Inquiry into Aspects of Workers' Compensation

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ATTACHMENTS WILL BE FORWARDED BY POST

The Association represents people with overuse injuries, many of whom are clients of the worker's compensation system. This injury is extremely common (see Attachment One *"Occupational Overuse Syndrome Stressors and the Workplace Project", page 4*) yet is still highly stigmatised and its treatment poorly understood. In Australia, it is difficult to even get accurate statistics on its occurrence because of decisions on the way that worker's compensation statistics are collected (statistics are for **types** of overuse injury such as epicondylitis, carpal tunnel syndrome, rotator cuff, or tendinitis).

Incidence and costs of fraudulent claims

The society would like to point out that the incidence of fraudulent claims is generally accepted to be very low and there is considerable evidence that many people who are eligible for worker's compensation do not in fact apply for it. (See Attachments One *Occupational Overuse Syndrome Stressors and the Workplace Project,* page 4 and Two *"Why Most Workers with Occupational Repetitive Trauma do not File for Workers' Compensation"*).

Methods used to detect and eliminate fraudulent claims

In the experience of many people who are customers of the worker's compensation system, every person who claims worker's compensation is treated as if they had made a fraudulent claim. In particular, the use of so-called independent medico-legal doctors is problematic in the following ways:
Medico-legal doctors often have no experience in **treating** patients with a particular condition yet part of their role is to recommend appropriate treatment.
In addition, they

- are extremely expensive and consume a disproportionate amount of the insurance dollar
- present polarised points of view which do not assist either the patient or the insurer
- derive most of their income, in many cases, from medico-legal work for insurers and are therefore not independent
- very often don't follow the AMA code of practice for medico-legal consultations and treat patients disrespectfully. This may take the form of being abrupt and curt, very patronising, or sarcastic. Patients are often humiliated by having to undress unnecessarily and sometimes hurtful comments are made about their appearance.

Most patients don't understand the nature of a medico-legal consultation, for example that the doctor will not respond to their questions or recommend treatments directly to them, and are therefore at a disadvantage during such consultations.

Many people are intimidated by medico-legal reports and don't understand that they are not truly independent, especially people who are uneducated, and/or don't have a good command of English, and this results in loss of their worker's compensation entitlements. We also suspect that women are disadvantaged in the medico-legal process, because they are traditionally less assertive.

In many cases the stress of the adversarial process worsens the effect of the original injury and makes it more difficult to recover.

The use of video surveillance is well-known to claimants and deters them from undertaking activities that will aid a return to normal life. This type of surveillance often succeeds in intimidating people out of their legal rights when they have been videoed undertaking normal activities, for example hanging out clothes or shopping – activities that may be very painful or difficult for them, but which they have no choice about doing.

Factors that lead to different safety records and claims profiles.

In the field of occupational overuse syndrome, very good evidence exists to suggest that the following factors are crucial (see Attachment Three "*The cost of shoulder pain at work*"):

- Lack of training in safe use of equipment
- Equipment that is not ergonomically designed and/or is not set up to suit the particular user
- Pressure to be highly productive at work, especially measures such as automatic counting of keying rates
- Lack of variety at work
- Long hours

Adequacy, appropriateness and practicability of rehabilitation programs.

In the experience of our members, the following factors are essential to successful rehabilitation.

Emphasis on the needs of the worker

Generally the emphasis in rehabilitation programs is on the needs of the workplace, not the needs of the injured person. In fact, these needs are not really in conflict. Most injured people want to recover and return to work. However, if they feel, as they frequently do, that their recovery is not a high priority and that workplace demands prevent them from recovering, this alienates them from the workplace and engenders a mentality where the workplace is seen as their **opponent**.

Tailor the approach to the injury

Rehabilitation often takes a "one size fits all" approach to injury. It is assumed that all injured workers need to return to work as quickly as possible after injury. If workers with OOS return to their previous duties, this approach jeopardises recovery. This type of injury is generally recognised by medical experts to need months not weeks for recovery. (See Attachment Four "*Time to abandon the Tendinitis Myth*").

Consider work-place culture as a factor

There is considerable evidence that aspects of workplace culture affect rehabilitation (see Attachment Five *"The impact of workplace culture on injured workers return to*

work"), especially support from managers and co-workers, belief in the reality of the injury, and provision of suitable duties.

Allow the worker to have some control over the rehabilitation process

One important factor that has been shown to be crucial in maintaining health generally is the degree of a person's control over their work. When people are injured and return to work they often feel that they have very little control over many aspects of their life: treatments, activities at work, hours of work. Injured workers may persist with treatments that are damaging or useless because of this lack of control. In addition, people are stigmatised because of their injury and may feel that they have little to contribute either at work or at home. All of this inhibits recovery and may cause depression. **Rehabilitation should be a true partnership between the injured worker, the workplace and treating professionals.**

Return to work at an appropriate time

Due to the emphasis on **speedy** return to work, it is often attempted during the acute phase of an injury, before it has settled or responded to treatment. In particular, companies which emphasise their ability to speedily achieve a return to work put such unrelenting pressure on claimants that it amounts to harassment and causes considerable mental and emotional distress.

Provide suitable duties

When people return to work there is often a lack of suitable duties: people are generally given the same duties at reduced hours, that is, people resume the duties that originally caused the injury. In the case of OOS, this often leads to re-injury and a chronic condition that is not curable.

Provide equipment and training to support return to work

Work places are reluctant to provide the equipment that people need for a successful return to work, for example voice-operated software or a telephone headset. Even when these are provided, long delays are common and training is not available or is patchy.

Research treatment

While the physiological basis of OOS is fairly well understood by researchers, it is not understood by most GP's who treat inappropriately with anti-inflammatories (see Attachment Four "*Time to abandon the Tendinitis Myth"*). Unfortunately, there is currently no well-founded evidence-based treatment for this very common injury. Our own research has shown that many treatments recommended for OOS have serious adverse effects, especially surgery and traction. Therefore, research into treatment should be a priority.

The most promising current research on treatment suggests that multi-disciplinary rehabilitation may be successful for OOS patients but this is very rarely available in Australia. (See Attachment Six "*Presentation and response of patients with upper extremity repetitive use syndrome to a multidisciplinary rehabilitation program").*