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STANDING COMMITTEE ON EMPLOYMENT AND WORKPLACE RELATIONS

Reference: Aspects of workers compensation

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HOUSE OF REPRESENTATIVES

STANDING COMMITTEE ON EMPLOYMENT AND WORKPLACE RELATIONS

Wednesday, 20 November 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 Dutton, Mr Hartsuyker, Mrs De-Anne Kelly and Mr Wilkie

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

Committee met at 9.08 a.m.

NEESHAM, Mr Harry, Executive Director, WorkCover Western Australia

CHAIR—I declare open this public meeting of the House of Representatives Standing Committee on Employment and Workplace Relations inquiry into aspects of workers compensation. I welcome Mr Harry Neesham from WorkCover Western Australia. Thank you for making the time to meet with us today. The proceedings here today are formal proceedings of the parliament and, therefore, warrant the same respect as proceedings in the House. In providing your evidence today I ask that you do not name individuals or companies or provide information that would identify those individuals or companies. The committee is interested in broader generic principles and the issues that you may wish to raise. The committee cannot extend parliamentary privilege to allegations about particular individuals. The committee prefers that all evidence be given in public but, if at any stage there is evidence that you would like to give in private, you can make a request to the committee and we will certainly give that consideration. I invite you to make some preliminary remarks and then we will move to questions.

Mr Neesham—I have been the CEO of WorkCover since 1981, so I have reasonable experience in this area. One of the issues that we tend to lose sight of is the fact that 90 per cent of injured workers proceed through the systems, regardless of which state, without any impact or impediment in terms of receiving their benefits and getting back to work in their normal process. I suppose that most of the legislation that is dealt with across the states relates to that small five per cent.

I will first of all outline the Western Australian system. We have a privately underwritten system in Western Australia. We have 11 insurers and 28 approved self-insurers. It is a no-fault system, with some access to common law. The premium rates are determined by the Premium Rates Committee, which is chaired by our Auditor-General. The committee sets recommended rates, and there are constraints on the insurance industry exceeding those without approval if the loading is to go beyond 100 per cent. Under the statutory system, workers are entitled to maximum compensation, which is the prescribed amount of, currently, $130,609. In addition to that, they are entitled to medical benefits at 30 per cent of that amount, with an ability to increase that by a further $50,000. In terms of access to vocational rehabilitation, they are entitled to seven per cent of that amount, and there are other minor benefits, such as travelling, which are provided for in the legislation.

Availability of common law is restricted to two thresholds. The first is a 16 to 29 per cent disability, which is capped at $274,000 maximum benefit entitlement, and for those with 30 per cent or greater it is uncapped. The 16 to 29 per cent group have to elect at six months and leave the statutory system. Those with disability of greater than 30 per cent or those who are seriously injured remain on benefits, and there is no impediment to them remaining in the statutory system and then accessing the common law.

In our scheme, we deal with injured workers from day 1. There is no excess. In 2001, 46,005 workers claimed workers compensation. Of those, 20,678 lost time of one day or more. There were quite a few who were simply medically treated and went back to work. I suppose that is the group we really look at—the 20,678. In terms of the costs on the system, 59 per cent went direct to the workers—and that was 31 per cent by weekly payments, 14.7 per cent through

redemption of their statutory entitlements under the workers compensation system and 13 per cent through common law. The average recommended premium set by the Premium Rates Committee was 2.47 per cent. That is the average across the system.

Currently, the government is looking at reforming our system to improve the statutory benefits and access to common law. The final package has not been announced by the government, but the directions statement indicated that it was looking to achieve greater efficiencies through improving the processes by which workers could access common law and through increasing statutory benefits. It will also involve changes to the dispute resolution system, again looking at providing a much more effective system. It will include the reintroduction of legal representation at all levels within that system, which was removed from the system in 1993.

Certainly the other aspect which is a major issue in workers compensation is improving the focus on injury management. We have had a process of injury management in operation since 1997, and the government's intention is to build on that and improve its delivery. They are the general aspects. Would the committee like me to deal with the issues that were part of the terms of reference? You were looking at the issue of data on the cost and incidence of fraud. Would you like me to progress on that?

CHAIR—I think that would be helpful to the committee; thank you, Mr Neesham.

Mr Neesham—My belief is that there is very minimal opportunity for fraud in our system. Let us take this from the worker's perspective. First, the worker would have to convince a doctor of their disability. Second, the worker would have to convince their employer that it was work caused, even though the statutory system is a no-fault system. And, thirdly, the worker would have to convince the insurer. We have a process of review in that the insurer or the employer can refer the injured worker to a doctor of the insurer's or the employer's choice to verify the claim. If you look at our system from that perspective, you can see that there is a filtered mechanism, which I believe is fairly effective.

In my 20 years I think there have been two cases of workers being charged with fraud. That is not to suggest that people do not put in claims that are not knocked out by the system. We have a dispute process and last year there were 3,500 disputed matters. Not all of those are as to initial entitlement; about 2,000 related to initial entitlement. Unfortunately I do not have the statistics about how many of the disputed claims were successful. They go through a conciliation and arbitration process, if you like, to determine whether the worker is entitled. So we are looking at a very small number of people who have their matters disputed. As I said, you are looking at 2,000 out of 46,000. I do not have the statistics, but from a non-scientific point of view I would suggest that a very small proportion of those 2,000 would be denied benefit on the basis of no entitlement.

In terms of employers, we have a fairly comprehensive database. We have in excess of 60,000 employers registered on our workers compensation database. I have an inspectorate that inspects and investigates employers. We certainly identify employers who do not have workers compensation cover. In a lot of instances these are small employers who are just starting business.

Proceedings suspended from 9.19 a.m. to 9.39 a.m.

CHAIR—Mr Neesham, I apologise for the interruption. Would you please proceed.

Mr Neesham—To make it easier for me, and for the committee, I will go back and start with the employers again. I had just finished speaking about the workers' side of things. I will go back and talk about the issue of compliance from an employers' perspective. There are two aspects of that. There is compliance in terms of having a policy—if you are required to have a policy, actually having that policy. The second one is having taken out a policy you actually pay your due amount of premium. From the point of view of my role in this, we do have a compliance function. In terms of the second element—the employer paying their full premium—that is really part of the contractual arrangement between the insurer and the employer. The insurance industry carries out comprehensive checking of the wages declarations by employers and they have under the policy an ability to go out and do a wage book inspection. We also have that power under our act and where the insurer has difficulty in actually achieving their aim in that regard we do go out and conduct wage book inspections as necessary. It does not happen a lot because most of them are able to achieve that.

From the point of view of compliance, we have a series of processes for determining the requirement for people to have a policy. First of all we look at all the new businesses that are created and we do a check of those. Not every business created has people who are workers so they are not required to have a policy but we certainly do conduct new business investigations. We then target specific areas of employment where we may have identified issues. Over the years these have varied, for instance, in the case of milk delivery. Nobody thinks of the young people on those milk delivery trucks as workers—they are just kids doing a job. In fact, on the basis of their employment they are workers and should be appropriately covered. There are other various aspects of industry—the building industry, the shipbuilding industry. We have targeted over a period of time a series of industries as we believe appropriate. We also do regional inspections. We let people know we are coming. That is part of the compliance process. That has an appropriate effect on people complying.

The other major area is if somebody takes out a policy and then does not renew that policy. It could be that they have gone out of business; it could be that they are no longer employing. We investigate every one of those to determine that they are not required to have the policy. We find a fair proportion of employers find the cost too high or they have forgotten or whatever. We certainly do carry out that sort of inspection. In more recent times we have also gone into doing a broad brush inspection. The whole of the inspectorate goes to a particular location—one of our industrial areas—and investigates every employer in that area. To give you some idea, in the three years 1998-99 to 2000-01 we identified 1,734, 1,537 and 1,516 uninsured employers. In the last year we prosecuted six of those employers because it was deemed that they had deliberately not meet their requirement. To put that into perspective, we have just under 80,000 employers on the register. I think I said 60,000 earlier but it is in fact just under 80,000.

The other way by which you can see whether people, employers in particular, are complying relates to a claim that is made where there is no insurer—that is, it is a claim made on our uninsured fund. Certainly in that regard we have only a very small number of claims of that nature made. In fact, in more recent times the majority of those have related to claims of long duration—that is, asbestos type claims where the employer is no longer in business and there is no record anywhere of the employer's insurer. In some instances the insurer has gone out of existence.

We certainly have a compliance role with service providers. We have vocational rehabilitation providers and we accredit those and monitor those against performance standards. We are currently in the process of getting far more detailed information on other aspects of our system. For instance, the medical fraternity is a key aspect of our system but we do not actually have any requirement for its members to be registered other than as registered medical practitioners. Our data on those is obviously kept by the insurers themselves so we do not actually have specific data which would indicate to us the need for training and/or supervising their role within the system.

CHAIR—Thank you for that. That has been a very helpful overview. I will ask my colleague Mr Wilkie to lead off with questions.

Mr WILKIE—Firstly, Mr Neesham, I would like to acknowledge your earlier comment that you believe there is a very low incidence of fraud by workers, which I think is very encouraging. A number or submissions that we have received have indicated the difficulty of providing rehabilitation return to work mechanisms in rural areas. Do you have any comments about the difficulty that workers may have in accessing rehabilitation programs in rural areas?

Mr Neesham—There are two aspects that I would like to comment on. The first one is that the bulk of injured workers are rehabilitated back into the system by their employers. The employers take them back when they are not exactly 100 per cent fit, give them light duties and manage them back into their work environment. There are, particularly in Western Australia, significant issues relating to injured workers being able to receive specialist vocational rehabilitation in country areas. Six vocational rehabilitation providers have country offices and the Commonwealth Rehabilitation Service services most major centres, but that does not detract from the problem for injured workers. If they are injured in a country location, part of vocational rehabilitation is to try to place them in other jobs when they are not able to go back to their existing jobs, and the availability of appropriate employment is a major issue for country people. I am not sure that putting more vocational rehabilitation people into the country areas would overcome that. It is certainly a major issue. As an example, I recently visited Broome. I spoke to four injured workers who were in vocational rehabilitation programs. All were happy with their particular program but the issue was more about what was going to happen when they finished their program. In some of those cases they were not going to go back to their pre-injury employment and it was a matter of what alternatives were available for them.

Mr WILKIE—A submission put by the National Farmers Federation said that workers injured out on a property often lived on site. They might have to travel to get therapy, having a lot of difficulty getting to the treatment and getting back.

Mr Neesham—Our system certainly provides for an entitlement to travel. I think the more difficult issue is getting to medical treatment. The availability of medical specialists is a real issue for workers who have some specific injuries. In the example I gave, they had to wait for the orthopaedic surgeon who visited monthly to actually come up, so sometimes their case is prolonged or their treatment is impacted by their distance from available specialist resources.

Mr WILKIE—If someone were on a major work site in one of our mining areas, would the scheme provide for them to be flown to and from Perth or another major centre to get medical treatment?

Mr Neesham—There is a provision for the reasonable cost of transport, and that is used in instances. I think the issue is that in many of those cases the company involved—that is, the employer—would in fact fly the worker out for the purposes of the worker being treated, but there is a provision in our act that says that they can receive reasonable travel costs associated with this.

Mr WILKIE—It sounds as if it is provided. Do you know if it is actually happening?

Mr Neesham—All I can say is that I have not had any major issue of workers not being able to access medical services as a result of that raised with me.

Mr WILKIE—Thank you.

Mr DUTTON—If we were looking for a best practice system in Australia, what sorts of performance indicators would we need to assess in making a fair comparison of the systems that operate separately in each of the states?

Mr Neesham—That is a very difficult question to answer because each of the systems is based on a development that has occurred over 100 years. I suppose that, as the systems have evolved, the two competing key criteria that all systems have looked at are the affordability of the system and the adequacy of the benefit. For instance, the Pearson review in this state considered that a system that cost somewhere on average between 2.4 and 2.7 per cent of wages was affordable from an employer's point of view. It is then a matter of what that translates to in terms of the benefits structure, and I suppose all systems look to trying to adjust their structures to meet that cost imperative. When you look at most systems, you are looking at the Pareto rule—that is, 80 per cent of your injured workers cost 20 per cent of the cost of the system. It is the other 20 per cent who represent the higher cost to the system. More specifically, at the end of the day the just less than one per cent in our case, for instance, who access common law represent in excess of 13 per cent of the cost at the present time. That figure was once as high as 31 per cent. So it is a matter of how you balance your systems. I think that if you were to actually say, 'Let's remove all the barriers and let's go back and try to establish a system that in fact represents an equal playing field on which nobody has any benefits or any entitlements'—and there is a problem there—it would then be a matter of saying what is reasonable.

As I say, you could pick something like the Pearson recommendation so that somewhere between 2.4 and 2.7 per cent of wages will present this amount of premium. If you allow that, in our system, 59 per cent of that premium dollar goes to the injured worker, eight per cent to lawyers, 14 per cent to doctors, eight per cent to hospitals and the balance to the cost of administering the system, then you apply that to a benefit regime to injured workers. I think that is the only way you could do it. Then the issue is: do you have simply a no-fault statutory system, as in South Australia, or do you have a totally common law system, as occurred in Australia prior to 1904, or do you have a combination, which applies in a number states? They are the questions that are unfortunately political more than administrative. I do not know whether that has helped you.

Mr DUTTON—Yes, I appreciate that. I wanted to quickly ask a question on the second line—I had to leave before so I did not fully hear your statistics with regard to employer fraud. Am I correct in saying that you said that there were roughly 1,700 cases that you investigated where there was an allegation of employer fraud and six prosecutions were brought?

Mr Neesham—No. What I said was that there were 1,700 employers found to be uninsured. We prosecuted in six of those cases. The others were all required to take out a policy and bore a penalty. But, as I said before, a lot of those were small businesses that had just established and were unaware of their requirement. Others were employers who had had a policy which had just not been renewed and which was subsequently renewed and dated back to cover for the full period so there was no exposure, if you like, of any injured worker to not being protected by that policy.

Mr DUTTON—I would just like to get those figures right. You say that there are about 80,000 employers that are covered under your scheme in Western Australia. Of those, last year 1,700 were uncovered or found to be lacking in appropriate policies and out of those there were six prosecutions that were brought.

Mr Neesham—Yes.

Mr DUTTON—What happened with those six?

Mr Neesham—They were all convicted—and that goes through the court process.

Mr HARTSUYKER—There has been a lot of discussion during the inquiry on medical assessment panels. How would you judge the usefulness of medical assessment panels in making the whole process smoother and fairer on both sides and more effective?

Mr Neesham—It depends upon the circumstances in which you are referring to the use of a medical panel, because if you are looking at it within the statutory system, that is one aspect. If you are looking at it as a basis for accessing common law, which is a determination, that is a separate thing. Attached to that is the process by which you apply the actual medical evaluation—for instance, various states use them in determining a level of impairment and some states use various editions of the US guides. In this state we currently have 'disability' as our definition, not 'impairment', and we have a disability basis—established by our local medical association back in 1994—as a basis for that assessment. I have seen situations where there have been multiple specialist and GP opinions given on a particular case from both sides—so, every time one side gets an opinion the other one goes and gets another opinion. In my view, it becomes very intractable. It creates a real issue for both parties, because both parties then go into adversarial mode.

I suppose having an independent panel adjudicate on the facts rather than someone adjudicating from a position of being a medical practitioner who is the family GP or a doctor who works for, in our case, the insurance industry or, in other states, the WorkCover Authority where they are perceived to have a bias in regard to the requirements, would be a good thing. I think the concept of an independent medical arbitrator, whether it is a panel or whether it is a single specialist, to break that conundrum of having two competing medical opinions—providing it is conducted in a forensic, structured medical way—has a lot to offer most of the systems.

CHAIR—The National Farmers Federation submission referred to a 15 per cent discount scheme for farmers in Western Australia who participated in a managing farm safety course, who also implemented a farm safety plan and did not have claims for 12 months. Do you see that as an effective incentive to improve safety?

Mr Neesham—What we experienced in Western Australia, certainly in 1999, was that the average premium in the state was 3.14 per cent, which was significantly above the 2.4 per cent to 2.7 per cent seen as a viable by the Pearson review. From that point of view, there has been a lot of emphasis on risk management. I suppose from our point of view we believe that generated an average increase in premiums of in excess of 30 per cent in 1999 and I believe that that impacted significantly on all employers in the state and brought a greater awareness of their responsibility under occupational health and safety. Certainly from an insurance perspective where they have spent a lot of effort in offering risk management and discounts associated with that—and they are generally back end discounts where they say, 'If you achieve this, you will get that'—that incentive has certainly impacted upon the attitude of a lot of employers in this state in my opinion.

The other aspect which was linked with that was, in 1997, the introduction of injury management where the relationship between the injured worker and the employer and the treating medical practitioner was emphasised in an endeavour to focus more at the very point of injury on what the future for the injured worker was—how it can best be managed. So instead of creating a gap between the worker and the employer the aim is to maintain contact, which is the best outcome for a worker. If they are able to go back to their same employer with the same or modified duties that is certainly a better outcome in terms of the person concerned.

CHAIR—Are you saying, if it is possible, that some duties assist in the process of getting injured workers back to the workplace?

Mr Neesham—Sorry?

CHAIR—Are you saying that some duties—if possible—assist injured workers to come back, provided that they are within—

Mr Neesham—If a worker is excised from the work environment and from their workmates, what actually happens is it creates two things: one on the worker's side is some degree of alienation and on the other side—that is the employer and/or their workmates—again there is alienation. We have found that, where you maintain that contact, it certainly has a significant impact on the outcomes for those people who are injured.

CHAIR—Are there incentives other than the National Farmers Federation one in place in Western Australia?

Mr Neesham—There was an average discount last year of about nine per cent across our whole system. A lot of that is targeted to the performance of the employer in terms of the claims record.

CHAIR—I have other questions. One of the other parties that have made a submission to the inquiry has noted that the duration of weekly payments in Western Australia is limited by a prescribed amount that does not apply in other states. That capping on the payments was introduced in 1999. The party that made this submission said that that has had a mixed effect on workers and employers, with some of the cost savings to the compensation shifted into wage costs—

Mr Neesham—I need to clarify that there are two aspects here. One is the $130,000, which is the prescribed amount and is for weekly benefits, in effect. The other relates to a capping on the entitlement of the worker, and that was capped in 1999 at 1.5 times the average weekly earning as the maximum. That has certainly had an impact upon workers who were earning in excess of around $45,000—those workers would then have their entitlement capped by that limit on entitlements. I think we need to separate those two things out. One has been there since the legislation was established, and that is a prescribed amount which is, under a no-fault system, the amount which an employer is automatically liable for. That has been in our system since it was established, I think. But the cap on weekly entitlements, which limits the maximum amount a worker can receive of the amount that is 1.5 times the average weekly earnings, was introduced as part of the legislative changes in 1999.

CHAIR—So it is five times the average weekly earnings—is that correct?

Mr Neesham—No, it is 1.5 times the average weekly earnings. Around $900 per week is the maximum entitlement. So that impacts upon more highly paid workers; it is a dampener on them. There are some elements within the working environment where that did not have any impact, because of award agreements et cetera where there were make-up pay provisions applying. I think the major area that it has had impact on has been the public service.

CHAIR—Thank you for that. The other submission also asserts that larger employers are able to negotiate discounts on their premiums but that, generally, smaller employers are constrained to paying the gazetted premium rates. Is there a cross-subsidisation between larger employers and smaller employers as a result of that?

Mr Neesham—That is very difficult to say. In fact, if you think about it, the recommended rate that is set is based on the cost to the system. That is set, I would suggest, as a safety net for the smaller employer. The smaller employer does not have the leverage to negotiate discounts but, at the same time, if the smaller employer had a major catastrophe then it would be paying a significant excess. The concept—I am not suggesting that it necessarily works—has always been that the insurers would look at the lower end, the smaller employers, as a pooled risk and treat them as the pool. Basically the recommended rate is set, and that really is the rate for the smaller employer as part of this pool. If they were in a purely risk rated system and they had a major catastrophe, they would be unable to continue in business for the next year. The reason for that is simply that, if they are paying, say, a $2,000 premium and they had a $50,000 claim, that translates to being unaffordable. So the concept is that the smaller employers are rated on the basis of a pool and the recommended rate is effectively set as the benchmark. I am talking in general terms; it is not specific. They are still each risk rated, so if a small employer has had a bad experience they can have their premium loaded by the insurer. Conversely, there are small employers who receive discounts, but those discounts are generally relatively small, in a five to 10 per cent band.

CHAIR—Shouldn't premium rate discounts be related to employer performance and return-to-work success? Isn't that an incentive for the small employer to ensure that they provide the things that you were commenting on before, which are contact with the injured worker and the opportunity for light duties if that is appropriate? There is no real incentive—

Mr Neesham—It certainly is an incentive but, in isolation, if you went onto a purely risk rated process you could have people being put out of business. That is how I see it. You have to

understand that I am relating this to a private insurance market. It is not the Queensland model, for instance, where they do have the ability, because they control the whole premium pool, to deal with each individual employer on a specific employer basis. In our situation you have insurers who have a mixed bag of employers arranged from large to small, and they then balance their portfolio to cover those costs. It is not as though somebody has all of the small employers and can deal with them individually and obtain a premium return to afford the cost of claims. It is a little bit more difficult in a privately underwritten system, where one insurer may—because of the nature of their portfolio—end up with a 'bad year' compared with another who has a very good year. For the most part the recommended rate is seen as the base rate for the smaller end of the employer size market. I do not know if that is helpful.

CHAIR—It is; thank you. I understand that the Western Australian government is recommending a panel approach to medical practitioners. I think one of my other colleagues raised this.

Mr Neesham—We have a panel in existence. We have always had that in the act, but it related first of all specifically to industrial diseases—that is, asbestosis, silicosis and mesothelioma. There was also an ability to have a general panel, but from my knowledge it had not been used until it was introduced to look at the issue of accessing common law, and that is where it has come into effect in more recent times.

CHAIR—Should medical practitioners across the state have some occupational medicine training? Would that assist? Is it practical?

Mr Neesham—There are two aspects here. First of all, our system provides the worker with the right to their choice of doctor. Unless you train every doctor in some element of occupational medicine, there are going to be circumstances where workers, because of their location or their situation, are going to have a medical practitioner who is not necessarily skilled in occupational medicine. There are groups and medical practices that are set up specifically to look at servicing injured workers and industrial areas where they gain quite some knowledge of the work environment. I suppose to some extent we have been endeavouring to train GPs in the issue of injury management, for instance, which we believe is a part of that process, but it is still a voluntary issue. In answer to your question, yes, it would be very helpful to the whole system—injured workers and employers—if medical practitioners had a degree of knowledge of occupational medicine and knowledge of the occupations in which their patients operate, because it would give them a much clearer understanding of the ability to be part of injury management.

CHAIR—Finally—and I hope it is a short answer, if I may—there has been a lot of research over the last 10 years on the Western Australian workers compensation system. This is probably an unfair question. What elements of the current scheme do you see as best practice and, in hindsight, what would you have liked to have seen done in a different way?

Mr Neesham—It is very difficult for me as a public servant to postulate on what is clearly a government prerogative. Since 1978, when we had the judicial inquiry by Judge Dunn, our system has seen a fairly stable situation going through from 1983 to 1991. Then our system experienced a significant increase in common law. There were the 1994 amendments which sought to address that but which in fact did not achieve the legislative intent. There were the 1999 amendments, which did. They are currently being examined by the present government to

reposition the system based on the outcomes of those examinations so that it is more equitable but without losing the cost structure that has been achieved.

In terms of best practice, I think the fact that we have a system that provides for 99 per cent of injured workers in a statutory no-fault system is often lost on people. The fact that you have a system that meets the requirements of 99 per cent of injured workers is clearly a benefit. It does not matter what or how you legislate; there are always going to be circumstances where one person is disadvantaged over another when you actually have a choice, and in our system we do in terms of accessing common law.

Member of the audience interjecting—

CHAIR—Excuse me, we will just proceed, if you don't mind.

Mr Neesham—I think that we do have a balance in our system between statutory benefits and common law. The ability of governments to balance that and to maintain a stable environment is certainly important, but probably more important are PPR—prevention, payment and rehabilitation and/or injury management. They are the three key elements of any system, and getting those in balance is the challenge.

CHAIR—Mr Neesham, we are going to have to draw to a close now. Thank you very much for your time and your submission today.

[10.24 a.m.]

GUTHRIE, Mr Robert, Head of School of Business Law, Curtin University

CHAIR—I welcome you and thank you for joining us today. I apologise for delaying you. The proceedings here today are formal proceedings of the parliament and warrant the same respect as proceedings in the House. In providing your evidence, please do not name individuals or companies or provide information that will identify those individuals or companies. The committee is interested in the broader principles related to the terms of reference and the issues that you may wish to raise. The committee is not prepared to provide the protection of parliamentary privilege to allegations about particular individuals. We would like all evidence to be made in public but, if there are matters that you would like to raise in private with the committee, please advise us of that and we will consider your request. Would you like to make some preliminary remarks before we move to questions?

Mr Guthrie—I am here in my capacity as a person who has been involved in three government inquiries in relation to workers compensation matters. I will preface my remarks by giving you background in relation to my experience with workers compensation. I was admitted to practice in Western Australia in the early 1980s and practiced for about eight or nine years as a legal practitioner in Perth, acting exclusively for workers. I subsequently sold a share in my practice and commenced academic life at Curtain University. In 1991, the then minister for labour relations, the Hon. Yvonne Henderson, requested that I prepare a report in relation to dispute resolution in the workers compensation system here. I did this report and it was presented to her and was subsequently the subject of legislation in 1992. In 1999, I was one of the members of the Pearson inquiry, and I understand that Mr Neesham has mentioned that report. The Pearson report was put together by me and Des Pearson, who is the Auditor-General, and one other—isn't it terrible? I have forgotten the other author's name; it will come back to me in a moment. That 1999 report was a very important report and led to the establishment of the current Western Australian system. That report was the genesis of what we currently have in existence.

Last year I was asked to do a report for the current minister for employment protection, and that is the report that I made as a submission to this inquiry. I have sent details of that and I understand that you have been given the executive summary of the report. I have a copy with me. It is a very large document; it is actually available on the WorkCover web site, but it is rather awkward because it is actually 500 pages long. The report was done at the request of the minister to look at the implementation of the Labor Party direction statement. When the current Labor government was elected, it had already put in place a platform for reform of the workers compensation system prior to the election. When they were elected, I was asked to flesh that document out. So my report is an attempt to implement the Labor Party platform in relation to workers compensation. It runs to about 10 chapters dealing with a range of issues, some of which are matters of concern to you today. Employer fraud is something that has been raised particularly, and fraud generally; but it also canvasses issues in relation to medical panels, dispute resolution and the rates of payment of benefits. If you have any specific questions, I can answer those.

CHAIR—Thank you, Mr Guthrie.

Mr Guthrie—The name of the report's co-author is Brendan McCarthy. He will never forgive me for forgetting him. Brendan McCarthy, Des Pearson and I were the authors of the Pearson report, if that could be reflected in the record.

Mr HARTSUYKER—There is a lot of discussion about fraud and the categories of fraud, with employee, employer and insurer fraud. Have you got any estimates for the quantum of these? If so, what are they?

Mr Guthrie—The short answer to that is no, but I will give you the long answer to it. The issue of fraud is an interesting one, because it is frequently raised as something that dogs workers compensation systems, and frequently it is the worker who is the subject of substantial publicity and criticism. When I did last year's report for the minister, I made an effort to investigate the issue of fraud in relation to workers. Some of the research I did looked at information from the United States. There are a few web sites which specifically canvass fraud in the United States system. Whilst the United States has a variety of systems, the data is of some relevance. I was able to glean from that information that the incidence of worker fraud is actually quite low and poorly documented. Whilst it is a frequent allegation of insurance companies that there is a level of worker fraud, I have not been able to ascertain any exact estimates of it. Over the years, I have spoken to insurance company representatives of a variety of forms and of considerable status, and none of them has been able to give me any exact data or statistics on it. The frequently quoted statistic is something like one or two per cent, which I think is a fairly insignificant rate, given the complexities of the system and the number of people involved in it.

Having said that, I also looked at the issue of employer transgression or fraud. My report specifically touches on that in chapter 7 under 'Insurance matters'. Point 7.9 on page 215 commences a discussion of the issues of employer fraud. I heard some of the evidence given by Mr Neesham—and he has the current data on it. What I was able to pick up is that, when you talk about employer fraud, it is more likely that you will be able to obtain data in relation to that matter. I would include in the issue of employer fraud the issue of failure to insure—because it seems to me that that is fraud on the system. If an employer has a statutory obligation to insure and does not, that is a form of fraud. You heard Mr Neesham talk this morning about the rates of non-insurance. My data goes up to the year 2000. The number of detected employers who failed to insure was around 1,500 and there were seven prosecutions that year—which indicates that the level of prosecutions is quite low. I would understand why that is so, and I would accept to a certain extent that what Mr Neesham says is correct: that there would be a number of employers who had commenced business but, through ignorance, had not taken out policies. Nevertheless, it is a considerable burden on a system when employers do not insure.

In Western Australia, there is an uninsured fund which pays workers' claims where the employer is not insured. Of course, every time a worker makes a claim against that fund, that is an added burden against the system. WorkCover, through the general fund, has the right to recover any payments made to a worker out of the general fund. But I understand it is difficult to recover, because quite often an uninsured employer is also an employer who has gone into liquidation because they are directly liable for any claims.

So the short answer is that I certainly do not deny the fact that, in any scheme where you have a form of insurance, there is likely to be a fraud of some kind. I think it is very difficult to detect fraud. If you ask me to try to categorise the types of fraud in terms of workers, I would say that

you have the fairly straight-out category where a worker makes a claim well knowing that they have no such claim at all—that is, that the injury took place at home or at some other place that is not work related. The incidence of that, in my experience—and I am drawing on the fact that I was in legal practice full time, working exclusively on workers compensation—is, very low indeed. I can think of only three or four workers, out of literally thousands of cases I was involved in, where that took place. In most instances where that takes place, a lawyer acting ethically will be able to detect that and make it clear to that worker that they should not proceed. On the rare occasion where a case gets to trial, the worker usually gets detected. I would say the incidence of that bland, straight-out fraud is very low indeed.

There are more difficult instances where a worker has a genuine claim and does not make their best efforts to return to work—either because of a psychological overlay issue, which in fact may be quite genuine, or because they are malingering. Those things are very hard to detect. In the literature that I have been able to research it is very unclear, from the medical profession's point of view, how you detect malingering. The tests for that are extremely uncertain. I would think it an area fraught with difficulty once you try to isolate that area and say that people are fraudulent because they are malingering. It is very difficult to detect.

Just to finish on this point, I looked at the reported cases of fraud and malingering, which were very rare indeed. The state where there is the most number reported—in the sense of cases which have gone to a hearing for prosecution for fraud—is South Australia. It appears to me that that state has quite strict provisions in relation to fraud, in that the language of their sections is broader and catches more people. They seem to have higher numbers of prosecutions of worker fraud there. In terms of fraud of the system, it may be wrong to concentrate on worker fraud—because the major burden on the system is in fact non-compliance by employers.

Mr HARTSUYKER—When you say that fraudulent cases are generally detected during the trial process, how are those frauds generally brought to light?

Mr Guthrie—There are a number of checks and balances. First of all, when a worker lodges a claim they have to make clear that the claim is work related. There are two major areas in which a worker can make a claim: a disease that is significantly contributed to by the work; or an injury by accident, which is a specific trauma. In the case of specific trauma where, for example, a worker says they have broken a leg, they have to represent where that leg break took place—either at work or somewhere else. In that instance, if the worker represents that the accident took place at work but in fact it did not, usually the fraud is detected through adequate and appropriate questioning by the worker's own lawyer. If it unfortunately gets past that gate-keeping process and goes on to trial then, certainly in my experience, the worker tends to be detected at trial. Unfortunately, that is too late, of course—the damage is done. But before that there is the insurer making its own investigation. There are a number of checks and balances in the way of a worker who sets out to make a fraudulent claim: in the first instance, there is the insurance claims process; in the second instance, a vigilant lawyer representing the worker should be able to detect fraud; and, the third—and the worst result, of course—is the worker going to trial. Again, in my experience only a very small number of workers are actually prosecuted for perjury in relation to workers compensation matters.

To complete the answer, the issue of disease-related claims is much more difficult, because the worker may genuinely believe that they have a disease which is related to their work. It comes down to a medical issue. It is very difficult to say that a worker is fraudulent when they

have a disease which they see as having a connection with their work but which a medical practitioner says there is none. There is frequently a temporal connection between the onset of a disease—because, for example, it became worse at work—and yet the aetiology of the disease is such that a medical practitioner says that it could not be work related. In those situations it is not fraud but a mistaken claim.

Mr DUTTON—I have a question in relation to cost shifting, which you have touched on. Are we able to quantify the extent of that at the moment? How many people have ended up parked on a disability support pension in dubious circumstances?

Mr Guthrie—The short answer is no, but let me explain the long answer. On page 240 of my report there is a list of things which I thought should be done in the future as research. Item 11 says that the effects of cost shifting in compensation claims should be a matter for further research. It is not possible for someone working in a state jurisdiction to easily get the kind of data that you ask about, because that is a federal institution that is looking at disability support pensions; and we would have to get that from Centrelink. I think cost shifting takes place in a number of areas in all workers compensation systems, particularly where you have caps on weekly payments. Our cap at the moment, as Mr Neesham explained, is 'A worker who goes under workers compensation will be capped at 1.5 average weekly earnings.' As he correctly indicated, for people who have an income above $45,000 this basically means that they will be capped. For people below that, it is of little effect.

My recommendation in the report, which you have the executive summary of, says that the cap should be raised to two times average weekly earnings. That would put it basically on par with most other states. Having said that, that was somewhat of a compromise because there was a range of opinions as to the idea of capping. Interestingly, insurance brokers consider that capping is a significant problem for their clients—that is, the employers—because many employers continue to pay above the cap for the sake of industrial harmony or in the hope that this will continue or revive the employment relationship. In other words, once you start capping a worker you may create an alienation process with the worker, and you may choose not to do that.

Mr DUTTON—What sort of incentive are you providing for a return to work or an interim management scenario? If you have a worker, for argument's sake—and I understand what you are saying—who is on average weekly earnings and goes into this system and is capped at 1½ times, is that person paid at what their normal rate of pay would have been prior to the injury, or are they paid an inflated amount?

Mr Guthrie—No; they would never be paid more than their weekly earnings. They would never profit from workers compensation. That is probably a misunderstood point. I do not say that you have misunderstood, but frequently the case is made that you can make profit from workers compensation. The truth is that you simply cannot. Everyone who goes into the compensation system suffers some kind of loss, either because they stay on weekly payments for an extended period and the system says that those payments should be capped and reduced, or because overall there is a loss of earnings because they have not returned to work and they could have made extra money.

Your question is critical to the whole issue of workers compensation, because it is tied up with what we do with the worker in terms of returning them to work. If you focus on the issue

of doing that by a mechanism of disincentives, of capping their wages, the system will not achieve any good outcomes. To go back to some of the early reports, Justice Woodhouse did a report for the Australian government back in 1975 and drew on the New Zealand system, where there is a system of caps in place. The logic there was that, if you had paid the worker their same wage, there would be no incentive for them to go back to work; therefore their wage should be slightly reduced. His figure was about 80 per cent of their average weekly earnings.

It is important to go a step further. You need to have a process of sound injury management. You also need to have a mechanism built into the legislation which has a requirement that the employer protect employment and try to introduce the worker back into employment. Most states have a statutory 12-month period where they say, in effect, that the employer must keep the job open for 12 months. This is a very common statutory provision. Western Australia probably has the weakest provision in Australia, perhaps together with Tasmania. Our section only says that you should keep the job open for 12 months but that, after that, the worker can be dismissed; and, prior to 12 months, even if the employer does not provide the job they will only be subject to a fairly moderate penalty—about $5,000. So in other words, there is not a great incentive or disincentive for the employer to keep the job open. The main thing that gets a worker back to work is, firstly, a facility by people trained in injury management to recognise a person's potential to return to work; secondly, the right medical advice and treatment that facilitates that; and thirdly, the fact of having a job.

Section 84AA is the 12-month period, but it does not go far enough. For example, if the worker is dismissed it does not provide a procedure which allows for reinstatement of the worker. It also does not put in place a procedure where, if the employer does not provide that job, it will have an effect on their premium. Those sorts of provisions do exist in New South Wales and South Australia, and my report recommends that they put in place in Western Australia. You need a range of tools to get people back to work: injury management and a solid provision to protect employment—and, to some extent, the issue of capping weekly payments is also there. You need all of those. And do not ignore the fact that people need some assistance to get back to work.

One other thing which is probably as important is the question of a second injury fund. In some states—Victoria, South Australia and New South Wales—they established what is known as a second injury fund. This is similar to the idea that Centrelink have had in the past where, if a person has been out of work for a long time, you offer a new employer some incentive to take them on. So you might pay them half the wages for a period of time or three quarters of the wages, and you might assist them with money to make some adjustments to the workplace. Those systems exist in New South Wales, South Australia and Victoria. We do not have a system like that here.

One of the main disincentives to that is the fact that we have a private insurance system. In those states where you have a sole insurer, or a government based insurance system, you can set up a fund which is devoted to that re-employment prospect. We need to work on that in Western Australia and juggle that within our private insurance system. I think it is possible. It is one of the recommendations I have made. It needs further work. But I think it is a very important thing that you can also go to an employer—and I am thinking here of an injury management professional who says to the employer, 'This worker cannot go back to their old job but you, as a new employer, if you employ this person, have the incentive to do it because we will, for example, pay half the wages for the first six months. We will also help here with the workstation

and we will change that and we will pay $2,000, $3,000 or $5,000 as an incentive to do it.' I think they are pretty powerful tools to get people back to work.

Mr DUTTON—I have a final question. Taking you back to the basis of my initial question, how do we identify, even if the figures were available from Centrelink, for argument's sake, those who were on disability support pensions? I am talking about the X number of people from WA who come onto a disability support pension each year out of the workers compensation system. How would we identify those people that the WA WorkCover or the WA government were trying to park onto disability pension to satisfy their own figures?

Mr Guthrie—There has been some work done by Centrelink on this because obviously it is a major concern for them that they would be picking up shortfalls in the compensation systems around Australia. It has been a concern for at least a decade that I can think of. In terms of identifying them, Centrelink would probably be the best people to talk about it. In Western Australia, most compensation systems are either settled by payment of a lump sum of some description under our compensation legislation or, alternatively, they are paid by reason of a judgment in the district court for a common law claim, in which case their claim comes to an end, they have a lump sum payment.

I suspect that the cost shifting into the Centrelink area is not of the magnitude that was first thought. The reason for that is there is a preclusion period which prevents people from accessing disability support sickness benefit for the lifetime of their lump sum. If you are familiar with the calculation that gets done by Centrelink, they look at the lump sum. They divide that by the average weekly earnings—that is, from the federal statistician—and that gives them a number of weeks which the worker cannot access social security. In other words, there is already a mechanism which prevents, to a large extent, costing shifting.

When I was looking at cost shifting here, I was concerned about the fact that, on the face of it, insurers and employers are saying that we currently have a system in WA which is delivering premiums around 2.7 per cent of wages but in fact there is a pool of money out there which is being paid outside the compensation system by employers as wages. So the worker who goes on compensation but whose wage is not stopped because the employer has an agreement with a union or decides that it is better employment practice to continue to pay at the full rate—they are in fact subsidising this compensation system. That is what I mean by cost shifting. They are not obliged to make that payment under the compensation system, but they do for other reasons. That suggests that, firstly, the compensation system is not doing it properly or, secondly, there is some other better employment practice that makes employers do it.

The other area is journey insurance cover. We do not have that in Western Australia and workers either take that out privately, through their union or as an extra payment to their employer through their wage system. As an example, at my own university, we pay about $30 per year to cover ourselves driving to and from work. That is a cost which used to be borne by the employer but it has now been shifted to the individual worker.

Mr WILKIE—I am very interested in following up this point about employers not making contributions and that being fraudulent, thus increasing the costs of insurance for everybody. Have you any idea what sort of reduction in premium may occur if everybody paid as they should?

Mr Guthrie—I do not think I could possibly answer that. I think that is an actuarial question. The best guide—I know you do not have the full report—is on page 219 and 220 of my report. There is the data in relation to the amount of money which is being paid out of the uninsured fund. There is a suggestion that it is pretty stable at the moment but it is still in the area of $2 million to $3 million which is paid out through the uninsured fund.

I guess you would spread that figure across the amount of premium which is collected, which I think is currently about $600 million. It is not a large amount—and I suspect it is mainly small employers that are in this situation—but it has some impact. Putting it in the context of the allegations which are usually made against workers, I think it is reasonable to balance it up against the fact that there is documented and statistical data on employers.

Mr WILKIE—We are going to receive evidence a little later from someone who is suggesting that one of the problems we have with fraudulent claims is the ease with which workers can put in a workers compensation claim and the fact that normally the claims are accepted and paid out.

Mr Guthrie—That is a perspective, I suppose. As to the ease with which a claim can be made, it is certainly harder than making a claim under most insurance policies, because it has statutory requirements which insist that it be work related and that the worker establish that there has been some loss of weekly earnings or that they require medical treatment. I think that it is not an easy system at all, certainly not in my experience. It is the case that probably 90 per cent of claims are accepted and paid; that is because they are genuine claims. That is probably the case in any insurance system. I heard Mr Neesham talk about these things usually being difficult at the margins. The truth is that in most systems it is the 10 per cent of claims lodged which cost the most amount of money and the 10 per cent of claims which are the most difficult to assess.

It is worth talking about stress claims, for example, which are inordinately hard to deal with. It has been the practice of insurers in this state and I think most states to decline stress claims as a matter of course. But I should also say that there are a number of insurers who have actually changed their mind and their strategy in relation to that. It is worth drawing to the attention of this committee the fact that there are two or three insurers who are actually accepting stress claims without making serious investigations into whether or not they are work related. In other words, they are simply accepting that if a worker lodges a stress claim it is more economical to treat the person to try and facilitate their return to work and put them through the compensation system than it is to actually aggravate that person's condition and make it virtually impossible for them to make a claim and put them through the compensation system. So sometimes, in fact, it is commercially sensible for claims to be accepted. It is a perspective that they are too easy to claim, but I would say that that is because they are genuine and/or there are commercial decisions which makes sense, and that is particularly the case in stress claims.

Mr WILKIE—The meat processing industry put in a submission to us last week which stated that they believe that fraud is virtually rampant in their industry. They were blaming insurance companies on the basis that often insurance companies will be quite happy to make payments because that increases premiums and thus increases their profit margins. They claimed that doctors are often in with the employees because they are usually their friends. They made a suggestion that lawyers tend to follow up cases on a regular basis, even though there is no likelihood of their really being genuine cases, on the basis that they then benefit because they

have more work through making those sorts of representations. I am interested in your comments in relation to some of those types of issues, because it has been probably the only submission of its type that I have read so far. Have any of those sorts of claims rung true with anything that you have looked at in the past?

Mr Guthrie—They are pretty familiar, and there would not be an inquiry that I have done—and there have been three now—where I have not heard that kind of allegation. There are three things there: the claims are too easy; the insurers pay them because they want increased premiums; and lawyers somehow generate claims. I suppose I have to declare an interest in the last one, being a lawyer. But I have also studied this area intensively for the last 10 years.

There are certainly some cases where legal practitioners have not proceeded claims with sufficient alacrity. That does not necessarily mean that they are not doing their job properly; it may be through lack of skill or whatever. I think it is a diversion to focus too much on that. I think Mr Neesham gave a statistic that lawyers took up eight per cent of the costs of the system. I think that statistic is doubtful. There are significant expenses which are included as lawyer expenses which are in fact medical reports—which should not be. But, coming back to your first point, I do not think there is much sense in the comment made that insurers want to increase premiums so that they can make a profit. If in fact they are allowing claims for workers, they are making more payments to the worker and therefore any increase in premium would be absorbed by the amount that the claims are taking up. So I do not think that is a sensible comment.

As to doctors being workers' friends, I have certainly heard the reverse allegation frequently—and some of the people who have been present here this morning would give you chapter and verse about how the medical practitioners they have seen would be in the keep of insurers. I think these allegations are very easy to make but very hard to substantiate and frequently untrue. It is certainly the case that a medical practitioner will have a particular perspective on how a person should be going back to work and what their progress should be, but in most instances those opinions are fairly validly sustained, whether they fall on behalf of the employer or the employee.

What I think is more concerning about your comments is that for most employers the compensation system is a mystery. They are frequently alienated from the system due to the fact that they have an insurance broker between them and they do not have direct contact with an insurance company. They are frequently not au fait with the requirements of the act. In the case of the meat industry, I know from personal experience that there are a range of diseases within that industry which, under the act, are deemed to be work related—I am thinking of conditions like leptospirosis and conditions which are contracted through meat contact—which may of course influence anyone in the meat industry who thinks that they are hard done by.

One of the things that any compensation system needs to do is to directly involve employers in the processes of compensation. One way that you do that is to establish—and I think one of the members of the committee has raised this as an issue—a link between the insurance premium and the employer's achievements in terms of return to work and safety record. In my report I attempted to address that by saying that there should be direct statutory links. It has already been spoken about this morning that there are informal processes. It is certainly the case that large employers do get discounts and smaller employers are not able to get them. The rationale for that is that if you give discounts to small employers you disturb the premium pool

of those small employers and it therefore makes it uneconomical. I think that is a fallacious argument.

I think what is happening is that the insurers are deliberately dividing the pool into various categories—small and large. If you give a discount to a small employer, then necessarily you must affect the premium of the small employer. But if you take the premium pool en masse that argument does not hold up. In a system where you have private insurance, it is a difficult argument you have to get around, but if it is a sole insurer system or a centrally run system with insurers perhaps as the agents, a lot of those problems fall away. In any system you need to have good communication between insurers, their brokers and the employers so that those kinds of beliefs are not perpetuated. I have heard them over and over again. Once people understand the complexities of the system, they are probably less inclined to make those sorts of comments.

Mr WILKIE—I would just point out that they are not my views; they are the views that were expressed to us last week.

Mr Guthrie—I understand those views are in submissions. I believe those views are clearly honestly held, but in most cases they are very hard to substantiate.

Mr WILKIE—We had evidence given to us earlier in the inquiry. I cannot quote the people giving it, but I think it was one of the Commonwealth agencies that also have a scheme. They found that fraud was very low and that the level of claims was very low. They also had control over occupational health and safety of workplaces, so they could not only charge premiums but also ensure that workplaces actually lived up to the arrangements they have in place for occupational health and safety. Do you believe that where you have really sound work practices in terms of occupational health and safety that the level of claims would normally be low?

Mr Guthrie—I think that you need to work on that as a feature of the system. I think it might be a mistake to focus on that solely and say that if you reduce the number of claims you will therefore reduce the cost to the system. The reason I say that is that the statistical data in Western Australia shows that in fact we have had a reduced rate of claims or accidents in Western Australia. It has been declining for the last 10 years. Yet since 1995 we have had increased payouts in terms of compensation common law claims. They have stabilised—in fact, I think stabilised is not the appropriate term: they have fallen. Their cost to the system has fallen since 1999. I will come back to that in a moment, if I can. But it may be focusing on one single issue.

After 10 years of studying these things, the thing that comes home to me is this: you certainly need to have sound occupational health and safety practices and I think it is good to have links between the insurer and the provider of occupational health and safety, somehow. In this state, we have two bodies—WorkCover and WorkSafe—who need to work together to bring about good outcomes. It may be appropriate to have them actually as one body.

The other thing which I think is absolutely crucial in this, and this is the point that came home after all these years, is that really the only mechanism which will contain costs is actually returning workers to work quickly, and focusing on the mechanisms which do that is a very important thing. Even if you have a scheme which puts people back to work or gets them out of the system, you have the problem of cost shifting into Centrelink. So to avoid those costs you need to have sustainable return to work programs, and that I think is something which most

states are working on. Those are the key elements: good health and safety and good return to work. Then the level of benefits is not so critical. We have focused over the years on the actuarial evidence about how much we should pay people and what they should get on weekly earnings. My view is that if you are getting people back to work then the costs will come down. The big issue is the duration of claims: how long a person stays on compensation is usually the damaging issue. If you can get a person back to work within six weeks instead of 12 then the amount that you save is enormous. Those are the key issues. But I do not discount occupational health and safety.

Mr WILKIE—Thank you for that. I compliment you on your submission and presentation today.

CHAIR—Thank you very much for your time today, Mr Guthrie.

[11.04 a.m.]

SHANNON, Dr Peter John, Psychiatrist (Private capacity)

CHAIR—Welcome. The proceedings here today are formal proceedings of the parliament and warrant the same respect as proceedings in the House. In providing your evidence today I would ask you not to name individuals or companies or provide information that would identify those individuals or companies. The committee is interested in the broader principles relating to the terms of reference and the issues that you may wish to raise. We are not prepared as a committee to provide the protection of parliamentary privilege to allegations about particular individuals. We prefer as a committee that all evidence be given in public, but if there are matters you wish to raise as a private submission to the committee we will certainly consider the request, if you make it. I invite you to make some preliminary remarks and then we will move to questions.

Dr Shannon—You have the document I prepared before. I responded because I saw the advertisement in the paper and I think this is a very important issue. In part of my work practice I see people with workers compensation claims and I feel that gives me some experience in looking at this. My area, of course, is psychiatry and psychological issues, so I do not claim any expertise in areas of physical injury or anything like that.

I have become fairly concerned from time to time about the way an emphasis is put on the idea that psychological issues are not real workplace issues by some people. I am really very much against the reductionist view that persons are employed as something like industrial robots with no emotions, feelings or psychological reactions. One of my reasons for putting the submission in and coming before you is that I feel that any system that takes into account physical problems but ignores psychological aspects is only a partial system and I think that is to be regretted.

I would just like to say a couple of things about a couple of topics that I think are quite important from my point of view. One of the problems, which I have mentioned under 'Assessment' in my report, is one which I think bedevils all medical assessment—namely, how we come to a conclusion. I thought it was mainly in my field that it was a problem, but recently I saw two very experienced colleagues try and work out what percentage of disability a person who had had a neck injury suffered. It was really quite interesting watching these two very experienced people try and work out what the percentage was. So I think it is a problem for all medical areas. It is especially a problem in psychiatry, particularly in some places such as WA, where the act says that we have to give a percentage. I think there are ways around that.

I would like to suggest that one of the things to look at is some good way of assessing psychological impairment in a workplace directed situation. In my report I mentioned several examples that I do not think are particularly good. I suggest that the Department of Veterans' Affairs method of having a multiaxial system is probably the closest to the best you can get, but it would need to be refined for a workplace situation. It is certainly not ideal for a workplace situation, because in the Department of Veterans' Affairs it is really orientated on what percentage they get as their entitlement. That is not exactly what you want to do in a workplace

situation. Then, if you have a tool like that, people need training in the use of it. It would not be a tool that just everybody could use; people would need some training in it.

The other area I would like to mention in the broadest context is rehabilitation. I frequently see people who have been sent to some form of rehabilitation which does not fit their particular needs. I heard your previous presenter saying that it is was important to get people back to work early, and it certainly is, but very often in that process somebody will be told—probably by a medical practitioner—that they can go back to light duties, which seems like a good step on the way to getting them back to work. But it is not all that uncommon for the employer to then say, 'I haven't got a job that supplies light duties.' I do not think that is the employer being difficult; I think that is just the nature of the workplace they run. Then that person very often does not get progressed anywhere, as far as going back to work is concerned. It is not quite as simple as just saying: let us get people back to work. For people who are not fit to go back to work full time in their old job, an issue that needs to be looked at is how to get them back to work. It is not simply: 'Let's do it.'

Another issue that comes up time and time again in my experience is retraining. It arises when a person who has had some sort of injury cannot go back to the work they used to do for physical reasons and then their employer says, 'I haven't got an alternative job.' That is quite legitimate. That person does not need rehabilitation; that person needs retraining. That is something that is not very well dealt with in most acts, as far as I can see, and there is usually neither the money nor the resources in the system to help the person retrain. As I am sure you are aware, retraining costs money; these people usually have families who are dependent on them, and they do not get the retraining.

The tragedy is that these people often end up getting some sort of settlement which, although it may be a little or a lot, is not enough to live on for the rest of their lives, obviously. They end up getting out of the work system and becoming people who perhaps do a little bit of work somewhere but who are essentially on disability support. Yet some of these people are the very people who are the best trained in one sense. They are not trained in particular skills but they have work experience. They have worked hard for years and they know all about getting up in the morning, going to a job and doing a job. Then something happens and they do not have a job, they cannot get the training and their life is put into considerable chaos. That is when I usually see them—when they get thoroughly depressed and despondent because they are stuck in a system that does not seem to be helping them. I guess that covers what I see as the important issues I think something can be done about. I would be happy to leave it open to your members now.

Mr WILKIE—We have heard about the exacerbation of stress due to the adversarial nature of the workers compensation system. Do you believe that an alternative process is appropriate for stress claims? I will give you an example. I can quote from experience. Someone was on stress leave and was not putting in their sick forms for time off. One of the reasons for that was that they were sick. It got to the point where they had to have a letter written to them to advise them that, if they did not put in something, they would forfeit their employment. That would obviously have put greater stress on them again. How do you deal with those sorts of claims? Is there an easy answer to that?

Dr Shannon—I am not sure that there is an easy answer. We live in a world where the reality is that people do have to put in forms and things like that so, if I was involved with somebody

who was having difficulty with that, I would certainly spend some time working with them to make sure that those claims did go in. But I do not think that that solves the larger issue that you raise, which is whether an adversarial system is the way to sort these problems out. Certainly, I was of the opinion a few years ago that that was absolutely the worst way to do it. But it seems that we have not developed a better way, in the sense that when it becomes too hard for one party, whether it be the insurer, the employer or the worker, the other parties need to have some leverage to be able to get things to move. For instance, if an insurance company is being very difficult and not authorising treatment that is recommended by medical practitioners, as happens sometimes, what leverage does the worker have to get that done? If somebody is recommending to the worker that there is no reason why they cannot follow this ABC path and the worker says, 'No,' there seems to be some need to encourage that person to go along that line, if it is reasonable. The idea that these matters can all be resolved around the table is a good one, but it does not always seem to work, for one reason or another. Certainly, the ideal situation would be that it would happen there first: people would sit around the table and try to work it out, with all parties being represented. But, as I say, when it does not work, you need some backup or follow-up, whether that is a strict court situation or something else. I am not really an expert in that area so I cannot really make a recommendation on that. We live in a world where things do not always work perfectly.

Mr WILKIE—Do you think that the current system encourages the exaggeration of stress claims by workers? It has been suggested that sometimes people put in questionable claims about the actual level of stress that they have been suffering and, therefore, exaggerate their claim.

Dr Shannon—I think that there is some exaggeration of claims, but what tends to make it worse is the fact that, when people feel that they are not being taken seriously, they get agitated and then blame that on the original incident or injury. It certainly seems to me that the less conflict you can have very early on the better. Some sort of protocol that everybody—the employer and the insurance company—knows about is probably a very good way of stopping that sort of aggravation early on.

Very often I see workers and they say, 'I have never put in a claim before; I did not know what happened', and they are quite mystified. I have seen some situations where employers bend over backwards to help workers, and that seems to work very well. Sometimes the employers do a whole lot to help somebody and then feel that it has not worked, and then they get frustrated, but at other times people are not dealt with well, right from the very beginning. That is where a good, clear protocol would play a very important role, ensuring that everybody knew what to do.

Mr WILKIE—A number of submissions have indicated that workers compensation claims associated with stress are normally difficult to substantiate and only a few claims actually get accepted. We also heard today that a lot of insurance companies are paying them out on the basis that they are hard to disprove. What has been your experience?

Dr Shannon—From my experience, one can make a fairly good assessment of whether the work situation, or whatever it is, has caused the stress. I do not think that is hard. I think the problem lies in assessing the level, and this is why I mentioned in my presentation that we really need something that helps us assess that level much better. If we did that, people would be able to get those things sorted out quickly. Certainly I think that the quicker stress claims are

sorted out the better, in one sense or another. In my experience, if people are treated quickly and get their claims assessed quickly, it is not uncommon for them to get back to work and get on with life. In such cases, the claims are minuscule compared with other claims where somebody is not going to work again. Such claims really add up to perhaps a few weeks off work and a few medical appointments and that is it—they are all over. Those are not huge claims.

Mr WILKIE—What proportion of people going out on stress leave return to work?

Dr Shannon—I have not got figures for that, but I would think it is quite a good proportion of people.

Mr WILKIE—I will put that in context. People would often claim that the stress has been incurred at work and they have gone off on stress leave. But when they return to work the same factors are still there. Would there be a recurrence of that stress related injury?

Dr Shannon—In a few cases that I can think of, the person is just depressed. When you get them over their depression, they go back to work and see their workplace completely differently. I can think of a classic example of a patient like that. He looked as though he was never going back to work. We got him over his depression and he is back working; the place is just as stressful now as it was before, but he is coping very well. So there is that aspect to it, but there are also often some personality factors involved with other staff members. If the employer is able to deal with those in some way, those people can usually go back to work without any problems. There are other people, of course, who do not go back; but when I see somebody who is on stress leave, I am quite hopeful that they can go back to work again and that it is not the end of the earth.

Mr HARTSUYKER—Do you see that medical assessment panels, rather than having a more adversarial approach, have a role in relation to assessment of stress cases?

Dr Shannon—I think they have a quite useful role, yes. I have been on a few and I think they can give reasonable advice to those who are deciding the situation.

CHAIR—One of the other parties that has made a submission has made a lot of recommendations with regard to medical practitioners. They suggested that medical practitioners be provided with the option of determining the work relatedness of an injury or, alternatively, clearly declaring an inability to make such a determination. Do you see any value in such an approach?

Dr Shannon—I think it is a fairly specialised area and it is probably an area where particular people would make a better job of it than others. For instance, occupational physicians do that very regularly. I think there are people who are qualified to make those decisions very well, but I do not think every medical practitioner would make the decision at the same level of expertise, simply because of their practice or their experience.

CHAIR—The same party has suggested that medical practitioners have a statutory responsibility for their work relatedness determinations. I am not quite sure how that would work but, again, do you see merit in such a suggestion?

Dr Shannon—I do not quite understand how it would work either. I would think medical practitioners are responsible in some sense for their decisions anyway. I would presume that we would be open to common law claims if we made any outrageous suggestions about the person working or not working. I do not really see the point of having some other extra statutory guidelines—or whatever you might like to call them—apart from that.

CHAIR—The claims associated with stress are fairly difficult to substantiate at times. Could you give us an overview of your experience with stress claims? You mentioned before that quite often, if people overcome their depression, they are quite happy to return to the workplace, although the same factors prevail. In assessing stress, is this an area that would be open to fraud or do you believe that it is in fact an area where claims largely are legitimate?

Dr Shannon—I think any claim could be open to fraud, but I do not think it happens very often. I guess one could make a stress claim, but I think when somebody like me is faced with a person who is making a stress claim it has to reflect on all their life—not just that they cannot go to work. If somebody is really stressed and cannot go to work but is quite able to get on with their family life and everything else, that raises issues with me about what is going on with this person. I think you can make a fairly reasonable assessment of what is causing the problem.

For instance, the most recent person I saw is a person who has a lot of stress in their life. Somebody had been attributing it to the break-up of her marriage, but it was quite clear when going through her history that her husband getting up and leaving was probably the thing that she was going to party about, if I can explain it that way. The other stresses in her life were the things that were really important, and some of them were work related and some were not. She has a sick child, for instance, and that obviously impinges on a person. You have to take those things into account, and often the situation is complicated like that—there are other stresses in a person's life. For example, in the case of the person with a quite sick child, you have to ask what part that ongoing sickness plays. Yet there are obviously workplace stresses and injury stresses. There can be lots of stresses in our lives but you have to tease those out. I think it can be done, if people spend time on it.

Mr DUTTON—I have a follow-up question in relation to the evidence that you have just provided. If it is the case that stress is caused by at least two or more factors, one of them being work, and that a person is on workers compensation or having time away from work, how do you decide whether it is work related or whether it is a contributory situation? Can you define what proportion is attributable to work and what is attributable to an unhappy marriage or a situation at home? How do you deal with that situation and whether or not the employer is then responsible for that claim?

Dr Shannon—I acknowledge that it is very difficult. I think this is one of the reasons why allocating percentages to things makes it extremely difficult.

Mr DUTTON—It is near impossible, isn't it, to determine whether one condition was present before the other or whether one aggravated the other?

Dr Shannon—You can get some idea by following the history of exactly what has happened in the sequence. But I think it is impossible to allocate it and to say, '10 per cent is work; 20 per cent is home.'

Mr DUTTON—If those two conditions were present, that would not preclude a worker from claiming workers compensation, would it?

Dr Shannon—Not usually, no, providing the work obviously was causing a significant amount of stress. I think 'significant' is the word that is usually thrown around by lawyers. But if there is absolute chaos in the rest of their life and work is a little part on top of it, you have to assess it in that fashion.

CHAIR—Dr Shannon, thank you very much. We appreciate your time today.

Dr Shannon—Thank you.

[11.33 a.m.]

BELLAMY, Ms Annette Ellen, Director, Health, Safety and Workers Compensation, Chamber of Commerce and Industry of Western Australia

CHAIR—Welcome; thank you for coming today. The proceedings here today are formal proceedings of the parliament and warrant the same respect as proceedings in the House of Representatives. In providing your evidence today, I ask that you please do not name individuals or companies or provide information that would identify those individuals or companies. The committee is interested in the broader principles and the issues that you may wish to raise. The committee is not prepared to provide the protection of parliamentary privilege to allegations about particular individuals. The committee would also prefer that all evidence be given in public, but if there is a matter you would like to raise in a private submission to the committee, please make that request we will certainly consider it. I now invite you to make some preliminary remarks, and then we will move to questions.

Ms Bellamy—Thank you for the opportunity to address you today. My remarks will be an overview of our written submission. In that submission we have addressed the terms of reference. It is therefore quite a specific submission that does not address the broader aspects of workers compensation. I will confine my initial comments to the terms of reference. We really have no data on the incidence and costs of fraudulent claims, but we come here today with a concern. That concern is twofold. The first is the ease of entry into workers compensation and the second is the lack of enforcement of penalties for wrong entry into the system. Those comments, again, are specific to the Western Australian system.

In regard to entry into the system, we think that there are a number of major drivers. Apart from the ease of entry, those drivers include the high cost of exposing fraud and the fact that we therefore see very few cases of fraud exposed. I cannot recall the last such case in Western Australia. That is not to say that there has not been one, but I certainly cannot recall one in the time I have been involved in the system. We also find that the benefit structures are an issue. That is not to say that the existing benefit structures in Western Australia attract fraudulent claims, but I think there is now sufficient research to show that very high benefit structures have the potential to attract such claims.

Another driver is the lack of strategies within the systems to identify and punish fraudulent behaviour. To my knowledge, there are no strategies in place within Western Australia to identify these claims. They are only identified in cases where the claim is very blatant but, because of the ease with which injured workers or others can enter the system, fraudulent claims do not become obvious. The last driver is the lack of control by employers over insurance premiums and the management of claims. Those responsibilities are subrogated to the insurers, and the insurers do not always consult with employers with regard to either the management of those claims or the genuineness of those claims.

The next term of reference is about costs. As I said before, we do not have any hard data on costs. What we do know, particularly through our management of claims for a number of large employers who are self-insured, is that the cost to employers of investigating claims is quite high. For a reasonably minor claim, our experience is that the cost could be in the vicinity of

$3,000 to $4,000. That is the direct cost—it does not take into account any of the indirect costs. If, for instance, we investigate a claim and then deny that claim, there is no strategy within the system to investigate whether or not it was a fraudulent claim, so the costs of the investigation rest with the employer either directly, if they are self-insured, or indirectly through insurance premiums.

The other concern in that area is that disputes with regard to claims are discouraged. You are possibly aware that within the Western Australian system there is a monitoring program of insurers and self-insurers. Part of that monitoring program is the measurement of disputes that go to the Conciliation and Review Directorate, and I know that self-insurers are at times quite discouraged from disputing a claim. There are other ways in which you can deal with a claim than taking it to dispute, so that in itself does not assist in the identification of fraud. It also does not assist in dealing with fraudulent behaviour, should it be discovered.

The last area is rehabilitation. Our submission makes some strong recommendations in regard to rehabilitation. It is important to say at the very beginning that we see rehabilitation as an externally provided service. We tend to talk about injury management, which is about providing either internal or external services that assist an injured employee to get back to work. Our focus is on bringing employees back to work. All that should happen must happen to ensure that that is the outcome. In some respects, we see that as the major outcome. We recognise that there may well be some employees who will never go back to work. Certainly, the majority of employees can go back to work, whether that is with the same employer or another employer. We see that as part of the injury management process.

We have taken the hardest stand with externally provided services. We believe that there are some cases where those services are used as a claims management tool. They could be used by either party. When they are used as a claims management tool, it provides great discouragement to the whole principle of return to work. It is not about return to work: on the part of the insurer, it is about showing a capacity or, on the part of an employee, showing an inability to work, because that may well benefit them in a common law claim.

The greatest barrier to successful injury management or return to work has been common law. In our experience in managing claims, once we know there is potential for common law and that could start with seeking legal advice, you can frequently see a change in the injury management program. That injury management program may change from a return to work, a part-time return to work, being off work or alternatively from being back at work to dropping off and being unfit for work.

That brings me to a number of recommendations that we made with regard to service providers and, in particular, to medical practitioners. We have a concern within the system that there is not a nominated gatekeeper. To enter into the workers compensation system takes little more than a medical certificate to say that it is a work related injury. There is no requirement on the medical practitioner to do any investigation whatsoever. We know that in a number of circumstances there is no investigation and it is the word of the worker. In saying that, I think there are a number of cases that are clearly work related, and so we are now drilling down on the minority of cases where there is some question as to whether it is work related.

In the recommendations, we are saying that medical practitioners should have a choice. We do not believe it is always the role of the medical practitioner to determine whether it is work

related but they should be given that choice. If they choose to make that determination and they believe they are competent to do so for whatever reason—I am not questioning in any way their professional competence—they should be responsible for that determination. That brings in a sharing of the responsibility in regard to the acceptance or denial of a claim because the responsibility now is totally on the employer, possibly through the insurer, to do it.

Overall, the principle that we are espousing is that there are only two parties to the system: the employer and the employee. All of the other parties are service providers to the system. If those service providers choose to become involved in that system, they should have some responsibility, which should be placed on them by the system. It is their choice, but they should have the responsibility. What is happening now is that, if a service provider makes a decision, it is up to the employer to either accept or deny that. It becomes very expensive.

Unfortunately, we do not have stats in regard to some of those costs because many of those costs are indirect costs and are not directly picked up in the reporting to WorkCover in this state. The reporting requirements are changing and so, within about 12 to 18 months, I think we will have a better feel of some of the indirect costs and some of the direct costs which are currently not reported. But, until we have a better feel for those costs, it is very difficult for us to determine just where they are and the extent of them—other than saying we believe that, in some circumstances, they are very high.

Mr HARTSUYKER—Ms Bellamy, you have mentioned the issue of fraud. We have had quite a number of witnesses who have said that they believed employee fraud was occurring at very low levels. The flavour of your submission tends to indicate that your organisation does not believe that to be the case. In the absence of detailed figures, on what basis do you make that supposition?

Ms Bellamy—We actually do not. My opening comment—and I guess I did not make this point as clearly as I should have—was the fact that we responded to your terms of reference.

Mr HARTSUYKER—So it is still only a very small percentage?

Ms Bellamy—Within the overall system, it is not a major issue. Our concern is more with the structure of the system. We believe that there are a number of structural changes that could be made to give us greater comfort that fraud is not occurring.

Mr DUTTON—What systems are you aware of that are in place to help detect repeat offenders making workers compensation claims out of that small minority that you spoke of? Are there systems in place that you are aware of or records that employers keep?

Ms Bellamy—No, there is not. It is an issue that we have been examining just recently. I requested some data because of another area in which I am involved: we were examining the aged care industry and stats within the aged care industry. We examined data on repeat clients—unfortunately I did not bring that data with me but I would be more than happy to submit it to the committee—and I must admit that I was very surprised at the level of repeat claims. I think it is an area that—through my involvement with the Workers Compensation and Rehabilitation Commission—we will examine in the future.

Mr DUTTON—We have taken some evidence during this inquiry that one of the optimum scenarios would be for an injured worker to return to work not necessarily in the same role that they fulfilled before, so it might be a lower skilled job or something with a lower stress level. Is that a practical scenario to impose upon business? I would imagine that that is probably more practical for big business than it is for small business. Is that a feasible avenue to pursue?

Ms Bellamy—It is difficult with small business and it also could be difficult with some workplaces where they are predominantly labour intensive and the injured employee may not be able to carry out any of the tasks that are required within that workplace. I think it is important, as part of the injury management, to return that person to work. The aim of the injury management should be a return to work. That return to work could be into another workplace.

I can give a practical example of a case we have at the moment which involves a trainee. That trainee was placed in aged care. The trainee had a pre-existing back condition which became worse during the traineeship. We have now taken her out of that traineeship and placed her in a different traineeship, which I think is business administration. She is actually flourishing within that traineeship and I think her potential for another job within that business administration area, when she finishes her traineeship next week, is very high. It was interesting because it was a self-selection process for her to enter aged care, but we learnt very quickly that it was just an inappropriate traineeship for her and we were able to move her very quickly.

The short answer is that it is a matter of having your finger on the pulse at the time and to make the best decision to be made at the time. If I have a concern in this area, it is with the externally provided services: at times, I think they do not fully understand the demands of the workplace or the full abilities of the injured worker, in terms of how and where they place them. We have seen at times that, in order to show a work capacity, they are placed in workplaces that are happy to take people on rehabilitation, for a whole range of reasons. I suggest that is not the best or the most appropriate strategy.

Mr DUTTON—We took some evidence this morning that suggested that one feasible system may be a Commonwealth subsidy, for argument's sake, or a state-based subsidy providing some sort of financial incentive to employers to take workers in the process of rehabilitation into their employ. Is that something that would be welcomed by business, or would it be met with scepticism?

Ms Bellamy—It is an issue that has received some discussion recently in the state and within the committees of the Workers' Compensation Rehabilitation Commission. It is not a strategy that I would support. There is a responsibility on employers to do all that they can to return an injured worker to work. That could be to their former workplace or to another workplace. I think employers are adopting the injury management principles and we are seeing, and the data is certainly starting to show, a much higher return to work through injury management. I do not know that a financial incentive will help. I know that there are some unemployment programs that receive financial incentives but in this situation, unless a person has been out of work for a very long period of time, a financial incentive is not the ultimate answer.

Mr WILKIE—I want to ask you about employer fraud and people not paying their compensation insurance premiums. Chamber of Commerce and Industry members normally pay quite a lot to be members, and so they are usually reputable businesses. I would argue that they pay their workers comp insurance before they pay their CCI dues, because it is quite an

expense. Given that, and given that other employers who are not paying it would therefore be driving premiums up for your members who would be paying compensation for premiums, I am surprised that CCI does not have a much stronger position about employer fraud in relation to not paying premiums. What exactly is the CCI's position in relation to employers who do not fulfil their obligations?

Ms Bellamy—Our view is that employers have an obligation to pay their premiums, and should they not pay premiums they should be subject to the full enforcement of the law. Having said that, there is no evidence to suggest that it is a major issue within Western Australia. Examining the strategies that WorkCover use to ensure that premiums are paid, it seems to me that it is not a major issue. Because we have got a privately underwritten system, that system uses brokers and those brokers, as part of the insurance package, encourage payment of workers compensation premiums. And the numbers that have been uncovered by WorkCover in the past four or five years have been minimal. We certainly have a very strong position that employers should meet their obligations under the act, whether it be the payment of premiums or any other requirement.

Mr WILKIE—I raised that because one person has given evidence today regarding fraudulent activities by employees. This person gave evidence that suggested there were only two convictions over the last 20 years that he can remember, whereas in the last year alone 1,700 employers were found to be uninsured, seven of them were charged and were, I believe, convicted. It suggests that employer fraud in relation to not paying premiums is a far greater problem for Western Australia than employee fraud.

Ms Bellamy—We have 80,000-odd employers, and many of those employers are going in and coming out of business frequently. The difference between employer fraud and employee fraud is that employer fraud, or the nonpayment of premiums, is actively investigated, whereas the lodgment of claims that could be fraudulent is very rarely investigated. If there is no investigation, there is no identification.

Mr WILKIE—That is an easy statement to make. What I would like to see is the facts in relation to that. A number of people have said that they do not really investigate, but we have also had insurance companies that have given evidence earlier in the inquiry that have said, 'Where there is a dubious claim, we do investigate it, and we have found that, in most cases, there isn't a problem.' I would be interested in exploring that issue. Also, you made the comment that, if employers have a problem with a person making a claim, they are often discouraged from pursuing that. How are they discouraged from pursuing that?

Ms Bellamy—In terms of the first question, I did make the point—I guess not clearly—that insurers and self-insureds do actively investigate claims. The cost of that can be up to $3,000 or $4,000. At the end of that investigation, all that happens is that a letter goes off to the employee saying, 'Your claim is denied.' My experience has been that, when that letter goes off, nothing further happens. There is no action taken against the employee in terms of cost recovery or in terms of them having submitted a claim that could be fraudulent. Nothing happens.

Mr WILKIE—Have you got any idea about the numbers of the sort of incidents that we are talking about, because that information would be very important when determining the level of the problem?

Ms Bellamy—No. The insurers are the only ones that can provide that. In terms of our administration of claims for self-insurers, it is relatively low because I think the general management of claims is different. It is very much a hands-on management, whereas with the insurers it is a file management. We act as claims administrators, but we work very closely with the organisations in terms of drilling down quite closely on the claims. I suggest that the number that we investigate is smaller than the number that the insurers investigate. Having said that, I have not crunched the numbers but I would suggest that it is three or four per cent of claims we fully investigate.

Mr WILKIE—Of those that you investigate, how many would you think have grounds for nonpayment?

Ms Bellamy—All of them, otherwise we would not investigate them. It is very costly to investigate a claim. It is interesting that, within our system, to send somebody along to a general practitioner costs just over $39; to send somebody along to a specialist with the report costs closer to $1,000. So it is very expensive.

CHAIR—You raise the point in your submission about medical practitioners. They seem to be the first of those groups that, as you said, have employer-employee as central to the question of injury rehabilitation and the veracity of claims. All others are simply service providers to the process. The first line, if you like, is the medical practitioner. I think you made the point in your submission that the medical practitioners, probably quite properly, feel a great obligation to take their patients' version of the injury as given.

Ms Bellamy—Yes.

CHAIR—They act as the advocate for the patient—not unnaturally, because it is what they are trained to do. How do you suggest, then, that one approach that? Should there be—as there is, for instance, for disability support pension, federally—only certain practitioners that are accredited to assess injury? I notice you have suggested that the medical practitioner should be able to declare their inability to make a determination, which again places them in an awkward situation with their patient. How do you suggest that you get around that?

Ms Bellamy—I would just like to make a couple of comments first. I accept your comments with regard to medical practitioners, and certainly they are advocates for their patients. In terms of work related injury, we can easily split it into two areas. The first is the medical condition—and medical practitioners are competent to assess that medical condition. The second part of that is whether or not that medical condition is work related. If we go back to the old examples—did it occur on the sports field on Sunday or did it occur at work on Monday morning?—I do not think that medical practitioners are always in a position, nor do they always have the time, to make that determination, because to make that determination requires the collection of evidence and that evidence may or may not be medically related.

So what I am suggesting is that where it is very clear-cut that it is a work related injury, then the medical practitioner may well say, 'In this circumstance it is: it is a broken arm, it has happened at work.' There may well be other cases where the medical practitioner, almost protecting that relationship that they have with their employee, can say, 'In this case, I am unable to determine the work relatedness of this injury.' That is not the medical condition itself but the work relatedness of it. When I have spoken to medical practitioners—again, I have not

spoken to a large number of medical practitioners—it is not a concept that they are uncomfortable with. I think they are frequently in a difficult situation where the employee will say it is work related, they feel some discomfort but there is very little they can do. They have a surgery full of other patients and they really do not have the time nor the resources nor the ability to determine that work relatedness.

It gets back to what I was saying before, that under our system we do not have a formal gatekeeper. There is nobody, at this stage, that says, 'Yes, it is work related,' or 'No, it is not.' So what happens is that the first medical certificate almost becomes prima facie evidence of a work related claim. It is then up to the insurer or the employer to accept that claim or disprove it, and to disprove it becomes very expensive. There have been situations, even in my own experience, where the claim is no more than, say, two doctors visits, which is less than $100. We say, 'To investigate this claim will cost us a couple of thousand dollars. To pay it will cost us $100. We know that it is finalised. There won't be any further problems. There is not the potential for common law, therefore we will accept it. We will pay it; we will close it.' It shuts down the payment and everyone can get on with their lives. The point that we are making there is that there needs to be a formal gatekeeper. In a high percentage of claims that formal gatekeeper can be the medical practitioner, but there will be others where there needs to be another gatekeeper. With respect to those claims, then I would like to see, whether it is through WorkCover, certainly the ability to refer that claim out so that it can be further investigated and it is not the total responsibility of the insurer.

CHAIR—Who would you envisage it being referred out to?

Ms Bellamy—It may be that we just have particular protocols in place. Once it defaults down, those protocols would be addressed and could be monitored by WorkCover.

CHAIR—Are there any further questions?

Mr WILKIE—Yes, I have one. It relates to what you were saying before about the cost of an investigation and people having no ability to pay it back, and therefore often people do not proceed. Even though they might not get their compensation, there is no penalty on them for causing that expense to the employer. If there were to be a penalty system—for example, for employees who did that—could the chamber of commerce live with a system that would also penalise employers who were not fulfilling their obligation under the same sort of circumstance? I make that statement because of the 1,700 employers who were found to be uninsured, and only seven of those were charged. It is a two-way street at the moment: you have got employees who may not be doing the right thing and they get dealt with, but you have also got a lot of employers who are not doing the right thing and are not necessarily getting dealt with. Any system would have to be a two-way street.

Ms Bellamy—Yes. In terms of the nonpayment of premiums, the rules are in place; it then becomes an operational issue. As I was saying before, once the rules are in place we expect the agency to enforce those rules and take whatever action is appropriate to ensure that the legislation is complied with. The point that I was making about the employees is that I do not think the rules are yet in place.

Mr WILKIE—I imagine it would be costly if an employer could take a civil action against an employee in those circumstances, if they believed they were not entitled to any money.

Ms Bellamy—Absolutely. In the broader sense of it, there are certain rules in place that allow actions, but it becomes very expensive, if you have already spent several thousand dollars on a claim, to take a civil action—unless there is a pressing need to do so. For most of us, we say, 'That one is closed. Let us get on with it.' It becomes very disruptive for the workplace. It is not an avenue that we would pursue lightly. Costs aside, there is a whole range of reasons why we would not pursue it.

CHAIR—I have one last question. You say that it is not so much the fraud but the system, although you make reference to some very small claims—a couple of doctor visits and a week or two away from work—which are simply not cost-effective to investigate or pursue. Are you suggesting that there is a potential for considerable fraud but that it is very difficult under the existing system to discourage it, investigate it, and quantify it?

Ms Bellamy—Exactly.

CHAIR—But there is the potential—in a very minor way.

Ms Bellamy—Yes. The potential is there. What we do not know is if people are abusing the system.

CHAIR—Thank you.

Ms Bellamy—I would make one other comment. I did not answer your second question about the registration or licensing of doctors. I see some benefit in licensing doctors—not in licensing per se, but providing the option—

CHAIR—I think 'accrediting' is the word I was using.

Ms Bellamy—Whether it is accrediting or licensing, it is more about the principle that underlies it, and that is that doctors opt to work within the system. Initially there are no barriers, but they opt to work within the system. Once they are within the system, then they work to the protocols of the system. If they do that, then I think we start to look at the fee structure, at the provision of information, at training and competence—not their professional competence but their knowledge of the system. Then we have a collective group to whom we can, through the Workers' Compensation and Rehabilitation Commission, give dedicated service to ensure that they have a very good, thorough knowledge of the system and work within the boundaries of the system.

Mr WILKIE—Obviously from your submission you are indicating that there are a range of factors involved in workers compensation as a general area that really need addressing. Do you believe that there really needs to be a broader inquiry to look at all those other issues that you could not have addressed in the submission today because of the limited focus of the inquiry?

Ms Bellamy—Yes, I do. I am aware that there will be a broader inquiry by the Productivity Commission, although I have not seen the terms of reference of that inquiry. It is very difficult to investigate one or two areas in isolation, because the workers compensation system is very complex and very interdependent. Certainly, my experience with the changes to the workers compensation system is that, even though we have looked very closely at the intent of those changes during the 15 or 16 years that I have been involved with it, it is very difficult to project

how even a minor change would work within the full system. To investigate an area in isolation is very difficult. I would rather see a more comprehensive investigation.

Mr WILKIE—I could not agree with you more.

[12.11 p.m.]

JONES, Mr Kerry, Occupational Safety and Health Adviser, Master Cleaners Guild of Western Australia

WESTOBY, Mr Ian, Executive Director, Master Cleaners Guild of Western Australia

CHAIR—Welcome. Thank you for joining the committee today. The proceedings here today are formal proceedings of the parliament and warrant the same respect as proceedings in the House. In providing your evidence today I ask you not to name individuals or companies or to provide information that would identify those individuals or companies. The committee is interested in the broader principles relating to the terms of reference and the issues that you may wish to raise in reference to those. The committee is not prepared to provide the protection of parliamentary privilege to allegations about particular individuals. The committee prefers that all evidence be given in public but, if there are some matters that you want to raise with the committee in private, you can make that request to the committee and we will certainly give it consideration. I now invite each of you to make some preliminary remarks, and then we will move to questions.

Mr Westoby—Perhaps I can give you a bit of background about the Master Cleaners Guild. Obviously, it is the peak industry body of the contract cleaning industry in WA. We have a sister body down the east coast. In WA, our members employ about 12,000 people. The cleaning industry in Australia is probably the biggest employer of Australians per capita, and so workers compensation has a huge impact on our industry. The gazetted rate that operates in WA is close to 10 per cent for our industry. When you think that our industry works on two to three per cent profit margins, workers compensation has a huge impact on our industry. The nature of the business is that a lot of the people work in isolation, which creates a special difficulty when a claim arises: who or what was responsible?

The fact that, under the ANZEC coding, you cannot pull out the actual statistics for cleaners—you cannot do it in other areas either—means that they have almost become meaningless. We have a discussion going on with WorkSafe at the moment. They called us in because of our outstanding record, and we have actually proved mathematically that you cannot get it above four per cent, not nine per cent. They have gone off to find out why it is nine per cent and not four per cent. Another reason we can get down very closely is that there are probably only two insurers in this state who will now insure contract cleaners—if you are lucky. It is a huge issue. At the smaller end of the market, there would be operators who do operate without workers comp. They would not be members of the guild, because you cannot be a member of the guild unless you have workers compensation. As is required by the law, you cannot be a member; I have to see their certificate. The Insurance Council reckon that the percentage of companies throughout Australia operating without public liability and workers comp is around 25 per cent. It is quite frightening, when you think of the ramifications if a claim arises. That is a very broad picture from my point of view. Kerry has a lot of expertise in this area and has done a lot of research in this area, not only for the guild but for his own interest, so he can take any technical questions.

Mr Jones—The guild recognises the interest of the committee in gaining insight into recommendations that may concern changes to macro issues that currently impact on workers compensation schemes around Australia. In relation to the terms of reference that we have been asked to address, we have some specific comments. I will pick the eyes out of those comments in summary.

The first point we would like to make in relation to the cost of fraudulent claims, the incidence of fraudulent claims and the structural factors that may encourage such behaviour is that we have no basis upon which to express an opinion as to the extent of fraud in the system. We do not research that. We do not have access to statistics on that. We do not actively evaluate that aspect of the system. However, we do observe member feedback in dealing on a day-to-day basis with employees who have submitted claims. In the view of members, there is a propensity to overstatement of the level of impairment and disability in relation to their claims.

Why might that be the case? There are some key factors that we think are significant in relation to that issue. Firstly, there is the ongoing existence of no-fault legislation throughout Australia. The members believe that, as a result of this, once a claim has been submitted—and I know, having just overheard the previous speaker, that the point was made about the ease with which claims can be submitted and the difficulty then in undertaking assessment of those claims and determining work relatedness—in reality many claims proceed on the basis that it is easier to accept the claim than to reject the claim. The view is that, having assessed that claim, by instituting quick and efficient management hopefully the claim can be dealt with and resolved to both the employee's and the employer's satisfaction. Having said that, the fact remains from our members' point of view that there seems to be a burdensome load placed on the employer and their representatives to actually disprove the claim—as opposed to the reverse situation where the employee, other than by means of submitting a first medical, is required to prove their case.

Supporting that, one of our major areas of concern is the area of involvement of general practice in the certification of injured workers. We make some fairly bold assertions in our submission in relation to the competence and professional practice of general practice in relation to that role and responsibility. Specifically, we claim that, in relation to their involvement, there is widespread evidence of medical incompetence and unprofessional behaviour. That claim obviously cannot go unsubstantiated, and so I would like to dwell on that point for a moment. The first thing is that, in relation to the conduct of general practice—as opposed to the conduct of general practitioners, as individuals—general practice, in our view, is not set up on a model of service delivery that enables the general practitioner to fully exercise the responsibilities that are delegated to them in the system. The reason for this is that it works on a high-turnover, short-consultation and, very frequently—99.9 per cent of the time—practice-based model whereby the general practitioner never leaves the office from which they consult.

In relation to the demands that should be imposed on medical practitioners in fulfilling their obligations to workplace management of workplace injuries, we believe that that model is fundamentally flawed and for this reason general practitioners are unable to fulfil their responsibilities to the system. To refine that down a little further, we say that there is evidence of widespread failure to communicate with the workplace, with employers and other providers of service in support of the injured worker's return to work. There is uniform evidence of the failure to properly investigate the workplace when a worker submits for what is reportedly a work related injury. There is often a failure to consult and/or identify at the work site the nature

of the duties other than by means of what the worker reports. With due respect to the worker, the reality is that many workers cannot describe in sufficient detail the content that is necessary to make an informed and professional decision on which we believe certification should occur and, for that matter, it is not an independent assessment.

Furthermore, we believe that in relation to the training that is afforded general practice in this area and the various initiatives that have been purported to have been undertaken at various state levels, if not federal levels, in relation to practitioner training, a high percentage—well in excess of 90 per cent—demonstrate that they have not been able to avail themselves of such training and that their competence in terms of understanding the nuances of the workers compensation system and the requirements on them is in effect non-existent. Thus, we find the advice that they give to injured workers to be fundamentally flawed.

In terms of the accountability issues that flow on from that, the guild maintains that there is indeed a need for recognition of medical involvement in the area of workers compensation being a speciality medical practice area. This should occur by means of accreditation and/or licensing of medical practitioners working in the field. While we appreciate that in the first instance this is a numbers game and that if, for instance, we were to suggest that injured workers only consult with occupational physicians and/or other qualified specialists it would not be a feasible proposition in the short term, there does need to be a long-term strategy put in place to ensure the transition management of medical practitioners to a level of competency that we believe is necessary in the system.

To that end, we propose that matters of work related injury should be at the determination of occupational physicians. One of the inadequacies in the area of access to training for occupational physicians is that training is only available in the Eastern States; it is not uniformly available in universities throughout each state. We believe that structurally this is a flaw undermining the ability of general practice to aspire to an area of specialty and competency development that would appropriately support the system, and so we advocate that development. In summary, we are proposing that general practitioners need to be accountable for the outcomes that they are currently certifying, and we do not believe that that accountability currently exists.

However, there are other structural influences that we believe are very significant. The first is the influence that legal involvement, unions and union solicitors have on the system, particularly the aspect of the intent of the system and the objective of return to work. Without doubt, it is the case that injured workers who are subject to legal advice on the grounds of either a workers compensation and/or common law liability claim are frequently advised by their advisers to reserve their options. I can confidently state that position because, in an equivalent hearing one week ago, when I sat before the minister for consumer affairs and labour relations, Mr Kobelke, the legal advice provided and tabled in that hearing was exactly that. It was a one-line statement that, as a result of the current interactions that hinge on the issue of worker entitlements and claim entitlements that are subject to certain terms and conditions of legal entitlement, solicitors routinely advise their clients to maintain their options open. This simply means that in instances where return to work is imminent and medically certified as achievable, workers are being advised not to return to work, not to return to full-time work, to assume only part-time work and in some instances to maintain a level of disability or impairment—I draw a distinction between those two definitions and I will comment on that in a moment—and to

overstate that position with a view to not only keeping their entitlements and options open but also maximising their entitlements under their claim.

I think that one of the key structural issues that needs to be addressed by this committee, and other committees around the country currently addressing issues in the system, is the notion of intent of the system. If the intent of the system is workers compensation, settlement and out of the system, then make it that, clearly state it as such and enable it to occur. If the intent of the system is, as it should be and as we believe and advocate, for return to work management, early intervention and support for the injured worker, then clearly state that. In relation to state developments in that area, you may be aware that the proposed amendments to the legislative title now place less emphasis on workers compensation and more emphasis on injury management, with the underlying emphasis being on return to work.

Moving on from that, I want to make a point in relation to the notion of intent which, if you accept my proposition, should focus on return to work issues. One of the primary concerns is that it is our members' experience—and anecdotally I can confirm that it is the experience of other providers and employers across Australia—that as soon as it becomes evident that a worker has a work capacity, in many instances, because of the legislation enabling this, workers opt for a change of medical practitioners and/or rehabilitation providers. We have an issue with this. We believe that workers certainly have an entitlement to choice and that ought to be preserved, but that choice ought to be exercised up-front. Once that choice is made, the choice should remain as is, except under exceptional circumstances that could be applied to the respective WorkCover bodies and a case put. But as a routine course of action, we strongly argue for preserving the right of choice up-front but, beyond that point, removing the right for a change of provider, because clearly workers are all too easily able to manipulate an outcome based on their exercising the right of choice and change.

I made reference earlier to the definition of disability and impairment, and I would be happy to address that if clarification is required, as well as the further aspect of handicap. Putting that aside on the assumption that you are familiar with the terminology, we raise for your consideration the concern about the lack of uniformity of impairment ratings throughout Australia—disability ratings in some settings. Clearly, when we talk about system evaluation, let alone individual worker evaluation, the lack of standardisation in approach in this whole matter makes the validity and reliability of assessments very questionable. Furthermore, the focus of the system tends to be very much outcome based, namely: 'Does the person settle their claim, redeem it and receive a lump sum?' and we evaluate that cost, plus expenses; or, 'Does the person return to work?' in which case we evaluate that outcome, whether it is with the same employer or a new employer, and the variations that go with that. So we quantitatively evaluate outcome.

What I believe we fail to really get a grip on are some of the qualitative issues in the system. The qualitative issues really come to the issue of the culture of the system. Ms Bellamy before us made the point that the workers compensation system is extremely complex, and I am sure that is overstating the situation to people like you who are well and truly familiar with that. But, notwithstanding that, it is a complex system and the culture that prevails within the system is a series of interactions from a number of vested interest parties. For that reason I think there has been a general failure in the system, based on a pure focus on quantitative outcome measures, to properly evaluate what in fact are the dynamics that are underpinning the culture that prevails and the attitudes that prevail.

Our submission argues that, whilst it is appropriate to look at the quantitative issues, there is some need for some qualitative research to be undertaken to understand the actions of the stakeholders in an objective and well-researched manner rather than hearsay and conjecture and finger pointing and all the rest that goes on. We would prefer to see it put back on the table and evaluated in some critical but objective professional way rather than the toing-and-froing that tends to occur in these forums. To that end, one of the critical issues is the development of standardised impairment ratings. Tying in with that we assert that, because of the issue of choice of general practitioner and for that matter the treating medical specialists, when it comes to the matter of disability or impairment rating which is applied we view a very broad variance in the level of competency demonstrated by medical practice in that area. This is of serious concern and needs to be urgently addressed and changed.

Moving on to the next term of reference, which is the methods used and costs incurred by workers compensation schemes to detect fraudulent claims and the failure of employers to pay compensation, our comments are as follows. The first is that, as Ian has alluded to in his opening remarks, there is a major problem with the industry classification system. The fact that an industry such as the cleaning and asset maintenance industry cannot access data specific to its own area of employment, given that it is one of the largest employers in Australia, is in itself, we believe, evidence of a failure of the system. Therefore, when we make our effort to adopt best practice, to research performance, compare benchmarks and revise our overall health and safety management systems within the industry, we are to some extent—not totally because we believe that we are making very good headway—hamstrung by the fact that we cannot make reliable comparisons. We would advocate for a review of the current coding system. Having said that, we also accept, at the end of the day, that the issues that you refer to under these terms of reference essentially centre on the issue of management performance.

Looking at management issues across industries as opposed to pinpointing individuals, which we have been asked to refrain from—not that we intended to in the first place, but we shall refrain—we note massive duplication in the system, federally and state-wise. We notice at a state level, even when industry initiatives are initiated for development of occupational health and safety and workers compensation systems and supportive procedures and manuals, there is gross duplication of expenditure, manpower and the rest of it.

I can quote a very relevant one to our industry. This industry in Western Australia has developed an OSH management workers compensation risk management manual and procedure which has been uniformly implemented to members of the guild. Within a matter of months of that, South Australia effectively released an identical kit. When we inquired as to the budget that was expended on that compared to the budget that was expended here in this state, we found that that expenditure undertaken by them was five- to sixfold the cost expenditure here.

Mr Westoby—But we pay for it here.

Mr Jones—We pay for it as an industry. Whoever paid for it is one issue but, on the other hand, the manner of duplication is something that greatly concerns us. Having accepted that management performance and management responsibility is essential to this area of inquiry, we believe that there should continue to be a self-regulatory approach to management in the area and that there should be a tight interrelationship between the management of workers compensation and occupational health and safety. In a number of states that is not the case, particularly here in Western Australia. We do not believe it is anywhere near the extent that is

necessary. We have two separate administrations in WorkCover and WorkSafe, and we have clearly established that even the ability to data transfer is extremely limited at this point. That is something the current state government is looking into, and we are hopeful that change will occur in that area. Whereas there has historically been a tendency to divide and separate the two areas, we strongly advocate that there needs to be a very close relationship between the OSH risk management legislation, policy, procedures et cetera and the management of workers compensation.

We point out that one of the things that is problematic—again Ian made brief reference to it—in relation to labour hire trends is the further distancing of the relationship between employer and employee in such arrangements. Furthermore, we note that there is a tendency—not only within the cleaning and asset maintenance industry but also, from our observations and discussions, across the industry—to seek to distance responsibility for workers compensation and public liabilities by contracting out. This understanding on the part of many employers is fundamentally flawed, because it is not possible, by our understanding—correct me if I am wrong—to abrogate responsibility to third parties under such arrangements. There is continuing responsibility on the principal contractor or the principal employer to follow through and enact their responsibilities to supervise the labour hire organisations, the contractors or whoever it may be. So there is a whole area of misunderstanding and misinformation, which indicates a need for education, training and also, very much, clarification of who the principal employer is, who the principal contractor is and the responsibilities of those individuals.

Moving on to your final term of reference—the factors that alter safety records and the adequacy, practicability and benefits of rehabilitation programs—in relation to the issue of data collection and the assertion of some parties in relation to their submissions, we believe, on the basis of the current quantitative statistics that are generated throughout Australia, (1) that there is a lack of qualitative input and (2) that, because of the great diversity that exists between the various jurisdictions in relation to their respective legislation and their definitions and systems, accurate, valid and reliable comparisons are extremely difficult. That is in no way to seek to avoid responsibility at the end of the day; I am just simply pointing out a statistical fact as well as a practical management reality of what exists currently.

As a part of that, one of the things that we advocate is some uniformity of data collection systems and some uniformity of legislation throughout Australia. We know that this has been looked at over a very long period of time and argued by many people who have preceded you and no doubt will be argued by many who follow you, but we believe that it is time for a national system to be seriously contemplated. In line with our call for qualitative measures, we believe that there needs to be acceptance that we go beyond cost and beyond return to work outcomes and look at the issues of morality, equity and social justice in this overall analysis of workers' and employers' rights and entitlements.

Above all else—and this is something that has happened in many systems around Australia, but I can categorically state that it has been an overwhelming failure in the Western Australian state system and, again, is currently the subject of redress—is the issue or notion that, if return to work is the intent of the system, it has to be practised on the basis of early intervention and early referral for rehabilitation. At the current time we have referrals occurring on average in excess of 200 days from the date of the accident. That is patently unacceptable. If this review is to achieve anything, it should be looking at the reasons why this is so.

Pointing some of those issues and reasons, we believe that, again, medical practice has a major issue to respond to in this area. Fundamental flaws in communication are occurring in general practice, not only in communication with specialists. I might add that it is not only flaws; I would suggest, in 99 per cent of cases, it is a total absence of communication, because such communication is seen as the general practitioner's role. Because of the litigious nature of the system, the general practitioner is very reluctant to certify without direction from the specialist, so substantial delay is occurring. You may end up with specialist intervention, hospitalisation, treatment and discharge, often where the person is returning home and is not returning to work at that stage, and the general practitioner is not necessarily informed of the post-operative management requirements or treatment requirements. As a result of their reliance on specialists, we start to see the merry-go-round start up whereby the general practitioner defers a decision on return to work in favour of consulting with the specialist and then the reporting to-ing and fro-ing commences.

We believe that in the protocol of management—not only for GPs, which hopefully I have clearly emphasised and stated already, but also for specialists—the specialists need to have made known to them and have included in their management protocols prior to hospitalisation, at the point of hospitalisation, surgery treatment and discharge that, as part of that overall patient care, discharge planning and management, return to work should be one of the fundamental points of discussion as to what occurs and what does not occur. If the medical specialist is not considering such factors, then how on earth can the medical specialist and then ultimately the general practitioner determine whether the interventions that are being proposed are reasonable in the context of total patient care? It is all very well to say that they have a bung shoulder or a bung leg or whatever; that we have to fix a fracture or repair this, that and the other. But if it is not done in the context of what the person requires to do at the end of the day, then it is not holistic management or medicine and in our view it is inadequate to the needs of the workers compensation system. I think I will rest at that point and invite you to ask questions.

Mr DUTTON—I understand your comments in relation to general practitioners and I have a lot of sympathy for that argument. How do we get over the problem in this scenario: I might go and see a general practitioner who I have been seeing for a long time and who is aware of my background, medical details and existing ailments that I may have. He can therefore form some sort of basis for his decision as to whether or not it is a workers compensation matter. If we move away from that system and into a system of independence, how do we pick up the detail of that patient's past history which may have some direct bearing on whether or not that person has a right to a claim?

Mr Jones—That is an excellent question and it comes to the point of the protocols that are used at the point of medical assessment. Answering it in reverse to start with, I believe it is on that basis that the general practitioner fails to provide the answers that are necessary; that they do not undertake the full evaluation, having the balance of the medical history of the individual on file and on record, hopefully; and that they do not take into consideration, I believe, the full scope of the work presentation.

Looking at it more specifically from your angle, the way in which I envisage that being done is that when the worker presents, say, to a physician for certification of work capacity, I would see that the protocol would involve the normal clinical evaluation and history taking that is, and should be, part of a routine medical examination. As part of that exercise, I think there is the

opportunity then for the physician to corroborate the evidence provided by the worker with the general practitioner. So I believe that the next phase of that, before certification is given, should entail the physician contacting the general practitioner and saying: 'Just examined your client. This was the presentation, these are my findings, including past medical history. Is there anything over and above this that you think is relevant to my considerations of this matter?' I think corroborating, and having multiple and independent sources of, evidence is one way of strengthening the opinion. If you rely on one opinion, you very severely erode the possibility of getting an unbiased and accurate assessment of the patient's abilities.

So we have done the physician's assessment and we have corroborated his findings with the general practitioner. In addition, I then see that the physician contacts the employer and/or—I would hope 'and'—where it is not already known, visits the workplace, establishes the work duties and demands or contracts the appropriate vocational rehabilitation services to undertake such assistance before a determination is then finally made. This can be achieved—and here we are not talking about a two- or three-week time span; we are talking potentially about a week's turnaround—in under a week with appropriate management. At the moment, the appropriate management of referral does not occur.

Mr WILKIE—Are you talking about that sort of system being put in place for all workers compensation claims?

Mr Jones—Yes, I am. But bear in mind my remarks about the feasibility of this and the need for a transitional program of management to be put in place. Because we have few physicians in relative terms available at this point in time, and given my statement that I believe that general practice has to be brought to account and has to make the transition up to a level of competency that is required, it is quite clear that a management strategy needs to be put in place with a realistic time frame that will allow for such transition to occur.

I said that there are two stages that need to develop. One stage is to highlight that problem that I raised: that there is not uniform training available throughout Australia. I think this is a key area of concern. This is a specialty area of medical practice, in our view, and needs to be fostered and developed; therefore, implement the training opportunity. The second stage is to implement an implementation schedule over a five-year period—that is arbitrary at this stage; you may need to look at the practicalities, but it needs a bit of long-term planning to implement. Then at a point in time you determine—which is ultimately realistic—have a cut-off point and say, 'Okay, from here on, workers compensation matters will only be dealt with either by physicians and/or accredited medical general practitioners who have demonstrated competency in understanding the act, the stakeholders in the system, workplace matters et cetera.

Mr WILKIE—How do you think your membership would feel if the cost of doing that meant that their premiums might have to double or triple? I ask that question because, given your evidence that there is minimal evidence of any fraud at the moment—

Mr Jones—No; that was not my statement. Our position is that we are not in a position to comment on the level of fraud in the system because we do not have those estimates.

Mr WILKIE—In your evidence you said that you have no evidence of fraud, only anecdotal evidence provided by people who believe that there might be some fraud. I ask that question because right now you are saying you want to introduce this system for all workers

compensation claims. If someone went to the doctor at the moment and claimed one day because they had had an injury at work, the doctor might say, 'Yes, it is a workers compensation claim; you can have that,' whereas if this system were in place they would have to go to another doctor, who would take twice or three times as long to see them as a general practitioner, and then that person would have to discuss that with the employer, which would cost even more time and money for someone, ultimately the employer. Wouldn't that system lead to a situation where your costs would have to blow out dramatically?

Mr Jones—The statistical evidence points out that the largest cost in the system is not your short duration, quick return to work, one-day claims, although you may incur a small additional expense. The greatest cost is in your long-term, long-tail claim.

Mr WILKIE—But wouldn't they be getting referred to a specialist now? Wouldn't the GP refer those people to a specialist?

Mr Jones—Yes, although the point of the recommendation is not on the basis of referral to appropriate specialists when indicated. The point is that we are talking about the point of admission to the system. We are talking about appropriate assessment of work relatedness in the first instance and appropriate management therein. We assert that, at the moment, general practice does not appropriately assesses work relatedness and is not in a model of practice that enables them to assess that and that, at the end of the day, their current level of training and competence is not such that we have confidence in their ability to carry out that function.

Mr WILKIE—Do you know of anyone who has done any work in costing such a proposal?

Mr Jones—I understand that the actuarial assessments that have been undertaken by Minister Kobelke and his advisers have taken into consideration some of those issues—you would have to direct your inquiry to him as to specifically what. But I know that there is some sympathy with and acceptance of a need for dramatic improvement in the competency of general practice involvement. As to just how far they will want to extend that and whether the actuarial cost stacks up in terms of changing to specialty input as opposed to general practice input, I suggest you inquire through his office.

Mr WILKIE—Thank you.

CHAIR—Thank you for your submission, Mr Jones and Mr Westoby.

Proceedings suspended from 12.51 p.m. to 1.33 p.m.

O'HALLORAN, Mr Paul John, Principal, O'Halloran and Associates, Barristers and Solicitors

CHAIR—I welcome Mr Paul O'Halloran. Thank you for coming today. Are there any comments you would like to make about the capacity in which you appear?

Mr O'Halloran—I am also part of the Justice for Victims campaign.

CHAIR—The proceedings here today are formal proceedings of the parliament and warrant the same respect as proceedings in the House. In providing your evidence today, please do not name individuals or companies or provide information that would identify particular individuals or companies. The committee is interested in the broader principles relating to the terms of reference and in issues you may wish to raise relating to those. The committee is not prepared to provide the protection of parliamentary privilege to allegations about particular individuals. I understand, Mr O'Halloran, that you have made a document available to us. The committee has not had an opportunity to consider the document as yet; it will be considered in December at the next sitting of parliament. Consequently, it has not been authorised for publication and does not yet have the protection of parliamentary privilege. The committee generally prefers that all evidence be given in public, but if at any stage you wish to give evidence in private please ask to do so and the committee will consider your request. I now invite you to make some preliminary comments and then we will move to questions.

Mr O'Halloran—As the submissions detail, the issue of compensation fraud is in my view a non-issue, particularly in Western Australia. The incidence of fraud amongst accident victims is very low. I think the official figures show it to be less than one per cent. I made it clear that I have acted for over 5,000 accident victims over 22 years and have never come across one case of compensation fraud against any of them. There have been a small number who I would say have exaggerated or made inconsistent statements about their claims, but none of them have ever been charged with or convicted of fraud and, to my knowledge, none of them have ever been so guilty. I have also had the opportunity to speak to the Injured Persons Action and Support Association, who also deal with cases of thousands of injured people each year. I am able to inform the committee that IPASA have had the same experience as I have had. In my submissions I give the example of David, whom I had the opportunity of speaking to:

> Approximately 2 years ago, I did speak to a man named David, who was convicted of compo fraud. He told me that he had served 6 months of an 18 month imprisonment for this offence. He was apparently caught on surveillance video working at a time when he was supposed to be unfit for work and receiving workers' compensation for being so unfit. He was filmed operating a harvester or similar machine on a farm. Although David protested his innocence, the surveillance film sealed his fate and it appeared to be an open and shut case of compensation fraud. However, upon his release, David and his lawyer continued to plead his innocence and became more suspicious about the film that was taken and the date it was taken on. His lawyer showed the film to an eminent botanist, who was able to confirm that the film could not have been taken at the time shown because of the wildflowers that were present in the film and which would not have been in bloom at the time the film was taken. After further lengthy and expensive inquiries, it transpired that David had been set up and that the film had been concocted and manipulated by either the Insurance Company or their private investigator, or both. Needless to say, David received no compensation, no costs and no apology. He remains to this day devastated by this experience and feels that the whole incident has ruined his life.

I know that one of the terms of reference for this inquiry is employer fraud. I think that is also quite rare, from what I hear. Obviously, I do not deal with many employers, but I am a small business man myself and as part of my campaign I have had the opportunity to speak to a lot of

employers. I do not see this as fraud, but I am able to tell you that a couple of years ago Minister John Kobelke, the local labour relations minister, made it clear that 21 per cent of employers, or thereabouts, were not insured for workers compensation. That in itself is not evidence of fraud, but I understand from evidence given to you this morning by the Chief Executive Officer of WorkCover, Harry Neesham, that—I may be quoting incorrectly; this is all third-hand—there were 1,700 uninsured employers out of 80,000 registered with WorkCover WA. If that is the case, it is inconsistent with what the minister was telling us only 18 months ago or thereabouts, when he indicated that 21 per cent were uninsured. The points raised here are: who is correct, and why is nothing being done about this?

The other issue with employers is that some of them are not only uninsured but lying about the kinds of people they employ to minimise their insurance. I make the comment in the submissions that part of the reason so many people are uninsured may be that they simply cannot afford the premiums being asked of them by insurance companies. I also make the pointed remark in the submissions that the committee appears to be pointing the finger at the wrong people. For whatever reason, you have avoided looking at insurance companies as part of the terms of reference, when the anecdotal evidence and my experience show that the real faults in the system are the insurance companies themselves. For the best part of 10 years we have been told we cannot afford full common law payouts because of a so-called crisis in the system, which clearly never existed.

Since the last election I have been able to obtain figures kept by WorkCover and Harry Neesham himself. They show that over 21 years there has been a surplus every year when you compare the premiums collected against the payouts, that there was a surplus even before 1993 and every year since, and that the cumulative surplus is now $1,800 million. I am told by the Insurance Council itself that overheads to be taken out of that represent about 15 per cent of premiums but, balanced against that, the insurers have of course been able to invest those funds. So there is certainly no crisis here that warranted the slaughter of common law rights that we saw not only in this state but also, according to my colleagues over in the east, in the Eastern States as well.

The same comments apply in relation to public liability, which is a bit out of your terms of reference. Again, we were told there was a huge crisis that would require the elimination of many payouts. We now know from insurance companies' own figures that the figures there are even more startling. Australia wide, far from being a crisis, the figures reveal a surplus of $5,700 million more than has been paid out on public liability alone in the last 23 years. As I have mentioned in my submissions, that raises the question of why Justice David Ipp felt the need to hand down a report which will give rise to the elimination of countless claims. He gave that report and, after the report had been commissioned and handed down, he then told us who he thought were the real culprits all along: the insurance companies. He is quoted in the *Financial Review* as saying that it was due to their greed, incompetence or negligence, or a combination of all three. Plaintiff lawyers and victims groups ask: 'Why on earth did he do it in the first place? Why didn't he tell us sooner?' That is all part of the federal government's initiative. What I am starting to see here, along with countless victims, is that all these inquiries and reports seem to lead to the same result and they always seem to benefit insurance companies. It is a very pointed question. I hope it is not one which you take personally. We do find it disturbing that so many inquiries around this country fail to make mention of the role of insurance companies. It goes without saying that they are very conspicuous by their absence today.

They are the opening remarks I would like to make. I have given further examples in my submissions of the things that we are concerned about here. Some of them do not touch on your terms of reference but are incidental to them. It is very difficult to talk about fraud in a compensation system without talking about the insurance companies themselves. I think you are really putting yourselves in a difficult position—or at least Minister Abbott has put you in a difficult position—by not addressing that issue. It is one which is of grave concern to people out there. You may have gathered that there was a protest downstairs this morning that hundreds of people attended. They beg to differ with the terms of reference that we see in front of us.

The figures of what the insurance companies have been earning are quite startling. In contrast with that, you are seeing the decimation of people's rights. People are losing their homes. These might be your children one day—or you, your wives, husbands, brothers or sisters who go out to work. After all, it is they who vote, not the insurance companies. Looking at the submissions, there are some 10 million who go out to work. Each one of them takes a risk of being injured every time they go through the front door. Many of them are now starting to ask why it is that the government, both federal and state, appears to be hell-bent on taking their rights away, based upon a crisis that demonstrably does not exist.

A few remarks were made by Harry Neesham, as I have been told third-hand, about medical panels. The committee was told they work well, but no comment was made in relation to the stacking of these panels. The Injured Persons Action Support Association, IPASA—who will address you at another time—have come up with conclusive evidence that, far from working well, these panels are in the nature of a star chamber. There are three doctors sitting at any one time, being paid $1,200 per hour between them. In each and every case, the chairman of that panel comes from the insurance side of the industry. It is a fait accompli. Once injured workers appear before these panels, it is very obvious what the outcome is going to be. When Neesham says that they work well, I do not know which state he has been in. He has not been here. That is not our experience at all—far from it. It is a disaster. It is a system that he has helped to put in and that is why he is defending it. I have no reason to say this. I am married to a doctor. The doctors I speak to are scandalised by what they hear goes on at WorkCover on their so-called independent, objective medical panels.

You were addressed on the issue of travel for injured workers in the country. You were told that that all works well and that normally insurance companies make funds available. That has not been my experience as a practitioner in this area for 22 years. Again, I do not know what system Neesham was talking about. That has not been my experience. It has not been the experience of the Injured Persons Action Support Association or the victims I talk to.

You were addressed on the issue of premiums. The premium rate here is roughly 2.8 per cent of wages. That is quite acceptable. I agree with Mr Neesham that that is a good figure. But I got the impression from what I heard that he made it out to be the country's best practice and a really terrific situation. How about Queensland, when we talk about the issue of common law? As I understand it, Queensland has the lowest premiums in the country—1.55 per cent, which is roughly half our own—and has full common law. We have been told, over and over again by insurance companies and their lobby groups, that we as a country cannot afford full common law. Apparently, we could all afford that for 80 or 90 years in WA before they told us we could not! So you have to ask yourself about the system in Queensland, which has a similar population base, a similar accident rate, similar demographics and a similar likelihood of injuries to ours. I have spoken to Queensland lawyers, victims and union people and they all

say, 'It's a wonderful system. What's wrong with your system?' So why is it such a problem? I will tell you why: the people that run Queensland's non-government insurer are answerable to parliament and the people. It is not a handful of private insurers, as we have here, who have hijacked and corrupted the system to their own end.

Before they came along, common law worked extremely well here. I was a practitioner of that era for about 10 years before it changed, and it worked extremely well. You never heard from people like me; now the government never stops hearing from people like me. And I can tell you that this is just the beginning. What you are doing has all been tried before here. I do not mean this in a personal way, because you have been kind enough to let me address you, and I appreciate that. But by going down this road of pointing the finger at injured people—and I appreciate that you are dealing with other issues as well—you are losing credibility as a parliament if you do not include in that process insurance companies; otherwise, it makes it look as if you are biased against injured people. The feeling they have, whatever your own good intentions no doubt are, is that they have suffered enough. They want an open inquiry into what is going on in the insurance industry. I do not gain anything by saying these things. The last thing I want to do is get into a war situation with insurance industries. I would have liked to have had a working relationship with them; I did for many years. Now it has got to the point where so many people are losing their homes and being ripped off here that people have had enough, and I simply represent those people. Thousands of people who cannot fit into this room now speak through me.

Let us not beat around the bush: we need to speak bluntly about these issues. Please do not think I am being blunt or disrespectful towards the committee; I am not. It was stated off the record that the head of WorkCover here backdated a deadline. I am not troubled by the fact that I do not have privilege for these comments: my view, as I said to the secretary of the committee, is let them sue. No-one has sued me yet for the things I am saying, because they are true. I asked the head of WorkCover three times on live radio—three years ago on 14 December 1999—when the deadline was to put people's claims in under the new rules to bring their common law claim. This is slightly different to what your terms of reference are, but I think you need to hear it as you have come a long way. I asked the former Premier that, too. One of the reasons why the former Premier is no longer here is this campaign. The former Premier was also asked when that deadline was.

It is 11 o'clock on the morning of Tuesday, 14 December, on live radio with 50,000 people listening, and I am asking the Premier of the state and the head of WorkCover when the deadline is to put your claim in under the new rules—a deadline they set two months early that affected every working person in this state who had been injured through no fault of their own. Court did not answer the question. I asked Neesham three times, and he circled around it. We have a transcript of the interview. He did not answer the question. I then warned everyone listening to the radio. While I was warning them, the previous Premier accused me of being the master of gutter advertising, of being a discredit to my profession, of not telling it straight and of scaring people and doing it for the money. That did not worry me, because the main thing was that I had got the warning out and people then knew that the deadline was at 5 o'clock that day. We now know that on 4 o'clock or thereabouts that day Neesham, who had not admitted the deadline, passed a regulation which had the effect of backdating the deadline to the night before, to stop people claiming compensation.

So when he pontificates in all of his submissions—and I have read all of the submissions he has put to you—about people committing compo fraud, the people here and the people downstairs and the people out there who go to work would all like to know: what are you going to do about that? That is the sort of thing they are saying. Why is it that when we have these inquiries it is all about compo victims when in fact we know, from all the inquiry reports you have read or should have read, that it does not exist anyway—or, if it does, it is in negligible terms. You have heard the horse's mouth—you have that from John Kobelke; I gather you even have it from Harry Neesham today—that compo fraud in this state is at negligible levels.

I give an example in my submissions of a chance meeting I had with some of the people who were making these sorts of comments behind the scenes—in fact, not only behind the scenes; they were making them to our face. At a Law Society meeting that I attended with a lot of lawyers, Gary Moore of SGIO and Daryl Cameron of the Insurance Council basically stated to us that one of the big concerns they had was fraud—fraud among victims and fraud among their lawyers. My ears pricked up. What fraud? Where? I am in the area. Who are they talking about? The lawyers in the room were a little bit stunned by it. What does this all mean? People were saying, 'Maybe we shouldn't be getting into this. This is too controversial.' I said to them—with people shushing me, by the way—'You tell us who these people are. Who are these lawyers and who are these victims who are committing fraud? I would like their names, addresses and details so that we can refer them to the police and the barristers board for striking off.' They did not want to get into it.

We confronted them about it more; we pressed them even further, as my submissions state. Finally, they gave a couple of examples—one of which was about someone who had been working outside and had picked up a plate and put in a compo claim. The impression they gave, without saying so, was that he had picked up a dinner plate. Everyone said, 'Oh, that is obviously ridiculous.' It seemed unbelievable. It seemed incredible. And that is because it was. I half recognised that claim as one of my clients. When I went back to the office I went through the file. It turned out that the plate they had been referring to was a steel manhole cover, weighing 80 kilograms, which this man was attempting to lift unassisted.

These are the people who are no doubt giving you submissions and whispering in politicians' ears about compo frauds and victims and how you have to do something about it. They seem to have hijacked the whole debate. That is what I am feeling and that is what victims are starting to feel: that they do not seem to have a voice any more. Let us hope that in the wash up of all this, when you have heard all this evidence and you have read the kind of things I have been saying, there is going to be a bit more perspective brought to this and that you finally get around to having an inquiry into insurance companies. I do not just mean the HIH one, which was so scandalous that you had no choice but to inquire anyway. I am saying, 'Do not stop there. Let's go further and find out who's really to blame for the so-called fraud in the system.' I would be one of the first people to say to you that, if fraud is rampant in the system, something has to be done about it. If lawyers are committing fraud or victims are committing fraud, the system is in complete disarray. It is a system that has no credibility. I do not want to practice in a system like that. But I have to say to you it is very rare, and I hope that is the sort of message that is coming across loud and clear.

I think Abbott has gone down the wrong road altogether in this inquiry. It is a road that the previous minister, Graham Kierath, went down, much to his peril. He lost his seat by a country mile because of his approach to injured people. It is a disaster from a political point of view,

because politics is all about perception. If you go out attacking injured people—unless you have darn good evidence—you do so at your political peril. At the end of the day you require their vote. You might say that parliament goes beyond mere votes and being popular. It is about propriety and what is honest and good and truthful in the community. That is true. But all the inquiries so far have revealed not the slightest scintilla of evidence beyond a small proportion of people out there who will always commit fraud. Those people should be arrested. Far more people who have committed fraud should be charged and convicted. Let us not have another inquiry about it at taxpayers' expense; let us call the police and have them charged and dealt with. That is the way we should approach it.

A number of other things were mentioned, particularly by Neesham. He says—and this is laughable—that 99 per cent of injured workers are apparently happy with the system. That is absolute bunkum. The level of disquiet about WorkCover here and about the system is reaching epidemic proportions. That is why you have seen the tip of the iceberg this morning. That is the tip of the iceberg. I do not know any injured worker who is happy with how they have been treated by the system, by insurance companies or by WorkCover in particular. Presided over by somebody who is prepared to backdate a deadline, it is little wonder that I say WorkCover neither works nor gives you any cover.

We talk about WorkSafe, an organisation set up by the same Graham Kierath, which often turns up to accidents weeks or so after they happen—all too late. Again, there has been a lot of disquiet and unrest about that situation as well. All that injured people are asking for is a fair go. They are not asking for a Rolls Royce system. They just want to be looked after the way they used to be. What bosses are saying to me is, 'When we pay out our premiums, we expect our staff to receive fair benefits.'

The issue of disability was raised by Neesham. He said that we are going to change that to impairment, but he does not explain the significance of that. Let me explain to you what that means. What it means is this: if we go to a level of impairment rather than one of disability, that means that the doctor is not even allowed to take into account that person's incapacity for work. So you will have a workers compensation system in which even the inability of a person to work is disregarded. They are going to use the USA guide that, compared to the local guide, would probably be more at home in Dr Josef Mengele's Auschwitz library, from what I hear. The assessment of impairment is twice as tough as the local guide that has been used successfully for years.

They are also going to deny victims the right to claim for their psychological problems and loss of sexual function. So you could be a nurse in the system that Neesham is telling you is working wonderfully, have your pelvis crushed, be assessed at 15 per cent—because that what you are under the workers compensation act here—and not be able to claim for your loss of sexual function or psychological problems. You would probably be taken off to one of their medical panels, and they would find that there is not much wrong with you anyway, and you would not be able to sue for it.

There is an awful lot that needs to be done to help injured people here. I do not know of any injured person who asked to be injured, who asked to be out of work. Many of them are losing their homes as we speak and many have before this. That is why I am pretty angry about it all, having looked into the eyes of many of them over the years.

You were told about the level of uninsurance by employers. Neesham apparently told you that it was 1,700 out of 80,000 who were registered with WorkCover. John Kobelke told us a year or two ago that it was more like 21 per cent. I would make that more like 16,000 compared to 1,700. The level of uninsurance in this state is appalling and something needs to be done about it. If WorkCover is not capable of doing it, something needs to be done about WorkCover. What we are saying is that WorkCover needs to be shut down. It is a disaster; it has not worked.

I gather that Neesham told you that 17 companies were charged with compensation fraud. I am not in a position to comment on that. But I also note that he agreed that compensation fraud amongst victims is negligible. So here you have it from Kobelke, the local minister; you have it from the insurance industry, from what you have been told; and you have it from Neesham himself. Some of the case studies I read from the insurance companies that were disclosed to you were just absolute nonsense. It was just so obvious that there could have been so many other explanations for those case studies that were put to you. They did not even seem convinced themselves that compensation fraud was a problem. We know it is a problem. We know there should not be any compensation fraud. I would be the first to say that I do not condone it; quite the opposite. I think far more should have been done about it than has been done, if it is the problem we are told it is. The fact is that I do not believe it is. I think what is happening here is the perpetuation of a process of stigmatising injured people, dehumanising them, demoralising them and making them feel like they are all on the take and that they are getting something for nothing. And that has been the kind of culture that we in Western Australia rejected long ago.

The submissions speak for themselves. They are pointed. Some of them do not deal directly with the terms of reference—please forgive me for that. There are so many serious issues raised there that I felt that this was at least a federal forum where we could get some of things down on paper that people have not been able to get across before. We are extremely concerned about where it is going. It seems to me that, as the years go by, the plight of injured workers goes from bad to worse to even worse.

We are very disturbed by the fact that this inquiry is taking place at all and that there are limited terms of reference. There is an old saying in politics: never have an inquiry unless you know what the outcome is. The terms of reference here are very pointed. They should have included insurance companies. I think it is a tragic waste of opportunity that they have not. I think you would find that, if they had, the credibility of this inquiry would have been very much enhanced. Justice not only must be done but must be seen to be done. When you leave out insurance companies from the inquiry, when there is so much disquiet about what they are up to, you—or the persons who set up this inquiry—do parliament a disservice. At the end of the day, you are servants of the public. It is the public for whom I speak at this stage. This is not just some vested interest or crusade of mine; I have been propelled by the public to finally speak out on their behalf because many of them are incapable or too injured and too sick to do so, or do not have access to the media. I could talk for a long time. I know your time is limited, so thank you for giving me the opportunity to speak. I am happy to address any questions you might have.

CHAIR—Thank you.

Mr DUTTON—On page 3 of your submission, you speak of an exhibit A. I do not think we have received that.

Mr O'Halloran—No, they were not sent to you then.

Mr DUTTON—That is really the basis of a lot of your conjecture, isn't it?

Mr O'Halloran—I think they were photocopied, but I was not able to fax them to you in time, obviously. I am sorry, I will just see if I have it here. Exhibit A is McCarthy's speech?

Mr DUTTON—No, it sets out the premiums collected each year. It is the basis for your claim that there is a $1.8 billion surplus over the 21 years.

Mr O'Halloran—Yes, that is all here. I have got those. They have been put together pretty hastily in the time we had, obviously. There are two tables: the one on the back is the public liability issue and the other side deals with workers compensation. I will hand them out to you. They were obtained from the annual reports from WorkCover's own web site. You will see there is a surplus each year of premiums collected versus payouts. They have actually being compiled by the Injured Persons Action Support Association based on the figures revealed on the WorkCover web site.

There is also Brendan McCarthy's evidence given to a state parliamentary inquiry four years ago, which I also gave evidence at, which I will also hand out to you. McCarthy was very close to the insurance industry and was certainly no friend of injured workers that I could see. But you will see there that, despite what he said in public forums—blaming lawyers and victims and so on for the problems in the system—when he actually gave evidence he was man enough to admit that the real problem was not the injured workers or their lawyers at all; in fact, he said they were the last people that caused the problems. He said that the problem was the insurance companies. He accused them of manipulating their outstandings to make their books look like whatever they want. In other words, he is talking about cooking their books—and I do not think he is talking about a recipe for pavlovas, either! He also said he had long suspected they are charging suspiciously similar premiums in a so-called competitive market. He does not elaborate on that, but clearly he is talking about premium price fixing, and there are anecdotal suggestions in Perth that we have heard about that there is a premium price fixing cartel going on.

Mr DUTTON—I understand that, and I do not take any issue with what you are saying. I appreciate the efforts that you have put in. You have kindly provided this statement and you have pointed to the anecdotal evidence of fraud that you suggests exists in society, as you would claim it does in certain sectors of the community with regard to either employer or employee fraud. Certainly that is a conjecture that is put forward by a lot of people. But, as you rightly point out, some of the witnesses we have had before us would dispel some of those fears. I am asking you for substantive evidence of your claims in relation to insurance companies. I understand that your cause may be well based and that you are well intentioned, but what substantive evidence—not anecdotal evidence—can you produce to this committee that backs up your claims?

Mr O'Halloran—Obviously I was not privy to any discussions that took place—they would be the last people who would be saying anything. But we have been told, year after year, day in, day out, by the insurance industry: 'There is a crisis in the system. We cannot afford the payouts, common law claims are through the roof, payouts are through the roof, there's not enough money to go around, premiums must go up and payouts must go down because there is

a crisis.' You have it from WorkCover's own figures here that there is a surplus in the system every year and that the surplus now is tracking out at $1.8 billion in the last 23 years. Obviously I am not privy to what insurance company executives are saying, or memos or anything of that kind. I simply say to you that these figures alone are entirely and wholly inconsistent with a crisis. That is not the same as me saying they are committing crimes. No, I am not; I do not have evidence of that. What I do say to you is that Brendan McCarthy—

Mr DUTTON—Sorry, if I can just stop you there, because we are restricted by time, as you know. I accept your document; that is fine and that may be, you may submit, some sort of prima facie case. But you stated in your evidence before that if there is fraud committed in the system, it is committed by the insurance companies. Fraud is obviously a crime. Could you outline to me the basis for that assertion?

Mr O'Halloran—I do not have evidence of insurance company bosses committing fraud as such, no. We have cases where people have been signed up on release forms and where all sorts of things were changed. I think you have got that from the APLA submission as well, where people were duped into signing various documents and signing away their rights. In fact, there was the example in one of the submissions of an 18-year-old boy who was brought into a hotel room and asked to sign a document, not realising he was signing his rights away. Those sorts of things are very common, from what I hear from IPASA.

Mr DUTTON—But, with respect, a lot of people with an opposing view to yours would say that that is the case with regard to solicitors, medical practitioners, employers or employees. It is all conjecture. It is the same, with respect—

Mr O'Halloran—That is not conjecture. You were given a case study.

Mr DUTTON—Just hear me out. I am not trying to dissipate what you are saying, but I am trying to make the point that it is anecdotal evidence.

Mr O'Halloran—No, it is not. You were given that evidence by a lawyer, on behalf of the Plaintiff Lawyers Association, who knew that was going to be put into the evidence of this committee. He gave me an example of a teenage boy who was brought into a hotel room—not knowing why he was even going to the room—and asked to sign some documents, which destroyed his case. We hear of those stories all the time. Examples of those can be given to you by IPASA as part of the submissions. I have obviously not been able to get them all together in the time I have had.

Mr DUTTON—If we could get them then that would be most helpful.

Mr O'Halloran—Absolutely. You will get legions of them.

Mr DUTTON—Do you understand what I am saying?

Mr O'Halloran—I do, yes.

Mr DUTTON—For us to form the basis of any recommendations, to base them upon one extract—

Mr O'Halloran—This case of David is fraud. There is no doubt about it. This guy was franked. It is very clear. In the case of David, where he is working, the film was tampered with by either the insurance industry or their agents or both. That needs to be investigated. If you are willing to investigate it, you should do so. You should do so if you want evidence.

Mr DUTTON—It is not our brief to be investigating these matters.

Mr O'Halloran—You are asking me a question and I am giving you an answer.

Mr DUTTON—I am saying to you that what we need is the facts brought forward.

Mr O'Halloran—I have given you one. That is one case. I spoke to David himself and he said: 'I was stitched up by the insurance industry. I was not working at the time I was receiving workers compensation.'

Mr DUTTON—Did you make a complaint to the police on his behalf?

Mr O'Halloran—No, I did not.

Mr DUTTON—Has he made a complaint?

Mr O'Halloran—Not that I am aware of, no.

Mr DUTTON—With respect, as you said before, that would be the body that would be charged with investigating it.

Mr O'Halloran—Yes, but it does not mean it did not occur. The fact that it has not been complained about does not mean it did not occur. You said you do not want anecdotal evidence. Here is a case from someone who has told me this and who has not done anything about it. He apparently asked for an apology from the former Attorney-General, and none was given. That is just one example.

Mr WILKIE—The Chamber of Commerce and Industry, in talking about fraud, also said that one of the problems is that workers can access compensation very easily. They said the ease with which workers compensation claims are made and accepted is a real problem. Has that been your experience?

Mr O'Halloran—I do not have that experience at all, no. Some do, some will swing the lead and some have done so but, for the vast majority, it is a very difficult process and it is not one that many of them want to be in, in my experience. We now know where the chamber of commerce are coming from. Basically, the chamber of commerce purport to represent employers, and they do represent employers, but what they do not tell you is that some of their most powerful members are insurance companies. They have been pushing the insurance company barrow for the best part of a decade: asking for payout cuts, common law cuts and so on. Not once have you ever heard them coming out and asking, apart from what McCarthy said in evidence: 'Why are all our members paying exorbitant, ridiculously outrageous premiums? Why don't we have an investigation into the insurance companies?' High premiums do not

necessarily mean there is a crisis; it might actually mean they are ripping us off. You never hear the chamber of commerce exposing that.

Instead of asking for payout cuts all the time—and payouts have been cut to the bone anyway—why don't they turn around on behalf of their 5,000 members and say, 'All our members have been paying too high premiums for so long'—and most people have not been able to sue for 10 years anyway—'so why are we still paying them?' Common law, for 80 per cent of people, does not exist anymore, yet premiums have continued to skyrocket—as you will see from these figures. I do not need to prove individual cases of fraud, Mr Dutton. Those figures are entirely inconsistent with the nonsense that has been pedalled around this state for the past 10 years. If you want 10,000 people to tell you that, they can do that, but that will not help you very much. At the end of the day, we have been told that we cannot afford full common law, that we cannot afford to pay you decent benefits, because the premiums are not sufficient for the payouts. But they are. What bigger case of fraud can there be? They have repeatedly lied to us through their teeth.

Mr DUTTON—What I asked you for before was a substantiation of your claims.

Mr O'Halloran—You are asking me for something I cannot give you, in fairness, aren't you?

Mr DUTTON—I am not trying to be unfair to you. All I am saying is that, if there is evidence there, put it before us and we can act upon it.

Mr O'Halloran—I have given you one case study of David. If you want David to appear before you and give a submission, let us see if he is prepared to do so. That is what he tells me. I am sure IPASA itself would give you other examples of the skulduggery that goes on in the hands of insurance companies. There are legions of those cases. If that is what you want, you will get them.

Mr WILKIE—In relation to the Commonwealth, you have made comments about medical panels. We have had a suggestion made by a person who gave evidence earlier that doctors should be trained in occupational evaluation. They were suggesting that, once these panels are in place, every person who puts in a claim for compensation should go before one of these types of panels.

Mr O'Halloran—I bet they are. I wonder why!

Mr WILKIE—This was not an insurance company. What would the cost of that be?

Mr O'Halloran—Twelve hundred dollars per panel. The point about medical panels is that they can so easily be corrupted, hand picked and stacked, and that is what has happened here. You might say, 'Where's the proof of that?' The proof is in the panels that have been constituted, from what we have heard. As a lawyer, I am not even allowed to go down there; we have only got this from talking to individual victims. When we have the name of the chairman of the panel, who often drives the debate, we find that invariably they are from the insurance side of the debate. That could not be mere coincidence. I will tell you why. There are about 250 doctors on the WorkCover medical panels. I have worked out that 10 per cent of them sit regularly. It just so happens that the 10 per cent who sit the most are the ones who act for the

insurers. The other people on the panel are just the B team making up the numbers to give it an appearance of being balanced and impartial. Many of those 250 doctors on that panel have never been asked to sit at all, particularly the ones who are supposedly more on the plaintiff side of the equation. One of them will never sit, because he died years ago. His name is still on the panel.

Mr WILKIE—Thank you. Madam Chair, I make the comment in closing that I agree with the views you have expressed that the inquiry should be far broader than it currently is. I have made those comments in a lot of other forums.

CHAIR—Mr O'Halloran, you made the point that the opportunity for common law claims has declined. In relation to the premium increases that you have shown us in the chart, when did the opportunity for common law claims generally decline?

Mr O'Halloran—It was in 1993. That is a good question. You will see that the premiums have continued to rise unabated. Even before common law was effectively almost wiped out, premiums exceeded payouts. In the last three years—when they have put in a level of impairment or disability of 16 per cent or more; it is even harder to prove now—the premium to payout ratio has gone through the roof. In the last three years alone, the insurance industry in this state—this so-called struggling insurance industry that is crying poor and laughing all the way to the bank—has collected a $763 million surplus. Again, I do not need to prove fraud there. It is absolute hogwash that we have been hearing for the most part of 10 years.

CHAIR—You said common law claims ceased generally in 1993.

Mr O'Halloran—No, they did not cease; they were attacked, and various thresholds were put in which removed about 80 per cent of claims. With the current proposals that Kobelke is putting up, I would say 99 per cent of claims will be abolished, particularly when you combine them with the Ipp suggestions, which I know will be the next stage in the federal parliament's process of taking on board Ipp's suggestions.

CHAIR—Prior to 1993, the total workers compensation costs payouts were in fact less than they are after 1993. Does that include common law?

Mr O'Halloran—Yes. Before 1993 we had full common law. We had that for about 90 years, and it worked very well. I am a practitioner of both systems and I am able to tell you that I had no complaints about it; it worked well. Injured workers, on the whole, were happy. If you talk to IPASA they will say, 'There were problems, but nothing like it is now.' But, in the last 10 years, common law has all but been wiped out—not completely but it is about to be in the coming months, if these proposals are enacted. Before 1993 the insurance industry was still deriving a healthy surplus virtually every year. They were clearly making profits out of it; otherwise, they would not have been in the business. I find it strange that Queensland, with a similar population to ours, has full common law—there is a slight election process you have to go through, which is not terribly difficult, from what I can gather—yet their premiums are the lowest in the country. If we are all concerned about premiums—as we all appear to be now—and business and putting people to work and so on, why is common law such a pariah when full common law appears to work quite well?

CHAIR—There are a number of aspects of Queensland that we are looking into, such as the potential for cost shifting, but that is a separate matter. Can you supply the committee with details on the quantum of common law claims, perhaps in the last 20 years, and how they have declined?

Mr O'Halloran—Ten years ago there were probably something like 2,000 or 3,000 common law claims a year. That would be my best guess. Most people do not bring a common law claim even if they have got one. I would say that at least half the people coming to see me have a claim but do not bring it anyway.

CHAIR—With the greatest respect, a guess is probably not good enough for the committee.

Mr O'Halloran—I do not have any schedule for you.

CHAIR—Do you have access to one?

Mr O'Halloran—I know how many people are now bringing claims. From the latest actuarial figures, in the last 12 months those over 30 per cent, which is full common law, numbered 56 and those above 16 per cent numbered maybe 400 people in the entire state. That is out of 40,000 accidents a year in this state, 20,000 involving lost time. So you are talking about a very small number of people who can now sue.

CHAIR—I do not mean to argue with you; I am just trying to get to the core of what it is you are saying to the committee. The quantum of claims each year has grown, despite the fact that common law claims, as you have said, have declined.

Mr O'Halloran—That is because it has been made harder. Although there are fewer claims, having people fighting harder and harder to bring those claims has escalated costs in many ways. In other words, the more barriers they have put in to stop people suing, the more expensive the whole process has become.

CHAIR—I know we are going to have to move on, because others are waiting, but I think it is an important issue. I cannot see why the quantum of claims is rising. Are there claims then in other areas that—

Mr O'Halloran—Weekly payments would also have increased, because the population has increased. This deals with workers comp and common law. Obviously, the population has increased quite dramatically in the last 10 or 15 years, so that would account for a fair bit of it. It would not be common law. I would say that common law has well and truly come down in dollar terms, never mind in number terms. But, of the ones who get through now, the common law claims are bigger than they ever were, because the barriers to entry are now so high that it has almost created an arms war fighting over what is left. That is what tends to happen: the more barriers you put in the way, the more work is engendered for lawyers and doctors—which we are not looking for. We are just saying that we want a fair system. If you want to give us more work, keep putting barriers in the way of common law.

Mr WILKIE—Do you have any idea what percentage of these payouts would be costs?

Mr O'Halloran—Eight per cent are legal costs, as a rule, as I think you heard this morning. I agree with Neesham's assessment of that. I think common law is around $100 million a year and has been for some time. It is quite an acceptable level in the scheme of things. But in the last three years there was a $763 million surplus. Why are we in a situation where 89 per cent of the population who would otherwise be able claim cannot bring a common law claim and are suffering such financial hardship when these other people are clearly making a killing? It does not make any sense to me.

Mr WILKIE—What do you think happened in 1998-99? I know we are running out of time.

Mr O'Halloran—I know what happened. The Gallop government brought in a threshold of 16 per cent—under instructions, again, from the insurance industry, who were demanding it, telling them we were in a crisis. Before that, there were two reasons you could sue—either over 30 per cent, which gave you full common law access, or a future loss of earnings of over $106,000. They got rid of that so-called second gateway and said, 'It is either 30 per cent for full access to common law or over 16 per cent disability.' That is why this surplus has really taken off. So the insurance companies have done extremely well out of it. When you combine what Ipp suggested and what Kobelke is now suggesting we do with common law here—basically a 20 per cent impairment, use the USA guide, strike out psychological claims and loss of sexual function—those 56 people who got through over 30 per cent last year are down to about six people. We are talking *Titanic* survivor numbers. Kobelke will lose office over it—rest assured about that—but those people will also lose their homes. I think this government will fall over this issue, as the last one did and the Kennett government before it. Common law was one of the main issues that destroyed the Kennett government.

Mr WILKIE—I see that in the 1998-99 period the payouts were almost equal to the collected premiums and the profit was a surplus of $72 million. Is that because people put in a lot of claims?

Mr O'Halloran—I think that there was a rush before the changes came through. A lot of people came to the barrier that might have taken a couple of years extra to get through. A lot of them were rushing through their claims.

Mr WILKIE—I just wanted a clarification on that figure and why it was.

CHAIR—Mr O'Halloran, thank you very much for appearing and for your information.

Mr O'Halloran—Thank you for listening to me.

[2.22 p.m.]

CARMODY, Mr Adrian, President, Rehabilitation Providers Association Western Australia

GORDON, Mr Robert Oliver, Member, Executive Committee, Rehabilitation Providers Association Western Australia

JOHNSTON, Ms Jan, Member, Executive Committee, Rehabilitation Providers Association Western Australia

CHAIR—Welcome. Thank you for meeting with us today. The proceedings here today are formal proceedings of the parliament and warrant the same respect as proceedings in the House. In providing your evidence please do not name individuals or companies or provide information that would identify those individuals or companies. The committee is interested in the broader principles and the issues with regard to those that you may wish to raise. The committee is not prepared to provide the protection of parliamentary privilege to allegations about particular individuals. The committee prefers that all evidence be given in public, but if there is a matter you would like to raise in private then the committee will certainly give consideration to it. I invite each of you to make a preliminary address and then we will move to questions.

Mr Carmody—The Rehabilitation Providers Association (WA) Inc.—RPA (WA)—represents service providers of occupational rehabilitation and prevention activities throughout Western Australia. The RPA (WA) was incorporated in 1988, and its members have significant experience in workers compensation matters, particularly in dealing with the interface between stakeholder groups—that is, the insurance companies, governments, statutory authorities, injured workers, doctors and employers. The RPA (WA) members would also be involved with up to 6,000 new workers compensation cases per year in the Western Australian system. In addition, RPA (WA) members service the needs of Comcare cases in this state.

The RPA (WA) is an affiliate member of the Australian Rehabilitation Providers Association Inc.—ARPA—which represents the occupational rehabilitation industry nationally. RPA (WA) has two representatives on the ARPA council. The RPA (WA) executive and its members fully support and endorse the position paper presented by ARPA to the inquiry into aspects of workers compensation being conducted by the House of Representatives Standing Committee on Employment and Workplace Relations. The issues raised in the ARPA submission and the recommendations for improvement are consistent with those encountered by RPA (WA) members within Western Australia.

I will now present the salient points from the ARPA submission rather than reiterate the entire document. I will keep with the same headings used when we made our presentation in Sydney and just highlight the salient points. Firstly, in this submission the RPA (WA) recommends alternatives for improving performance and strategies for achieving optimum return to work outcomes based on best practice. It is not our intention to talk about fraudulent claims or workers in this situation but really to refer to the adequacy, appropriateness and practicality of rehabilitation programs and their benefits.

I turn to the issue of industry safety. Without doubt one of the most significant factors contributing to industry injury profiles is management culture and competence. Furthermore, structural change in the economy can also result in increased workplace change that includes downsizing and increased levels of uncertainty and anxiety for both management and employees. There is a direct relationship between the onset of such events and an increased frequency of workers compensation claims.

RPA (WA) has identified lack of measurement as a serious issue which undermines decision making of all participants in the management of the rehabilitation system. Consequently, ARPA has commenced the establishment of a national database designed to capture objective outcome measures from all occupational rehabilitation providers in Australia. We estimate it will be at least a year or 18 months before a useful picture will emerge from the collection of this data.

On the issues of adequacy, appropriateness and practicability of rehabilitation programs, the legislation generally refers to employer obligations and specific commitments such as resourcing in-house management of the return to work process—for example, appointing a rehabilitation or return to work coordinator. In regard to referral to occupational rehabilitation services, large employers, particularly self-insurers, have the experience that demonstrates the logic and cost-effectiveness arising from high levels of commitment to effective rehabilitation, including early intervention strategies.

Without question, the most significant determinant of a successful rehabilitation outcome is delay in referral to occupational rehabilitation services. Achieving early referral and streaming injured workers into appropriate occupational rehabilitation services is the biggest challenge confronting the workers compensation occupational rehabilitation system today. Treating doctors have demonstrated they generally do not have the time, inclination or expertise to deal with injury management outside their treatment facilities, much less in the workplace.

There appears to be no clear benefit derived from bureaucratic controls. In fact, there is ample evidence to support the view that excellent results can be achieved from a less bureaucratic approach such as in the examples of Comcare and the Tasmanian schemes. According to *Return to work monitor 2000/2001,* these two schemes have the highest return to work rates and have minimal controls over professional practice.

We believe that more effort needs to be put into ensuring employers take workers back to the workplace. In WA, 25 per cent of the injured population is redeployed with a low success rate and a high cost ratio for that group. Intensive redeployment efforts can be successful. However, the majority of such injured workers become demotivated and give up the search for new work, even with continuing occupational rehabilitation assistance. Without doubt, it is the goal of all participants to see the injured worker return to work as soon as possible. I move on to the recommendations for improvement in the submission, which include:

1. ARPA recommends the removal of existing systemic barriers to the early referral of injured workers to appropriate professional rehabilitation services. This will maximise the effectiveness of efforts to get injured workers back to work as soon as possible and minimise the loss (in both human and financial terms) to injured workers and employers.

… … …

4. ARPA welcomes the management role of the relevant state and territory workers compensation authorities, however, it recommends that performance standards be outcome driven rather than process (i.e., input) driven.

… … …

6. ARPA supports the continuing emphasis on educating employers, and facilitating their assumption of responsibility for the injury management of their own employees. Employers must be the first line of detection of the need for injury management. However, to achieve this, employers require input from the treating Doctor and this communication process must be fostered.

… … …

8. Many injured workers are unable to return to their former employment because of factors associated with the extent of their disability or restricted opportunities for work in their original workplace. Such injured workers would benefit enormously, as would insurers, employers and community, if a national second injury scheme could be implemented. Such a scheme would facilitate the redeployment of workers with a disability (and a continuing claim liability) to a new workplace, while offering some form of time limited premium protection as an incentive for the new employer. Examples of current incentive schemes are RISE (SA), WISE (Vic), JobCover (NSW) and the Alternative Employer Incentive Scheme (NT).

9. Maintaining a capacity to settle claims is an important option that must remain available to insurers and injured workers in those instances where no positive occupational rehabilitation outcome is realistic. Mandatory ongoing requirements to participate in rehabilitation where there is no achievable goal is demeaning of permanently disabled workers and wasteful of resources.

That is the end of our formal submission. Do you have any queries to make to us directly?

CHAIR—Thank you. Do your colleagues have any comments to make?

Mr Gordon—One of the key points is early intervention of rehabilitation providers in the management of injured workers. We have for the committee a graph and survey sheet indicating the delays in referral which can exist in the system in Western Australia in particular through the introduction of more bureaucratic process to the system of referral for rehab. As we pointed out in the submission, having more bureaucratic process delays referral and increases the likelihood that someone is going to remain off work following rehabilitation.

Mr WILKIE—How would you respond to the suggestion that there should be a national regulatory framework?

Mr Gordon—For rehabilitation or insurance?

Mr WILKIE—Both.

Mr Gordon—There are consistencies that can be applied through all the schemes. The introduction of a national framework, if contemplated, should be done in conjunction and concurrently with the state systems, and employers should have the opportunity to elect either one system or the other. There are a lot of good things within each scheme, but having the heads of workers compensation driving a national scheme is probably not going to result in it coming to fruition, because they are all covering their own state responsibilities rather than looking at it from a national point of view.

Ms Johnston—Which are quite different.

Mr WILKIE—Comcare and Tasmania are operating their own schemes which are less bureaucratic. What makes them less bureaucratic—less paperwork? Why are they so good as opposed to others?

Mr Gordon—In WA, for example, three-party agreement is required prior to a referral being initiated for rehabilitation. Just by due process the three-party agreement can take one, two, three or four weeks to engage all the parties to agree on a referral procedure. The delay that is caused by that loses valuable time for that worker to return to work.

Ms Johnston—That is a fundamental point in the outcome of the whole system. Return-to-work rates are lower; costs are higher and positive outcomes are not as good because of the delay in referral. That is the reason our outcomes are not as good as in Tasmania and in the other states.

Mr Gordon—With the situation where referral is easily made, the injured worker can gain access to rehabilitation services and you can deal with things in the workplace quickly. The whole emphasis should be on getting the person safely and effectively back to work, not on the bureaucratic processes to initiate it—they are not present in the two systems of Comcare and the Tasmanian system.

Mr WILKIE—In the Comcare and Tasmanian systems, who would refer people to the rehabilitation program—just a doctor?

Ms Johnston—It can be any of the parties and that is what we recommend—the injured worker can refer themselves, the doctor can make a referral, the insurance company may make a referral or the employer may make a referral.

Mr WILKIE—Then how do you respond to the suggestion that we have heard today that we need to have doctors sitting on a panel to determine whether someone is eligible before they can be referred to anybody?

Ms Johnston—I think that would be a very bad idea.

Mr Carmody—Given what we been through since the changes to the legislation in May 1999, we eventually get to a point where somebody recognises after maybe 180 days that somebody needs to be referred to a rehabilitation provider and then we might have arguing between the three different parties as to who might be the provider who will best suit that person's needs. But there are lots of other questions that come into that process.

Mr Gordon—On that, we made the comment in the submission that we do not see doctors as being a key party in the driving of an occupational rehabilitation program. By and large, general practitioners are extremely busy and do not have a lot of time to deal with the assessment of an injured worker during initial visits. They certainly do not have time to attend the workplace and assess work suitability for an injured worker. So to have a process which involves a panel—not just one doctor—making a decision would delay the process even further. Indications are that it is blowing out already.

Mr WILKIE—What you have just suggested though, that doctors are not necessarily qualified to make some of those recommendations, has been used as an instance where doctors should not be making a determination about whether or not somebody is eligible for compensation—that they really need to be assessed by a more qualified group or individual to determine whether they are eligible for compensation in the first place.

Mr Gordon—I suppose I was not indicating that they were not qualified for it; I do not think they are in the best position to do it.

Mr WILKIE—Are you talking about rehabilitation referrals?

Mr Gordon—Rehabilitation, yes. The assessment of whether or not someone has sustained an injury and whether that injury is compensatable is not necessarily a medical one either—it depends on what has happened in the workplace. The system here in WA is a no-fault system. Providing it is determined that someone has sustained the injury, they would be entitled to compensation. I do not think the process should be delayed by referral to a panel.

Mr WILKIE—In, say, Comcare and Tasmania again, where it is less bureaucratic, has there been a blow-out in the number of people using the service? Is it dramatically higher than it is here?

Mr Gordon—The referral for rehabilitation in Tasmania certainly is one of the highest in the country. WA has one of the lowest referral rates for rehabilitation. But commensurately, the costs per case are lower because you are getting people referred earlier, so the overall costs of the programs are lower.

Mr WILKIE—Do you have any specific cost-benefit analysis that we could get that would demonstrate that?

Mr Gordon—We could provide that.

Mr WILKIE—That would be good, thank you.

Mr Carmody—It is important to note that, if the psychological and social problems that occur following an injury are not addressed quickly, they can blow out and quickly overlay on the medical issues. It then becomes very difficult to provide a definitive diagnosis. Although I work with many good GPs who are interested in workers comp and do make the effort, many GPs do not recognise that the employee is suffering stress or depression or anxiety because of their reaction to the injury and their confusion with regard to the system. The system is incredibly complicated, especially if you are dealing with people with learning disabilities or people with English as their second language. There is a whole array of people out there who have not had the opportunity to be educated and who get into a significantly depressed state very quickly. That may be addressed by antidepressant medication, as opposed to addressing the issues on rehabilitation, informing that person, educating them, opening up the questions with the employer and the insurer, and driving towards resolution of the claim. As I said, there are many excellent GPs but, in the main, they do not have the time to get on the phone and ask the employer, 'Do you have light duties available?'

Mr Gordon—The information we have here is a cost-benefit analysis on early intervention. If you need anything further than that—

CHAIR—We certainly appreciate that. Thank you for appearing before the committee.

Mr Carmody—Thank you very much for the opportunity.

Ms Johnston—Thanks for the opportunity.

[5.43 p.m.]

METTAM, Mr Kim, Director, Western Australia Operations, Charles Taylor Consulting

CHAIR—Welcome. Do you have any comments to make on the capacity in which you appear?

Mr Mettam—I am a director for a British multinational in Western Australia, an adviser on workers compensation and self-insurance in Australia.

CHAIR—Thank you. The proceedings here today are formal proceedings of the parliament and warrant the same respect as proceedings in the House. In providing your evidence today we would ask you please not to name individuals or companies or provide information that would identify specific individuals or companies. The committee is interested in the broader principles and issues that you wish to raise in relation to that. The committee is not prepared to provide the protection of parliamentary privilege to allegations about particular individuals. The committee prefers that evidence is given in public but if there is some matter you would like to submit privately to the committee, if you make that request we will certainly give it consideration. I invite you now to make some preliminary statements and then we will move to questions.

Mr Mettam—I will open by commenting about the 80-20 rule. I will read a little extract about it. Working in workers compensation, I have found that you have a lot of traumatised people and scarce resources, and the combination of the two always makes it very difficult to get a good, fair and equitable balance. Regarding the 80-20 principle, there are a few paragraphs here which I thought were a good introduction to where I am coming from in terms of my view on the system. It is from a particular book on the 80-20 principle:

> Today, we take it for granted that we can compare two related sets of data—such as the distribution of incomes, and the distribution of the people earning them—and observe the disparities. So if we find that 80 percent of total income goes to 20 percent of people, we may not be particularly impressed; we may say, so what? It was Vilfredo Pareto's genius to make comparisons like this for the first time. But what is awesome and spooky is how prevalent the pattern of predictable imbalance is, when applied to almost any two sets of related data.
>
> In evolution, in business, in society, and in life generally, including our personal lives, there are always a few powerful influences, a few things that really matter—and also an enormous amount of background noise, which claims our attention and distracts us, but which is best ignored because it doesn't matter. In paying attention to the background noise, which persuasively masquerades as important, significant and urgent, we limit our effectiveness and squander the energy that should be devoted to observing and co-opting (or avoiding) the powerful forces around us.
>
> It is easy to concede that the 80/20 principle operates across the broad canvas of life; we can hardly deny it when we look in detail at the facts of any particular case. Yet nothing is more difficult, as I have found myself, than to keep remembering that, beneath the burly-burly of ordinary life—when we are continually assaulted by demands on our attention and time—the 80/20 principle is still operating, and requires a very selective response if we are to be effective. We may know that the 80/20 principle applies, and yet behave as though we didn't.

What I suggested in my paper was that the workers compensation system tends to focus its resources in an average way across all cases. I was counselling that you really needed to recognise what the 20 per cent of cases that were producing the 80 per cent of costs were, because it is in looking at those 20 per cent that answers to the system will be more effective. By having more effective answers, more money is made available for the rest of the system. It is a strange irony in our system that, by not doing that over many, many years, the benefit levels

are continuing to be constrained and, in the world that we live in, they will get even more constrained.

We have to get smarter about how to use the resources in workers compensation. I guess that, in a sense, that is part of the charter that this inquiry has. I believe that it is possible to reduce premium costs for employers and increase benefits for employees. I know that sounds almost like a politically correct or glib statement to make, but it really is possible to do. But it needs the discipline of a 20-80 approach to make it work. In the paper I mentioned my long experience, which is about 27 or 28 years of working for the corporations. I do not work for insurance companies, so I do not have an insurance company background. I work with the people—both injured and disabled people—the organisations and the employers. That is my background.

I have found over many years that there is a small number of cases that cost most of the money, typical of 80-20. They tend to be the illness based cases—that is, someone has an underlying disease or condition of some sort which has some relationship to work in varying degrees. It might be a very tenuous relationship and in most cases it actually is a tenuous relationship, but because of the way the system works the full impact of that is attached to the work and that flows through to the costs. I have seen some people who have been very seriously injured and I do not think that they got anywhere near enough money out of the system for their serious injuries, whereas I have seen some people with extremely tenuous links to work enjoy very large benefits. This is where there is an imbalance in the allocation that society makes in workers compensation.

One of the tendencies of illness based cases is that there tends to be a heightened vigilance about activity intolerance, which I think I have mentioned in the paper. That relates to the fact that—and this is like a six- or seven-hour conversation cut down to about 15 minutes—if you take Maslow's hierarchy of needs and look at people's satisfaction in their job and what actually satisfies people in coming to work, everybody has a different combination of satisfaction for needs. If the job is not satisfying their needs—that is, they are only there for the income, for a lower order needs—nothing you do is going to change their motivation to come back to work.

I was going to recommend that your inquiry—if you have not already done so—get hold of the Fordyce book and have a very close look at it: pull it apart and go through it. It is a benchmark piece of work and a lot of what I am saying comes out of this book or is backed up by it. Boeing Co., which is in the paper I mentioned, carried out a study in the early 1990s and found that a greater predictor of someone having a workers compensation claim was whether they were happy in their job, which then links with the hierarchy of needs scenario. Therefore, Boeing were looking at selection techniques so as to match people that would be happier in their job and thus a safer risk. Some of the large corporations are finding now that, while they have done all the things with systems—they have a safe workplace, they have made investments in hazard management and they have almost this missionary zeal about safety and attitudes—that will get safety performance down to a certain level but then it does not shift. Therefore, the question is: how can you shift it further? I am a strong believer in a zero loss culture; I think any organisation should target that—that is, there should not be anybody having any injury or disability in the workplace. One of the ways to get the shift is to look at the happiness of people in their work and select people as to whether they will be happy in the sort of work they will be doing. That is where Boeing were coming from. Incidentally, there is an excellent little piece in the Fordyce book as well, on page 41, which also relates to that area.

With regard to illness based claims, there has always been a strange idiosyncrasy in the Australian compensation system that we have a compulsory form of insurance on employers; it has to occur. Every now and again I have to pinch myself to remember that that is the case. It is compulsory for employers. Yet, when legislative change is considered, the problems that employers have are rarely looked at in great depth. I would maintain to this day that, for all the energy and resources directed to the design of workers compensation systems, there still is a relative lack of knowledge about the problems that employers have with the dynamics behind workers compensation. That is, as Pareto suggests, most of the problem is with the illness based conditions. I refer to the fact that there is a concept—not only a concept—a model of imposition of disability and a lot of the rehabilitation coordinators will actually do courses in interpersonal persuasive techniques to overcome the tendencies of imposition of disability that take place. Their performance will often be judged on just how persuasive they are towards people either getting out of an imposition of disability syndrome or never getting into it in the first place.

Going back to the problems for employers, there is a huge amount of effort put into rehabilitation around Australia. I can remember certain state governments saying, 'The answer to workers comp is we will just make rehabilitation work and it will reduce the cost.' That is all well and good but, from my understanding of the problems for employers, one of the problems is availability of jobs. If the jobs are not available, no amount of activity is going to make any difference. In fact it will probably be counterproductive, so it is important that employers be supported in making available transitional jobs to get people back into the work force.

When you have people with illness based conditions who may be imposing disability because of reasons to do with life coping skills or a whole series of particular problems, it becomes so much more difficult to make that transitional job available. Once you bring a person back in, you undermine the moral of the working group who look around and quickly frame a view that might say, 'This person is really here for reasons other than a medical reason, it might be a life coping reason.' Often a work force will be less sympathetic or understanding, particularly when it happens to them over a sustained period of time with many cases.

I will give an example. I found over the years, I used to say, 'What is roughly the level of incapacity that should occur in a large corporation?' I worked out a yardstick, which was roughly one in every 200 people. You will have roughly one person off full time for a year for every 200 people, so that would be a yardstick. When I was called into an organisation in Victoria, I discovered that they had 12 people off for every 200 people. You would then start to say, 'What is causing that? From a standard of one, we now have 12 off. Why?' What I found was that it was a young work force, highly mechanised, highly paid and working for a primary labour market employer with wonderful conditions. These are all the things where we would normally expect people would want to continue to work. The problem was that the area around was primarily a secondary labour market and all sorts of distortions and behaviour over several generations had occurred in that area. For those reasons there was a propensity to make illness based claims. What it suggested was that, in our system, it is very easy to make an illness based claim. So there was a culture which was basically to make an illness based claim, retire at about 33 years of age and sue the hell out of your employer. There was a secondary and tertiary reinforcement taking place for that culture. People were behaving objectively and that is why 12 out of every 200 employees in that plant were off full time for a year on workers comp instead of the standard of one person.

The process which arbitrates an illness based claim versus a trauma based claim is the interaction between a physician and an individual, where the individual acts as a message sender. As a message sender, they will send a message—usually in their interests. The doctor will receive that message and there will be certain behaviours that might take place. I draw on money as an analogy. Actors on the stage will use facsimile money, and each actor knows that, whilst it looks like money, it is not really money. In a message between the doctor and the individual, whilst it looks like money they both know that it is not really money, so to speak. Whilst the message is about what is happening at work and the symptoms of an individual, both the doctor and the individual know that it is not really a work caused problem. There may have been a longstanding history of the issue; but it is a facsimile and therefore it is attributed to work.

I mentioned in my submission that, in some states, the Evidence Act actually protects an individual from an employer being able to say, 'You say it comes from work. Give us the right to look at your medical record in regard to a claim for workers comp or work relatedness.' The Evidence Act in those states actually precludes that from taking place. A barrister can actually say in court, 'They would not give us approval. The jury may or may not take that into account.' I would say: save the system the cost; let the truth be discovered. If someone has a history of illness, then let it be discovered when it is relevant to the claim being made. In my view, that one little change in that state would have a Pareto impact—a hugely disproportionate impact—on the costs in that state in areas like common law. So, rather than a total focus on the gates of common law, there should be a simple process of saying, 'Let's be objective and let the truth be discovered.' It is my thought that we should not have a situation in Australia where every state has its own evidence act. There should be a standard template which should be used across all states. It is just ridiculous that it is not that way. It really is. It is almost embarrassing to explain that to international organisations.

I will move on to cost. I have often said to companies that come to me for advice about whether to do self-insurance and how to handle things that we should have a template that is based on the fact that it is unacceptable to have a workers compensation cost of more than one per cent. It is absolutely unacceptable to have it at more than one per cent; it should be less than one per cent. I have seen several large multinational corporations with extensive work forces run with a workers compensation cost of less than one per cent. It is possible to do. In workers compensation there are basically two dynamics: benefit rules and process rules. Both of those have to be designed with a particular target in mind, and that is that the cost to the community should be one per cent or less. That may sound almost provocative, but one per cent is one person in every hundred.

Figures can often be meaningless on a piece of paper, but the current average cost of the different state systems is somewhere between 2½ and 3½ per cent. In a sense, that ratio means that 2½ or 3½ people per 100 people in Australia are on workers compensation for one year. That is a very large figure for our whole work force, and that is why I say that it is unacceptable and that one per cent should be the maximum. At one per cent, there should be plenty of money to improve the benefits for the people who have severe traumatic injuries at work. The way to do that is to change the allocation of moneys so that there is less money weighted to the illness based claims and more money weighted to the trauma based claims.

I guess the other thing I would be saying is that it is sad about our various comp systems—not in all states, but in some states. Throughout your life you either win the lotto, inherit money

or you work damn hard every year, make and save an incremental amount and gradually over the years you build up what could be a nice retirement nest egg. Our whole country should be doing that in terms of workers comp systems. Incrementally, every year, the funding should be making a little modest surplus, building it up so that as that fund builds so too can the level of benefits and the facilities that can be made available to injured people be built up, rather than having some states facing major deficit issues and not being able to take advantage of that incremental build-up.

That has got me right through what I wanted to say. I gave some thought as to how to design benefit rules around trauma and illness. I then concluded that I might take some stabs at that but really what needs to happen is that as a country, as a microeconomic policy, we need to be right on top and understand the full extent of the problems that employers face. We need to be right on top and understand the scope and extent of illness based claims in our workers comp system. I am also a great believer in the fact that when you understand a problem in great depth you get the best solution to that problem, rather than guessing a solution and then finding several years later that you may have got it wrong. Then you have got all the complications of getting it wrong and you have still got the original problem to fix. My counsel to the inquiry is: I think you are on the right track to get out there and find out what the problems are; study the problem and therein is the solution.

CHAIR—Thank you. Mr Hartsuyker will lead off with questions.

Mr HARTSUYKER—Do you believe that a voluntarily imposed disability constitutes fraud in a large proportion of cases or has the claimant convinced himself that there really is something wrong and it is genuine?

Mr Mettam—I think it is genuine. I have found that it is a bit like the example of the facsimile or counterfeit. If the person knew it was counterfeit money and they were trying to hand it over, then it is fraud. But I think that in most cases they do not realise it is counterfeit money. They actually genuinely believe that it is the real thing, and they believe that because it is appropriate in their life. Some people would say it is a way of socially withdrawing from the workplace or it is a way of being able to make somebody responsible for some problems in their life. So, no, I actually do not think there is large-scale fraud in the workers comp system. But, I must say, I think that where there is fraud, it is extremely expensive.

I will mention a case that I had, because I will not give any names. It was deliberate fraud on the part of both the doctor and the individual. The organisation I was giving advice to pursued both of them and was quite successful in the end. The doctor was writing out total incapacity certificates and he made a mistake, because the individual was actually working in another industry which required medical fitness certificates. In the same week, the doctor was writing out certificates warranting full fitness for work. It goes back to the fact that in Western Australia you can get a third-party order and obtain the medical history. It was only by doing that exercise that we discovered the fraud was going on, because the doctor could not change his notes. It was there and it had to be discovered. That is why I think it is so very important that early on in a process full discovery should be given.

CHAIR—Should we be employing happy people? That is a trite question. You did make the point that this voluntary imposition of disability is related to a wider discontent that people have, either with their workplace or in other areas.

Mr Mettam—Yes. I must give you a general answer to that because there are a lot of specific answers that I could give. Do you have time for me to read another extract from this?

CHAIR—Five minutes is probably all we have.

Mr Mettam—It will be less than that and it goes right to the point. It states:

> Suffering may develop in response to longstanding and unresolved pain problems or as an expression of emotional distress. That distress may relate to emotional problems unrelated to work or it may arise as a consequence of job-worker interaction. Work-related suffering may arise because the job requires skills, speed of performance, precision of performance, strength and endurance, or, in some other manner, coping skills greater than the worker can provide. The job may have been a poor fit with worker abilities from the outset or it may have evolved into one. Changes in the worker as a result of injury, ageing, or for some other reason may make a previously adequate job-worker fit no longer tenable. Those and other possible reasons may underlie worker distress, suffering, and activity intolerance in relation to a job.

So all of those reasons could lie behind it. They are saying here that medicos tend to seize on the report of pain and attribute incapacity and a withdrawal from work. Another comment I have often made before is that there is a fundamental conflict of interest with an attending physician. It is very difficult for, say, an individual's own doctor to attend and be objective because they have a contract with their patient and must always act in their patient's best interests. Our workers comp system tends to make an assumption that the doctor will always be objective. I often think, 'Well, if I were a doctor, it would be very, very difficult to be objective.' What do you do with somebody whose whole family has always come to you and you know their whole background but then that individual suggests that it is tough at work at the moment, they have a bit of a pain in their back and they would rather be off? You would write a certificate for them.

Mr WILKIE—How often would that happen, realistically?

Mr Mettam—The plant in Victoria that I was giving advice to had a ratio of 12 people off full time versus my normal findings of one off full time. It happens where the circumstances fit.

Mr WILKIE—Was it the same doctor?

Mr Mettam—It was the same doctor. But usually they have a referral network and they refer to certain other doctors who then back that position. It is the same doctors; it is like a little suite.

CHAIR—I think your message out of all of this—if I may be so bold as to summarise you—is that there should be fewer resources devoted to illness based claims, leaving more for the really traumatic claims.

Mr Mettam—Yes.

CHAIR—Is that central to the message you are sending to us?

Mr Mettam—It is central; and there should be more understanding of the illness based claims to ensure that there is not inequity. There are some lines where you would have someone who may pick up a heavy weight and cause a disk protrusion. Is that a trauma base or is it an illness base? It depends.

CHAIR—That then begs the question of who or what structure in the system allows illness based claims to get the precedence they get. Is it just a fact of nature; is it the doctor-patient relationship; are the insurance companies too weak; are the doctors not the correct people perhaps to be assessing that initial claim for compensation? What is the fault, then? You have said that these people with illness based claims are not fraudsters; they genuinely believe that they are unwell because there is some dislocation in their life. But what structure is enabling them to do that? What should we be looking at?

Mr Mettam—I think there is a lack of objectivity in the medical assessments; that is one thing. I think a lack of understanding of the problems that the employer faces contributes. I also think it goes to the judiciary; it is a common subject these days, but over the years there has been such a mutation in the tests of negligence that we have now developed a no-fault system in common law. In my view, that is the fundamental reason we have all the problems we have, because no country can afford two no-fault systems—at its origin, workers comp was to have a no-fault system. I have seen time and time again common law undermine the capacity to bring people back to work and to fire up the imposition of disability. That is really sad. I have seen people lose their cases and virtually lose their whole lives, because the system has taken them that way.

Also I think we can be a lot smarter with returning people to work; but, by not understanding what the problems are for employers, we have not got that far yet. I know that an adviser to the government in this state has suggested that second injury funds should be considered. Maybe they should be. They have pluses and minuses, but perhaps that is another area that needs to be looked at.

CHAIR—I am sorry; second injury?

Mr Mettam—Second injury funds, which relieve an employer. In returning people to work, you basically need to have transitional jobs. Getting people back into their work scenario can stop them from getting into the imposition syndrome. But there is a range of people for whom transitional jobs will never solve the problem; they need a permanent job change.

CHAIR—I do not mean this in a facetious way, but should we have some sort of 'work for workers comp' system; that is, a transitional, light duties type of voluntary job system?

Mr Mettam—Yes—and, by understanding how that could work, we could really make it work. An organisation with goodwill will make available transitional jobs, and the systemic design problems in the system blow it up. They blow it up because the people who go into those transitional jobs never leave them. It is like a sponge and it fills up. An organisation only has so much that it can do, and then it blocks. The jobs that all the other people behind are looking for are suddenly not available because they are all filled. I have seen that happen too and it is really sad.

CHAIR—Mr Mettam, we will have to close there. Thank you very much.

Mr Mettam—You are welcome.

[3.19 p.m.]

FERGUSON, Mr Bruce Wayne, National President, Association of Risk and Insurance Managers of Australasia

TILLEY, Ms Kate, Publicist, Association of Risk and Insurance Managers of Australasia

CHAIR—Welcome. Thank you for coming to meet with us today. The proceedings here today are proceedings of the parliament and warrant the same respect as proceedings of the House. In providing your evidence today we would ask you, please, not to name individuals or companies or provide information that would identify individuals or companies. The committee is interested in the broader principles related to the terms of reference, and issues that you would like to raise in reference to that. The committee is not prepared to provide the protection of parliamentary privilege to allegations about particular individuals. We would prefer that all your evidence be given in public but if there is a matter that you would like to raise privately, and you request that, the committee will give it consideration. I now invite you to make some preliminary remarks and then we will move to questions.

Mr Ferguson—I would like to explain exactly what ARIMA is. ARIMA is basically a professional association representing people who are engaged in the practice of risk management throughout Australia, be they in large corporates, state and federal government departments or government trading entities or local councils. We have a very broad spectrum of membership. They are the people who are dealing, amongst other things, with workers compensation issues at the coalface, if you like, from the employers' perspective. ARIMA has been around for over 20 years—in fact, about 26 years—as a body trying to create a forum for people dealing with these issues at a company or departmental level to be able to share knowledge and experience on how to better deal with these matters.

In the submission that we gave earlier this year we discussed the principles of self-insurance and how a certain number of our members have found that to be beneficial in terms of cost control. In fact from my work, in my paid employment, for a self-insurer, which is only based in New South Wales, I can say that we found that the cost to our organisation, including provisions for claims going forward, is significantly less than it would be if we were in the state-run scheme. I am not sure if anyone can explain with exact accuracy why that is, but there is always anecdotal evidence of people talking about cross-subsidisation and so forth built into the scheme formula.

Since we made that submission we have had an opportunity to survey our membership on this matter as to whether they would like a national workers compensation scheme as opposed to a state based one. In particular, we asked those members who had operations across jurisdictions, either in multiple states or territories. The answers were unusual. Of those who answered the survey, we had a response rate of 44.3 per cent saying yes to a national scheme and 56.6 per cent saying no. We are unable to determine, because we have not drilled down behind those numbers, whether or not the ones who did not want a national scheme were significant self-insurers or were participating in state based schemes. That is something we would propose to do going forward. But it was certainly an interesting outcome from our perspective because in our association it has been a truism that a national system would be better, given that there are some

organisations which have to deal with different legislation in every state in which they operate in, and some operate in all of them. So there is that aspect.

In terms of the fraud element, I suppose there are always anecdotal stories by people who relate having evidence of somebody being able to undertake activities that belie the injuries that they profess to have. I do not think one could ever generate sufficient statistics to either prove or disprove the level of supposed fraud in the system, other than that from our members' perspective there is an element of fraud in the system—whether it be doctors who may give certificates far too readily or who are known for giving certificates to employees who, for a variety of reasons, may feign an injury. As to the extent of it, I do not think anyone can judge that.

In terms of the impact that occupational health and safety and injury management might make on those things, one things that is very clear is that self-insurers, who are essentially dealing with their own money rather than insurers' money or schemes' money, find that their costs are much less because they are using their own money. They have a stronger incentive to have early intervention programs to ensure that, if there is an injury, it is not left to—for want of a better term—'fester', or for people to develop the mentality that they cannot return to work. People are made to feel as though they are important and that they are wanted back at work, and every effort is made to get them back at work for suitable duties once they are fit to do so. That seems to be a feature across every person who has a successful self-insurance scheme for workers compensation—early intervention and return to work on appropriate duties. The longer people stay off, the less likely they are to return. It is as simple as that.

CHAIR—Ms Tilley, do you have some preliminary comments to make?

Ms Tilley—We have statistics from a company that back up what Bruce is talking about.

Mr Ferguson—Yes. A member in Queensland, as we said in the submission, found that once they started their self-insurance licence in that state, their average lost time per claim reduced by 30 per cent on a fairly rapid basis since 1998. That is not an unusual experience.

Mr DUTTON—I am sorry, can you repeat that?

Mr Ferguson—One of our members in Queensland became a self-insurer in 1998, and since that time they have found that the average time lost for workers compensation claims has reduced by 30 per cent.

Ms Tilley—On the self-insurance issue, one of the things that members do say is that it is quite difficult for them to become self-insurers—in Queensland, particularly. There are only, from memory, 11 self-insurers. It is very difficult to become a self-insurer because of that legislation. There are other members who would like to be self-insurers but cannot because they do not meet the criterion of the company being the right size. I think in New South Wales it is a bit easier.

Mr Ferguson—There is perception amongst some that those who are, in particular, administering state schemes do not want too many self-insurers because often they are the people who are putting most effort into rehabilitation, occupational health and safety and so on. Ultimately, if you made it too easy, you would have only those in the state scheme who have

poor claims experience, and the costs of those schemes would be proportionately worse because of that. So there are quite a number of hoops to jump through if you want to become a self-insurer in whatever jurisdiction.

CHAIR—Can you explain to us what being self-insured means?

Mr Ferguson—Essentially you make a submission to the appropriate authorities in a particular state. You have to have, amongst other things, the appropriate claims management staff within your organisation. You have to have some guarantees behind your funding so that if there is a problem with cash flow in a company they know that there is either catastrophe insurance behind it or bank guarantees and the like. You are subject to the same legislation as the fund managers or the insurers. So you must manage your claims in accordance with the guidelines that are legislated for. So to all intents and purposes you have to operate as if you were an insurance company or a fund manager. You are subject to the same controls that they are, except that you are doing it with your own staff and your own money.

CHAIR—Did you have any further preliminary comments to make?

Mr Ferguson—No.

Mr WILKIE—I notice that that unnamed company is probably one which is a national company. I am surprised they are not operating that nation wide. Is that because they cannot?

Mr Ferguson—Essentially you have to apply in each state as required. You cannot apply on a national basis. It may take up to two years to get a licence in some states.

Mr WILKIE—You may have covered this earlier but I also note that—if it is the same company I am thinking of—they put that 30 per cent reduction down to the fact that they have an early rehabilitation intervention program—

Mr Ferguson—That is right.

Mr WILKIE—which is holistic and includes the coordinator, the worker, the doctor and the claims officer, who all work together.

Mr Ferguson—We did touch on that. I think that from any perspective early intervention works. Even if you go beyond workers compensation to public liability, you find that if you let people sit at home and worry about their injuries they will perceive that they really have a problem. If you get on the front foot and try and do something to help them, their mental attitude towards recovery is much better.

Mr WILKIE—I imagine the people you are dealing with would have workers compensation insurance. We are touching on fraud here. It has been suggested that employers who do not have workers compensation are also committing fraud because they are required to be members. In many cases they are not and that is putting a severe burden on other workplaces to cover their costs by paying higher premiums.

Mr Ferguson—Generally the organisations in our association are of a certain size so that they would have a person who is, in a large part or wholly and solely, responsible for risk management insurance issues. I cannot recall any of our members who would not have appropriate arrangements in place—either a self-insurance licence or a policy in that state. From anecdotal evidence and personal experience you find that it is the smaller organisations that might do that—the one- or two-person show. Obviously if there were enough of that it would have an inflationary effect on the schemes.

CHAIR—We have been given a chart showing the total workers compensation payments received by self-insurers and the insurance industry. If you are self-insuring do you pay your own premium?

Mr Ferguson—Generally there is a premium mechanism internally. You have to ensure that you have money to pay for your claims. Each year you are required to have an actuarial estimate of your forward liability because, as you would be aware, these are what the industry would term 'long-tail' claims, in that they take many years to resolve. So it is important that there is an appropriate provision made in the books of the company to have the money there to pay the claims when they finally come to a head. You are not necessarily paying a premium per se. You do have to pay a licence fee to WorkCover, but that is a different issue. Generally the organisations will have an internal premium regime based on injuries, time lost or claims costs, depending on what suits that company.

CHAIR—The chart that we have been given—these figures refer to Western Australia—shows that in the last decade the payments received have gone from $285 million to $661 million but the payouts have gone from $253 million to $388 million. That is an enormous increase in the margin between those: from $31 million to $273 million. If you are saying that self-insurers have significantly reduced their costs, does that account for the difference here, from the self-insurer's point of view?

Mr Ferguson—I would not really be able to comment accurately on that. The premium calculation formula varies from state to state and it is mind-bendingly difficult to follow the logic of some of it in certain circumstances. Obviously, as a New South Wales resident, I am most familiar with that scheme and I know that, essentially, the formula is one that tries to make the larger organisations more claims responsive in their premium payments. The larger you are, the larger is the percentage of your premium based on claims experience rather than payroll. Essentially, situations have arisen in the past where scheme actuarial estimates have felt there have been surpluses and there have been increases in benefit because it was felt there was a pool of money there. Over time, because of escalation of those claims, that pool really was not there. But the benefit increases have had an inflationary effect on premiums, for the larger employers certainly, because benefits have increased. As soon as you increase benefits you increase premiums, because there is a direct correlation.

CHAIR—That has not happened here, has it, according to figures that we have? They come from WorkCover's annual report, so they must be reasonably accurate.

Mr Ferguson—I am not in a position to confirm or dispute those figures.

CHAIR—A previous witness said—and I am using their expression—that it was in fact the insurance companies that were the cause of the problem.

Mr Ferguson—It is like most things—there is never one cause of a problem. Depending on what jurisdiction you are in, whether it is a fund manager or an insurance company, you can have an individual case officer who is very good or very poor. I have recent anecdotal evidence from my own family, who run a business in New South Wales, that certain things happen with their small company that cause their workers comp premium to skyrocket, even without their knowledge, because the case management within the insurer is not following the proper protocols. So, yes, there is potential for that, there is no doubt about that. If they are not as zealous in pursuing early intervention type claims management, as described in our submission, they will have an effect on what the ultimate claim cost is and certainly on premiums.

CHAIR—Thank you very much.

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

That this committee authorises publication of the proof transcript of the evidence given before it at public hearing this day.

Committee adjourned at 3.38 p.m.