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SUBMISSION

I am currently the medical officer at the Workers Medical Centre, Brisbane, caring for those whose working lives have met with adversity. This centre is managed by representatives from affiliated unions. It is closing on July 312003, primarily because of funding issues. I also have experience caring for the staff of an organisation employing *3500* people, and as a community general practitioner.

I have identified problems with, and formed opinions about, workers compensation schemes, that may be from a different perspective to those of other individuals and groups making submissions to this inquiry.

1. Multiplicity of schemes

A multiplicity of schemes is confusing for the providers of medical care. Most doctors become familiar with one scheme and its entitlements and how to manage cases within its system. In Queensland this is WorkCover, which is the insurer for the majority of workers. Over the last few years about 24 larger companies or organisations have become self-insurers. They also operate under THE WORKCOVER ACT QUEENSLAND 1996 (with amendments and regulations) and under the regulatory supervision of QComp.

In my work at a center with expertise in workers compensation, as well as dealing with WorkCover and the self-insurers, I have also dealt with Comcare, SeaCare, and the Victorian and New South Wales systems. All have slightly different rules and arrangements. I have been fortunate to have research officers to assist with acquiring the particular knowledge of the rules that was needed to handle these cases.

It is my opinion that there was no advantage to having separate schemes. Keeping the rules and procedures standardised would assist those who provide medical care.

2. **Problems for administration staff at medical or allied health practices**

Confusion with billing arrangement between WorkCover and each self-insurer is common.

There is the necessity to have alternate billing arrangements if the claim is not accepted by an insurer. Stress claims in Queensland often take over 3 months for decision. If rejected, billing is often then transferred to Medicare, but this system requires that

billing is submitted within 6 months of the service. There is not much leeway within a practice's account system, and a patient's multiple visits may be at risk of non-payment.

The above examples show the increased complexity needed for the accounting system, which is therefore more costly to maintain.

I have noted that staff at reception of some practices will say to a new patient, seeking treatment for a work related problem, that the practice does not deal with workers compensation, or alternately that the patient can pay the bill up front and seek reimbursement themselves. An injured worker, expecting to have reduced income, is therefore placed in a difficult situation.

3. Self-insurers

Injured workers accessing compensation with a self-insurer are unable to distinguish between the roles of the company as employer, insurer, and rehabilitation manager. If they have a disagreement with one section, then the bad feeling *affects* all aspects of that person's employment. These difficulties may be observed by other employees. A perception that making a claim will result in unfavourable attention will reduce the numbers of claims made. (A reduction would be more likely for numbers of minor claims but not for serious injury claims.) The bad feeling will however affect all employees' morale. If the situation is recurrent, the cumulative effects will eventually affect a company's profit margin.

Communication between doctors and self-insurers can be a problem. In Queensland, if doctors are educated about contacting WorkCover claims managers when there are difficulties, they will do this with the patient's consent. It is unlikely that a doctor unfamiliar with a self-insurer would as readily contact the relevant person within the organisation, because of the perceived blurring of roles. This problem with communication, and the outcome of poor communication which is delay, is why self insurers prefer that their workers making claims are managed by the company doctor. The stated reason for employers preferring the company doctor is that they will be familiar with the company's suitable duties programs. It is my opinion that a GP would be able to formulate a suitable duties / graduated return to work program for a patient provided the employer provided adequate descriptions of the available duties. The failure of communication of many employers in providing descriptions of duties and to indicate availability of these duties, can be the cause of unnecessary delay in workplace rehabilitation.

There are disadvantages for some injured workers in using the company doctor, a requirement of some self-insurers. The worker may prefer their own GP in whom they have confidence and with whom they have an expectation of continuing care. The company doctor is often perceived as "being on the side of the employer". If the causation of the illness or injury is disputed or if the incapacity is permanent but the insurer is closing the case, medical care still needs to be given to the patient. For difficult claims the GP, who has continuing care, will be the best advocate for the patient in achieving an outcome that retains the patients dignity and potential for getting on with life after adversity.

4. **Delays in claims decisions**

Doctors want their patient well and back at work as quickly as possible. Until a claim is accepted they are not sure if the medical expenses will be covered by the insurer. If the patient has a condition that is best managed by referring for investigations and specialist medical opinion, the cost of the difference between the Medicare rebate and the fee may have to be borne by the patient if the claim is rejected. Patients not receiving their regular income may be reluctant to proceed. This is particularly applicable to physiotherapy which does not attract a Medicare rebate. Delays in mobilising after injury can prolong the return to work period.

If an urgent operation is needed it is unlikely that a private hospital will accept the risk of non-payment by the insurer. Most severe industrial trauma therefore goes to public hospitals. The focus there is on treating the injury, not on a quick return to work. An example of this is patients after fractures remaining on a waiting list for hospital physiotherapy, when they are eligible, with an accepted claim, to access private physiotherapy, which in any case would be more focussed towards capacity for return to work.

5. Illness acquired over a period of time

The Dust Diseases, eg Silicosis, Coal Workers Pneumoconiosis, Asbestosis, and Noise Induced Hearing Loss are recognised as being acquired over years of exposure. Decisions may have to be made by the claimant and the certifying doctor, as to which jurisdiction is the appropriate one for lodging a claim if the worker has moved interstate or from Commonwealth to State employment.

With differing rules between jurisdictions there are further complications for decision making. An example of this is with industrial deafness. In Queensland the claim is accepted for lump sum compensation only if the initial reported loss is greater than 5%, and subsequent loss is only eligible after a 3 year period and a further 1% loss. Comcare requires a 10% initial loss and subsequent loss of 5%. A worker with hearing loss will provide a full work history. Often the medical officer suspects that the loss, for instance in a 50 year old boilermaker, started many years ago during the trade apprenticeship, and has only become apparent now because of the added effects of aging. Hearing protection has only been supplied by employers for about the last 10 years, and worn consistently by workers for the last 5 years.

It seems to me that it is often quite by chance as to which employer within a jurisdiction has the loss attributed for causation. When the worker has been employed in the construction industry the list of employers may run to several pages, and many of the employers are now out of business. Surely it would be fairer if there was one set of rules across Australia and a pool of money contributed by all employers within an industry for claims with accumulative exposure causation.

6. Definition of a worker

Claims decisions may be delayed particularly in the building industry when it is unclear if the injured patient is a worker or a contractor. A clear definition accepted in all jurisdictions is needed.

Consideration also should be afforded to those people, no longer workers due to retirement or change to contractor status, who have an injury such as Industrial Deafness that has been acquired over time. In Queensland a claim is eligible if made within one year of ceasing to be a worker.

An ex-worker dying **of** mesothelioma, with a history of asbestosis exposure in the workplace, may also be in a difficult situation with regards to making a claim as the delay in a common law case going to court averages four years in Queensland. If a universal scheme is envisaged, without access to common law, arrangements will be required to include ex workers such as in the previous example, to satisfy the community's expectation of fairness.

Summary

This submission has highlighted areas of concern. It is my opinion that in Australia we should have a standard overarching WorkCover Act and an overarching regulatory body. There are many areas in which we can improve. The doctors who deal with the patients and the system are important contributors for identification of problems and ideas for improvement.

Signed at Brisbane, 7 July 2003

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