Workers Compensation and Injury Management Bill 2021 (Consultation Draft)

Comments

General

Thank you for the opportunity to comment on the Consultation Draft of the Workers' Compensation and Injury Management Bill 2021.

[redacted]

As an introduction, before addressing the Draft Bill, we would like to outline the importance of the role of an independent Workplace Rehabilitation Provider (WRP) in facilitating successful return to work outcomes.

We acknowledge the complexities of the workers' compensation system in which the employer pays the premiums and are affected by premium increases for lost time injuries, the insurer pays for services when a claim is lodged and needs to ensure sound fiscal management of the claim, treating practitioners wanting to provide appropriate services to assist with recovery and the injured worker who requires appropriate care and assistance in their recovery which includes their recovery at work. The Workers' Compensation and Injury Management (1981) Act exists to ensure injured workers are appropriately compensated including the right to access to independent workplace rehabilitation services. Independent workplace rehabilitation is a vital element of the workers' compensation scheme and access to such services needs to be underpinned by robust legislation rather than set in regulation which allows for future manipulation and interpretation from stakeholders who can determine what is and is not a reasonable expense.

Due to complexities of the varying stakeholders, it is the independent nature of our role that allows all parties for be fairly heard, for all parties to be equally involved and for impartial education on the roles and processes around the return to work process which results in improving return to work outcomes.

Below are a number of examples in which the independence of the WRP was instrumental in facilitating the most fair and optimal outcome:

1) A situation where the treating General Practitioner is a family friend and has been for many years. The injured worker may provide a certain perception of their role which may differ from the perception of the employer. The GP would then tend to side with the worker and medical certification would be based on the worker's perception. In this case the WRP can perform an objective Job Task Analysis to clearly define the work role and physical demands. Both the worker and employer are invited to be part of this assessment. If the assessment was performed by an internal individual (whether insurer based or employer based), the degree of perceived impartiality could be compromised. The worker's ability to return to the physical demands can then be objectively discussed with the worker and the GP.

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2) A situation where an employee is on a return to work program performing meaningful alternative work duties. In this instance the employer has employed a relief to perform the injured workers' previous role and the injured worker is in receipt of full compensation whilst performing the alternative role. There have been situations when WRP's aim to progress the person to the pre-injury role and the employer is reluctant to because they would like the status quo to remain, ie the insurer to continue to pay the injured workers wages to complete alternative duties. The employer is therefore effectively using a workers' compensation entitlement as an additional workplace resource which is not appropriate. As a WRP, our role is to ensure that parties meet their obligations in the return to work process. In this instance the employer is educated on the appropriate use of the weekly wage entitlement which is to support the person back to the pre-injury role and/or alternatively negotiations take place with the employer to see if they will pay the injured worker's salary for performing the alternative role if it is believed to be meaningful and valuable role to the employer. If the WRP was not an external independent provider, this situation may not be managed in the same manner.
3) There have been occasions when an employer has provided suitable duties and the treating practitioner is in support of these duties. However the worker continues to outline a number of barriers about participating in the return to work program. As an independent Workplace Rehabilitation Provider, we are able to use our clinical and counselling skills to explain to the worker their obligations under the Act. The clinical skills required to perform this requires the ability to deliver the message in a way that makes sense to the worker (taking into consideration any cultural and linguistic needs in addition to the intellectual capacity and mental state of the injured worker). By virtue of being an independent party, and being skilled in the area of human relations, an independent Workplace Rehabilitation Provider is better equipped to deliver this message in a meaningful way and engage the worker in active participation and/or allow them to make an informed choice about accepting consequences of non-participation. There have been times when another stakeholder may deliver a similar message and the worker either does not understand or feels threatened by the process which then results in further complications which ultimately affects return to work outcomes.
4) We have had situations where injured workers may have sustained a physical injury, however upon a thorough assessment it has been identified that the individual has experienced past trauma not related to the workplace incident. Taking into consideration the biopsychosocial model, we understand that importance of early psychological support to the injured worker to assist with minimising protracted recovery due to mental health issues. In these cases often the employer is aware and supportive, however an insurer may not extend liability of payments to cover psychological treatment. There have been times where we have been able to negotiate such but other times this has not been met with approval. Whilst many employers may have an Employee Assistance Program, this service is short term and possibly not equipped to address long term trauma. In these situations, the worker and the treating practitioner can become frustrated with the insurer. We would then spend time educating parties on the parameters of the workers' compensation system to minimise anger as this can lead to longer term issues. We would then explore options to ensure that the worker has access to appropriate holistic care such as a GP Managed Care Plan. As an independent party, our role does not cease if request for treatment is not approved. Instead we continue to understand the importance of overall recovery and seek to explore options that would enable the worker to access all appropriate treatment.

Paramount to the success of the workplace rehabilitation role is ability for the injured worker to have a choice in provider. It is noted that the Draft Bill addresses choice of Medical Practitioner but does not address choice in WRP. Our submission will address this.

We are aware that the level of complaints regarding WRP in WA is low and this is because WRP are highly skilled independent parties equipped to manage the complexities of return to work matters when faced with differing and often opposing agendas from different stakeholders. The Victorian Ombudsman Report detailed many short comings of insurer management of complex injured workers and this needs to be taken into consideration with the Draft Bill in terms of the decision making power regarding the injured worker's workplace rehabilitation needs.

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The above is most important in the proposal of moving workplace rehabilitation from an entitlement to an expense. By virtue of it being an entitlement, the provision of independent workplace rehabilitation is the worker's right to access. This has been the case and has been the language for the time that [redacted]

It is our belief changing workplace rehabilitation from being an entitlement to an expense will significantly impact on the perception of a workplace rehabilitation provider being independent and impact the workers' perceived control of their recovery.

Whilst the intent to move it from entitlement to an expense is not to diminish the rights of an injured worker, we believe that that moving it to an expense will result in this being the case. The proposed change provides no net benefit to the worker and possibly results in reducing the decision making power of parties such as the worker themselves, the doctor or an employer.

It has been recommended that access to workplace rehabilitation be set out in regulation yet to be drafted. Under the current Act, workers' have clear expectation of their right to access independent workplace rehabilitation services and regulations not yet draft will not provide the same certainty.

It is our belief that workplace rehabilitation is best provided when it is an entitlement to the worker. It is the worker's entitlement to access independent services to assist in their recovery at work as it is the worker's entitlement to access medical treatment for functional recovery. This has been the fundamental way workplace rehabilitation has been provided to date and without clear justification of the net benefit to the worker for this change, it is our recommendation that it remains an entitlement.

Draft Bill Items

Part	Division	Section	Comments
1	3	8	[redacted] supports the clear guidelines regarding injury arising from participating return to work programs or to undertake workplace rehabilitation which includes attendances at work-trials
2	2	41 (2)	Provisional payments to make reference to workplace rehabilitation expenses in addition to medical and health expenses. This is outlined as priority 2.4 of the Insurer and Self-insurer Principles and Standards and the section for payments on a without prejudice basis for pended claims. If provisional payments are legislated, it should include workplace rehabilitation.
2	3	56	Though this is an election commitment, there are some concerns about increasing the step down approach when taking the health benefits of good work into consideration. There is an abundance of literature supporting the need to encourage return to work as soon as practicable following an injury. We acknowledge that it is important to ensure that workers are appropriately compensated during the time they are unable to work, however scheme design does impact on the return to work behaviours. It is common that workers will be guided by financial reward (work itself provides financial reward so this behaviour is normal). Workers will often withstand a degree of manageable discomfort (eg strained relationship with a line manager, minor niggling physical discomfort with performing certain jobs) should there be a financial incentive. Whilst this is a difficult comment to make, but a system that is designed to promote early return to work needs to consider the wage payment. By increasing the step down to 26 weeks, an unintended consequence may be delayed financial incentive to return to work. An injured worker is already faced with some difficulties with returning to work and at times the only driver is the financial reward. Obviously with workplace rehabilitation assistance, we approach this holistically and help the worker rediscover the other benefits of returning to work, however this takes time. By delaying the step down, it can unfortunately result in removing one of the initial (and possibly the only) drivers for returning to work therefore delaying return to work efforts. Should the Government proceed with this election commitment, it is recommended that any worker who has been off for more than 4 weeks is referred to an independent accredited workplace rehabilitation provider. This will enable additional barriers to be identified early and strategies implemented to promote the best chances of the worker successfully returning to work.
2	4	70	It is noted and agreed that medical and health care expenses are to be referred to as "Compensation for medical and healthcare expenses". Workplace Rehabilitation needs to be added as a compensable expense. In the current Workers' Compensation and Injury Management Act (1981) it is listed in schedule 1 cl17 along with medical expenses. With medical and healthcare expense being changed in this manner in the Draft Bill, workplace rehabilitation expenses should be changed in the same manner. Whilst this may be better covered in Part 3, Division 4, section 172 to 181, the wording of access to workplace rehabilitation needs to be in line with medical and other health expenses, that is "Compensation for workplace rehabilitation expenses". We will address this later on.

			Additionally, it is noted that compensation for medical and health expenses will be 60% of the prescribed amounted, increased from the previous 30%. [redacted] understand that it is a small number of individuals who apply for an extension on medicals. [redacted] suggests that rather than increasing the medical and health expenses to 60%, that there is an easier pathway to access further funds when the 30% has been achieved. To increase it to 60% of all claims may impact on the financial viability of the scheme. There is a concern if medical expenses increase significantly, insurers may reducing spend in other areas such as workplace rehabilitation in order to maintain fiscal management of a claim. Another issue is that increasing to 60% may potentially increase settlement amounts. This may have the unintended consequence of making the settlement pathway a more attractive pathway for workers rather than the scheme being designed to encourage return to work outcomes.
3	2	164 (1)	[redacted] supports the workers attendance at case conference. When a WRP is involved, they are instrumental in co-ordinating return to work case conferences. Therefore the addition of Workplace Rehabilitation Provider as another party who can organise and request attendance to a case conference. It is also recommended that the maximum number of times a case conferences that can take place is removed. The factors affecting the number of case conference required to achieve a successful outcome are multifaceted (the injured worker's normal coping mechanisms, the nature of the injury, the worker's pre-injury role, the employer's understanding of the return to work process, the length of a program, the biopsychosocial issues present etc) and can unfold over a long period. Stipulating the maximum number of times a case conference can occur fails to take these issues into consideration.
3	4	170 (2)	Consider rephrasing to "Workers can, only if they agree, attend a medical practitioner chosen or nominated by the worker's employer or employer's insurer to perform any of the functions set out in subsection (3)". Therefore have been times when the workers' GP is unfamiliar with the workers' comp process and the worker requests assistance in finding an appropriate Doctor to manage their return to work program. Often this is done with other stakeholders, employers, insurers or workplace rehabilitation provider. The current phrasing of Part 3, Division 4, Section 171 (2) may prohibit this from occurring Rephrasing it, to allow it to occur with the worker's consent is more in line with what occurs in practice. This does not negate the fact that workers have a choice in their treating Medical Practitioner.
3	4	171	Consider rephrasing to allow attendance at medical examinations only if workers consent. There are times when the employer or employer's representative is a first responder and will be present for medical examinations and procedures. This is especially true for workers and employers in remote areas. There have also been occasions when a worker has specifically requested a workplace rehabilitation provider be present for a medical consultation. An example of when a WRP has been asked to attend a medical consultation is (details are vague to protect privacy): A worker who sustained multiple injuries and multiple fractures. The worker has been managed by the public health system due to presenting at the emergency department following the incident. This worker has recently moved to Perth and had very little support. Additionally due to past life experiences, this worker demonstrated traits of helplessness. As a result following the injury, there was no clear medical management other than attending the public health system's outpatient clinic. The worker was not proactive in organising any medical care but was compliant in attending what had been organised by the public health system. At the initial assessment, it was determined that a General Practitioner was needed in order to be the nominated practitioner to manage the worker's injury and treatment needs. This was discussed with the worker and with consent an appointment was made with the worker's choice of medical doctor.

			In this instance the worker requested the WRP attend to help articulate her situation and needs. This meeting would not be a return to work case conference as the worker was not in a position to commence any work activities. The worker was in the initial stages of recovery and required clear medical guidance and management including further investigations and then referrals to private Specialists who could provide better continuous care. Our requested attendance at this medical consultation was to assist the worker. It should be noted that whilst we were happy to provide this especially in the early stages of our involvement, a clear pathway of equipping the worker with the required skills to better assert his/her medical needs in the future would be a focus of our involvement. Consider removal of regulations to issue a certificate of capacity. At every return to work case conference a certificate of capacity issued and given there is a requirement for workers and treating practitioners to attend case conferences, the statement about not issuing progress certificate of capacity needs to be removed as this can result in confusion across the two clauses (ie Part 3, Division 4, Section 171 and Part 3, Division 2, Section 164)
3	4	172	Rather than titled Provision of workplace rehabilitation services by approved workplace rehabilitation provider this should be rephrase to "Compensation for workplace rehabilitation expenses" and moved to Part 2, Division 4 so that it is in line with medical and healthcare expenses which was also previously in schedule 1 of the Workers' Compensation and Injury Management Act (1981). The injured worker should have the right following a workplace injury to access the services of an appropriately qualified Workplace Rehabilitation Consultant to co-ordinate their return to work needs. This was instrumental in the previous Act, and it should not be changed in this new Act. Being the worker's entitlement, provides assurances that the worker can access independent, specialised services to help facilitate their return to work and prevents other parties being provided discretion on when and how workplace rehabilitation may be provided. This provision was instrument in the previous Act, and it should be retained in the new legislation. [redacted] understands that one possible reason that workplace rehabilitation is being moved to an expense is that a significant number of referrals are initiated by the insurer. It is important to note that the data in relation to this may not truly reflect the source of referral. We have many examples of when the referral has been initiated by a source other than the insurer, yet as the insurer enters the data on WorkCover on-line, the referral is coded as insurer initiated. We can provide evidence that 98% of our referrals are from sources other than the insurer, yet it is quite likely that 100% of these cases are lodged onto WorkCover on-line as insurer initiated.
3	4	172 (1)	This provision should allow for treating practitioners and insurers to also determine a need for workplace rehabilitation. It should also make reference to the worker's choice of provider.
3	4	180	[redacted] strongly recommends that access to workplace rehabilitation remains a compensable expense for injured workers. Workplace rehabilitation is instrumental in the overall workers' compensation scheme as indicated in the title of the Act. It is paramount to the injured worker that their ability to access independent workplace rehabilitation is underpinned by robust legislation and not a matter for regulations. In WA, workplace rehabilitation providers achieve a high return to work rate with low level of complaints and this is evidence that having workplace rehabilitation as an entitlement allows providers to work in the most fair and just process for the worker and all other parties especially in a system with so many different presenting agendas.

3	4	181	[redacted] believes that the current gazetted fixed rate is the most fair reward system to ensure all injured workers receive the service required to assist with their return to work. To date the return to work rate achieved by workplace rehabilitation providers in WA has been high with very few reported complaints. The fact that workplace rehabilitation is a worker's entitlement and also that there is s a gazetted fixed rate are likely to have contributed to these outcomes. There are a number of studies have concluded outcome based payment structures for providers especially in the health care system do not improve outcomes for the workers and also have not resulted in reduced cost of programs with. In some instances outcome based payment for providers led to poorer outcomes for individuals with mental health issues. Incentivising payment via an outcomes model has led providers to focus on the incentivised indicators and not the entire process. For an injured worker, their journey to achieve the return to work program is an individualised process and it is instrumental that all parties work with the injured worker, at their pace (taking into consideration so many factors). It is important the return to work goal is the ultimate aim, but equally important is empowering the worker to ensure that the journey to reach that goal is their journey and not manipulated by other parties due to any incentivised process including an outcome based payment structure. The committee that reviewed the service quality of the Jobactive program (a program that received media attention in relation to its outcome based payment structure) noted evidence that the outcome driven funding model contributed to inadequate servicing of a disadvantaged group. In addition to this, the outcome payment structured led to smaller, boutique providers not being able to operate. This then reduces the choices for the recipient of the service. Literature has suggested that a fee for service model with clear performance indicators is a highly effective reward system for providers servicing individuals in a health care setting. With the Workplace Rehabilitation Providers Principles and Standards of Practice recently being launched, coupled with a gazetted fixed rate would ensure high performance and accountability of workplace rehabilitation providers in WA. The above needs to be taken into consideration with respect to any future proposed changes to the fees and charges of workplace rehabilitation services. Sources: https://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Education_and_Employment/JobActive2018/Report/section?id=committees%2Freportsen%2F024217%2F26936 https://www.mq.edu.au/__data/assets/pdf_file/0010/796636/Outcomes-based-funding-models_190626RF.pdf https://link.springer.com/article/10.1007/s10198-018-0989-8 https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6502565/