AUSTRALIAN NURSING FEDERATION

Publishers of the Australian Nursing Journal and the Australian Journal of Advanced Nursing

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De-anne Kelly MP
Chair
House of Representatives Standing Committee on Employment and Workplace Relations
R1 106
Parliament House
Canberra ACT 2600

Dear Mrs Kelly

Inquiry into aspects of Australian workers' compensation schemes

I have attached the ANF submission to the above inquiry. Please contact Debbie Richards in the Melbourne office (or research@anf.org.au) if you require any other information.

Yours sincerely

JILL ILIFFE
Federal Secretary

WORKERS COMPENSATION INQUIRY

1. ABOUT THE ANF

The ANF is the national union for nurses, with branches in each State and Territory of Australia[1]. The ANF is also the largest professional nursing organisation in Australia. The ANF's core business is the industrial and professional representation of nurses and nursing. The ANF's 120,000 members are employed in a wide range of enterprises in urban, rural and remote locations in both the public and private sectors, including hospitals, health and community services, schools, universities, the armed forces, statutory authorities, local government, offshore territories and industry.

The public sector remains the primary employer of registered and enrolled nurses. In 1997, 63.4% of registered nurses were employed in the public sector, 23.5% were employed in the private sector, and 13% in the aged care sector. Also in 1997, 51% of enrolled nurses were employed in the public sector, nearly 17% in the private sector and 32% in the aged care sector.[2]

The ANF represents nurses in the development of policy in nursing, nursing regulation, health, community services, veterans' affairs, education, training, occupational health and safety, industrial relations, immigration and law reform. Policy input within the ANF is through consultation with the branches and their members and representation of each branch on the national executive and the national council. National subcommittees cover professional issues, occupational health and safety, industrial issues, publishing, aged care, midwifery, and rural and remote area nursing. The ANF represents nurses internationally through links with other national and international nursing organisations, professional associations and the international labour organisations.

2. BACKGROUND

The latest Government Report into Nursing[3] predicts nursing shortages will amount to some 31,000 nurses in just 4 years time.

It concludes that the main issue for nursing is the retention of existing staff and the re-entry of registered (but not practising) nurses.[4]

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1 ANF Victorian Branch, ANF Tasmanian Branch, ANF SA Branch, ANF WA Branch, ANF NT Branch, ANF ACT Branch, Queensland Nurses Union and the NSW Nurses' Association.

2 AIHW 2001 Nursing Labour Force 1999 AIHW Canberra.

3 National Review of Nursing Education 2002 – A Duty of Care, Commonwealth of Australia 2002.

4 Ibid p. 199.

Summarising comments received as part of the review process, the Report states that the main causes for the current shortage of nurses and the inability to attract and retain nurses are the problems faced by nurses within the work environment.

Among the key issues, the Report identified: inflexible rostering; violence within the workplace; overwork; poor working conditions; and a highly stressful work environment as major factors influencing a nurses' decision to leave the profession.[5]

Furthermore, the Report identifies occupational health and safety as a key concern nominated by Review respondents. It states:

> ***"... Safety was seen as directly related to the increasing pressure and stress nurses are facing and the inherent risks and dangers in working long hours and large amounts of overtime. Hospitals and Nursing Homes are areas within the health and aged care sectors that most commonly experience injuries and subsequent workers' compensation claims (Submission from Queensland Nursing Council). Many submissions called for employers to ensure the safety of nurses in the workplace and when leaving work".***[6]

It recommends that Commonwealth, State and Territory health ministers, other employers, and management in all health, aged and community care sectors address these and other workplace issues through the establishment and implementation of a suite of policies to be developed and implemented in consultation with staff.[7]

On an industry level, the Health and Community Services sector rates seventh highest out of eighteen industry groups in relation to the incidence of injury per 1000 employees, and has the highest percentage of compensated manual handling type injuries resulting in 12 weeks or more of compensation payments.[8]

Employees in this industry are exposed to a wide range of hazards and while manual handling type injuries result in the highest number of reported claims, there is a high level of exposure to other hazards such as:

- Violence in the workplace;
- Shiftwork and poor rostering;
- Hours of work/Fatigue;
- Chemical hazards eg. glutaraldehyde, cytotoxics;
- Psychological Injury/Stress;
- Needlestick, scalpel cuts.

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[5] Ibid p.199-200.
[6] Ibid p.181.
[7] Ibid. Recommendation 30p.
[8] Workplace Relations Ministers Council, Comparative Performance Monitoring, Fourth Report, August 2002. p.16.

3. TERMS OF REFERENCE

General Comment on the Terms of Reference

The ANF is concerned with the broad approach to this inquiry. Problems and other matters concerning workers compensation schemes should be examined and dealt with by the relevant parties within each jurisdiction.

While no compensation system is perfect we acknowledge that in some jurisdictions, significant improvements have been made and we would oppose any steps which may be taken to weaken existing workers compensation systems.

A. Incidence and costs of fraudulent claims and fraudulent conduct by employees and employers and any structural factors that may encourage such behaviour.

The ANF cannot comment on the extent of fraudulent conduct with respect to employees. This should be a matter for each jurisdiction to determine and develop the appropriate response if indeed there is a problem.

However, evidence gathered from the health industry does suggest the contrary that many nurses do not necessarily report incidents or injuries and even more fail to make claims for work related illness and injuries.

The issue of workplace violence, is a case in point. A survey by the *Australian Nursing Journal* in 2002 found that over one quarter of nurses had experienced violent incidents on a daily basis during the last year, and over 40 percent had received physical injuries at work.[9]

The extent of under reporting in relation to this matter is noted in a recent stud y, of NSW hospital emergency departments. It was found that 20 percent of nurses never reported the incident, 54 percent rarely reported, 7 percent sometimes reported, 5 percent mostly reported and 14 percent usually reported this type of incident.[10]

B. The method 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.

[9] Australian Nursing Journal July 2002 Vol 10 No. 1.
[10] J Lynham, "Violence in New south Wales Emergency Departments", (2000) Vol 18 No. 2 Australian Journal of Advanced Nursing p.8.

It would appear that a disproportionate amount of resources are generally directed at identifying fraudulent claims by employees. The claims process requires that employees comply with a vigorous set of procedures and medical tests both before and after a claim is accepted.

Employers, it would seem are not subject to the same stringencies in relation to meeting their legislated responsibilities under the various workers compensation schemes.

For example, evidence reported by Victorian WorkCover Authority states that:

> *"Despite a statutory obligation for employers to forward a claim to their authorised agent within ten days, the data shows that a significant number of employers are failing to do this – 40% of claims are reported late".*[11]

Other examples cited by ANF Branch workers compensation officers include:

- Employers and insurers providing incorrect information concerning rights and entitlements;
- Employers and Insurers not paying employees' full entitlements, and/or withholding access to certain services which may be available;
- Automatically rejecting claims and delaying the process leaving the employee without adequate income support. In some cases it has been over 9 months before the claim is finally resolved;
- A survey of injured nurses conducted in Victoria showed that 39 percent felt they had been unfairly treated by the employer and 47 percent by the insurance companies who administer the scheme.[12]
- Employer and/or insurers put up continual obstacles, making every step of the way distressing and difficult. All their actions serve to reinforce the view that it's the employee's own fault. An employee's rights and entitlements under the relevant legislation are often not observed, placing additional personal and financial burdens on the injured worker.

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[11] The Case for Change, Victorian WorkCover Authority, p.9)

[12] "Buried But not Dead, A survey of occupational illness and injury incurred by nurses in the Victorian health Service industry". ANF Vic Branch injured Nurses Support Group, By Elizabeth Langford 1997

C. 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.

In the time available the ANF is not able to provide a comprehensive response to the points raised in the above terms of reference. Due to the number of issues the scope of the inquiry generates and the breadth of the subject, our comments are confined to the following:

1. Data Collection

Workers compensation statistics across all jurisdictions significantly understates the level of injury, disease, and death which are occupationally or work related.

The data used by all jurisdictions is based on the number of accepted claims, it does not include all workplace injury or illness.

According to the results of an ABS survey claims data represents less than half the incidence of workplace illness or injury. The survey found that 54 percent of workers who had suffered workplace injuries or illnesses had not sought workers' compensation or reported the incidents to workers' compensation schemes.[13]

2. Injury Rates Health & Community Services

Accepting that the statistics are an understatement of the level of injury and disease, data compiled by the National Occupational Health and Safety Commission shows that Registered Nurses have an incidence rate of compensated injuries of 21.58 injuries per 1000 employees or 14.34 per million hours worked.[14]

As stated earlier the Health and Community Services sector, has a higher than average incidence of compensated injuries and experiences the highest percentage of body stressing (manual handling) injuries and the highest rate of repetitive movement injuries, which are often the high cost injuries.[15]

A recent case study on Performance Outcomes – Aged Care Sector [16] identifies some of the issues associated with positive occupational health and safety outcomes in the workplace.

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[13] Ibid p.7.
[14] Compendium of Workers' Compensation Statistics, Australia, 1990-00, National Occupational Health and Safety Commission, June 2002.
[15] Workplace Relations Ministers' Council op. cit. p.24 & p.31.
[16] Workplace Relations Ministers' Council, Comparative Performance Monitoring, Case Study on Performance Outcomes in the Aged Care Sector, Second Report on the Health & Community Services Industry. Bryan Bottanley and Associates. August 2002.

This project focused on factors that influenced injury outcomes in the aged care sector and formed part of the results of the Workplace Relations Ministers' Council, Fourth Report.

While noting the shortcomings of relying on claims based outcome data, the study suggests that for any sector there are three levels of intervention that are likely to influence outcomes:

- Institutional level: covers workers' compensation schemes, OHS legislative framework etc.
- Industry level: covers structural factors relevant to sector, industry networks etc.
- Workplace level: covers management systems and approach, communication and consultation arrangements etc.[17]

In the aged care sector the study identified factors relating to the workplace level as the reasons for differences within jurisdictions [18] (ie. management systems and communication and consultation arrangements).

These issues were also identified in a cross jurisdictional case study comparison between Queensland and NSW hospitals[19]. It was noted in this Report that OH&S systems and their implementation are central and cited studies which showed that there is an association between low claims incidence and factors that are markers of good performance. These markers include: management taking responsibility for OH&S arrangements; consultation within an organisation and having effective OH&S systems in place.[20]

The aged care study found that the introduction of "No Lift" policies for nursing staff, (a major initiative of the ANF), dramatically reduced risks and consequent claims. The report also acknowledges the role of some State Health Departments and OH&S agencies in their support for this policy and notes that "the success of this policy appears related to its single focus, its occupationally specific application, its direct impact on risks and active support by the ANF at all levels".[21]

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[17] Ibid p.57.
[18] Ibid p.58.
[19] Workplace Relations Ministers' Council, Comparative Performance Monitoring, Occupational Health & Safety and Workers Compensation, Comparison between Queensland and New South Wales Hospitals, Exploratory Cross-jurisdictional Case Study. Dec 2001.
[20] Ibid p.85.
[21] Workplace Relations Minister's Council – Aged Care Sector Study op. cit. p.57.

As reported in the aged care study, the No Lift program is one of the few interventions that have been evaluated by independent researchers. It cites a study by Engkvist[22]comparing a hospital with a No Lift program to two hospitals functioning without such a program. The results showed that nurses at the control hospitals had twice the relative risk of back injury.[23]

It also refers to an initiative by the Victorian Department of Human Services to assist public hospitals to implement programs designed to eliminate or minimise manual handling associated with moving or transferring patients. The indications from the evaluation conducted so far is that there are significant and substantial reductions in lifting claims in the facilities taking up a No Lift approach.[24]

These initiatives illustrate the advantages of an approach which combines appropriate institutional, industry and workplace factors, and as noted in the aged care study for the maximum impact on performance, actions at each level need to be mutually reinforcing.[25]

In relation to occupational health and safety the ANF has identified some particular areas requiring Federal Government interventions and recommends that the following occupational health and safety strategies be implemented:

a) That the Federal Government introduce 'no lift' programs across the aged care sector;

b) That the Federal Government introduce a national reporting system for violence and aggression toward nurses and other health workers in order to understand the factors which give rise to violent incidents, the extent of the problem, and to inform the development of strategies to prevent violent incidents occurring;

c) That education and other support measures for managing violence be available to and routinely provided for nurses as continuing education in the workplace;

d) That employers be required to ensure that nurses do not work alone in areas of high risk or where the level of risk is unknown;

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[22] Introduction of No Life Policy, Engkvist, I-L, paper presented at Work Congress 5, Adelaide 2001.
[23] Workplace Relations Ministers' Council Aged Care Study op. cit. p.49.
[24] Ibid p.50.
[25] Ibid p.58.

e) That the Federal Government commission research into the long term effects of exposure to glutaraldehyde and that a process is put in place to eliminate the use of glutaraldehyde in health and aged care sectors within the next two years;

f) That the Federal Government in conjunction with State and Territory Governments develop a process to eliminate the use of latex products in health care delivery within the next two years.

D. Adequacy, appropriateness and practicability of rehabilitation program and their benefits

Employers have a responsibility to ensure that workers injured in the course of their employment have the opportunity to return to work, when they are able, to their previous or equivalent position.

Reports from ANF Branch workers compensation officers show that too often rehabilitation is not taken seriously by either employers or insurers. The following comments indicate some of the problems in this area:

- There is pressure to return to work to early, often contrary to the treating doctor's advice;
- Nurses are not made aware of the rehabilitation services available;
- It is difficult to access effective rehabilitation;
- No rehabilitation and return to work plan provided;
- The employer refuses to provide alternate duties even when modified duties are clearly possible;
- There is little or no support from management for the rehabilitation process;
- Provided with meaningless tasks; workers become demoralised and depressed and are pushed out of the system once entitlements to weekly payments cease;
- Access to independent rehabilitation providers is restricted;
- If it is established that it is not possible to return to pre-injury duties the opportunities for retraining are extremely limited or non existent.

The survey of injured nurses in Victoria found that for those who were able to return to some form of work, 46 percent were receiving less income than their pre-injury earnings and only 48 percent were able to work at their pre-injury job or hours.[26]

Employer compliance with rehabilitation and return to work obligations appears to be deficient across all jurisdictions while it is too easy to work around the legislation by claiming there are no alternative or modified duties available.

For partially incapacitated workers this usually means that once the entitlement to weekly payments cease, their services are terminated and they are left injured, without a job, without an income, and in many cases without access to social security payments and future employment prospects.

[26] Langford op. cit. p.10.