head office saying that I hadn't followed protocol [when I] saw my own doctor…. I have been told that it is a $500 retainer [for medical expenses] before it would go to workcover."**

When asked if this is an isolated incident of if it is a direction from head office the SDA representative agreed.

In July the Injured Workers Support Network helpline received a call from a young worker injured after a car accident on a sales trip who asked the following question:

"My HR has told me not to put in a Workers Compensation claim that they would pay out of their own pocket for my treatment if I didn't do that. I want to know if this promise would be binding on them. Can I rely on it because I don't want to put in a claim because I know what they are going to think of it."

The statistics for workplace injuries verses claims also identifies a trend away from reporting.

Between 2010/11 and 2013/14 the rates of reported serious injuries resulting in a workers compensation claim have decreased by 26%. The table below identifies the dramatic drop in work conducted by (now) SafeWork NSW between those two years.

Workcover actions:	2010/11	2013/14	Difference
Visits to workplaces	24,752	26,280	1,528
Notices were issued	14,854	6,545	-8,307
Penalty Notices	587	92	-495
Prohibition Notices	832	673	-159
Improvement Notices	11,318	6,545	-4,773

Between 2011 and 2014 the workload of Safework NSW has dramatically decreased so the decline in claimed workplace injured cannot be contributed to the work of SafeWork NSW over this period. (*Workcover NSW Annual reports 2011/12, 2013/14*)**.**

Throughout Australia between 2001/2002 and 2011/12 the frequency rate of serious injuries dropped by 7% *(SafeWork Australia Australian Workers' Compensation Statistics 2011-12)* but the incident rate of serious injuries reported for NSW has been stable at between 13% and 14.2% (*SafeWork Australia Key Workers Compensation Information, Australia 2015, 2014, 2013, 2012*).

Since the 2012 laws came into force accepted claims have dropped by 37,109 with approximately 5-9% of all claims declined, a percentage that has been relatively stable over the past 10 years.

The actual number of claims made (accepted or otherwise) in NSW has dropped by approximately 21% during this time. The difference between serious injuries reported (-7%) and claims made(-21%) is disproportionate. This can only indicate that a significant number of injured workers are not making claims when they are injured.

This suggests that there are other factors at play for the reduction in workers compensation claims in the NSW Workers Compensation System. As identified through the two examples, one of the most logical reasons for this reduction is the role employers are playing in preventing workers from making claims. Another is the complexity of the system and yet another is the pressure from our society.

Complexity of the system

The Workers Compensation system is actually a series of micro systems and is difficult to capture in a flow chart. From making the original claim to participating in a work capacity decision to obtaining a total body impairment percentage calculation each aspect has its hoops and its pitfalls. These are in addition to the processes of lodging any legal proceedings that may be required such as appealing an insurers decision. For instance, each new or renewed request for medical support is considered a new claim by the system. This complexity leads a number of injured workers to give up early on when making a claim or to pull out later on when the pressure of meeting the expectations of this complex system starts to drag at them.

Either way the stats for the insurers and the regulator look great, less claims, but the person behind that stat suffers just because the Government and insurers create and enforce a system that drives people away from obtaining the assistance they need to recover from a work related injury.

Pressure from society

The social stigma attached to workers compensation pre-dates the 2012 changes. It has been described by one caller to the Injured Workers Support Network Helpline in these terms:

> **"If I had an injury from playing footty I'd be considered a hero by work and my workmates, a hard bloke. But I've got the injury because of work and on the job, I ain't considered a hero now."**
>
> **(IWSN helpline call September 2016)**

The issue may be complex but there is little done by the regulator or iCare to tackle this social stigma.

For example:
iCare has made a significant showing of supporting our Paralympian's in Rio this year (iCare Facebook page for reference), this is commendable, iCare has done nothing to address the issue of social stigma attached to having a workers compensation claim which is not commendable.

and:

The Regulator has put out one press release stating that it had won a court case against a worker fraudulently claiming workers compensation, it has not put out a press release against an employer who has no workers compensation (the injured Workers Support Network has assisted two members in 2016 to make complaints about their workplaces lack of workers compensation).

This stigma holds eligible people back from making a claim for workers compensation. It prevents them from accessing medical services they require and places them at the mercy of their employer's kindness. It is unacceptable that there is no support being provided to workers injured at their workplaces to combat the social pressure.

The Processes for making a claim

The process for making a claim can be convoluted. For instance there are four forms that can used as the basis for creating a claim:

- Other Work Related Injuries Claim Form
- Initial Notification of Injury
- Permanent Impairment Claim Form
- Worker's Injury Claim Form

The information provided by the regulatory leaves it as unclear which one of these four should be filled out by the injured worker, the employer and/or a third party on behalf of the worker.
All non self-insurers provide some form of online lodgment service, which is helpful, but there are significant differences in the advice provided for lodging claims
For instance:

- QBE does not inform the injured worker that they can lodge a claim without having to go through their employer but their website is aimed at employees. (*https://www.qbe.com.au/business/claims/workers-compensation-employee-checklist*).

- Employers Mutual, GIO and Allianz target their online lodgment only at employers:

    - *https://www.eml.com.au/services/state-schemes/new-south-wales/*
    - https://www.gio.com.au/business-insurance/workers-compensation/claims-nsw.html
    - https://www.allianz.com.au/business/workers-compensation/nsw/claim-lodgement/

- CGU have a generic lodgment target and, out of all the five insurers, is easiest to navigate.

None of the insurers offer information and advice on how to lodge a claim in a language other than English.

Once the claim is lodged the process for accepting or denying a claim is not smooth. We refer elsewhere in our submission to the insurer's use of private investigators and independent medical examiners so this aspect, most associated with the initial claims process will not be discussed here.

Obtaining medical records

Both legislation and guidelines provide powers to the insurers to obtain medical records of injured workers who have made a claim. To do this though, the injured worker needs to provide consent. If consent is not provided then the insurer can deny a claim or withhold payments. This is an abuse of power in and of itself. Under the Health Records and Information Privacy Act 2002 no one can access medical records without the patients approval, this control over their own records is taken away from an injured worker by the workers compensation legislations power to deny a claim or suspend payments in an ongoing case if the patient doesn't approve.

The Injured Workers Support Network admits that access to prior history regarding an injury is required to adequately assess a claim. The more pressing issue is the scope of the requests from the insurers to access injured workers records.

The letter requesting permission from the injured worker generally asks for all medical records rather than relevant medical records.

> **"My medical records have my elderly mother on them as well as my children, It also has some illnesses that are private, that have nothing to do with my injury. The letter states that if I don't give them permission my claim can be denied. Can they really ask for everything?"**
>
> **(IWSN helpline call May 2015.)**

The request for all medical records apart from being illegal is generally a fishing exercise by the insurer to find a reason to deny a claim. This is particularly used for psychological claims where an historical psychological illness (such as a past bout of depression) is used by the insurer to deny a claim by invoking it as an "existing and ongoing" illness. The insurer in this case will not consider the possibility that the injured worker has previously overcome the illness or that the workplaces' psychological or emotional violence (generally called bullying and harassment) could have triggered or re-injured the worker.

> **"I suffered depression after a death in the family six years ago and took medication for three months, the insurer is concerned that I haven't overcome that and what happened at work has nothing to do with my post-traumatic stress disorder"**
>
> **(IWSN helpline call July 2016)**

The insurer's tactics in denying claims

"The insurance company delayed decision of liability till after last Xmas .. Before Xmas my then CM told me if I wanted to be paid before Xmas I had to go back to the doctor an tell him to change my certificate .. As a single parent Xmas was hell as I didn't do what my case manager said. They accepted liability two weeks after Xmas.. Insurance companies and their private investigators are dogs that don't care for the truth only themselves"

(website comment September 2015)

"Denial of Liability for a injury. When I go through the process [appealing an insurer's denial of the injured workers claim] and go to the commission, I would say at least 90% of those get overturned."

(Regional Solicitor RTW inquiry participant)

A significant number of all denied claims taken to the Workers Compensation Commission are overturned by that commission in the workers favor. This suggests that the insurers are doing something intrinsically wrong when they deny claims.
This ehavior is routinely reported to the Injured Workers Support Network and is so common, it can't be put aside as isolated incidences and certainly the Victorian Ombudsman's investigation in to the management of complex workers compensation claims and WorkSafe oversight dated September 2016 identifies many systemic tactics that the Injured Workers Support Network sees in denying claims.

Delaying:

- Waiting for the last minute to send letters out and sometimes backdating those letters giving injured workers less than the required legislated time to respond.
- Telling the injured worker over the phone that the insurer was thinking about denying a claim, then not sending an official response so the injured worker can take action in appealing the decision.
- Refusing to accept the doctors work capacity certificate and telling the injured worker to "go back and get another one"

Overloading:

- Arranging appointments with investigators, rehabilitation providers, doctors and others in a tight timeframe (we have heard of three visits to investigators and doctors each taking 1-2 hours in different parts of Sydney in one day).
- Sending letters packed with questions for treating doctors which the insurer expects the injured worker to follow up on.

- Making numerous phone calls to the injured worker over a single day.

Obfuscation:

- The use of legalese in the letters to injured workers.
- Denying that they are the insurer despite the employer providing papers to the injured worker identifying the insurer as the one they pay premiums to.
- Not providing the injured worker with information regarding the injured workers rights.

Ignoring:

- Refusing to communicate with the injured worker regarding their claim.
- Not following up with the injured worker regarding a missing element of their claim form (such as an address where a phone number and email address were provided)

Bullying:

- Telling the injured worker that their employer will sack them if they don't return to work.
- Telling the injured worker to "get over it" when they suffer depression.
- Threatening to cut the injured worker off when they assert their rights (as with the requirement for the insurer to provide ten working days' notice of an independent medical examiner appointment).
- Calling injured workers lazy and job shy.

These behaviours, all of which have been told to the injured workers support network helpline are designed to retract their claim and/or accept the insurers eventual denial when it comes.

Refusing provisional liability

The Workplace Injury Management and Workers Compensation Act 1998 – Sect 267 provides for the capacity to begin payments to an injured worker within 7 days of the initial notification. Section 268 provides insurers a capacity to withhold this if there is a "reasonable excuse" for not doing so.

Reasonable excuses include:

- There is insufficient medical information
- The injured person is unlikely to be a worker
- The insurer is unable to contact the worker
- The worker refuses access to information
- The injury is not work related
- The injury is not a significant injury (the injured workers incapacity is less than 7 days)
- The injury was notified 2 months after it occurred and is likely to have required a claim immediately after the event.

Within these reasons an unofficial one exists: "this is a psychological claim". It is the experience of the Injured Workers Support Network that psychological claims are more likely refused provisional liability in larger numbers than any other form of claim. The official

reasons given are generally insufficient medical information and an assumption by the insurer that the injure date has been incorrectly identified by the claimant.

Insufficient medical information:

This excuse is widely used by the insurers to knock back provisional liability in all forms of claims but within psychological claims is very common. The main reason for this is that the treating doctor has given an imprecise diagnosis and one that does not accord with the DSMV 5 manual. Generally the doctor writes “stress” or “anxiety”. Two terms widely used in normal speech but are not considered accurate medical diagnoses. The insurer will rarely ask the injured worker for further details prior to denying provisional liability in these cases.

This excuse also appears to be an oxymoron as the reason for provisional liability has always been to allow the worker time to recover while also allowing the insurer to obtain information.

The impact of this is that the injured worker will have to use their personal leave while away from work (if they have any to use), that their employer will disbelieve the injured worker and any care the injured worker will need in the immediate term will come out of that workers own pocket. It places a pressure on the worker that is extremely counterproductive to their hope of recovering from their injury.

Time of injury:

The work capacity certificate filled out by the treating doctor does not allow for a “period of time” clause. Is requires a specific date. With psychological and emotional violence this “date” is inaccurate as the injury is acquired over a period of time. Some workers claim it from the date the doctor writes the certificate of capacity, which appears to be the most acceptable form, but it is often the case that the injured worker has had several previous visits to their doctor over the same injury prior to that doctor and worker concluding the injury is work related. When the injured worker or doctor is interviewed regarding the injury they will tell the truth about these visits leading the insurer to be able to place doubts around the requirement for the claimant to report the injury “immediately after the injury takes place” (this scenario is also true of body stress injuries).

The impact of all of this is a delay in treatment for the injured worker, further exasperating the original injury with un-necessary complication when the worker is most vulnerable and potentially creating a greater barrier to recovery.

Psychological injuries “Reasonable action”

The Workers Compensation Act 1987 states at Sect 11a “No compensation for psychological injury caused by reasonable actions of employer”. What is or isn’t reasonable actions are largely defined through the Fair work Ombudsman’s rulings and other industrial instruments. Unfortunately the insurer case managements approving or denying claims have limited

understanding of the industrial nuances of reasonable actions and will use any statement from a manager that it was a management action which precipitated the claim to deny a claim under this section.

This excuse does not consider the lead up actions of the employer or the circumstances of the workers situation prior to making a decision (as was demonstrated as necessary in Jackson v Work Directions Australia Pty Ltd [1998] NSWCC 45) nor does it identify the practice of "managing out" injured workers with a mental health issue (acquired or pre-existing).
It also enables further systemic abuse of psychologically ill workers by workplaces by legitimising the performance management processes of targeted workers.

A further problem with reasonable management is the timing of management action. It is regularly the case that a staff member suffering psychological or emotional violence at work or bullying and harassment will be placed on a performance management plan either as part of the violent action or as a result of the symptoms of the psychological illness. The insurers will automatically assess these as "reasonable management actions" rather than the actions themselves being a cause or symptom of the illness.

The problems in making a claim for injured workers whose primary languages are other than English

Put simply, the forms, the advice, and the guidance for filling out a workers compensation claim is in English. A worker whose dominant language is not English is placed at a significant disadvantage because the system is designed to be accessed entirely through the English language. Insurers will not accept paperwork in languages other than English and the only reliable means of working through a claims complexity is through interpreters and generally through the insurer themselves.

This absolute reliance on the insurers (accessed through interpreters) compounds the problems faced by injured workers as identified throughout our submission.

Recommendation:

- That the Committee recommends to the government that the Insurers provide information on making a claim in languages other than English.
- That the Committee recommends to the NSW Ombudsman an investigation into the actions and systemic problems with the Insurers within the NSW workers compensation system as was conducted by the Victorian Ombudsman.
- That the committee recommends to the NSW Legislative Council a further inquiry into the impact on injured workers of the NSW Workers compensation system
- That the committee recommends the establishment of an independent workers compensation ombudsman with power to investigate complaints against insurers behaviours at all times of the claims process and compel insurers to rectify when appropriate.

- That the work capacity certificate be changed to reflect a period of time as well as a specific time for accumulative injuries.
- That reasonable and unreasonable management action is more accurately defined for insurance case managers.
- That the committee recommends the removal of “insufficient medical information” as an excuse for insurers to withhold provisional liability.
- That insurers and the regulator be forced to provide appropriate and accurate information in languages other than English.

The insurers

Significant concerns exist with the role insurers play in the current system.
These concerns have been articulated daily to the Injured Workers Support network. They include.

Inconsistency with case managers

> **"Since the start of my claim I have had 16 different case managers. Each time a new case manager comes on board they ring me up and invariably ask me to tell them my story. I always thought they had my file in front of them. Why couldn't the just read that rather than ask me again and again."**
>
> **(Helpline call August 2015)**

This quote identifies a strong problem within the Workers Compensation Insurance industry. In 2009 in a report by PricewaterhouseCoopers the following was noted:

> **"…there is high turnover of case managers, which can be attributed to a number of factors, including: large and demanding caseloads, lack of specialisation, inadequate performance management (including accountability and incentives), and limited opportunities for training and development, to name a few."**

Though dated the statement in the PricewaterhouseCoopers report is reflected in the experiences of injured workers. Anecdotally we have heard that the turnover rate of staff

> **"What can you do when it appears your case manager is not doing the right thing ie like often changing your pay day without warning?**
>
> **What if the case manager is part time so that often things do not get done in a timely manner?.... My current case manager has changed my pay day so often I now live in anxiety that is not relieved until I see the pay go in. It is a stress I never had ever before in my life. Centrelink treats my friends with much more respect."**
>
> **(Website comment July 2015)**

within the workers compensation insurers can be as quick as six to eight months.

Level of professional training provided to case managers

The level of training provided to case managers first appointed to their positions is not adequate to the needs of the injured workers they have been appointed to assist.

> **"It really annoys me that these insurance company case managers, with NO medical expertise, can tell you what your medical requirements are. Often over ruling specialists (I am sure they were the kids picked on at school and now they get to play God..)."**
>
> **(website comment July 2015)**

The bulk of the training is delivered in house and can be between two weeks (QBE) or non-existent. The only formally recognised training available is through the Certificate IV in Personal Injury Management (Claims Management) FNS40310 (8 subjects are required to achieve a competency) attached as Appendix A

.
The course structure for the Certificate IV is:

- BSBPMG510A - Manage projects
- BSBRES401A - Analyse and present research information
- CHCCOM403A - Use targeted communication skills to build relationships
- CULEVP401A - Present information on activities, events and public programs
- FNSCUS401A - Participate in negotiations
- FNSCUS402A - Resolve disputes
- FNSISV405A - Analyse insurance claims
- FNSPIM303A - Work within the personal injury management sector
- FNSPIM304A - Manage claims
- FNSPIM401A - Plan and implement rehabilitation and return to work and health strategies
- FNSPIM402A - Represent personal injury management agent or insurer at conciliation and review hearings
- FNSPIM403A - Educate clients on personal injury management issues
- FNSPIM404A - Assist injured persons with job placement
- FNSPIM405A - Facilitate a return to work
- FNSPIM409A - Maintain customer relationship
- FNSPIM411A - Manage personal injury case loads

Within these 16 subjects only one: "Plan and implement rehabilitation and return to work and health strategies" includes an element where the health needs of an injured worker are addressed- and only then in part.

This course is presented to the inquiry to highlight the significant lack of medical or remedial knowledge insurance companies insist on for their case managers.
Another example of this lack is in their advertising for new case managers:

Out of all the five main insurance companies currently under contract with the NSW Government only one (and in only one instance) insisted that any potential employee possessed experience or training in an allied health field.
Four out of the five made this trait desirable as opposed to a required trait.
One Allianz did not include the trait as either required or desirable. In contrast all required variations on negotiation and motivating clients. (Examples at appendix B)

The insurance companies' lack of targeting of their case manager capacities is an obvious systemic decision within their organisations. This systemic decision is visible in the CGU's lack of requirement for their state manager of Workers Compensation to have no experience within the Workers Compensation System of NSW and did not reference any need for understanding of an injury (appendix C).

This systemic lack of experience has a significant impact on injured workers entering into the system and is seen in part by their over reliance on independent medical examiners and injury management consultants.

The Injured Workers Support Network is aware that the vast majority of claimants, as part of the insurers' investigations into the legitimacy of their claim, are forced to participate in a medico legal examination by the insurer.

The insurers' stock letter which enables this to occur relies on the WorkCover medical guidelines for a referral to an Independent Medical Examiner per part 2 of these guidelines with that power stemming from Workers Compensation Act 1987 - Sect 9a.

Part 1 of the Independent Medical Guidelines states the following:

> **"Referral for an independent medical examination is appropriate when information from the treating medical practitioner(s) is inadequate, unavailable or inconsistent and where the referrer has been unable to resolve the issues related to the problem directly with the practitioners."**

This section implies that the insurance case manager assessing the claim has enough understanding of the list given in section 9 as of the Workers Compensation act 1987.

> **"(2) The following are examples of matters to be taken into account for the purposes of determining whether a worker's employment was a substantial contributing factor to an injury (but this subsection does not limit the kinds of matters that can be taken into account for the purposes of such a determination):**
>
> **(a) the time and place of the injury,**
>
> **(b) the nature of the work performed and the particular tasks of that work,**
>
> **(c) the duration of the employment,**
>
> **(d) the probability that the injury or a similar injury would have happened anyway, at about the same time or at the same stage of the worker's life, if he or she had not been at work or had not worked in that employment,**
>
> **(e) the worker's state of health before the injury and the existence of any hereditary risks,**
>
> **(f) the worker's lifestyle and his or her activities outside the workplace."**

Parts (a), (b), and (c) can be adequately identified with the given training provided by the Insurer and through the certificate IV course. Parts (d), (e), and (f) require a level of medical knowledge that the evidence indicates the insurance case managers do not possess are not pursuing through their recruitment practices, are not training their staff in and are not attempting to instill through any workplace culture within their organisations. A prime example of this lack of pursuit is the fact that the do not require any health qualification from their medical management specialists again evident through their recruitment procedures.

The regulator has, during consultations with the Injured Workers Support Network, identified that insurers have difficulties in the "lack of clarity" the medical profession is providing insurance case managers. The Regulator has told the Injured Workers Support Network that this concern has been addressed by the Australasian College of Surgeons. Given the lack of expertise within the insurance companies and their evident reluctance to pursue expertise in medical knowledge this disconnect is understandable. The Injured Workers Support Network does not believe though that this disconnect is in any way the fault of the Medical Fraternity.

By its very nature, assessing a work place injury requires those doing the assessments to possess more than a "highly desirable" knowledge of medical terminology practices, investigation and procedures. It requires actual knowledge. Removing any conspiracy theory regarding the insurers attempts to minimise current and future financial risk by making claiming workers compensation hard and time consuming, it is this lack of insistence that the insurance companies acquire and maintain adequate medical knowledge in house that results in the insurance companies utilisation of external medical professionals to interpret or re-interpret the diagnosis and recommendations of their practicing colleagues.

Inappropriate behaviour by case managers

> **"I was in my monthly appointment with my doctor, the insurance lady was there as well, telling my doctor that he had to change my certificate to state that I could work again or else they would have to cut me off my weekly benefits. The doctor did that, and then they used that certificate to cut me off my weekly benefits because I could work again. I asked my doctor why he changed my certificate and he said because he felt pressured by the case manager to do that."**
>
> **(helpline call undated 2014)**

According to several current and past insurance employees, insurance case managers have to attend at least two case meetings per week in most insurers. These meetings generally take place at the doctor's offices and during a scheduled medical check-up with the injured worker.

> **"I wasn't told that I could refuse to have a case manager in there with me. Ever since I got injured the case manager has insisted that I go, even making the appointments or ringing up the office telling the doctor they will be there."**
>
> **(Helpline call undated 2015)**

> **"I had a case conference this week with my doctor and the case manager. She had absolutely no interest in helping me get better and only wanted my doctor to upgrade my certificate so I could do limited work. She babbled on about getting me training for something (sounded like she was reading a script) and ignored my doctor who kept telling her I could not go back to work"**
>
> **(member statement November 2014)**

> **"I haven't had a case manager yet who had due regard for the feelings, wishes, or rights of others."**
>
> **(website comment September 2015)**

The issues with case managers are systemic:

"Despite what people think most case managers (at least the good ones) hands are tied a lot of the time anything over a certain amount of money needs to be approved by a higher authority."

(website comment February 2016)

"I was taught to use the full waiting periods in the training they gave me to manage my work load."

(private statement 2014)

Insurance case managers work under a system in which they only exert the outcome of control, the control over an injured worker. Individual case managers can be nice:

"I never had a problem with the way my case manager would treat me"

(Case note September 2014).

And they can be abusive:

"The case manager in the booth beside me treated her clients like they were dirt, and took pleasure in denying them whatever she could deny them."

Private conversation with case manager July 2016.

"My KPI's were two work capacity assessments, two case meetings a week (visits) 100 cases at all times plus a share of the new cases as they came in. That was straight after my two weeks training."

(Private conversation with case July 2016.)

They are under pressure:

The reaction from injured workers who have spoken to the Injured Workers Support Network towards case managers is nearly entirely negative. With one member described them:

> **"A CM [case manager] is a two-legged animal with a corkscrew soul, a waterlogged brain, and a combination backbone made of jelly and glue. Where others have hearts, they carry a tumor of rotten principles."**

In preparation of this submission the Injured Workers Support Network conducted a simple statement frequency review on contributors to our website and injured workers who have contacted us through our helpline and interviews since July 2014. Out of 2800 recorded interactions only three are recorded as identifying a positive relationship between the case manager and the injured worker. This is in comparison to around 30% positive interactions between Insurer paid Independent Medical Examiners and injured workers, 10% positive integrations between Insurer paid investigators and injured workers and 40% positive interactions between rehabilitation case managers and injured workers.

The existence of negative opinions against insurer case manager should be of no surprise and might cover many aspects of that relationship mainly the natural resentment against a "gate keeper" within a system. But the same theory should apply to Independent Medical Examiners, Rehabilitation case managers and Investigators- that the statement frequency review indicates a greater range of positive statements towards these three groups indicates reliability in the expressed stories of those near 2000 contributors regarding their interactions with insurer case managers.

The near universal negative experiences our members have with insurance case managers

This pressure, even with good caseworkers, leaves them potentially unable to provide appropriate levels of support to injured workers encouraging a healthy recovery from their injuries and their return to work.

The issues with KPI's and their impact on the service injured workers receive from their companies insurers moves beyond the individual caseworker into the structure of their pay and the pay of their team and management. The Injured workers support Network is aware that bonuses are paid for performance at a team level and beyond to meet KPI's more attached to the closure of files rather than the successful recovery of an injured worker or their reintegration into paid employment. The current monetary value of these bonuses are unknown but in the past the Injured Workers Support Network has heard that they can be as much as $5,000 over a given financial year per individual case manager.

These bonuses, tied as they are to the removal of an injured worker from the books, skews the emphasis individual case managers place on the service they provide injured workers away from recovery and or adaption to their injury into a purely fiscal control over the injured workers case file.

These bonuses are also paid to the company as a whole, giving the system in which the case managers act a focus away from the recovery of an injured worker and skewed again to a financial control outcome focus. The less money the insurance system pays the more that system pays to the individuals involved in that insurance system.

This monetary focus plays into the strengths of the insurance business model. This model has long been the reinvestment of funds obtained through policy premiums in the short, medium and long-term financial markets. The systems emphasis on reinvestment is evident through any of the five main insurance companies yearly accounts.
The value of the workers compensation work to the insurance companies is significant with profit margins of 20% being the common margin. This margin is at least five percentage points more than their regular business products.

The result of all of this is that the insurance companies place a greater emphasis on cost reduction within their workers compensation product ranges than any other product range. They emphasise cost reduction as their main focus rather than customer value and loyalty again different from their other product ranges. This control of costs comes at the real cost of the services provided to injured workers.

This emphasis is also seen through the rewarding of case managers, teams and companies through a yearly awards ceremony held in September each year. In these awards no emphasis is placed on the health recovery or adaption of injured workers. Emphasis is on file closures and cost reductions.

Documentation from the case managers:

The lack of care towards the recovery and or adaption of injured workers to their injuries and the greater emphasis on managing injured workers out of the system and reducing costs to the insurer finds its most significant outlet in the preparation and management of injury management plans.

Injury management plans are a significant document within the workers compensation system for the achievement of an appropriate outcome for injured workers. They are compulsory for all injured workers with a whole person impairment (or Total body percentage) of greater than 20%:

Workplace Injury Management and Workers Compensation Act 1998 - Sect 42
Definitions

"injury management plan" means a plan for coordinating and managing those aspects of injury management that concern the treatment, rehabilitation and retraining of an injured worker, for the purpose of achieving a timely, safe and durable return to work for the worker. An injury management plan can provide for the treatment, rehabilitation and retraining to be given or provided to the injured worker.

“Workplace Injury Management and Workers Compensation Act 1998 - Sect 45
Injury management plan for worker with significant injury

(1) When it appears that a workplace injury is a significant injury, an insurer who is or may be liable to pay compensation to the injured worker must establish an injury management plan for the injured worker.

(2) The injury management plan must be established in consultation with the

employer (except when the insurer is a self-insurer), the treating doctor and the worker concerned, to the maximum extent that their co-operation and participation allow.

(3) The insurer must provide both the employer and the injured worker with information with respect to the injury management plan.

(4) The information that the insurer must provide to the injured worker includes a statement to the effect that the worker may have no entitlement to weekly payments of compensation if the worker fails unreasonably to comply with the requirements of this Chapter after being requested to do so by the insurer.

(5) The insurer must keep the employer of a worker who has received a significant injury informed of significant steps taken or proposed to be taken under the injury management plan for the worker. This subsection does not apply when the insurer is a self-insurer.

(6) An insurer must as far as possible ensure that vocational retraining provided or arranged for an injured worker under an injury management plan is such as may reasonably be thought likely to lead to a real prospect of employment or an appropriate increase in earnings for the injured worker.

(7) An insurer must give effect to an injury management plan established for an injured worker and for that purpose must comply with the obligations imposed on the insurer by or under the plan."

In reality an injury management plan is the case plan of a case manager, bearing little if any resemblance to a plan in which "the treatment, rehabilitation and retraining of an injured worker" is discussed or implemented. In a study of ten random injury management plans the Injured Workers Support Network undertook 80% of the written plan related to obligations the injured worker had towards informing the case manager of their actions, attending meetings and or appointments and only 10% of the written plan had any significant emphasis on managing or recovering from an injury. No injury management plan identified any rights the injured worker had.

The plans provided to the Injured Workers Support Network further were not made in consultation with the injured worker or their doctor; they were written up prior to any consultation taking place and given to both the injured worker and their nominated treating doctor as a finalised document.

Of those plans where medical treatment was identified, a significant number of these stated past actions, and not future actions. A few with a future action identified that permission was required from the insurer prior to the treatment occurring.

None of the injury management plans included information that would allow a nominated treating doctor to refer directly to an identified medical service.

None of the injury management plans included information that would allow a nominated treating doctor to undertake a review of their patients progress either through referral to a

specialist or medical investigations.

All of the injury management plans included a threat to suspend weekly payments if any aspect of the plan was not adhered to.

These plans are next to useless for the recovery and or adaption of an injured worker to their injuries.

It is of further note that when the Injured Workers Support Network requested examples of injury management plans a significant number of respondents in the survey identified that they had not received an injury management plan or had not had a review of their existing injury management plan (some dated over two years in the past) and that those plans which were updated did not reflect the currency of the respondents injury if that injury changed in any way.

It is a concern to the Injured Workers Support Network that a tool placed within the current legislative framework that was designed to map out and manage the treatment and recovery of an injured worker is universally ignored by insurers.

Information provided in plain English and in languages other than English

Despite the requirement to ensure that information is provided to all workers in a way in which they can comprehend it. Insurers continue to fail to adequately provide information in languages other than English.

> **"I never received a letter that was in Vietnamese, I had told them that I could not read English, I can read Vietnamese."**
>
> **(Return to Work Inquiry August 2016).**
>
> **"I can't understand the letters they send me."**
>
> **(Intellectually disabled member case notes June 2015-November 2015)**

The lack of information provided to injured workers in languages other than in English is of concern as it significantly disadvantages the injured worker in understanding the complex nature of the workers compensation system, denies them adequate time to respond within the strict timeframes set by the legislative framework and is an insurmountable barrier in the injured worker exercising their rights.

> **"I completed the equivalent of year 12 education in Vietnam, I didn't understand what was happening to me and what the insurer was doing when before my solicitor's secretary started to assist me with the interpretation of the letters. If the letters were in Vietnamese I wouldn't have a problem."**
>
> **Return to Work Inquiry August 2016.**

The lack of interpretation can lead injured workers miss the significance of a letter requiring action.

> **"We see a lot of Asian women with limited English and an injury. We try to help them as much as we can but we find it hard to interpret the legalese the insurer use in their letters. The insurers don't try to help them understand."**
>
> **Asian Women at Work caseworker. Unions NSW Return to Work Inquiry august 2016.**

Example:

> Intellectually disabled member, injured 12 months prior to contacting the Injured Workers Support Network through a referral from a member of parliament received a letter regarding a suspension of weekly payments stemming from not attending a vocational assessment organised by the insurance case manager. The injured workers support network was able to assist the member to re-organise the vocational assessment and avoid the suspension. That vocational assessment was followed a few weeks later with a work capacity assessment and decision. The member, not knowing the meaning of either document did not understand the importance of either letter was prompted to return to the Injured Workers Support Network after a phone call from the insurer confirming that he would be cut off the system in 2 months' time. The injured workers support network again represented the member to WIRO who intervened and the appeal of the Work Capacity Decision was accepted by the insurer (which was subsequently overturned by the Regulator)

The insurer in this example was fully aware of the injured workers disability, being it was highlighted in the original Certificate of Capacity but no allowances was made in the use of language by the insurer or the flexibility in the time frames insisted on by the insurer. By not providing adequate consideration for the injured workers disability they distinctly discriminated against the injured worker.

The perception of English problems has also been identified by members and others.

> **"I read English well enough, I speak and understand it without problems, I didn't need an interpreter for anything except during the Workers Compensation Commission hearing. It was my accent that caused the case managers trouble. They would speak slower to me than to my husband. It was obvious to me that they thought I was stupid."**

Discrimination against injured workers who have known and obvious disabilities or trouble understanding English is nearly universal amongst insurers but may be argued to be a continuation of the discrimination these community groups live with in general. The systemic discriminatory behavior becomes more obvious with the treatment of workers who have suffered a psychological injury due to emotional and psychological violence in the workplace.

One of the common impacts of Posttraumatic stress disorder, depression, and anxiety is their impact on the cognitive capacity of the sufferer. Thought processes slow, intellectual engagement weakens as does comprehension of the spoken and written word. Insurance case managers make no allowances for this reality- treating an injured worker suffering from a psychological illness the same as those suffering from a physical illness which, unfortunately is the same as those with an intellectual disability or from a Calt background.

There is an innate complexity to assisting workers who have sustained an injury at work that, based on the experiences of our members over four years, is evidently beyond the capacity of the insurers to meet. The problems stem from the legislative framework which makes no allowances for a collective need of disadvantaged community (the intellectually disabled, the CALT community and the psychologically ill in particular) and does not encourage best practices within the insurance companies to meet those challenges. The systemic problems are also inherent within the insurance companies being that their business model is based on financial investments and fiscal reductions rather than service provision this is evident from their recruitment strategy for case managers, the provision of bonuses to their staff and management based on results other than the recovery and or adaption of the injured workers they are meant to service and the distinct lack of training provided to their case managers in understanding the health needs of injured workers. This systemic problem finds its impact in the behavior and actions of the insurers case managers in assisting injured workers with a lack of understanding of their health needs, personal circumstances, a concentration on workload management rather than health management, coercive behavior towards other professionals as well as injured workers and finally the constant changes in case managers injured workers experience. This last aspect might identify a quicker than normal turnover of case manager employment which has been reported to the Injured Workers Support Network by internal staff.

Recommendation:

- That the current use of insurance companies to provide case management for injured workers be abolished.

- That nominated treating doctors or alternative allied health professionals be utilised to manage injured workers cases from the very beginning of the claims process.

- That the system of financial and other bonuses provided to insurers be abolished or significantly amended to emphasis the medical recovery and/or adaption to an injury rather than the monetary management of the injured workers file.

- That, until such time as the current system's utilisaiton of insurance companies to manage injured workers recovery and or adaption from their injuries is abolished:
    - The insurance companies be forced to employ staff with an allied health qualification.
    - The culture within insurers be further investigated and training and management systems be introduced to ensure a greater emphasis on the respect of injured workers their care and health outcomes.

- That the training provided to case managers, whether within insurance companies or through other appropriate service provision be compulsory and given a medical care emphasis currently lacking.

- That the injury management plans be strengthened to the extent that they originate from the nominated treating doctor and injured worker rather than the case manager.

- That all correspondence from the insurers or alternative case management system be provided with information on the injured workers rights and access to independent support.

The medical approval process

Delaying treatment causes significant risks to the ongoing health of an injured person.

The delaying of treatment takes three main forms.

- Denying treatment
- Investigating treatment prior to approval.
- Interruption of treatment.

As indicated in the previous items the medical approval process within the current system is reliant on an insurance clerks opinion rather than a doctors opinion. This regularly results in significant delays in identification of the extent of an injury, and treatment of that injury. This delay, built into the legislation, is an extremely large problem within the workers compensation system.

In a survey conducted by the injured workers support network and shared with the Statutory Insurance Regulatory Authority over half of the respondents identified that simple as well as complex requests for identification and treatment were delayed by the insurers for more than the legislative timeframe of 21 days.

The Workers Compensation Act 1998 - sect 279 states that the insurer has 21 days in which to determine liability for any claim for medical expenses compensation

> **(1)** Within 21 days after a claim for medical expenses compensation is made the person on whom the claim is made must determine the claim by accepting or disputing liability.

Improvements have been made recently to the number and type of medical support services injured workers can access without making an additional claim under section 57 of the 1987 act. These are nearly all time limited to the first three months of an injury (mri's, ultrasounds for example) and can only be accessed once without some form of pre-approval from the insurer.

The process for approval can be quite complex. In general the application for approval comes 60% from the nominated treating doctor or specialist and 40% from the Injured worker themselves (projected figures only).

There does not appear to be a special medical claim form for either the doctor or the injured worker to utilise. Claims are therefore made using:

- The original workers compensation claim form.
- A letter or over the phone to the insurance case manager.
- On the Certificate of Capacity or
- In the injury management plan (if developed by the Doctor and the Injured Worker).

The non-existence of a special medical claim form leads to ambiguities in the request from the very beginning. This can lead to delays due to the lack of information provided on the request, delays in understanding the requirement for the medical intervention and delays in

the insurer communicating with the requesting doctor/specialist to gather further details on which to make a decision. These delays are due to the system in place for making a medical claim rather than any malice on behalf of the insurer.

Where malice does play its part though is in the assessment of the request.
The insurance case manager can, without adequate proof, delay the treatment in several ways.

1. Delay the request for further information until the 21st day. Therefore giving them another 21 days after that information is provided back to the insurer.

2. Order the injured worker to see an Independent medical Examiner or an Injury Management Consultant.

   This has the effect of delaying the treatment for at a minimum of 10 days but more likely to be a month if the time it takes for the Consultant or Examiner to report back to the insurer of their findings.

3. Deny the claim based on the Consultants or Examiners report.

   This can be despite of that consultant/examiners approval of the treatment. This forces the injured worker to either a. give up the claim and forgo the treatment or b. fight the claim:

   a. If the injured Worker fights the claim this can be further delayed due to Worker Compensation Commission hearings –the obtaining of a solicitor, the normal process of evidence gathering and lodgment, then the wait for a hearing then possible further examination by an Authorised Medical Specialist, the process of mediation and the process of a hearing. This is reliant on the injured worker being able to access the Workers Compensation Commission to begin with as there is a barrier of $5,000 to be provided assistance through WIRO.

   b. If the injured worker does not wish to go through the Workers Compensation Commission the matter may be dealt with through an internal disputes process with each step (of which there are usually three) taking between 3-6 weeks to be completed.

One example of this delaying practice was with a member who required specific footwear due to his accident where his left foot was shortened. The need for such footwear was identified at the earliest possible moment after emergency surgery. In his case it took the insurer 14 months to approve and pay for the required foot ware.

Even if the claim was made through official practices being the medical certificate and injury management plan. There is no guarantee that this service will be formally approved. Several of our members have stated that, based on the inclusion of a medical intervention within one of these forms they proceeded with the treatment only to have their reimbursement knocked back by the insurer as no formal letter was given by the insurer to the injured worker that these treatments could proceed.

Denial of treatment

Denial of treatment has a significant impact on the health prospects of injured workers.

Denial of treatment generally occurs when:

- **a.** The insurer perceives that the treatment has minimal to do with the original injury or
- **b.** Where the treatment is perceived by the insurer to not be necessary, too interventionist or where the advice from their medico legal Examiner/consultant has suggested a conservative approach to treatment (i.e no surgery is required).
- **c.** Where the treatment is designed to maintain an injured workers level of functioning.
- **d.** Where the treatment is considered by the insurer to be too expensive.

The types of medical intervention that are most likely to be considered to have minimal causal link to an injury are general health and wellbeing related in particular counselling for a physically injured individual or a weight loss/exercise program for people whose physical weight prevents them from accessing surgery.

> **"I gained over 30kgs after I was injured just because I wasn't as active as I was before. There is surgery available for me but I need to lose 20kgs before the surgeon will consider it. I can't lose the weigh because I can no longer exercise the way I used to and I can't get the surgery because I can't exercise. My doctor has requested the support of a dietician and exercise therapist to help me get to the point where I can have the surgery but the insurer has said that my weight isn't their problem. If I weren't injured I would be exercising I wouldn't have put on the weight in the first place."**

This linking can also be used to deny someone treatment for a secondary injury such as chronic depression, stress related illnesses, pressure induced injury from using one part of the body to compensate for the originally injured part (common in those injured workers using assisted mobility devices such as walking sticks and crutches but also common with a general physical injury).

The result of such a denial is an ongoing reduction in functionality with those injured workers giving them less opportunity to either recover or adapt to their original injury.

Another common reason for denial is that a medico/legal examiner/consultant has written that an injury should be treated "conservatively". This judgment is generally given in contradiction to the injured workers specialist who identified the need for the procedure. This appears to be a difference of opinion between the treating doctor/surgeon and the insurers medico legal professional. The system though favors the insurers position rather than the treating medical professionals position. If there is fault in the medico legal's opinion then this prevents the injured worker from accessing the medical treatment they require causing further harm to the worker.

Injured workers may not fully recover from their injury. In the case of a partial recovery and those facing the situation where there will be no potential for recovery the only option is an adaption to their acquired disability. An adaption to a disability is a lengthy process involving a significant change to their physical and psychological wellbeing. Generally, the treatment for their injury will fall into two parts, the initial treatment which attempts to rehabilitate the injured worker to a new level of functioning and the maintenance of that new level of functioning. Maintenance of functioning is likely to be a lifetime journey for the injured worker, which, though potentially not as intense as the treatment to rehabilitate, is just as important and just as likely to result in negative outcomes if not adequately addressed.

The current workers compensation system as implemented by the insurers and the regulator pays little heed to the requirements of maintenance of functioning.

> **"I had a back injury that sent me to bed for six months a few years ago. Since then I have been able to retrain myself as a real estate agent and got back o full time work. I was receiving fortnightly massages and physiotherapy that enabled me to sit on a seat at work and in the car long enough for me to do my job. My insurer has just told me that they are no longer going to pay for this. I can't afford to pay for it myself so I can't keep doing it. I know I won't be able to keep working unless I get this support"**
>
> **(helpline call September 2014)**

> **"The insurer stopped paying for my hydrotherapy. They said I could pay for it myself, I'm on the dole after they cut me off I can't afford to pay for weekly sessions let alone pay for the public transport to get me there. It was the only thing that kept me up right, I've spent two weeks on the couch now."**
>
> **(Helpline call, September 2015.)**

Denying ongoing treatment or new treatment, as it is "maintenance" not recovery is a significant issue with the newly introduced extensions for medical assistance. Despite an injured worker being legislatively able to access maintenance programs beyond their recovery, which is allowed under these new rules, insurers appear to be reluctant to approve them. Several of our helpline phone calls are regarding the denial of medical supports during this period of time as they were not considered to be "necessary to your recovery." Despite their necessity to maintain a level of physical and psychological functioning.

Investigating treatment prior to approval

As mentioned previously there is a propensity for insurers to demand a "second opinion" of treatment prior to an approval (or a review of current treatment). This can delay treatment for upwards of a month and is often used for claims involving surgery.

Surgery can be among the most expensive medical interventions the workers compensation system will need to provide injured workers and, in particular forms of surgery the benefit of the outcome can be an unknown factor (back surgery for example). These forms of surgery can be contentious among surgeons but the practice of investigating the necessity of surgery moves well beyond the number of surgical interventions, which the medical profession may consider contentious.

The utilisation of independent medical examiners and injury management consultants is widespread among insurers for a wide range of surgical interventions. These second, third and even forth referrals for the same treatment act as a delay in receiving such treatment, leaving the injured worker in pain, reducing the effectiveness of the surgical intervention in some cases and in the worse cases causing such intervention to become useless as the body reacts to the injury in a way the surgery was designed to prevent.

These investigations can also include the use of private investigators to "inform the Examiner/Consultant" this will usually take the form of a paid investigator to follow the injured worker throughout a week or a day, taking video and photos of them as they perform their daily tasks in an apparent effort to ask the Examiner/Consultant does the injured workers behaviour indicate that they need the surgery?

The ethics of these actions will be discussed in another section of this submission but the impact of this level of intrusion is to again delay a decision by the insurers case manager to approve surgery by at least two weeks at a minimum as the surveillance takes a week and it is usual for a report to be delivered in over a week after that surveillance is taken.

Interruption of treatment

Another significant way in which treatment is delayed and in some cases such as psychological claims can be more serious than delaying the start of treatment is the interruption of treatment.

The most significant examples of this interruption are in the payments for medication. Currently there are two ways payments are made. The first way is through an account with a particular pharmacist the second is the reimbursement of the worker who pays for the medication from their income replacement.

In the first case the pharmacist has to agree to establish an account on behalf of the injured worker with the insurer. In several cases, pharmacists blatantly refuse to do this for a variety of reasons. The main being previous experiences with the insurers not paying the bills in a timely manner. Other pharmacists will not establish these accounts due to the paperwork involved. When this occurs it is the injured worker who has to negotiate with the original pharmacist to provide this services, not the insurer.

Another scenario that occurs is that a pharmacist will establish an account with an insurer for the injured worker but later stops this service due to the insurer not paying the bills in a timely manner.

The final scenario that occurs is that the insurer refuses to establish an account with a pharmacist.

In the cities this issue can sometimes be overcome by the injured worker through finding a pharmacist who is willing to establish an account. In regional towns where pharmacists are limited sometimes to one or two, this issue becomes intolerable. Those pharmacists cannot be expected to absorb the costs associated with providing medication to the injured workers in that town without the assurance that these costs will be paid in a timely manner by the insurer. Even in the cities such as Sydney, access to pharmacies can be limited due to travel limitations of the injured worker or the simple lack of pharmacies within the suburb.

When an account cannot be established with a willing pharmacist it is the injured worker who must bear the initial cost of obtaining their medication. In this case the injured worker is required to request a reimbursement of the money spent. For a certain period of time, even if the insurer is regular in their payment processes this leaves the injured worker worse off. Most injured workers will have to budget $38.60 per prescription filled because they will not meet the criteria for the concessional payment. It is also likely that they will be using more than one type of medication doubling the cost or more. This cost is borne by the injured worker for at least 2 weeks prior to reimbursement as this is time period given to insurers for the reimbursement period. If the reimbursement is late then the injured worker will have to chase this up with the insurer. This is just another burden the injured worker has to bear. A burden, which does not rightly belong to the injured worker.

The other area where an interruption caused by the insurer and allowed by the current workers compensation system is noticeable is in delaying or ignoring the payment of allied health professionals while treatment is occurring. The injured works support network is aware of numerous examples of this holding back of payment to professionals. In particular with physiotherapists and psychologist services.

> **"I had three sessions with my physio and was ringing up to make another appointment when the receptionist told me that I couldn't do that because the insurer hadn't paid the physio for the past three sessions."**

In physiotherapy and in counselling the need for regular sessions is important to the treatment process. An interruption in either of these can put back treatment or cause treatment to be ineffective. The current guidelines allows for up to eight sessions of either allied health professional within the first three months only, with some further space for assessment and activity beyond this. The issue is that eight sessions may not be enough to find an appropriate resolution, in particular for counselling of workers carrying a psychological injury where ongoing treatment is a necessity.

In general, insurers only approve up to six sessions at any one time, a report with a recommendation for further sessions must be provided by the medical professional before they again are approved. This report is basically a new medical claim and the insurer has another 21 days to approve this and can easily take longer than this statutory time frame. This provides no consistency for the injured workers treatment. This framing becomes even more

difficult for the injured worker if the task of the therapist is maintenance rather than initial recovery This submission will speak more of this lack later.

As with pharmacists the payment of allied health professionals is another problem, with regular instances of bills not being paid in a timely manner.

Recommendation:

- That the committee recommends the approval period for medical claims be reduced to 7 days

- That investigation of medical claims only takes place where there is not a specialist report attached to the medical claim and this only when necessary for one to be provided.

- That the same penalties currently applied to government departments to pay fees within 30 days applies to Insurance companies.

- That the regulator and iCare work specifically with the Pharmacist guild in NSW and consult more broadly regarding an agreement on the payment of pharmaceuticals within the workers compensation system.

Independent medical examiners

The use of Independent Medical Examiners within the workers compensation system is prolific. In essence the Independent Medical Examiner is the go to authority of the insurers for obtaining favorable medical assessments, which they can then use to argue a quasi-legal case against an injured workers claim (original or medical).

According to the legislation and guidelines, independent medical examiners are appointed by the insurer on behalf of the employer (section 119 (4) of the 1998 Act). The guidelines identify that the use of an Independent Medical Examiner is:

> **"appropriate when information from the treating medical practitioner(s) is inadequate, unavailable or inconsistent and where the referrer has been unable to resolve the issues related to the problem directly with the practitioners."**

The injured worker must attend an appointment with an Independent Medical Examiner.

> **"I can't come to the next meeting [Injured Workers Support Network local meeting]. The insurer has lined up 8 medial assessments for me next week from Wollongong to Sydney."**
>
> **(helpline call April 2015)**

"A worker receiving weekly compensation payments can be required to submit themselves for subsequent independent medical examinations when information from the treating medical practitioners remains inadequate, unavailable or inconsistent and where the referrer cannot resolve the issues related to the problem directly with the treating practitioner(s) and: the subsequent independent medical examination is with a specialist medical practitioner with qualifications relevant to the treatment of the injured worker's injury; and

- the employer/insurer has evidence that the worker's medical condition as a result of the injury has changed; or
- the employer/insurer has evidence of a change in the worker's health not resulting from the injury which will affect the worker's participation in the labour market; or
- the employer/insurer has evidence of a material change or need for material change, in the manner or type of treatment; or
- the worker makes a claim for section 66 lump sum compensation or work injury damages; or

- the worker requests a review pursuant to a notice issued under section 54 of the 1987 Act or section 74 of the 1998 Act and includes additional medical information that the employer/insurer is asked to consider; or

- there has been at least 6 months since the last independent medical examination required by the employer/insurer; or

- the last independent medical examination was unable to be completed."

These requirements do not have a mechanism for identifying if a treating Doctor or specialist has provided adequate information to the insurer. In practice, referrals to Independent Medical Examiners will always contain a phrase to the effect that the information provided by the injured workers nominated treating doctor/surgeon has been "inadequate". This can and does occur whether the doctor's information would have been more extensive that the report from the Independent Medical Examiner the injured worker was sent to.
Doctors report that there are problems with the requests insurers make for further

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"The reports I write for insurers go for ten pages sometimes, they can take me up to a day to produce but will usually be two hours of solid work. I answers the questions posed and provide reasons for my opinion. The problem for me is that the insurer doesn't want to pay me for this time, they ring me up asking for the report but they don't mention payment even at the statutory rate which doesn't meet my normal costs. They just expect me to do it for free."

(private conversation with Western Sydney Dr July 2014)

"The insurer tries to claim I haven't sent them the report, they say my information isn't enough. I train doctors, I specialise in this, I know what I am doing but the insurer tries to play tricks all the time. It's sorry for them that I have a very accurate tracking system on all my practices communications with the insurers, If I send a report I have the tracking for that report. That doesn't stop the insurer from using an IME, it just stops them from lying that I didn't send them the report."

(Private conversation with Dr 2015)

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information as well:

Despite how comprehensive a report from a surgeon may be, the Insurer has a right to refer the injured worker to an Independent Medical Examiner. The use of the Independent Medical Examiner is therefore not about obtaining a second opinion

> **"I'd already been to two surgeons before the insurer sent me to the IME. The insurer had both their reports."**
>
> **(Helpline call date undocumented)**

The Insurers are also likely to double up on Independent Medical Examiners doctor shopping for the answer they like and can use in a court case. This is despite of, or possibly because of, the Workers Compensation Commission rules that allows only one Independent Medical Examiners report to be submitted.

> **"The insurer sent me to two IMEs for my leg injury, they only used the second of those reports at court and never gave me access to the first IME report. My solicitor told me that this was probably because the first IME would have agreed with my own doctors about my condition"**
>
> **(member statement September 2015)**

There is disconnect between the wording within the legislation and guidelines and the reality of the use of Independent Medical Examiners. The injured worker reads the word Independent and is shocked to learn that this doctor is far from independent. The Injured Workers Support Network has so far not publicly released the names of the six Independent Medical Examiners about whom we receive significant complaints to. Given that at least one of those named (and only one) has been identified by one member as "going into bat" for them against the insure (they were appointed by the insurer), the reason for this should be evident. We are prepared to provide the list of six IME's to the inquiry upon request and without public release.

In 2015 the Injured Workers Support Networks lobbied then WorkCover for significant changes in the way Insurers use Independent Medical Examiners. The outcome of this lobbying was the decision by the now Regulator and iCare to enforce a choice for the injured worker of three Independent Medical Examiners. Anecdotally this choice has reduced the number of referrals to Independent Medical Examiners and an increase in the perception in the eyes of the injured worker of the independence of these examiners. Members and Helpline callers report that they will go online to check reviews of the three choices they were provided prior to making their choice. The Injured Workers Support Network fought for this change, as it would go some way towards balancing the power between the insurer and the injured worker and increases the propensity for the Independent Medical Examiner to live up to their title of Independent.

Recommendation:

- That the current system of Independent Medical Examiners be abolished in favor of a three person/dr committee to assess the medical condition of the injured worker as is regularly used by the Workers Compensation Commission and in other jurisdictions.

- That the Committee recommend that the insurers be forced to only access one independent medical examiner per injury and per case with the choice of Independent Medical Examiner being given to the injured worker.

Injury Management Consultants

In response to the changes the Injured Workers Support Network has been able to make to the use of Independent Medical Examiners, we have seen an increase in the use of Injury Management Consultants. Unlike Independent Medical Examiners, Injury Management Consultants do not need to demonstrate professional standing in the area in which they consult.

This increase is directly linked to an abuse by the insurers on how the injury management consultants are used.

The guidelines state:

> **"An injury management consultant does not become involved in commenting to the referrer on:**
>
> **The appropriateness of treatment or diagnostic procedures liability for a workers compensation claim."**

In August of 2016 alone the Injured Workers Support Network has:

- Assisted two members with their Work Capacity Decision Appeal process where an Injury Management Consultant was used to deny ongoing liability.
- Has received helpline calls where the caller reported that their doctor has been 'advised" by the Injury Management Consultant to change the certificate of capacity to full time work.
- Has viewed one letter from a Injury Management Consultant where the treatment regime of the injured worker was called into question.

Further into the guidelines it states:

> "The injury management consultant MUST verbally discuss the injured worker's capacity for work with the nominated treating doctor. A minimum of three attempts at discussion must be made by the injury management consultant within the report submission time frames. The injury management consultant may discuss the following:
>
> - issues in relation to treatment and diagnosis (if required) and options to overcome barriers to return to work
> - current work capacity
> - availability of suitable duties
> - how the NSW workers compensation system operates
> - the importance of timely, safe and durable return to work

- obtaining agreement on work capacity, prognosis for recovery and time frames for the return to work plan.

The use of Injury Management Consultants by insurers is predominantly within the Work Capacity Assessment process. In theory an Injury Management Consultant is available to be used in this way except, when a work capacity decision is handed down which cuts an injured off workers compensation due to their increased work capacity the Injury Management Consultants report is used. All Work Capacity Decisions the Injured Workers Support Network have seen in the last two years use section 74 to deny the injured worker any ongoing liability. This is a denial of liability based on the report of an Injury Management Consultant.

In today's workers compensation system an injury management consultant has become a medico legal practitioner as with the Independent medical examiner. As such they no longer perform the spirit of the functions outlined in the Guidelines or as described on the WorkCover website:

> **"Injury management consultants are facilitators who assist insurers, employers, workers and nominated treating doctors in overcoming barriers to complex return to work and injury management situations."**

Injury Management Consultants are able to advertise their services to businesses and tailor their services to the needs of businesses:

> "We take a commercial approach
>
> We add value to our client' bottom line and we deliver a significant return on investment by:
>
> Reductions in musculoskeletal claims.
>
> Reductions in premium costs associated with claims being open for shorter periods and less frequently.
>
> Reductions in productivity costs due to more staff being onsite working at full capacity.
>
> Reductions in time loss due to a reduction in regular trips to offsite health providers.
>
> Reductions in labour hire costs to induct and train new staff when others are injured."
>
> (http://www.bodycare.com.au/benefits-to-you/)

This practice appears to be widespread but other services take a less open approach to their sales pitch than the company quoted above.

Recommendation:

- That the committee recommends the prohibition of injury management consultants from advertising their services.

- That the use of an injury management consultant be the decision of the nominated treating doctor only.

- That independent medical consultant reports be excluded from any legal or administrative proceedings within the system including work capacity decision and liability claims.

Private investigators/Factual investigators

"What are the laws of being followed by insurance Private investigators and constantly driving past your house and filming you etc?"

(website comment November 2014)

"My insurer followed my 22 year old daughter and my husband around and the report even shows the investigator videoed a random person around my age who was in the shopping centre my daughter went into. I am adding this to my list of complaints and my husband told the insurer he was not happy with our daughter being stalked."

(website comment December 2014)

There continues to be a significant over use of private investigators within the workers compensation system.

The community at large may associate the use of private investigators with the uncovering of fraud within the workers compensation system. This is not the most common use of private investigators though. Within the current system private investigators are more likely to be used as a medical assessment tool rather than uncovering fraud.

The injured workers support network is aware that insurers commonly used private investigators prior to a referral to an independent medical examination or injury management consultation to inform those medico legal contractors of the "reality" of the injured workers injury. It is not common for the private investigators to ensure their reports identify whether someone is meeting or exceeding their restrictions, but just to record and report the injured workers activities. The Injured Workers Support Network believed the use of private investigators in this fashion is a gross invasion of privacy and so subjective that it becomes useless in any professional or academic sense, but its use is all too common.

The injured workers support network is aware that private investigators have been known for trespass onto property, prank calling services to attend the premises (such as ordering a taxi or a pizza) to photograph injured workers, in appropriately follow others such as the children of injured workers as they attend school or university, purposefully move items (such as kerbside bins) within the property of the injured worker to 'catch out" an injured worker when they (or others) move those items back into place and refuse to answer questions when confronted by injured workers. The injured Workers Support Network believes that all of these acts are illegal and encourage members to report the matters to police.

This you will all have a giggle. Quite some time ago, my husband was battling 'Galyath' Allianz. The short story, they put surveillance on him for quite some time. I even took over a cup of tea to the agent who patiently sat in his car waiting for us (the bait) to leave. They followed my husband many a times…..

BUT the classic was – my husband's wives (note plural) and cars (note plural) owned was laughed at in the Commission.

The report had his wife (of many) had long brown; short black hair; long blonde hair, short, tall, solid, thin etc etc. The photos of my neighbours (who were suppose to be my husbands wife's) was a many – they too thought it was cute they were married to him.

My husband also drive many cars – its funny cause he only owns one…..

There are three professions in the world I would not do (please do not take this personally if you are in this industry) – Funeral/Undertakers – Real Estate Agents – Used Car Sales …….I think I can now add to this profession – "Private Investigators"……

Moral to the story – I wonder what it would be like to 'stalk' the Insurance Companies staff? I am sure 'Triple Zero' would be called straight away.

All I can say is 'Just sigh'"

(Website comment April 2014)

We are concerned with the use of private investigators against members who suffer from a psychological illness. We are aware of at least two occasions where the impact of a private investigator has resulted in a member being scheduled under the mental health act due to uncontrollable episodes of paranoia. Other members who suffer from a psychological illness continue to live with periods of paranoid thoughts due to their discovery that their insurer has employed a private investigator to follow them.

We firmly believe that the insurers over utilisation of private investigators for medical investigations is abusive and likely to re-injure a worker suffering from post-traumatic-stress disorder among other psychological illnesses.

Prior to approving workers compensation claim the insurer is also likely to use a private investigator to follow and record an injured worker. We are also aware that the cost of hiring a private investigator is around $5,000 per week. The costs incurred by the system of the over use of private investigators is astronomical. For comparison the current cost of employing a counsellor to assist an injured worker with a psychological claim is between $100 and $400 per hour (counsellor being the lower cost, clinical psychologist accounting for the higher number). If the money invested by the insurer into proving fraud through a private investigator was diverted to providing assistance to that injured worker to recover this $5,000 could equate to 50 sessions nearly a years' worth of treatment. It is for this reason why the Injured Workers Support Network views the employment of private investigators to be an unacceptable waste of the schemes money as well as being abusive.

The use of private investigators also breaks any trust the injured worker may have with the insurer. It is worth noting at this point that one of the largest rehabilitation providers in NSW, Procare, are also providing private investigators to the scheme's insurers. This fact should break the trust of any injured worker currently in the care of Procare. But the general use of private investigators ruins the trust that an injured worker has with their insurance case manager.

Recommendation:

- That the committee recommends the severe curtailing of the use of private investigators or factual investigators within the workers compensation system to only investigating potential fraud and as directed and employed directly by the regulator.

- That the committee especially recommends the immediate cessation of the use of private investigators/factual investigators in reporting to and informing any medical investigation processes.

Injury Management Plans

Out of any of the changes made in 2012 to the Workers Compensation System the injury management plan appear to be the most useful in focusing professionals on the health needs of an injured worker.

Injury management or health management plans in one form or another have been utilised within the disability support industry, drug & alcohol rehabilitation services, mental health services and with patience recovery from cancer or other life threatening illness. In these areas the health management plans (which is what they are generally referred to as). Encompass a wide range of health related activities including treatment, investigation and management.

Unfortunately there are stark differences between the contents of these health management plans and the injury management plans currently being prepared by insurance case managers.

> **"Yes, injury management plans – what a total joke. I wasn't even consulted about the one I got – it was just sent to me and I was ordered to comply. Mmmm"**
>
> **(website comment September 2015)**

The first stark difference is that the injury management plans used by the insurers bear no relationship to the management of the health, recovery or adaption from an injury by an injured worker. They are essentially case management plans which in any other area would be used solely by the case manager to assist them in fulfilling their employment obligations towards a client.

It is common for these injury management plans to include items such as when a case manager will contact an injured worker, how many case conferences that case manager will have to complete and the requirements of the injured worker to "be polite" to the case manager while containing minimal if any reference to the injured workers treatment plan.

The second stark difference is the way in which the health plans vs injury management plans are formulated. In essence case conferences are used by practitioners to develop health management plans and review the progress of those plans. Those meetings then form the basis of a revised or new health management plan. Case conferences within the context of the workers compensation system are more likely to concentrate solely on the return to work obligations or intentions of the injured worker and an interrogation of the doctor as to why the medical certificate reads as it does.

The third stark difference is that health management plans are made within a consultation process where equality of opinion and decision is paramount. The views and opinions of the, in this case, injured worker are central to the development of a health plan. In the workers compensation system injury management plans are completed by the insurer case manager

without reference to the injured worker or the nominated treating doctor. They are delivered to the injured worker as a fete-accomplice and no discussion or consultation would have occurred prior to the plans development.

Fourthly health plans are centred on the philosophy of patent control of empowerment on the basis that the therapeutic agent that empowerment is will increase the co-operation and ownership of those plans of the patient increasing the chances that a. the plan will be followed and b. that the plans will lead to a successful recovery or increase in health. The use of the injury management plans by insurers disempowers injured workers by not allowing them to be involved in their construction.

Finally health plans are a living document, referred to at various points in the relationship by the patient, doctor, other treating professionals and the case manager. Changed and adapted when necessary to reflect the current situation of the patient. In the current system injury management plans are a static document. It is common for an worker who has an level of disability that would necessitate an injury management plan according to the legislation to not have one, or to have one but one that is years old and certainly the Injured Workers Support Network has not heard of or seen an injury management plan that is reviewed at regular intervals and adapted as circumstances change.

It is the opinion of the Injured Workers Support Network that the injury management plan could form a central tenant to the recovery process of all injured workers if implemented correctly. With regret the current systems implementation of the injury management plan is woefully inadequate, serving the needs of neither injured workers nor their treating team.

It is the injured workers support network's opinion that the greater utilisaiton of a true injury management plan can overcome several problems in the current workers compensation system.

1. They can focus the case management of the injured workers recovery towards their health.
2. They can remove the requirement for continuous decision making on behalf of the insurer. If the health needs of the injured worker are properly represented within the injury management plan ongoing treatment, medical investigation, recovery and maintenance of an injured workers health, recovery and adaption to an acquired disability can be adequately met.
3. They can provide a level of self-control over an injured workers rehabilitation and or adaption to an acquired disability, which is currently absent from the system.

Recommendation:

- That the committee recommends the regulator enforce mandatory training on what an injury management plan is and how one is created that reflects the actual injury management needs of the injured workers.

- That the creation of injury management plans be taken out of the responsibility of the insurers and given to the nominated treating doctor and the rehabilitation case

manager with a prerequisite that the rehabilitation case manger as an health qualification.

- That injury management plans be accepted by insurers as a contract between then and the injured worker to assist that worker return to health.

- That injury management plans be the focal point of support services provided to the injured workers.

- That a independent ombudsman be appointed to ensure

Workers with highest needs

The Injured Workers Support Network has concerns for the way in which injured workers with total body impairment percentage (or whole person impairment) of above 30% classified in the 2015 legislative changes as workers with highest needs.

The first concern is whether the injured worker has actually had an impairment assessment. This includes whether those injured workers who were classified under the old scheme have had their scores transferred into the new scheme.

> **"I needed to know where I fell into because it would have affected how I was going to get treated and you do get treated differently depending on how the insurer determines the change from the old to the new. Under the old scheme I was 40% for back, 30% for the neck, 15% for left leg, 15% for the left arm, and about 2% for scarring. In 2013 I had a letter from the insurer saying I was classified as seriously injured, but no percentage was provided. To even get the letter took me fighting with the insurer and I had to get work cover involved before they would do anything. If I had just sat back and did nothing they wouldn't have ever acknowledged that I was seriously injured. Five fusions to them wasn't considered serious enough."**
>
> **(Interview with injured worker September 2016)**

The next concern is that insurers are not taking the time to even do impairments to begin with. The new legislation has lengthier support and care provisions for those workers with greater impairments. This structured support means that under the 2015 system these impairment classifications are significant. Despite their significance the Injured Workers Support Network is aware that insurer initiated impairment assessments are decreasing rather than increasing in frequency.

> **"I was injured in 2014, my suitable duties ended in September 2015. The insurer has never once suggested or wanted me to have an assessment for impairment."**
>
> **(conversation with injured worker September 2016)**

A further concern is that when an injured worker obtains an impairment assessment the insurer invariably fights the results of this, causing stress and anxiety for the injured worker and delaying access to benefits. This is as much a result of the litigious nature of negligence claims as it is a reluctance of insurers to provide benefits to injured workers.

Finally even when an injured worker has a total impairment percentage of greater than 30%, the insurance companies are well known for ignoring this percentage and treating that person as if they were someone in a lower percentile.

Workers with highest needs are also under the same bureaucratic pressures as other injured workers. For instance, insurers continue to insist on monthly certificates of capacity for workers with highest and higher needs knowing that the prognosis of those injured workers is not likely to improve.

They are also just as likely to be subjected to work capacity assessments and decisions.

> **"I was given a whole person impairment of above 30% by the WCC, I have just been given a letter by the insurer for a work capacity assessment. I know the law says they can't do it but they can send me to an appointment. I don't know why they are doing this?"**
>
> **(IWSN helpline call August 2016)**

It appears that the insurers are not adhering to the legislative protections provided to workers with highest needs and are attempting to ensure that no other worker is classified as a worker with highest needs.

Recommendation:

- That the care and support of workers with highest needs be removed from the insurers and placed with another government agency who are more capable of ensuring the care and maintenance of these seriously injured workers.

Transitional implications 5-year mark & Transitional Payments

The NSW workers compensation legislation was passed in July 2012. In the proceeding months the Injured Workers Support Network saw a significant number of injured workers lose benefits due to the work capacity assessment and decision over all 5,000[1] injured workers lost support due to this law.

In 2014 we saw a significant number of injured workers lose their entitlements due to the mandatory 130 weeks cut off laws. In 2016 and 2017 we will see a similarly significant number of injured workers cut off due to the five year mandatory ending laws. We have seen the numbers of people receiving support after a work place incident resulting in an injury or illness decrease by approximately 9% since 2012. The percentage of long-term claims remains relatively steady over the last four years currently resting at 9%[2]. The most significant decline in claims occurred in 2012/13.

With the 5-year mark since the changes in the legislation occurring in 2017/18 it is likely that a similar spike in ended claims will occur again.

Injured workers faced with the five year cut off are those with serious injuries, which in one way or another prevent them from obtaining employment. In general these injuries are coalescent with a limited range of employment that either they are trained to perform and or their physical disability allows them to perform. For example:

One member was fired from his job after he was seen losing his footing walking on the warehouse floor where he was placed in charge of stores after a leg injury while driving a truck for the yard. He is over the age of 50, never finished school and had worked as a long haul truck driver for 30 years prior to his acquired disability. Employment prospects for this member within his industry is limited due to his acquired disability and he cannot find a sedentary position as he has no computer skills and limited sales skills. There has been no effort to retrain the member.

[1] The Impact on Injured Workers Of Changes to NSW Workers' Compensation: July 2012-November 2014 Report

[2] Safe Work Australia *Comparative Performance Monitoring Reports* 10---17, 2008---2015

One member in the same industry has a back injury after a work place incident. He cannot work again as a long haul truck driver due to his inability to sit for more than one hour without a break. He is capable of working as a driver trainer but the insurer has so far denied him financial assistance to obtain this qualification. One of the consequences of his injury is a more sedentary lifestyle; this lifestyle has led to him being obese. He is willing and has asked for assistance from the insurer to lose the weight but this has not been considered important by the insurer. Due to his weight he cannot sit in the trucks used for the driver training qualification. As with the first example, he left school early and cannot use a computer for more than basic functions.

Both members in these examples are facing the loss of their entitlements in 2017 both members have not been assisted to transition into new work by the insurer and both have injuries that are likely to qualify them for the disability pension. Despite the likely acknowledgement by the federal government that they have a disability, which will prevent them from working, both are going to be removed by the insurer from the system due to the legislated 5-year cut off time.

The Transitional Payment issue continues to vex and concern injured workers left on the system. The maximum transitional payment is set to just under half of the potential payment available for people injured after 2012. The calculations for transitional payments are confusing. When everybody was set on a transitional rate a work capacity assessment was done these were done when the system was new and the issues raised in previous submissions regarding the fairness of those work capacity assessments have a continued legacy for these injured workers.

Work Capacity Assessments and Decisions

The 2014 review of the exercises of the WorkCover Authority had a lot to say regarding Work Capacity Assessments and Decisions. The Injured Workers Support Network can confirm some progress has been made in certain areas of the Appeals process.

The Merit review process is now quicker than the previous two months but we would be surprised if the average equated to less than 31 days. The merit review also appears to have become fairer, with some members identifying that they were contacted by the reviewing officer regarding further explanations of parts of their appeal. There also appears to be more professional oversight of the quality of these reviews by the SIRA.

There are some areas that have become less supportive of the injured workers though. The capacity to appeal to the WorkCover Independent Review Office was reduced when the State Insurance Regulatory Authority changed the guidelines reduced the requirements on the insurers.

The legalistic nature of the initial decision has increased to a point where an average person would find it hard to understand exactly what the reasoning for the decision would be.
The Investigation processes of the insurer have increased as well, with private investigators being used to follow, record & report back to the insurer prior to a work capacity decision is done and the use of Injury Management Consultants in determining ongoing liability.

Some things have not changed since 2014. Insurance companies continue to use and abuse the work capacity assessment and decision processes. A typical example of this is as follows:

A Member was asked to attend a case conference involving an employee of a rehabilitation company who had conducted a vocational assessment, the insurance case manager and the nominated treating doctor.

At that case conference both the rehabilitation employee and the insurance case manager pressured the nominated treating doctor to change the injured workers work capacity certificate so that our members capacity was lifted to 5 hours a day for three days (total of 15 hours). The reasoning from the Rehabilitation employee and insurance case manager was that the rehabilitation company would be able to find the member a position or training if the work capacity certificate hour restrictions were raised, this was believed by the nominated treating doctor. Two weeks later the member received a "fair notice" (a letter from the insurer saying a work capacity assessment was being conducted).

After a period of approximately two weeks the member received a Work Capacity Decision letter which used the doctors updated work capacity certificate as the main justification for ending weekly payments to our member.

The scenario above is common enough throughout our membership to be of significant concern.

The legalised language

In recent times the style used by insurers in their work capacity decisions has changed. We believe this is in response to the intervention of WIRO since 2012 with an emphasis on the procedural requirements of the letters. The result of this is a work capacity decision letter (or indeed any formal communication originating from the insurer) is difficult for the average person to understand.

The Injured Workers Support Network received an average of two calls a week from injured workers who have received either the fair work notice or the Work Capacity decision notice. Due to a lack of resources we provide only advice and general support to the majority of those who seek assistance. Despite this, we provide greater assistance to some of the population.

- Injured Workers who have an existing or acquired intellectual disability (including limited literacy skills)
- Injured workers who have an existing or acquired psychiatric disability
- Injured Workers whose second language is English and who cannot adequately communicate in English.

This has been a recent addition to our services and the number of people serviced who fit into this category has been small (so far we have assisted five people).

In advertising this service we have encountered a significant issue with the insurers in that they are not recording or acknowledging those injured workers who have identifiable needs, as with our target population, beyond their current injury. In the case of those we have assisted with intellectual disabilities, the insurer has made no record of this in their files; they have also not provided any further support services to the injured worker to assist them to understand the paperwork or their rights. They have not obtained further assistance for the injured worker with an intellectual or psychiatric disability to ensure they can understand the process and they continue to provide information in language, which is inherently incomprehensible to the injured worker.

In the case of injured workers for who English is a second language insurers have been identified as using interpreters if and when they communicate either on the phone or in person at a case conference. In the case of the work capacity assessment or decision the letters and information is provided only in English. In the few cases we have dealt with where interpretation is required the injured worker has had to source assistance from others in their family or community to interpret the letter and access the appeals process.

In both of those examples above, the timeframes between the injured worker realising the need for help and accessing that help creates significant difficulties in meeting the timeframe set in the legislation for appealing an insurers work capacity decision.

In reading through the 2014 report by this committee I can honestly say that nothing has changed for those people who struggle to understand the legalised language now used by the insurers in their work capacity decision letters.

Issues with the Work Capacity Assessment

The work capacity assessments are not a therapeutic tool designed to assist injured workers back into the work force. In reality these are an in investigation tool aimed at moving someone onto Centerlink benefits.

The utilisaiton of injury management consultants and to a lesser extent in this era independent medical examiners is one of those tools which are routinely used to create an appearance of legitimacy, as with the reports from the private investigators, for the removal of an injured worker from benefits. These have been discussed elsewhere in this submission.

Vocational Assessments:

Vocational assessments review the physical capacity of an injured worker, their current skill set, training and work experience in an attempt to place the injured worker into a industrial stream that could result in an opportunity for employment. They can be useful tools in identifying training and experience needs of an injured worker but their current use within the workers compensation system is far from these origins. Currently the aim of the vocational assessment is limited to the identification of potential jobs with minimal regard as to whether a worker would be successful in obtaining a position within those jobs.

Vocational Assessments take a psycho social, medial approach to identifying the capacity of a worker to join the job market. Based on this assessment and a work skills/experience assessment they then review the Meta job market to try to place the psycho, social, medical assessment within the criteria of that meta job market. Taking this analysis of the workers fit with the Meta job market the assessment then contacts several employers to identify a general fit between the injured worker and individual employers and workplaces. This is where the assessment ends. The main problem with this form of assessment is the assessor is not required to identify training needs to expand the injured workers capacity, nor are they compelled (currently) to match the individual employer with the “candidate” being the worker themselves. No assessment is required to identify systemic issues the worker may face in obtaining a position within that workplace wit the exception of some vocational assessors who might identify location of work and general barriers to work (beyond the injured workers restrictions) such as age barriers and cultural barriers. The end assessment becomes an exercise in near futility.

Some assessments that the Injured Workers Support Network has reviewed for its members have included gross miscalculations of fit for the jobs recommended as in the following examples.

The identification of a suitable job as a bus driver for one member whose previous position was interstate truck driver with a "gimpy right knee" (injured workers words) after an road accident and which has been medically identified as only intermittently able to sustain its strength. The risk to the public if his knee was to give way and he was unable to apply pressure on the break peddle was not identified in the vocational assessment.

Case notes January 2016

The identification of a suitable job as a forklift driver for one member who was unable to raise their knees above 10 cms and had an accompanying lifting restriction. In this case the individual job may have been suitable except the assessor gave no consideration to the fact that all forklifts have at least two steps of between 30 to 50 centimeters which would need to be overcome prior to him being able to access the fork lift.

Case notes April 2016

The identification of a suitable job as a triage nurse for an ex emergency services nurse. This job may have been entirely suitable except that, because the injured worker had not worked as a nurse due to her workplace injury she no longer had a practicing certificate (which the insurer could have prevented if it had been willing at the time it was due for renewal to pay for the practicing certificate).

Case notes May 2016

A suitable duty as a chef based on an injured workers past experience (40 years ago) as a camp chef. This was despite the injured workers current condition which caused his hands to profusely sweat meaning he could not safely handle objects without the potential for him to lose grip.

Case notes August 2016

A suitable job as a cash-in-transit security office based on the injured workers previous experience as a cash runner for a supermarket some 30 years ago. Despite the fact that this particular injured worker continues to suffer mild PTSD due to being held up at gun point while last working in this role.

Case notes July 2016

The lack of locative placement of the injured worker

The current work capacity assessment includes psycho (the individual's psychological) social and medico needs, wants and boundaries but lacks a systems approach to potential barriers or bridges to gaining employment. For instance current legislative framework denies a review of the physical location of the injured worker or the job market when deciding on work capacity. The lack of such acknowledgement of the realities for workers in general can create a dramatic and unrealistic expectation that an injured worker would move away from their support base within a regional area to a city based location to find employment deemed suitable to them.

"I was told that I could work as a sales assistant, in my town those jobs are rare and if they do exist are only part time. The insurance case manager said I could be forced to move 700 kilometers away to Adelaide to find work."

(member in Broken Hill 2014)

This unrealistic focus is an added pressure on regional injured workers and should be included in vocational assessments and taken into consideration when making a work capacity decision.

It is also worth noting that this propensity to place pressure on people who are essentially considered job seekers if a decision is made that there is no ongoing liability exists only in workers compensation. Job seekers on a new start allowance are not pressured to relocate.

Recommendation:

- That Work Capacity Assessments and Decisions be discontinued and replaced with a review, which does not lead automatically to cut off.
- That the right to legal support be provided to injured workers appealing for all three forms of appeals after receiving a work capacity decision.
- That the location of the injured worker be considered when making a work capacity assessment.
- That any market testing of an injured worker by a rehabilitation case manager or insurance case manager be an actual market test where the injured worker's job applications are put forward rather than the current thought exercise.

Returning to work

The Government figures do not adequately identify whether an injured worker, removed from the support of the workers compensation system, has returned to work or is unemployed at the time they were removed. In 2013/14 WorkCover reported that there were 48,476[3] total open workers compensation claims. In the same year there were 88,085[4] total accepted claims with 20,286 open claims over three years old from injury. 39,609 claims were closed during that year.

WorkCover claims an 87% return to work for all claims in that year. That figure is only the "headline" percentage. The current percentage for that year is 78%[5]. The 2016 percentages for returning to work are equally as confusing with 82%[6] of all workers on workers compensation in NSW stating that they had returned to some form of work in the survey period. The headline rate for 2016 was 90%.

More important to those two figures is the stable return to work rate. Those questionnaire participants who have had three months or more work over the survey period. This figure for 2013/14 is 65% for NSW[7].

The statistic for stable return to work are comparable to the statistics for the length of time injured workers are unable to return to work due to their injuries. It is commonly accepted that approximately 60% of all injured workers spend less than 13 weeks away from work due to a workplace injury without greater support beyond medical rehabilitation. If this is comparable to the stable return to work statistic then the headline rates and the claims that the NSW workers compensation system is in some way responsible for the either the headline or current return to work statistics is compromised. Firstly the headline figure cannot be used by the system to claim successful intervention as the majority of that success is related to either the minor nature of the initial injury and the medical care provided to the worker after their injury. Secondly 22% of all "successful outcomes" in 2013/14 were not stable and the worker either returned to income support from the system or received federal income support from Centrelink payments.

These statistics do not emanate from the system itself, they emanate from a survey conducted of injured workers. The system itself either does not systemically collect statistics on successful outcomes or these figures are not being released by the regulator. In essence the government is not told whether their efforts are successful or otherwise. They are told only when an injured worker is removed from the workers compensation system and

[3] WorkCover Authority of NSW 2013-14 Annual Report

[4] The Impact on Injured Workers of Changes to NSW Workers' Compensation: July 2012 – November 2015 Centre For Workforce Futures

[5] Safe Work Australia – Return to Work Survey Headline Measures Report (Australia and New Zealand) 2014

[6] Safe Work Australia – Return to Work Survey Headline Measures Report (Australia and New Zealand) 2016

[7] Safe Work Australia – Return to Work Survey Headline Measures Report (Australia and New Zealand) 2014

"returned to the workforce" which can mean either they have returned to work, or they are receiving Newstart or disability payments from the federal government.

Issues with Returning to Work

> **"I want to know when a gradual return to work is no longer gradual as you are stagnate and have been for five years and then becoming more stressed and then require less time at work, will this happen for ever or will they say ok u can no longer work full time you are now part time"**
>
> **(website comment July 2015)**

Protection of Injured Workers from Dismissal

Section 248 of the Workers Compensation Act 1987 provides an injured worker with six months of protection from being dismissed if unfit for work from the first instance.
It is the injured workers support networks experience that this section is adhered to by the majority of employers. To the letter. On average the Injured Workers Support Network helpline receives three calls a week from injured workers who have been fired six months and one week after their injury. Our websites third most visited page is entitled "What is a valid reason for termination? Dismissing an employer with long term medical issues." The issue of dismissal after six months, above nearly all other issues the IWSN deals with, is the largest concern for workers injured at work.

In essence, the six months is used by an employer as a waiting period, there is no protection for workers who have returned to work but not to full duties or indeed for workers who may return to full duties outside of the six month period.

The legislation also allows for an employer to rely on a secondary medical report for whether the injured worker can return to duties or not. This can lead to a situation where the insurer has made a work capacity decision that the injured worker can return to full duties based on their medical evidence, but the employer utilises a new medical investigation to insist that the worker cannot return to full duties, therefore capturing the worker in limbo. Chucked off support from the workers compensation system but prevented from returning to work by their employer, then fired at six months.

Section 248 is at most a procedural hurdle for employers rather than a protective force for employees.

"I was scared to tell the boss that I'm was injured because I just didn't think I'd get any other work at the time [casual worker]. So I told the boss that I was going back to China for 3 months. After 3 months I did feel better and I started sewing again in the beginning my output was definitely a lot less but I did start to get better and after about 6 months I was probably producing about the same amount of clothing as I had before the injury. I had been advised by my doctor though that every hour I should stop work stretch and come back to the machine which I did and that really did help."

(Return to work Inquiry participant August 2016)

Situable duites

The Workplace Injury Management and Workers Compensation Act 1998 at section 49 states employer must provide suitable work:

(1) If a worker who has been totally or partially incapacitated for work as a result of an injury is able to return to work (whether on a full-time or part-time basis and whether or not to his or her previous employment), the employer liable to pay compensation to the worker under this Act in respect of the injury must at the request of the worker provide suitable employment for the worker.

Maximum penalty: 50 penalty units.

(2) The employment that the employer must provide is employment that is both suitable employment (as defined in section 32A of the 1987 Act) and (subject to that qualification) so far as reasonably practicable the same as, or equivalent to, the employment in which the worker was at the time of the injury.

But:

(3) This section does not apply if:

(a) it is not reasonably practicable to provide employment in accordance with this section, or

(b) the worker voluntarily left the employment of that employer after the injury happened (whether before or after the commencement of the incapacity for work), or

(c) the employer terminated the worker's employment after the injury happened, other than for the reason that the worker was not fit for employment as a result of the injury.

It is the experience of the Injured Workers Support Network that (3),(a) is used by employers to deny suitable duties to injured workers on a systematic basis.
Despite the existence of "return to work inspectors" it remains the case that an employer need only state that there are no suitable duties for them to comply with this section.
Although there is a penalty attached to the non-provision of suitable duties, the Injured Workers Support Network is unaware that this has ever been enforced. We have referred callers and members to the newly established return to work inspectorate within Worksafe NSW. Members who have used this service have reported two things. The first is that the inspectors are nice and helpful, taking the time to understand the issues surrounding the need and supply of suitable duties. Where inspectors have attended workplaces to investigate suitable duties the members have said that they were professional and represented the (workers) needs with dignity.

The members have also reported that they have not been successful in obtaining suitable duties despite the intervention of the return to work inspectors.

Insurers should be doing more to insist that Employers provide suitable duties

The responsibility for assisting an injured worker to obtain suitable duties within the current NSW workers compensation system rests with the insurer. Unfortunately the Injured Workers Support Network is unaware of any examples where the insurer has made an effort to ensure suitable duties are offered by the employer. There are examples of rehabilitation case managers assisting both the employer and the injured worker to identify and maintain suitable duties but again this isn't common enough.

More common than both of these examples is the insurer upholding the employer's insistence that there are no suitable duties available at the workplace and the insurer then insisting that the injured worker job seek for a new position rather than any attempt to maintain their original employer or position.

Suitable duties should be meaningful

The Workers Compensation Act 1987 defines Suitable duties as suitable employment as defined in section 32A.

"suitable employment" , in relation to a worker, means employment in work for which the worker is currently suited:

(a) having regard to:

(i) the nature of the worker's incapacity and the details provided in medical information including, but not limited to, any certificate of capacity supplied by the worker (under section 44B), and
(ii) the worker's age, education, skills and work experience, and

(iii) any plan or document prepared as part of the return to work planning process, including an injury management plan under Chapter 3 of the 1998 Act, and
(iv) any occupational rehabilitation services that are being, or have been, provided to or for the worker, and
(v) such other matters as the Workers Compensation Guidelines may specify, and

(b) regardless of:

(i) whether the work or the employment is available, and
(ii) whether the work or the employment is of a type or nature that is generally available in the employment market, and
(iii) the nature of the worker's pre-injury employment, and
(iv) the worker's place of residence.

The reality for most injured workers is that their employers pay little attention to these requirements either under or overestimating the injured workers capacity for suitable duties.

The cliché image of an injured worker being sent to the lunch room for eight hours a day is unfortunately still an all too true reality as is the employer insisting that, despite the size of their operation, there are no suitable duties for the injured worker.

Expanding the range of suitable duties available to the injured worker.

One ongoing concern based on the construct of suitable duties as identified in the legislation is a reluctance of employers and insurers to attempt to expand the range of suitable duties available to an injured worker either through retraining or re-deploying an injured worker for the period of time they are injured.

A positive example of this is one from our members who, after a leg injury, was no longer able to drive a truck. The site manager arranged for the worker to be redeployed into a newly created position of site assistant. His role was:

Fleet management (ensuring the trucks were registered and maintained), equipment management (ensuring the workshops had the correct tools and equipment required prior to the start of the shift and load safety (ensuring that all loads were safely contained on the trucks as they were loaded up.

This role added to the efficiency of the site but ended when the upper management of the company decided that the injured worker was surplus- and then let go.

(*Penrith member*)

Expanding the capacity of an injured worker to fulfill roles within an organisation not only assists with the retention of that injured worker but will assist the injured worker move to a more suitable role within the organisation if their acquired disability prevents them from returning to their pre-injury duties. A simple example of this might be training an injured builder in quoting for new jobs or a shop assistant in business management to move them into the head office.

The capacity to use training and redeployment as a tool for ensuring there are suitable duties for injured workers are not considered within the legislations construction and are regularly ignored by insurers and employers but should be.

Pressure to return to work

As the system is entirely geared towards a return to work the pressure placed on injured workers to do so is intense. Insurers use any assessment as a result of the one question can this injured worker return to work, rather than an indication of progress towards that goal. The threat of being suspended is continually enforced by the insurer and some rehabilitation providers increasing the pressures felt by injured workers to return to work, whether physically/psychologically ready or not. Employers use the process to bully their workers to either return despite their medical condition or withhold employment from their workers.

This is despite the injured workers own internal pressure to return to work. The folk tale of the lazy injured worker is a fictitious and damaging urban myth – the insurers and employers appear to embrace this myth though.

Both are likely to ignore the medical evidence of ongoing injury, recovery or acquired disability in favor of this myth and continue to pressure the injured worker to return to work, or at least end their claim.

Assistance to return to work

The whole workers compensation systems propaganda is contained within the envelope of “return to work”. Leaving aside the impact this has on those injured workers who cannot return to work due to the extent of their acquired disability the system places this responsibility onto the injured workers themselves.

From the work capacity certificate to the injury management plans currently used tells the injured worker that if they do not follow the plan to return to work they face suspension of their benefits without a structured independent instrument to appeal the decision to suspend.

The system places some services to assist the injured worker to return to work but accessing these are dependent on the insurer agreeing to them.

The first and largest potential for assistance is the rehabilitation services.

Rehabilitation services are in two forms. The first is the medically orientated rehabilitation support consisting of physiotherapy and occupational therapy for the most part. These services are dedicated to ensuring the injured worker has recovered enough to return to work. The second form is the job support services consisting of same employer return to work or new employer return to work. In both cases the rehabilitation support is geared towards re-education (not necessarily retraining) of the injured worker so that they are physically and/or psychologically orientated to returning to the workforce.

In all cases the rehabilitation service is structured to enforce the return to work process in the main part through the financial relationships they have with the insurers.

These financial relationships can be very close; there have been examples in the past of insurers owning rehabilitation services outright. Austbrokers a leading insurance broker in the Australian/New Zealand market purchased a controlling stake in Allied Health Australia in 2015. JLT Australia plc owns Recovr group, a leading rehabilitation provider in NSW. Though not active within the NSW workers compensation system it is an example of the integrated business model that has taken place in the past (with Allianz owning Recovr between 1987-2006). Though we have not been able to discover a direct ownership between current WorkCover accredited rehabilitation services and the five insurance agents in NSW there exists contractual arrangements between the five insurance agents and several rehabilitation services. The exact details of the financial arrangements are not public knowledge but appear to be along the lines of the rehabilitation service offering insurers a set and discounted price for services in exchange for being "preferred providers" for injured workers the insurance agency are case managing.

These arrangements obscure an injured workers right to choose their rehabilitation service as well as providing incentives to rehabilitation providers to actively close injured workers support quickly either directly through financial incentives or through numbers of referrals to the compliant rehabilitation service.

The end result of this industry level interference is that rehabilitation services may not have the interest of the injured worker top of mind when providing return to work assistance.

> **"They [the insurer] put me onto a rehab provider that shall remain nameless, I think they're actually in business [together], yeah they basically, unless you prefer to become a driveway attendant like that console operator at a service station they didn't want to know your name, I thought nahh!. the whole time I ended up retraining myself to the computer of stuff and I got back to work I actually find a job with data entry sort of thing. I went back to the rehab provider and they said you're not coming anymore, I said no I already got a job. They said good we will put it down we you this job. I said, "you will not", and they said you have to sign this. I said "how dare you would take the credit and get the money and you did nothing". They were not very happy with me."**
>
> **(return to work inquiry participant August 2016)**

Systemic barriers to returning to work

The system itself lays barriers to returning to stable work.

The most significant barrier is the lack of emphasis on the recovery and or adaption to a workplace injury or acquired disability within the system. This is evident in the insurer's behaviour in refusing or delaying appropriate medical treatment as discussed elsewhere in this submission. This lack of emphasis increases the time away from work for injured workers. It also increases the likelihood or re-injury or secondary injury if the worker is returned too early to their duties.

Other systemic barriers within the system are the disincentive to return to work inherent in the payment system. Insurers receive financial bonuses when an injured worker has returned to work or more rightly stated returned to the workforce either employed or unemployed, rehabilitation services receive a bonus if an injured worker returns to work, injured workers do not receive a bonus when they return to work. What occurs is that they have their financial support taken away, they have their medical support reduced and they have limited capacity to re-enter the workforce with the sword or Damocles loosely associated with having to declare a past workers compensation claim when attempting to find work.

The fear of losing benefits is also a disincentive to returning to work.
The system is structured to benefit a return to work beyond 15 hours a week. If an injured worker can work 15 hours a week they are no longer subjected to the statutory cut off times embedded in the legislation. If they are unable to work those hours then they are subjected to the statutory cut off times. If they are able to work but either for less than 15 hours a week or unable to find work for more than 15 hours a week then they continue to be subjected to the statutory cut of times. So why would they attempt to find work? Even if they are able to work more than 15 hours a week they are subjected to further work capacity decisions which, based on their demonstrated capacity to work 15 hours a week, will likely subject them to further cuts in their weekly income replacement by the insurer wanting and willing them to be able to work more hours.

Location is another barrier to returning to work. The Workers Compensation Act 1987 at section 32A (b) (iv) states that suitable employment cannot pay any heed to the residence of an injured worker. This particular exclusion appears directly aimed at injured workers in regional areas of NSW. With rural industries being in the highest category of dangerous workplaces this exclusion appears to be extremely selective in its scope.

> **"My insurer threatened me that it didn't matter that I was living in Broken Hill, they told me that if there was a job in Adelaide I could lose my benefits if I refused to take it. My family, my friends are in Broken Hill, why should I give up them just because an insurer wants to close my case?"**
>
> **(Broken Hill member 2015)**

The reality for injured workers in regional NSW being forced to relocate or else lose their benefits is an injustice that needs to be rectified. Social support is extremely important for someone recovering from an injury, in particular someone recovering from a psychological injury; the use of this exclusion by insurers to force regional workers to either lose benefits or relocate is counterproductive to their efforts to rehabilitate an injured worker.

Others not in the regions also suffer from this exclusion clause. In particular those injured workers with an acquired disability which impacts their mobility.

> **"I am not allowed to drive my car due to my injury according to my doctor's diagnosis of my condition. My employer says the have suitable duties at a site 2 hours away on public transport. There is a worksite less than 20 minutes away from my home by bus and its one of the biggest in the state. My employer has told me that they haven't even considered placing me there."**
>
> **(Hurstville member 2015)**

Training for a new position

> **"I have been waiting since 2014 for my Insurance Company to approve any retraining, even though I have been sacked from my job I have done since I left school and due to my injury will never return to that career.**
>
> **I have requested training but instead of approving this they would rather get second and third opinions. I was forced to attend two different Injury Management Consultants within four months. In my opinion this is 'Doctor shopping' to have two of these so close together.**
>
> **Instead of providing training for any job options approved, I am constantly asked to provide 'job logs', looking for jobs that I have had no previous experience in and require training before you could gain employment in these fields."**
>
> **(website comment June 2016)**

Accessing training for an injured worker who is unlikely to be able to return to their original position should be one of the first steps considered and taken by everyone involved in the workers compensation system. Unfortunately insurance case managers appear to be reluctant to take retraining seriously or else have a system restraint placed on them to deny training.

Training within the system is accessible through several ways. Education or support equalling up to $8,000 per injured worker if they qualify with a total body injury percentage of over 20%. Or through sponsorship from the State Insurance Regulatory Authority which is accessible to any injured worker with a claim as long as they haven't received any form of

damages payout or haven't been told their weekly income replacement support will be terminated.

In both cases it is up to the insurer to agree to the provision of the training and the cost of the training. Our members report that the insurers are quite happy to support training that is of low cost (under $1,000) and of a short (one or two days) duration. Training that may be longer or more costly are routinely denied by insurers.

The limitations on retraining are also galling. Limiting access to the newly announced education fund to those injured worker who are seriously injured is arbitrary and does not reflect the difficulties individual injured workers may have in either returning to a position within their pre-injury industry. For example:

One member was a truck driver for over 25 years, his injury precluded him from returning to his driving job. Since the medical decision that he would not return to his pre-injury job was made he had been asking for assistance to become a driver trainer, this was consistently denied to him until secondary health complications meant that he was unlikely to be able to access the truck in which driver training lessons were using.

A rehabilitation case manager suggested that one member could retrain as an interpreter in the three languages that this member spoke. This was a skill area in which the member was interested in doing and fitted within the limitations of their acquired disability, further one of the languages has a paucity of available trained interpreters within NSW. Interpreter training is both lengthy and costly. The insurer would not even consider interpreter training for our member, instead offering training as a security guard (a two day course).

The provision in the guidelines for the subsidised training from the Regulator is even harder to obtain. The Injured Workers Support Network is only aware of one recipient of this subsidy and that dated to before the 2012 changes. The qualification that a recipient cannot have received a payout in any form eliminates most injured workers with a total body impairment percentage over 10% within the system. The fact that this money is used by the injured worker to retain a standard of living which they may have enjoyed prior to their injury and which is not replaced by the current workers compensation system is not considered by the regulator, nor is there any acknowledgement that the regulator/system should be attempting to use this to assist the injured worker back into the workforce is something that should be addressed.

Maintenance of trade certificates

"Working as a nurse I need to maintain my nursing certificate. As an Injured worker I was unable to afford to do this myself but was likely given my doctors prognosis to go back to my old job. Unfortunately for me that process fell during the time I was on workers compensation and the insurer refused to assist me in maintaining my certification or in paying for the course that would allow me to obtain my certification once I started to recover. I can't work as a nurse again because I don't have that certification."

(Helpline call July 2015)

"I had a diggers ticket, a heights ticket and a crane ticket. I lost all of them while I was recovering and the insurer refused to help me get them back despite them saying that I could go back and do those jobs again and trying to cut me off."

(Penrith member 2014)

Maintaining trade certifications are vital to those injured workers who are likely to be able to return to their substantive or similar duties in those professions where certification is required. The two examples shared above are among many calls to the Injured Workers Support Network Helpline over the past two years where the insurers have refused to provide funding for their maintenance or recover once they are lost. They constitute a significant barrier to those injured workers affected and demonstrate reluctance by the insurers to adequately return injured workers to a position when this involves expenditure from their accounts.

Recommendation:

- To enforce a requirement for the regulator and insurers to report and be compensated on the actual stable return to work.
- To enforce a requirement for the regulator to report on the both the employed rates and unemployed rates of people who are being removed from the workers compensation system.
- To rewrite section 248 of the 1987 act to ensure the right of return is retained until independent medical assessment identified that they cannot return to that employer.
- To remove section 248 (b) (iv) from the 1987 act.

- To ensure the regulator & Safework NSW provides greater oversight of the insurers to ensure they make some effort in ensuring the employers identify and provide suitable duties that match an injured workers capacity.

"The law has double standards here ,the insurance company will tell you and its law you do not have to disclose to a potential employer you have had workers comp or a previous injury , after all you would be silly to apply for a job you cant physically do or mentally do , where the employer gets you is if you see a company doctor and gives you bad bill of health or restriction its grounds for instant dismissal too lie on a job application , after all its all about you moving forward if i wanted the job i would do what ever it took to re enter the work force.

as they say sometimes you have to loose to win."

(website comment February 2016)

General discrimination within the employment sector

An all too common discussion with injured workers is the discrimination they face when applying for new employment with a new (or old) employer.

There are some exclusions that we need to make prior to commenting.

Age discrimination

It is generally acknowledged that the NSW industrial sector regularly and systematically discriminates against the hiring of new staff if that person is over the age of 45. This discrimination has been well documented in academic and governmental literature and awareness campaigns have been conducted by both the Federal and State governments to combat this form of discrimination. The Injured Workers Support Network excludes as discriminatory employment practices experienced by our members transcends age and the employment of our members reflects the general experiences identified in age discrimination reports.

Sexual & racial discrimination

Both are factors in the NSW employment market but the experience of our members again reflects the experiences of the general employment market in both of these regards.

Discrimination against an identified or perceived sexuality is more of a cause of injury amongst our members rather than a barrier to further employment.

Disability discrimination.
This form of discrimination is again common amongst our membership and is reflective of a. the employment market at large and b. over-represented in our membership due to the higher level of people who have acquired a disability due to a workplace incident. Though more difficult to exclude from this discussion, our membership retains a high number of people who have recovered from an injury or whose injuries have not resulted in a permanently acquired disability which limits their capacity to work in their chosen field. The Injured Workers Support Network believes that denying someone employment due to restrictions is an act of disability discrimination which is worth highlighting to the Law and Justice Committee but

Discrimination against a potential employee who has had a prior workers compensation claim is a real and present barrier to people who have been injured at work .

Example 1:

> **"I went to a mate of mine who had just opened up a business in the same industry and was hiring new staff. I'd worked alongside this guy for near on 10 years. I asked him if he would hire me given my experience. The mate knew I had been injured at work, he was there that day, and he knew I had recovered so now I could work again but with some restrictions. His response was apologetic but negative. He said he was sorry and if I hadn't put in a claim he could have hired me and made the adjustments, but he said I was too much of a risk in the new business for him to hire me."**

Example 2:

> **"I put in my application, I had given my tax file number over and had been assigned a manager, a shift and was registered to do the OH&S training before I started work. Then I didn't hear a thing from them. What happened was that on my OH&S form they asked if I had previously had a workers compensation claim and I said yes. I also said I had no restrictions for the job I was doing. They hired a bunch of people the same way as they hired me, just on the papers no interview. What was the difference between them and me? I'd ticked yes to having a workers compensation claim and they didn't."**

One of the most common questions our helpline receives from injured workers who are looking to re-enter the workforce after they have recovered and or adapted is "Do I need to tell my employer if I have had a workers comp claim?" The answer we have to provide is "only if you have been asked.
The reason for this answer is twofold. We know that having a workers compensation claim is a detrimental mark when applying for a new job. We also know that lying on your application form is a reason for dismissal from employment in and of itself.

The injured worker is then caught in a catch 22. If they tell the truth, then they are likely to be denied the position- despite their capacity to do the job or the merits of their application. If they lie and are discovered to have lied on their application form the act becomes worthy of immediate dismissal.

Insurers and some rehabilitation case managers will tell their clients to lie:

> **"My insurance case manager yelled at me on the phone, told me I was purposefully undermining my job application by ticking the box that said I had a prior workers comp claim"**

> **"The rehab lady was working with me to get a job. She told me straight out that I should lie if I was asked the question from the interviewer."**

The Injured Workers Support Network Helpline takes calls from people recently injured and wondering if they should put in a claim. One of the concerns expressed by people calling with this issue is the impact on their future job prospects :

> **"If I put in a claim then my boss said I wouldn't be able to get a promotion in the department."**
>
> **"I was told by my doctor that its hard to get a job one you have a workers compensation claim."**

The active discrimination against a prospective employee who has a workers compensation claim has been identified by the Australian Human Rights Commissioner as an act of disability discrimination under the federal legislation. Yet only within the Queensland jurisdiction are employers prevented from asking this question. There is no government campaign to discourage the act from occurring and as such the act flourishes and actively works against the efforts of the "return to work" ethos of the current systems framework.

Discrimination against people with "restrictions"

People with work "restrictions" can and should be considered as people with an identified disability. Disability discrimination is illegal under federal and state laws but is blatant when prospective employees apply for jobs and have to identify that they have certain restrictions on their capacity to fulfil the requirements of the position they are applying for.

These requirements are rarely identified within job descriptions or in advertisements.

It is in the concept of flexible employees where the underlying problem stems (leaving aside any personal bias against disabled workers an employer may have).

> **"I had applied for a job as a warehouse manager, would have paid me some good money. The Employer was aware of my workers comp claim and didn't mind that, what they were worried about was that I wouldn't be able to help shift a 40 ton load once a year that came from China. They didn't want to look at doing it with a crane – they just used manual labour to do it with and I wasn't allowed to lift more than 10 kgs at a time. I didn't get the job."**

It may be considered relevant to a position that a job with known requirements that doesn't fit the prospective employees physical capacities is unsuitable to that prospective employee. Unfortunately the current workers compensation system in practice does not consider this to be relevant when that case manager or rehabilitation case manager enforces the requirement for an injured worker to apply for between two and ten jobs a week with the threat of suspension from weekly payments if this is not done.

There is available to a new employer a significant amount of federal and state funding to accommodate a worker with a disability. This accommodation is rarely identified to the injured worker or to a prospective employer so a position that may be suitable for one employee with the purchase of appropriate equipment may be denied because that employer sees the applicant as not worthy enough for this purchase with or without government assistance in making that purchase. It is my understanding that the budget for these assistance schemes are underutilised every financial year.

Discrimination by the home employer.

The discrimination against workers with an acquired disability (as identified in restrictions). Is even more pronounced with the home employer.

In the recent return to work Inquiry that the injured workers support network participated in. there were a number of stories where a government department would refuse to countenance the re-engagement of an injured worker due to their "restrictions" some departments such as health and education had a significant number of suitable positions throughout their work areas but the stories from our members is that these department have a propensity to refuse this.

This reluctance to re-employ workers with an acquired disability is also evident in companies such as Woolworths and Coles among other large multi-state employers.

This discrimination is against these companies own disability employment policies and demonstrates the fickleness of these policies as practiced by these employers.
If an employee becomes disabled, they are likely to find the organisation turning against them than providing assistance to them. This makes a lie out of any statement these companies publicly make in support of disabled employment and speaks to the heart of the problem disabled people face within the NSW job market. If these companies are not willing to be inclusive of their current employers who have an acquired disability, what hope is there for a disabled person to enter into these companies?

Recommendation:

- To pass legislation that restricts employers from asking potential employees if they have had a workers compensation claim.

The impact of the 2015 Benefits reforms

The Injured Workers Support Network welcomed the 2015 benefits reforms when they were announced, though acknowledged that they didn't go far enough to ensure adequate support to long term injured workers.

Health Reforms:

The health reforms gave an extra year (to life depending on total body impairment percentages) to all injured workers as a minimum after their weekly income replacement had been removed.

As welcome as these strategies are the backdating of the benefit has been of questionable practical merit to our members. For members who would be in the lower percentile (under a 10% total body impairment) the impact has been minimal to non-existent.

"I was never contacted by my insurer, I never knew about the new benefit."

(file note July 2016)

"They insurer sent me a letter saying that I could reapply for some medical benefits from then on for a year. I was kicked off in 2013, they stopped paying for my physio well before then, the damage has been done."

(file notes Feb 2016)

"I put in a claim for my medications when I got the letter, they knocked it back because I hadn't sort insurers approval for the medication from them prior to purchase."

(file notes Feb 2016)

"I charged them for the physio and the gym, they paid promptly which was a surprise"

(member conversation 2016)

Some members did report a positive result though:

For members who have been given the extra time while still receiving weekly income replacement the benefits are still largely unknown. This is because though the benefits exist, the access to those benefits continues to be controlled by the insurers and the same problems

as identified in our submission regarding the medical claims process applies with the exception of the issues of maintenance of physical and mental functioning, which is systematically denied by the insurers. This problem exasperates itself with the extension of medical benefits, as most insurers do not consider that maintenance of functioning is worthy enough to receive medical care under the workers compensation system they administer.

The Workers Compensation Commission

Members report a spectrum of experiences with the Workers Compensation Commission process. From those cases, which have been going on for years to quick resolutions and positive interactions, whether the member was successful or otherwise.

But there are some issues that should be brought to the attention of the Inquiry.

Waiting times:

A common complaint from members attending the Workers Compensation Commission is the waiting times between lodgment and hearing. This can be between 3 months and a year in some cases. There are multiple reasons as to why these waiting times exist but the main issues appear to be the legalistic nature of the proceedings, with evidence gathering, multiple visits to Independent Medical Examiners. The actual timing of mediation and arbitration for matters other than medical care appears to be complementary towards the commission. Though more resources for the commission would assist, there are minimal complaints regarding the time it takes for a matter to be heard and a decision to be handed down.

These same timeframes exist for medical decisions though and it is in this area where expedited hearing should be more common than what they appear to be. A waiting time of three months between lodgment and decision is a lengthy delay in treatment for an injured worker. Though this is a legal area, shorter timeframes are required to ensure consistency of care and greater recovery.

The Legal environment employed by the commission.

The most common complaint regarding the commission, beyond waiting times, is the way injured workers feel like second wheels when it comes to hearings, arbitrations and mediations.

> **"My solicitor was talking to their solicitor in the corridor and then they went into the room with the arbitrator. When my solicitor came out of there he told me that a settlement had been agreed upon and I should sign the document. I didn't understand what was going on at any time. I was told by my solicitor that this deal would be the best I could hope for, so I signed. I felt I shouldn't have even turned up."**

The issue highlighted in the quote moves beyond the commission work and into the realm of how solicitors treat their clients but the Workers Compensation Commission should ensure that injured workers understand what is occurring and how that impacts on the injured worker.

The $5,000 minimum

The Workers Compensation Commission has placed a financial barrier on the matters they will hear. In General this is $5,000. This limitation is to the disadvantage to many injured workers with "minor" claims who wish to challenge a decision by their insurer who has denied medical or practical care.

For example:

> **A member who may require paracetamol to manage ongoing pain taking two a day may have their claim for this medication denied by the insurer. As this form of medication may cost $180 a year the capacity to appeal the insurers decisions is limited to an internal appeal within the insurer (generally denied by the insurer), an approach to the Regulator who is reluctant to give an enforceable order to their insurers or an approach to WIRO who have no power to make an order to the insurers to pay. $3.50 a week may seem small amount but the cost becomes a greater percentage of the available funds of someone receiving minimum income replacement from the Workers Compensation system.**

This issue focuses itself more when the medical care denied is physiotherapy, massage or other time limited medical interventions. These costs can and do fall below the $5,000 barrier to a Workers Compensation Commission appeal. With the capacity to appeal an insurers denial taken away, it is more than likely that the service, identified as required by the injured workers doctor, will not be provided.

Recommendation:

- That the Workers Compensation Commission be adequately resourced to assist with the quick and timely access to a judgment, with particular consideration for medical claim disputes.

- That the Workers Compensation Commission be provided with greater powers to provide judicial oversight into all aspects of an injured workers claim. In particular with work capacity decision.

The Medical Profession

> **"My GP was hopeless at starting or dealing with my compensation claim so I found a new GP who got to the nuts and bolts of it immediately. He had previously been my son's GP so was familiar with our family history."**
>
> **(website comment March 2016)**

The medical profession both doctors and allied professionals are the best arbitrators of the needs of injured workers to rehabilitate that exists within the NSW Workers Compensation system. They are routinely ignored and bullied by insurers to change their diagnosis and conform to the wishes of the insurers. The evidence for this lays in regular and consistent reports from our members of insurance case managers insisting on attending the medical appointments of injured workers and either bullying or negotiating with the doctor to down grade their professional opinions as stated in the work capacity certificates, the refusal of insurers to give weight to a nominated treating doctors work capacity certificate in the insurers written work capacity decisions and the consistent use of independent medical examiners and independent medical consultants to refute the professional judgements of the injured workers specialists and nominated treating doctors.
This practice is so common the following quotes stands for approximately 20% of all calls to the Injured Workers Helpline in any given week:

> **"Can my insurer insist on attending my doctors' appointments with me?"**
>
> **"Can I change doctors because my doctor is refusing to work with me because of the pressure the insurer is putting on them?"**
>
> **"My insurer wants me to get a second opinion on my surgery because they don't believe my own specialist."**
>
> **"Can my insure insist I go back to my doctor to get a replacement work capacity certificate?"**

The main issue injured workers face with the medical profession, apart from the above, is the ongoing exodus from the system by general practitioners. The injured Workers Support Network is aware that there are a growing number of general practitioners who refuse to manage workers compensation claims. In 2014 this was identified in Bathurst, in 2015 Broken Hill and Penrith through to Lithgow. The Injured Workers Support Network in these cases approached several General Practitioners in these areas to represent our members and try to

mitigate this exodus, in doing so we have gathered the names and locations of several doctors who are willing to assist injured workers in these areas and have compiled a list of these doctors on our website.

In conducting this intervention we identified that the main reason for the exodus was the lack of information provided to General Practitioners regarding their rights and their responsibilities towards their patients.

The main issue is the mistaken belief that the General Practitioner is less responsible to the injured worker than the insurer or employer. Part of our intervention was to assure the General Practitioners we spoke with that their professional obligations towards their patient along with that patients' rights and the doctors rights remain. It appears that the insurers have attempted to undermine these rights through their interference.

Another aspect to this exodus is the reluctance of insurers to adequately reimburse General Practitioners for their time in writing reports and responding to the insurers written requests (this matter is addressed elsewhere in this submission).

The final aspect is the pressure on the doctor from the insurers to change their medical opinion to the detriment of the injured worker and against their professional opinion.

The Legal Profession

The Legal professions involvement in the Workers Compensation System is currently integral to the wellbeing of injured workers within that system. Unless an injured worker is part of a Union who provide integrated support for injured workers within their structure such as a dedicated workers compensation officer or trained union organisers as some but not all unions do, the injured worker is reliant on a lawyer to ensure their rights are heard in the Workers Compensation Commission.

The Injured Workers Support Network attempts to provide accurate guidance to injured workers on their rights but our resources are stretched and the system currently does not allow for non-legal non-industrial assistance to represent injured workers within the workers compensation system.

The legislation as it stands prevents a holistic approach to legal support by the legal profession though. Despite the passing of the 2015 changes, injured workers continue to be disadvantaged when appealing a work capacity decision by not being able to access legal support in the preparation of a report. This is assistance given internally to case managers when they write their decisions and review their internal appeals. Even when the insurers, as is the case with some self-insurers do not access internal legal support, they possess professional knowledge and skills denied to injured workers due to the specialisation in workers compensation matters. This is a discriminatory practice.

When cases are taken up by the legal profession there is a tendency for lawyers to only want those cases where a negligence claim can be made against an employer. This is where the profit is for the legal profession. The Injured Workers Support Network does not in any way disparage this practice, it is impossible for a regular person to win a negligence case without legal support. There are concerns that the process for permanent impairment benefits though. The financial benefit to the injured worker is prescribed by the legislation depending on their total permanent impairment. Once the medical calculation has been done the Injured Workers Support Network believes the payment of this benefit should be automatic and not a litigated matter.

The restrictions in place for suing for negligence is also a discriminatory practice, again reliant on the injured worker bearing an acquired disability equating to 11% of physical functioning or 15% of psychological functioning. The permanent impairment calculation does not include a calculation on the social, familial or other non-medical impact of an injury the injured worker may bear. For example, the loss of functioning in a knee may not equate to an acquired disability above the 11% threshold but may prevent that injured worker from participating in their chosen sport- this impact may be more deleterious to the individual than the loss of time at work due to the psychological impact of this loss. The capacity for that person to sue their employer for negligence is therefore important to that person and the impact may be greater than the physical impact the medical calculation would make.

Restricting the capacity for lawyers to represent all injured workers takes away from the rights of the injured worker and prevents them from a fairer compensation for their injuries.

WorkCover Independent Review Office

The Injured Workers Support Network is appreciative of the assistance the WorkCover Independent Review Office provides to injured workers.

It provides generally the final stop prior to calling a lawyer for the resolution of an issue with an insurer or with the regulator. Members in general have expressed gratitude for the work the office has provided to assist them to resolve a problem.
\
There remain significant restraints on the WorkCover Independent Review Office in providing such assistance. The first is that their power to resolve issues is generally unenforceable, an insurer can and has ignored the representations made by the staff of the office in several matters. The legislation is not explicit in its provision of the powers to the WorkCover Independent Review Office to make binding rulings on the insurers. Currently when an insurer refuses to comply with a non-binding ruling WIRO forwards that ruling to the State Insurance Regulatory Authority requesting that they enforce the ruling with the insurer. This is far from the ideal of an independent office.

The Independent Legal Assistance and Review Service
The Injured Workers Support Network is again appreciative of the support the Independent Legal Assistance and Review Service has provided our members and the Injured Workers of NSW. Members who have reported back to us regarding the advice and assistance of this service in general speak positively of their interaction and the usefulness of their advice.
There are a few concerns with the role of the WorkCover Independent Review Office within the workers compensation system though.

The Injured Workers Support Network would like to convey its appreciation of the efforts the current office holder has made in establishing and enforcing the independence of the office but also acknowledge that this independence has significant constraints and is better place outside of the Ministry for Innovation and Better Regulation. It should be invested with the powers and functions of the office of an ombudsman either as an independent ombudsman or within the current NSW Ombudsman's office. As with Victoria there a significant issues with the systemic behaviour and corrupt practices of the insurers within the NSW scheme towards injured workers. To such an extent that a permanent ombudsman with the power to investigate the individual and commercial practices of insurers, self-insurers and employers as well as any other stakeholder within the current NSW workers compensation system.
There is a real and ongoing issue of capture and control from the other governmental sectors of the workers compensation system hanging over the WorkCover Independent Review Office that must be removed.

Procedural reviews.
The WorkCover Independent Review Office retains a position within the system in the Procedural review of work capacity decision appeals. These reviews deal only with the legality of the actions of the insurer and not with the merits or otherwise of the original work capacity decision. Over recent years the WorkCover Independent Review Office has done a good job of wedeling out the procedural faults with the work capacity decisions of the insurers to such an extent that though their annual report identified still a majority of appeals were upheld by the office the percentage that was upheld has steadily decreased since the offices creation.

(61.6% in 2015/14, 73% in 14/13 in 13/12 only two were received by the office both of these were upheld). It is likely that 2015/16 will mirror this trend.
Though this implies that the system is becoming more efficient it remains the case that the only independent review within the system is limited to whether the right letter has been sent out at the right time rather than whether the right decision has been made by the insurer to begin with.

Recommendation:

- To transform the Workcover Independent Review Office into a NSW ombudsman office either underneath the current NSW Ombudsman office or as an independent office.

The State Insurance Regulatory Authority

The State Insurance Regulatory Authority was established in 2015 after the legislative changes of that year. They have been establishing themselves since that period and re-writing and or consolidating the issuing quite a large number of guidelines since then.

During the period of 2015-2016 the Injured Workers Support Network has had regular meetings with the State Insurance Regulatory Authority. During these meetings members, injured workers currently receiving workers compensation have always been in attendance and lead the discussions for the Injured Workers Support Network.

The board of the Injured Workers Support Network made a decision part way through 2016 to end these meetings as they felt the State Insurance Regulatory Authority were not making progress or showing willingness to engage as equal partners with the Injured Workers Support Network. We have several outstanding issues with the State Insurance Regulatory Authority which include:

- The ongoing lack of final sign off by the State Insurance Regulatory Authority to the agreed upon Memorandum of understanding with the Injured Workers Support Network
- Insurers should be forced to adhere to the Workers Compensation Commission [Workers Compensation Regulation 2010 Part 9 49 (1)] of only one IME report (therefore only one IME referral and assessment) per injury claim.
- Ensuring Independence of Insurer IMEs.
- Ensure that all IME's used by insurers to assess claims are practicing and treating medical professionals up to date with their professional learning points.
- The Injured Workers Support Network would like WorkCover to institute a justification practice with the insurers to ensure that their decision to refer to an IME is reviewed prior to a referral to an IME.
- Appropriate complaints mechanism for Injured Workers subjected to unprofessional practices by IME's.
- Peer review of IMEs practices.
- Receiving reports by IME's.
- The ongoing practice of allowing IMES to refuse support persons to accompany the injured worker in the appointment.
- Establishing and enforcing time frames on the creation and implementation of Injury Management Plans with insurers.
- The underutilization of Injury Management Plans to pre-empt the requirement to seek approval from insurers before certain medical and related procedures take place.
- The lack of review of created Injury Management Plans.
- The lack of consultation with injured workers and their treating doctors in the creation of an Injury Management Plan.
- The utilisation of Injury Management Consultants for work capacity decisions and shopping of Injury Management Consultants by insurers.
- The separation of Injury Management Plans from the Work Capacity Assessment process.
- Addressing inappropriate Customer Service provided by the insurers and WorkCover call centre.
- Lack of adequate processes to ensure confidentiality of worker information within self-insurers and the parent company.
- Access to rehabilitation for all injured workers and in particular the enforcement of the right of the injured worker to choose their rehabilitation provider.

- The lack of understanding, training and enforcement of appropriate Pre-Injury average Weekly Earning decision by insurers.

The State Insurance Regulatory Authority's capacity to manage complaints against insurers is so far untested, or at a minimum unknown as they do not release any statistics of complaints managed or enforceable undertakings given to insurers.

One of the most significant issues is that the State Insurance Regulatory Authority continues the behaviour and practices of the old WorkCover with their favour towards the insurers in a way that appears to make them as captured to the insurers as before. This capture of the government department was a feature that came into considerable focus during the 2012 upper house inquiry and again during the bullying and harassment inquiry of 2014. The Injured Workers Support Network is yet to see any significant differences between the behaviour between the old and the new.

An example of this is in their continued refusal to allow easier access to the medical records of injured workers held by the insurers. Under section 154Kof the Workers Compensation Act 1987 Ownership of records it states the following:

> (1) Subject to the regulations, all records and other documents made and kept, or received and kept, by a scheme agent in the exercise of functions on behalf of the Nominal Insurer are the property of the Nominal Insurer.
> (2) The Nominal Insurer may give directions to a scheme agent with respect to possession, custody and control of, and the granting of access to, those records and other documents.
> (3) A scheme agent must comply with any such directions given by the Nominal Insurer to the scheme agent.

This provides that the Nominal Insurer (the government either iCare or the State Insurance Regulatory Authority) have the capacity to ensure that injured workers do not have to jump through legal hoops to obtain their medical records, a right afforded to all NSW citizens in any other circumstance. Despite two years of requesting this to occur, and for the system to become more transparent and health focused as a result, the then WorkCover now State Insurance Regulatory Authority (and iCare) continue to refuse to consider this as a option.

Another example is the enforcement of an injured workers right to have someone accompany them to an assessment or appointment with an Independent Medical Examiner. In this case the State Insurance Regulatory Authority argued that they would not allow this to occur due to the "concerns of the doctors might feel uneasy and reluctant in front of a support person." (paraphrased statement made at a joint meeting). This is despite their position to enforce this practice through guidelines and the right to a support person being enshrined in the Guidelines for Medico-Legal Consultations and Examinations at point 2.

> **" The examinee has the option of having an accompanying person present during the history and/or the examination. This should be explained to the examinee when the interview is being scheduled. The role of the accompanying person is to support the examinee, but not to answer questions or contribute to the assessment. However, should the examinee have an intellectual or speech difficulty, it is appropriate for the accompanying person to assist in the communication between practitioner and examinee."**
>
> **(http://www.mcnsw.org.au/page/317/resources/policies/)**

It is to be recommended to the then WorkCover that our suggestion that injured workers referred to an independent medical examiner be given a choice of three as close to the injured workers place of residence as is possible, but this remains the most significant change the State Insurance Regulatory Authority has made in all our consultations with them.
Consultation and change within the State Regulatory Authority has been haphazard at best with injured workers.

Even when the State Insurance Regulatory Authority agrees with the Injured Workers Support Network and its members they appear to be helpless to stop the practices of the insurers. The Issue with Injury Management Plans (addressed elsewhere in this submission) being a significant case in point. The State Insurance Regulatory Authority agree that they are not adequate to the task and, despite this admission, they have yet to make any changes to the procedures of the insurers in issuing these very vital plans.

Information on the rights of an injured worker put out by the State Regulatory Authority is as haphazard as their consultation and change. The guidelines for injured workers make very little reference to the rights of an injured worker, spending the majority of the publication reasserting the responsibilities of the injured worker towards their insurer.

iCare

The Injured Workers Support Network is unable to comment adequately on the functions and performance of iCare. It continues to be an elusive and fairly secretive organisation within the current Workers Compensation System. It has yet to publicise insurers performance statistics as occurred under WorkCover and its only significant publication appears to be the winners of the 2016 “case awards” which the Injured Workers Support Network views as an insult to the injured worker through their provision of an award to case managers, case management teams, individuals and organisations for the ongoing debasement of injured workers within the workers compensation system. The awards are not given for excellence in the recovery of their clients, nor for achieving stable employment outcomes for injured workers. The criteria essentially awards insurers for the continued systemic abuse of injured workers and the denial of their rights. More information is given over on the iCare website to these awards than the rights of injured workers or guidance to injured workers.

Recommendation:

- To ensure that there is an open and public accountability of iCare and insures through regular disclosures
- To end iCare’s practice of awarding the “case awards”

SafeWork NSW

The injured workers support network has had minimal contact with SafeWork NSW since it was formed in 2015. During our meetings with WorkCover and afterwards SafeWork NSW was a regular attendee and made appropriate contributions when topics arose which affected their practice.

The Return to Work inspectorate of SafeWork NSW has previously been commented upon in this submission.

The Injured Workers Support Network supports the submissions of unions to this inquiry in relation to SafeWork NSW.

Impact of other laws on the workers compensation system.

The Injured Workers Support Network would like to bring to the attention of the committee our observations on how the Workers Compensation System routinely ignores other legislations designed to assist and protect injured workers.

The Health Records and Information Privacy Act 2002

Insurance companies as this act currently defines them are except from applying the principals contained within this act or adhering to its requirements. This is through an act of omission in the definitions rather than, according to their requirements in the NSW Workers compensation acts, the actual daily work carried out. the definition of a “welfare service” is telling in this regard:

Section 4 Definitions:

> "health service" includes the following services, whether provided as public or private services:
> (a) medical, hospital, nursing and midwifery services,
> (b) dental services,
> (c) mental health services,
> (d) pharmaceutical services,
> (e) ambulance services,
> (f) community health services,
> (g) health education services,
> (h) welfare services necessary to implement any services referred to in paragraphs (a)-(g),

The role contracted to them by iCare certainly fits neatly into point “h” of these definitions, but this act also includes the following statement:

> "health service provider" means an organisation that provides a health service but does not include:
> (b) an organisation that merely arranges for a health service to be provided to an individual by another organisation.

Insurance companies within the workers compensation system are contracted by the government to do more than “merely arrange for a health services to be provided”. They assess the need for the health service and have final decision over whether someone will have that health service a decision so strong, that the only way to overturn that decision is through a court of law.

The Health Records and Information Privacy Act 2002 also contains 15 principles within schedule 1 of the 2002 act. These principles are directly relevant to the personal situations the injured worker faces when they have a workers compensation claim managed by an insurer. In particular principle 2, 7, 8 and 9:
Schedule 1:

2 Information must be relevant, not excessive, accurate and not intrusive.

(1) An organisation that collects health information from an individual must take such steps as are reasonable in the circumstances (having regard to the purposes for which the information is collected) to ensure that:

7 Access to health information

(1) An organisation that holds health information must, at the request of the individual to whom the information relates and without excessive delay or expense, provide the individual with access to the information.

8 Amendment of health information

(1) An organisation that holds health information must, at the request of the individual to whom the information relates, make appropriate amendments (whether by way of corrections, deletions or additions) to ensure that the health information:

9 Accuracy

(1) An organisation that holds health information must not use the information without taking such steps as are reasonable in the circumstances to ensure that, having regard to the purpose for which the information is proposed to be used, the information is relevant, accurate, up to date, complete and not misleading.

Recommendation:
That the committee recommends the workers compensation legislation be amended to include the requirement for Insurers to adhere to the NSW Health Records and Information Privacy Act 2002 and in particular the principles of the Health Records and Information Privacy Act 2002 .

Disability Inclusion Act 2014

An injury within the workplace can lead to a physical, psychological or intellectual disability as defined under the Disability Inclusions Act 2014 section 24 Meaning of “person in the target group”.

The Disability Inclusion regulation 2014 Schedule 1 contains the following principles:

The disability service standards are as follows:

Each person with disability receives a service that promotes and respects the person’s legal and human rights and enables them to exercise choice like everyone else in the community.

Each person with disability is encouraged and supported to contribute to social and

civic life in the person's communities in the way the person chooses.

Each person with disability is supported to exercise choice and control over the design and delivery of support and services to the person.

When a person with disability wants to make a complaint to a provider of a service, the provider of the service will make sure the person's views are respected, that the person is informed as the complaint is dealt with, and that the person has the opportunity to be involved in the resolution process.

Each person with disability is assisted to access the supports and services the person needs to live the life the person chooses.

Providers of services to persons with disability are well managed and have strong and effective governance to deliver positive outcomes for the persons they support.

In too many varieties of ways insurers as the service provider for people with disabilities does not adhere to these principles. These are mentioned previously in this submission but to identify a few:

The withholding of information, the abuse and degradation some insurance case managers use against injured workers, the use of private investigators who follow injured workers as a medical diagnostic tool the near universal refusal to assist injured workers to retrain in an skill or field of their choosing. These practices amongst many do not adhere to the Disability Inclusion Act 2014.

Recommendation:
The committee recommends the government enforce the principles contained in the Disability inclusion regulations 2014 for all professionals and all insurers working with the NSW Workers Compensation scheme.

Anti-Discrimination Act 1977

Part 4A of the NSW Anti-Discrimination Act 1977 states the following:

49A Disability includes past, future and presumed disability
A reference in this Part to a person's disability is a reference to a disability:

(a) that a person has, or

(b) that a person is thought to have (whether or not the person in fact has the disability), or

(b) that a person had in the past, or is thought to have had in the past (whether or not the person in fact had the disability), or

(d) that a person will have in the future, or that it is thought a person will have in

the future (whether or not the person in fact will have the disability).

And:

49D Discrimination against applicants and employees

(1) It is unlawful for an employer to discriminate against a person on the ground of disability:
(a) in the arrangements the employer makes for the purpose of determining who should be offered employment, or
(b) in determining who should be offered employment, or
(c) in the terms on which the employer offers employment.

(2) It is unlawful for an employer to discriminate against an employee on the ground of disability:
(a) in the terms or conditions of employment which the employer affords the employee, or
(b) by denying the employee access, or limiting the employee's access, to opportunities for promotion, transfer or training, or to any other benefits associated with employment, or
(c) by dismissing the employee, or
(d) by subjecting the employee to any other detriment.

(3) Subsections (1) and (2) do not apply to employment:
(a) for the purposes of a private household, or
(b) where the number of persons employed by the employer, disregarding any persons employed within the employer's private household, does not exceed 5, or
(c) by a private educational authority.

(4) Nothing in subsection (1) (b) or (2) (c) renders unlawful discrimination by an employer against a person on the ground of the person's disability if taking into account the person's past training, qualifications and experience relevant to the particular employment and, if the person is already employed by the employer, the person's performance as an employee, and all other relevant factors that it is reasonable to take into account, the person because of his or her disability:
(a) would be unable to carry out the inherent requirements of the particular employment, or
(b) would, in order to carry out those requirements, require services or facilities that are not required by persons without that disability and the provision of which would impose an unjustifiable hardship on the employer.

(5) For the purposes of subsection (3) (b), a corporation is taken to be the employer of the employees of any other corporation which, with respect to the first mentioned corporation, is a related body corporate within the meaning of the *Corporations Act 2001* of the Commonwealth.

The Injured Workers Support Network would like to direct the committees attention to two

aspects of this Act and its impact on the Workers Compensation System.

The first is the discrimination experienced by someone who has been on the workers compensation system in his or her attempts to find work. It is regularly reported to the Injured Workers Support Network that employers regularly ask if the prospective employee has had a previous Workers Compensation claim. It is rare to scarce that if that person answer yes to this question that they will be the successful candidates. This is in direct contradiction to the first extracted piece of the NSW Anti-Discrimination Act 1977. The question posed to the prospective employee identifies that person directly with either having, had, or potentially having a disability. This form of discrimination is so prevalent that both insurers and rehabilitation case workers train injured workers to lie if asked this question.

The second is part 49D (4) which makes it legal for an employer to sack an employee with an acquired disability if, in the perception of the employer, that employee:

(a) would be unable to carry out the inherent requirements of the particular employment, or

(b) would, in order to carry out those requirements, require services or facilities that are not required by persons without that disability and the provision of which would impose an unjustifiable hardship on the employer.

The guiding paragraph above those two sections makes no mention of the capacity of the employer to reassign a worker who, as the result of a workplace incident, has to live with an acquired disability. This law makes it legal to discriminate against a worker who has an acquired disability. This allowance significantly reduces the viability of any return to work goal of the workers compensation system.

Recommendation:

That the committee recommends the Workers compensation legislation includes the same protections as the Queensland legislation in making it illegal to ask a prospective employee if they have had previous workers compensation claim.

That the committee recommends to the government that Anti-Discrimination Act 1977 49D (4) does not apply to workers who have had an workplace injury.

The outcome of the Victorian Ombudsman's Investigation into the management of complex workers compensation claims and WorkSafe oversight and the relevance to the NSW Workers Compensation System.

Due to the nature of the work the Injured Workers Support Network involves itself with the investigation into complex claims is of extreme interest to our members and ourselves.

There are three stages in which an injured worker may contact the Injured Workers Support Network Helpline or join one of our nine local networks throughout NSW.
The first stage is at the very beginning of their claim, either prior to claiming or within the first month. The advice sort form this cohort is generalised in nature mostly consisting of questions such as:

- What is the workers compensation system?
- What will happen when I put in a claim?
- What if the claim is (or was) rejected?

The second cohort are injured workers who have been in the system for a few months generally centred around the 13 to 30 week period.
For this group the involvement and questions is significantly more complicated.
Questions surrounding payments, denials of liabilities, work capacity decisions, return to work plans, obtaining legal assistance are common concerns.

The third and more prominent cohort are injured workers who have been in the system for six months or more. Those whose injuries are complex, who have generally been fired from their workplaces and whose claims can rightly be considered complex according to the Victorian Ombudsmans definition.

The Injured Workers Support Network can confirm for the inquiry that the findings of the Victorian Ombudsmans report are just as relevant within the NSW context as they are in the Victorian context. With the exception that in NSW we do not have a medical panel to provide oversight for medical claims.

For example:
On page 7 of the Victorian report Unreasonable decision-making by agents point 12

> **"Contrary to the key principles, my investigation found numerous examples of agents selectively using evidence to reject or terminate a claim, while disregarding other available evidence. This occurred even where the weight of evidence**
> **in support of the worker's claim was considerable. One former agent employee said that for claims staff, 'it was a matter of just finding something to terminate on'."**

This is evident in the NSW system to a large degree.

> **"I was sent to two IMEs before they denied my claim. They only provided me with one of the IME reports. My solicitor told me that this was because the other IME would have been favourable to my claim. "**
>
> **(Member, Gosford meeting 2015)**

> **In one Work Capacity Decision the insurer decided to ignore the Nominated treating doctors work capacity certificate in favour of an IMC's report which stated that a. the injured worker had not recovered from their injury and b that at the time of examination the Work Capacity Certificate was correct (but should improve in the future).**
>
> **(file notes August 2016)**

This same Work Capacity Decision included a report from a specialist where the examination took place a week after the IME examination. This report concluded that the injured workers injury had not significantly improved. The insurer did not provide this to the IME for that IME to update their own report with this new information. That specialist report was also ignored by the Insurer in their reasons why the insures liability should cease. This reflects the findings of the Victorian Ombudsman in paragraph 13 dot point 1.

At dot point 2 of paragraph 13 the Victorian Ombudsman reports:

> **"Requested multiple supplementary reports from IMEs in an attempt to influence or change their opinion, which some witnesses described as a 'fishing exercise'**
>
> **Though we have no direct evidence of this pressure on IMES's the Injured Workers Support Network regularly receives reports from members and treating doctors on the pressure insurers place on Nominated Treating Doctors and Specialists to change their reports and work capacity decisions. Including:**
>
> **Threats to allied health professionals to cease contracts if the reports are not changed.**
>
> **Lying to nominated treating doctors about offers of training to injured workers if the work capacity certificate is changed to include full time hours.**
>
> **Threatening the injured worker that they will be cut off the system unless they pressure their doctor/specialist/allied health professional to change their report.**
>
> **Using private investigation photographs and reports in an attempt to convince the nominated treating doctor that the injured worker is lying. "**

The issue describe in the Victorian Ombudsman's report regarding insurers attempts to change medical professionals minds are commonplace within the NSW workers compensation system.

Doctor shopping, as identified in the Victorian Ombudsmans report is also commonplace within the NSW system.

The Injured Workers support network conducted a survey on the Insurers use of IME's in 2015. This identified that X number of respondents reported that they were sent to more than one IME by the insurer for that IME to review the same injury.

Doctor Shopping also occurs in other circumstances.

There are two types of rehabilitation services in NSW. There are services that are "preferred" by insurers and those who are not.

"Preferred" rehabilitation services have contracts directly with the insurers. These contracts, as described by rehabilitation professionals who have discussed them with the Injured Workers Support Network, restrict the billing costs of rehabilitation services in return for a guaranteed number of referrals per year. Injured workers are then referred to these preferred rehabilitation services and are only briefly told (if at all) of their right to choose their own rehabilitation service. Where this is most stark is in the referrals to Vocational assessments, where the choice of rehabilitation service is removed from the injured worker and referrals are made as per the internal list of contracted rehabilitation providers.

The "report" shopping is prevalent within this system as well.

"The insurer contacted me and asked me to change rehab provides because they didn't think the one I was with was helping me [that rehab provider was not a preferred rehab provider]. So they sent me to another mob who did another vocational assessment on me, the second in three months."

Leading questions continue to be problematic with the insurers. The questions asked by insurers to independent medical examiners are a case in point. The typical questions the insurer asks the IME are as follows.

Medical Liability:

- Based on the evidence on file do you agree with the diagnosis provided at the time of the injury?
- Do you believe the alleged injury arose out of or in the course of employment?
- Are there any pre-existing factors that may be related to this Injury?
- Is the worker's employment a substantial contributing factor to the alleged injury? In assessing this please consider whether the injury or a similar injury would have happened anyway at about the same time or at the same stage of the worker's life if he or she had not been at work or hand not worked in that employment?
- In the case of a disease injury, is the work the main contributing factor to the causation, aggravation, acceleration, exacerbation or deterioration?
- Is the worker still suffering from a work related injury and if not when did it cease?
- Is the evidence in the surveillance material provided consistent with our clinical observations and with the diagnostic features that you have reached?
- Does the surveillance evidence cause you to change the opinions that you have expressed on the subject of symptoms, disability, prognosis, fitness for work and treatment needs?
- Please advise the current work capacity. Please specify the suitability duties (capabilities) and hours (with justification).
- What is the worker's prognosis and the timeframes for return to both suitable duties (if currently unfit) and pre-injury duties?

- Are there any pre-existing conditions impacting on the worker's current level of certification and fitness for work outside the compensable injury?

Reasonably necessary treatment/services and cost:

- In your opinion what is the most appropriate treatment if any (including expected duration)?

It is notable that there is only one question asked of an independent medical examiner regarding treatment options. Questions regarding the worker's injury are all couched in terms of whether the insurer is liable for the injury rather than simply asking what the medical issues the worker is facing in the opinion of the IME.
It is also useful to note that the above example was taken from an IME report regarding a worker who's claim had been accepted a year prior to their appointment with this particular IME and that this report is currently being used as part of a work capacity decision, not to identify whether liability should be accepted.

Point 19 of the executive summary identifies that Insurers are making decisions despite rulings of the, in the Victorian case, medical board. The Injured Workers Support Network is aware in NSW of cases where the insurers have refused to follow the directions of the Workers Compensation Commission after an arbitrator has ruled in favour of an injured worker. In most cases this is done through delaying (in one case up to two years) the delivering of either a service or payments to an injured worker.

The Injured Workers Support Network has for some time been requesting an inquiry into the behaviour of the Insurers towards injured workers in NSW. We believe that this inquiry will find similar tactics being used by the insurers in NSW as they use in Victoria.

Recommendation:

- To recommend that the NSW Ombudsman conducts a similar investigation into the system in NSW.