AUSTRALIAN MEDICAL ASSOCIATION
(SOUTH AUSTRALIA) INC

8 December 2016

Ms Sue Sedivy
Executive Officer
Parliamentary Committee on
Occupational Safety, Rehabilitation
and Compensation
House of Assembly
Parliament House
North Terrace
Adelaide SA 5000

occhealthcommittee@parliament.sa.gov.au

Dear Ms Sedivy

Inquiry into The Return to Work Act and Scheme

Thank you for the opportunity to submit to the inquiry of the Parliamentary Committee on Occupational Safety, Rehabilitation and Compensation into the Return to Work Act and Scheme, and for the extension of time to do so.

The AMA(SA) has the following comments to offer, which reflect feedback from our membership relating to the Scheme. Some of these comments may also have been included in direct submissions to you from the profession: we support members to make individual submissions where they are so inclined.

In terms of the inquiry itself, we received feedback that the terms of reference are somewhat limited and come at the question of Act changes and workers' compensation from a particular perspective.

Apart from data that relates to the Scheme's financial status, there is limited data available to the community or health professionals on benchmarks, key performance indicators, or how the objects of legislation are reached.

Medical professionals have considerable involvement with treating short- and long-term injuries and disabilities as a consequence of work, often caring for those who do not claim, have rejected claims, or after the claims resolve. AMA(SA) members can provide qualitative feedback based on community and clinical experience.

However, the legislation is new and thus the time frame since its introduction is relatively short to effectively evaluate the changes, particularly on injury outcomes and disability. Attached is the latest available report from Safe Work Australia. This is date stamped August 2015, so presumably there is a further update pending. However this data lags the changes as the study base is 2013-2014.

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There is a strong argument for workers' compensation systems to provide data and monitoring of processes and outcomes transparently, and to have regular reviews of key parameters of the legislation. This would be predicated upon establishing appropriate metrics and data collection, as well as input on comparisons and interpretation. It does appear early to look at some of these issues with full granularity in the context of the change date. Quantitative data is important. Evaluation planning is an important part of the regulatory process, and for the compensation environment, research and data collection should be fostered.

Importantly, the AMA(SA) and AMA(SA) membership should be involved, as key stakeholders, in relevant aspects of review and in providing an experienced and representative input.

Whilst there is an important consideration around WPI, the most important issues relate to work injury and illness prevention, early access to quality treatment and rehabilitation services and better return-to-work outcomes. As such, most of the modifiable/avoidable/avertable factors are early, occurring within the first few months of injury, before WPI becomes a consideration.

The Victorian Ombudsman's report highlights some important issues with the claims process, aspects that could be readily monitored. Research from Queensland, New South Wales and Victorian compensation systems (mainly motor accident) point to claims process, perceived injustice and early injury factors. Evaluating and monitoring how WPI operates in this Scheme, and comparing it to other schemes, should be self-evident.

"Accumulative" injuries are a considerable area of difficulty – in some circumstances, there are clear exposure-effect associations and, in other circumstances, the multifactorial nature of causation or risk factors, including genetic, environmental, age, prior trauma, lifestyle etc can make causation inferences difficult for clinicians and those making determinations. In the scheme this sits as a legal, procedural issue more so than a medical issue, though as the first step, doctors write the certificates, and in other circumstances provide advice to decision-makers. The reality is a multi-causal, multimodal biopsychosocial model where shades of grey are common.

In relation to the terms of reference for the inquiry, we received feedback that any system that is adversarial runs the risk of becoming extremely bureaucratic and longwinded, with the patients suffering unnecessarily. Normally, medical practice is collaborative and, in hospitals and other places, on a daily basis, medical professionals come together for different views and opinions, and decide what is in the best interests of the patient. To separate medical practitioners means that there shall be different opinions and thus an opportunity to increase adversarial dialogue at the expense of patients.

We received feedback that terms of reference a) to h) are bureaucratic and, by altering one way or another, perceived benefits may be more or less, at potentially an increased cost. Any caring society would produce a system of compensation that is fair. However, it needs audit so that it is not open-ended and the end counterproductive. The more complex the system, the bigger the industry, the greater the opportunity for diversion of funds from patients. We received some feedback suggesting that "any jurisdiction in Australia or, indeed, overseas that has a simpler system than ours is worthy of consideration".

Also, we received feedback that this Scheme contains an element of perceived inadequate descriptors, an example of this being the Section on "Mastication and Deglutition". If the Assessor providing the report is uncomfortable, and unsure of what is required, then we received feedback expressing grave doubts that the recipient could make effective use of the information supplied.

Further, we received feedback that the bureaucratic expectations in the headings of the report are certainly useful as reminders of the details required, but can make preparation of the report cumbersome, time consuming and confusing, which clinicians surmise adds to the paper load required, particularly in relatively straight forward cases. We received feedback that based on experience to date, the system requires and demands an appropriate clinical update to avoid these above difficulties.

We received feedback from a psychiatrist practising in the field that ReturntoWorkSA leadership have been proactive in implementing a system that permits cooperation with treatment providers and is more user-friendly, thus far, toward injured workers than previously, but that there remains opportunity for disputation, and the process of investigation and disputation is corrosive and produces long-term disability.

There is concern that removal of medical practitioners from the initial phases of dispute resolution by the closure of medical panels SA was not helpful, and that criticism of the process of Medical Panels SA failed to consider the effects of the legal process.

We received feedback that RTWSA, whilst striving for early intervention, is an untested entity and the current two years proposed for a cap on income maintenance may prove insufficient – the timeframe should be considered in light of evidence. Also, the failure to provide compensation for psychiatric impairment is inconsistent with legislation in other states and is not in keeping with the academic literature nor the experience. Mental health conditions should be recognised as medical conditions that can cause disability and treated as such. Treatment data on treatment resistant posttraumatic stress disorder and depression, which is ample, supports the statement. With the governments at state and federal level highlighting the needs of those with mental illness, this statement and the need for closer examination of the impact of the legislation should be obvious.

Feedback to AMA(SA) highlighted that the report by the Victorian Ombudsman has found evidence of unreasonable decision-making, including the 75 per cent of 130-week termination decisions overturned by the courts, strongly suggests that at the disputed end of the spectrum, the balance is tilting away from fairness. This report also noted a need to target quality assurance process to those IMEs subject to a high number of complaints. We received feedback that this is worth considering in SA.

We received feedback that it seems that some insurers regard the medical profession as wishing to keep their patients ill for longer to warrant further attendance and generate income. Aside from the fact that this is obviously completely contrary to the codes of ethics and conduct that all doctors must abide by, it is also not borne out by the facts, including the undersupply and high demand for doctors, additionally notable in the workers' compensation field, and the motivations and job satisfaction of doctors.

On this subject, there are increasing concerns in relation to the allocation of patients to medical examiners. Under the legislation a patient may choose an assessor. In reality, the worker has little knowledge of the area and relies on their solicitor or case workers etc. Our members are concerned that the process of allocation of patients is flawed. The outcome is that there will be a bias in the allocation, and such disproportionate allocation will encourage doctors to leave the system as their case load reduces. Also the perception of seeking 'favourable' reports is preserved. The AMA(SA) forecast this problem in the initial consultation of the legislation where we sought to have a random allocation process. We have had preliminary discussion whereby we suggest that an alternate allocation process for permanent assessment be considered which provides an 'arm's length' approach.

To echo comments you may have also received directly, the AMA(SA) supports that there remains considerable work to be done in educating employers regarding compensable injury, educating health providers to engender a proactive approach to treatment and encouraging liaison with insurers and employers.

Yours sincerely

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