AUSTRALIAN MEDICAL ASSOCIATION
(SOUTH AUSTRALIA) INC.
ABN 91 028 693 268

your AMA your voice your profession

16 March 2018

Hon John Mansfield AM QC
GPO Box 464
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RTWReview@sa.gov.au

Dear Sir

Independent Review of the Return to Work Act and Scheme

Thank you for the opportunity to submit to the independent review of the return to Work Act 2014. Firstly, I am glad to provide for your information and consideration, three supporting documents:

- Interim response to the review, dated 15 December 2017
- AMA(SA) response to Return to Work SA on Medical Fees Consultation
- AMA(SA) submission to the Inquiry into the Return to Work Act and Scheme of the Parliamentary Committee on Occupational Safety, Rehabilitation and Compensation

The AMA(SA) has invited comments and feedback from our Return To Work Reference Group, and also invited feedback from our broader membership and some doctors with a special interest in the area. Below is collected some of the feedback received for your consideration. As there are varied and specific issues and concerns among the profession, we have opted to provide you with an overview of feedback rather than an AMA(SA) position on all matters. The views included are not necessarily an organisational view of the AMA(SA). Should you seek an AMA(SA) position on a specific issue we would be happy to consult and advise.

You will note in the feedback below a range of criticism regarding the PIA process. The AMA(SA) is very concerned about the consistent feedback that the legal profession is directing patients to preferred PIA assessors. This concentration not only acts as a disincentive to many doctors to remain accredited but also is leading to questionable findings, as illustrated in our members' comments. What is even more disappointing is that this potential bias was recognized by the AMA(SA) prior to the introduction of the scheme and we had recommended and supported a random selection process which may be delivered either electronically or managed via an independent body such as the AMA. This proposal was not accepted at the final stages and unfortunately we now have the issues of selected referrals, as indicated by many of our members. We believe the significant amount of work being directed to a few local and even interstate specialists is worthy of investigation.

Thank you for the opportunity to provide this feedback, and do not hesitate to contact us should further information be of assistance.

Yours sincerely

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Enc

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FEEDBACK RECEIVED BY THE AMA(SA) ON THE RETURN TO WORK ACT AND SCHEME

- ***Permanent impairment assessments*** – The current situation where a permanent impairment assessor is nominated by the worker has caused many problems. In practice, the assessor is usually nominated by the worker's lawyer and this in turn has seen a preference for referral to a *very* small number of assessors who will provide high impairment ratings. The justification for the high impairment ratings is often made on spurious medical grounds that would easily be refuted on the lightest of legal cross examination. However, the structure of the process means that such cross examination does not occur. This has seen grotesque errors of medical fact go unchallenged. This is damaging to medicine and sets really unfortunate precedents for the interaction of medicine with the law.

- ***Impairment ratings due to disorders of the digestive system*** – Related to the above point is the absurd situation where South Australia now has the most constipated population of workers in the nation – apparently. Similar problems with dry mouth and reflux are being asserted, unchallenged, by impairment assessors. Invariably, the problems are said to arise as a consequence of prescribed medication, most particularly analgesic and antidepressant agents. The arguments are specious and most importantly, do not reflect the wealth of international evidence which suggests that these problems are usually mild, reversible and eminently treatable. Again, the system has allowed false claims to be made that damage the reputation of therapeutic medicine. Additionally, there is a real danger that a reluctance to treat injured workers may arise due to grossly exaggerated claims of medication side effects.

- ***Complex regional pain syndrome*** – The latest revision of the impairment assessment guidelines substantially reduced the level of criteria required for the diagnosis of CRPS to be accepted for permanent impairment rating. However, there was *no* concomitant reduction in the impairment assessment ratings awarded once the diagnosis was made. The AMA 5 criteria were undoubtedly very strict, but allowed injured workers to access a very high impairment rating where the criteria were fulfilled. The current situation has seen something of a rush to try and get a CRPS diagnosis, invariably by plaintiff lawyers. In my experience, very few individuals actually meet even basic criteria for this diagnosis, but the rewards on offer mean that the pressure for diagnosis is very strong. The important problem here is that giving a wrong diagnosis to a patient is both unethical and potentially damaging, from both a physical and psychological perspective. In my opinion, RTWSA either needs to return to the AMA 5 criteria for CRPS diagnosis or it needs to modify the impairment ratings that can be awarded based on the relatively flimsy diagnostic criteria it has adopted since 2015.

- ***Mental illness and discrimination*** – I have strong views about the discriminatory nature of the Act towards workers with a mental illness. In practice, if a worker has a prior psychiatric history, which could include say post-natal depression which would not impact on a future psychiatric illness, then their claim is disallowed. I have been told that many general practitioners would not even put in the claim and would advise workers not to. Although this has undoubtedly helped the financial state of RTWSA, I believe strongly that this sort of discrimination is directly opposite to the objectives of the National Mental Health Plan and beyondblue to destigmatise mental illness and encourage people to visit doctors if they have a mental health problem.

- ***Collaboration versus adversarial approaches*** – Medicine is collaborative and the law adversarial. Every day in our hospitals etc we have different opinions and come together to plan best patient care. If we are kept apart then argument can become an industry and a lengthy process occurs with our patients suffering and costs. This is our situation today. If our legal colleagues could remain with points of law eg fault, rights, accountability etc and

we are able to focus unfettered on health then I envisage a more efficient system with patient management the highest priority.

- ***Form format*** – New form format is very difficult to use and not useful to anyone.

- ***Permanent Impairment Assessments (PIA) and Whole Person Impairments (WPI) –*** The basic physiology of any sensory evaluation, including subjective hearing testing, clearly supports that there is a test/retest variability. This may be non-significant or significant. The current Act, as outlined in Section 22 (10) of the RTW Act details only PIA assessment is required (in order to determine the WPI), in a situation where a worker is "seriously injured". There is no other mention in the RTW Act that specifies only one PIA, and quite clearly chronic steady state hearing loss ("noise induced hearing loss") does not qualify for this category of "seriously injured".

  It is well recognised that a significant number of workers are *not* given a choice when determining their assessor (via the [worker's] plaintiff lawyer) and hence any subsequent single WPI assessment has an immediate bias and cannot reflect a true independent assessment. I refer in particular to the well known sequence of events whereby a worker is approached by a hearing aid company, union or mail drop, who then refers the worker directly to their chosen worker's plaintiff lawyer, who then registers the application for noise induced hearing loss.

  There are several occasions where this chosen lawyer quite clearly refers the worker to his own selected ENT assessor, the latter often being an interstate "fly in fly out" Accredited Specialist. The latter category of Specialist is often provided with suboptimal clinical facilities, and the accompanying assessment often demonstrates bias towards the worker. This bias cannot be reviewed by an assessor that does not exhibit bias due to the current restriction of one single WPI assessment only.

  This view is highlighted in the RTWSA primary submission on page 9, last paragraph: "*There is significant involvement from lawyers in the WPI process, including advising workers which assessor to select".*

  It is incomprehensible to believe that this sequence of "rail roading" offers the worker a choice of assessor. As a South Australian trained assessor, I believe that it is discourteous to utilise out-of-state assessors, bearing in mind that the Accredited Assessors in South Australia have undergone local training, and attend relevant RTWSA Meetings in Adelaide, which is time-consuming and not renumerated. It has been brought to my attention that the SAET has been instructed to issue Practice Direction/Consent Orders, emphasizing the importance of Section 58(1) of the RTW and Part II Division 5 (as directed by Justice JP McCusker, President of the SAET).

  Recommendation of doctor providing feedback: It is essential that two Independent WPI assessments be undertaken on a worker in order to: remove the current bias that exists, that is largely determined by the plaintiff's (worker's) lawyer; provide some semblance of choice for the worker as is required of the Act; and provide a more accurate WPI based assessment of impairment.

- ***Training of Requestors*** – On many occasions, the standard request is not only lengthy, but annoyingly time-consuming, having to address a series of disorganised, almost random type questions. I believe that this type of information is substandard. This still occurs, despite the fact that the AMA Reference Group has in previous years recommended a template (for each specialty) which has been constructed with due effort and professionalism, this appears to be ignored.

  It is of immense personal annoyance when the *non medically qualified requestor* demands that the assessor contact them to justify, and for the requestor then to agree to any further

investigations. I consider this approach to be an attack on my personal integrity. Quite frequently the requestor is unavailable (part time worker), which does not all go well for the smooth running of a clinical practice from both the specialist and the worker's point of view.

Recommendation of doctor providing feedback: The level of education and training of requestors must be improved. The necessity to undertake relevant investigations should be at the discretion of the assessor, and any decision be left to the discretion of the Specialist Assessor, with appropriate justification for such investigations be detailed in their subsequent report.

- ***Assessment times*** – The issues of seriously injured workers needs consideration. The assessment time is too slow and needs to precede the two-year cut off. A number of workers seriously injured medically, but not meeting the 30% cut off have wound up in hospital; the majority, however, are seeking to acquire their superannuation (successfully) their fate will not be known for the next two years when their super runs out. The cut off for psych remains too high at 30%; research into the outcome of such patients needs to occur. Clinically, I see patients at 20% or above who do not re-engage in life; however the risk is of removing the incentive to recover and I have not seen a way around that yet. My view is that the system now functions much more effectively; and the clinical results I'm seeing are very good.

- ***Change to PIA so that worker chooses an Assessor*** – When the PIA was first authorised we, as becoming Registered Assessors, spent a weekend of our own time and passed exams to become accredited. Referrals were made by Case Managers and Legal Representatives, as well as Self-insured Employers. The assessment could be challenged and with disputation, when it did occur, negotiations could occur or it would be sent to the Tribunal. Since the change in legislation in July 2015, whereby the worker could choose his own Assessor, the number of Assessors performing PIAs has fallen considerably. The current figures available from RTWSA to date are 3,440 PIA assessments, 45% (almost half) of which have been performed by only six doctors. This is despite the other accredited Doctors being suitable to provide an assessment. The reason why only six doctors are being requested to perform almost half of the assessments needs to be evaluated. Clearly, to my mind, the decision of whom the worker is to be referred to for a PIA needs to be determined by the Case Managers, Self-insured Employers, or the worker's Legal Representative. Certainly there should be a choice but to withdraw the choice from the Employer and Case Managers is surely wrong, particularly in light of the recent figures indicating that the bulk of the assessments are being performed by only a handful of PIA Assessors.

  Despite the request for transparency as to who is performing the PIAs, Return to Work SA has not, or will not, provide this information. The PIA has gained even more importance given the significance of the 30% WPI which can result in a worker receiving WorkCover entitlements until their retirement age. It is important that the PIA be performed in an unbiased manner.

  Consideration of a panel nominated by the RACP for a Consultant Physician, The Faculty of Occupational & Environmental Medicine and the RACS Orthopaedics, be formed so that referrals from all stakeholders could be made in the cases of Permanent Impairment assessors where there are concerns of inappropriate assessments. The panel should have the powers to refer to the Minister of Industrial Relations and if necessary AHPRA.

- ***IME Fees need to be reconsidered –*** IME fees need to be adjusted and increased. The assessments appear to becoming more complex.

- ***Cancellation Fees –*** It is inappropriate that a doctor can only charge a minimal Cancellation Fee, if the cancellation occurs within 48 hours. A Cancellation Fee should be

considerably more and in line with other States. The current Cancellation Fee does not take into account that Doctors cannot fill their appointments in such a short space of time.

It is also important to acknowledge that an IME is generally allocated 1 hour, which is different to a "regular" patient in my practice where an initial consultation is 30 minutes and a review patient 15 minutes. The IME requires quite intensive history taking and an examination. The Cancellation Fee therefore needs to be increased.

- ***IMA Fees need to be increased –*** Although IMAs are infrequently being used, the fee is incompatible with the intellectual requirements of such a consultation. It would appear that the IMAs were a substitute for the Medical Experts Panel. If they are indeed a replacement for that opinion, fees for such should be considerate of the complexity of the case.

- ***Complex PIA Fee –*** Beyond 3 body parts there should be payment per body area or injury, even if it is an assessment of a previous injury for deduction as this adds further complication, time and stress, and the assessments may be subject to expert evidence in any dispute. These are added professional services which at present are done for free. This service is particularly important in complex cases and in particular Return to Work SA where multiple injuries result in a potential WPI at the 30% level.

- ***Skin/TEMSKI PIA should be a separate body area/injury –*** Initially Impairment Assessors were told scar assessments were very quick and easy, could be done on the run, and were not counted as a separate body area. Now Assessors are asked to assess the skin as a whole organ and deduct other existing scars. When this occurs, skin should be charged as an extra body area/injury.

- ***Process of making Impairment Assessments compliant with the orders –*** Audits for assessments can be time consuming and should attract a fee except where there is a simple calculation error made and needs correction.

- ***Benchmarks and data*** – Feedback on the value of providing trend data and comparing against interstate benchmarks, as well as examining data post-claim and beyond the two year period, as some injuries/conditions require treatment extending beyond two years, and data on reskilling and job services.

- ***Coordinated interdisciplinary management*** – Feedback on the benefit of coordinated interdisciplinary management, with a range of medical and allied health input. People in rural and regional areas are at a particular disadvantage.

- ***Code of conduct, information and privacy*** – Feedback relating to mobile case managers/return to work coordinators that information management is important, including privacy, and that a code of conduct would be of assistance.

- ***Impairment ratings and thresholds*** – Feedback on 'discordances' between work ability, whole person impairment ratings, and medical treatment needs, indicating conditions with lower impact combined with moderate impairment reaching a threshold, while others eg with spinal fusion may not reach the threshold due to lack of scarring or seqela.

- ***Disputes and PIAs*** – Feedback on disputation around Permanent Impairment Assessments calling for improved assessments and dispute resolution for Assessments, with greater use of technical experts/other stakeholders. Concern flagged at potential errors with PIA – positive measures may include developing benchmarks, and use of a technical advisory expert group for specific issues.

- ***Mobile managers and case conferences*** – Feedback to maintain and increase the provision of mobile managers who are able to attend mini-case conferences close to patients' consultations with their treating doctors as a positive initiative.

- ***Interpretation disputes*** – Feedback that many disputes have been on interpretation of the new act, with delays in treatment to result, suggesting protocols to enable a good treatment outcome regardless of any dispute, and if a dispute is resolved in favour of the worker the period of delay should be added to the overall period of both wage support and further medical treatment. Also, clarification of wage support around surgery recovery times.

- ***Reskilling*** – Feedback that reskilling include workers undergoing prolonged periods of recovery, whether or not they may become fit for their previous employment.

- ***Previous claims*** – Feedback of concern that a loophole exists that a worker who is assessed as suffering 30% or greater whole person impairment can not receive the entitlements associated with that degree of disability if some previous claim for a lesser degree of disability has been settled.

- ***Termination of wage support*** – Feedback that many workers are still undergoing treatment and unable to return to work when they receive a letter advising imminent termination of wage support without advice about future/potential entitlements. It is suggested advice should be sought from the treating specialist first.

- ***Remuneration*** – Feedback that management of patients with injures which are covered by third party insurers is substantially more demanding; that remuneration is inflexible, being based on average fees charged for non-compensable patients, and that this is in large part why so many excellent doctors and specialists refuse to treat compensable patients, and that the overall cost to RTWSA for an increase in doctors' fees would be a minor expense compared to all the administrative costs incurred, which to a large extent are perceived by workers and their doctors as excessively intrusive. Also that not all consumables used in the treatment of compensable patients are paid for example injection materials, which should be rebateable.

- ***Joint replacement surgery*** – Feedback that criteria for acceptance of liability for the cost of joint replacement surgery, subsequent (often prolonged) rehabilitation, and any adverse outcomes, be reviewed and tightened.

- ***Pre-existing conditions*** – Feedback that workers suffering a temporary or permanent aggravation of a pre-existing condition impact as much on an employer's premiums as a new injury and that this is a step backwards from the previous legislation and provides a serious disincentive to take on anyone with any pre-existing condition.

AUSTRALIAN MEDICAL ASSOCIATION
(SOUTH AUSTRALIA) INC

8 December 2016

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Dear Ms Sedivy

Inquiry into The Return to Work Act and Scheme

Thank you for the opportunity to submit to the inquiry of the Parliamentary Committee on Occupational Safety, Rehabilitation and Compensation into the Return to Work Act and Scheme, and for the extension of time to do so.

The AMA(SA) has the following comments to offer, which reflect feedback from our membership relating to the Scheme. Some of these comments may also have been included in direct submissions to you from the profession: we support members to make individual submissions where they are so inclined.

In terms of the inquiry itself, we received feedback that the terms of reference are somewhat limited and come at the question of Act changes and workers' compensation from a particular perspective.

Apart from data that relates to the Scheme's financial status, there is limited data available to the community or health professionals on benchmarks, key performance indicators, or how the objects of legislation are reached.

Medical professionals have considerable involvement with treating short- and long-term injuries and disabilities as a consequence of work, often caring for those who do not claim, have rejected claims, or after the claims resolve. AMA(SA) members can provide qualitative feedback based on community and clinical experience.

However, the legislation is new and thus the time frame since its introduction is relatively short to effectively evaluate the changes, particularly on injury outcomes and disability. Attached is the latest available report from Safe Work Australia. This is date stamped August 2015, so presumably there is a further update pending. However this data lags the changes as the study base is 2013-2014.

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There is a strong argument for workers' compensation systems to provide data and monitoring of processes and outcomes transparently, and to have regular reviews of key parameters of the legislation. This would be predicated upon establishing appropriate metrics and data collection, as well as input on comparisons and interpretation. It does appear early to look at some of these issues with full granularity in the context of the change date. Quantitative data is important. Evaluation planning is an important part of the regulatory process, and for the compensation environment, research and data collection should be fostered.

Importantly, the AMA(SA) and AMA(SA) membership should be involved, as key stakeholders, in relevant aspects of review and in providing an experienced and representative input.

Whilst there is an important consideration around WPI, the most important issues relate to work injury and illness prevention, early access to quality treatment and rehabilitation services and better return-to-work outcomes. As such, most of the modifiable/avoidable/avertable factors are early, occurring within the first few months of injury, before WPI becomes a consideration.

The Victorian Ombudsman's report highlights some important issues with the claims process, aspects that could be readily monitored. Research from Queensland, New South Wales and Victorian compensation systems (mainly motor accident) point to claims process, perceived injustice and early injury factors. Evaluating and monitoring how WPI operates in this Scheme, and comparing it to other schemes, should be self-evident.

"Accumulative" injuries are a considerable area of difficulty – in some circumstances, there are clear exposure-effect associations and, in other circumstances, the multifactorial nature of causation or risk factors, including genetic, environmental, age, prior trauma, lifestyle etc can make causation inferences difficult for clinicians and those making determinations. In the scheme this sits as a legal, procedural issue more so than a medical issue, though as the first step, doctors write the certificates, and in other circumstances provide advice to decision-makers. The reality is a multi-causal, multimodal biopsychosocial model where shades of grey are common.

In relation to the terms of reference for the inquiry, we received feedback that any system that is adversarial runs the risk of becoming extremely bureaucratic and longwinded, with the patients suffering unnecessarily. Normally, medical practice is collaborative and, in hospitals and other places, on a daily basis, medical professionals come together for different views and opinions, and decide what is in the best interests of the patient. To separate medical practitioners means that there shall be different opinions and thus an opportunity to increase adversarial dialogue at the expense of patients.

We received feedback that terms of reference a) to h) are bureaucratic and, by altering one way or another, perceived benefits may be more or less, at potentially an increased cost. Any caring society would produce a system of compensation that is fair. However, it needs audit so that it is not open-ended and the end counterproductive. The more complex the system, the bigger the industry, the greater the opportunity for diversion of funds from patients. We received some feedback suggesting that "any jurisdiction in Australia or, indeed, overseas that has a simpler system than ours is worthy of consideration".

Also, we received feedback that this Scheme contains an element of perceived inadequate descriptors, an example of this being the Section on "Mastication and Deglutition". If the Assessor providing the report is uncomfortable, and unsure of what is required, then we received feedback expressing grave doubts that the recipient could make effective use of the information supplied.

Further, we received feedback that the bureaucratic expectations in the headings of the report are certainly useful as reminders of the details required, but can make preparation of the report cumbersome, time consuming and confusing, which clinicians surmise adds to the paper load required, particularly in relatively straight forward cases. We received feedback that based on experience to date, the system requires and demands an appropriate clinical update to avoid these above difficulties.

We received feedback from a psychiatrist practising in the field that ReturntoWorkSA leadership have been proactive in implementing a system that permits cooperation with treatment providers and is more user-friendly, thus far, toward injured workers than previously, but that there remains opportunity for disputation, and the process of investigation and disputation is corrosive and produces long-term disability.

There is concern that removal of medical practitioners from the initial phases of dispute resolution by the closure of medical panels SA was not helpful, and that criticism of the process of Medical Panels SA failed to consider the effects of the legal process.

We received feedback that RTWSA, whilst striving for early intervention, is an untested entity and the current two years proposed for a cap on income maintenance may prove insufficient – the timeframe should be considered in light of evidence. Also, the failure to provide compensation for psychiatric impairment is inconsistent with legislation in other states and is not in keeping with the academic literature nor the experience. Mental health conditions should be recognised as medical conditions that can cause disability and treated as such. Treatment data on treatment resistant posttraumatic stress disorder and depression, which is ample, supports the statement. With the governments at state and federal level highlighting the needs of those with mental illness, this statement and the need for closer examination of the impact of the legislation should be obvious.

Feedback to AMA(SA) highlighted that the report by the Victorian Ombudsman has found evidence of unreasonable decision-making, including the 75 per cent of 130-week termination decisions overturned by the courts, strongly suggests that at the disputed end of the spectrum, the balance is tilting away from fairness. This report also noted a need to target quality assurance process to those IMEs subject to a high number of complaints. We received feedback that this is worth considering in SA.

We received feedback that it seems that some insurers regard the medical profession as wishing to keep their patients ill for longer to warrant further attendance and generate income. Aside from the fact that this is obviously completely contrary to the codes of ethics and conduct that all doctors must abide by, it is also not borne out by the facts, including the undersupply and high demand for doctors, additionally notable in the workers' compensation field, and the motivations and job satisfaction of doctors.

On this subject, there are increasing concerns in relation to the allocation of patients to medical examiners. Under the legislation a patient may choose an assessor. In reality, the worker has little knowledge of the area and relies on their solicitor or case workers etc. Our members are concerned that the process of allocation of patients is flawed. The outcome is that there will be a bias in the allocation, and such disproportionate allocation will encourage doctors to leave the system as their case load reduces. Also the perception of seeking 'favourable' reports is preserved. The AMA(SA) forecast this problem in the initial consultation of the legislation where we sought to have a random allocation process. We have had preliminary discussion whereby we suggest that an alternate allocation process for permanent assessment be considered which provides an 'arm's length' approach.

To echo comments you may have also received directly, the AMA(SA) supports that there remains considerable work to be done in educating employers regarding compensable injury, educating health providers to engender a proactive approach to treatment and encouraging liaison with insurers and employers.

Yours sincerely

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7 March 2018

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Dear Simon

Medical Fees Consultation

Thank you for the opportunity to comment in relation to the proposed fees for 2018-19, prior to the final decision and gazette of fees agreed.

We note the legislation requires Return To Work SA (RTWSA) to consult with stakeholders prior to a fee schedule. We note your initial paper forms part of the consultation process.

We request that our response be properly considered in light of the spirit of true consultation. Specifically we wish to register our concern on a number of assumptions that have been made in the method of calculation of fees and the decision making around the proposed increases (or not) that have resulted.

The AMA(SA) sought feedback form our members by way of our Reference Group and a survey to all members.

Whilst 90% of respondents agreed with the 1.8% increase, being the AMA equivalent for General practice attendance fees within Schedule 1A, 70% of respondents were not in agreement with the 'no-change' to fees for the remaining Schedule 1A and 1B fees. Respondents were a mix of General Practice and Specialists.

The lack of increase of fees for Specialists is regarded as a negative message to this group of doctors providing work for RTWSA and it is our general opinion that this will lead to a decline in providers across a range of specialities. This is particularly disappointing given the effort that has been provided over past years, at the request of RTWSA, to seek increased participation rates from clinical specialists.

For example, one area that has historically been a challenge has been psychiatry. The prevalence of mental health issues in the general community has increased and the awareness to address the problem is being recognised by Commonwealth and State governments. Yet in this offer we again see zero recognition for the psychiatric services being provided by psychiatrists. The latest lack of an increase for this group of specialists will mean that RTWSA has failed to provide an increase in fees to psychiatry for 7 years, the last being in 2011!

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It is indefensible that this be seen as a recognition of the increased prevalence and the need to address psychiatric issues in the injured workers.

As one psychiatrist stated *"I work in a field where I understand many of my colleagues refuse to see or treat RTWSA patients. I suspect this decision would reduce the number of psychiatrists available to treat patients with mental illness".*

We therefore strongly suggest that this category of specialist fees be re-examined and an increase of 1.8% be made which would provide some acknowledgment for the CPI indexation and the additional infrastructure and service provision costs incurred by medical specialists.

There are several other specialty areas with similar arguments for fairer treatment. To this end we shall be seeking amendments in the legislation to allow a reasonable fee for specialists, to reflect that RTWSA patients are more difficult to manage, have very frequent psychological co-morbidities, and do not recover as well as private patients.

Specifically, the use of the average of fees charged to private patients is manifestly inadequate and does not reflect the 'average' RTWSA patient and presentations. This issue has been long argued by AMA(SA) and has been ignored. It is not until the fee structures can reflect true demands that it can be expected that RTWSA patients will get timely access to their specialist of choice, given that currently so many specialists simply refuse to see this group of patients.

We also note the increase is effective for 1 year with no ongoing 3 year CPI or other index. We find this again to be a failed policy and one that will only lead to further uncertainty in 2019. It is poor practice for a scheme of such importance and impact on the injured workforce to limp along with one year gazetted fees and no indication of surety for at least a 3 year period. Such policy only further acts as a deterrent for medical practitioners seeking to be engaged in the scheme.

Many of our members have commented on the need to recognise that the typical Workers Compensation injury, and medical assessment, is associated with additional paperwork and documentation over and above the normal consultation, hence cannot be compared with the present totally inadequate Medicare rebates which you would be aware have been frozen for many years.

Another comment stated *'there is one fee for reports. This takes no account of the complexity of the report and the range of issues that need to be addressed. This leads to an inadequate reflection of expert opinion'.*

Whilst the nature of many tasks may become easier over time and by contrast, some harder, it is important to examine what the task entails and consider reductions and increases according to difficulty, complexity and time. The current perceived 'macro-economic' approach for complex tasks is seen to again lead to a poor reflection of value for effort for the medical profession.

Given the lack of increase in specialist areas and the absence of fee increases across some items, our membership is becoming increasingly intolerant of the medical profession continuing to absorb the ever increasing costs of their services without an increase in their fees. Many doctor's fees for private patients (for both consultations and surgical procedures) are already substantially higher than for compensable patients. The difference in reward is only partly offset by the provision of medical reports. An effective reduction in fees, which is what would happen were the fees for Medical Specialists to remain the same, would see a further reduction in the number of Surgical Specialists being willing to see compensable patients.

Whilst CPI is not high, it is not zero. It is incomprehensible that somehow, despite this fact that there is no increase in specialist fees. Indeed it has been previously stated that the average

increase in running a medical practice is well above CPI. This includes the increased charges for electricity, salaries, equipment, insurance, council rates and charges etc. All these costs are absorbed by the medical practice. Clearly the current RTWSA offer is well below these increases.

In summary, the AMA(SA) recognises and supports the previous agreement to move to AMA rates for General Practice Attendance fees within Schedule 1A. We have previously sought that RWTSA and previously WorkCover, move to AMA rates across *all categories* and medical groups. This we understand has been acceptable in other jurisdictions. It has not resulted in inadvertent price hikes and is acceptable within the profession. We again ask the RTWSA Board to consider this approach when considering the appropriate and respectful fee levels commensurate with the complexity of the work involved, the deterrence of the administration time and costs and the recruitment and retention of doctors willing to engage with the scheme and hence provide health care for injured workers.

Yours sincerely

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15 December 2017

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Dear Judge Mansfield

Review of the Return to Work Act 2014

Thank you for the opportunity to provide comment on the scheduled review of the *Return to Work Act 2014.*

Under the Act, assessment of permanent impairment through a work injury is to be determined according to the Impairment Assessment Guidelines, based on the American Medical Association Guides to the Evaluation of Permanent Impairment 5th Edition. Only medical practitioners trained in the use of these Guidelines and approved by the Minister for Industrial Relations can make these permanent impairment assessments (PIAs) on which entitlements are determined.

Case managers used to be able to refer to the assessor likely to provide the most accurate assessment. However, under changes to the legislation, injured workers (or the unions representing them) are able to select their own assessor. This has meant many accredited assessors have been marginalised as unions select practitioners to suit their case.

The Australian Medical Association of South Australia (AMA(SA)) notes that neither of these approaches is designed to be impartial and fair – neither for the community nor for assessors.

Prior to the adoption of this amendment, assessors were required to spend a weekend of their own time, had to pass examinations to become accredited and then spend more of their own time maintaining accreditation. Subsequently following the amendment, through no fault of their own, many of these assessors have been sidelined. In addition, the AMA(SA) believes that it does not serve the community to have either case managers or unions select assessors to suit their argument.

The AMA(SA) therefore proposes a system of randomly allocating an accredited assessor to ensure that the system is impartial and fair.

In addition, the Interim Review Report and Final Recommendations proposed including a narrative test for a seriously injured person if they did not meet the 30 per cent threshold for determining permanent impairment. However, the AMA(SA) notes that a narrative is not medical, scientific and cannot be objectively measured. It is therefore inappropriate to implement this as the standard of proof for a decision on permanent impairment.

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The AMA(SA) supports continuing to rely on the Guidelines as they have brought a degree of objectivity to the assessment process and must be retained as the benchmark against which permanent impairment is assessed.

Ensuring impartiality and fairness, based on an objective analysis of the evidence must be the goal in the assessment of permanent impairment.

We would be pleased to provide further information if it should be required.

Yours sincerely

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