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Official Committee Hansard

HOUSE OF REPRESENTATIVES

STANDING COMMITTEE ON EMPLOYMENT AND WORKPLACE RELATIONS

(SUBCOMMITTEE)

Reference: Aspects of workers' compensation

FRIDAY, 18 OCTOBER 2002

SYDNEY

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HOUSE OF REPRESENTATIVES

STANDING COMMITTEE ON EMPLOYMENT AND WORKPLACE RELATIONS

(Subcommittee)

Friday, 18 October 2002

Members: Mrs De-Anne Kelly *(Chair)*, Mr Bevis, Mr Dutton, Ms Hall, Mr Hartsuyker, Mr Lloyd, Ms Panopoulos, Mr Randall, Ms Vamvakinou and Mr Wilkie

Members in attendance: Mr Bevis, Mr Dutton, Mr Hartsuyker and Mrs De-Anne Kelly

Terms of reference for the inquiry:

To inquire into and report on matters that are relevant and incidental to Australian workers compensation schemes in respect of:

- the incidence and costs of fraudulent claims and fraudulent conduct by employees and employers and any structural factors that may encourage such behaviour;
- the methods used and costs incurred by workers' compensation schemes to detect and eliminate:
  a) fraudulent claims; and
  b) the failure of employers to pay the required workers' compensation premiums or otherwise fail to comply with their obligations; and
- factors that lead to different safety records and claims profiles from industry to industry, and the adequacy, appropriateness and practicability of rehabilitation programs and their benefits.

WITNESSES

Subcommittee met at 8.42 a.m.

GOODSELL, Mr Mark Andrew, Director, New South Wales, Australian Industry Group

RUSSELL, Mr David Haldon, Senior Adviser, Australian Industry Group.

CHAIR—We will begin the inquiry into aspects of workers' compensation with apologies for our delays in Sydney traffic. I welcome here today representatives from the Australian Industry Group. Thank you for coming to meet with us. The proceedings today are formal proceedings of the parliament and warrant the same respect as proceedings in the House of Representatives. The committee prefers that all evidence is given in public, but if there are matters you would like to submit in private, please ask to do so and the committee will consider your request. I invite each of you to make some preliminary remarks and then we will move to questions.

Mr Goodsell—Thank you. I do not want to make any great detailed remarks in addition to the submission that we have made in writing. I will broadly make three general points. Firstly, fraud does happen in workers' compensation. Secondly, it does have costs. Thirdly, the systemic response to that fact should be fairly broad ranging and should be based on the assumption that fraud, if it happens, has costs and is a legitimate issue for the design of a workers' compensation scheme to take into account. I will go back to those three points in a little bit more detail.

Firstly, fraud, to us, covers a range of behaviours. The most obvious example is where a claimant makes a claim, but there is no injury. Secondly, there are also cases where there is an injury, but it is not work related as defined by the given legislation. Thirdly, there is a work related injury but the time it takes for a person to recover from the extent or the effect of that injury is exaggerated, and that affects the time it takes for the person to recover, the amount of treatment that they attract and the amount of benefit that they attract.

In addition, probably all those things would have attending to them examples of parallel fraud, or parallel misrepresentation by service providers or representatives in the course of doing that. It may not; it may simply be behaviour by the claimant. But, separate to claimant fraud, there are also examples of fraud by treatment providers that are not related to a fraud by a claimant. They would be things like overservicing where you could not say that it was the worker's fault that he was being overserviced.

That is the general picture to us of what is encompassed by the concept of fraud. How much of it goes on? It is very hard to say. As a guide, if you step back and look at the whole scheme across all industries in all states, you might say that five or 10 per cent of the activity that is going on could be fraudulent. If you ask an individual employer who has had one or two recent claims that they did not have a great experience with, they might say 30 or 40 per cent of claims. We would accept that there is a lot of subjectivity in the assessment of what is fraud. The point we are really trying to make is that it does happen, and it would be naive to assume that it does not happen to the same extent that it happens in other forms of insurance or in welfare benefits and things like that.

As to the costs of fraud, although we do not think fraud is really a major issue in terms of the numbers of cases, most people who are injured at work do not cost their employer, or their workers' compensation scheme, much money. They get their injury treated and go back to work pretty quickly. However, where there are problems, it can cost schemes a lot of money. There is

a significant cost to society as a result of that directly in terms of claims costs to employers. For example, in New South Wales, the scheme deteriorated significantly through the mid-1980s.

The Grellman inquiry in 1997 showed that the major cause of the cost blow out of the scheme was the fact that the number of people who were off work for more than six months had doubled. At the beginning of the 1990s, something like six per cent of people who were off for a week were still off after six months, and by the middle 1990s that was 11 or 12 per cent. It was not a lot of cases, but it was something like four or six per cent of cases to which you could attribute most of the cost blow out in the New South Wales scheme. The leverage effect of having systemic flaws leading to problems can be quite great. I am not saying that all that blow out was attributed to fraud. I am just making the point that the leverage effect of just a few systemic problems in a workers' compensation scheme like this leading to a cost blow out can actually lead to a massive cost blow out not in proportion to the number of people taking advantage of that systemic flaw or being subject to that systemic flaw.

There are other indirect costs, however, that worry us just as much. One is the poor credibility of workers' compensation schemes from time to time with employers. That creates risks for injury management. Employers have a very profound responsibility in relation to workers' compensation to make sure that they contribute what they can to an injured worker's recovery through offering them alternative duties where they are available to offering a supportive environment et cetera. To the extent that there is fraud in a scheme, that jaundices or prejudices employers' views about the legitimacy of that role, and I think that should not be underestimated.

The other problem is that employers, and all of us, would like to think that Australian workplaces are being made safer all the time. Again, to the extent that a workers' compensation scheme lacks credibility, that must undermine people's efforts to create a safer workplace. That is a concern that we are conscious of. Indeed, we are of the view that, for a lot of purposes, the two issues of workers' compensation and OH&S ought to be structurally separated. They are often thrown back into the same basket for administrative reasons, but they are two different exercises. Perceptions and prejudices about what is going on in workers' compensation get in the way of proper safety management from time to time.

In relation to scheme design—another issue that I foreshadowed—a workers' compensation scheme should be designed on the principle that most claims are not fraudulent, but it should not be designed on the assumption that there are no fraudulent claims. In any good scheme design, there should be a fair and robust process to identify and manage fraud in workers' compensation. If you do not do that, then the only other mechanism that you have available to manage that process is, in the end, to divide the total benefits pie that is available amongst both deserving and fraudulent claimants. By definition, that means that deserving claimants will get less. As I said earlier, you could probably apply the same principle to social welfare design and to other forms of insurance.

It is for the benefit of everyone that there is an assumption that five or 10 per cent, or somebody, is going to have a go, either willingly or unwillingly, when you have a scheme like workers' compensation. You ought to build that into your thinking when you design the scheme, rather than take the more naive approach that workers' compensation is there to compensate injured workers and injured workers would not misrepresent their position, so you will not do anything about it. If you look at a lot of the schemes, the mechanisms to deal with those

problems tend to be bolted on, rather than built-in. Good scheme design would demand that they are built-in from the start, rather than bolted on in a reactive way as evidence emerges of problems with the scheme or there is political pressure about it or something like that.

That is probably all I need to say in summary. Our submission goes into more detail. We have drawn heavily on case studies that our members have provided, and they are presented in the submission. Of course, we have not hired investigators to test the veracity of all those case studies but, in all cases, they are matters that have gone on for some time, and probably a lot of the facts in there are matters of record in the individual files in those cases. That is the strongest evidence and the strongest message: not just in New South Wales, but nationally, there is still a level of anxiety amongst employers that workers' compensation has not quite been got right.

CHAIR—Do you have anything to add, Mr Russell?

Mr Russell—I have nothing to add to the opening comments.

Mr HARTSUYKER—Is there any evidence, or are you of the view, that there is any difference in the propensity for fraud to occur when the employee is either on his way to work or from work, as opposed to the propensity for fraud when he is at the workplace?

Mr Goodsell—The answer is no. Anecdotally, journey accidents are a potential massive weakness in most schemes but I do not think the volume of claims contributable to journey accidents warrants a conclusion that it is being exploited in that way, to be fair. It may be. I am not sure what conclusions you can draw from that. The result is that our policy positions traditionally have not really zeroed in on journey claims. It is annoying to an employer that the scheme is liable for injuries over which he has no control. Under the contract of employment, you cannot control the behaviour of an employee on the way to and from work. I am not sure whether anyone has ever tested that—but you cannot. In most schemes, those costs go against the scheme rather than the employer's individual record. For those reasons, it is not a major issue for us.

Mr Russell—I would say, anecdotally, that there often seem to be some common themes with fraudulent claims not so much on journey times but on matters that occur late on a shift on a Friday night that suddenly get reported on Monday morning. When you see that pattern, you advise the employer who rings you up about it to investigate further and make sure that they pursue all options with the insurer in terms of investigating the matter, because there seems to be a recurring theme.

We have a large manufacturing base in our membership. The members often work shiftwork and the level of supervision is often not as high on those afternoon and evening shifts. You do see an incidence of claims that are made on the Monday morning after the Friday shift. Obviously, if that is supported with evidence that the person is an active sportsperson, or something like that, then we always encourage our members to look into those matters closely and encourage their insurers to do the same. We have made a few examples about that in the submission.

CHAIR—You have given us some case studies. You made the point, Mr Goodsell, that while the number of cases may not be significant in themselves, although this was difficult to ascertain, it would seem from the case studies you have presented that the impact, when these

do occur, on an individual employer or employee, is quite harsh. I notice that there is one employer whose premiums went up by $14,000 a year. Do I understand that it is more the impact when it does occur than necessarily the incidence of fraud?

Mr Goodsell—I think that is right. There are lots of workers' compensation claims. The overwhelming majority do not cause anybody any heartache. The ones that cause heartache to employers are obviously the ones where there is a massive premium effect. It is a rational response. There are also the ones where employers have endeavoured to provide a safe workplace. In fact, the employer may have had a history of very low claims and then suddenly there is one, two or three significant claims. That is the second example.

There is a differential effect, particularly with small business. Small business operators probably have a more immediate reaction to these kinds of cases than large companies that are run by a professional management team who, in a sense, are one step removed from the workplace. For a large public company or a large professionally run company, they probably just manage the numbers on these kinds of things like workers' compensation. They would tend to have a workers' compensation manager who would deal with the issues and they would not do it personally. When a small business has somebody making a claim against them which will have a significant effect on their premiums going forward, they do take it very personally. The person is actually having a go at them, not the insurer or the company, because they are the company.

A lot of those cases are typically companies with, say, between 10 and 50 employees. The reaction we get from our members is certainly more heavily weighted towards those types of companies. I think that is because the managers of those companies feel it more deeply and personally when a systemic flaw in a scheme allows these things to happen. Larger companies live with it a bit easier. It does not make it better; it just makes it easier for them to live with.

CHAIR—You have mentioned that, generally, medical practitioners who have a long relationship with a patient understandably pursue the objective of meeting that patient's medical needs. You have implied that this is not always perhaps the most objective way for the medical practitioner. What recommendations do you have with regard to service providers such as medical practitioners and rehabilitation managers?

Mr Goodsell—The general point we make is that the medical profession seem to bring to workers' compensation their traditional private practice/private patient model of treatment. From what I understand, that brings with it the fact that something like 80 per cent of what they know about the injury they get from the patient. I assume that works on the basis that, in most private treatments, what incentive is there for the patient to exaggerate or lie about that? The question we are really asking is: is that entirely appropriate for a scheme where there is a legitimate third-party interest in how that patient presents and what is done about that injury? Again, that is another one of the realities that we think ought to be borne in mind in relation to workers' compensation.

Some of the more detailed recommendations that we make in the submission go to questions such as: if an injury goes for a certain length of time, how appropriate is it for just the local GP or the person's normal doctor to continue treatment? We accept that there is definitely an efficiency for short-term claims in allowing GPs and local doctors to treat people and get them back to work. We are not saying that everybody should be treated by a specialist doctor. In a

sense, this is getting back to my original point about building in design elements that just assume that in a few cases something may be going wrong and a scheme's response ought to be to say that the longer a claim goes, the more interest people outside the doctor/patient relationship have in that being done properly. So one response is to say, 'Why wouldn't you, if one party or the other wants it, have a different regime of medical treatment apply that is more openly objective about the best outcomes?' The second major recommendation is about the education of doctors, which is a very common theme that is happening in all the states at the moment.

CHAIR—Who should undertake that in your opinion?

Mr Goodsell—Logically, doctors who wish to engage with occupational medicine, even at this level, need to understand as part of their professional training, that an injury in a work environment probably needs different treatment from what I would term a 'private injury', because there is a relationship overlaying the injury. They need to understand that there is a third party in the room. In answer to your question, the best response is that it should be built into the basic training of, ideally, all medical providers because most of them would see workers' compensation claims.

CHAIR—What about existing doctors?

Mr Goodsell—The answer would be the same, that it should be built into the training. I suppose in the short term it could be a function of the state WorkCover authorities to drive those campaigns. One frustration we have with these things is that, when we talk about reform of the scheme, the remedies that are applied to some of the service providers, such as doctors, tend to be a bit softer than the remedies that are applied to employers. When we talk about employer premium noncompliance, for example, we talk about fines and monitoring and things like that. When we talk about doctors we just talk about education, and I think it needs to be a bit stronger than that. There needs to be, in general terms, performance monitoring of doctors on how well they are returning people to work. If there are, for example, medical providers who do not really seem to be able to produce occupational medical outcomes consistent with normal practice, the system ought to investigate that. It should not just be education at the front end but ongoing monitoring as well.

Mr Russell—There would be some simple reforms you could also add. One would be making it a requirement across the country—and some schemes are better on this than others—for a doctor to contact the workplace about one of these matters. We have put that in our recommendations. At the moment they have to accept at face value what an employee says or a patient says without testing it—there is no requirement for them to investigate further.

Mr Goodsell—That is a consistently recurring theme, that doctors not only are not required to have, but some seem to go out of their way to avoid having, any kind of discussion with the employer about matters that it seems they have already formed an opinion on, such as what does the person do at work or are there alternative duties at work? That is why that is a particularly important issue. It is a very great source of frustration for employers that there is this third party called a medical provider who is making judgments about their businesses and has never had any contact with them.

CHAIR—We are probably going to have to keep things reasonably succinct, and I know Mr Bevis has quite a number of questions so I will pass over to him.

Mr BEVIS—Thank you. Mr Goodsell, there are a few things arising out of what you have said that I have made a note of and that I may get the time to pursue here or we could possible look at later. Firstly, thank you for your submission; I make it a practice always to carefully read submissions we get from the AIG because I think by and large AIG does a pretty fair job. Can I go to the case studies you have cited. In paragraph 2.1.2 there is a case study and at the end it says:

Despite this footage—

which, on the face of it, would demonstrate that the claim was dubious—

the insurer recommended due to the reputation of the judge ... that a settlement be offered.

I think I know what you mean by that but I just want to be sure. Do you want to explain what that means?

Mr Goodsell—That is just a statement of fact, that the employer was told by the insurer that the tribunal they had drawn did not put as much store in video footage as the employer expected.

Mr BEVIS—One of the reasons I think it is significant is that elsewhere the submission refers to having independent medical practitioners being called in, and a bit of the conversation that has just been occurring goes to that. I guess there is a question here of the independence of those who are involved in either providing critical advice or making decisions. The assumption that appears to underlie both is that, on the one hand, there are doctors who might be very lenient—that is, more supportive than others of a claim—and, conversely, doctors who would have the opposite view—that is, be less supportive of claims. I guess the assumption that underlies that statement that we just referred to in your submission is that there are some in the judiciary who might be seen to have a preference to back claims and others who would deny them. Is that a fair take on how you see it?

Mr Goodsell—I do not think that was the point we were making in that part of the submission. We are saying that you have to assume that there are different views about how things are carried out and the system has to take that into account. That case was an example of the frustration employers have when they think they have evidence of something that is relevant to the matter and they are told that the system will not give weight to that relevance. The broader question about objectivity or otherwise, we think, should be dealt with by making sure that in relation to medical evidence the people who are making those judgments are, by and large, expert in that area. That is a New South Wales case. The problem with the New South Wales system, in our view, which has been partially remedied recently, was that a lot of medical decisions were being made by non-medical people; they were being made by judges.

Mr BEVIS—Doesn't that happen in common law cases? If I have an accident anywhere else and I am injured and I sue someone for it, who makes the decision ultimately about whether or not I am entitled to get a benefit? It is not the doctor; it is the judge—the jury, possibly—is it not?

Mr Goodsell—Yes, but in relation to workers' compensation there seemed to be cases where there was not a transparency about why the decisions were being made on the evidence that was being presented. There were cases put to us of disagreements between claimants and insurer doctors about the level of impairment and judges making decisions even outside that range.

Mr BEVIS—How is that different from a common law action? For example, if I am at a shopping centre as a customer and I slip on a wet floor, I am not an employee who slips, I have no workers' compensation claim, but I am entitled to take action. How is the action I would take as a non-employee different from what you have just described?

Mr Goodsell—It way well not be. That is probably part of the reason why there is now debate about the whole form of insurance that is wider than workers comp. The debate we had in New South Wales last year was seen as a very narrow debate about workers' compensation; it actually, in our view, was a precursor to a wider debate that has happened about insurance, the nature of insurance, the nature of liability, and the dispute processes to resolve that liability. I do not disagree that is it not different, but something that is almost seen as an administrative process, like workers' compensation, probably works best as an administrative process. Those kinds of common law processes do not make sense to a lot of people involved in the day-to-day running of the system and they cause frustration. We think this should be addressed. The fact that it may be a common law principle, or a principle of common law process, does not necessarily mean it is the right process for workers' compensation.

Mr BEVIS—I hear what you say. The next case refers to an employer's premiums going up by $125,000 on the back of one claim. Can you give us further details about that—$125,000 over what period of time, what were their premiums, what does that represent as a percentage? It seems to me to be extraordinary that one case would produce an increase of $125,000 in premiums for what is identified as a small operator.

Mr Goodsell—I suspect that was probably over a period of three years, which is the period in which the claims cost washes out under the New South Wales scheme.

Mr BEVIS—Understandably, that is still alarming for a small operator who I assume has fewer than 20 employees. If you have the information at some point down the track, I would be interested in it.

Mr Russell—We will certainly endeavour to provide you with some further information on that case.

Mr BEVIS—Thank you. At paragraph 2.2.3 on page 10 of your submission there is a case study of a malicious claim. Was that picked up by the existing fraud provisions?

Mr Russell—No, it was not.

Mr BEVIS—No-one took action?

Mr Russell—No. I understand it was reported to the insurer but, essentially, it was not followed through by the company—other than with a first report—because I think they had managed to resolve it and they were not suffering the financial loss after they cut off the employee's wages. But, no, it was not followed through.

Mr BEVIS—In your conclusions and recommendations at paragraph 2.4 on page 13 of your submission the second indented point refers to:

... some other unrelated event in the employment relationship or many months after the supposed event hence precluding proper investigation ...

I am not sure I have made the link there. Why was proper investigation not possible?

Mr Russell—The situation we are referring to there is where the employee is no longer working for the employer after the claim is made, so it is very difficult to verify the veracity of the claim. Equally, if it is made after the claim, sometimes it is very difficult to verify your management records on the situation, because things may have changed in the business in the intervening period.

Mr BEVIS—When a claim is put in in New South Wales, does the employer, as part of the application, fill in a section that goes off with it so that the employer is aware of the claim?

Mr Goodsell—Most claims are made through the employer, although since 1 January that does not necessarily have to happen. Claims can now be made directly by the employee or their agent directly to the insurer, and the employer is subsequently told by the insurer that the claim has been made. That is an issue that we have some problems with.

Mr BEVIS—I can understand that.

Mr Goodsell—But, yes, generally the claim is made through the employer, who is able to tell the insurer their side of the story.

Mr BEVIS—Also in your conclusions and recommendations on page 13 of your submission you list as one of the characteristics that might give rise to suspicion a claim that relates to musculoskeletal conditions. Why should someone with a musculoskeletal condition immediately be suspected of being guilty of fraud?

Mr Goodsell—I do not think that is what we are saying. I think we are saying that, where a suspicion of fraud arises—

Mr BEVIS—No, your submission lists the most common characteristics giving rise to the suspicion of fraud, and that is one of them. Why should someone be put under suspicion of fraud because they have put in a claim for a musculoskeletal condition?

Mr Goodsell—They should not be. If, for example, they had an accident at work where they twisted themselves—and there were witnesses to that—and they fell in a heap on the ground, were taken to hospital and the diagnosis was that they had twisted something, there probably would not be a suspicion of fraud in relation to that. The point we were making was that, combined with some of the other factors—like not having any witnesses et cetera—one of the issues is the type of injury that is evident in the cases that our members say they have suspicions about. Those kinds of injuries are overrepresented. Perhaps that is not clear from the way we have constructed that sentence and the following points, but that is what we were attempting to convey.

Mr BEVIS—Should those indented points be connected by 'and'?

Mr Goodsell—No, not necessarily.

Mr BEVIS—Is it just the musculoskeletal point that should be connected with 'and'?

Mr Goodsell—I accept the point that it could have been expressed differently to exclude the interpretation you have given it. It was not meant to say that musculoskeletal conditions instantly give rise to suspicion of fraud, but fraud cases often have those kinds of injuries that do not have traumatic external evidence. That is common. It is up to the worker to say where it hurts; it is not obvious externally where the pain is.

Mr BEVIS—There is a preponderance of those injuries in the case studies you have presented. The second paragraph on page 14 of your submission says:

> The most common response from insurers to protests by employers is that if the alleged injury **could** have happened at work then we have to accept liability.

I find that pretty startling and I wonder if you could flesh it out. My personal involvement in these matters is some years out of date now, but I certainly do not remember having many successes on the basis that an injury could have happened at work. There was a fair sort of test applied to prove that it was either caused or aggravated at work. I think that is a fairly major statement.

Mr Goodsell—It is based on what our members tell us is their experience resulting from raising these types of cases—particularly in New South Wales but not limited to New South Wales—with the insurer, the agent, the WorkCover authority in the relevant state or whoever performs that role. It expresses the view that there appears to be an institutional bias towards accepting claims on the basis that, if there is some evidence that the matter could have been caused by work, it is viewed more strongly than evidence that it could have been caused by some other source.

Mr BEVIS—But there has to be evidence linking the claimed injury with the work environment other than the theoretical happenstance that it could occur.

Mr Goodsell—Yes. I think the words 'could have been caused by work' express the view that there is some claim of a connection with work. We are not saying that there is no claim of a connection with work.

Mr BEVIS—To succeed, there has to be some evidence. My experience is that you do actually have to produce some evidence apart from saying, 'This could have happened.'

Mr Goodsell—In some cases the evidence may be the employee saying, 'I lift things and twist at work and that's how I injured myself,' and if you ask the employer, 'Could this employee twist himself or lift things at work?' and the answer is, 'Yes, I suppose he could,' that is enough. That is the feeling.

Mr BEVIS—On page 17, under the heading 'Sanctions for failure to cooperate', your submission says, 'Insurers are understandably reluctant to impose this penalty'—referring to

penalties where people fail to cooperate with injury management plans. I do not actually understand why they are reluctant to impose it. Can you tell me why?

Mr Goodsell—I think 'understandably' reflects the insurers' experience that they often do not succeed at the end of a process of pursuing that kind of penalty. So the 'understandably' is an expression of pragmatism. This is a theme in quite a few cases. Employers are often told by insurers, 'In our experience you won't win, so don't bother trying and we won't either.' That is a very robust way of putting it, but that summarises what employers are often told.

Mr BEVIS—Are there some statistics on those cases that have been taken and on the rate of success or failure that would lead you to that conclusion and that we can get?

Mr Goodsell—We can attempt to get that information for you.

Mr BEVIS—Thank you.

Mr Goodsell—In a sense you are attempting to prove a negative, because what we are demonstrating here is that often the required steps are not undertaken because people's experience is that it not worth undertaking them. But we will attempt to flesh that out for you.

Mr BEVIS—On page 23 of your submission you comment:

A strange irony of some systems is often because of these good claims records, these employers are often the most penalised when claims do occur.

I wondered when I read that whether that in part explained some of the strange premium increases in the case studies that you had cited earlier on. I wonder if you can give us further details, either here or later, about the operation of those systems and how having a good record for a long period of time and then having, say, one bad incident means that you are in a worse position than if you had had a pretty ordinary record for the last few years instead of a good one.

Mr Goodsell—A lot of it is to do with the relative perception of how bad a premium increase is. We do have a number of cases where companies have had low or nil claims records so they have built into their expectations two things: one is that workers' compensation costs are low and the second is that it is insurance so that, if something bad does happen to you, you have cover. In terms of how experience rating works, we are trying to educate our members that in fact they do not have insurance cover, they have something slightly different. But they are quite shocked that, if they go for 10 years and suddenly have one claim, they end up paying for that claim for three years. Not having had claims, they do not often educate themselves about the likely effect on their premiums of having a claim, so when it does happen they are shocked and they have not built that kind of effect into their cost structure.

Mr BEVIS—If I understand what you are saying, that is a slightly different piece of information to what is here.

Mr Goodsell—Yes, I accept that. Having 'penalised' in there is our way of reflecting on the perceptions of the employer about how the system is treating them.

Mr BEVIS—They are not charged higher premiums, they are not actually penalised; it is just that—

Mr Russell—They pay a higher cost.

Mr BEVIS—Because they are unaccustomed to an increase, all of a sudden one comes along and that is a shock to them.

Mr Goodsell—And they then have to build both the cost of that claim plus the additional cost of having to manage any future claims into their ongoing cost structure.

Mr BEVIS—Sure; but that is actually not a penalty imposed on them.

Mr Goodsell—It is not a penalty in the sense that it is something that they are being hit for worse than if they had had an ongoing experience—yes, that is right.

Mr BEVIS—That explains the 'irony'. In the conclusions on page 25, you suggest that possibly employees who have a compensable injury that is accepted—they have put in a claim that has been approved—should perhaps pay some of the medical costs and rehabilitation services costs which they might get back later on depending on other things. Elsewhere in the submission you suggest that the amount of compensation they receive should be reduced to a level that is less than ordinary time earnings. That is in the top paragraph on page 17, where you suggest that they should get less than ordinary time—so it excludes overtime, penalties and other things—because they do not have to pay, for example, for their meals or transport costs. How do you reconcile saying that their compensable amount should be reduced because they are not paying whatever it is—a few bucks a day—for transport and meals, so they get less income, and at the same time you are suggesting that, on that lower income, they should be required to make a payment for medical services and rehabilitation?

CHAIR—I think Mr Bevis is referring to the top of page 17.

Mr Goodsell—The copy I have has different page numbering, so I have been doing a little mental arithmetic each time you have quoted a page.

Mr BEVIS—I am sorry. The initial comments I was referring to related to people paying their medical costs, which is in paragraph 4.3.

Mr Goodsell—Yes, I have that. It is the earlier comment in relation to benefits that I am looking for.

CHAIR—'Changes to the structure of weekly benefits' is the reference, and it is the second dot paragraph there.

Mr Goodsell—The excess issue is one mechanism for consideration to deal with the issue of having some control over the amount of treatment. Everyone is on the incentive plan, if you like, for treatment to be focused and for costs to be kept to a minimum. The previous point in relation to weekly compensation says:

Weekly benefits should be based on ordinary time earnings. Overtime and shift rates are compensation for a disadvantage—

Mr BEVIS—But you go further and say that, actually, it should not be, that you should get less than that. Is that what you are proposing?

Mr Goodsell—Yes. We think there is some merit in the view that there can be some small discount against the ordinary time earnings on that basis.

Mr BEVIS—By which you mean the income the employee gets while they are on compensable income. Is that what you are saying?

Mr Goodsell—Yes. However, that could be something that is phased in through the profile of an injury. We have put it rather blandly there, but it is not necessarily something that would take effect straightaway. The other thing that complicates that is that currently, certainly in New South Wales, the rate of compensation is actually set below ordinary time earnings, at the award rate, and the additional compensation comes from either individual employer arrangements or collective arrangements which exist through awards and industry agreements in some cases and not at all in some industries.

The subtlety of this question goes back to my opening point about the overall level of benefits. You could take the view that the overall level of benefits could be improved if we made sure that everybody who was getting them was deserving of getting them, and this is one of those arguments. Taking the New South Wales scheme as an example, one of the crude measures of cost control under that scheme is that benefits are set at the award rate. That, most people would accept, is probably not the appropriate level. In most industries there are arrangements to take it to ordinary time earnings, but that is not guaranteed. If you understand that that is the reality then these comments do not look as harsh as your comments would suggest. Certainly, we are an industry that, until recently, had one of those over-award accident pay agreements, and many of our members probably still pay that principle. So they are actually paying more than they have to now.

Mr BEVIS—So you are not suggesting that the payments made subject to awards and agreements and so on be supplanted by this—

Mr Goodsell—It is a bit messy at the moment. As I said, what a person actually gets when they are on workers' compensation not only depends on the workers' compensation legislation, it depends on all these other arrangements and they are a real hotchpotch. What you should do, perhaps, is standardise all of that. Having standardised that some people may receive more than they currently do. In that light, we would still like some sort of control mechanism that sends a signal that people are better off back at work. This is a crude control mechanism, but it is probably borne of our frustration with the system.

I am not sure whether we referred to them in our submission but there are other anomalies in some of the systems where people actually get more money if they go back on partial duties than if they were fully injured. That creates a real problem in getting people back to full work. If you are partially injured and you are offered light duties so you are working three or four hours a day the scheme in New South Wales, for example, pays you your full pre-injury earnings including overtime. We have had a bit of trouble getting anyone's attention to the problem that

creates for an industry like ours where there is a lot of overtime worked. We have plenty of cases of people coming back on partial duties but never getting better because they are actually better off partially injured than they are if they are fully injured. If they are fully back at work they have to actually work the overtime to earn it. So there are anomalies there.

These kinds of things have to be taken in context. We apologise if the way it was structured in our submission allows them to be taken out of context. We do not think there need to be wholesale changes to benefits, but there are some design tweaks that would need to be made if a government was starting from scratch. For example, if there was a national workers' compensation scheme there are some issues that you would want to look at that address these kinds of anomalies.

Mr BEVIS—I appreciate the issues you have raised in that answer. I think there is a good deal in that. I notice that the AIG has not made a submission in respect of the term of reference dealing with employer fraud. Is that because you do not believe it exists or was that decision made for other reasons?

Mr Goodsell—It is not that we do not believe it exists. We did not concentrate on it in this submission because it is not an issue that our members constantly badger us about. However, there are at the moment inquiries and programs aimed at employer compliance in various states including in New South Wales. We are broadly supportive of those mechanisms. The basic position—and perhaps we should have expressed it in our submission—is that it is in everyone's interests that, whatever the rules are, everyone is abiding by them. If we are allowed to verbally amend our submission here to make that point, it is that whatever the rules are in relation to premiums then they should be transparent, easily managed and complied with.

Mr BEVIS—Thank you.

CHAIR—Following on from the point that Mr Bevis raised about overservicing and providing an incentive for a return to work, who is it that encourages the overservicing? Is it the service provider or is it the employee? Would it not be better to apply the incentive or the disincentive, depending on what it might be, to the person who is gaining from the overservicing?

Mr Goodsell—The answer to the first part of your question is that it is a mixture. Certainly if you are a service provider then you are probably being advantaged by overservicing. Do employees get advantaged by overservicing? In some cases it would appear they do. In fact, there seem to be cases where going to rehab becomes an end in itself as an alternative to work.

CHAIR—Yes, you made that point.

Mr Goodsell—It is like people saying, 'I am not at work, because I am going to rehab.' When asked, 'When is that going to end?' they say, 'I don't know, but I am going to rehab.' So we think it is more complex than just the issue of the service provider. It comes back to this individual responsibility thing that has emerged in the broader insurance debate about where all the pressures should lie and whether everybody should have in some cases gentle and in some cases stronger pressure on them to aim towards some objective. This is an issue that some of our members are quite strong about.

CHAIR—If, psychologically, people have become attached to rehab, should there be some other mechanism or form of counselling or something to focus them again on the benefits of being an active participant in the work force?

Mr Goodsell—Definitely. The sad thing about long-term workers' compensation claims is that people become absorbed by the process and become absorbed by getting the lump sum or whatever is happening at the moment and they are not able to think about the longer-term benefits. The recent Sheahan inquiry in New South Wales into common law did some valuable work on what happens to people who go through long-term disputed claims and get a lump sum and what happens to them five or 10 years down the track.

CHAIR—What does happen?

Mr Goodsell—In a lot of cases, they are worse off than if they had actually gone back to work as early as possible.

CHAIR—Financially?

Mr Goodsell—Yes, financially. They often do not find employment again. I do not have the report in front of me, but the conclusions were that putting people through a long process with a lump sum at the end of it is not necessarily the best overall outcome for them. So, getting back your question, I think there is some utility and benefit, when people are going through a dispute process, in having some part of the system make them think about the bigger picture in terms of, 'What happens when this has ended? What are you going to do for work et cetera?' Some systems have that kind of overlay but, again, it is very much a bolt on thing. The main concentration is on saying, 'Here is a person who has rights; those rights have been infringed. Let's get a legal process remedy for those immediate rights. The minute that is resolved we do not want to know about that particular person.'

CHAIR—Thank you.

Mr DUTTON—Thank you for your submission, gentlemen. Following on from the chair's last point, would a structured settlement process be a deterrent to those people that might be seeking an overinflated payout or a lump sum at the end? Would that provide some disincentive for those people that would seek to take some fraudulent course?

Mr Goodsell—I think the short answer is yes. In some cases, the ability of the system to produce structured settlements rather than lump sums would have an effect on that kind of phenomenon.

Mr DUTTON—I take you to page 21 of your submission. In relation to the new South Wales scheme, it says:

... the percentage of serious claims has decreased 20% in the last 6 years. Average premiums however have increased from 1.8% in the early 1990's to 2.8% and have been subsidised at this level for the last two years.

Could you flesh out that issue a little bit?

Mr Goodsell—Different schemes have gone through this kind of cycle in different states over the years. New South Wales is just probably the most recent and stark example of a scheme where the cost profile got 'delinked' from the injury profile. To put it bluntly, from the reintroduction of common law in about 1992 through to the premium freeze in about 1996-97, there was not a steady increase. Premiums were not put up and then they were put up in two big lumps, one of 55 per cent in about 1995 and a further one of 12 per cent in 1996, to allow the scheme to recover some equilibrium. You look at that and you say, 'Okay, workers comp costs have gone up, what are the causes?'

The point we are making here is that you cannot look at the level of injuries. The level of significant injuries, which I think is defined as injuries where a person has more than a week off, actually decreased by about 20 per cent through that period. As far as the injury profile goes, there is no evidence that the types of injuries changed in any great effect. In other words, there is no evidence that in the past people were breaking fingers and now they are breaking arms. The injury profile did not change. However, the costs blew up. The point we make in that final sentence is that that is clear evidence to us that workers comp costs are a function of a whole range of things. People who say, 'If employers just didn't injure people they would not have a problem with workers' compensation,' are missing the point. The major determinant of workers' compensation costs is the level of injuries that are caused but trend fluctuations like that can often be attributed to what we call systemic flaws in schemes, not to the fact that injuries are happening at a greater rate. So the response has to be something other than pointing the finger at employers and just saying, 'You provide safer workplaces.' We take that for granted. We are doing that and trying to do that and the evidence of major injuries shows that we are doing that. So there is something else going on and it happens in every state and in all schemes at various times.

Mr DUTTON—The final point that I would make is in relation to an earlier discussion that you had regarding the situation with doctors. Do you think there is credibility, either for the employer or employee, in a national accreditation scheme for doctors who engage themselves in this process?

Mr Goodsell—I think there is. The big question is cost benefit: there would be a cost associated with that. As I said earlier, I do not think you would need to do that for short-term claims but what a system has to do is say, 'What profile of claims could end up being problems, not only in terms of fraud but in terms of injury management?' They are the ones that ought to get pushed towards an accredited medical scheme so that you have half-and-half. You have the efficiency of using GPs with the cost control of using accreditation for certain claims. I understand that GPs do not have much occupational medicine experience built into their training. If GPs are going to be exposed to occupational medicine in the normal course of events, maybe that is something that needs to be looked at.

CHAIR—One of the other bodies that have made a submission and are appearing today have suggested that to eliminate fraud by employers insurers should be able to conduct an independent audit of an employer's payroll. What is your feeling on that submission?

Mr Goodsell—Taking that without notice, provided there were some criteria upon which that was happening, I could see that as being a legitimate part of a compliance mechanism. We would be wary about fishing expeditions. Employers still have experience dealing with various bodies who have audit or inspection functions. They are not always used for the purpose for

which they are purported to be used, particularly with unions. There is a bit of evidence before a royal commission at the moment of some examples of misuse of safety inspection rights by unions. That would be a concern.

CHAIR—But if it were part of a package to address issues from an employee, service provider, medical and employer position, you would not necessarily be adverse to it?

Mr Goodsell—No. If we went to our members and said, 'There's a whole heap of problems with workers comp but they're going to be fixed up by this package,' I do not think we would have a lot of resistance to that if there was enough on the other side of the ledger to make sure that people knew things were happening. We object to the unilateralism where only one side gets picked on. We accept that workers' compensation is a very complex beast. We just want fairness to apply across the board so that if the wick is being turned up, it is being turned up all round for the common good rather than in respect of isolated pockets of reform. We would certainly be much more comfortable with that sort of thing if it was in the context of the overall package.

Mr BEVIS—I just wanted to be clear on the data in respect of the serious claims increase in New South Wales. The percentage of serious claims for New South Wales has decreased by 20 per cent. What was the percentage of total claims that they represented before the decrease and what is the percentage now?

Mr Goodsell—I would have to check the data. I will have to get back to you on that one. I need to refresh my memory on the basis on which that claim was made. However, it has been made fairly strongly for some time.

CHAIR—Thank you very much for appearing before us today. You are welcome to stay for the rest of the day if you so wish. We offer our sincere thanks for the effort you put into your submission and for your time.

Mr Goodsell—Thank you for the opportunity.

[9.58 a.m.]

DAVIDSON, Ms Jennifer, National Manager, Fraud and Security Risk, Commercial Operations, Insurance Australia Group

INGRAM, Ms Carolyn, New South Wales Product Manager, Workers' compensation, Insurance Australia Group

PEARCE, Mr Douglas, Group Executive, Personal Injury, Health and Commercial Insurance, Insurance Australia Group

CHAIR—Welcome. We have now gone from the AIG to the IAG—that is a pleasant irony. Do you have anything to add to the capacity in which you are appearing?

Mr Pearce—I am responsible for workers' compensation, amongst a large portfolio of insurance.

Ms Ingram—I am appearing in my capacity as someone involved directly in workers' compensation in New South Wales.

CHAIR—The proceedings here today are formal proceedings of the parliament and warrant the same respect as proceedings of the House. The committee prefers that all evidence be given in public, but if there is a matter you would like to raise as a private matter, feel free to ask the committee and we will certainly give that consideration. I invite you to make some preliminary observations and remarks, and then we will move to questions.

Mr Pearce—I will start by giving you a bit of background on the company. The Insurance Australia Group, which was formerly NRMA Insurance, is the largest insurer in the country. As I understand it, given that a transaction has been effectively completed this morning, we are substantially the largest general insurer in the country in that we bought CGU this morning—or at least that process is well and truly under way. I suppose we have not had a long background in workers' compensation. It came to us through acquisition. We purchased the SGIO, the Western Australian based insurer, three or four years ago. They were—and still are—a leading workers' compensation insurer in that state. It is the largest state where private underwriters participate in such a market.

Since then, we purchased the HIH portfolio of workers' compensation, at about the time of the appointment of the provisional liquidator. We did that for strategic reasons. It was a substantial part of the HIH business. It would be fair to say that we are either the largest or the second largest—it is a point of discussion we have with the Allianz—workers' compensation insurer in the country. We participate in all the markets that we are able to. Basically, Queensland is the one that we are not able to participate in. We participate both as a risk carrier in the states where it is underwritten by private insurance and as a claims manager on behalf of the governments where the workers' compensation is a government monopoly.

I will add a little bit more to it than that. That is the history of it. Our experience in bodily injury claims—we think more broadly than just workers' compensation—has primarily been in

CTP. We have participated in CTP insurance in New South Wales and the ACT since 1943. It was through that involvement that we were interested in workers' compensation. When we acquired the SGIO we saw very quickly the very strong relationship between the two classes of insurance and how skills in one can be used in the other. When the opportunity to buy HIH's workers comp business came up, we grabbed it with both hands because we saw it was a great business. But, very importantly, we saw the overlap and how the schemes can and should operate in similar ways. But we also saw very clearly how they can be quite different.

What we are trying to do with these businesses is unique in this market in that we try to manage them as a single entity. Typically, these businesses are run as workers comp in each state, and there is not too much overlap. I think Carolyn would attest to that. That was how HIH and most of our competitors did it, whereas we view all these statutory classes, as we call them—which are basically bodily injury—as a single unit, particularly from the claims point of view, and run it as such. The reason for that is that we are trying to take the best practice from each jurisdiction and apply it across the board.

We have an interesting perspective now that we have been in this business in a big way for about 18 months. As a CTP insurer, looking across the country and looking across the world at the best things happening in compensation systems we have always seen that these are basically in the workers comp areas. When we have actually acquired these businesses—and now that we are heavily involved in doing it—we have seen that there are huge differences in best practice and in how these schemes operate in getting people's injuries fixed and getting them back to work and back to their normal lives. The differences are quite dramatic.

In many ways, those differences are shown in what we refer to as the non-risk states like New South Wales and Victoria. I strongly believe the differences are driven by the incentive systems that are put in place, primarily from our point of view in the insurer remuneration systems. To an extent, the incentive systems that are there for claimants and, to a lesser extent, employees are driven by the compensation that is available. So, how these incentive systems operate generally determines the behaviour of insurers and claimants—and employers, for that matter. It is quite clear that there is very little consistency from scheme to scheme across the country, and in many instances the incentives drive to what I would describe as perverse outcomes.

That is the introduction and the background to our submission to this committee and to other inquiries that are current. We have counted around 30 different reviews of the insurance industry or insurance schemes going on across the country at the moment, ranging from the HIH royal commission to your own inquiry. There are reviews of just about every major compensation scheme in each state. The common theme in all of them is a drive for a single national scheme or, if they are going to be state based, uniformity in the schemes not only in terms of workers' compensation across the country but also all compensation schemes, primarily in CTP. We also include public liability where it involves bodily injury.

We believe that scale is critical. We believe that consistent benefit structures are absolutely critical. We think that scale would allow competition to come to bear. It would allow insurers to take particular segments of a market and focus on them. The rural segment is a great example and that is topical for us, having just acquired the CGU, who are very strong in rural Australia. It would also allow much better alignment between the national health system and the compensation systems. It is a point that is often missed but these two systems have a very

substantial interface, and at the moment the interface is inconsistent from state to state. That concludes my introductory remarks.

CHAIR—Would Ms Davidson or Ms Ingram like to make a statement?

Ms Ingram—No.

Mr HARTSUYKER—You mentioned the different classes of insurance. With the typical claims profile, are there any noticeable differences that come to light as you look at particular classes of incidents and the likely outcomes that result from them, such as time in getting back to work or time in making a full recovery if it were not a workers' compensation matter? Is there a correlation between the benefits that are available and the claim history?

Mr Pearce—We would argue very strongly that there is. The further a scheme goes to an unrestricted common law and lump sum benefit structure then the further it departs from early intervention and a quick return to work. The incentive structures are such that they drive the employee, the injured worker, to be off work as long as possible in order to maximise the compensation payment when it finally goes to court or is settled. This is as opposed to the no-fault schemes where the primary aim is to get people back to work quickly. We are very strong advocates of early notification of the claim and, in fact, early notification of the accident that gives rise to it whether or not it turns into a formal claim. That is for a very simple reason: it is only with early notification that you can get early intervention with rehabilitation. It is a well-established medical fact that the sooner you can get a rehabilitation program in place, the greater the chance of recovery.

Ms Ingram—The other real benefit within that is the ability to be able to influence stakeholders. As was made clear in the previous submission from the Australian Industry Group obviously the role of treating doctors is a real issue. Early notification allows all parties to try to influence the treating doctor in the first instance and, hopefully, to facilitate early return to work so it does not result in protracted unfitness for work, medical certificates, the things that result in delays in return to work and, in particular, increased premiums for employers.

Mr BEVIS—On page 9 of your submission there is a recommendation that I am interested in. It is about the better collection of data to enable a more accurate individual risk rating system. Can you flesh that out? What would be needed to produce the necessary data?

Mr Pearce—The starting point is a common agreement between the heads of workers' compensation as to what constitutes a workplace injury and what data they will collect. At this stage, most of them collect data on all claims—and policies, for that matter—in a great deal of detail, but the problem from a national point of view is that there is no consistency in the format and the data collected. The best collect great databases, but the worst are downright appalling.

Mr BEVIS—Where do we go to find the best?

Mr Pearce—My guess is that New South Wales and Victoria are very good. Queensland has a closed system and no private insurance participates in any form, but our understanding is that it is very strong. Our own experience in Western Australia is an example of where it was bad. That scheme basically went out of control through common law claims. The number and the cost escalated very severely in the mid- to late-nineties and there was no proper repository of

data at state level. In fact, the industry and the WorkCover authority relied on the data of the SGIO almost alone, because we were the only ones who were collecting data on common law claims and identifying them separately. It was a perfect example. It was almost impossible for the actuaries to do anything apart from with the data that we had collected, and I think that we represented about 20 per cent of the industry at that point.

Mr BEVIS—I would be interested if, subsequently, you have any pointers that you think might be useful for the Commonwealth parliament to consider, either directly or, in this matter, through COAG. There are two issues: some greater commonality of what is done and how it is collected and what it is that you collect that produces the information required. In respect of claimant fraud the submission says that the industry, anecdotally, on the grapevine or whatever, talks about five to 10 per cent being bandied around. As the largest provider in the area, are you able to give us any idea of what percentage of claims you act on and satisfy yourselves as being fraudulent? Is it in that five to 10 per cent range, or which end of the five to 10 per cent range is it?

Ms Davidson—We only started our fraud investigations into workers' compensation recently.

Mr Pearce—That is in New South Wales.

Ms Davidson—If CTP is an indication, we achieve an outcome in just over one per cent of claims. That is not to say that there is a greater percentage referred to us, but it is in terms of achieving an evidence based outcome.

Mr BEVIS—So that I understand that correctly, and to put it in the context of this, with CTP you can identify and satisfy yourselves that one per cent of claims are fraudulent?

Ms Davidson—No, that is the outcome that is based on fraud.

Mr BEVIS—Are they prosecutions?

Ms Davidson—They are not necessarily prosecutions.

Mr Pearce—They are more refusals.

Ms Davidson—It includes a civil arena outcome, in that we get a verdict for the defendant. It could be a criminal prosecution or it could be a person who, once they are pursued, withdraws their claim and we know that it was caused by the pursuit of fraud. But we definitely only stick to the fraud and record it as fraud if we are confident that it is fraud. It is not a guess on that one per cent.

Mr BEVIS—So you still only have one per cent of fraud that you can positively identify; some others you may have suspicions about?

Mr Pearce—Absolutely. They are the big wins, if I can put it that way. I suppose it is right to include the exaggeration of a claim as fraud. There would be multiple instances of those—I would estimate 10 times as many, at least.

Ms Davidson—The problem with finance fraud is that you have a dud cheque or you have a credit card transaction that is not met et cetera, but claims are our business so fraud can only ever be an estimate because we cannot unequivocally say, 'Yes, this is fraud,' unless we have formal evidence to support that.

Mr BEVIS—It is a bit like asking, 'How big is the black market?' If you knew the answer to that there would not be one.

Mr Pearce—The point to make about that is the fact that we have hard data on the one per cent. One per cent does not seem that many but they are the ones we win and it is a strong indicator that a multiple of that is the real problem.

Mr BEVIS—I understand. What does that percentage of claims translate into in terms of the actual amount of money that you pay out? Is it a similar proportion? Is it representative of the claims or is it at the higher or lower end?

Ms Davidson—I could not say what the dollar value was in a percentage term but I could certainly come back to you with that.

Mr Pearce—The ICA have made an estimate. Their estimate for risks—which is about 20 per cent of the overall market—is that it is costing about $300 million a year, so if you multiply that out it is $1.5 billion. I am not sure of the basis of the $300 million figure. In terms of the spread of claims, I think it is fair to say it is across any area—it covers both large and small. The major area is what we describe as non-demonstrable. I think this was part of the questioning earlier on about musculo-skeletal claims. For workers comp, it has always been for a bad back. That is not to say—and we are not saying—that people do not have bad backs. When you look at people in nursing homes, child-care centres or supermarkets, bad backs are endemic because people are lifting heavy objects and probably lifting them in an inappropriate and untrained way. However, if you want to create a false claim, it is a claim where there is no, as it says, demonstrable medical evidence of the physical injury. It was only recently—and this applies more to motor vehicles accidents—that I became aware that brain damage also falls into that category, albeit at the lower end of brain damage. Again, it is non-demonstrable. The physical effects of low-end brain damage do not show up on the X-rays and other scanning techniques. We have had instances where these have been fraudulently put forward. So it can involve a minor case of a bad back right up to something as severe as brain damage.

Mr BEVIS—Are there any figures or something that has some objectivity to it? You have given us some idea of the extent in terms of numbers but what about the extent in terms of dollars and how that sits within the general claims that you would have in a year? That would be useful. The five to 10 per cent estimate is folklore and the one per cent CTP is hard-core known but are either of those two estimates for employer fraud?

Ms Davidson—I have read estimates of 10 per cent similarly with employer fraud but I cannot recall the publication at the moment. I have read that percentage once.

Mr Pearce—In New South Wales, on behalf of WorkCover, we undertake audits of payroll. On a cost-benefit basis, we recover eight to 10 times as much as we spend in recovering so it is, in a sense, a highly efficient process. I am not sure how much we actually recover.

Ms Davidson—It is through WorkCover.

Ms Ingram—WorkCover in New South Wales have a requirement whereby the insurers complete approximately 100 wage audits per month. Those wage audits are typically targeted through a data mining process from WorkCover. It may be according to, say, industry groups. What we find is that in some instances it is not always underpayment of premium that comes up; in some instances we are providing reimbursements to employers because there has been a misinterpretation of the wages definition. It also needs to be considered that fraud or employer payment of premiums is not always to the negative. The returns are about eight to one. Where we do get the big hits they are large recoveries in relation to what is being paid for audits. We could provide some additional information from, say, the wage audits that have been completed previously—information on what sorts of inconsistencies have come about.

Mr Pearce—Is WorkCover appearing before the committee?

Mr BEVIS—If they are we can ask them about the collective data they have.

Ms Ingram—A separate report has recently been completed for New South Wales by the Office of State Revenue in conjunction with WorkCover. That does make some quotes in relation to the extent of it—as reasonably as you could, assuming that employer premium fraud does occur. The issue within that is that it is not just under-declaration of wages. There are parameters under legislation at the moment that do allow employers to look at changing company structures et cetera, to manipulate the amount of workers' compensation premium paid.

Mr BEVIS—Was that review done by Penny Le Couteur and Neil Warren?

Ms Ingram—Yes.

Mr BEVIS—We have that as an exhibit. I have not studied it but I have scanned it and tried to find the answers to those questions and I could not.

Ms Ingram—We could get some additional information.

Mr BEVIS—You may have been here for some of the discussion we had with the AIG. They have a number of case studies in their submission. It is a public document so if you have seen it I would be interested in your thoughts on it. It refers to advice that their member companies get from insurers. I want to get an insurers' perspective on it. For example, there was a case study where a weightlifter put in a claim for tendonitis and was then videoed lifting a 200-pound weight. It says:

Despite the footage the insurer recommended due to the reputation of the judge that the matter was scheduled to appear before that a settlement be offered.

As an insurer, what is the go?

Ms Davidson—As I said, we only commenced our fraud investigations into workers comp proper four months ago. Six months ago we started the capability training with claims consultants. So I can obviously speak only on behalf of our approach to it. We run a fraud

informant line, we educate employers on what services we actually provide with regard to fraud and we have one dedicated resource—an investigator—within New South Wales. We are more or less piloting this in New South Wales because we have to create the business case to commit resources, particularly in a non-risk state. We have to balance off the fact that some employers are going to suspect their employees as being malingerers so we take the balanced approach. If we have adequate information as opposed to evidence in the first instance we will pursue that, we will verify it through various data sources and then in consultation with the claims consultant—we have a multidisciplinary approach—an investigator and an intelligence analyst develop a risk management strategy that includes investigation of fraud, if we believe that is the requirement, and we will pursue that matter. If an allegation was made and we had supporting information on that allegation we would pursue an investigation.

Mr Pearce—But the specifics of this case—I cannot comment on detail—ring true given my knowledge about how these matters work. There are some judges that are pro defendant and some are pro plaintiff. It sounds to me as though that judge is pro plaintiff and the experience of the insurer in taking such matters before him on previous occasions has been that such evidence fell on deaf ears—or in this case blind eyes—and there is no point taking it forward. Putting it through that legal process will only add cost. It would be better to settle out of court and get it over with.

Mr BEVIS—That raises two questions for me. One is, if we are talking about having a panel of approved doctors—insurers having preferred doctors, workers' advocates having preferred doctors—the idea of an independent doctor, and if indeed we are saying that there are concerns about the approach that people in judicial roles bring to these matters, what chance is there of getting the so-called 'independent medical advice'?

Mr Pearce—There are a couple of aspects to the medical advice. Workers' compensation in New South Wales and in many of the jurisdictions across Australia is not, primarily, court based; it has been made, to a large extent, no fault. Where it is court based—and we still have that common law element—and if it is going through the usual courts rather than specific panels set up for workers comp, then you are into the full-blown, as I put it, hired gun mentality as to the medical evidence. There are two aspects to the doctors: one is doctors actually treating people and trying to make them better; there is also the medical evidence that both sides of the adversarial system put forward and, strangely enough, each side will try and get the best evidence that they can to further their own case.

If the proposition is 'What hope do we have under that system?' I agree that there is not much hope. That is why we strongly advocate the type of assessment where medical evidence is being used as a threshold or as a measure of some benefit structure. Typically it is used to assess the amount of pain, suffering and loss. We absolutely—I cannot emphasise it enough—support the use of independent, accredited doctors measuring that impairment and for that measurement to be binding. It cuts straight through the sort of hired gun mentality of 'What is the best evidence?' The absolute key to it is that the measurement process has to be a standard process. I know the plaintiff lawyers hate them, but the American Medical Association guides are the best available at the moment because, although they are not perfect, they are at least a standard—they are measurable and the outcomes are consistent.

Mr BEVIS—I would be interested if you could give some thought as to how we might go about selecting that panel of independent experts who do not fall into the traps that, I think, we

both accept. I am reminded of a comment we used to make when I was training to be a teacher: who certified the lecturers to certify the teachers to certify the students?

Mr Pearce—I can comment on that. In the New South Wales CTP there is a scheme currently running for the medical assessment system, as it is called. Although it has been running for only two or three years, it is very much working properly. The outcomes that are coming through, and they are now in hundreds of measurements, are very much in line with what the scheme was set up to do in the first place—the intent—that is, the number of claims and the types of injuries that get measured at a particular level, the critical level in this case being 10 per cent whole-of-body impairment. The types of injuries that are achieving the 10 per cent or higher level are very much in line with the group of claims that were put through, I suppose, a test process to see how it would work. What is happening is absolutely in line with the test process and it is absolutely in line with the intent of the legislation. So it does work. It has taken a while to train the doctors how to do it. They are selected and agreed—medical colleges, in fact, have a role in this. Medical colleges are absolutely keen about that because it is giving it back to the people who do control the doctors, as such. Western Australian workers comp is going down exactly the same path with the recent legislation, which we absolutely support.

Mr BEVIS—We might try and get some of that information. I have a final issue, just to finish off, and it refers to the second point that our earlier conversation raised in my mind. To what extent are some of the problems we look at in respect of workers' compensation victims of the broader litigious nature or the way in which the law fraternity operates? In that sense, it does not matter whether we are talking about this area of the law, a third party or a libel suit. If you can get some leverage as an advocate for your client and you know that the other party is probably going to be better off settling for, let us say, $10,000 and calling it quits rather than fighting the issue for possibly months and many more times that amount of money in a court, you would use the leverage at your disposal, which of course the corporate world does on a regular basis in its negotiations, one corporate to another. It is not unique to common law actions. To what extent is this just another symptom of using the leverage you have? If I am right about that assertion, do you have any thoughts on how it might be addressed or, indeed, whether it should be addressed in isolation in this area and allowed to function in all other walks of commercial and legal life?

Mr Pearce—I absolutely agree that there is no difference between the outcomes of a tort based legal process, whether it is workers' compensation, compulsory third party or public liability—particularly where it is all bodily injury. What drives the system—and we have studied it hard to try to understand it, and I think the proper way to view it is that it is a system based approach—are the incentives that are operating in there. From an insurance point of view, our definition of 'best' is not cheapest. Our definition of 'best' is stability; predictability is absolutely key.

So they operate in the most stable ways when there is not a terrible alignment of incentives. That sounds a bit peculiar, but it comes down to non-economic loss awards, which are pain and suffering awards, for small claims, which will typically be non-demonstrable claims. When the alignment of the monetary benefit to the claimant is of the same sort of order as the monetary benefit to the lawyer—and that is typically the case in a small claim of, say, $30,000 where $20,000 to $25,000 is for non-economic loss and the legal fees are $20,000 to $30,000—these schemes uniformly go out of control. That happens in cases such as whiplash or bad back where

the incidence is there but the incentive is not to get it fixed. Then, bang, you get thousands of these claims coming into the system. That is an example of it.

Mr BEVIS—Is there a way to remedy that?

Mr Pearce—Yes, I think there is a bit of a groundswell for moving away from tort based compensation. I think it is beneficial, in workers' compensation, for the injured claimant. I say this for a simple reason: monetary compensation is completely different from rehabilitation. Tort based systems are all about trying to compensate people, whether it be this year or in 10 years time, through money for the loss that they have incurred to their lives through injury. In its purest sense it does nothing about actually fixing them. I think the push with all of these compensation schemes now is very much to early intervention and getting people back to their way of life and their working life and, in the case of extreme types of injury, as close as possible to a normal working life.

Mr BEVIS—Could that lead to a situation where two people who are walking through a Grace Bros shop both fall over the same obstacle, one being an employee and the other a customer, would get treated differently?

Mr Pearce—Absolutely; that is what happens now. That is why we think tort law reform is required across the board. So it should apply just the same to public liability.

Mr BEVIS—That is probably outside our terms of reference, but it may nonetheless be a good idea.

Mr Pearce—I think it is a good case in point that many of the drivers for what is being referred to as the insurance crisis, which is all about public liability, are exactly the same drivers as in workers' compensation and CTP, because it is bodily injury with tort based compensation.

CHAIR—Mr Pearce, you have said a good deal about the other changes that need to be made, but I notice that in one of the other submissions it is asserted that if the alleged injury happened at work then we have to accept liability—that, generally, that is the insurer's response. The claim then proceeds and there is a premium increase for the employer. What check is there on insurers to make sure that they do not take the easiest path of resistance, as it were?

Ms Ingram—New South Wales legislation does indicate that we need to ascertain that employment is 'a' substantial contributing factor—but not 'the' substantial contributing factor. Where it becomes much more difficult for an insurer in being able to assess whether or not an injury did occur at work is, in particular, where it is physically demanding work and somebody could have done it on the sporting field or they could have done it in employment. The client service side incentive is in being able to assess what the factors are, what the evidence is, what we need to do and what we would be measured on within New South Wales. We need to ensure that we are making a sound decision based on the information that we are able to collect. If there is a gut feeling that the injury did not occur at work, we would pursue information—which may involve factual statements, witness statements or a workplace accident investigation. Certainly, through the fraud team that we have in place now, there is a much more active pursuit of that. Wording in legislation does create areas of greyness for insurers in regard to being able to detect it.

Mr Pearce—It is fair to say that, where it is a privately underwritten state or jurisdiction, the incentives for us to pursue such matters are very strong because we will be wearing the claims cost. Where we are acting on behalf of the government insurer, it depends entirely on what is in the legislation, what they are telling us to do and what they are paying us to do. It is easy to say, 'Go out and detect fraud and do this,' but if they do not pay us to spend the money on this sort of resource then it becomes quite difficult to do so and they are actually sending quite mixed messages. They tell us to do something but will not pay for it.

CHAIR—Who is sending these messages?

Mr Pearce—The WorkCover authorities can do that by what they ask us to do as opposed to what they pay us to do.

CHAIR—So they can have an appearance of being very vigilant when in fact they are not prepared to back it up.

Mr Pearce—Yes.

CHAIR—Who is the worst offender?

Ms Ingram—I do not know that there is a worst one.

CHAIR—I could pass on that!

Ms Ingram—As an example, in New South Wales part of our remuneration arrangement is based on measurement of complaints and market share, so the double-bind that it creates is that insurers want to minimise complaints, which therefore means that there needs to be strong evidence to dispute a claim. We are also measured on being able to make a soundly based decision on the liability of the claim, which will determine the type of evidence or the type of material that we will require to be able to make a decision—say denial of liability—there may be a double-bind.

Mr Pearce—I can actually say who was the worst: the previous New South Wales remuneration system, but they have seen the light and it is better. It was a good example of complete misalignment—it centred on process not on outcome.

CHAIR—I notice that you said that you undertake audits of payroll through WorkCover. Are they equally vigilant about pursuing fraud?

Mr Pearce—The way it operates is that we undertake the audits on behalf of them—

CHAIR—But this is of employers. Are they equally vigilant with employees in pursuing fraud?

Ms Davidson—WorkCover actually funds our resource, so we pay that back, but if you were to compare the results around the countryside New South Wales is probably a little more focused on employers understating their premium. If you look at the prosecution comparisons across the countryside, New South Wales does not have the prosecution figures that Victoria,

Queensland or South Australia have. We work very closely with their compliance unit, but I do not think they have adequate resources to respond to the issue.

Mr Pearce—To add to that, we do not want to be too hard on New South Wales because the New South Wales legislation is unique. In respect of the other state based monopoly or state insurers, the legislation is quite clear: the WorkCover authority is the insurer and it takes on all of those roles. They may or they may not use insurers to manage their claims, but if they do they do so as agents and there is a contractual relationship. The position is different in New South Wales. The old legislation where there was private underwriting was tweaked to take out the private underwriting of insurers, but it left every other function there. The state did not take on the underwriting responsibility and that is why there is the debate about where the deficit lives—and at the moment it does not live on the state's balance sheet which means that they are not underwriting it. As we understand it, it is owned collectively by the employers of New South Wales. Their legislation does not direct WorkCover to take on many of the roles of an underwriter because the role of the underwriter has disappeared into the ether. You can take the differences in performance back to the differences in the legislation and the different roles.

Mr HARTSUYKER—Where does that liability ultimately vest when the chickens come home to roost?

Mr Pearce—That has been a major issue for the current inquiries into New South Wales workers' compensation by the General Purpose Standing Committee of the New South Wales upper house and another review is about to take place by WorkCover New South Wales which will be focusing on that. As the legal analysis states, the conclusion is that it is not on the state's balance sheet. It is the collective responsibility of the current employers of New South Wales. It does not live on a balance sheet at this stage and it has never been crystallised. At some point in the future when the liability is large enough for a large employer, an auditor might say, 'No, you've got to take it on.' This will blow up on the day that happens.

Mr DUTTON—It won't be before the state election.

Mr Pearce—No.

CHAIR—We had a submission from the federal Department of Employment and Workplace Relations. In response to a question, they said that there was cost shifting. In other words, there were state based schemes which either involved systems where people could stay on workers' compensation for only two years, the amounts were capped and they had no form of employment. However, ultimately they would end up on the social security system. There was a de facto form of workers' compensation being offered by the Commonwealth. It is difficult to estimate, but I think the Productivity Commission worked it out as $200 million a year, although it seems likely that there could be as many as 45,000 people per year who have their social security affected by workers' compensation. What sorts of changes could be made so that the Commonwealth social security system is not a de facto workers' compensation scheme? What would insurers recommend?

Mr Pearce—Uniformity across the country where the interfaces between health and social security are clearly known, understood and designed. At the moment, they are ad hoc on a state-to-state basis and my understanding is that that submission is entirely right. In some states there

will be a far greater reliance on social security and public health than in other states. It is defined by the benefits structure for that state.

CHAIR—So it is a bit of a cop-out for some states. Instead of taking on their responsibilities, they have allowed the social security system, which in many cases does not have a rehabilitation aspect to it, to take on their responsibilities. Would you agree with that?

Mr Pearce—I do not know whether it has been done deliberately, but the different benefit structures mean that, yes, in some states people are more reliant on social security and health than in others.

Mr BEVIS—A related point is the definition of 'employee' for the purposes of cover. That is another area in which leakage occurs if people are not regarded as employees. In the tax system, for example, there are dependent contractors rather than independent contractors. Is that an issue that you have looked at? It has the same implications regarding the transfer of costs because those people simply fall through the state systems.

Mr Pearce—I do not know this issue in detail. I do know that we insure some groups that contract the contractors. It varies from jurisdiction to jurisdiction. In some jurisdictions they are well and truly. I am pretty sure that in Victoria they are because we have some strong commercial relationships with them. So it varies.

Mr DUTTON—In your submission you spoke about objective medical assessments and made a recommendation in that regard, which would seem commonsense, because obviously part of the problem is that it is a subjective test. You spoke about the New South Wales workers' compensation scheme. Do you say that that model is working well in regard to objective medical assessments?

Mr Pearce—Yes, that is a new one that is coming in. It is very much in line with the CTP one.

Mr DUTTON—How does it operate?

Ms Ingram—There is a requirement now—AMA5—which is in alignment with the CTP system. It is a tool that is used as an objective assessment. There is no accreditation process for doctors who complete those assessments. A doctor would need to complete a training program and then, following completion, would be able to complete assessments in accordance with those guidelines. They are used whenever a permanent impairment is attributed to an injury that is being used for the purposes of entitlement to common law or commutations as well as to calculate a permanent impairment and pain and suffering entitlement. It is difficult to say whether it is working well because it was introduced in January. We are still waiting to see the claims come through that have been applied using those assessment guidelines. Certainly, we are much more confident in relation to the objectivity and assessment results.

Mr Pearce—It has been heavily modelled on the CTP scheme, so it is at pretty much the same level. The point at which the assessment is important is different because it gives access to different benefit structures, but we strongly support the process because we know that it works.

Mr DUTTON—One of the primary reasons is that in the first instance it weeds out doctors who have notoriety for leaning one way or the other. Over the course of the inquiry we have heard evidence that it is a doctor-shopping exercise for some employers or employees or the people acting on their behalf.

Ms Ingram—Having the assessment completed by two doctors will result in some consistency in relation to the permanent impairment, but it will not necessarily weed out the doctors who complete the assessments.

Mr Pearce—I am not aware of the detail, but is it right that the assignment of the doctor is handled by WorkCover rather than by the claimant?

Ms Ingram—No.

Mr Pearce—We would be strongly pushing that it change from the claimant selecting their doctor to the WorkCover authority appointing a doctor from a panel.

Ms Ingram—We as an insurer will make the referral to a doctor whose name appears on the list as undergoing that training. It is not an accreditation process; it is just a doctor who has attended the training program.

Mr Pearce—It is not as strong as the CTP scheme. We are and will be making strong submissions, particularly through the new workers' compensation review in New South Wales, that that be tightened up. But it is a lot stronger than it was before.

CHAIR—Thank you very much for your submission and your time today.

Proceedings suspended from 10.49 a.m. to 11.06 a.m.

BRACK, Mr Garry, Chief Executive, Employers First (representing Hotel Motel and Accommodation Association as an affiliated association)

CHAIR—Welcome. Thank you very much for coming. We appreciate the fact that you have had a difficult day to get here. There have been a few false starts.

Mr Brack—There may be some misconception—I am actually from Employers First. The Hotel Motel and Accommodation Association are one of our 70 affiliated associations. Their representative indicated that he could not make it and asked if we could provide somebody to represent them. As I have had about a 20-year involvement in trying to get workers comp right in New South Wales, I decided to come along to talk.

CHAIR—Thank you. The proceedings here today are formal proceedings of the parliament and warrant the same respect as proceedings of the House. We prefer that all evidence be given in public, but if there is a matter that you see as confidential and you would like to give evidence in private please ask the committee and we will consider that request. Would you like now to make some preliminary remarks, and then we will move to questions.

Mr Brack—You have the submission from the association signed by Dennis Winchester, the chief executive officer. It refers particularly to the New South Wales scheme and one of the provisions introduced in the recent, fairly significant overhaul of the legislative apparatus in that scheme—namely, the provisional liability approval of claims process. The concern expressed by the association—and indeed by numerous other employer bodies, including Employers First—is that all the pressure associated with claims being made and approved under this apparatus is indeed for them to be approved without adequate investigation as to whether or not they are appropriate claims. If you look at the requirements, somebody could actually make a claim, even without a WorkCover medical certificate. It goes to the insurer—and I am talking about the insurer as an agent for WorkCover—and the insurer has seven days in which to approve the claim. If they fail to approve and if they do not have one of these statutorily prescribed 'reasonable excuses', then they can be liable for a fine of $5,500 per failed approval.

The seven-day requirement is very short in terms of the resources one might otherwise have to apply; previously it was 21 days. In many cases, they could not make the 21 days because they cannot get back confirmatory or opposing medical opinion within that period of time. They certainly cannot within seven days. Therefore, they have seven days to approve and they have a very narrow band of reasonable excuses. Their remuneration relies heavily upon approval and a variety of other things. It is theoretically performance based now to a greater extent than it was historically. Just the same, if you are told that failure to approve renders you liable to $5,500 of your own capital being exposed to risk, what do you think the likelihood is that insurers will be much more inclined to approve a claim rather than question it or put it to the side? Our experience says that by and large they are being approved in this hothouse environment, all designed to get a large number of claims approved.

That is the essential concern expressed. If one then looks at the concern of your committee, with the question of fraud and what have you, it is too early yet for us to know what the ultimate impact of this will be. The seven-day requirement has been in force now for barely part of this year. Will there likely to be a significant growth in the number of claimants making a claim?

Will the 70,000-odd no-lost time injuries turn into lost time injuries—or will some of them do that? Will somebody who was going to be off for a week legitimately because of a minor injury now be off for two weeks? Because this provisional arrangement can approve up to 12 weeks of payment with virtually no questions asked. They are the concerns that all of us have about the operation of this particular function.

There is some anecdotal evidence—it does not prove anything and it is too early to tell—in which some companies tell us that they have heard of rosters being drawn up amongst their employees as to who is going to go off this Friday or the next week and have a provisional claim approved. Assuming this were true, in the sense that they were rostering their absence I suppose it might mean that they were being appropriately managerial in the way they approach it, even though there is a fraudulent underpinning for all of this. If one has a large number of claims flowing through in this area and they then turn into longer term claims, or if they add a week or two to a lot of claims, then there will obviously be additional cost.

What does the evidence show us so far about the number of claims in New South Wales? The aggregate number of claims has dropped in this early period in the new scheme. You cannot actually take anything from this, because in all newly legislated schemes there is a honeymoon period where you get completely different claimant behaviour to that which normally develops over the longer term. Over the longer term you tend to get deteriorating performance and discipline in the scheme and a lot of problems creeping in. So it is only in those schemes where there is a system of constant surveillance and constant minor adjustments—or indeed major ones if they are necessary—to keep the scheme on track can you ultimately expect to have the right kind of outcomes.

In this newly legislated scheme with this provisional liability arrangement, it is completely uncertain where we will end up. We have a lower aggregate number of claims but a significant increase in the number of significant injuries claimed for. A significant injury, by definition in New South Wales, is one where the employee is expected to be off for more than seven calendar days—five working days. If they cannot come to work on the eighth day, even if that would not have been a working day, then that would be by definition a significant injury. That number has increased significantly. We do not know what is going to happen to those claims. For anybody to have a reasonable view, the actuarial life of those claims might be three to five years before we will actually see what the outcome is.

If you raise the question of what is the possibility of fraudulent behaviour or exaggeration behaviour developing as a result of this, our fear is that it is going to be pretty high. I think somebody asked the question before about how much fraud there is around. We have been debating that question for decades. Whenever you ask anybody who is in the industry, or lawyers, insurers or rehabilitators, they are likely to say, ‘I don’t think there’s much fraud around, but I think there is a lot of exaggeration.’ In some circumstances, if exaggeration is subconscious and somebody does not know about it, then maybe it is not fraudulent. But there is much of it, in our view, which is deliberate and conscious and therefore fraudulent, although it is described by this euphemism of ‘exaggeration’.

So that is the concern, broadly expressed, about where this might head. If you have an increased number of claimants and if they then develop into a longer term pattern, then the scheme in New South Wales would be in severe danger of financial difficulty. As we know, it has already been in financial difficulty for the best part of the last 1½ decades. We have been

negotiating on and dealing with a whole variety of issues to try and get it on track financially. Employers First have negotiated directly with the Labor Council of New South Wales to try and pursue an injury management approach, an evidence based medicine approach and a more disciplined approach to dispute resolution which we think are at the heart of an effective workers' compensation system—together with the question of suitable duties being provided by employers, early notification and early intervention.

We were pursuing a lot of those things reasonably well, but then the government decided it was going to sit on a variety of changes that we had recommended. Whilst we had indeed achieved significant reductions in cost from about 1998 onwards, the government stalled on further adjustments and now we have got this new package that has come in recently. We have looked at that and still we will not know probably for three years or so what the outcome of that package is going to be.

Mr HARTSUYKER—We need a bit of time for the issues relating to this to wash through the system. Does the group see the need for remedies against those who are making such provisional claims when the claims are later not upheld?

Mr Brack—Even though the claims may later be rejected, it is quite clear that the employer, if they are claims experience rated, bears what might be called the investigation costs. If that cost has to be borne by the scheme, there would seem to be a problem in the scheme in that someone makes a claim that is rejected and yet the scheme is still bearing all of those costs. If the individual employer were bearing those costs, there would seem to be an even greater inequity because the claim ultimately does not get approved but the employer bears those costs as part of their premium. The individual should be looked at in terms of bearing the cost. If there is no discipline in making a claim, then anybody can 'have a go' because there is no equity in an unsatisfactory outcome for that individual. They do not lose anything; they simply try it on. The employer bears that cost. If the scheme has got to bear the cost, then perhaps those costs ought to be borne across the scheme rather than by individual employers.

Leaving aside that, if you design a scheme so that the insurer as agent who is administering the claim has to essentially approve the claim and if the culture develops where they do approve it—and, indeed, the whole history of insurer performance has not been glowing when it comes to an examination of claims, vetting them and adequately taking into account employer views—then you get to a situation where claim approval becomes the norm; therefore, individuals say 'Let's have a go' because there is no equity in the loss, and ultimately you get a scheme that runs out of control. Certainly our experience is that one of the fundamental problems with schemes is the lack of discipline in dealing with claims. If you have no discipline in dealing with those that ought to be rejected, then in the end everybody can simply have a go.

If you get court decisions that deal fairly poorly with surveillance evidence that says this claim is unsatisfactory—for example, there is video evidence of this person performing work that they would not be able to perform because of the particular injury and they come along to court and say, 'I was very sore the next day,' and then the judge says, 'I can understand that'—if that tends to be the norm, then everybody knows that the claimant is going to be able to get up in most cases. That is the experience in New South Wales amongst the defendant law firms that represent insurers in subrogation for employers. Despite the fact that you might have evidence, that evidence is nearly always rejected by the court. Leaving aside simply finding that the employer is liable, when you look at the nature of the damages awarded in common law

circumstances, if you can always say that the circumstances were foreseeable—this comes back to the whole debate about common law negligence and what has gone on in the public liability jurisdiction; it is the same debate because we are talking about the same common law principles—if the judges are always, with the benefit of fairly significant hindsight, able to foresee or say it was foreseeable, then the employer will always be guilty. There was a case not so long ago of a nurse hit in the back with a hammer by a work colleague when the hospital ran a fete and the employer was found to be negligent on the basis that they should have foreseen that at a social function like this, a money-raising event like a fete, there would be pranks played and before the event they should have issued an edict that nobody shall engage in pranks and that if anybody does then there will be severe disciplinary action. The court in that 20-20 hindsight way says, 'You are negligent because you did not foresee that the ultimate reality was that somebody would hit somebody else in the back with a hammer; so pay $300,000 worth of damages.'

If you do not have a disciplined approach to the final jurisdiction—how you settle a dispute—how can you have a disciplined approach right at the front end of the scheme when somebody makes a claim? If you add to that a provisional liability arrangement, where everything is weighted in favour of approval, then the real danger exists that the scheme will run out of control. In New South Wales they have now introduced a significant alteration to the dispute settling mechanism. Nobody has any idea, really, how that will ultimately perform in the state.

I think comments were made by the last organisation about the method of evaluating particular claims and the guidelines in New South Wales. It is far too early to tell whether they will work effectively. There has certainly been an attempt to try and draft a more objective set of criteria, but some of those criteria—the ones about psychological injury—are obviously under significant debate. I know the unions are not happy because they think the criteria should be much more lenient and much more open. We are concerned about a set of criteria like that that says that the way to determine whether somebody is psychologically impaired is to look at whether they are a little unkempt and have one or more takeaway meals during the week. Nobody in this room is unkempt of course, but you might have your days. Everybody will no doubt have times when they are unkempt or when they go out for a takeaway meal. Yet they are the sorts of things that are put into the guidelines about how you determine whether there is psychological injury.

That is one of the areas which threatens future very significant blow-out. It went through a significant phase in New South Wales, then it was halted for a while. Because of changes to occupational health and safety law, it is now set for another significant blow-out here. That is a long answer to your question but the fact is that there are problems and, when you get claims that are made and not dealt with adequately, the employer bears the costs, either directly or indirectly, in the premium.

CHAIR—I just want to understand what it is that you are saying, Mr Brack. Run us through how a claim is made under this new provisional liability system. Did you say that there is no medical certificate?

Mr Brack—There may be, but it may not be necessary to have a WorkCover medical certificate.

CHAIR—But what about one from a doctor?

Mr Brack—It may not even be necessary to have that, ultimately.

CHAIR—Can you take us through the process in which somebody would access compensation?

Mr Brack—An employee could contact his insurer directly and make a claim on the insurer. He would say, 'I've been injured; this is what happened.' The insurer then is theoretically required to talk to the employer, the doctor and the employee. If the doctor is complicit—and there are plenty of cases where doctors have been complicit in people making claims in circumstances where the claim is a complete furphy—and the employee and doctor confirm circumstances, the employer might say, 'I've got no evidence of that happening. There were no witnesses.' It might be a real injury, in which case there would be no debate about it.

We are not talking about those cases where there is real injury, where it is obvious and where it is known. But somebody may come in and say, 'I've damaged my knee,' when you know they were playing football on the weekend. If somebody saw them at the bottom of the ruck and told the insurer but the claim was ultimately approved by the insurer, people would start to get cynical about the whole approval process. After the insurer's investigation of those circumstances, they talk to the employer and the employer says, 'It is fraudulent because of X, Y and Z.' The insurer then says, 'Well, if we go to court on this, historically we have no chance of winning because that is the way the court system works.' Therefore they approve the claim, provisionally.

CHAIR—Are you saying that there is no ability for employers to recoup the cost of claims—what they've paid up until that point—that are ultimately declined?

Mr Brack—That is the case unless there is fraud involved, in which case you can seek to take the matter on in the Workers' compensation Commission. If there is criminal fraud the proof requirements are obviously pretty significant, but even if the claim is rejected you do not recoup because that becomes part of the investigation costs. Those people who are claims experience rated wear those costs in their premiums and if they not claims experience rated the whole industry bears those costs.

CHAIR—On what basis would your claim be rejected when it was not fraudulent?

Mr Brack—It would be rejected only if the insurer believed there was adequate evidence to demonstrate that there was no injury at all or that the injury did not occur at work.

CHAIR—Isn't that fraud, though?

Mr Brack—Making the claim in circumstances where it did not occur? Yes, quite clearly. Those claims get made all the time. The statement, 'I don't think there is very much fraud' is a fundamental understatement by those involved in the workers' compensation industry.

CHAIR—Are you saying that claims can be declined but they are not pursued as fraud?

Mr Brack—Absolutely.

CHAIR—What percentage?

Mr Brack—I do not know the percentage but over 95 per cent of claims are approved now. I think it is 97 per cent.

CHAIR—So three per cent are declined?

Mr Brack—Three per cent may be investigated and then approved or investigated and then declined. Within that seven-day window you have to approve or alternatively have an appropriate reason for not doing so. If there is some clear evidence that there is something wrong they decline. They could then investigate further, and then ultimately reject or ultimately approve. That approval could be 12 weeks long, too, by the way.

CHAIR—If they are declined, there is no opportunity for the employer recoup the money expended to date?

Mr Brack—No.

CHAIR—I hope I am not mistaken, but you said that there is evidence of court decisions where even if video evidence is shown there is still a decision made in favour of the plaintiff.

Mr Brack—Frequently.

CHAIR—What percentage, roughly?

Mr Brack—I cannot say. I only know that from talking to law firms that typically handle these matters. The extent to which they talk about the losses that they incur even when there is surveillance evidence—it does not mean in all cases—is such that you know it is commonplace. Our own members talk about those circumstances where they were absolutely sure it was fraud but they got knocked off. I know from cases we have had a direct involvement in that employees who simply do not want to do the job they are there to perform or who do not want to do it in the way they are required or who do not want to do it in the circumstances in which they are required to do it can use workers' compensation as a way to 'bail out or get even' and the system can accommodate that.

You talked about doctor shopping before, and that certainly goes on. They can get a doctor who will issue certificate after certificate after certificate where plainly the intention is strategic and to avoid bringing that person back on suitable duties and to underpin that person's claim. When you look at the whole rehabilitation apparatus you try to design suitable duties and the person comes in and says, 'That's fine, I'll be in on Monday to do that.' Then you get a new doctors certificate that says they are not suitable for those duties. The doctor is complicit and that undermines the whole rehabilitation process and also provides support for any ultimate court debate about the dispute resolution.

Then you go along to the court and in the end these are not questions of proof. There is a fiction about the legal system. Are the circumstances proven? No, they are not. The judge says, 'I prefer the evidence of so and so as opposed to yours,' which means, 'I reject your evidence.' They come to a conclusion based on, 'Yes, I hear your evidence and I hear what the treating doctor has said in the certificate. Therefore, I accept your claim and reject all the other

evidence'—even video evidence and a range of other stuff, some of which may have been circumstantial but in the end these judges will frequently be accepting claims based on their evaluation of things that are unproven.

CHAIR—So there are plaintiff judges and defendant judges, are there?

Mr Brack—There are defendant judges, primarily. I am not saying that is the way they entered judgeship at all. It is very hard to tell how somebody will perform on the bench. I do not think it matters so much whether they were previously a plaintiff or defendant lawyer. It really depends on what kind of proclivities they develop on the bench. There is adequate experience that hard-nosed right wing—

CHAIR—I did not mean that. I meant that there are some who appear to have a particular bent.

Mr Brack—There is no doubt at all. Lawyers will say, 'Well, it depends who we get on the day as to whether or not you've got a chance.'

Mr DUTTON—What is the motivation? How do you break that culture? Why do they find themselves in that position? Is it some sort of social justice issue?

Mr Brack—If you are confronted by somebody who is injured—a common law damages action—and you are confronted also by a deep pocket, then social conscience issues seem to take over. Therefore, there is always a preparedness by a lot of judges to look for the deep pocket. Nobody will describe it this way, obviously, and they certainly will not say it before judges, but the reality of it is that they see the conclusion they want to get and then they find an avenue for working out negligence. So somebody being hit in the back with hammer is the negligence of the employer. 'Why?' 'Well, let's dream up the reason.' There are thousands of cases. It happens elsewhere—for example, in prosecutions for occupational health and safety breaches—because of the state of our law here in New South Wales, which has a tougher legislated standard than virtually anywhere else in the world. The rest of the world has the common law standard essentially—even in the codified countries of Europe—which is 'taking reasonable care'. In New South Wales we have an absolute obligation, but judges are always capable of finding that an employer did not do something that nobody else would ever have thought of in the circumstances, because they are using hindsight.

Mr DUTTON—That is almost a fraud within itself, isn't it?

Mr Brack—It is the nature of the judicial system. Part of this examination is taking place with the Ipp report—the inquiry about how you deal with common law negligence cases and what judges do. Over a period, if you track through the cases you can see a deterioration, as we would see it, or a more equitable approach, as others would see it, to claimants who come before them. Once a claim is approved, all the statements of claim following that will incorporate some new element. So if you look at 'loss of sexual function associated with an injured back', once a judge decides to approve a particular claim, you will find that all future statements of claim for the defendant lawyers—plaintiff lawyers—will come through with that in them. Whether or not there is any loss of sexual function, they are in them. If you look at the Griffith and Kerkemeyer home help kind of experience, once that decision was made just about every statement of claim had a Griffith and Kerkemeyer element in it, irrespective of whether it

was appropriate or not, and judges approved it. It is that deteriorating position that leads to the blow-out in the scheme. Our position in principle is that the scheme should provide reasonable compensation for those people who are genuinely injured. Then there has to be some kind of overall limit and some control over the dispute settling process. If there is no discipline at the end, there will be no discipline at the start. The New South Wales scheme has a problem in the front-end design. The real debate for us will be what happens in the new dispute settling approach at the end of all this. Will that actually discipline what happens at the start? We do not know that yet.

CHAIR—Mr Brack, time unfortunately has got the better of us. Thank you very much for appearing today.

[11.34 a.m.]

COOPER, Mr George Thomas, Director, Injuries Australia

STEWART, Mr Graham, Member, Injuries Australia

CHAIR—Welcome. The proceedings here today are formal proceedings of the parliament and warrant the same respect as proceedings in the House. We prefer your evidence to be given in public, but if there is any matter you would like to raise as private evidence, if you ask the committee we will certainly consider that request. I invite each of you to now make a preliminary statement and then we will move to questions.

Mr Cooper—We have been present during the evidence of the three previous speakers and that has been quite interesting. We would like to point out that workers' compensation and safety is about people, not money. All the other people have spoken only about money. The political intent that our forefathers had when they set up the safety and workers' compensation system was to look after the health of people at work, not to look after money. Money is just another tool to get the job done. That is all it is. I do not want to be critical of these people, but it is a pretty standard understanding when you consider that they are in the injured worker industry. If workers were not injured they would not have a job. It is as simple a truth as that.

If you look at some of the things that have been brought up—and their opinions are quite understandable—a gentleman over here asked a question about claims and how they can be unrecorded and all the other problems that there are. It is typical that IAG, even with all their resources, could not go around Australia and inquire from other jurisdictions about how they do it. We run on donations and on a postage stamp and we did it. I have something I would like to give you and it will show you exactly how other people do it, and do it better than New South Wales. It is the Victorian WorkCover claim form. In New South Wales you have to beg a claim form from the boss and if he is late getting it to you then you are late getting input inside. What you have in Victoria is a claim form you can pick up at any WorkCover office, and even in the post office in country areas. It is in triplicate. So the worker—the injured employee, as we prefer to call them—fills it in, has a copy for himself, a copy for the employer and a copy for WorkCover. The flaw in this system is that he has to give it back to the boss who can then delay putting it in, but at least it is recorded by WorkCover.

We can show you dozens and dozens of cases in which WorkCover does not know what we are talking about when we complain about something because there is no record of it. We have cases in which the form has not been put in for three or four months. Going along with that, the employer has to fill in a separate one, so the words should match. Why can't the insurance companies find out how the others do it? That is what we have been asking New South Wales to copy. As I said in my statement, we are loading it up on New South Wales because we do so much work there and I have specialised in it. They have just ignored us. We have sent them that and yet we cannot get anywhere with them. You can see the value of it; everybody has a copy. Right now with the New South Wales one you get an insurance company form, not a WorkCover form, and there is no copy. If you do not photocopy it there is no copy.

I am not very impressed with Mr Brack's anecdotal statements, because I do not think it does the inquiry a lot of good. He mentioned the cost to employers, and it is costly to employers and it should not be. If you go back to the Industry Commission inquiry, you will see that Senior Commissioner Scales in his conclusion said that in long-term injuries 60 per cent of the cost is borne by the injured person and their family and, of course, the community. We say it is 85 per cent. That is the sort of cost that a so-called free system is placing on people who get injured at work.

The AMA5 guides were mentioned. The AMA5 guides are not even popular with the American doctors. They were brought out in America to suit the American insurance companies. If you read them, you find they are stupid things. If you lose a foot, you are 44 per cent impaired; if you lose both feet, you are only 65 per cent impaired—I do not know how they have worked that one out, but that is their arrangement. We went through all this with New South Wales WorkCover and all they wanted to do was follow America. We believed that putting a price on human beings and parts of their anatomy is barbaric. Is the index finger of a concert pianist worth more than the index finger of a bricklayer? Work it out. We are not machines. We are not spare parts available to screw into the thing. Machines in the workshop are tax deductible—they depreciate and they do all sorts of wonderful things. If a machine gets damaged or breaks down, it is repaired as quickly as possible and put back to work. What about the fellow who is working the machine? What happens when he gets repaired? He is out the door.

So that is what we are saying to the previous speakers—good people as they are and well-meaning. They have got away from the fact that this is about preventing people getting hurt and, when people are hurt, getting them back to work. All the costs they talk about would disappear if they would only do what the majority of the self-insurers do: get them back to work. That was pointed out to the industry commission, and Commissioner Scales asked them why they self-insured. They said it was cheaper. When asked how much cheaper, they said at least 40 per cent, and their return to work rate was nearly 100 per cent. Here you have people doing it for, say, half the price and doing it twice as well.

We wrote to WorkCover and asked if they could copy their methods. There was no reply. We asked the self-insurers how they got the figures and how they were able to do it, and the answer was astounding. They said, 'All we do is follow the requirements of the legislation.' That means that New South Wales WorkCover was not following its own legislation. We believe—and there is some pressure being put on and we do not like the idea, I can tell you—that there is a great common law case against the government for neglecting these people. That is the sort of thing that we have learned just here listening to how people have got a different slant on things. We can understand that; they come from a different angle. But I would ask the committee to keep in mind that this inquiry is about people; it is not about money. Money is just another tool to do the job.

To add to our statement, we tried to point out that the greatest single thing they are doing is keeping us—that is, the injured people—out of any discussion about how the scheme is working or how it could be running. The issue of the IMA, the independent medical assessment, was brought up. It is under review at the very moment by New South Wales government WorkCover. Read who is on the committee that is going to decide on independent medical examinations for injured employees: the Australian Medical Association, the Australian Orthopaedic Surgeons Association, the Law Society, licensed insurers, the Health Care

Complaints Commission, workers' compensation, the Motor Accident Authority. There is nobody there from employers and nobody there from employees and there is nobody there from injured people.

They asked us whether we would comment on these things and we sent our letter back. The major thing we have been concerned about is the issue of country people getting sent to Sydney for medical examinations. It is awful. People are sick. Some are crippled. One person has had 24 trips. He has been dragged into Martin Place for some bloke to look at him and say, 'Yes, yes, yes,' and go away. Mr Brack talked about doctor shopping. I can assure you that insurers do it too. That is what they were doing. They were looking for a letter that said there was nothing wrong with that person. Only the other week we said, 'Why can't these people go to a doctor within their own postcode? Let us go and do it this way.' They have come back with some other comments and they wanted a reply in seven days, which is not enough time. 'You can do that,' they said, 'provided the doctor is not treating the worker or any member of his family, or has a pecuniary relationship with the worker or a member of his family, or is related to the worker.'

In country towns, doctors are in short supply. There is every chance that the doctor they send you to is probably treating your mother or your auntie or somebody else. We just said, 'A doctor'—and if they cannot be trusted, so be it. But who got around this? We would say the doctors because they want to drag them to Sydney. By the way, they get $800 for a one-page letter. Many members have had the same letter; it just has the name changed at the top. It is the same stuff; they just spew it out of a computer. That is what the insurers go for. We are trying to get it across that we want to work with industry and with WorkCover to use the collective experiences of injured people—and they will not talk to us. The minister does not reply to our mail. He gave me a 25-minute interview one day in a dark corner somewhere in Parliament House, and he had to rush off. We are the only ones who are locked out of any discussion. We do not say that we have all the answers—we don't—but surely we can say, 'This is not a clever way to do it. If this happened, this wouldn't happen.'

CHAIR—Mr Cooper, that is really helpful.

Mr Cooper—But Graham's story is very interesting.

CHAIR—We might have to give Mr Stewart an opportunity now.

Mr Stewart—I was injured in December 1996. I was crushed in a truck in the workplace, at our depot, to the extent that they had to move the trailer away to get me out of the position I was in. I was actually scissored by the truck, between the door and the floor of the truck. Numerous men in the yard had to help get the trailer away from the door of the truck where I was scissored in. From thereon it was an absolute roller-coaster ride. My settlement took place on 30 June 2000 after 3½ years of unbelievable medical examinations by my own Macquarie Street specialist and also the insurance company that sent me back numerous times to different doctors and then the same doctors. Prior to 2000, my wife and I were only living together—we were not married at the time. I was interviewed by the insurance company's psychiatrist who suggested that maybe my wife-to-be was hanging around for the money. She asked how our relationship was at the time. I said that it was extremely strained due to financial hardship and so forth. She said, 'She can always vote with her feet, can't she?' Without the support of this woman—whom I happen to be married to now—through what I went through, I probably wouldn't be here talking to you now.

There is no compassion—I am not looking for bleeding hearts and I am not a bleeding heart—for people who are injured. Sure, I know we do not live in a perfect world and I know for a fact that there are fraudulent claims, but I have hidden nothing from the day I was injured. I went through absolute hell for 3½ years. The settlement I got, compared with what I was capable of earning, was peanuts. My medical costs, and the pittance that I was paid for the 3½ years, totalled $114,000. The medical costs were unbelievable. I ended up with $200,000. Out of that, my fantastic, unbelievable solicitor and his barrister—and time does not permit me to go into the details; I thought I had a solicitor acting for me, but I ended up with a solicitor who was acting for his bank and his buddy who was the barrister.

What I wanted to get to and make clear is that it has left me with $160,000. But, in the meantime, the government in their wisdom sent me a letter—and I never collected social security for one day during the 3½ years of my claim—before I even got the cheque, because it took six weeks after the court hearing. Unfortunately, due to misinformation from my solicitor and barrister, I settled out of court, which is my greatest regret to this day. The letter said, 'We believe you've got a settlement of $200,000. We're now excluding you'—and, mind you, take this back from 30 June 2000—'from any help whatsoever, in accordance with the social security scheme until October 2005.' They divided my $200,000 up—not taking into account that I paid exactly $40,000 to my solicitor—by a figure which Social Security came up with, which is not much more than an unemployed person gets. They came up with an exclusion period until October 2005.

Also, because I settled on 30 June 2000 and the day after was the big introduction of the GST, I found out after appealing their decision that, if my court settlement had been 1 July, the exclusion weekly money would have been so much greater when it was divided into my $200,000. I get no CPI adjustment. I left school halfway through second year and I am no scholar, but I can see I get no CPI adjustment throughout my exclusion period. I get no compensation in regard to the GST that has come in—which affects me like it does each and every one in this room—because my settlement was on 30 June 2000, which means that I am left with the money I am living on. It just does not work.

My greatest regret is settling. I wish I had become a liability to them. I live on morphine every day as well as endone, which is another top-up narcotic drug, to cope with my days. It does not take the pain away; it helps me cope with the pain that I have. I can sit here and look each and every one of you in the eye and tell you that everything I say is above board and the truth, but I was treated like a criminal. The day I walked in the office of my solicitor in Sydney—his name was Peter Long, and I happy to tell you that; he comes from Gunnedah and has an office in Sydney—for the court hearing, he had his barrister there for me to meet for the very first time. The barrister spun around and said to me, 'Well, Graham, Peter's got it all wrong; you don't have a case.' They play mind games with you.

Mr Cooper—We asked Graham to come in because we have been helping Graham for some time. We run an 1800 telephone number—good people pay for it for us—and that is how we met Graham. We take out a little ad in the paper and people can ring. It was pretty obvious when I first spoke to Graham that he was suicidal. We get a lot of this. WorkCover will not admit that people do this. We know how many do do it.

CHAIR—Mr Cooper, can I interrupt you and ask you a question. I apologise for being rude. I notice on the last page of your submission—page 98, for our reference—you say that you can identify 50 suicides caused by work injury in New South Wales.

Mr Cooper—Yes.

CHAIR—Is that a figure you stand by?

Mr Cooper—At least 50; yes. One of the problems when we follow them up is that families cover up very well. It is a shame thing. These are country people, mainly, where there is nowhere to go. There is no work. The thing that broke our hearts was that, when we took it up with the most senior person we could in WorkCover, he laughed at us; he did not want to know about it.

CHAIR—I noticed you said that.

Mr Cooper—This is how we met Graham. He was on that verge. He said, 'I've got the pills in front of me; I'm going to take them.' We said, 'No, you don't.'

CHAIR—I am sorry to keep interrupting you, but time is very limited. It is a very valuable contribution—and we really appreciate your coming—but I am trying to get to the heart of what recommendations we can take from this very valuable information you are giving us. You are saying that, although WorkCover are very proud of the savings—$850 million a year—

Mr Cooper—No, once. It is a one-off saving.

CHAIR—eight per cent of that has gone to the insurer agents. But you also say that, from there on, there is not sufficient rehabilitation for these folk. Is that part of the problem?

Mr Cooper—Yes. Graham, how much rehabilitation did you get?

Mr Stewart—They put me in a computer class with 18 women. As I said, I left school halfway through my second year of high school, with very minimal English ability as far as spelling and that. They put me in a room with 18 women to learn a computer. I could not even type, therefore I could not keep up with the course, and after about five weeks I dropped out because I could not do it.

Mr Cooper—And it is his fault!

CHAIR—You found that your rehabilitation was really inappropriate to your skills; they had not made a real effort to—

Mr Stewart—None whatsoever.

CHAIR—You have also made the point that you believe that WorkCover is dumping people onto the federal government and you suspect that there is a sharp rise in the number of people receiving a disability support pension—again, no rehabilitation or opportunity to move on.

Would you like us to call people from the Department of Family and Community Services to try and establish what number are on a disability support pension?

Mr Cooper—We would love that. I had the old numbers. Before the change of governments they were public documents. For some reason they are not now. I worked for the department when I retired, so I had access to them, as they were then a public document. With the last lot of figures, I concentrated on what was going on where I live in the Hunter district. There were 33,000 people then receiving a payment waiting for some settlement from WorkCover, and it had the figures of what they recovered every month. I have some of the old figures with me, and they were recovering $5 million a month in the Hunter. This is compensation money paid to injured workers, but then it is paid back. The New South Wales government system dumps people onto Social Security so that they have shifted the cost. When the matter is settled and the person gets a so-called compensation payment, they quite rightly collect whatever money they lent him—

CHAIR—Centrelink takes that back?

Mr Cooper—Yes. They have shifted the cost of the injured worker. The figures that I have show that Social Security missed out on about 10 per cent of their money, which means that, from day one, they actually gave WorkCover an interest-free loan. This amounts to a huge amount of money. We wrote to the previous government and said, 'Will you get out of the system? Don't touch workers' compensation until the matter has been finalised. It is not your business.' Social security was not established to subsidise insurance companies, and we are saying, 'Get out of it.' These matters will then get settled properly, because that is what self-insurers do: they get the people back to work and then they are crossed off. As I said, the 97 per cent rate that they had back in those days is commendable. Very few cases went into the courts. There was no dispute. What has been happening, and still happens—it does not matter that they say that it does not—is that they will dump people off the system for real or imagined crimes. You have no recourse. You are finished, and you have to go to the Social Security. You are now in dispute. We also found a dumb thing that was going on in the trade union movement. When a fellow would get hurt, he would tell his organiser and they put solicitors in touch with him. He would then go into dispute. That gave the insurer an opportunity to dump them—'We are in dispute; what do we have to pay you for?' I said, 'What have you done to this poor fellow?' The thing is: return to work is one of the three standard pillars of work, and they do not do it. Self-insurers do it. There is a WorkCover document that was circulated. It has a great logo. It states:

WorkCover guarantees a service of rehabilitation of injured workers.

They do not do it. We talk about fraud. Don't you think that that would be fraud?

CHAIR—It sounds like fraud on the Australian people, doesn't it?

Mr Cooper—That is right; it is. The system is going along with huge amounts of money in the bank. It is up to around $7 billion that they have now, and it has doubled in the life of this present state government, yet we understand that the number of long-term cases have halved. What are they going to do with the money? We worked it out on the cases they have got and did some division. They would have to hand everybody back $1.2 million. I do not think they will be doing that. We are trying to put across that the Commonwealth should stay out of it. You are not there to subsidise them. Let them do their job. If someone like Graham had been given a

structured settlement that was controlled properly, he would not be in his present predicament where he has spent his money trying to get a business et cetera. He is now in that position where he is living on credit cards and things. We are saying that these people were living normal lives—looking after themselves, paying for their families. They get smashed up at work through possibly no fault of their own and they are thrown by the thousands into this situation. The New South Wales government WorkCover is the largest cause of unemployment in Australia.

CHAIR—That is a very radical statement.

Mr Cooper—That is the truth. Over 10,000 people a year have been dumped onto social security. When they shut down BHP at Newcastle, only 2,500 people were out of work. With WorkCover, it is like shutting down BHP four times a year every year, and that is what they are doing. The Commonwealth, in its good, thinks it has to do these things because a person has woken up, he has no income and he is knocking on its door. Even then, we would say that they would only get assistance from the Commonwealth when they have a WorkCover supplied letter that says the matter has been finalised, that it is all over—whatever it is, it is gone. Whether it is good or bad, it is something that has to be done.

Preferably, we would like to see a system that does away with workers' compensation insurance and that has human safety and workplace injury indemnity. This is quite interesting. We had the Australian Industry Group before us and we took a scheme to them in Newcastle. We were led up to them and we said, 'Have a look at it.' They went over it and said, 'Very good, we will come back.' They never came back. So we got to them again—and I have a copy for you. This is a way of doing it where you do not insure human beings like a piece of machinery or an inanimate object. It is a user-pays system, too. You are in control of it.

CHAIR—We would be most interested in that. Can you give us some details? I am sure my colleagues would like to see it.

Mr Cooper—You are welcome to it. Workers have no say in this thing. Their consumer rights are not there because they are not the consumers. They do not own the policy.

CHAIR—I would like to invite my colleagues to ask questions, because I am sure they are finding this as interesting as I am.

Mr Cooper—We were invited by the physicians' Australasian Faculty of Occupational Medicine to contribute to the *Compensable injuries and health outcomes* publication. We said to them that, when a person gets damaged at work, the medical system in Australia is world's best practice. The ambulance services, casualty—everything goes to work and everything gets done. It is the very best of everything. Once the claim form goes in, that is when the trouble starts and that is when the psychology comes in and where they are driving people mad. I will give you a statistic from the Medical Health Research Foundation. This tells us that one-third to three-quarters of all injuries that require medical assistance are non-compensable—so they are not on the road and they are not at work. This found that, for people who had a non-compensable injury, their chances of not losing their job and getting back to work were far greater than anybody who had a compensable identical injury. What you had was the WorkCover system and all the people who feast on it—we call them the camp followers—and who make money out of the system keep you on the system because it is to their benefit. I am pleased that you do have a copy. As I said, we were contributors.

Mr DUTTON—I want to ask a question which is probably best directed to Mr Stewart. I think that one of the things we need to look at as part of the recommendations of this committee is removing a payments system which is either encouraging people to pursue claims in a fraudulent sense or is providing for a more dire situation for those people who are deserving of the money, as is obviously the case in your scenario. Would you mind sharing with us some of the facts concerning the figures that you received before?

Mr Stewart—Not at all.

Mr DUTTON—What would your financial situation now be? Do you think you would be indicative of many people who receive lump sum payouts?

Mr Stewart—After paying the solicitor, I was left with—

Mr DUTTON—Just tell us as quickly as you can, please.

Mr Stewart—I was left with $160,000. I then tried two other businesses. The crux of the matter—and the hard bit for me—is that when I go and apply for a job, even one that I can cope with, I have to fill out an application form that asks, 'Have you had a WorkCover claim?' 'Yes.' 'We'll ring you later.' That is the truth of the matter. People can deny that, but that is the bottom line. So I envisage that the money that I have is going to run out. I do not want to live on a pittance for the rest of my days, be it on the dole or whatever, so we endeavoured to start up a couple of businesses. They failed and this cost us a lot of money.

With the remains of what I got, when I sold the last business I paid off $50,000 on the balance of what I owed on my house. I do not give a damn whether I have to beg, borrow or steal to eat, but if worst comes to worst I am not going to end up at the end of October getting a disability pension or something, living on a pittance and still having to pay my mortgage. I am not going to do that for nobody sitting here. I want some sort of security in life and my wife surely deserves it—the medical evidence is that she has lupus. What I am saying to you is that I am virtually broke.

Mr DUTTON—When did you receive your payout? How long ago was that?

Mr Stewart—It came on about 13 August 2000.

Mr DUTTON—So essentially two years ago?

Mr Stewart—Yes.

Mr DUTTON—The net result is that, out of the $160,000 that you got, $50,000 has really gone to something substantial—to pay off your mortgage.

Mr Stewart—After selling the last business.

Mr DUTTON—So you ended up with 50 grand out of 160,000 grand after two years?

Mr Stewart—Yes.

Mr DUTTON—Mr Cooper, do you think that would be indicative of many people who receive lump sum payouts?

Mr Cooper—I can tell you worse stories than that. One was written up in a full page of the *Newcastle Herald* and concerned a young fellow who was poisoned in a chemical works. He turned a valve on while he was in a vessel—the boss turned it on. His lungs were ruined. Nine years later he got a settlement of $116,000. He is a young married man with four children. His wife was not working. He owed Social Security $96,000 and the Health Commission came in because he owed $4,000 for medical services that he had received. He was left with $6,000 and he said, 'All I did was buy my wife a new washing machine.' He is broke. That fellow is out of a job for life. He will certainly be receiving social security for life—and that is what they gave him. We are not saying that we do not like lump sum payments; there are very severe cases when people have to be looked after. But get people back to work and then we will squabble about who was right and who was wrong.

Mr DUTTON—Part of the point that I am trying to make is that there is a financial disincentive for people to return to work, because some people who may not have had money in the past receive a lump sum. They might think that $160,000 or a couple of hundred thousand—whatever the figure may be—is a considerable amount. For some people there is no advantage in their mind in going back to work because they feel that they are going to be set for the rest of their lives. The reality is that that is not the case.

Mr Cooper—You are right. That happens to a lot of people—with respect to Graham. The people who get hurt are the ones who do the three Ds—the dirty, the difficult and the dangerous. They have not had the good fortune to have the education that you and I might have had. So some smart solicitor waves a cheque in front of them, it seems like a lot of money and it is the end of the world. We know that, to their credit, even the solicitors have tried to set up a system to help people to handle their money. But where do they go from there? Listen to what I said before: get them back to work before there is any talk of settlements.

Mr DUTTON—People still have that in the back of their minds, though.

Mr Cooper—They might have it there, but it is a lucky dip, a great big raffle: it depends on who's the judge, how good your lawyer is, what the weather is like today and who is the other solicitor. You can see similar injuries and the figures are anywhere. They are published and you can read them. As I said, we think that the first responsibility is to get people back to work.

Mr Stewart—Nobody in their right mind can say that $160,000 is a lot of money—anyone that is living in this world anyway. It was no incentive for me, I can tell you, none whatsoever, because I could earn more than that in the time that the injury happened with my own two hands. It is not a money thing. It is the fact that I am unable to do what I was able to do before the accident. They give you a lump of money and say, 'Go away, we do not want to know you any more.' Retraining to do another position of some description was non-existent.

Mr DUTTON—It is also a two-way process, is it not? Some people need to seek that skill out for themselves. If a computer course did not work for someone, then there may be something else that they could enrol in. It needs to be a process that both parties are engaged in.

Mr Stewart—I sat down with the Commonwealth Rehabilitation Service, and I would really like it if you could get some figures from them of their success rate with their clients and the money they charge to do it because I do not know of anyone who has had any great success with them. They seem to get this great warm and fluffy feeling that if they enrol you in some sort of a course that is great—end of story. They do not sit there realistically and think what can this man do? They enrolled me in a computer course when I was a truck driver.

Mr Cooper—In 1991, I went back to university and completed a Graduate Diploma in Health Science (Rehabilitation Counselling). With another formerly injured person, I set up a rehabilitation business and we did a lot of work, and every case we handled was from trade unions where CRS had failed. They had taken the money and could not get them back to work and these blokes wanted to get back to work. We always got them back to work, although into different things. But at the end of 12 months we folded because of the treatment from the insurers. When you do a rehab plan you work it out in steps: 'This is what we will do,' and when we get to that you ring up and say, 'I want to proceed to the next step.' In this particular case, I needed a special chair for a fellow. We were halfway through the plan and they said, 'We are not paying for that.' I said, 'It is a waste of time; all that we have done will get him there if he has this chair.' They said, 'We are not paying for that.' He did not get the chair and the fellow ended up giving it away, and that was one of our few failures. Then they delayed paying us. They held it up and held it up. They still owe me money now—GIO still owes me money.

What do you reckon? We gave it away because we were not here to keep them in business. No credit was given to us for being very successful in getting people back into some work—no credit at all. They were not interested in knowing about it. There are a lot of good rehabilitators there doing a lot of good work—we know them and we call on them and they are good to us—but they are restricted in how much money is even spent on rehabilitation. It clearly states how much, but there is no restriction on lawyers or medicos. We are saying that we have to keep costs in their place. We are all for that. But I do not think that they ever realise how important it was to the people to go back to work, and I emphasise that. Commissioner Scales at the Industry Commission was so impressed with the presentation we did in Sydney that he came to me and said, Would you help me to set up a visit to the Hunter?' They were going around Australia, but the Hunter was not on the program. We got the leagues club for one night. Two hundred and fifty people came out on a wet night. He listened to them and when it was finished he thanked everybody for coming out and having their say. He said, 'When I came here tonight I thought everybody would be talking about money, we must get money, but nobody has talked about money; you have all talked about jobs.'

CHAIR—Mr Cooper, that is an excellent note I am afraid we are going to have to leave it on. I would like you to take it on notice.

Mr Cooper—I thought I had it with me, but I will certainly get it to you—

CHAIR—Could you perhaps supply the secretariat with the WorkCover figures on rehabilitation. They must publish them.

Mr Cooper—They used to do them monthly. I have some here, but they are old ones. They are out of date.

CHAIR—If you could give those to Alison, we will try to get some of the more current figures.

Mr Cooper—Sure.

CHAIR—I thank you both very much.

Mr Cooper—There is one other thing that should happen which happens overseas. There should be an overseeing body. Nobody checks WorkCover. ASIS should be doing it because they are an insurance company.

CHAIR—Indeed. Thank you. We greatly appreciate your submission.

[12.16 p.m.]

KAPLAN, Dr Robert (Private capacity)

CHAIR—Welcome. Do you wish to add anything to the capacity in which you are appearing?

Dr Kaplan—I am a consultant psychiatrist at the Liaison Clinic in Wollongong.

CHAIR—The proceedings here today are formal proceedings of the parliament and therefore warrant the same respect as proceedings in the House. We prefer evidence to be in public, but if there is any matter you would like to raise as private evidence you may ask the committee and we will be happy to consider it. Would you like to make a preliminary statement and then we will move to questions?

Dr Kaplan—I hope I am not appearing before the committee to waste their time—

CHAIR—We do not say that about anyone—you are most welcome.

Dr Kaplan—When I heard about your activities I thought it was likely that you would have a lot of people doing the same job as me making submissions, but it turned out not to be the case. What I can offer the committee is not an academic or scientific assessment of the process of insurance claims or the outcomes but what you could call a clinical view from the coalface. I work not only in Wollongong but also in Sydney, so I have access to a lot of country cases—which were previously discussed here—as opposed to the city problems. Finally, in my work I not only do insurance assessments but work for HSA, the immigration department and a range of other people, including the Department of Veterans' Affairs, so it gives me a fairly broad look at the whole situation.

CHAIR—Would you like to continue. Is there anything else you would like to say?

Dr Kaplan—I could read into the record what I have put down as my briefing, or would that be repetitive?

CHAIR—Perhaps you could touch on some of the more forceful arguments you have.

Dr Kaplan—The point I would like to make is that fraud does not happen by accident. The way I look at it is more as a dimensional issue rather than what we call a cluster issue—in other words, it starts with small and relatively innocuous events, often unwitting embellishment, and it goes on to reinforcement by parties involved with the claimant and, at the very end of the line, you get the deliberate, conscious and focused attempts to deceive, if not to simulate injuries.

If I look at some other points that I have made, clearly some agents involved are colluding with the claimant. This is because they believe they are helping them, but there is a concept which is not widely known and it is called 'tertiary gain'. Tertiary gain is where you collude with someone in their illness behaviour because there is something in it for you—usually

money, exemption from certain duties or a change in your lifestyle. It is a feature of the work that I do that I tend to see certain occupational groups. This may be different for other colleagues in practice, but in particular I have found groups like policemen and teachers come forward very frequently for assessment with claims which in many cases are dubious and in many cases have an external agenda and occasionally I strongly suspect are fraudulently based. These claims are often based on what is called workplace stress, which is an extremely controversial area, and I am sure there has been a lot of discussion about that.

It is not only the claimant and the people around them who are at fault but also the people who are treating them and, often, assessing them. We need people who are completely objective, who do not see themselves as hired guns and who are trained properly in the job that they are doing. This is a particular issue in psychiatry, as you know. It is often said to us that the diagnoses we make are woolly, abstract and very vague. If you subject psychiatric diagnoses to validity testing, the accuracy of many psychiatric diagnoses are far better statistically than those for conditions like chronic congestive cardiac failure, which most GPs see every day. The problem occurs when you have people not sufficiently trained in psychiatric diagnoses making diagnoses. You get somebody going to a diagnostic manual—and you have probably heard of the famous DSM-IV; it is essentially something like a giant cookbook—flipping through it and putting their finger on the spot that seems to meet the idea of what they think the claimant has. They tick off the criteria and have an instant diagnosis. This is an appalling way to do it because psychiatric diagnosis is not arrived at by just ticking off lists; it is arrived at by detailed assessment of all the circumstances.

The next thing I would like to talk about is a concept that comes up very frequently, particularly with workplace stress claims, and that is the idea that any distress is pathological. You probably have some idea about this from the public discussion over the last couple of decades of the concept of grief—is grief a normal thing or is it something we turn into an illness? Clearly there is a big debate about this. When you assess claimants, particularly with workplace stress, it is important to accept that a certain degree of distress is normal and a part of most activities, if not confrontations, in daily life. This is taken into account in the diagnostic manual with the V-code disorders, conditions that present to doctors, psychiatrists, psychologists or counsellors in people asking for help. It could be a marriage problem, study problems at work or an occupational or workplace dispute. For the treating person, a V-code disorder indicates that you have a problem and we will assist you through it. But the V-code disorders are quite specifically not psychiatric illnesses. That means they are not compensable. This is an area where there is a small but growing recognition amongst assessors that we need to say, 'Yes, you have been upset by what is going on at work but most people would react the same way; this is not an illness.' That is all we can make of it. I have said most of what I wanted to say. I could give you many different examples, but I would like to let you ask what you like now.

Mr HARTSUYKER—We have talked about this practice of doctor shopping and so on. Is there a possibility that this could occur in a psychiatric illness? Do you think there is any benefit in controlling fraud where someone comes to seek an opinion claiming to have a particular illness that is work related which you do not believe is true? Would there be benefit in some sort of reporting system which would detect where someone had been to see seven psychiatrists and eventually found the eighth one who confirms that they have a work related illness?

Dr Kaplan—Yes, I do believe there would be benefit, but it would be enormously difficult to put into practice. I do not know whether you have heard of the condition of Munchausen's syndrome, which is the ultimate act of faking and simulating illness to get admitted to hospital and even have surgery. It has been a problem in medicine for decades. What do you do about the Munchausen type of patient? There are all sorts of problems with hospitals keeping black books and black lists.

Mr DUTTON—Are there any models operating overseas which are better practice than those operating here in Australia, particularly in relation to an objective medical assessment, which is something we took evidence on this morning?

Dr Kaplan—Yes, but I cannot tell you which countries. I understand that there is a growing movement in reality and in practice. Some countries have panels of assessors who are regarded as leaders in their profession. They do not work for either side; they are randomly selected and they monitor and assess each other via a peer review. I have always thought that is an outstanding way to go to produce the best possible result.

Mr DUTTON—What are your views on the way the New South Wales government is headed in that whole area at the moment?

Dr Kaplan—I do not have any set views. Clearly, any change is better. It seems to me that there is a good deal of light and dust rather than light emerging as yet.

CHAIR—Dr Kaplan, you said that grief is not necessarily an illness and stress is a normal part of life, so is there a distinct difference between being stressed or depressed and actually having a mental illness?

Dr Kaplan—I will try and rephrase that. Yes, there is a certain degree of stress involved in daily life and, of course, if you are suffering a bereavement you will be going through grief. There is a line that you pass where that becomes excessive or pathological, and that is when you would consider it a disorder. For example, you can have pathological grief and you can have the illness of depression rather than just feeling depressed.

CHAIR—A minister recently made the distinction between people suffering mental illnesses and people who may be seen as malingering. Was that a fair distinction—that being distressed or depressed is not necessarily a mental illness and should not be considered as such in insurance terms?

Dr Kaplan—Let me put it this way: I think the word 'stress' has been so utterly misused as to be devalued completely. There are only two diagnoses in the psychiatric manual which use the term: acute stress disorder and post-traumatic stress disorder. Depression is a different matter in that depression is a very common, very serious and very disabling illness. On the other hand, many people will use the term 'I'm depressed', and quite reasonably so, to describe a moment of transitory unhappiness or low mood. Perhaps that clears it up.

CHAIR—Yes, it does. For us, what recommendations are you making with regard to fraud? Do you think that the existing schemes for detecting fraud in the different states address that adequately, particularly when we get to the questions of psychological and pathological illness?

Dr Kaplan—My view is that the problem is—and I am not even sure if it is the right word—systemic. It starts right at the point of injury and it goes on to the GP, the psychologist, the rehabilitation service and, finally, the assessor. If we work on all of those aspects and if we get the highest level of professionalism, particularly with the assessment of psychiatric and psychological conditions, I think we will clean up the shades of grey leading to outright fraud cases.

CHAIR—When we clean up the shades of grey, what do you think we will find—more cases that are approved or more cases that are seen as fraudulent or perhaps without basis?

Dr Kaplan—The latter.

CHAIR—What about the disability support pension from the Commonwealth? I am digressing for a moment. We have already seen today that there is some evidence that the Commonwealth is picking up, unfortunately, those who are not being adequately cared for or rehabilitated under workers' compensation. Is there a percentage of people who have been assessed as recipients of the disability support pension when realistically they could have been properly rehabilitated or they did not have a mental illness? To what extent do you see that?

Dr Kaplan—I got most of my experience assessing people for disability pensions in Illawarra and Shoalhaven—I have done that since 1987—and I see far more cases there than in any other sphere of people who should not be there.

CHAIR—On the disability support pension?

Dr Kaplan—Yes. I could give a brief example: people who had a couple of panic attacks in the mid-eighties were put on a pension and somehow happily survived on that until the mid- to late-nineties, when somebody said, 'We'd better check up on them.'

CHAIR—The mid-eighties to now?

Dr Kaplan—Yes.

CHAIR—For those folk, would it be too late now to try and address their circumstances, perhaps give them some training and put them back in the work force? I suppose that it is also age related but, if they are younger people, is it possible to rehabilitate them?

Dr Kaplan—I want to make sure that I am answering your question correctly. The people that I see for disability that I think you clearly would reject are people with very minor and easily treatable psychiatric problems. My view is quite clearly, 'Get them treated; there is no reason why they should not get better.' I suppose that anything employment related would stem from that.

CHAIR—But you are saying that there may be a percentage on disability support who were assessed almost 20 years ago, perhaps inappropriately?

Dr Kaplan—I do not want to use the wrong figures, but certainly I have been surprised from time to time at how long they have been cruising in neutral in the system without any checks

and balances. In the end, when people have problems that can be fixed and they are not fixed, as a doctor you are always concerned. It is a shame.

CHAIR—It is a terrible waste from everyone's point of view, isn't it?

Dr Kaplan—Yes.

CHAIR—Have you done any work with the Commonwealth Department of Family and Community Services on looking at those people again and perhaps recommending a plan for them to get back into the work force?

Dr Kaplan—Sometimes they send the same people back to me over a period and I can follow their path. It is not an encouraging one.

CHAIR—Do you think there is work that needs to be done in that area?

Dr Kaplan—We have to change our views about rehabilitation in general. I do not recall the name of the gentleman who was injured—

CHAIR—Mr Stewart.

Dr Kaplan—Mr Stewart seems to me to epitomise the problem. Is it fair to say to him, 'We are going to rehabilitate you. You are poorly educated; you have only worked as a manual labourer and now you are terribly injured'? I am at a loss to see what we can do. I wonder whether we should say that there are some people, at this point in the process, whom we cannot rehabilitate. Let us look for a new path. But let us not dangle before them computer classes where they feel utterly frustrated and ill at ease.

CHAIR—What would you see as a new path?

Dr Kaplan—I have not got that answer, but it is better than simply saying, 'Rehabilitation for everybody solves the problem.'

CHAIR—Thank you for that. It was a most interesting submission. Are there any final points that you would like to make?

Dr Kaplan—No. Thank you very much for listening to me. It was a pleasure to be here.

[12.33 p.m.]

COPELAND, Mr Warwick, Treasurer, Australian Rehabilitation Providers Association

DELANEY, Mr Brendan, President, Australian Rehabilitation Providers Association

GORDON, Mr Robert, Vice-President, Australian Rehabilitation Providers Association

CHAIR—I would like to welcome witnesses from the Australian Rehabilitation Providers Association. The proceedings today are formal proceedings of the parliament and warrant the same respect as proceedings in the House. The committee prefers that all evidence be given in public but, if there is a matter you would like to raise as private evidence, please ask to do so and the committee will consider your request. I invite you to make a preliminary statement and then we will move to questions.

Mr Delaney—At the moment, we would like to touch on the major issues that we raised in our submission that we feel really impact on the process of occupational rehabilitation, as we would call it, and to talk about some alternatives which we would seek for improving performance and the strategies for achieving optimal return-to-work outcomes for those, based on best practice activities. We are obviously focusing mainly on the issues of the adequacy, appropriateness and practicability of rehab programs and their benefits.

One of the major issues, from our perspective, contributing to industry injury profiles is management culture and competence. From that, we are talking about attitudes and issues, specifically those of employers, workers and insurance companies themselves. We see that they obviously need to change and the culture of the process that we are all involved in needs to change. These are issues that have been touched on by the previous speakers that we have just picked on in listening to their comments. We feel, too, that there is constant structural change in the economy that we all deal with that can also result in increased workplace changes. There seems to be quite a direct relationship between the onset of such events and increased frequency of workers' compensation claims. Things such as downsizing in workplaces have a direct correlation to the number of workers comp claims going in. So there are issues there that impact on the whole process of workers comp in Australia.

As a national body, we have identified a lack of measurement as a serious issue when it comes to looking at workers comp systems. Basically, this undermines the decision making of all the participants in the management of the rehabilitation system. In terms of data that can be provided to this committee, the association is putting together a national database of case closure information. We have major concerns about the information that is currently collected by the individual WorkCover authorities for each state and territory. We are putting together our own database which will be contributed to by all state and territory jurisdictions in Australia. We are hoping that, within six months, we will have some very valid data that we can provide to the committee, if that is something which would benefit the committee.

Obviously, looking at the adequacy and appropriateness of the rehab programs, legislation in all states and territories generally refers to employer obligations and specific commitments to resourcing such things as in-house management for return-to-work processes. One of our major

concerns is that there is not really enough on how this process should actually work and how it operates within the industries. There is a lot of 'must do' but not 'how to'. We really want to look at some of the issues relating to how to do these processes more effectively. We tend to find large employers, particularly self insures, have the kind of experience that demonstrates the logic and the cost-effectiveness arising from high levels of commitment to effective rehabilitation, including what we see as one of the major implications—that is, early intervention strategies. We tend to see that these people are very active and have very proactive systems in place to manage injuries, and that is from day 1 of an injury.

We see one of the most significant deterrents to successful rehabilitation outcomes is the delay in referral to occupational rehabilitation services. We will touch on a little bit of data that we have which may assist in answering some of your questions on that. Basically, we see achieving early referral and moving injured workers into appropriate occupational rehabilitation services as the biggest challenge confronting the workers' compensations systems today. It is one of the issues which we as a national organisation see as a priority from our perspective in working with things such as the heads of workplace safety and compensation authorities across the board to try to work with them to assist this kind of process.

On the medical side, which I am sure has been touched on a number of times today, we as practitioners in the field have found that the treating doctors have demonstrated they do not have the time, the inclination or the expertise to deal with the injuries and the injury management outside of their own treatment facilities, let alone going to visit workplaces et cetera, which is a major problem. We see that a lot of the focus in the systems is not going to work if there is a heavy emphasis placed on the treating doctor being the linchpin of the whole process.

We also feel that, from a bureaucratic viewpoint with regard to individual WorkCover authorities throughout the jurisdictions, there seems to be no clear benefit derived from very bureaucratic controls. In fact there seems to be quite ample evidence, and we can look at just two areas such as Tasmania and Comcare, to support the view that very good results can be achieved through a less bureaucratic approach to managing the whole process of occupational reputation. It does not need to be overly bureaucratised to be successful, and that is what we are seeing on a regular basis.

There are a number of issues to do with redeployment, which are, again, of major concern to everybody. Obviously, we as practitioners would like to see fewer Mr Stewarts in the whole system. From our perspective we see intensive redeployment efforts can be very successful. However, the majority of the injured employees do become very demotivated and they do give up the search for new work even with continuing occupational rehabilitation assistance. There are a number of factors outside of the payment system which impact upon a person's ability to cope with an injury through the workers' compensation system. Just trying to deal with that in isolation is not effective.

We can provide very intensive programs to assist people in a redeployment phase of their rehabilitation process. More importantly, there do not seem to be enough incentives for the pre-injury employer to actually keep their injured workers in the first instance. Return to work rates are not fantastic for those cases that have as their goal returning to work with a new employer. In New South Wales I think the average at the moment is about 57 per cent or 58 per cent of all those on rehabilitation cases. We would like to see more being done to avoid people having to

move down the redeployment phase, and that is something that can be questioned at a later stage.

As an industry we are frustrated in that without a doubt it is a goal of all participants in the system to see that the injured workers do return to work as soon as possible. We all have the same aim and we are all trying to achieve the same result from our intervention. Unfortunately there are a number of factors which do not always allow us to work in that same track. Again, Mr Stewart and his representative talked about issues with regard to insurance companies and what they are trying to do. We find that quite often it is a huge impediment to our system and our services in that we seem to be working against each other instead of working together—from the doctor, the employer, the insurer to the provider, to the injured worker and all the people involved in that process. These are very numerous when you consider all the participants in the injury management process.

Looking at some of the areas which we feel are recommendations for improvement, we feel very strongly that one of the key points you would focus on—the removal of the existing systemic barriers to the early referral of injured workers—would be to refer to appropriate and professional rehabilitation services. We see that this will maximise the effectiveness of efforts to get injured workers back to work as soon as possible and minimise the losses in both human and financial terms to the system and to the community.

We really welcome as a national industry the role of the relevant state and territory workers' compensation authorities. However, we feel very strongly too that performance standards being used as performance indicators should be outcome driven rather than process driven. We also feel that there needs to be continuing emphasis on the education of employers facilitating their level and assumption of responsibility of the injury management of their own employees. Again, we support the idea of assisting employers to keep their injured workers in employment instead of having them look at the simplest and easiest way to remove them from their books to remove a problem. We all know that what tends to happen is that these people move from the state based system quite often into a federal system through Centrelink and some form of income maintenance program. That is not helping Australia as a whole.

I emphasise the point that education and systems can be improved to look at employers and how they can operate and manage their injuries in the workplace. Keeping the people at work is a vital aspect of what we are saying. Many of our injured workers are unable to return to their former employment for a whole range of reasons. They would benefit enormously from things such as second injury schemes to encourage and to provide more incentives to other employers to take these people on. Again, Mr Stewart indicated what happens as soon as you mention that you have a previous workers' compensation history—and whether we talk about EEO or antidiscrimination, we all know discrimination exists. It happens and it is very frustrating. In the area where I operate, there is, according to the news today, double the national average for unemployment, and therefore trying to assist people with injuries, with disabilities and those with a previous workers comp history back into the work force can be a major obstacle.

We obviously want to maintain as an important option the capacity to settle claims. The reality of it is that people who are injured may not be able to return to work. That is a reality. We feel that performance indicators looking at achieving outcomes can sometimes contradict the process—that is, you achieve getting someone back into work to get a statistic but it is obvious that that person may never get back to work for reasons of their injury. There should be

encouragement to identify those issues and to understand that that is a reality that we deal with every day and that we should not be looking to hide under statistics. If they are out there, we should be dealing with those kinds of issues.

That wraps up the overview of our submission and what we want to look at as the major points. If, as a result of questioning et cetera, there is other information that you would like to obtain from us, we are happy to provide that. The association on a national basis is made up of representatives from each of the eight state and territory jurisdictions that have rehab provider organisations. So it is very much a nationally based organisation, with the council made up of representatives from each of those states and territories. Thank you.

CHAIR—Thank you, Mr Delaney. Would your colleagues like to make a comment?

Mr Gordon—With each of the state bodies, we are looking at dealing with individual jurisdictions in relation to workers' compensation. One of the difficult things is that each state has its own system and its own regulations, while we are dealing with individual WorkCover authorities and the issues that surround accreditation of providers and how those providers are able to operate within each system. The national association was formed to assist and to cover things from a national point of view and to share ideas and concepts and to try and come up with best practice issues in rehab. One of the other things that we have seen on the move is the drive towards a national workers' compensation system. We were wondering whether the committee could outline anything as to the federal government's push towards that as well.

CHAIR—Not at this point in time. My colleagues might want to comment.

Mr HARTSUYKER—No, I cannot.

CHAIR—Did you want to make any further comments, Mr Gordon?

Mr Gordon—No. What is in the paper has covered our position.

Mr Copeland—The issue that has been overlooked in a large number of jurisdictions is that of early referral. One of our providers in New South Wales established back in 1995 a relationship with a large employer whose organisation had been down the track of government ownership, corporatisation and then privatisation. Over that period, the work force consisted of 3,300 workers in New South Wales. In the overall context of New South Wales or, indeed, Australia, that is very small. However, in May 1995, that organisation had a gross incurred cost of claims year to date of $10.4 million. At that time, it had over 500 claims that were sitting there in various stages. Mr Stewart talked about the long-term impact. That is the human impact which the rehab providers are dealing with every day. It is one thing to talk about the financial aspect and the impact on the employer; the impact on the employee is the issue that should be really looked at.

Over a three-year period we saw a situation where the number of days reduced from 131 days down to 12 days from injury to referral. We saw that referral to case closure reduced down to 65 days. Under New South Wales legislation we are required to monitor that file for 21 days from when that person is back to full-time normal duties to case closure. In reality, the cost to the employer was an average of $1,568 per case. In New South Wales currently we believe that the rehab cost per case is running at around two per cent. Back in these days here, and that

particular organisation ran that program for a period of three years, it went from $10.4 million down to $876,000. The state average at that time was $3,562 and we note that today the rehab cost is $3,487 on average per case.

We have seen since September 1998 in New South Wales, with the implementation of the early referral program, that the injury management advisers within the insurance companies are fighting to meet three days. This program here that we were talking about is making contact within four hours and face-to-face contact within 24 hours. That program was based on an employee assistance program as well as a rehabilitation program. We found that 22 per cent of all contacts were personal issues such as the wife is sick, the husband is sick, the kids are sick, they have to go to school, they have to go to a doctor or whatever. Twenty-four per cent of all contacts were industrial relations issues. In that situation the employer was able to handle a lot of the issues before they come onto the workers comp program. In doing that they reduced the cost significantly, as well as maintained their workers within the workplace, kept a far happier work force and certainly saved a lot of money for the state system as well as themselves and so on. In broad terms, I am saying that, if we are going to be looking at early referral systems, it must be early. Three days or seven days down the track is too long. People become hostile with the insurer, hostile with the employer and build up all kinds of resentment. The good doctor talked about psychological and other issues. They get cemented when there is resistance from the insurer or a lack of help. Most of these people sustain an injury, and if we can help them get back into life, normalise their whole life patterns, we reduce the costs and reduce the pain and suffering by doing that.

Mr Gordon—A statistic just released out of WA shows that the average delay for referral to rehabilitation, from the date of injury to being received by a provider, is 263 days. There is ample evidence to suggest that delay to referral, as we have talked about, significantly increases the likelihood that someone will not return to work.

CHAIR—Are they in the figures that you have submitted to us, Mr Gordon.

Mr Gordon—No, these have just been released.

CHAIR—You are going to provide them to us?

Mr Delaney—Rob has mentioned WA. In New South Wales the figures up to the end of July of this year for a 12-month rolling period show that the average period between injury and referral is just over four months. That is for those who are attempting a return to work with their pre-injury employer. Those who, unfortunately, have to go down the redeployment stage wait an average of 7.8 months from injury before they even get to a rehab employer.

Mr Copeland—It is significant to note that WorkCover do not add into the statistics any claim that is over four years old. They do not go into the system. So what they are doing is reducing the actual number of days.

Mr Delaney—What we must add on that aspect, too, is that they do count them as an outcome—they count the costs involved. They are not counted in achieving that figure between injury and referral.

Mr Copeland—That is true.

CHAIR—On page 147 of your submission, you say that the outcome rates for return to work, new employer, were WorkCover, 87 per cent. Is that correct?

Mr Delaney—For new employers on return to work provider results.

CHAIR—So what you are saying is that, for everybody who is injured, 87 per cent of them will find work with a new employer. Is that correct?

Mr Delaney—No. Were you referring to page 6 of the tables?

CHAIR—Yes. I am just trying to interpret it.

Mr Delaney—Under the New South Wales figures, we have two areas that rehabilitation providers are accredited for: those people who are returning to their pre-injury employer and those who are returning to a new employer—therefore, redeployment. At the time of producing this chart, 87 per cent per cent of those whose goal was to actually return to their pre-injury employer did so. That may not be a full pre-injury level—it may be 20 hours a week compared to a pre-injury level of 40 hours per week—but it is a return to work outcome.

CHAIR—They were people who wanted to return to work?

Mr Delaney—They are people who have come onto the rehabilitation process. The referral sources are mainly the insurance companies and the employers, with some doctors and some self-referrals. For the majority of them, it is questionable whether they want to be on rehabilitation and whether there are agendas. However, if a person is put onto a rehabilitation plan, they then become a statistic at the end of the day. The figure below that 87 per cent on the chart shows that, as of April 2001, 53 per cent of those with a goal of return to work with a new employer actually achieved that goal in New South Wales. An update on the figures to July 2002 is that we had a 89 per cent return to pre-injury employment and a 60 per cent return to a new job with a new employer. That is the New South Wales state average.

CHAIR—Does that vary between city and country?

Mr Copeland—Definitely.

Mr Delaney—Very much so.

CHAIR—That seemed to be the point that one of our previous witnesses was making, that there is a big differential between the results in the country—

Mr Delaney—There is a big differential. As part of our initial discussion, I mentioned that the area I come from—which is the same area as Dr Kaplan; that is, down in the Illawarra region south of Sydney—has double the current national average of 13 per cent, which was stated today in the media. Regarding the company that I manage, I note that our figures are well above the return to work average for New South Wales. However, our costs are also well above the return to work average for new employee cases because the intense one-to-one level of service that needs to be provided naturally makes for a more costly exercise. However, we are achieving above a 70 per cent return to work rate in that region, which is a region of high

unemployment. Unfortunately, WorkCover do not provide overall statistics broken up into regional areas to the general public. I am sure that their systems would be set up in such a way that they should be able to provide that information. I do not remember whether WA has figures.

Mr Gordon—We have a similar situation in Western Australia, where the WorkCover authority does not separate country and regional servicing from metropolitan servicing. They will often question why there are significant travel charges for certain case files when clearly the person is living 600 or 800 kilometres from the metropolitan area. Servicing regional clients is a difficult thing. It is a costly exercise. Trying to get return to work results in small communities where the availability of jobs is limited is a very difficult thing to do. We have previously raised regional issues with the state government in Western Australia and rehabilitation is a significant one.

Mr HARTSUYKER—You mentioned that the incidence of claims was higher during downsizing. Do you see that as being due to employers cutting corners in refocusing jobs and the way the company operates or do you see that as maybe a more emotional thing as a result of the corporate ethos going downhill and people being in a lower state of mind and looking for a way out—looking for other security?

Mr Delaney—I personally think there are some issues related to the concerns of what the company is doing. However, without sounding cynical—but I have been in this industry for 18 years—being able to obtain workers' compensation benefits is a way of ensuring continued income maintenance at a rate which is obviously a lot better than the Centrelink system would be able to provide to people who were out of work.

Mr Copeland—Some of the major employers certainly over the last couple of years have implemented employee assistance programs and, if I could use the term, 'departure lounges' for their staff. What we are talking about there is providing professional assistance to people to gain new employment. It is very daunting for people who have been employed with an employer for 15 or 20 years to all of a sudden have to go and find a new job. In those sorts of organisations, employers have reduced their costings quite significantly, and they have also reduced the cost of the human factor. Here in Sydney we have been involved with some government departments where there have been redundancies, and we have seen three senior executives, regrettably too late, who committed suicide.

The breadwinner traditionally has been the male, but that has been changing over the years. When someone has been going out to work for many years and the spouse—be it male or female—is at home with the children and doing other requirements, and they find themselves in a situation where they have nothing to do, they are not skilled at getting jobs in today's marketplace and, therefore, the impact on them is quite significant. They are the people who ultimately have psychological problems. They rely on the social security network and cost factors build up there. It is a growing band. If employers can recognise that as a major problem—and certainly the larger ones are doing that now—it will reduce that particular situation.

Mr Gordon—One of other things that we see on a regular basis is workers taking a lump sum settlement. Unfortunately, no structure is in place to ensure adequate financial counselling for those workers. They receive a lump sum of, say, $150,000 or $200,00, make three or four rapid payments for big items such as a mortgage, house or car, and then they are not able to

access social security benefits because there is a preclusionary period. As soon as the settlement has happened and the lawyers, the providers and the insurance company have finished with them, they are on their own. It does fall down at that end of settlement because there is no financial counselling support or otherwise on how they should manage their funds and particularly on how to return to the workplace. People try going into business, but 60 per cent of small businesses fail in the first year. I was not surprised to hear Mr Stewart's story earlier. Those things happen; we see them happen regularly.

Mr DUTTON—Are any statistics kept in relation to that sort of situation? Are you aware of any research that has been done on people who have been paid a lump sum with bad results?

Mr Gordon—Not specifically. One of the problems is that each system has its own jurisdiction and each jurisdiction has separate common law facilities. This is one of the issues that we are trying to overcome. What is needed is a rehab services provision that ensures that national databases keep information that is going to compare apples with apples.

Mr DUTTON—If you look at the three different tables that you have provided and the comparative data, you can see that in Queensland, for argument's sake, some of their record keeping in relation to this area is appalling. Mr Delaney, you spoke before about 56 or 57 per cent of people being redeployed. That leaves essentially 44 or 43 per cent of people. How did you break those figures down? What group would you put those people into?

Mr Delaney—Depending on the situation with their entitlements and whether they look at receiving a commutation from the workers comp systems, I do not know what figures there would be but they would either be continuing on as long-term workers' compensation cases and so become what they call a tail of the workers comp system, which is actually growing on a yearly basis, or they may well receive some form of settlement payment through either common law or just commutation through the system. Then, as Rob was saying, whether they remain on their own income maintenance or have to revert to some other form of income maintenance, I do not know because I do not know what data is actually kept.

Mr Copeland—Six years ago we were advised by WorkCover (NSW) that we had 35,000 cases in the tail. They are people who can be 52 weeks plus receiving some form of benefit from $5 a week through to several hundred dollars a week. In December 2000 the industry was asked to attend WorkCover to discuss ways of managing the tail. WorkCover stated at that time that the tail had grown to 60,000 cases.

Mr DUTTON—Over what period of time was that?

Mr Copeland—From 1996 to 2000. In September 1998 we had the injury management advisers implemented within the insurance companies that were going to stop the claims increasing. If you have a funnel that is four miles wide, you are going to catch every claim that is coming through and it increases that number. If you stop the claims coming through by better management, earlier referral, earlier contact and earlier dealing with the human issues, such as the barriers that people have within their particular situations, be it the treatment for their medical condition or family issues, that reduces the number. We believe that tail is something like 80,000 claims. WorkCover had been commutating something like 15,000 claims per year. So the commutation has not been the panacea for all ills nor has it been the panacea for all ills to have the injury management advisers. It is about being face to face and dealing with the human

issues with the claimants as well as with the employers. The employers will say they do not have suitable duties for an employee. In a lot of cases, we should get in there and look at what is going on and negotiate on those various different issues and other issues such as treating doctors. We have a situation where treating doctors sign off all the plans. Doctors do not—and we state it in our program here—have the time to go into the workplace. They do not understand the industrial relations issues or, indeed, the financial issues within the workplace. They may understand some of the issues within the injured party's family situation, but certainly they do not understand any of those other issues. Being able to put those issues together certainly will help to get those people back to work a lot quicker.

Mr DUTTON—What are your views on the provisional liability provisions that have been brought in from 1 January this year?

Mr Copeland—I made the comment earlier that the insurance companies are fighting to try to meet the standard of three days—that is for a significant claim that is going to be seven days plus. If they can get that down to within 24 hours, yes, you have a possibility. The reason I raised that example was that that was accepting liability for whatever—personal issues, industrial relations issues and workers comp. There was no problem at all with the employer or the insurance companies accepting that. That reduced the costs significantly and reduced the human impact significantly. I believe that that will be of benefit in New South Wales. However, we are finding that can be anything from three to seven days from that IMA making contact with the claimant.

Each of the claimants, each of those IMAs, is running with somewhere between 250 and 300 files. I do not know about anybody else, but I have difficulty handling three or four issues, let alone 250 or 300. The amount of time that those IMAs are allowed to submit to those individual claims is not enough.

Mr DUTTON—I know this is outside the scope of your submission, but is it going to restrict fraudulent activity or is it going to encourage it?

Mr Copeland—I guess the insurance companies are feeling very threatened by that and saying that this is going to increase fraudulent claims, but if the system is there, if the early referral screening process and rehabilitation process—and that is really what we are talking about—are there, that gets these people before they get into the condition mode. Let's face it: the medical fraternity, and even the rehab fraternity and the insurance fraternity, coach claimants to become very good if they are fraudulent. They become very good at what they ultimately set out to do. By getting early contact, getting into those people, dealing with the issues, breaking down each of the barriers, resolving those and then moving on, we should help to reduce the funnel opening at the front end.

Mr DUTTON—What about views on the legal fraternity's role in this whole fiasco? They are the creators of many ills in our society. How can we best deal with that side of the problem in this industry—and it is an industry that in many ways they have created and nurtured?

Mr Delaney—On the issue of provisional liability, just here in New South Wales, obviously, that may have the benefit of reducing disputes with regard to payment for appropriate medical treatment and for payment of wages to ensure that everybody can still meet their commitments—mortgages, child care, whatever—on a weekly basis. What we tend to find is

that, in the past, a large majority—and we are talking in the vicinity of 65 to 70 per cent of claimants who get to a rehabilitation provider—have already seen a solicitor. Talking about the delays between injury and referral, in some cases that might be seven, eight or 10 months. It is not out of the question that that may have occurred. But the fact is that the system encourages visiting a legal representative very early in the process. If the payment of wages, payment for appropriate treatment and getting appropriate attention from employers are dealt with very early, we would envisage that that should cut down the level of dispute. Looking at New South Wales costs again, going back to the last costs I have from WorkCover, 11.8 per cent was spent on legal costs in 1999-2000, compared to two per cent for rehabilitation costs. There is a huge problem when that kind of thing occurs. Again we would hope that, if things were dealt with appropriately within day 1 of an injury—getting back to what Warwick spoke about—you may divert a lot of those people who end up going down a legal path.

Mr DUTTON—We are dealing, obviously, with the human aspect that has been identified already and these people have been captured within the system for an eternity. But, like the public liability insurance argument that has been raging in recent months, it is a similar sort of parallel debate in this area. We have not really taken any evidence so far that looks at disincentives to the legal fraternity continuing to prosper out of these people's human misery.

Mr Gordon—It comes back to one of the points we made. If you can develop management culture towards dealing with the injured workers and the injured workers' approach to injury management at a very early stage, people will be far less likely to feel the need or pursue the need to seek legal involvement.

I remember an occupational physician at a seminar once said that he had never treated an injured worker on the day of injury who did not actually want to return to work. It was only as time went by that the psycho-social issues developed. The injury became less of the actual problem and more the external issues and the legal involvement and those sorts of things actually developed. If there is a good management culture within the employer organisation towards assisting an injured worker's return to work immediately and safely and seeing them within four hours of the injury, then a relationship is strengthened with the employer and the employee rather than one where the employee goes off to see a solicitor because their neighbour over the back fence says, 'You've got to go and do this,' or they have a seen a television ad that says, 'Come and see us and you will get the compensation you are entitled to.' It is that 'entitled to' expectation that needs to be taken out of the system, and people should just get back to work.

Mr Copeland—In relation to commutation, an article in the *Sydney Morning Herald* some six or nine months ago stated that in the previous 12 months—if my memory serves me right—$424 million was paid to claimants for lump sum benefits or commutation and $435-odd million was paid to legal practitioners. When we look at the impact of those people—and the gentleman who was here earlier talked about his benefit of getting a payout: it did him no good whatsoever—the focus should always be on normalising their life and getting them back into the workplace and on dealing appropriately with the human factors—the injury or other issues—that they have so that they are not impacting on the public purse. Stress and other psychological issues need to be dealt with; otherwise, they come back on the public system.

CHAIR—On that very positive note, thank you, Mr Delaney, Mr Gordon and Mr Copeland.

Proceedings suspended from 1.17 p.m. to 1.45 p.m.

GAILEY, Miss Lynn Elizabeth, Representative, Labor Council New South Wales

YAAGER, Ms Mary-Louise, Occupational Health and Safety and Workers' compensation Coordinator, Labor Council New South Wales

CHAIR—Welcome. The proceedings today are formal proceedings of the parliament and warrant the same respect as proceedings in the House. We would prefer your evidence to be given in public, but if you have some matters you would like to raise in private you can ask the committee and we will certainly consider that. I invite you to make preliminary statements and then we will move to questions.

Ms Yaager—From the unions' perspective in New South Wales, we are very happy with the occupational health and safety laws in New South Wales. The union movement think that we probably have some of the best occupational health and safety laws in the world. Certainly our enforcement is up there in terms of world standards, and the same can be said of our workers' compensation. The unions in New South Wales generally are happy with the scheme in New South Wales. Even though we had a dispute with the government over some of the reforms, we are happier with the New South Wales scheme than any other scheme that is operating. We believe that we have the most generous benefits. In particular, the new reforms that have gone through in terms of provisional liability are excellent reforms. There have hardly been any disputes since the reforms were implemented in January, and there have only been half a dozen disputes in the new Workers' compensation Commission; so there is a lot to be said for the way that scheme is operating. Also the latest actuarial advice indicates that the scheme is going forward well, claims are down and people are returning to work. Even though it is early days, there is certainly a trend of people going back to work early. We believe that is because, when people are paid on time, disputes are less likely to occur. People are getting treatment early and that is really encouraging and certainly beneficial to any scheme.

Miss Gailey—We obviously support everything that Mary has said. Our concerns remain primarily those of enforcement. In particular, in the sector that we represent—which is a highly freelance, casualised sector—there remains a worrying level of uninsurance. There is also an increasingly trend towards forcing people to work, notwithstanding the arrangements that exist, as subcontractors and towards forcing the individual to bear the workers' compensation insurance liability rather than have the company for whom they are working accepting the responsibility for taking out policies appropriately. So our concerns are about insurance and non-insurance on the part of employers.

Ms Yaager—There has been a lot of work in New South Wales, and the New South Wales government has recently released a compliance report which we hope is going to improve the area that Lynn has just highlighted—if the legislation is changed to implement the recommendations of that report.

Miss Gailey—Also the recent move in New South Wales to a single notification scheme is going to facilitate better levels of compliance in the reporting of claims. It has not been implemented, so it will be some time before we see the impact of that, but certainly the responses they have had from employer organisations are that that will assist.

CHAIR—Would you like to make any more statements to add to what you have said?

Ms Yaager—No. We would rather take your questions, so you can get our views on the issues that you are concerned about.

Mr DUTTON—We had some evidence today in relation to the tails in New South Wales WorkCover increasing quite dramatically—over the period from 1996 to 2000, almost doubling to $60,000. Do you see that as a concern? How could it be addressed, particularly in light of your submission in which you claim that 'employee fraud in New South Wales is negligible', which flies in the face of all the evidence we have taken to date?

Ms Yaager—No, I do not think so. In the past, those claims have not been managed very well. I have a background in insurance. Before I joined the union movement, I worked for a major insurer and I used to manage claims. What has happened is that those claims have not been managed well. Often claims sat there for six months before the insurance company determined liability and without the person returning to work. Therefore, the person was often terminated and they became a liability on the scheme because you had to continue to pay them. If somebody has been unemployed for six months or beyond two years, it is very hard to find alternative employment for them or for them to go back with the previous employer, so they become a liability on the scheme. There are two ways you can manage those claims. You can offer those claims a lump sum and buy them out—buy out your liability—or you can look at proper redeployment schemes and employment incentives for employers to take those people back to work. Those are the only ways to manage the tail. The tail has blown out also because of the return on investments. You will know that that has been a problem for the superannuation schemes as well as for the workers' compensation schemes.

Mr DUTTON—Fraud in the WorkCover scheme across Australia—and I imagine in New South Wales in particular—costs tens of millions of dollars a year. How can you claim—

Ms Yaager—Where is the evidence?

Mr DUTTON—that it is negligible?

Ms Yaager—Define 'fraud' for me.

Mr DUTTON—Hear me out. I want to know on what evidence you base the statement in your submission to this committee:

The Labor Council notes that whilst employee fraud in New South Wales is negligible ...

Ms Yaager—We have not seen it; it has not been demonstrated. No evidence has been put forward of employee fraud. Define what you are talking about in terms of 'employee fraud'. Where is the evidence? There is plenty of evidence of employer fraud, underdeclaring wages or not having workers' compensation policy. Time after time, the unions present this evidence to WorkCover. But, by the same token, WorkCover or the insurance companies do not bring forward these fraudulent claims. They have workers' compensation claims, yet why do they not run these claims as being fraudulent?

Miss Gailey—And it is worth noting that, in a substantial review of workers' compensation in New South Wales that led to the new legislation, all the work that was done demonstrated that employee fraud was of such little significance that the government moved to provisional liability, for the very reason that it was considered that fraud would not impact in any financial way and the benefits would dramatically outweigh the extremely low levels of fraud that do exist.

Mr DUTTON—You are not alone in that belief, but it is certainly not a widely held belief.

Ms Yaager—But there is never evidence to substantiate the claims put forward by those who share the view that workers are fraudulent. In our experience, we do not believe that to be the case.

Miss Gailey—And clearly in the review in New South Wales that evidence was not forthcoming; otherwise; the government would not have reached the conclusion that they did and moved to provisional liability.

Ms Yaager—All those claims are obviously being paid. There has not been one claim brought to the new Workers' compensation Commission of employee fraud.

Mr DUTTON—I do not know that that is the case. We have taken evidence this morning of particular problems with the judiciary. There have been particular cases where stark evidence of video surveillance footage has been presented before a commission or a court which has been dismissed out of hand and not taken into consideration in the deliberations and the ultimate outcome of that court process. It is clearly a very difficult situation for employers and for the courts to acknowledge that this fraud is present. So, before you launch into those claims, there is a systemic problem here that has been identified which we are trying to deal with in part as part of this process.

Miss Gailey—All that we can say is that in the course of the review in New South Wales that evidence was not raised and if it had been, as I said, I do not believe the government would have made the decision that they did.

Mr DUTTON—I do not have anything further.

Miss Gailey—In respect of what you are saying, those cases simply have not been presented to us, so we are not able to comment.

CHAIR—You recommend severe penalties for employers who fail to genuinely attempt to rehabilitate injured workers. We have had submissions from employer groups expressing frustration at the lack of participation by injured workers in attempts to get them back to work. The expression that was used was that people undergoing rehabilitation or occupational therapy become absorbed by the process and focus more on that than on the end objective, which is getting back to work. Obviously, this is a complex issue and there are many shades of grey in it

Ms Yaager—Yes.

CHAIR—But how do you see that that could be further enhanced to get a better outcome?

Ms Yaager—It is more about the employers actually taking a lot more control. As soon as they have an injury, employers do not want to know about it. They let the insurance company handle it and manage it and it goes off to a rehabilitation provider. But, if employers were actually educated and had the support system to support them once an injury occurred and had more intensive early intervention with that claim's management, I think that that would be the key. Most successful rehab providers that work with employers say that when the employer gets actually actively involved in a claim earlier on they can actually stop that happening—that is, stop the worker not returning to work or getting caught up in this rehab that should not be taking place. If there is overservicing, for example, they would be actually monitoring it and providing a quality assurance role over the rehab providers.

CHAIR—The overservicing is another question. How does one ensure that that does not happen and that in fact it is not becoming an end point in itself?

Ms Yaager—I want—and we have put this through the workers comp advisory council in New South Wales, of which I am a member—to get back to educating general practitioners and actually getting doctors to take more of a role in the whole clinical management of a patient, including the return to work, so that the doctor is actually managing that whole process to make sure that that overservicing does not occur. That is not only with rehabilitation providers but also with physiotherapy or ongoing treatment. So, if the doctor is actually educated and we allow them to play a pivotal role, that is the way that we can go to controlling the costs in that area.

CHAIR—We had a submission this morning about stress and psychological injury, if you like. The witness tended to indicate to us that—fraud is perhaps the wrong word—not all stress situations are actually pathological. Is that a situation that you see as well?

Ms Yaager—No. The doctor making the diagnosis actually has to be very specific in issuing a certificate about what the person is suffering from. But there are different forms of stress. If you are talking about ambulance officers and police officers, who as a part of their employment develop post-traumatic stress, we see quite a bit of that in the union movement as well as psychological stress. But the psychological stress I see is often coming from people working longer hours and trying to balance their family life and all of that. That often leads to stress. When we survey our members, the stress that the union movement sees actually arises from a lot of those types of things.

CHAIR—Is that pathological or is that simply the sort of stress that you see now in the drought situation or in the families associated with this terrible disaster in Bali? Is it actually pathological? Is it a mental illness?

Ms Yaager—For somebody claiming for stress, it has to be pathological. For them to claim for stress, the doctor actually has to follow a strict criteria for the diagnosis. Also, the insurance companies thoroughly investigate those claims. If they do not think that they are work related, they do not have to pay them under the new provisional liability. That is one of the excuses that they have for not paying a claim. We have not seen very many stress claims going to the new workers comp commission, so it appears that most of them are genuine.

CHAIR—On another point, do you see any difference between rates of rehabilitation and final employment in the country areas in New South Wales versus the city?

Ms Yaager—Most definitely. The rural sector is just dreadful. The latest research says that there are two deaths per month on Australian properties, and that is notwithstanding all of the injuries. Often, people are injuring their own—they are not only injuring workers but injuring their own children and family members. It is very hard. I do not think any of you are doing research into the rural sector, either, about how we can offer farmers incentives to take somebody back once they are injured or how we can offer them a financial incentive while that person is rehabilitating for somebody else to assist them. These are all the recommendations that the unions have been putting forward for years. If you really want to look at rehabilitation and redeployment, you have to actually look at financial incentives for employers to take people back to work.

CHAIR—Thank you very much for appearing today.

[2.02 p.m.]

GAILEY, Miss Lynn Elizabeth, Federal Policy Officer, Media Entertainment and Arts Alliance

CHAIR—I invite you to make some preliminary remarks.

Miss Gailey—From our union's perspective, one of the biggest issues that we confront—apart from, as I said earlier, employers who are expecting people to work as a subcontractor, notwithstanding the genuine relationship that they are entering into—is a real concern about the lack of harmonisation between workers' compensation legislation around the country. As we indicated in our submission, we regularly have members who find themselves literally in a black hole because of where they were employed, where they are subsequently working and the lack of harmonisation between the jurisdictions. We do not particularly want to—and I do not think the federal government thinks this is the case either—move to a national scheme at all. But we do think that there is an urgent need to address those gaps so that people, notwithstanding their best efforts—and best efforts on the parts of their employers as well, who have often taken out three and sometimes four policies in different states in anticipation of being covered—do not find when they are injured that they have nowhere to go.

We think that the federal government could potentially play a role in moving the states towards harmonising the legislation. Maybe a better alternative would be to establish an uninsured liability and indemnity scheme federally for those circumstances where people do fall between the cracks. In the same way that there is a scheme like that in New South Wales, which addresses primarily people whose employers have not taken out a policy, at a federal level there could be a scheme that would address the gap. So somebody who used to live in South Australia, as we indicated in our submission, who subsequently moves and then is engaged by someone in South Australia and injures themselves in the ACT may find that they are on their own.

I would imagine that there would be some synergies here with the road transport industry, and there would be other sectors. It is a real issue for our union in that it is an incredibly mobile work force, because film and television production, for instance, takes place across the country—notwithstanding where the production company might be based—and because live theatre and concerts tour.

Mr HARTSUYKER—If a production company, for argument's sake, were based in Sydney and employed somebody from the industry who travels to North Queensland, is that person not covered under the New South Wales policy?

Miss Gailey—Let me say at the outset that I am not the world's greatest authority on all of the legislation and all the jurisdictions, but if a company is based in New South Wales and takes out a policy in New South Wales the policy travels with the employees.

Mr DUTTON—Yes, that is my understanding.

Miss Gailey—If the company is based in Queensland and hires people from interstate, those people will be covered in Queensland unless they cross the border into New South Wales. In that case the Queensland people will be covered but the people from other states will not be—and variously the ACT legislation is different. The problem is that all the legislations are a bit different. You end up with a complicated set of arrangements, and companies—no matter where they are based—will often crew and cast nationally and then they will move.

Then you have the other circumstance which happens in live theatre particularly where you might have a company set up in New South Wales and they will use a New South Wales company for the New South Wales season and then effectively close their books and open up a Victorian company for the Victorian season. So, if you have an injury that travels across the two, you can have a great big hole in the middle there as well. It is almost as though every time we run across one problem there is another set of circumstances we have not met before. That is why we tend to think that a federal scheme is needed to pick up those people. In these instances, it is not simply a matter of the employer's lack of good intention; it is just that there has not been a way in which those people could have been insured.

Mr DUTTON—How would we get people back to work specifically in your industry? It is obviously a difficult scenario. The ultimate outcome from much of the evidence we have taken is to get people back to work as quickly as possible and redeploy and rehabilitate. But how would that be possible in your industry?

Miss Gailey—It poses enormous problems. Some companies such as the Sydney Theatre Company—or major symphony orchestras, the Sydney Opera House, the Australian Opera and the Australian Ballet—continue on, whereas the real issue is in film and television, because somebody can injure themselves and the production can finish two weeks later and there are no jobs at all to go back to, let alone suitable duties. For instance, you might have a grip whose work is rigging and that sort of thing. Even if the production has not finished, suitable duties are unlikely to be found in the costume department. So there are real issues in this kind of industry—finding suitable duties and the fact that there may well be no jobs at all by the time a person has recovered. The area of commercials is the other area in which people might be employed for only two days. That poses a really big problem.

CHAIR—It is a similar situation to that of the trucking industry. That is not to say the roles are the same, but they travel interstate a lot and they have found a very similar situation. What would your advice be to us to overcome that—some sort of Commonwealth leadership to see that the states have a uniform approach?

Miss Gailey—I think a scheme that covers those who are uninsured, for whatever reasons. I do not think there would be a massively huge call on it, because I do not think there would be terribly many industries outside ours—road transport is an obvious one; IT might be another—where people are moving to the extent that they are in the sectors we cover. But, if there were a federal scheme for the uninsured, that would really assist.

CHAIR—What do people who find themselves in this unfortunate situation of being injured and not having insurance do? Do they fall back on the social security system?

Miss Gailey—They have to.

CHAIR—So again the Commonwealth picks up because the states do not have a uniform approach.

Miss Gailey—Yes, that is exactly right. It goes back to the federal system anyway, because they are on sickness benefits.

CHAIR—Do you have any nationwide figures on the number of injuries per year in media and entertainment?

Miss Gailey—Unfortunately we do not. As I said earlier, things might improve with the single notification scheme. We do not have those figures because the data collection is handled differently around the country and because there are a number of self-employed people who often do not report at all and just wear the injuries. A lot of people just do not claim. I was talking with WorkCover the other day about the number of people in film and television who have lost fingers in the last couple of years, and they looked at me in horror and said that they did not know about any of them. That is sometimes because people have not made a claim—they have just said, 'I'll get it sewn back on and get on with the job,' and sometimes because they have been put on a subcontractor arrangement and have not bothered to claim on their own policy, if they have one. So data collection is incredibly difficult.

CHAIR—How can someone believe they are an employee and then find later that they are a subcontractor? Are their contractual arrangements with their employer not very clear?

Miss Gailey—You will often find in film and television, where people might only be engaged for a couple of days, that it is done over the phone and nothing is in writing. Then when it comes to the crunch they will say, 'But you were a subcontractor.' We have also had instances with overseas companies which pick up a whole set of other legislation that the federal government has just completed a very big review on and is moving to fix in a lot of areas. Our submission mentions one of our members who was killed—

CHAIR—Yes, I read that.

Miss Gailey—working for a British company. They had just issued contracts deeming that everybody would be a subcontractor. They did not take up workers' compensation and they remitted no PAYG tax. They avoided a vast array of things just so that they did not have to pay a whole set of taxes—payroll tax and all the rest of it. People will take the jobs because, for performers, we are looking at 90 to 95 per cent unemployment in the industry at any one time. So although we can say to people, 'You do realise that these two days' work could be your last if something goes wrong,' people are so desperate for the work that they are going to take it. That is a real issue. The other area that is a real problem is credit card films—you have probably heard of them—where people are making films with effectively no budget. They put the costs that they absolutely must outlay on their credit card and talk people into working for nothing in the hope that this will be the breakthrough film that will set them up for life, and they have no policies at all. Obviously the union does not support those kinds of arrangements, but they go on.

CHAIR—I had never heard of a credit card film before. Now I know what it means.

Miss Gailey—Obviously that cannot be addressed by this kind of inquiry. The areas that are your concern are those where people are being asked to enter into relationships which the tax office, the union and any number of other authorities would characterise as employee relationships but they are being asked to be treated as subcontractors.

CHAIR—Is your union state based or federal based?

Miss Gailey—Federal. We have state branches but we are also federal.

CHAIR—Is there an award per se?

Miss Gailey—Yes, there is.

CHAIR—Is that a federal or a state award?

Miss Gailey—There are so many of them. We have a number of state awards and we also have federal awards.

CHAIR—Miss Gailey, thank you for that.

[2.15 p.m.]

MARCHIONE, Dr William (Private capacity)

CHAIR—Welcome. The proceedings today are formal proceedings of the parliament and warrant the same respect as proceedings in the House. We prefer evidence to be given in public but, if there are some matters that you would like to submit to the committee in private, we would be happy to consider that request. I now invite you to make some preliminary statements and then we will follow on with questions.

Dr Marchione—Before I commence, I would like to present to the committee a summary of my speech.

CHAIR—Thank you for that.

Dr Marchione—I would like to thank you for inviting me here to give a doctor's perspective on the problems you have outlined and that we are addressing. Firstly, I would like to address the problem where the data on the incidence and costs of fraudulent claims is lacking. This lack of data occurs due to various reasons that I have noted in my summary. One is the lack of information sharing which is due to the onerous privacy laws. Another that I have found is the lack of a subclassification system for fraud. It is all bumped into one group. In the COP system, the police differentiate by classifying the institution where the fraud was based—for example, financial retail. However, studies done in the States have found it useful to subclassify fraud into the different types of insurance fraud—workers comp, CTP; they are separate.

There is also a lack of a standardised data acquisition tool. We do not have that. As a GP, I think that we form an important structural link between the insurers and the workplace. If a claim goes on, we have a very significant power in convincing the patient to go on or not to go on with a claim. We have a lot to give to an inquiry which is looking at trying to minimise fraud. Often the first cog in the process is to see the GP, and their attitude could be sympathetic or indifferent. For instance, with someone who does not care what the insurance company has to pay, you often find that their attitude is: 'Oh beauty, that is an insurance company; that is a $48.50 consultation instead of a $23 one.' As a GP, I have gained the impression that the level of fraud at all levels of insurance is increasing. I have no figures for that because of the reasons that I have mentioned, including privacy and the lack of a tool with which we can document this type of behaviour. That unchallenged assumption is one major reason for my recommendations.

CHAIR—Anecdotally, within your own area of work, do you see this increase?

Dr Marchione—Yes; I see the threshold at which people make a claim is much less, and it depends on external influences rather than on their own problem. A determinant might be a financial problem, so basically how sick they are will depend on other problems in their life—and often money is the solution. As GPs, we see people who ask, 'Doctor, can I make a claim on this? I did this 15 years ago, but I went snow skiing and slept in tents on the rough turf and I woke up with this back pain. Do you think the thing I had at work 15 years ago could have contributed?' If you are in a situation where the patient trusts you and they have been seeing you for years, you are in a dilemma. They may have admitted to you that it is fraudulent. You

have a dilemma as to whether to reveal the fraudulent nature of the claim or abide by the fiduciary doctor-patient privacy relationship. I am not sticking to my speech at all, but anyway.

CHAIR—I interrupted you. I apologise for that.

Dr Marchione—That is all right. I think that GPs have a lot to give. Once a train of claim, as I call it, is commenced, it is often difficult to reign in. I have submitted a system of documenting undesirable patient behaviour. The reason this is important is that insurance fraud in the States, where they have looked at it, costs about $100 billion a year, and they found that bodily injury claims accounted for 50 per cent of that. So I think it is very important, and GPs have a big role to play if you are serious about looking at cutting fraud in the future, because it is becoming more and more sophisticated. The privacy laws and the rules we have on the nature of the doctor-patient fiduciary relationship need to change. We need to alter the strategy when looking at this problem. If we do not, the rules will become safe havens; fraudsters will know what the laws are and they will know what to do and what not to do to get around them. If you keep changing them, you must have an open view in the long term. In the long run we need to have an open mind towards the privacy law. It is not the be all and end all.

I have also noted a contradiction. The national privacy principles, which came into effect in December last year, very specifically outline an exemption in 2(f). A group is exempt if 'the organisation has reason to suspect ... unlawful activity'. It used to be only in a life or death situation; now they have expanded it. If you get doctors to document undesirable patient behaviour—that is, fraudulent behaviour, which is one group on my database—and you can provide an adequate indemnity to them, or any member of the public, you can have a system that prevents fraud before it happens, rather than wait to count the costs afterwards and lose all that money. There are merits in a system where you can prevent fraud occurring and use GPs to report it much earlier. But you have to have a reason for them to want to do it. If it is not worth it for them, they will say, 'That is an extra job we have to do'.

Mr DUTTON—What motivates doctors?

Dr Marchione—I can tell you now it is not money! It must be something else. I have found that there are innate problems in the system and we must overcome them to try and eat into this for the future. One is that there is denial that it is occurring. I know it is; we just have to get the figures. I have outlined that we need to be open-minded in the future in relation to our rigorous laws. These become predictable and safe havens, if you know what I mean, for people in the future and future claims. We have a dilemma about not reporting someone for fear of the privacy provisions, but we have an obligation to report a criminal act. I think there is a code or law that we have to do that. Is that right? I am not a legal person, but I think there is. Then there is dilemma that we are damned if we do and damned if we don't.

You have the submission titled 'A monitoring system' in front of you. That allows for transparency which will follow when a service provider and a service receiver—I am the service provider and the patient is the service receiver—are equally accountable for their actions. This is supported by recommendations 30 and 31 of the Ipp committee, which has just finished their inquiry. The panel's view was that a court is entitled to reduce contributorially negligent plaintiff damages by 100 per cent, whereas previously it was a maximum of 90 per cent. There must have been a lot of 10 per cent claims going through. I did not know that a plaintiff could only be contributorially negligent up to 90 per cent, so they would always get 10 per cent. I

found that crazy. I heard some legal people saying it was bloody hard to get settlements now that people are fighting. We might find that judges look at things differently now. But that is down the track, when they have had WorkCover pay for a lot of their time off, for income protection, whatever, and I think prevention might be better than getting to that final settlement stage because the train of claims is long.

A response I got from the federal Department of Health and Ageing on my monitoring system was not that they were not interested but that they saw the Privacy Act as being the limiting or prohibitive feature. However, on the other hand, there is a federal privacy law that says you are exempt if you suspect there is a criminal act. Being in a general practitioner's seat, I feel that that is when we have to act to prevent it going down the track, not when they see the physio who will send it back to another doctor, who will send it back to the doctor. I think any new workers comp claims should go through a GP other than the regular GP, because what you find is that people will put you on the spot. If it is someone new and independent, someone who has never seen them before, then that doctor does not mind saying, 'It does not sound right to me.' I approach it that way. I see a lot of people who just do not claim. I know I am not supposed to do it but I give my opinion if they ask me. I will say, 'It doesn't sound like it. I cannot tell you if that is from that, because I am not a specialist, but ...' You can tell false claims.

I think there is a failsafe mechanism you can use if you look at the monitoring system. If you had, say, three different doctors who say that this patient is exaggerating 90 per cent or 100 per cent, that might be a good thing. There are doctor shoppers. Once they have seen 13 doctors in two months they get a call from the Health Insurance Commission, whose data mining techniques allow for that. Data mining uses all these parameters. You can use the doctors classification in my system as one of the parameters. Because all these things get put on the same time grid you can get a graph of a patient profile over a certain time and within certain populations.

I have already spoken to people from the data-mining school out at ANU. A lot of them deal with the CSIRO in doing research. They have various tools they use. I am not saying that they have endorsed the product, but they were interested in hearing more about it and in seeing if there was any government interest. I will finish on that point. The main aim of my presentation is to obtain preliminary feedback from government with a view to further developing my tool in conjunction with the research groups as I have mentioned. That would be on a trial basis at first of course. Applications and benefits will flow from this monitoring system.

CHAIR—Dr Marchione, thank you. That was a very helpful overview. You are very interested in developing Fair Go Mate, which is a monitoring system.

Dr Marchione—Yes, that is my company name.

CHAIR—Great name! And this monitoring system for—

Dr Marchione—It is subjective to doctors' impressions. A lot of employees find that fraught with danger, and I agree with that; however, we do not have anything better than this at the moment.

CHAIR—I will pass to my colleagues first, because I talk too much.

Mr DUTTON—Not at all. Doctor, you said that you have had some dealings with the Department of Health and Ageing. One of the barriers they saw was the privacy issue. Did they raise any other concerns?

Dr Marchione—They said that my system fell beyond the boundaries of Medicare data accumulation. I can submit my correspondence with them for you if you want to read it. They said: 'All medical data collected by the Commonwealth relates to provision of Medicare and falls under the Health Insurance Act and must meet strict legal privacy and confidentiality criteria; therefore it would be unlawful for the Commonwealth to assist or support collection of patient data'. I think they were under the impression that I was a private institution wanting to sell patient data. The reason I am here is that there is a problem that I want to solve. Whether my system gets used by Medicare, the Health Insurance Commission or a body such as WorkCover, that is what I am here for. WorkCover's response was similar: 'We are bound by privacy issues.'

Mr DUTTON—My point was whether that was the only issue that they raised.

Dr Marchione—Yes. That is it.

Mr DUTTON—They were not critical of your system; they did not suggest that it could do this already?

Dr Marchione—Other people have mentioned that it is subjective; it is due to a doctor's impression. That is what WorkCover said. They said that it is reliant on the accuracy of a GP's impression, but there are mechanisms whereby you can overcome that. You can get three different opinions. If three different doctors get the same opinion, then you are likely to be right, but not 100 per cent. There is no better system at the moment.

Mr HARTSUYKER—You raised a point that has already been raised about the fact that a family doctor with a long-term relationship with a patient would give a different answer to that of a doctor dealing with someone who just walked in the door and posed the question, 'Is this a work related injury?'

Dr Marchione—You approach it differently.

Mr HARTSUYKER—Yes. If you get someone who goes around doctor shopping—

Dr Marchione—It is not only for drugs but also for certificates, pills and opinion—which is much bigger.

Mr HARTSUYKER—It would be a very simple reporting exercise, I would have thought, to have a couple of fields in a reporting mechanism indicating the fact that someone has approached you with a particular complaint on the basis that it is a work related claim. Once he has done that three or four times, one would expect that that would be very useful information.

Dr Marchione—Yes, I think so.

Mr HARTSUYKER—I find it interesting that more barriers are put up for something that has some significant potential benefit.

Dr Marchione—This is the second response that I had from the Commonwealth department of health. The first one I had was even more condescending. I was approaching the insurance problem and saying that contributory negligence is going to be much more important for claims in the future, for the reasons indicated in recommendations 30 and 31. To get contributory negligence, you would need to improve the information that a magistrate has, so you would need a mechanism like this to document behaviour. It is not intended to take the power of the magistrate away, but it is intended to help them make a decision. They use the test of reasonable doubt, so how they make that decision depends on how much information they have.

If you have a system like this, which is centralised, although bound by privacy principles, there could be an exemption. If you could indemnify doctors from doing that, then the system would be beneficial in the long run and we could cut down on fraud costs by prevention. You will see it in the four groups I have formed. It is a risk management tool, so if people do not want to take their tablets or do not follow up physiotherapy—I get it all the time: 'I didn't go to the pool this week' or 'for the last three months; she's hopeless up there,' and I ring up the lady and she says, 'He hasn't turned up'—how do you document that? You do not; you cannot. If we even try, they can sue us for libel.

But there is an exemption to the privacy law. You must enforce that to the department of health if you want to make something like this work. The lawyers in the department of health should know that, especially considering what this guy said who responded to me the first time. And he was a lawyer! He said, 'No, you can't do that; forget it.' Of course, since then, the results of the negligence committee have changed the proportion that a judge can give for liability, and it is equal now. I have tried to get some endorsement. People in the research area at CSIRO were interested. Simon Hawkins does a lot of that stuff. I cannot say that it is CSIRO who is interested. He said that it is good but that we have to get a preliminary response from government first.

CHAIR—That has been very helpful, particularly the point you made about someone initially presenting and exploring the opportunities for claiming workers' compensation. I notice that federally somebody applying for a disability support pension has to go through a different doctor. There is a special doctor allocated by the Commonwealth to do that, for the very reason that you rightly draw out here. The family doctor feels an obligation: he probably treats the whole family, so it is difficult to say no. I think that that is a very productive suggestion.

Dr Marchione—The monitoring system?

CHAIR—The monitoring system I think is very worthy and very sound. But your suggestion about the initial consultation is a very good point. Having seen it work in the disability support pension area, I can see the importance of that.

Dr Marchione—In Lithgow, where I work, there is a lot of social welfare and a lot of people from jail. I am not saying that they are different, but they are looking for every nook and cranny that can occur and if they injure themselves at work they think they have won the lotto. I can pull out cases everywhere—

CHAIR—So you know of fraud? We have been told by one of the other witnesses that there is no fraud in New South Wales.

Mr HARTSUYKER—Virtually none—nonexistent.

Dr Marchione—Theoretically, I would have to say that I do not know. I can tell you that I have convinced people that it does not sound like it is a case to me, but they have gone through WorkCover and I have not seen them again. So they get lost in the system or they go to someone else. Unless you have this documenting system, a plaintiff lawyer down the track is not going to bring out all the doctors that the plaintiff has been to. He will pick and choose the ones he wants.

Mr DUTTON—What percentage of people who come to you would legitimately be on a disability pension?

Dr Marchione—Well, this guy was walking and talking and doing everything but, because he had high blood pressure and diabetes, the previous doctor had said that he was disabled. I could not believe it. I found it was different because I had only moved into the practice. I said, 'Look, I can't fill this in. You can do your buttons up.' He said, 'Sometimes she has to do them for me.' Because there are new criteria, I asked, 'Can you do your buttons up?' He said, 'Oh, sometimes.' A sympathetic doctor would respond, 'Oh, all right.' You can take what they say as gospel or you can question them. I have not seen him since—I lost two regular patients. I do not care, because the way I run a practice is that I am pretty ethical in what I do. If someone wants to rort the system, I am not going to be part of it.

CHAIR—Thank you. We felt very ethical too. It is very good of you, with a busy practice, to put the time and effort into making a submission and seeing us this afternoon. We appreciate that greatly.

[2.43 p.m.]

GILLEY, Mr Richard, Managing Consultant, RiskNet Group

CHAIR—Welcome. The proceedings here today are formal proceedings of the parliament and warrant the same respect as proceedings in the House. The committee prefers that all evidence is public, but if there are some matters you would like to raise privately before the committee you can make that request and the committee will certainly consider it. I invite you to make some preliminary remarks and then we will move to questions.

Mr Gilley—The RiskNet Group is an affiliation of management consultant groups who operate in the areas of workers' compensation and occupational health and safety. Firstly, I would like to table some information about insurance fraud generally, which I have taken from the Internet. It is from the USA Coalition Against Insurance Fraud. It is not specific to workers' compensation, but it sets the scene for some of the comments I may make later about how fraud continues to flourish. Would that be acceptable?

CHAIR—We will consider whether to make that public, although if it is on the Internet it should not be a problem. Thank you for that.

Mr Gilley—One of the major issues—and if the committee has not come to this determination already I feel that it will shortly come to a similar determination—is that there is no empirical data about the prevalence of fraud in workers' compensation. Most of us are relying upon anecdotal evidence from various sources. I suspect that one of the first issues that the committee will need to come to terms with in its findings is a need for a centralised database to collect data on fraud. What do we mean by 'fraud' in workers' compensation? Firstly, we have to deal with some issues of definition. It is commonly believed that 'hard' fraud is not very prevalent—that is where people stage accidents in order to gain benefits. However, the prevalence of 'soft' fraud, which is fraud by exaggeration, is considered to be widespread. In the New South Wales environment, fraud by exaggeration is considered to be anything up to 20 or 30 per cent of claims costs. Underlying that is something that I do not believe has yet been dealt with by any of the regulatory bodies in Australia: the aiding and abetting of fraud by the medical profession and other providers who are, for want of a better term, allowing claimants to obtain benefits when they are not entitled to them. I will explain that in a little more detail when you go through my evidence-in-chief.

There are other reasons why fraud flourishes, in my opinion, and I will go through them quickly. Workers' compensation courts typically have no jurisdiction over fraud; they are administrative by nature. They determine whether or not a claimant is entitled to benefits. They are not able to make a determination on whether the claimant or anybody else involved in that particular case has perjured themselves or set out to commit fraud. So one of the things that needs to be dealt with is the way the court system operates in determining the outcomes of claims. When a dispute gets to the stage where it has to be resolved in a court case, the court should also be able to hold claimants who have obviously perjured themselves in contempt and perhaps refer those claimants on to other sources to be pursued for that. The very nature of workers' compensation claims means that there is a no-fault system across all of Australia. From the outset, there does not seem to be any major attempt to bring to the attention of

claimants the fact that committing a fraud or exaggerating a claim are fraudulent matters which can be dealt with under the various crimes act legislation.

The funding arrangements in the various states and in the federal jurisdiction are mostly centrally managed funds or managed funds—in other words, they are not owned by the insurers and the insurers take no risk. That is the case in Victoria, in South Australia, in New South Wales, in Queensland and in the federal arrangement. Only a small number of states are privately insured. What has tended to happen because of that—again it is my view and I have no evidence to support this—is that the skills that an insurer would otherwise exercise in determining a fraud in those jurisdictions do not exist. There is no expertise in fraud detection by the various insurers who act as agents for the various government schemes. That is a symptom of the schemes not being owned by the insurer. It is not their money that they are paying out, it is somebody else's money, so nobody really owns it.

There does not seem to be consistent antifraud legislation across Australia in the workers' compensation environment. States have different ways of treating fraud. Some treat it quite harshly. New South Wales has sought to do that in the legislative changes it has brought in over the last couple of years, but in other states that is not necessarily the case.

The final comment I would like to make is that there does not seem to be a public awareness of fraud in insurance matters—and that is supported by some of the stuff I have shown you today. In fact, it seems to be the case that insurers are fair game. People who are normally honest citizens are quite happy to exaggerate a medical condition if it means that they can stay at home on workers comp benefits a bit longer, and they are quite happy to exaggerate other forms of insurance claim. It seems as though there is no major push in the public that defrauding an insurance company is a bit like defrauding a bank. Those are the comments I would like to make before your questions.

Mr DUTTON—In your submission you say that claimant and employer fraud is estimated to cost the New South Wales system at least $400 million annually. Where do you source that figure from?

Mr Gilley—This is the difficulty we have to deal with. We do not have any empirical evidence—it is anecdotal; it is from my experience of working with the insurance industry, which I have been involved with for longer than I care to remember. I have been involved in managing claims on behalf of my clients.

Mr DUTTON—That would be your projection based on your expertise in the industry. Is that right?

Mr Gilley—Indeed.

Mr DUTTON—Does the same apply when you go on to legal costs and you give figures for administration of $180 million; doctors, $160 million; and lawyers, $240 million?

Mr Gilley—Those statistics are probably drawn from the *NSW Statistical Bulletin*, which is published annually.

Mr DUTTON—So that is sourced?

Mr Gilley—You can source that data. It is generally a couple of years behind.

Mr HARTSUYKER—Do you see that medical practitioners could have a more proactive role in helping to reduce insurance fraud, both by putting some onus on the patients and in a more orderly reporting system—perhaps a compilation of databases that might assist to control fraud?

Mr Gilley—The short answer is yes. There are a number of issues that you have raised, though, that perhaps need some elaboration. Am I permitted to engage in a little role play to illustrate a point?

CHAIR—If you wish.

Mr Gilley—For the purposes of the role play, I will ask Alison to pretend she is a medical practitioner—this is where a lot of the difficulties lie in workers' compensation. I will be the patient. I am going to demonstrate, I hope, how simple it is to gain a medical certificate that then entitles me to workers' compensation benefits:

Doctor—What have you come in to see me about today?

Patient—I have this terrible back injury, Doctor.

Doctor—How did that come about?

Patient—I work in the filing department of the New South Wales parliamentary committee on workers' compensation. They are making me stack up files eight feet in the air. It is like a piano wire going. I am in agony; I can hardly move.

Doctor—How long have you had this pain?

Patient—It started about 20 minutes ago. I had to stop work immediately.

Doctor—Have you contacted your employer about this pain?

Patient—Yes; they sent me down to see you.

Doctor—We might have to take a few details.

You do not get to undress me, by the way! You can see what is developing here. I suspect that, if you are a good doctor, you are now going to do a couple of things. You are going to do some hands-on investigation. You have taken a history. I have told you how sick I am and how much pain I am in. You have now established the doctor-patient relationship and you are sympathetic to me. You are now going to put your hands on me and do some rudimentary tests, and I am going to squeal in agony every time you touch me. So to protect yourself you are going to say, 'I can't possibly send this injured worker back to that miserable, rotten employer who has caused this injury.' And because I cannot detect anything myself I am going to arrange a series of investigations, which typically involve referring me on to some sort of specialist.

Alison is able to do a number of things. She can say, 'I do not believe you,' in which case I would have got up, walked out and gone around to see you, Mr Dutton—another doctor—and gone through the same process. If you had said, 'I do not believe you,' I would have gone to someone else. Eventually I would find a doctor to support me. That is how easy it is to get that piece of paper. Alison then gives me a couple of weeks off work, because that is how long it is going to take for me to get in to see a specialist.

Specialists do not want to see workers' compensation claimants. They are a pain in the backside. One of the reasons is that specialists often do not get paid. An insurance company assesses the claim when it has all of the details and says, 'Hang on, that is not a work related claim, so we are not going to pay any of the expenses.' So the providers have provided their services and they end up having to fight for the money. So there is probably at least three or four weeks of waiting before I will get in to see a specialist. In the meantime, Alison is not prepared, as a good doctor—and she feels she is—to send me back to work or do anything with me until she is a little more certain about what my condition is. So I am off work for a month. What have I done to establish this?

Mr HARTSUYKER—You have acted superbly.

Mr Gilley—Thank you. I am not saying that this happens in the majority of cases. Please do not believe that. But people can exaggerate the way they feel when they first see the medical practitioner. Medical practitioners who are used to dealing with workers' compensation issues will, at the outset when seeing a patient, set the expectations from that point forward. Good doctors do that. There are lazy, incompetent and greedy doctors who do not do that—or, for whatever reason, they do not do that. What they do is give a medical certificate saying, 'Totally incapacitated for all types of work.' That sets off this train.

Mr DUTTON—In New South Wales now, with provisional liability—

Mr Gilley—With provisional liability it is just open slather.

Mr DUTTON—So you have a doctor's certificate for a fortnight. Within seven days you are into the system. You are at home receiving the same money as you would be receiving at work. What incentive is there to return to work?

Mr Gilley—None. If you look at the way benefits are structured, I know this sounds a bit sad, but depending on how many children you have—if you are on the average weekly income, earning $800 a week as a process worker, and you have eight children—you may get exactly the same amount of money staying at home as if you were at work, no matter how long you stay at home. It is not time limited whilst you are totally incapacitated. So your incentive is not to get better.

If we go back to the question you first addressed to me about whether doctors could do a lot more, in my view they can if they are sufficiently interested. To start with, unless somebody is on life support or is referred immediately for bed rest, they are not totally incapacitated. There is a massive amount of evidence to support this. We have people holding down jobs who are very severely injured. I have worked with a number of people in that situation myself—people who are paraplegic or quadriplegic and who are holding down jobs. Unless you are on some sort of bed rest or life support, you are not totally incapacitated. I am quite happy to accept that you

may not be able to go back to your pre-injury work, but that does not mean to say that you cannot do anything.

Medical practitioners need to recognise that, because at the moment nobody is challenging them when they write out a certificate saying, 'Totally incapacitated.' The patient walks into the surgery, for goodness sake. How can they be totally incapacitated? If you ask, 'How did you get here?' they might say, 'I drove here.' So you are fit for sedentary duties. You walked into the surgery, so you can do walking duties. Maybe they are time limited. You can drive—you drove down here. All of these things are open to somebody who is injured at work.

Admittedly they might not be able to go back to their pre-injury duties, but they are able to do something, not just sit at home. Once that first month has been and gone, they have got the TAB account established, they are getting used to seeing the afternoon television programs and the sickness role has set in. Everybody is supporting them in the sickness role—the mother is now doing the work or the father is now doing the work the mother used to do—and it all becomes a big support thing. The doctors start to say, 'You beauty: I've got a workers comp claim and I can continue on $55 a go'—which is how much they get paid for issuing the report, plus their consulting fee. Then all the physiotherapists and everybody else get involved in it.

If you look at the statistics, you will see that that is not shown in the actual medical costs. In New South Wales the medical costs to the scheme are about five to six per cent of total claims payments. Nobody has really attacked that. Legal costs were 14 per cent. So everybody said, 'There's too much money being spent on the dispute resolution process.' Medical costs themselves are not particularly high, but what we need to look at now is that providing the services in the way they are being provided is causing a massive blow-out in the costs to the scheme. How we control that I am unsure. There may be a couple of recommended ways of doing that. One is the use of evidence based medicine, which came from South Australia in the early nineties, went to Victoria in the mid-nineties and is still to be introduced in New South Wales. If the medical protocol says that the treatment of back injury must be active, any doctor who prescribes bed rest should be questioned. If the medical protocol says that there is no point in prescribing that a patient wear a back brace because there is no evidence to support the idea that it does any good, any doctor who prescribes one needs to be questioned. We could pick out the top three or four cost impact injuries and develop medical protocols for them. They have done it for the management of back injuries in Victoria and South Australia and they have done it for stress claims. They have not yet done that here in New South Wales and it still has not been promulgated across Australia. Perhaps medical protocols should be adopted across all jurisdictions.

The other thing is that only those doctors who understand the system should be allowed to practice in it. The legal profession dealt with this a number of years ago by having accredited specialist legal areas, one of which is personal injury. The same thing should happen with medical practitioners. They need to be able to show that they understand what workers' compensation is all about. Instead of just passively taking a history from the patient, they should say, 'Who do you work for? I will get them on the phone now and see if there's anything they can get you to do. I see that you walked into the surgery, so you may be able to walk for 20 minutes at a time or sit for 20 minutes at a time or you can do something. Let me ring your employer to see if they can do that. If they can't accommodate you, I can refer you now to a rehabilitation provider who can help you try and find something with your existing disability.'

That is the way the system was set up and that is the way the system should work. I am afraid it does not.

CHAIR—Mr Gilley, on page 4 of your submission you say that Victoria 'shifts much of its costs to the Federal system'. Can you explain what you mean by that?

Mr Gilley—Benefits are time limited, and they appear to be more time limited in Victoria than they are in other jurisdictions. If your injury extends beyond that time, workers comp benefits cease, which means you are then thrown upon the federal assistance scheme.

CHAIR—Social security?

Mr Gilley—Yes. I guess there has to be some further study into how prevalent that is and what effect that has on the costs of workers comp in Victoria in comparison with other jurisdictions. All jurisdictions cost shift to some extent or another, but Victoria has been particularly good at doing that.

CHAIR—Thank you. This has been a very useful and interesting submission.

Resolved (on motion by **Mr Hartsuyker**):

That this committee authorises publication, including publication on the parliamentary database, of the proof transcript of the evidence given before it at public hearing this day.

Committee adjourned at 3.05 p.m.