Review the Return to Work Act, 2014

We write in relation to the review terms of reference released by the Minister for industrial relations on 14 November 2017. The attached submission is in response to the terms of reference and the submissions of Return to Work SA dated 148 January 2018.

The extent to which the scheme, the dispute resolution processes, and the South Australian employment tribunal act (2014) have achieved a reduction in the number of disputed matters and a decrease in the time taken to resolve disputes.

It is difficult to comment on whether there has been a reduction in the number of disputed matters and a decrease in the time taken to resolve disputes due to the shortness of time the new act has been in operation. There are a number of disputes in relation to interpretation of the new legislation and as these matters are being appealed, mainly by Return to Work SA, to higher jurisdictions there is a bottleneck of disputes within the tribunal awaiting the decisions of the Supreme Court.

In our view the number of disputes is also due to the position taken by Return to Work on a variety of issues where there is a blanket refusal to negotiate even by way of a commercial settlement. This was particularly apparent with transitional issues where minor disputes could have been resolved if Return to Work were willing to negotiate, and has also resulted in a backlog of claims sitting at the judicial level that might have been able to be otherwise settled. Examples can be provided on request.

Costs on appeal

Whilst the new Act requires RTWSA to pay for the worker's costs on the appeal at the Full Bench of the SAET and Supreme Court this often occurred under the old Act by agreement between the worker and the WorkCover Corporation where the matter was considered scheme critical.

Our understanding is that the majority of the appeals to the Supreme Court are currently being made by RTWSA and not the worker. As a result many matters are sitting at the judicial level of the Tribunal waiting for the appeals to be heard. It is also noteworthy that there is a disparity in access to equal representation in the appeals process where Return to Work engage senior counsel at higher than the gazetted rate and yet the worker is asked to bear the additional cost of senior counsel if the charges are above the gazetted rate.

We note that in 2016-2017 RTWSA spent $28.8 million on legal costs. Legal disputes increase when a new Act comes into operation as interpretation and testing of the new legislation is required. The impact of the new legislation on pre-existing injured workers under the old act has also resulted in an increase in disputes as the long term injured workers attempt to be classified as seriously injured under the new scheme.

Return to Work SA has also, in our experience, been unwilling to entertain commercial settlements to resolve disputes, and have taken firm positions that were, again in our view, counterproductive and a waste of legal costs.

Whether the jurisdiction of the South Australian Employment Tribunal under this Act should be transferred to the South Australian Civil and Administrative Tribunal.

The Return to Work Act, 2014 and the Fair Work Act are complex pieces of legislation. Many work incidents involve both workers compensation and industrial issues, for example serious and wilful misconduct, the setting of average weekly earnings and underpayment of wages, psychological injury/bullying, harassment and discrimination. The specialised nature of the Employment Tribunal results in Judicial members having an understanding of these areas of law and allows cases where there may be multiple causes of action, for example harassment and psychological injuries arising out of one incident or a number of connected to be heard before one Judicial member rather than the need to run a number of actions in different jurisdictions. This results in better use of Tribunal time and decreases legal costs.

Accordingly, it is our view that the jurisdiction to handle disputes under the Act should remain with the SA Employment Tribunal.

The extent to which there has been an improvement in the determination or resolution of medical questions arising under the return to work act.

We respectfully disagree with return to work SA's submissions in relation to the Mitchell decision. The role of a Judicial member is to make a decision based on evidence before the Tribunal. This does not involve accepting in total the medical opinion of one particular medical advisor but to consider the evidence provided to assist in reaching a reasoned decision.

It is not entirely clear how Return to WorkSA reaches the view that the decision of Mitchell runs contrary to the objects of the scheme in that it encourages a culture of litigiousness, perversely incentivises the taking of medications that have negative outcomes for workers (such as opioids) and embeds a culture of dependence and sickness rather than focusing on the worker's capacity to return to work.

Mr Mitchell is a long-term injured worker who has suffered quite serious side-effects (secondary injuries) due to medication taken for the work-related injury. Mr Mitchell has a relatively serious lower back injury that warrants a permanent impairment of 26%. It is most likely that he does not have a capacity for work due to his primary injury, however, unfortunately does not meet the 30% permanent impairment threshold to be classified as seriously injured.

In our experience injured workers have been prescribed and taken large amounts of opioid medication to enable them to return and/or remain in the workplace in an attempt to avoid being on the system. We have seen multiple examples where workers have been prescribed and taken greater than 180 Panadeine Forte a fortnight to remain in the workplace. In our experience the vast majority of injured workers do not wish to take large amounts of pain medication over prolonged periods of time, but instead wish to return to their life prior to their injury.

Prior to the implementation of the Return to Work Act, 2014 a number of submissions were made in relation to the use of the AMA Guides for whole person impairment assessments. Some of the issues raised were that the guides were clearly not an objective assessment of impairment as two doctors can undertake identical assessments which result in vastly different impairment assessments. In other words there were concerns that not all accredited assessors would assess in

the same manner. In our opinion the situation has not changed significantly. For example, we have received reports in relation to the same injury where one accredited assessor has assessed a permanent impairment of 32% and another has assessed 25%. The disparity between assessors is clearly shown in the number of assessors being used by workers who have received legal advice.

The subjectivity of assessments is, in our opinion, another reason why the Act should allow a discretion to deem workers as seriously injured even though the threshold of 30 % impairment has not been reached.

The performance of return to work SA in managing claims, including Return to Work SA outcomes in reducing instances of work injury.

This submission will be limited to comment on the performance of Return to Work SA in managing claims as we are not in a position to comment on any Return to Work SA outcomes in reducing instances of work injury.

1. The introduction of mobile claims management service model has not been without problems. This is most prevalent when the early intervention:
   - Is used as a means of inappropriately and inaccurately gathering medical information during a worker's consultation with their medical provider which is then provided to the "eligibility person' who is determining the claim;
   - Is used as a means of inappropriately advising workers and their doctors that an injury is either an aggravation of a pre-existing injury and not compensable or the injury is not compensable.
   - Is inappropriately used as a means of collecting and recording information in relation to the mechanism of the injury and requiring an injured worker to reinact how the injury happened in front of the employer/doctor.
   - Creates a conflict between the mobile case person returning the worker to suitable duties and maintaining the employer as a client of the claims agent.

2. In our experience the performance of claims agents in relation to the processing of payments to injured workers has great room for improvement.

   It is our experience that workers are rarely reimbursed within 14 days of providing receipts for medical treatment or expenses. This is problematic particularly where injured workers are already suffering financial difficulties.

   The claims agents often advise that they have 30 days to reimburse expenses, pay backpayments due, or pay lump sum entitlements. When awaiting receipt of lump sum payments workers are often advised that the claims agent is waiting for Centrelink clearance, yet when Centrelink is contacted the worker is advised that no clearance has been sought.

   There is rarely any acknowledgement that many people are in difficult financial circumstances, often living from pay to pay, and that a failure to pay within the prescribed period results in financial hardship.

When medical expenses are reimbursed the payments are often not itemised and is difficult for workers and their representatives to reconcile the reimbursement.

The delay in reimbursing or paying workers' legal fees, barrister fees, disbursements, and fees for treating medical providers' reports is also problematic. These items are rarely reimbursed or paid within 14 days and can often remain outstanding for months despite regular follow-up. It is not uncommon for workers' solicitors to have to resort to issuing multiple applications to the Tribunal alleging undue delay in relation to the same medical expenses. We have heard anecdotally that medical providers and barristers when engaged by return to work SA or their delegates and representatives receive payment within 14 days routinely, and their fees are never challenged but, when engaged by workers' representatives are generally not paid on time or issue is taken with their charges. This has resulted in many medical providers refusing to provide reports without prepayment and in some cases refusing to treat workers compensation patients due to the difficulty in being paid for their services. This clearly causes prejudice to injured workers.

The performance of self-insured employers, including outcomes and reducing instances of work injury.

- **Observations on performance of self-insured employers.**

Initially when the scheme changed on 1 July 2015 there was a spate of long-term injured workers who had transitioned on medical expenses only being stood down from work on the alleged grounds that the self-insured employer did not have suitable duties. Eventually these workers were provided with suitable duties but, often only after disputation in the SA Employment Tribunal and / or applications pursuant to Section 15(2) of the Act when Return to Work SA concluded that the self-insured employer was not complying with its obligation to provide suitable duties. Unfortunately these workers were without income over this period and as a result placed in financial hardship due to the action of the self-insured employers.

We are also aware of instances where self-insured employers treat work-related injuries as non-work-related despite having been advised by the worker that the injury was sustained in the workplace. In such instances workers have been advised that their injuries are not compensable and instructed to take sick / personal or annual leave for any periods of incapacity, requiring the workers to seek legal advice to access their legal entitlements pursuant to the Act.

In one example of which we have firsthand knowledge an injured worker continually presented at the employer's first aid centre with an injury sustained in the workplace but was denied medical treatment and told that there was nothing wrong with him. In this specific case the worker's first language was not English and he found it difficult to assert his workplace rights. Eventually the worker's condition became so bad that he consulted his own general practitioner and was then provided with a work capacity certificate. Unfortunately this did not occur until 12 months after the injury and the entitlement to medical expenses had expired. This matter was resolved in the tribunal by way of redemption.

A common practice with some self-insured employers is early intervention. One particular self-insured employer of whom we are aware regularly insists that injured workers sign a document

saying that they elected to accept early intervention rather than pursue a workers compensation claim. In these cases the injured workers were not advised of how this election might affect their entitlements to medical expenses and weekly payments of income maintenance in the future. Many workers had signed these documents and, when they later had periods of incapacity, were unable to claim weekly payments as they had not made a workers compensation claim, and so were not paid. Unfortunately as legal practitioners we often do not see these people until after their employment has been terminated, or their entitlements have expired, or will have expired before the matter can be heard at the Tribunal. There does not appear to be any pecuniary disincentive for employers who knowingly subvert the system.

In one example of which we have first hand knowledge a worker was suffering from swelling to her fingers due to the repetitive nature of the work. She elected to have in-house medical treatment rather than lodge a workers compensation claim. Unfortunately the in-house medical treatment did not resolve her condition and so she consulted her general practitioner. The worker then advised the self insured employer that she had consulted her general practitioner and was told that she needed to lodge a claim prior to securing a work capacity certificate from the general practitioner. The worker was questioned as to why she consulted a general practitioner and did not use the in-house medical provider. When she explained that the treatment from the in-house medical provider was not leading to improvement or resolution of her condition, she was instructed to await further instruction. A few days later the worker was terminated from her employment on the basis that she was still in her probationary period and was not a "good fit" with the company. In that specific case an unfair dismissal claim is being pursued and a workers compensation claim will be lodged. However, unfortunately the worker has been without weekly payments or suitable duties for an extensive period of time.

Therefore whilst many self-insured employers have early intervention treatment programs through which they fund treatment of minor workplace injuries without the need for a workers compensation claim, we have found that in a number of cases the early intervention treatment and in-house treatment is used to avoid or delay legitimate claims. In the case of delay in legitimate claims, such delay can result in a situation where the 52 week medical expenses entitlement period expires before the delayed claim is determined.

We are somewhat suspicious of the reported low incidence of claims with self-insured employers as, in our experience, the early intervention process is a way of reducing lost time injuries without actually and adequately addressing workplace safety.

A further concern in relation to self-insured employers is the failure to provide adequate information with regards to workers compensation processes, the lodging of claims, and workers' entitlements. We have also noted that many employees who are not native English speakers are not provided access to professional interpreters, but instead are required to rely upon the assistance of other employees whose English may be slightly better, but still potentially inadequate for the purpose.

Changes in return to work rates at key milestones outlining factors influencing any improvement or deterioration.

Factors contributing to non-seriously injured workers failing to achieve a return to work within two years.

A percentage of injured workers will have injuries that significantly impair their ability to return to work even though they have not been classified as seriously injured. This highlights the deficiencies of the 30% permanent impairment threshold for serious injury classification. In our view, the law should be amended to allow a discretion to deem a worker as seriously injured even if they do not reach the 30% threshold, based on a significantly reduced capacity for work. This discretion should, in our view, extend to workers who have sustained a number of injuries over time which have resulted in a total incapacity for work.

We currently have a client who is a boilermaker who sustained a head injury in the workplace which resulted in an acquired brain injury. Unfortunately the worker had a previous head injury as a teenager but, despite this, was able to function and gain qualifications and work as a boilermaker. The self-insured employer is attempting to argue that the permanent impairment for the previous brain injury should be deducted from the worker's overall permanent impairment. If this were to occur the worker will not reach the 30% permanent impairment threshold to classify him as seriously injured despite the fact that he is now unable to return to any form of employment as a result of the recent injury. If the new scheme is to truly look after the seriously injured then it should do so in a way where a discretion can be exercised to assist those workers who are unable to return to work.

Similarly, situations where a worker has sustained a number of workplace injuries over time which, collectively, result in a total incapacity for work but, because no one injury alone results in the 30% impairment threshold, the worker does not qualify as seriously injured, can lead to highly unjust results. In such circumstances the worker may be permanently and totally incapacitated for work but, because that incapacity results from the cumulative effect of a number of separate injuries, the worker is treated the same as someone who has sustained a single, minor workplace injury. This clearly leads to unjust outcomes.

The question of what constitutes a return to work must be considered. A return to work can encompass the following:

- a return to full preinjury duties;
- a return to preinjury duties with minor modifications and restrictions in relation to those duties;
- a return to alternative (productive) duties with the same preinjury employer;
- a return to work with different duties with a different employer.

New scheme claims experiences:

A major barrier contributing to not returning to work within two years is multiple injuries sustained in the one trauma or arising out of the one trauma. For example where a worker sustains bilateral upper limb injuries requires multiple surgeries after conservative treatment has failed and these surgeries have to be undertaken individually which takes them outside of the 104 weeks from the first date of incapacity arising from the injury. The worker then has a further 52 weeks of medical expenses in which he/she is expected to rehabilitate and retrain often under extreme financial hardship due to the cessation of the weekly payments of income maintenance. One would

anticipate that section 21(3) of the Act may be of assistance, however, Return to WorkSA rarely approve interim assessments under this section.

A worker can also undergo surgery and then return to work on modified duties (which duties are not considered productive and therefore unpaid) or on modified duties on reduced hours and sustains a secondary injury due to the primary injury is often unable to achieve a return to work within the first two years. The injured worker is at a further disadvantage because a claim for the secondary injury is either a sequelae to the first injury and therefore part of the two years of weekly payments or is classified as a new injury without an entitlement to weekly payments due to the decision in James Last or to a reduced entitlement to weekly payments based on the hours of modified duties. The other complicating factor is that the medical expenses in relation to the primary and secondary injury will often expire at 156 weeks after the primary injury despite further treatment being required.

An injured worker may well return to alternative duties within the two years, however after the expiry of the two years find that these duties are withdrawn by the employer as they are non-productive or classified as non-productive duties which results in the injured worker being without employment or income. It is of concern that post the two years performance management may be unfairly exercised on injured workers as a way of eliminating an employer's obligation to provide suitable duties.

The process pursuant to Section 18 of the Act may appear, at first glance, to provide some protection to injured workers whose employers have unreasonably withdrawn duties. However, while the Section 18 process may provide some benefit to injured workers within the first two years after their injury, because a real sanction can be imposed upon recalcitrant employers during this period – if they are ordered to provide duties and fail to do so, they can be required to, effectively, pay the injured worker's weekly payments – no such sanction applies after the entitlement to weekly payments has come to an end. As a result, it appears that employers can withdraw duties after weekly payments have ceased, and even ignore an Order of the Tribunal to provide such duties, with impunity or without sanction. In our view the Act should provide for a significant sanction to be imposed upon employers who fail to provide suitable duties to injured workers beyond the two year period of income maintenance which is, after all, the period in which workers with a diminished capacity to secure work on the open job market most need the security of paid employment and the protection of the Act.

Any additional recommendations regarding reskilling services to assist return to work outcomes;

It appears that the claims agents have adopted a policy whereby no retraining \ rehabilitation will be provided once the entitlement to weekly payments of income maintenance has ceased. As a result injured workers are either being pushed to undertake retraining before they are capable of doing so due to high levels of medication and or recovery / rehabilitation commitments, or miss out on the opportunity to become reskilled or upskilled to assist them to find work with their diminished capacity.

Any other recommendations based on your review of the administration and operation of the Act which you consider appropriate and consistent with the objects of the Act;

1. Section 21 (3) – this section allows return to work to make an interim decision to the effect that a worker will be taken to be a seriously injured worker despite not being able to be assessed for permanent impairment due to not having reached maximum medical improvement.

   Unfortunately Return to Work SA is not, in our experience, utilising this provision due to a concern that once the interim decision is made it cannot be overturned if a worker chooses not to be assessed. This position by Return to Work SA is unnecessarily putting injured workers under financial strain whilst they wait for their injuries to reach maximum medical improvement. There may be many reasons why an injured worker may choose not to be assessed for permanent impairment, such as the requirement for a total knee replacement in the future or further surgery within a few years which would result in that injured worker being assessed at over 30% whole person impairment, or that the worker may quite reasonably fear that there will be further secondary injuries which have not fully materialised by the end of the two years of weekly entitlements, or workers who may have only recently undergone surgery and have not yet reached maximum medical improvement.

2. The Section 22 process

   Section 22 sets out a scheme for assessing the degree of permanent impairment. We have noticed a number of issues n relation to this process

- Injured workers are often not aware of the importance of the section 22 process in relation to their entitlements, such as, in particular, workers with English as a second language or limited literacy skill. Interpreters are often not provided when the s22 process is discussed/commenced – eg in relation to choice of doctor and agreeing the draft letter.
- While injured workers may be advised that only one assessment may be made in respect of the degree of permanent impairment arising from one or more injuries (including consequential injuries arising from the same trauma) and any injury that may subsequently develop or manifest itself or develop after the assessment of impairment is made will not be assessed, the level of actual understanding of, or consequences of, this concept is often not appreciated by the injured worker.
- The accredited assessors are not reviewing all injuries related to the trauma in particular secondary injuries if these injuries are not contained within the draft letter to the accredited assessor.

Given the importance of the Section 22 process we would suggest that there be a requirement that an injured worker obtain independent legal advice addressing the consequences of the Section 22 process prior to agreeing the accredited assessor and the draft letter to that accredited assessor, and that the claims agent be required to contribute towards the legal

cost of such advice (in a similar fashion to the legal professional advice in relation to accepting a redemption).

3. Section 18 process – as detailed above we believe that the Act should provide for some sanction to be imposed upon employers who fail to comply with an order of the Tribunal to provide suitable employment to an injured worker beyond the two year entitlement period for weekly payments. Currently no such sanction exists.

   Furthermore, in relation to the Section 18 process, recent decisions of the Tribunal which concluded that the regulated legal fees payable for such process are inclusive of counsel fees have meant that injured workers are required to pay significant legal fees if they wish to ask the Tribunal to compel their employer to provide them with duties. This is a powerful disincentive to injured workers to exercise this right which is an important part of the Act and the scheme. We are of the view that this issue should be remedied so that worker's whose employers unreasonably refuse to provide them with suitable employment are able to seek the assistance of the Tribunal without suffering significant financial prejudice or risk.