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TRANSCRIPT OF PROCEEDINGS

PRODUCTIVITY COMMISSION

INQUIRY INTO NATIONAL WORKERS COMPENSATION AND OCCUPATIONAL HEALTH AND SAFETY FRAMEWORKS

PROF M.C. WOODS, Presiding Commissioner
DR G. JOHNS, Commissioner

TRANSCRIPT OF PROCEEDINGS

AT MELBOURNE ON THURSDAY, 26 JUNE 2003, AT 9.12 AM

Continued from 25/6/03

PROF WOODS: Welcome to the Melbourne public hearings of the Productivity Commission inquiry into national workers compensation and occupational health and safety frameworks. I'm Mike Woods, I'm presiding commissioner for this inquiry. I'm assisted today by Dr Gary Johns, a commissioner also for the purposes of this inquiry.

As most of you will be aware the commission released an issues paper in April setting out the terms of reference and some initial issues. The inquiry explores the opportunities to develop national frameworks for workers compensation and occupational health and safety. Our full terms of reference are available from our staff. The commission has already travelled to all states and territories talking to a wide cross-section of people and organisations interested in workers compensation and occupational health and safety. We have talked to groups from a diversity of backgrounds and met directly with government organisations, unions, employers, insurers, service providers and others, listening to their experiences and their views on future directions.

We have now received over 100 submissions from interested parties. I would like to express our thanks and those of the staff for the courtesy extended to us in our travels and deliberations so far and for the thoughtful contributions that so many have made already in the course of this inquiry. These hearings represent the next stage of the inquiry and we will release a draft report by the end of September. At that point there will be an opportunity to present further submissions based on the draft report and attend a second round of hearings. We aim to sign the final report by March 2004. I would like these hearings to be conducted in a reasonably informal manner and remind participants that a full transcript will be taken and made available to all interested parties. At the end of the scheduled hearings I will provide an opportunity for any persons present to make an unscheduled oral presentation should they wish to do so.

I would like to welcome to the hearings our first participants, Self Insurers Association of Victoria. Could you please, for the record, state your names, your positions and the organisation that you are representing.

MR HARRIS: My name is Peter Harris, I'm the chairperson of the Self Insurers Association of Victoria and I also work for - I'm the workers compensation manager for Carter Holt Harvey, a self-insurer.

PROF WOODS: Thank you very much.

MS WALLACE: My name is Nerida Wallace, I'm an adviser to the Self Insurers Association of Victoria and I'm also principal of Transformation Management Services.

PROF WOODS: Thank you very much. You have a presentation you wish to run us through?

MR HARRIS: Yes.

PROF WOODS: Thank you.

MR HARRIS: Yes. Our submission is a work in progress. We've been consulting extensively with our members via meetings and also via a survey which is in progress. So what we're presenting today is results to date, a formal submission we'll be presenting to the commission within the next month. So the preliminary results - - -

PROF WOODS: You're conscious of our timetable and clearly the earlier we get it the more we can incorporate it into our thinking for the draft report.

MR HARRIS: Yes. That's why we're presenting the results today. We'll be aiming to get more responses but I think 27 July is our target date to have the results in to you.

PROF WOODS: Thank you.

MR HARRIS: We'll be responding to the points and issues paper and adding some additional comments on the self-insurer contributions to the various schemes. There is a total of 32 slides in this presentation. Just briefly, self-insurers in Victoria, there is currently 37 self-insurers and we represent approximately 10 per cent of state remuneration. All self-insurers are members of our association. But we do have, from time to time, associate members which are companies who are either considering application or actually have current applications into self-insurance. We also, I guess, subcontract to about 6 per cent of the premium pool to third party labour hire firms and so forth. So our influence, I guess, extends beyond our own employees to a significant proportion of insured employers as well.

We have very active working committees focused on both claims and rehabilitation as well as safety. Those committees represent us with other stakeholders at various forums with the WorkCover authority. Our members are mainly drawn from the top-100 companies. The survey which we'll leave with you, two copies of the results to date - currently, as I said, we've got about a third of our members who have responded.

PROF WOODS: You're talking 10 to 12 members or somewhere around there?

MR HARRIS: 14. Obviously we would be hoping to get a higher - with a membership of 37 we are able to aim for much higher responses than larger

membership-based organisations may. But the time frame does reflect - the responses we're getting are company responses. So obviously companies need to consult within their structures to make sure they're accurately reflecting their company's position on a range of matters. As I say, we structured that based around the issues paper.

So starting off talking about national frameworks. We've got a majority support for a national framework. Particularly - an interest for us is consistent compliance regimes in both workers compensation and health and safety. We'll talk a bit as we go through about some of the difficulties we experience through having the current inconsistent regimes of compliance in both of those areas. There is less current support for consistent benefit structures. I think that the reluctance to get behind a consistent structure at this point in time is - as where we are at the moment compared to where we would need to be to have a consistent structure across the states. So in other words there is very little of consistency particularly in the workers comp. So for us to take quite a quantum leap between having virtually no consistency to having a benefit structure that is consistent so - - -

PROF WOODS: By consistent you're meaning uniform as your ultimate aim?

MR HARRIS: Pretty much.

PROF WOODS: What you're saying is because of the diversity at the moment you see that that would be some way into the future.

MR HARRIS: Yes.

PROF WOODS: Even once you had a uniform benefit structure, would you see it appropriate to then, in terms of this financial expression be able to vary between localities to reflect, say, differences in average weekly earnings or some such other local characteristics?

MR HARRIS: We haven't really - - -

PROF WOODS: Haven't got down to that.

MR HARRIS: Got down to - - -

PROF WOODS: No, that's fine.

MR HARRIS: - - - whether a consistent structure should still allow for local variations or whether we really should have a truly consistent entitlement regime across the country.

PROF WOODS: For "consistent" I should read as "uniform"?

MR HARRIS: Uniform, yes.

PROF WOODS: Yes, thank you.

MR HARRIS: I guess the views are that there is much more short-term and immediate prospects of having frameworks, compliance regimes. As we go through some of the requirements of self-insurers, there is lots of scope to get uniformity or consistency in the short term. Maybe into the future that would lead to consistency and uniformity in benefit structures. But we see there are far more complex hurdles to that than there would be to some of the self-insurance arrangements. There is very strong support from our members, not just through the survey, but through our meetings for an option - and I'll stress "option" we wouldn't want compulsory national self-insurance but certainly an option for companies to choose national self-insurance and opt out of local regimes.

PROF WOODS: Some of your membership in fact, where they are so eligible currently under the federal legislation, are seeking to be self-insurers under that federal - - -

MR HARRIS: Under Comcare.

PROF WOODS: Into that national scheme, Comcare.

MR HARRIS: There has been some interest in that but we will comment on the Comcare option shortly.

PROF WOODS: Yes.

MR HARRIS: One aspect - we'll talk a bit more about barriers to self-insurance or access to self-insurance. I guess our views are that companies should be free to choose self-insurance and the test should be their capacity to manage and financially be secure as a self-insurer. So we are opposed to arbitrary requirements in Victoria. We don't have a head count requirement which we're pleased about. The public sector doesn't have access to self-insurance which we believe it should, as it does in other states. One of the difficulties we have though is many of our companies are multinational or have common ownership with other businesses which are operating in Victoria, but the rules only allow a self-insurer to be the corporate entity in Australia. So we may have sister organisations which are all part of the same ownership internationally but we'd either have to apply for individual self-insurance licences or we'd have a range of - parts of the business would be self-insured and other parts would be insured. So we see the scope to remove some of those barriers, to get the benefits both for employees and for business - - -

DR JOHNS: Do you have an example - without naming a company if you don't want to but just head office, I guess, or a parent company versus the other satellites, or what are we talking about? What sorts of other functions aren't self-insured?

MR HARRIS: Certainly a motor vehicle manufacturer whose head office is in the States. They have a number of businesses but the Australian businesses are set up as different businesses of Australia, but they're all owned by the one and they all report through to the head office in America.

PROF WOODS: So the manufacturing element might be big enough and you can get through the finance arm or the sales arm or the service arm.

MR HARRIS: Yes, or they may have the one large manufacturing brand and other smaller brands that are part of the same group but structured as different corporate entities in Australia.

DR JOHNS: And WorkCover or whoever it is just simply doesn't recognise that the smaller entities are part of the larger company.

MR HARRIS: Well, the legislation as it stands in Victoria and in many other states refers to Australian entity. So that would - that's a barrier to being more flexible, I guess.

PROF WOODS: So those corporate structures report independently up to head office somewhere overseas, whereas if they had to go through the device of creating a holding entity in Australia to which they reported, they could then - through a legal device that has no command and control you could achieve it but that's all it would be, a legal device.

MR HARRIS: The company I work for - Carter Holt Harvey Australia Pty Ltd, to which all the divisions are subsidiaries, apart from joint ventures - we do have joint ventures again which are precluded from being part of that arrangement. So there could be scope for - we could be joint venturers with another self-insurer but that business entity would again have to apply under its individual identity. It couldn't be part of our self-insurance arrangement or a partner's.

PROF WOODS: Mind you, joint ventures are deliberately not single ownership for a whole range of reasons. So I'm not sure that you would necessarily therefore be able to expand self-insurance across it. You choose joint venture for a whole range of reasons, whereas a wholly-owned or controlled entity is a different matter.

DR JOHNS: But you'd leave that choice to the joint venturers.

PROF WOODS: Yes.

MR HARRIS: So I guess we're just saying, the scope for more flexibility with demergers and mergers and so forth, the current arrangements create barriers and difficulties to corporate change of structure.

PROF WOODS: We have had examples where demergers have meant that a part of the demerged entity doesn't meet the head count and therefore loses its self-insurance.

MR HARRIS: That's a very good illustration of how farcical a head count requirement can be because that company is still fit and proper to self-insure, it's just changed the numbers. So we're saying the access should be easier.

PROF WOODS: "Easier" needs a bit of definition. Are you talking about more lax prudentials? Are you talking about no occ health and safety audits? Are you taking away head counts? Are you saying the claims experience no longer matters, we'll find easier at some stage?

MR HARRIS: Yes. Certainly there's strong support for a national option and we'll talk a bit more about what the national option might require.

MS WALLACE: Can I just add a point to Peter's common ownership.

PROF WOODS: Yes, please.

MS WALLACE: The common denominator for these companies seems to be that they have one office that deals with all workers compensation matters and that's where they get concerned about these self-insurance definitions because regardless of what's happening to that corporate entity, the files are still coming back to one place and the management is still happening from one place. They've just got to manage them in different ways according to whether they're self-insured or insured.

PROF WOODS: Okay.

MR HARRIS: Just one of the issues tabled in the terms of reference is occupational health and safety in a national framework. Through our members there is strong support for OH and S administration at a national level. We'll talk a bit more about what that means, but there's certainly a qualifier that a national framework or a national standard would clearly need to be a superior model to what it's replacing.

PROF WOODS: Are you going to go through what your concerns are with a national Occupational Health and Safety Commission model?

MR HARRIS: Yes, we've got some comments on that.

PROF WOODS: Thank you.

MR HARRIS: So in terms of a standard there is the Australian standard on health and safety systems, AS4801. So there's some support from our members, and a lot of the states in different ways will refer to that standard and in Victoria obviously a safety map is a standard which is put up, or a safety auditing system, that makes reference to AS4801. There is acceptance from self-insurers in Victoria that some safety standards is an acceptable part of the requirements of the self-insurer.

PROF WOODS: As a precondition for licensing or just as a demonstration of good corporate governance? I mean, I have detected from time to time concern that occ health and safety audits as such shouldn't be tied to your annual licensing. I'm not quite sure what view you're putting forward.

MR HARRIS: At a high level we're accepting that it's reasonable to have some examination of a company's safety system, safety performance is part of that consideration of self-insurance. The detail of how that's judged, the standards it's judged against and then once established as a self-insurer, the ongoing requirements - we will talk about the ongoing audit and activities.

PROF WOODS: Okay.

MR HARRIS: Just commenting on multiple jurisdictions, there's very strong support from members for the statement that multiple jurisdictions and operating in them poses additional costs and restraints for a national company or for multinational companies that operate in Australia.

PROF WOODS: Now, some of your members have independently come to us, with your blessing, with some detailed information on those costs and we've been grateful for that. If I could just encourage others through you to also look at what some of the participants - whether they be the Westpacs - others have come to us already and demonstrate the costs in a very practical way that's very helpful to us.

MR HARRIS: I guess I'd add to that. It's not only costs. I think when you've got multiplicity of regulations and codes it diminishes their effectiveness.

PROF WOODS: Yes, that's an important matter as well. They were referring to wanting to have and in fact having a single safety culture and management system throughout the company. So, yes, I take that point as well. Optus is another one who has provided that sort of detail.

MR HARRIS: Many of us obviously operate in most states, if not outside of Australia as well, and we're aiming for best practice and safety standards which is diluted when you've got a whole range of different - when you get down to their implementation - codes and regulations and so forth.

PROF WOODS: Yes, I think that's a very powerful argument.

MR HARRIS: The heads of the Workers Compensation Authority and the minister's council, there's very strong support from our members that neither forum is effective as a national coordination, particularly in the area of workers comp. So we do feel that there is a need to have some momentum behind opportunities, whether it's a national framework, mutual recognition, national systems, and those forums don't seem to have the - or haven't demonstrated in the past sufficient resolve to achieve uniformity or consistency. So we certainly would value more comparative data in the work that has been prepared would support some self-insurance subsets of the - - -

PROF WOODS: When I saw that as I was going through this yesterday, what struck me is you're an association of self-insurers, your membership is quite extensive; why can't you self-regulate in terms of production of data? Why does someone else have to do that, given that this is entirely in your own hands? You're the self-insurers. Why can't you be producing the regular comparative data? In fact, there's probably some consultants out there who assist you who would no doubt, for a fee, help.

MR HARRIS: That's something we could do but we do, I guess - and that's duplicating our current system. If we were able to replace our reporting requirements to the various state schemes, including WorkCover in Victoria, and replace that with an industry-based data, then that would be an alternative. But at the moment, if we were to set that up, it would be a duplicate of what currently exists with our data exchange.

PROF WOODS: In the days of electronic data, I would have thought it's just setting up a separate address to which it goes and gets compiled. I mean, we're not talking about creating new data and new costs, we're saying data can go this way but that same data can go that way and get assembled, compiled into a national data bank of self-insurers at, I would have thought, a marginal cost of less than a cent - not a big issue.

MR HARRIS: Certainly it has been suggested and - - -

PROF WOODS: Anyway, I commend it to you for the - - -

MR HARRIS: Yes, yes. So yes, the data - whether we do that ourselves - but

certainly there's value in getting more data than what's currently available.

PROF WOODS: Data is an enormous issue in this inquiry.

MR HARRIS: But there is a national comparative - there is a process already in existence with comparative data, so we'd like that to include reference to self-insurance, and that has been - I think it's - there is some support from our members for a - they say "properly resourced", whatever that might mean, but better resourced than the current national set-ups, to coordinate and I guess to put some momentum behind cooperation between local regimes.

PROF WOODS: Do you have a design for such an entity or just a plea for such an entity? You've had some thoughts on that?

MS WALLACE: It's an ongoing development process.

PROF WOODS: If you want to come back on that in your subsequent submissions - - -

MR HARRIS: Yes. Looking at the proposed models, the 1-6 that are tabled in the issues paper, there's some support for mutual recognition. It's a recognition that a self-insurer approved in one state would be able to self-insure in another state without having to duplicate applications and approvals. There's no strong support for Comcare, which reflects some concern about the benefit regime of Comcare.

PROF WOODS: Maybe not today - I'm particularly conscious of time - but if you could identify the four features of Comcare where you can put forward powerful argument for change, and they'd have to be, you know, fundamental issues. We're not talking about, "Let's tinker this and change that," but, you know, what fundamental change could you strongly argue in the Comcare model that could carry weight that would therefore make it more attractive to members? It might be the long tail characteristic or it might be that the AAT as a dispute resolution mechanism isn't relevant to private sector membership, or it might be an access to common law issue or whatever, but if you could keep it a very restricted number of absolutely core things, but such that if they were put through, that your membership would say, "Well, that's now looking more like a scheme."

MR HARRIS: Yes.

PROF WOODS: But not 20 desirable things.

MR HARRIS: There's a statement there on it. We'd certainly do that, as to what are the major barriers and concerns about Comcare.

DR JOHNS: Could I just ask - it says, "Some support for mutual recognition." Do you think that's a reflection that it's just an unlikely route, or are there difficulties with mutual recognition?

MR HARRIS: I think difficulties.

DR JOHNS: Yes.

MR HARRIS: You know, there's question marks about how it would work. If New South Wales - if we were recognised, say if my company was recognised and approved as a self-insurer in New South Wales, how would the other jurisdictions that we're operating in be up to that, given the different entitlement regimes and so forth? So think that's why there's a reticence, is trying to think through how would it work in practice.

DR JOHNS: You would probably have to prove yourself up in each jurisdiction anyway before they give you a tick, so you've already spent your money in a sense. Yes, okay.

MR HARRIS: But I think we need to give some more thought to that - I mean, I think there was an element of mutual recognition with the ACT and New South Wales - need to hear more about any barriers or problems with how that works.

PROF WOODS: If you could explore that and even if you then conclude that the practicalities are such that, you know, it's unlikely, that's in itself a valuable commentary to us.

MR HARRIS: What there is strong support for is choice, so a choice of a national versus a local self-insurance option, some sort of external standard-setting that doesn't vary from jurisdiction to jurisdiction, some standards for whatever auditing is reasonable, that there's a consistent standard of auditing, and we'd also got there "consistent credential regulations". So again, we don't want different tests and rules in different jurisdictions. We've commented there on the general sort of concept of should OH and S and workers comp be separate or combined, when you're talking about regulators, and we've got mixed views amongst our membership on that.

What we do have strong support for is if companies are demonstrated to have high standards of safety systems, then that should be recognised in other compliance activities. So just as Victoria has a focus, 100 - targeted approach to the worst performers - it should have the opposite of that for the best performers and spend less focus and time on employers who have already established a high level of practising standards. Just adding - we've touched on access to self-insurance already, but there's general agreement that the different access arrangements do add costs to our companies, and nearly half of the respondents, the cost is such that it's a discussion

and it's an issue that reaches the board level when they discuss their health and safety/workers comp arrangements.

Maintaining self-insurance, most of our members say that the renewal audits - we have an annual self-audit regime and then every three or four years, we also have to renew the licence that we've already qualified for, and most of the members agree that that's duplicative and adds extra cost. There was some support for having some sort of audit process at renewal, but not one that duplicates what's already in place.

PROF WOODS: So to the extent that you could demonstrate you had the manuals, the safety equipment, the procedures, then that should be virtually taken as given? I mean, you do some risk auditing to just verify that, yes, it's still there, but not a complete re-audit. Is that the sort of thing you're talking about?

MR HARRIS: Yes, and there's probably scope to question the renewal process. When you put that against the concept of applying and gaining a licence, and then having an annual regime of reporting and auditing that is to prove continuing performance of an acceptable standard, the actual place for renewal on top of that is pretty - - -

PROF WOODS: What would you include in a - clearly if a company's credentials significantly deteriorated, such as there was doubt as to whether they could carry long-term claims or that they hadn't been timely in renewing any catastrophe insurance or something, that would be cause for concern, wouldn't you think?

MR HARRIS: That would be cause for concern regardless of the renewal process. That would be - - -

PROF WOODS: No, but it's just the renewal process formalises - I mean, otherwise you're under constant renewal. I mean, presumably you don't want the threat of withdrawal of licence on a daily basis, but a renewal just formalises that, "Let's run the ruler over the key elements."

MR HARRIS: I guess some of the comments and views we have is that both the annual audit and reporting requirements, and the renewal process, is over-regulation.

PROF WOODS: Yes. Well, we only need one of those, not both, but whether we define it as annual cheque or renewal or however you define it, what would you see as the key element of such a process of review?

MR HARRIS: I think the key elements as they stand are pretty reasonable. If it's not on top of the other annual reporting - if we wound back some of the annual reporting requirements and focused on the renewal process then we wouldn't have as much duplication.

PROF WOODS: Okay.

MR HARRIS: With access there's obviously support that it should be uniform access requirements across the country. As we said there's some support for mutual recognition and some consistency in the regulatory framework. So that's just reinforcing what we've said. In terms of the risk of self-insurers failing, there's a strong support for the current bank guarantee arrangements we have in Victoria. I know some states have a separate pool that self-insurers contribute to. There's not strong support for that option.

PROF WOODS: What, you don't like to act in concert and support each other?

MR HARRIS: I think there's a user pay principle that we're happy to take that guarantee to cover our own risk and have each company do likewise. Excessive loss or contingent liability insurance: there are concerns that there are some aspects of cover that's not possible to purchase in terms of terrorism.

PROF WOODS: Right.

MR HARRIS: We think that acts of terrorism would be a concern to the community and therefore some states have responded with a community based response, if there was an act there would be a general levy to cover workers comp liability, such as the proposed - my understanding is there's some moves in that area with property risk. So self-insurers in Victoria are more exposed than other employers. In terms of whether the government should actually offer that insurance, there's mixed views amongst our members. I know there are some schemes where you can only buy it from the government. I think if the government was to offer it we would want matters of choice as where we would purchase our excessive loss insurance.

PROF WOODS: That's not quite how that's worded. That's worded as the government actually paying for it, whereas what you're talking about is you purchasing, ie, paying for it but the product being offered by government. I'm happy with the latter interpretation.

MR HARRIS: Yes, I don't think we're suggesting that the government picks up the tab. OH and S legislation, there's support for some central control of regulation. There's less support for a raft of new legislation but again the variety of codes and regulations et cetera incur costs and affect our capacity to implement them, I guess. We talked about that before. With the National Occupational Health and Safety Commission, some mixed support for the commission but there's strong support that there's scope for a more practical industry focus to the commission's approach.

PROF WOODS: But when I read that, I wasn't sure - and in conjunction with your earlier statement about a new national model - whether the problem was the fundamental design of the National Commission or the output that the commission is producing. When I came to this one I detected that if its focus became even more practically oriented and if there was commitment by the states that they would implement uniformly, then that might actually solve a lot of your problems. So in going back to your earlier statement, maybe on that side with those changes, there would be less demand for a change in the organisational structure.

MR HARRIS: In health and safety, yes, and workers comp - - -

PROF WOODS: You're actually wanting to change what it does and how it is implemented at the grassroots level.

MR HARRIS: I think the previous comment was more directed at the workers comp - national perspective on workers compensation which NOHSC doesn't obviously - - -

PROF WOODS: No, separately.

DR JOHNS: Do the self-insurers have a seat or an input to NOHSC?

PROF WOODS: Only through ACCI.

DR JOHNS: In via ACCI. So this second dot point that NOHSC should also report on self-insurer safety issues, is it in a sense a reference you want to give them.

MR HARRIS: Yes.

DR JOHNS: What in particular is the issue there?

MR HARRIS: I think where that's coming from is looking at not only the self-insurance employees - it's referring to some of the best practice initiatives and standards that self-insurers have either for their own employees or for contractors that are on their sites. But that information isn't perhaps finding its way into the NOHSC process.

DR JOHNS: So in a sense you want your best practices recognised. It's more a matter of you having a voice in that forum.

MS WALLACE: And disseminate it. That's what's not happening.

DR JOHNS: Okay.

PROF WOODS: Are you concerned that those who represent you therefore aren't giving sufficient weight to your interests? I presume you can take that up with ACCI.

MR HARRIS: It's probably a line of representation that we haven't - - -

DR JOHNS: That's an unfair question.

PROF WOODS: We're the commissioners. We're entitled to do that.

DR JOHNS: Okay.

MR HARRIS: Yes, it is a line of representation that we do need to pursue. It's also a line - just talking about locally in Victoria, we are represented on most stakeholder forums but the one WorkCover forum we're not is the safety forum which we've continued to raise our concerns about because we do believe self-insurers have an added perspective that's of value to those sorts of forums, whether it's national or state. So we'll take that on to pursue our representation with NOHSC. We have had some discussions at a national level. I should say that our submission is certainly consistent with the National Council's submission that you would have received from Darryl Turner in Adelaide.

PROF WOODS: We did; a most able presentation, well crafted.

MR HARRIS: Good. Regulatory efficiency: there's strong support for the comment that regulated requirements do not always receive proper attention from government and sometimes issued and changed with limited regard for commercial impact. I would say in Victoria the consultation with stakeholders, including self-insurers - putting aside by comments about the safety forum - in other areas has improved. But there certainly have been occasions when changes have been implemented without going through what we would think would be a proper process.

PROF WOODS: Have you got sort of one or two seminal examples of that that you could put to us, and we'll accept that they're at the extreme for the purpose of making an argument. It would just help us understand the trade-off to the extent there may be any between safety as expressed in a particular view versus commercial reality. I'm sure you would have a strong support for safety as such but what you're arguing in those particular examples, no doubt, is how it is presented and what is required isn't well aligned with commercial imperatives.

MR HARRIS: And whether it's safety regulations or regulations in relation to self-insurance or workers compensation needs to satisfy a sort of value added test and certainly would be subject to external scrutiny. Again I must comment that has improved in recent years in Victoria. We've got some legislated changes that are

currently on the table where there's probably greater consultation than there has been perhaps or there has been certainly in the past.

There's some support there for saying that it would be useful to unions and other stakeholders to have more information about the inspectorate - the outcomes from inspectorate activity. But there's not any great complaints or issues with how the inspectorate in Victoria conduct themselves. Just in response, we've had some quotes of additional costs that are companies are claiming cost to self-audit next year between 30 and 60 thousand dollars each extra each year.

PROF WOODS: If you could in your final submission give actual examples where you can say company X or it might be a name but - - -

MR HARRIS: Yes.

PROF WOODS: Thank you.

MR HARRIS: We do support the current model which can use private accredited auditors.

PROF WOODS: The Queensland model.

MR HARRIS: That's also in Victoria. Apart from renewal we also have - they're not accredited by WorkCover, they're accredited by Jozans. We're talking about safety auditors which is an appropriate external coverage. Coming to coverage and definition of injury for the purpose of compensation, there's strong support for the proposition that access - it says "national scheme" but access to a workers comp scheme in general - should be confined to situations which an employer has control over. Again we think the more remote the control or even if there's no control over something that results in an injury and is compensated, that dilutes the impact in terms of the safety message that might be there for that company.

PROF WOODS: The journey to work is the main one you're targeting there or just one of many?

MR HARRIS: I guess it's also in the context of the recent prejudice decision in Victoria.

DR JOHNS: Perhaps you want a definition that creates, I guess, a stronger line between who's in and who's out.

MR HARRIS: Employment is the significant factor, or something along those lines. We think if an employer is held liable for - if someone happens to have a heart attack at work rather than at home, it deflates the credibility of the scheme. Where

you're trying to send a message to employers you can improve your safety and the benefit is you will then enjoy reduced costs.

DR JOHNS: I guess if you have a particular formulation it would be useful. If you don't - your sentiment is clear but if you have a particular - - -

MR HARRIS: That's I guess, the principle. If you have a performance management scheme for employees you want to reward them on the basis of their performance, not on things they've got no control over. We see the same principles - - -

PROF WOODS: Perhaps if you could illustrate with some examples of where clearly decisions that have occurred fall outside of that principle.

MR HARRIS: Redemptions: there's a strong support amongst our members for a redemption component to a scheme which effectively there isn't, or very, very limited in Victoria with the appropriate - whatever that means - entitlement or entry point.

PROF WOODS: That might be one of the aspects of Comcare that you might want to look at.

MR HARRIS: There's reasonable support if we are to have common law. The Victorian model of common law as it stands at the moment has got reasonable support from our members.

PROF WOODS: Am I taking from that amongst your members that although you might have an in principle preference to not have common law, there's an acceptance that common law does have a role to play, and provided access is predominantly for those who are sort of long-term, significantly impaired, that it does have a role and that members acknowledge and accept that?

MR HARRIS: There's mixed views but there's an acceptance, yes. I think that's a fair way of describing it, even though some members would actually support retaining; others would be supportive of removing it as an acceptance. There is an acknowledgment though that is does interfere with rehabilitation and the return-to-work process.

PROF WOODS: But if we're talking about somebody who is seriously injured with no prospect of returning to work, then we're not talking about return-to-work rehab but we are talking about life rehab.

MR HARRIS: Which comes back to the entry point for common law as to whether those people - - -

DR JOHNS: Where does common law add value in those cases? You can determine that without a court proceeding. Anyway, people seem to be wedded to their own scheme sometimes. I think people have been wedded and beaten down.

PROF WOODS: I think "acceptance" is the right term.

DR JOHNS: A familiar term in these proceedings.

PROF WOODS: Yes.

MR HARRIS: Elections can turn on common law. Compared to some states we didn't see that escalating legal costs are an issue for Victoria or for self-insurers in Victoria. Scheme sensitive cases: this is a work in progress. We're having some discussions with WorkCover as to - if a self-insurer has a claim that has the potential to set a precedent or attract media publicity, what sort of communications should take place between the self-insurer and the scheme. We do believe that self-insurers should have the authority to manage that claim as it's against them and not be - in the past there's been some suggestion that the authority may take over management and make decisions on that or try and exert influence over those decisions. So we'd certainly want to resist that.

DR JOHNS: So the authority maintains the right to be a party to a litigation when it chooses in a particular critical case. I would have thought of course it would but you're saying it shouldn't be allowed to.

MR HARRIS: No, we think our responsibility is to the authority as a regulator and is to report and to make sure we're complying with the act and the terms of our licence. They're not a coinsurer. We bear the full liability. The underwriter for excessive loss, if it's a significant claim, would have a say in the decision-making. But the authority is like a fellow insurer and should be seen differently than a regulator. In some states - Queensland, for example, you've got QCOM and WorkCover separately.

DR JOHNS: But if someone sues one of the companies, part of your association, it's almost impossible to exclude a government authority coming to the table as part of the litigation, isn't it? Is that what you're saying or am I misunderstanding?

MS WALLACE: No, what they're seeking to do is to be involved in the actual litigation management process.

DR JOHNS: Not the management side.

MS WALLACE: They've got every right to seek leave to appear.

MR HARRIS: "Should we appeal? Should we settle?" - and so forth.

DR JOHNS: You don't want to get involved in the actual management.

MR HARRIS: Historically there has been an occasion where there's been - - -

DR JOHNS: Yes, that's the distinction for me, good. Thank you.

MR HARRIS: Dispute resolution: there's quite general support for a conciliation type approach. There's a comment that there may be scope for some specialisation. At the moment conciliators will see the full range of matters and even though legal costs aren't a big issue for us there may be scope to cut them back.

PROF WOODS: At the national level, we're seeking your views on which models seem to be performing best, looking across the various jurisdictions.

MR HARRIS: Medical costs. We do see some benefit in companies having the right to direct, identify doctors with particular expertise, who can be familiar with types of injuries in the workplace, to provide treatment. I guess we do have difficulties at times with the lack of accountable - difficulties in influencing, controlling - not controlling - influencing some of the medical practises in terms of treatment and certification in particular. So maybe, faced with certificates, putting someone off work totally when we're fairly convinced we've got some very light, suitable duties that could be safely accommodated - - -

PROF WOODS: Any solutions that you come up with from that you can put in your final reports.

MR HARRIS: Yes. Similarly, rehab. I think there's obvious advantages for an employer being able to spend some time and effort selecting and inducting a provider into the business, so we think it's important to get early return to work to have that infrastructure in place before an injury occurs. Just on location, this is coming into - - -

PROF WOODS: Sorry, on rehab, because you're not paying premiums, you're not subject to the process through WorkCover, therefore you do choose your own rehab provider?

MR HARRIS: We do, and we'd want to continue to be able to do that.

PROF WOODS: So this isn't a plea for some change, this is a plea to retain what you've got.

MR HARRIS: In some states that's not - - -

PROF WOODS: Yes, I understand.

MR HARRIS: But certainly in Victoria we do choose. The last couple of slides are on contribution specifically, so two of the companies surveyed have made business decisions about location of entities, and one of the factors has been the contribution fees, the high contribution fees for some businesses in Victoria compared to some of the other states. As you know, there's a different formula in every state. The formula in Victoria is directly related to WorkCover's expenditure, in addition to specified costs. So self-insurers acknowledge that it's only fair and reasonable that we contribute to certain scheme costs, such as the conciliation service and the medical panels, the administration of self-insurance, but what we do have difficulty with is the actual method of how that's calculated, what we should fairly contribute.

That chart shows the red line - is the increase in self-insurer contributions since 99. We had negotiated a - that red line also reflects a freeze of what the prudence regulations had projected to increase at an even higher rate. The blue line is what we thought the increase was going to be, and the green line is getting down to perhaps what we think it should be. So this is work in progress. We've been working for some time with the authority in breaking down the costs and trying to allocate what we think and what sort of proportion should be attributed to self-insurers to improve the transparency.

PROF WOODS: One or two insurers who are multi-state have given us their contribution figures in each of the jurisdictions. If more members could give us that actual hard data, that would be helpful, and clearly that's not commercially in confidence. I mean, it's paid to a public entity.

MR HARRIS: I mean, simply in Victoria it's based on remuneration, and the other states are usually some sort of tariff rate or notional premium. What we think principally should govern contributions in Victoria and elsewhere is that there should be parity or fairness about the contribution, the recognition that becoming self-insured means we do obviously take on the risks so we shouldn't be still covering a risk in that formula. There should be some incentive or disincentive, based on performance, and recognition of safety initiatives, minimise subsidisation either to the insured group - - -

PROF WOODS: Sorry, just to go back on that one. If you have that last dot point, recognition of individual safety initiatives, then you're going to have to have demonstration of individual safety initiatives, ie audit of - so one goes hand in hand with the other. You can't get the benefit unless you do the demonstration, and the demonstration requires the audit. Okay.

MR HARRIS: Minimising any cross-subsidisation, either within our group or across to the insured employers - try and keep it a simple process. Where we are contributing to public good, we'd like to see greater transparency as to what proportion by contribution is going to, for example, advertising or other public-good type activities, and some forward planning. We are now getting up to a year's forecast, but beyond that - and wherever possible, such as conciliation and so forth, a user-pay model be applied, and if there are public-good programs, there obviously needs to be some effectiveness criteria or accountability so that they are demonstrated in their value.

PROF WOODS: Terrific. Well, thank you for the opportunity. We've gone through it beforehand, which allowed us to go through and identify areas that we wanted some elaboration on. That actually deals with my issues as we've gone through.

MR HARRIS: Yes. Thank you.

PROF WOODS: So that's been very helpful. Are there any sort of concluding comments that you wish to make?

MR HARRIS: We'll leave with you the work in progress report on the survey of our members, two copies of that, but I think the general view is that there's certainly scope to get benefit for self-insurance and beyond self-insurance by greater - whether it's consistency or uniformity between the schemes and across the country, but it does need a driving force and we'd certainly be happy to be and expect to be part of that as a stakeholder.

PROF WOODS: Thank you very much, and your ongoing contribution to this inquiry is very gratefully received. We appreciate the work that you've done and if you could take note of those other matters and incorporate them, either in supplementary bits of paper to this, or incorporate them in your final report prior to our draft. Thank you.

MR HARRIS: Thank you.

PROF WOODS: Yes. That's terrific. Thanks very much.

PROF WOODS: Could we call forth the next participant, the Australasian Faculty of Occupational Medicine. Can you please, for the record, state your name, position and organisation you are representing.

DR FISH: My name is David Gregory Fish. The position I hold in that organisation is vice-president and president elect representing the Australasian Faculty of Occupational Medicine within the Royal Australasian College of Physicians.

PROF WOODS: Thank you very much. You have prepared a very detailed submission for which we're very grateful. Do you have an opening statement that you wish to make that sort of draws together some of the key points?

DR FISH: The key elements that we consider are important are that any compensation system must bear in mind the primary objectives of what the compensation system exists for. All the discussion around definitions, around prudential requirements and so forth should bear in mind that the primary aims of the compensation system are threefold. As we see it, number one is to encourage prevention of occupational injury and disease; secondly, to provide treatment of injury and disease arising out of work and, thirdly, is to ensure the rehabilitation will prevent disability and handicap arising out of those incidents.

That's the primary focus of our submission. Being a medical organisation we don't pretend to have knowledge about prudential requirements or insurance premiums or anything of that nature, and anything we commented on that bear on those matters are only made from the perspective of their impact on those primary objectives.

PROF WOODS: Thank you. You've just clarified the first point for me. In your introduction you talk about a primary interest in the prevention, detection, treatment and management of injuries and illnesses caused by and related to occupation, and then a secondary interest in the effective management and work placement, so as to minimise risks to those persons and to others. I didn't see rehabilitation sitting in there as such. I was trying to read it into management of injuries or management and work placement of persons. So it is in there, it's just how you've expressed it in - - -

DR FISH: Yes, that introductory comment is about our organisation and what our broad objectives are, rather than the overall focus of this submission.

PROF WOODS: Thank you. That's helpful. You then go through a series of definitions and again that's useful because then when I read subsequently I understand precisely what it is you're referring to, although I noted that perhaps it was just a minor oversight that you say:

> state based compensation systems shall be read to include Comcare and the compensation system of the Northern Territory.

I'm sure you weren't meaning to omit the private sector scheme in the ACT.

DR FISH: No, that was an oversight.

PROF WOODS: I'm sure they won't feel offended by that. You then go through the situation now and deal with workers compensation in a number of aspects. In terms of recovery from injury, you make the statement:

> We submit that effective early intervention reduces long-term disability and handicap.

That's a common theme that we have coming to us and it's helpful that we can quote the Australian faculty in that respect. No doubt there is some chapter and verse of particular evidence that you were drawing on for that statement. If you were able to encapsulate that into a user-friendly form that we could draw on - as I say I'm not looking for a PhD thesis on the issue, but if we could quote you in this respect and then refer to a body of evidence in a brief manner, that would be helpful to us.

DR FISH: One of the key issues regarding that is that there are a lot of schemes in place that deal with the issue of early intervention. The question of effectiveness of those processes really is the question you were putting to me and not all early interventions prove to be effective, if I can put it that way. So I think the focus is on what are the effective processes and we'll certainly give you some more evidence on that in a subsequent submission, if you would like.

PROF WOODS: That would be helpful, without going to considerable detail. I understand how well resourced such organisations are, so we don't want to - - -

DR FISH: It's volunteer work.

PROF WOODS: Precisely. So I'm conscious of placing demands on you in that regard.

DR FISH: Sure.

PROF WOODS: There are two points: one is that the forms of treatment may not be effective but the processes are - only intervention is a common mantra but when you look at, system by system around the various jurisdictions, some of them have delays built into them, not deliberately but through the process that they go through to either recognise it as a claim or at what point you bring in the rehab provider or how quickly an employee must notify either the insurer or the employer. There are

all sorts of processes that inadvertently intervene in what generally is considered to be a fundamental principle. Thank you for that.

Common law again you make the point that its "slowness can delay recovery and act against minimisation of disability and handicap." I think that's sufficiently clear on that one. You do make a point though that we may draw on:

> The availability of common law for pain and suffering does not improve health outcomes. In fact the opposite has been shown in some jurisdictions.

Then you make reference to more detail later. That's an important point in considering that issue. The previous participants said that there is recognition amongst an employer body at least, or an acceptance of there being common law in some cases, but that acceptance needs to be measured against a statement such as this that in your view there is some evidence that doesn't in fact improve health outcomes.

DR FISH: The access to common law is a vexed question. It's really a question of - the purpose of it - if it is to punish employers for negligent acts there is some point to that but its very slowness and if I can say its very random nature of the outcomes in many respects actually mitigates against that. We don't think it's particularly effective in providing an incentive to employers to institute preventive programs. Secondly, common law does have a point which could be undertaken by other mechanisms of providing lump sums for people who require significant change of lifestyle or change of occupation through processes of setting up their own business, for example, also for them to be able to do so.

So there is a point to lump sums being available. Whether common law is the appropriate mechanism, we don't believe so, and whether there should be some statutory process you would favour saying that where a person needs a lump sum to set up their own business and that is a reasonable expense, that that should be dealt with through that statutory process. That's what we would rather see, and then it is a sort of generally available process for people in that same circumstance, not dependent on the vagaries of the common law process.

PROF WOODS: Do you want to comment any more on that or is that sort of consistent with - - -

DR JOHNS: Yes, although everyone seems to think that a lump sum would be good in setting up a business. The worst way to start a business is with a lump of money. You just lose it. I'd rather have the skills to run the business first, but I know it's just in the conversation. Yes.

DR FISH: The lump sum is required for infrastructure.

DR JOHNS: Yes.

DR FISH: For training.

DR JOHNS: But it's a means of moving on.

DR FISH: Yes, it's a means of getting to those ends abroad, having infrastructure and training to carry out their own business.

DR JOHNS: Yes.

PROF WOODS: Are you at one with the legal fraternity in your views on this?

DR FISH: I don't believe so. You need to ask the legal fraternity.

DR JOHNS: Which brings us to that other paragraph where you're recommending - where there are ground-breaking attribution of cause - say this case where bowel cancer was related to stress - should be subject to review by an independent medical panel, and that's the sort of thing that comes up in a court of law and is said to be ground breaking. How do you set something up where a medical panel somehow says, "Well, we want to rehear the case and we reckon it's not determinate?" It's pretty hard to provide a different forum that overrides the court that is said to have greater insight.

DR FISH: There are two issues here. One is whether the decision should have been made in that legal forum anyway is the first question. The second is the process of review. Our contention is that medical questions regarding the linkage of work exposures, work processes to medical outcomes, particular types - in this case, cancer due to stress should be decided by medical processes, not legal processes, and that there should be - there are many models of that within the Australian compensation jurisdiction where for example in Victoria, medical panels is the process that deals with defined medical questions, and most other jurisdictions, if not all, in Australia have some process similar to that. However it may not be called a panel, it may be called a tribunal or whatever it's called.

PROF WOODS: A collective body.

DR FISH: Yes, so we - - -

DR JOHNS: In some ways, I mean, in one instance you have lawyers cross-examining medicos who are sitting at the bench, in the other case you have lawyers sitting on the bench cross-examining medicos as witnesses. So they're both

in there trying to get to the heart of the matter I guess.

DR FISH: I suppose it's a question of whether the decision at base is made on the basis of all available scientific evidence and opinion or it's made on the basis of the selective presentation of scientific evidence and opinion made within a legal setting. Now, you could say that's the fault of the people presenting the evidence, that they don't bring that forward, but it's a fact of life that the witnesses called by either side in the legal process will be selected for the way they are known to have expressed their views in the past, and we don't believe that's a helpful or appropriate process when the vast body of opinion is ignored for the extremes of opinion, if you like. We don't see that that's useful; a difficult one.

DR JOHNS: If you had a win, you'd consider it was scientific; based on scientific evidence but, yes, it's an old but a very good debate. I understand that.

PROF WOODS: Where you're talking about prevention, you make the statement:

> AFOM considers that prevention of injuries should be the first consideration. Strenuous effort needs to be made to encourage workplaces -

and then you say, "particularly medium-sized workplaces." Now, we've heard a lot of debate about the capacity of small business and micros to be adequately trained and educated in workplace safety and the like. You've targeted medium-sized workplaces. What lies behind that?

DR FISH: I suppose we would have to go back and see if we do have any evidence to support it. It is an anecdotal statement, number 1. Number 2, the base of that anecdotal statement is that our collective experience as an organisation is that medium-sized workplaces seem to have difficulties setting up systems which are suitable for large workplaces, as your previous presenter was talking about, and have imposed on them requirements which make it difficult for them to do it on virtually an ad hoc basis, that the much smaller and micro companies get away with. They seek advice when it is needed and as it is needed.

So the medium-sized employer is in the situation really of having to decide whether to set up expensive systems or of seeking ad hoc advice and assistance when it's needed, and we don't think there's - - -

PROF WOODS: So there is a transition somewhere between - - -

DR FISH: Yes.

PROF WOODS: - - - what you expect and get from small, and what you expect

from large.

DR FISH: Yes.

PROF WOODS: You're saying that they're not quite deciding where they are.

DR FISH: No, and again anecdotal evidence is that some of the most severe individual injuries we see that seem to occur within those medium-sized workplaces and where the greater difficulty of meeting regulatory compliance occurs, meeting regulatory requirements.

PROF WOODS: Very good. You make a plea for funding be provided to one or more research organisations. What's your view on the quality and availability of data for research at this point in time?

DR FISH: We haven't specifically addressed that, so I'll express a personal opinion in this matter.

PROF WOODS: Please.

DR FISH: It's hopeless, is the short answer. There's very little good information available. We do have a lot of information about the workers compensation costs and outcomes of workers compensation. We don't have much about the effectiveness of prevention programs that have been put in place by various employers and employer-type organisations. We think that there's - really there's very little data on which to base most of the recommendations that need to be made in those areas. We are very good at looking at overseas information regarding chemical X causes a particular cancer. That's great; of looking at the necessary exposure levels to cause that.

Then going into the question of how do we minimise the exposures to that chemical within Australian workplaces is - suddenly things start falling apart. We don't have good data on that. So that's really where - it's the practical application of prevention issues within the workplace that the data is really lacking in our view.

PROF WOODS: Who is best placed to gather the data is I guess a question for us.

DR FISH: There's two aspects to that. One is sort of overall global data on what's being done and what's effective, and I don't know quite honestly because I think the National Occupational Health and Safety Commission should be pushing that issue harder to have more generally available information on those prevention initiatives. So it would seem a national body of that nature should do it.

DR JOHNS: In your view though, where would you go and look? I mean, would

you gather together OH and S inspectors and say, "Well, you blokes ought to know," or would you go to other occupational - those dealing in occupational medicine or insurers who manage risk assessment - I don't know - or all of the above.

DR FISH: Can I just ask what's your question at this stage? I'm unclear.

DR JOHNS: Sorry, yes. I guess everyone wants to set up a committee to say, "Gather some data and analyse this." It's a nice recommendation, but I'm not even at that point. I want to say who would gather, who knows about this stuff and who is in the best position to know what's good and what isn't?

DR FISH: I think there are multiple stakeholders needed here. We're not the only professionals in occupational health and safety, and there is a big body of health and safety professionals in Australia, and so I think that would be - one group I think should be involved, and they would nominate who of the membership should be involved in that. I think that those who are impacted by the disease need - by the injuries and diseases - need representation, and I'm strongly in favour of there being work or union representation or some representative of the people who are potentially at risk because they're, after all, the people we're trying to assist through this whole process. We don't want to forget that, and those bearing the costs need to also have a say. Whether that's employers, government, employer representatives, I think they need a say as well in how this process is put together.

DR JOHNS: Do, say, self-insurers not seek out these people? Get the best information from them? I presume these dialogues happen - - -

DR FISH: Multiple levels.

DR JOHNS: - - -all around the place. Yes, they seek out advice from - through the occupational health and safety processes that exist in whatever jurisdiction they're operating in and since that's largely a process that involves employer-employee consultation with advice from professionals that's largely the way the process is carried out, in my observation, within Australia. But for you it doesn't seem to end up with a pool of readily recognisable and accessible data.

DR FISH: No. There's - if I can just go back a step there's the question of nationally available data and secondly there's availability of research and I think they need to be separated in that distinct initiatives can be individually researched appropriately and that information disseminated through both professional and general occupational health and safety forum, so they're more generally available. So while everyone gets hung up on the national data collection side of it - - -

DR JOHNS: Yes.

DR FISH: - - -because we're having this discussion here, a lot of useful information can still be generated by appropriately targeted individual research efforts which don't need a national data approach. You can do a lot just by targeting individual issues. In Victoria we've had the example of the Victorian WorkCover authority taking on the national - taking on a large back campaign and - to try and prevent disability from back pain. There was a recognition that the ergonomic interventions, all the safety interventions, while a necessary and good idea, had not resulted in significant reductions in the incidence of reported back pain and the amount of disability and that a new approach was needed. By taking on that back campaign and setting aside funds for research, which is now published as the outcomes of that, that's generally available and useful information. So targeted interventions and research of that sort, I think, are much more required - - -

DR JOHNS: Yes.

DR FISH: - - -and more likely to be useful and a lot of agonising over the best national data collection process, which has been talked about for over 25 years that I'm aware of - as long as I've been involved in this aspect of medicine we're yet to get any good outcomes. So I see good outcomes occurring in the targeted research area all the time, so - - -

DR JOHNS: So to add to that, give me a sense of how many medical schools have a significant base in occupational medicine. I mean, are they each - is it a significant area around Australia?

DR FISH: We'll step back I think. I'm not sure that that relates to the data collection side, but occupational medicine in Australia is taught - I don't have the data on me but my - my recollection of it - an audit was done about two years ago as to - two or three years ago as to what the status of that was - is that most of the medical courses don't have a targeted teaching of occupational medicine within their curricula. There are very few that do. Most have targeted teaching on public health which, in most cases, includes anything from a few hours through to multiple hours specifically on occupational health, occupational medicine issues. So it's usually incorporated within medical skills, the teaching of medical undergraduates within the public health stream of teaching.

As an aside, I work part-time at Monash University and do some undergraduate teaching in public health and occupational medicine there and there is a move at the Monash Faculty - there is a change occurring at the Monash Faculty as it has occurred and is occurring throughout most of the universities in Australia towards a change of curriculum approach from specific discipline teaching - anatomy, physiology, biochemistry, pathology - to an integrated problem-based learning approach throughout the entire curriculum. The discussions that have gone on regarding the development of that curriculum have recognised the need for a greater

input of a public health component to the teaching program and including in that, occupational health teaching. So population-based health teaching is assuming greater importance in the curricula for medical undergraduates in Australia.

DR JOHNS: But these are the specialists, presumably, who will have to undertake the research that you would find necessary?

DR FISH: Well, it's undergraduates.

DR JOHNS: Yes.

DR FISH: There are also postgraduate programs in Australia and again I don't have my fingertips to the exact number but there would be the order of six or eight universities around Australia teaching either occupational health and safety or teaching specific elements of that, whether it be safety science, ergonomics, medical aspects of occupational health in various degrees around Australia. So there is postgraduate - it's largely seen as a postgraduate subject rather than an undergraduate specialisation. It's seen as something that is done postgraduate.

DR JOHNS: Good. Thanks very much.

DR FISH: Have you got any more - - -

DR JOHNS: No, no.

PROF WOODS: No, that's been excellent. Are there any other matters that you want to draw to our attention? We note that you have various references to the community fund and other such matters but I think they're spelt out sufficiently in the document.

DR FISH: I suppose just to make a comment about the community fund, the reason that we have come up with that is that we're trying to balance - and there may be other ways of achieving this balance - between the needs of the injured person who needs money to live, needs medical treatment or other treatment and needs to re-establish their life, and that of the employer who is being held accountable for things which are not necessarily preventable. We've used the example in the document of a lot of musculo-skeletal injuries that are accepted under workers compensation having a significant contribution from aging and long-term activities rather than the singular event that causes the onset of symptoms. While we recognise the need for the individual to be compensated, treated and looked after, there's a lack of incentive for employers to do much about it in terms of prevention because it's not preventable in the strict sense. Therefore they're being held accountable through their premiums to - for things which they shouldn't be, in our view, and it is really a community problem of the aging population and what should be happening with

aging workers.

PROF WOODS: The contributory negligence, is that of getting old?

DR FISH: Yes. So that's why we've recommended the community fund. If there are better approaches to it - as I said at the start we don't pretend to be experts on how the insurance system should be set up, but as long as the primary issue of giving an incentive to employers to do something about what they can prevent and to not waste their time or angst over the injuries that occur that they can't prevent, that's where that is coming from.

PROF WOODS: Other than to be aligning duties, having recognition of any levels of frailty of the workforce.

DR FISH: That's certainly an alternative approach, though we would need to be aware of the equal employment opportunity acts - - -

PROF WOODS: Yes.

DR FISH: - - -and disability discrimination acts which also impact.

PROF WOODS: Yes, there are multiple factors to take into account, but we read that proposal with interest.

DR FISH: Okay.

PROF WOODS: If not that proposal there is an underlying principle there that's really reflecting on it.

DR FISH: You've mentioned one issue that you'd like us to follow up on and that is the issue of how early intervention contributes to eventual recovery. Are there other issues you'd like us to follow up on, either with some evidence or for further consideration.

PROF WOODS: Given your organisation, you know, it's a powerful statement in itself but if we can expand on that, there are no others that immediately came to my mind.

DR JOHNS: The difficult one to quantify is - for me the interest is what skills you bring to the business of keeping workers healthy or returning them to work is a resource question. So it's important that we know how many of you are there and how many times in a sense you don't get to play a role.

DR FISH: I can tell you how many there are.

DR JOHNS: In a sense, are you a bit player - - -

DR FISH: There's about 400 of us throughout Australasia, including New Zealand. So we're not a large organisation.

DR JOHNS: I wonder if you see 5 per cent of the entire pool of injured workers, for instance, or - - -

DR FISH: A very small percentage. We would admit that because the vast majority are dealt with through general practice and other specialists. One of the roles we see us having is that like all specialties it shouldn't be just to usurp the role of the general practitioner. It is there to assist the general practitioner when they have a problem, and the employer when they've got problems, and to provide education to those forums as well. So we don't see that we're going to end up seeing every injured worker in Australia. That's an impossibility. There is a model in Sweden that comes close to that where they have injured worker clinics. Everyone is sent to those, but we don't see that that's viable in Australia without a vast change of culture, political upheaval, decimation of the AMA and numerous other things that wouldn't happen.

DR JOHNS: That's the next inquiry.

DR FISH: Numerous other things would have to happen because it's not part of the culture of Australia to go that way.

DR JOHNS: Thank you.

PROF WOODS: We appreciate your time.

DR FISH: Thank you.

PROF WOODS: We will have a short adjournment for morning tea and then resume.

DR WIGGLESWORTH: Eric Wigglesworth is my full name. I'm a self-funded retiree. I have the honorary position of a senior research fellow at Monash, but that's honorary - honorary of course meaning unpaid.

PROF WOODS: Yes. I understand that. You have presented us with a submission. Do you wish to speak to the submission in the first instance?

DR WIGGLESWORTH: If I may do so, yes please, sir.

PROF WOODS: Thank you.

DR WIGGLESWORTH: I sent you a written submission, but since I wrote that, I've done some other work, and I've brought with me this morning three pieces of technicolour - but my great antiquity prevents me from using some of the modern devices around, so you're back to bits of paper.

PROF WOODS: We are in like mind. It's all right.

DR WIGGLESWORTH: Thank you, sir. On the pink piece of paper - I may take you through that one first. I've long had the view that there is a culture of accidental injury by state or by jurisdiction. That means that if you have a high rate of motor vehicle accidents, for example, you also have a high rate of occupational injury, and, and, and, and, and. Recently I have discovered that all the American data, unlike the Australian, is available on the web, and I've downloaded it. What I did - I found the five states with the highest rates - mortality rates, these are - of road traffic accidents and tabled them. They are: Mississippi, Alabama, New Mexico, Arkansas and Wyoming. The US average is in the middle. The ones with the lowest mortality rates are at the bottom. If you look at the successive column, you will find that motor vehicle traffic accidents are the highest in those five states; that all other injuries are highest in those same five states; that drowning injuries are much higher than the American average in those five states, as are falls, as are burns.

The unintentional accidents by using firearms is also indicative. If you look at the bottom five states - 0.1, 0.2 – very low indeed as compared with places like Mississippi, which is ten times - twenty times as much. The occasional one is the children under 5, where again, one wouldn't want to be a child in Mississippi. You would be much better off, for example, if you were in Massachusetts, again by a factor of almost 10 - and the same with all other injuries. The interesting one - I've done a lot of work over the years on accidents at railway crossings. Believe it or not, the rate of collisions at railway crossings - these are not deaths: they're collisions - in the five states, with one exception at Wyoming, is higher in those five states as is in the other ones. By contrast, and on that note, the cancer death rate and the heart death rate varies but does not show the same pattern.

So my fundamental thesis on which I'm asking your indulgence this morning is that there is in some states a higher level of occupational injury than in the same industries in other states. This would be useful if we could find out what those numbers were. But the present plethora of compensation schemes that abounds in Australia - the various restrictions there are on them mean that we're comparing mousetrap cheese with Edam, with Gorgonzola, whatever - they're all cheese, but they're very, very different brands. On the green piece of paper, if I may draw your attention to that, you'll see what can happen in some cases where there are good research results and when there's good data. What I've done here is taken the road traffic death rate for Australia from 1948 to 1970. Under that time, I'm in print as saying that that mortality was out of control.

When you can predict how many people will be killed simply on the basis of the number of motor vehicles that there are on the road and the number of people that there are for those motor vehicles to kill, then that's an uncontrollable situation. So it remained until 1970. What happened in 1970? You can see, sir, on the third - the yellow piece of paper, at the top. In 1970, the Royal Australasian College of Surgeons did some work looking at the death rate in the Snowy Mountains scheme under Bill Hudson, and showed that he no longer lost his engineers falling over the edge of the mountains when he fitted seat belts to their vehicles. So the college campaigned vigorously for seatbelt use, and in 1970, the Victorian government passed mandatory seatbelt legislation. And because - and this is my point, sir - because there was good, adequate, comprehensive data for the whole of Australia, every man and his dog was able to do a piece of research saying, "Does this work?"

David Andreassend, David Burke, John Lane - all the big names are there, including of course, the one at the end whom I'm far too modest to mention. But it showed quite clearly that this is an effective piece of legislation. Once you know that, the road safety research community really gained strength and went further down the track. From that point onwards there has been a steady and continuing decline in road traffic accidents, largely due to the influence of the road safety research community, some of it based at Monash - not all of it. That same formula - the number of deaths and the number of vehicles - can be applied not only to Australia as a whole but also to the individual states. In the middle of that page, you'll see what happens when you look at the figures for the actual states. Three of them are in red and they're higher than the Australian average, and three of them are in black and they're lower than the Australian average.

When you look at an occupational injury, there are only a limited number of studies as to how they work. But if you look at a paper published in 1970 you will see three states are in red, because they're above the Australian average - absent from work for one week or more - and three are in black. It's the same three states. That work was repeated by me in 1990, this time in two stages: both for absence from work for one week or more and serious injuries, absence from work for six months or

more. Again, with one exception, the same three states are high and the same three are low. The thrust of what I'm offering this morning is that if we haven't got adequate data then we can't measure changes. If we can't measure changes, we can't quantify and document any improvements that come to mind, and it's time that we got out of the 19th century and went into the 21st century.

I hope that the commission will use - influence its power to generate just that sort of activity. If we had comprehensive compatible data, for example, we could be able to look - off the top of my head, the construction industry, notorious because it has such a high level of injury. Are the levels of injury in Queensland different from those in Victoria? I'm not saying in which direction they are, but I'm willing to bet that they differ. If we could first quantify that then we could look at why. Is it because of work practices? Is it because of legislation? Is it because of other factors? Drowning, for example, is very low in most of Australia as compared with China because we have the Herald Learn to Swim campaign, which took off successfully. Almost all kids - certainly all my kids - learned to swim by the time they were eight. In some other countries that doesn't apply.

So it can be legislative initiatives, it can be public health initiatives, it can be all sorts of things - but until we know the numbers first, we're hamstrung. That, sir, is the thrust of what I want to say. Thank you for listening to me.

PROF WOODS: Thank you, and thank you for your submission as well. You raise a number of supporting arguments in that which we've taken note of. One of the issues you raise is that employers and self-employed aren't covered in many respects, and therefore data is difficult to capture for them. What's the way through in those situations? I mean, a lot of self-employed who do trip or slip or sprain during the course of their work - apart from cursing themselves and then going to trundle off to the GP and get treated under the Medicare system, there's no way it would show up as an occupational injury, and yet it may well have been in their office, which may also have been the study or the back bedroom.

DR WIGGLESWORTH: The present system, sir, is exactly as you report it there. The system needs to change. Business and industry report regularly and continuously on a variety of things: how much production is, average weekly earnings, and, and, and, and. That is documented and recorded and reported by the Australian Bureau of Statistics. Now, I see no reason whatsoever why to that list there should not be added "List of occupational injury". It does not have to be written as public information except in tabulated form. Plenty of stuff that goes to the ABS already is confidential and remains confidential. The ABS have a capacity for analysing, tabulating and publishing information that is totally outside the competence of the National Occupational Health and Safety Commission. It's hardly my field of interest but certainly the experience and the work I've done with and for the ABS over the years has always been marked by a great deal of goodwill and

helpfulness on their part.

PROF WOODS: You mentioned by way of your example in your opening comments, the construction industry where there is a large number of self-employed as - they used to call them subcontractors but they don't any more.

DR WIGGLESWORTH: In my language they still do call them - - -

PROF WOODS: The subbies. We know who we're talking about.

DR WIGGLESWORTH: Yes, the subbies.

PROF WOODS: Primary industry is I guess another one that fits into that category where there is a great deal of self-employment is the transport industry, the trucking industry.

DR WIGGLESWORTH: Absolutely. So there are two points: first, the fact that some small groups of people mightn't be as good, it does not mean that we ought not to go ahead on the broader brush.

PROF WOODS: No.

DR WIGGLESWORTH: The second thing, to the best of my knowledge and belief - and you can correct me if I'm wrong - they are required, I think, all the subbies to take out self-insurance of some sort or another. The self-insurance part of that insurance policy could be the collating of information by the insurers themselves who, I would think, have automatically got some records because of the insurance claims that come their way, and I would think that would be the source from which that information could be gleaned.

PROF WOODS: You make reference to - or you identify a criterion that you would prefer as absence from work of eight days or more because that sort of signifies some seriousness of the injury, I guess. Is that a criterion that's based on pre-existing administrative practice or is it - I mean, if it's a time period that aligns neatly with what is already collected then the additional burden will not be great. But if it's a period that is out of alignment then creating yet another cut of reporting would compound the cost.

DR WIGGLESWORTH: Again, two parts to my answer, please. The first is it is intended to be a figure that's commonly available, a figure that's in common use. Before the National Occupational Health and Safety poked its nose in, the different state collections were based on different criteria. If you lived in Queensland or Tasmania or Western Australia, those ABS officers reported injuries resulting in absence from work of one day or more. In Victoria and South Australia the criterion

was one week or more. In New South Wales they used the old-fashioned criterion of three days or more. That was introduced by the factory inspectorate in 1833 in the first Factories Act on the grounds that if you were absent in those days for three days or more then you've lost your job because the employer won't hold the job open for you, so you've got to be seriously hurt, and that was the criterion that was used by the factory inspectorate.

As I say, it was repeated in New South Wales alone, amongst the various states of Australia. But one week or more is a reasonable figure, I think, it's a convenient figure, and it's one that to the best of my knowledge is gathered at the moment. Both my studies have been based on a one-week criterion.

PROF WOODS: I assume it's for illustrative purposes but some of your examples I have a little trouble with: one where you're talking about eye injuries and you're saying that the proportion of eye injuries can legitimately be described as being anywhere between a massive 17 per cent - and then you say - of all occupational injuries to a tiny half of 1 per cent. Well, I wouldn't have thought that's actually strictly correct. If you said it was 17 per cent of all occupational injuries with a duration of absence of one to seven days then in fact that is correct and in the latter case but if taken into account for injuries lasting for more than four weeks then it's half of 1 per cent then that's also correct. But you couldn't correctly say that it's a massive 17 per cent of all occupational injuries.

DR WIGGLESWORTH: Well, I don't say - - -

PROF WOODS: But within the category you could but - - -

DR WIGGLESWORTH: I don't say it but you've picked on one of my sort of sore points. I objected in the strongest terms to a manufacturer of safety spectacles saying, "Did you know that 17 per cent of all injuries are eye injuries. Buy your safety spectacles from us." That sort of - those sort of lies, damned lies and statistics, if I may get back to that one, and it depends on who you are as to which figure you use and that figure was used, I think, quite irresponsibly by that particular manufacturer, and I won't - no, I won't - - -

PROF WOODS: I think if you'd attributed it to somebody it would have helped me.

DR WIGGLESWORTH: Yes, it would have helped, yes. Thank you for the question.

PROF WOODS: Because it seemed to be illustrating exactly the wrong point and I now in that context understand it. Perhaps you could then help me with one more which is at the front end of your submission because you say that:

> In 1905 to 1909, for each of five deaths from infectious disease there were just two from accidental injury; in 95-9 for each five deaths from infectious disease there were 16 deaths from accidental injury.

That's constructed in such a way as to appear large and alarming but when I work through the figures I find two things: one is that infectious disease deaths per 100,000 have in fact come down, I think, roughly - if I can work through the figures - from about 150 per 100,000 down - I think it comes down to about 15, if I can work through your sums, and accidental injury has come down to about 25, but it's also come down. I was just having trouble converting your statement into what's actually happening because in both cases it's come down, sure, infectious disease deaths have come down more and that's a valid point.

But then when you look at what's in accidental injury and your figure here is a brilliant demonstration of it, a large component of accidental injury is motor vehicle in 95-9, and happily it has stabilised compared to the trend that was following up to 1970. But the component of accidental injury that was motor vehicle back in 1905-09 methinks was - - -

DR WIGGLESWORTH: Zero.

PROF WOODS: Precisely. So you'd really have to take out motor vehicle injury out of the accidental injury to get some comparability. All I'm saying is, you know, data is good but what you do with it and how you use it, one needs to be very cautious of.

DR WIGGLESWORTH: You have the advantage over me there, sir, because you're not writing the submission, I am. I've got two choices: one is I can give you the entire table which I have in five-year increments from 1905 onwards and send you the whole lot for you to plough through though which is simply over-swamping you with paper unnecessarily, or I can abbreviate it, and in the abbreviation I tend to lose some of the points. The main point I'm making, sir, is in one area we have good research - - -

PROF WOODS: Yes, yes.

DR WIGGLESWORTH: - - - and in the other we have less and that's the thrust of - - -

PROF WOODS: I'm happy with that point but I could get to it by looking at just what's happening in each case and allowing for some other factors that come in, rather than this gone from five to two, to five to 16 which when I do all the adjustments I come to the conclusion, well, maybe it's not quite that dramatic.

DR WIGGLESWORTH: Point taken.

PROF WOODS: Yes, thanks. It caused me a little time to wander through but I enjoyed the exercise. Your central argument about availability of data and therefore that being a powerful force for identifying research opportunities and consequent reform and improvement is taken. I mean, we have no problem with that. Dr Johns.

DR JOHNS: Yes, I guess we're all a bit intrigued as to why after many, many years of the NOHSC process we appear not to have sufficient comparable data that satisfies yourself and others.

DR WIGGLESWORTH: I think the McKay report will give you the answer to that one. When Bernie McKay wrote the report on the review of Worksafe he made the point that what's missing in the NOHSC set-up is expertise. Tripartism is not a value basis, some of the sorts of things, like research, that NOHSC should have been doing. An analysis of data and collection of data is another one.

PROF WOODS: But can't they commission it? I mean, there's a secretariat of NOHSC as well as the tripartite membership. So can't they work out that that's - - -

DR JOHNS: I thought that's what they did to some extent. The published data, you're saying it's not sufficiently comparable?

DR WIGGLESWORTH: No, as I say, it's different types of cheese and you can't really put them all together because of the differences. I had hoped that NOHSC would have tackled that and I think if the first chairman had been Richie Gun, instead of Jim Brazel, then I think Richie would have done that and we would now have a decent set of - - -

DR JOHNS: We read Richie's letters to the editor every other day.

DR WIGGLESWORTH: I haven't seen him for many, many years. Certainly both he and I were candidates for that job and we swapped notes as to what we would like to do and in both our wish lists was a decent set of comprehensive national data.

DR JOHNS: The US data is fascinating because those measures of accidents and the two groupings are almost a measure of development, you know, the north-east states, New York, Connecticut, New Jersey et cetera versus Alabama and New Mexico.

DR WIGGLESWORTH: May I congratulate you on your observation. The only thing that so far I've found correlated with the top and the bottom is the year of

statehood.

DR JOHNS: Yes.

DR WIGGLESWORTH: The ones at the bottom were all granted statehood in 1787 or 1788, I think it was. All the ones at the top were granted after 1850. So it's exactly your - it's exactly the point that I think - - -

DR JOHNS: But it's a substitute measure of development and education, if you like - - -

DR WIGGLESWORTH: Yes.

DR JOHNS: Sophistication et cetera et cetera.

PROF WOODS: I do hope you're not going to go on and do the Australian parallel.

DR JOHNS: I will, I will, oh yes.

PROF WOODS: Can that be struck from the record.

DR JOHNS: I'm a Queenslander. Where are you from? No, but I guess my point is so it's - data is a powerful tool but, in a sense, we're looking at sophistication. People get to a point in their development where they've developed Wyoming and then they say, "Well, okay, now we can settle upon the next issue," whether it's seatbelts or safety at work or whatever. So these things there's a sort of a hierarchy of needs. Isn't there?

DR WIGGLESWORTH: Absolutely, without any question of doubt. The best information that I know of is some information put out by Gordon Athley when he was founding Professor of Occupational Health and Safety at Ashton in Birmingham. He looked at deaths in the running of railways on the one hand and deaths in mining on the other. From 1850 to 1900 there were pretty well, both of them, even stevens. Then both of them went down like this. Now, mining is totally different from the running of railways and yet they're got run - run around in pretty well - in parallel. His thought was exactly what you just enunciated, that there comes a stage in there where you are determined to get yourself organised, whether you want to build a railway to whatever - what - and I'll come to another example in a moment. You're determined to do something and you don't care what the price is. But then, when it's done you say, "Okay, the price is too high," and so it goes down and that's exactly the point you're making.

The only Australian example I know of is: Clem Jones, when he was Lord

Mayor of Brisbane, said, "I will sewer Brisbane in three years," and he did. But if you look at the mortality data for occupational - for occupational injuries in Queensland in those three years - and I was teaching at Ballarat at the time - the peak goes up just like this and then comes down again. So I think the determination was there and we're going to do it at all costs and there was a cost in lives, as that group so happened. But then it's now come back and I think - so I think that your observation, I think, is one with which I would most strongly support.

DR JOHNS: The extent to which this occupational injury is a problem is then, in a sense, in the eye of the beholder.

DR WIGGLESWORTH: Not if you're injured.

DR JOHNS: No, no, it's a real problem but the extent to which governments, the society considers it important enough is again this measure of development, if you like.

DR WIGGLESWORTH: What a fabulous hypothesis, if I may interrupt. Wouldn't that be a wonderful thing to test and look at and change and change through, because once - if that is true, and I personally agree with you entirely - okay, what factors are there by which we can change the philosophy? How do we, in effect, work around it? Do we use a media campaign, which has been pretty ineffective in the past, in those cases? Do we use some other form? Do we use financial benefits? How do we get out of the problem? How do we address it? Until we know its dimensions and its features we're really - we're just shooting in the dark.

DR JOHNS: But it is also a matter of choice.

DR WIGGLESWORTH: Yes, absolutely.

DR JOHNS: This is not Sweden. We don't go for total solutions and we sort of pick and choose as we go along. So I guess our role is to try to get there to - to give strength to those whose interests it is to try and minimise harm to be able to do so.

DR WIGGLESWORTH: Yes.

DR JOHNS: But the broad consensus on what is acceptable is more a political issue, I guess - as a policy issue, beyond us.

DR WIGGLESWORTH: It's very hard to know. We did some work last year again, looking at drowning in China as compared with Australia, where we have swimming pools - I remember the Herald Sun thing was enormously successful here and Joan Ozanne-Smith, who was in China delivering a paper on precisely this thing got an enormously popular - strong reception. Her thought was that China should

copy Australia and build pools and teach its kids to swim and then your drowning rate, which is 10 times higher, will go down. And that went down very well indeed in the media - the local media picked it up. Now, what will happen I just don't know. It is, as you say, a political issue, and I think, if you're in politics, you have to decide on the benefits and the dis-benefits.

If we spend money on swimming pools what happens to our programs for hospitals, for SARS and all the other bits and pieces that come along and where do you put your priorities and how much money do you have? So I think again you're right but our political masters take charge. Again my point is that is that if you want to influence politicians you can say what you like, "I think this, I think that, I think the other," and the politicians will say, "Give me the numbers" - - -

DR JOHNS: Sure.

DR WIGGLESWORTH: - - -and that's what I'd like - is to be able to do, to give numbers.

DR JOHNS: Well, do you have a particular priority for NOSHC? I mean, if you were to direct their research effort for the next year or two what would you direct them to do, given the restraint on resources et cetera et cetera?

DR WIGGLESWORTH: No, I think if you look at the paper by Quinlan sometime last year - Michael Quinlan of course was strongly associated with it - and he said to all intents and purposes they're a dead duck and I tend to agree with him. You know, they had been emasculated first by Peter Reith and now by Tony Abbott. Their resources are pretty well nil. Even their library, I'm told, is under threat. So I really think that they - they certainly don't have the depth of expertise that would enable them to sit down, roll their sleeves up and say, "Okay, this is the information we want, this is how it should be categorised, this is how we're going to collect it, and, and, and, and" - in the same way that the Bureau - ABS - would have got that expertise at their fingertips and they use it consistently. So I'm inclined to think that the right solution is to go back to where it came from. The ABS produced it in the years before NOSHC and both my studies are based on ABS data and I would see no reason why, in the present scheme of things, they should not be the vehicle for the restoration of what are much needed data.

Now, that is a political issue about which I am totally unable to comment. It's outside my field. I'm shooting off on opinion rather than established fact. It might cut against the grain. It might be quite impossible to implement. But in the need for getting some comprehensive, decent data in the shortest time available my instinct is to go back to the people with whom I have worked over the years and of whose ability I have the greatest respect.

DR JOHNS: Thank you.

PROF WOODS: Very helpful. We understand the data issue and your evidence gives greater support and focus to that, so thank you for that. Are there any concluding comments that you wish to make to us?

DR WIGGLESWORTH: No, thank you for the hearing. Thank you for the time and the effort and the ability to come and hear.

PROF WOODS: Thank you very much.

DR JOHNS: Thank you.

PROF WOODS: If we could ask the next participants, OT Australia, Victoria, to come forward. Not present as yet.

PROF WOODS: Thank you. We welcome our next participants, OT Australia Victoria. Could you please for the record state your names, positions that you hold and organisation that you are representing.

MS JOHNSON: Louise Johnson, executive director for OT Australia Victoria.

MR LI: Bo Li, senior project officer with OT Australia Victoria.

MS FARQUHAR: Bronwyn Farquhar, professional representative, OT Australia Victoria.

PROF WOODS: Thank you very much. We have the benefit of a submission from you, but do you have an opening statement you wish to make?

MS JOHNSON: Yes, we do.

PROF WOODS: Please proceed.

MS JOHNSON: We also wanted to provide you with you some concrete examples of some of the key concepts that we've presented in our submission.

PROF WOODS: That would be most helpful.

MS JOHNSON: Thank you. OT Australia Victoria is the professional body that's responsible for representing occupational therapists in Victoria, and I just quickly wanted to summarise the key features in our submission.

OT Australia Victoria strongly supports any initiatives that will bring about a national framework for the closer alignment between occupational health and safety with compensation across all jurisdictions. These initiatives will have a number of long-term benefits to the health, safety and wellbeing of employees and their employers, including the prevention or minimisation of work-related injuries through closer working relationships between employers and employee with a reduction in pain and suffering for employees.

Secondly, the timely referral to specialist help once a work-related injury occurs to ensure prompt and appropriate assessment and treatment.

Thirdly, the promotion of proactive working relationships between the employer, employee and rehabilitation professionals by utilising specialist knowledge at a local level so that rehabilitation is carried out within the work context to achieve optimal outcomes.

Fourthly, the achievement of links between prevention, early intervention and

rehabilitation of work-related injuries to enable benchmarking of best practice and to promote further research. We believe that these initiatives will provide major savings for employers and compensation systems.

I want to just briefly hand over to a couple of other team members to make some brief statements as well.

PROF WOODS: Please.

MR LI: Thank you. Just to recap some of the points, OT Australia believes that a closer alignment between the occ health safety and compensation systems will ensure a smooth continuity of care from the injury prevention through to post-injury management and intervention. The close alignment will ensure and promote the closer links between the employer, the employee and the rehabilitation providers and thus ensuring optimal outcomes are achieved and the decreased cost to the compensation scheme and the community in general.

Traditionally, occ health and safety has traditionally rightly managed injury prevention, whereas compensation has banished rehabilitation. However, from a practical and functional point of view, the injury prevention and rehabilitation go hand in hand, and there are benefits in terms of quality of care and cost that would seem to be dealt with in the continuum.

In terms of the work that occupational therapists perform within those two systems, occupational therapists are able to pick up the potential injury before an injury occurs by having closer working relationships with an employer, and he or she is able to do that by modifying workstations and equipment and materials and procedures. An occupational therapist is also able to assist us with early signs of injury to self-manage, integrate strategies into their work practice in ways that minimise further risk and thus ensuring a workplace based rehabilitation program to optimise recovery and minimise pain and suffering. I just want to hand over briefly to Bronwyn, who may have a practical illustration of this from her practice.

MS FARQUHAR: With regard to the continuing of health care this is something that I've practiced for some time with results that are demonstrated through a longitudinal study over now 15 years. I've always believed that early intervention should occur prior to injury occurring. In other words, in an industry such as manufacturing that have a very poor record in terms of injury and cost, that one can identify risks and hazards and provide controlled procedures that can eliminate a lot of the cause of hazards or reason for hazards, modify equipment, services provided within the industry, and train workers so that they have a better understanding of their bodies and are able to self-manage and self-correct in the industry itself. So I have, for some time, conducted programs in industry aimed at achieving just this and, in one that I would like to highlight, one manufacturing industry, over a period

of six years, we were able to decrease the number of WorkCover claims from 37 to five and then, over the next few years until this very time, we're down to two. This was compared with the industry average for that particular industry - was far better. Statistically significant, in fact.

The programs carried out and the results of those programs were highlighted in a paper that I provided at the World Congress of Occupational Therapists in Sweden, the response to which was extremely positive, with many other occupational therapists from other nations citing us as providing a benchmark in best practice. I'd like to see that - - -

PROF WOODS: So can we become complacent?

MS FARQUHAR: Have we become complacent?

PROF WOODS: No, can we become complacent if we're best practice already?

MS FARQUHAR: I don't think we are. I don't think this is universal enough. I think there's some isolated examples of good practice that need to be adopted and I think one of the barriers to adopting that is that there are very few - well, there's no incentive, currently, for employers to - at least they're aware of the cost benefits - to undertake preventive measures because they are costly, but compared to the result of one WorkCover claim are, in fact, very, very inexpensive. Prevention is no stranger to insurance companies. We see that with house insurance and car insurance, where people understand the benefits of behaviour modification, I suppose, in promoting good behaviour, and I just wonder why that doesn't translate automatically into the WorkCover situation.

MR LI: Just also - - -

PROF WOODS: Please, yes.

MR LI: Just also a couple more comments. In our submission we highlighted there is no single model that - of best practice in early intervention rehabilitation has been identified. The Western Australian WorkCover Report highlighted a few characteristics of best practice and these include the use of multi-disciplinary aggressive functional restoration programs, the early diagnosis and the appropriate referral for rehabilitation, good case management communication between all key parties and the availability of suitable duties with the employer.

Now, in the case in Victoria we believe the rehabilitation seems to be primarily driven by cost containment. Our rehabilitation needs in Victoria is managed by six different insurance agents, whereas occ health and safety are managed by the WorkCover authority directly. I think that - we think that's to the detriment of

rehabilitation because the varying approaches are less likely to be shared between the agents when they are competing against each other and this lack of sharing of information prohibits the building up of a professional body of knowledge and exchange of good data to enable the WorkCover authority to highlight the strength and weaknesses of different approaches and thus, their association with the more effective outcomes.

MS JOHNSON: I think it's in - coming back to your question as well I think there's great opportunities for greater links between occupational health and safety functions and rehabilitation and at the moment there are the great divisions between those two areas of involvement and in our submission we have provided some ideas about how those links could be strengthened. I think that's one of the barriers that has an impact on best practice and cost savings for the system and the - and the - prevents those benefits flowing on to injured workers and their employers.

MS FARQUHAR: I think in terms of injury prevention too that one can pick up in a troubleshooting sort of capacity early signs of injury or discomfort and deal with those. If perchance then that person goes on and has a claim then at least there's a good understanding of the workplace from which that person has come and hopefully that injured worker can remain at work and be assisted at the workplace, and that's within the context of the duties that he performs on a day-to-day basis, not outside, in a rather artificial environment of practices that might be quite unfamiliar with the context.

PROF WOODS: I thought that was a very good point about rehabilitation on site, because not only does it mean that you're dealing with the rehabilitation in the context of the duties that are relevant but you're maintaining the employer-employee contact - - -

MS FARQUHAR: Exactly.

PROF WOODS: - - - connection with the work ethic, the networks of support from colleagues. I mean, they didn't all come out in your points but as I thought through what was said there, I could see them. There was a lot of positives.

MS FARQUHAR: I think a very negative factor when somebody is off work and the data certainly demonstrates that the longer someone is off work, the less likely they are to return. There have been studies by Wadell and Burton and various other people I could quote, who say that if somebody is off between four and 12 weeks, for instance, they're unlikely in say 10 to 40 per cent of cases to get back within one year. As you've hinted at, the relationship between employer and employee starts to break down and the employee starts to become aware of strategies to use to stay off work, as distinct from working within a culture that supports and encourages, where there's a sense of working together to achieve a common end. That has to raise

morale and I've found certainly in an industry with which I've had very close contact has increased productivity over time, the business has increased, the numbers of workers have increased but WorkCover claims have decreased, and absenteeism.

PROF WOODS: You make reference to the six-year longitudinal study - - -

MS FARQUHAR: Yes.

PROF WOODS: - - - and you quoted the figures, claims coming down from 37 per year to five per year and then you said now down to two per year.

MS FARQUHAR: To two in the last 12 months.

PROF WOODS: Now, what are employee numbers doing during that time?

MS FARQUHAR: They've actually increased.

PROF WOODS: Okay, because in the absence of that bit of information I could draw - - -

MS FARQUHAR: I have a paper here, I'm sorry, and it's actually the paper that was presented in Sweden that will highlight all of those figures.

PROF WOODS: Okay. And that's available for us.

MS FARQUHAR: Yes, certainly, I've made three copies.

PROF WOODS: Excellent, thank you. Okay. That just solves that. Now, if you can produce that outcome it does sort of beg the question, well, given that employers, employees and employee representative bodies are all motivated to have safe workplaces, why isn't it self-evident to them that this sort of thing should be done in their own localities?

MS FARQUHAR: I don't think people understand that these services are around and I think that is probably one of our problems in occupational therapy. Vets Affairs, for instance, publish a list of accredited occupational therapists who are experienced in the area of dealing with the elderly. I think this could well be done and provided to employers so that they have immediate access to those that can provide assistance. At the moment it's very reactive and almost punitive. Worksafe Victoria are doing a wonderful job of going into industries and highlighting where there is a need for change. But very often employers are left floundering, "Well, what do I do now?" There is of course a guideline through the manual handling regulations, for instance, as to process.

PROF WOODS: For hazardous chemicals or various other - - -

MS FARQUHAR: Various other things - manual handling strategies, how to eliminate, you know, identify risks and so on. But very often they don't understand the control procedures that should follow and they do need somebody experienced to guide them in that and very often it can be a cover-up job because this is a punitive system that is going to fine them if they don't do certain things, rather than pat them on the back for doing what should be done in the first place. And I believe that if there was an incentive offered, as there is in motor car insurance and home insurance to employers, that they would be far more motivated to make contact with the right professionals.

PROF WOODS: But isn't the incentive to get a lower premium?

MS FARQUHAR: Well, yes.

PROF WOODS: But, I mean, your premium if it's experience rated is lower if you have lower accidents, if you're of a sufficient size. I mean, it doesn't happen at the micros but - because they're industry rated more than experience rated individually in most cases. But certainly for the medium and large, experience rating shows on their payment by way of premium. So why isn't that an incentive, why isn't that working?

MR LI: I suppose part of that is there's also no incentive for employers to take on any preventative work from - - -

PROF WOODS: But preventative work flows directly then into accidents which flow into premium.

MR LI: Into prevention.

MS FARQUHAR: Try and tell an employer that he has to pay $600 for a scissor lift and to compare that with the cost of a WorkCover claim. They don't seem to understand that through prevention the savings are going to be extreme. So there needs to be more information.

DR JOHNS: But it's a product you have to sell them in a sense, I guess, and it's even worse at the lower end where they don't take a premium that's related to their behaviour. You don't have much to play with.

MS JOHNSON: I think, just to add to what Bronwyn and Bo have said, I think there's not always a good enough awareness of the sort of services that are available in terms of preventing injury amongst employer groups. There's been a number of initiatives to provide information to employers, particularly amongst certain groups of employers, there's still a lack of awareness about the sort of services that are

available in the marketplace to preventative sort of work that Bronwyn has been talking about.

I think it's also important to be able to put the employers in the driver's seat. If they have the information and a heightened awareness about the sort of services that are available to reduce costs and the potential for WorkCover claims, then they're more likely to act and - - -

PROF WOODS: In which case we need to align incentives and let's work out who's got the greatest incentive to invest in making them aware, and that question is pretty easily answered, so no doubt you're making that investment.

MR LI: As we highlight in our submission, in many instances employers don't necessarily make the link between injury and satisfactory occ health and safety practices and even when they do identify the injury has occurred and there could be a possible cause for that in the workplace, they don't know who to turn to and where to turn to, and that's where the professionals and the professional provider would come in to assist employers to overcoming that. But at the same time the Victorian WorkCover authority has also increased the focus on occ health and safety through its Worksafe area in terms of field officers out there doing work site inspections.

While the initiatives, we believe, that would assist and facilitate some of those, great integration is to have the field officers to be able to identify the areas where they need increased focus on preventative measures, and to have more responsibility to actually investigate, to look at if injury has occurred or whether or not an appropriate rehabilitation has been provided and managed appropriately - and follow up, yes.

PROF WOODS: Okay. Can I just ask a couple of questions on your submission itself? Just for clarification, registration isn't required in, what, New South Wales, Victoria, Tasmania, maybe the ACT, as I read this?

MS JOHNSON: That's correct.

MR LI: Yes, that's correct.

PROF WOODS: Okay, but you have a self-regulating entity so that your own profession, though, accredits people. So I mean, in that sense, if somebody wants a professionally accredited OT in Victoria or in New South Wales, they go to your association and say, "Is this person a member?"

MR LI: That's correct.

PROF WOODS: So the information is there; the process is there. It may not be statute-based but it's there anyway.

MR LI: Yes.

PROF WOODS: Okay, although presumably it does mean that anyone in those states can claim to be an OT, can they?

MS JOHNSON: That's correct.

MR LI: There's nothing stopping them from doing so.

PROF WOODS: Okay, but if I was an employer I'd want to make sure that the professional body that was self-regulating also agreed that they were an OT, and they can easily get that information.

MR LI: Yes.

PROF WOODS: So that really isn't a problem in that sense.

MR LI: Sorry, I just want to make another statement while we're talking about the context of registration of occupational therapists. Issues do arise where OTs work at border towns. For example, in Mildura, if an occupational therapists who's working in Mildura is engaged by an employer across the border from South Australia, he or she must register herself with the registration board of occupational therapists in South Australia first, otherwise he or she may be prosecuted.

PROF WOODS: Now, presumably those who live in the border towns would have made that precaution.

MR LI: Yes.

PROF WOODS: But it's also an argument for getting rid of the legislation and just having professional self-regulation nationally.

MS JOHNSON: Or national registration.

PROF WOODS: National registration but it doesn't have to be legislation because legislation means the government is interfering in your processes.

MR LI: I think we've highlighted in there that professions such as physiotherapy are recognised under the Mutual Recognition Act.

PROF WOODS: Yes, saw that.

MR LI: The same, I guess, cannot be said for occupational therapists.

PROF WOODS: No. Now, it's interesting that in - you talk about inconsistency in registration and then you go on to a table and I notice that two of the states that don't have legislatively-based registration are at the two ends of the pay spectrum. So you can be not legislatively-registered in New South Wales but get $120 an hour and you can be not legislatively-registered in Victoria and get $60 to 80 an hour. So they're at both ends of that spectrum.

MR LI: Yes. I think while one of the issues that we've faced is the fact that many occupational therapists in Victoria in particular have felt that they're undervalued professionally. In many instances if you're operating in that inner scheme whereby once you've taken out all the small business expenditure, you're operating between 20 to 25 dollars an hour, and whereby a larger provider or insurance company can offer you a higher rate because you have the wealth of professional knowledge and experience of working in that system, then you'll be tempted to drop out of that system as a provider and work as say a medical injury management adviser in an insurance agent. That's to the detriment of the injured workers because they're not getting that wealth of experience that that person has had, and at the cost of the scheme and also to the community in general.

PROF WOODS: Okay. You make reference to lack of supervisory involvement in returning an injured person back to work was considered the second-most significant factor in increased disability costs. That's a very powerful point. I haven't read the study itself yet to understand the adequacy of its methodology, but it is a strong point. To some extent employers, including their supervisors, however feel that in some jurisdictions they disconnect with the employees not through any lack of goodwill necessarily on either part, but because third parties take control of the process that the insurer or the rehab provider or somebody starts to manage the employee but doesn't connect the employer. Now, to some extent that picks up what you were saying in your case study earlier, but could you elaborate on that for me?

MS FARQUHAR: Can I just clarify there that you're saying that the third person coming in - that they can distance themselves more from - - -

PROF WOODS: Well, the problem then becomes that the employer loses contact with the employee, because the employee is being managed by a third party - so how do you get around that problem?

MS FARQUHAR: This is where some integrated activity is essential. I know that in the many, many workplaces where I've conducted programs, I've insisted on employers being involved in the training process, so that they can encourage and in fact support - if we're trying to integrate an exercise program into the work process that they will encourage that and not say, "Hey, you're wasting our time," and start producing - and that they understand that through supporting their workers,

understanding their workers and changing that culture and having people work together, they're actually going to increase productivity rather than not. So I think it is an integrated, multi-modal approach that assists understanding across the board from the CEO right through to the factory worker, if you like, so that they're all part of the same knowledge bank and there is a sense of us working together. Would you like me to go further on that?

PROF WOODS: I think I understand the point, unless there is some point you want to raise in particular.

MR LI: Perhaps just a case in illustration: OT Australia Victoria was involved as a part of a stakeholder group under the current Victorian WorkCover Authority's sprains and strains pilot project. Part of that project is to have a central case coordination role conducted and managed by the agent and also the medical practitioner. We strongly believe that a closely managed case is one that's going to achieve better outcomes than one that's not appropriately managed. However we also made a point about early intervention because the pilot projects only examine those injured workers that have been off work for more than six weeks. The consensus of the stakeholders is that the best, most effective treatment and interventions are carried out in the zero to six week period. That is something that we've made a point in our final evaluation report.

We also made a point in saying that we do agree a better coordinated case management approach towards injured workers' rehabilitation is the one that is going to deliver the outcomes. Under the current sprains and strains pilot, the management of it, whilst it's better than what it has been previously, there are ways to make it better and improve it. That's why having early intervention would tie into that, and I guess Bronwyn's previous studies and examples illustrate those benefits.

MS FARQUHAR: It's a bit like closing the door after the horse has bolted once you've waited six weeks as we mentioned before. But I think that integrated, coordinated continuum of approach is one that does involve all levels. If people can see cost savings in that first year, they are sold. They will go on using this approach. But if I pick up an injured wrist in a workplace where I'm running a program, and find that two or three on one line are also complaining of a sore wrist, this is the time for me to get in there and look at the equipment they are using and their work methods. It's not later when they've all sort of lined up for carpal tunnel surgery.

DR JOHNS: So given that, who buys your services? Who are the employers most likely as a question of scale, I guess, as to who can buy your services, or are they self-insured people where the incentives are directly about controlling their own risks and so on.

MS FARQUHAR: It's been both. I'm a small provider. I have a small team and

most of it is by word of mouth. For instance we seem to be doing heaps in the hospitality industry. So it goes through an industry - who's good, who's running programs, who's saving us money?

DR JOHNS: Meaning what - the individual hotels buy your services?

MS FARQUHAR: Yes.

DR JOHNS: Pubs - - -

MS FARQUHAR: Yes.

DR JOHNS: Quite small - - -

MS FARQUHAR: No, large city ones.

DR JOHNS: Yes.

MS FARQUHAR: I suppose that's the point - but that's the network.

DR JOHNS: But there's also the reason why only the large ones buy your services, presumably. They're the ones who can afford you.

MS JOHNSON: I think it has to do with whether employers have the knowledge about the sort of help that's out there. It relates back to that. I guess it's going to be larger employers that have slightly larger budgets that might opt for these sort of services first, and the more enlightened employers that have best practices and thinking in terms of occupational health and safety that would buy in such services, or those who have got a track history of WorkCover claims and have seen the impact and want to do something about it.

MS FARQUHAR: But we're not talking great expense here. We're talking relatively cost-effective, low budget if you like - you know, hours of professional service.

DR JOHNS: All I'm saying is cost-effective is in the eye of the beholder. The person who is paying the bill has to make that judgement. We certainly would.

MS FARQUHAR: I think if you get the outcomes, you know, you certainly get the work. But there aren't enough of us and there aren't enough perhaps being encouraged for the very reasons Bo and Louise have mentioned.

DR JOHNS: How come there are so many OTs - 1400 in Victoria? What's happening here? You've got 30 per cent of all the members of OT Australia. Is that

right?

MS JOHNSON: There are over 1400 occupational therapists and the largest percentage work in the public sector, with a much smaller percentage working in the private sector. The percentage working in the private sector that are available for the sort of work that Bronwyn is doing is much smaller in Victoria compared to some of the other states where it's easier to make practice more viable because of greater compensation. So we have a lower percentage of private practitioners in Victoria compared to say New South Wales.

MR LI: The other point is that the profession itself is female-dominated. I think the Australian Institute of Health and Welfare in this labour force study quoted something around about over 90 per cent of the workforce are female-dominated and over 80 per cent are aged between 25 and 40. So that's another factor that's affecting the pupils to build up their professional knowledge and conduct in a viable small business.

DR JOHNS: Why is that a problem?

MS JOHNSON: Just natural attrition - through child rearing - - -

DR JOHNS: I see.

MS JOHNSON: - - - and time out.

DR JOHNS: Yes. So, well, I'm aware of that.

PROF WOODS: They're caring, commissioner, they're caring.

DR JOHNS: I know. I just didn't make the connection, initially, I'm sorry. I don't think that way.

MR LI: Also, the point I mentioned earlier about, you know, having that level of remuneration recognition and not being able to - getting a satisfactory outcome out of that and if you can get better recognition and better pay doing another job, the chances are most people take it up.

PROF WOODS: I'm sure you haven't seen us as the wages tribunal.

MS JOHNSON: Just highlighting the issues.

MS FARQUHAR: I think we're all more excited about the concept of wellness management overall than injury management. Yeah, that's - you only have to look at smoking - to get right away from what we've talked about - and they're finding

increasingly there's a very strong correlation between smoking and back injury, so we're looking at a link between musculoskeletal and other health management practices; some research recently.

PROF WOODS: I think I've exhausted my particular questions. There are some particularly nice little pieces in there that we'll give consideration as to whether they might fit into the report, "The early multi-disciplinary diagnosis assessment referral can positively influence outcomes," et cetera, et cetera. But yes, that's been very helpful. Thank you. Is your national - OT Australia National, I assume, is that what we're called? They haven't presented and neither have any of your colleagues in the other states, they're probably too busy earning $120 an hour.

MS FARQUHAR: Exactly.

MS JOHNSON: I guess in Victoria the profession is particularly passionate about these issues and we've been working very closely with these issues and talking to the Victorian WorkCover Authority, so this was a natural progression of the work we've been doing to submit this information to you.

PROF WOODS: Thank you for that. It has been very helpful.

DR JOHNS: Yes, thank you.

MS JOHNSON: Thank you for your time.

MS FARQUHAR: Thank you very much. With regard to leaving documents behind.

PROF WOODS: Yes. If you pass them on to my staff they will then make them available to us and to others. We will adjourn until 1.30.

PROF WOODS: Our next participant is Mr Michael Spooner. Thank you for coming. For the record could you please give your name and any organisation that you may representing.

MR SPOONER: My name is Michael Spooner and I'm actually representing myself.

PROF WOODS: That's fine. You're most welcome. We have a submission from you but do you want to go through the situation for us?

MR SPOONER: Yes. I just felt that after - it's nearly 12 months since I had an accident. As you can see, I'm reasonably qualified in the WorkCare situation now since I severed my arm. They did a good job of putting it back, but pretty much I found from even back the second week in hospital, when I was approached by the social worker to fill out the WorkCare forms and what have you, there seemed to be a distinct lack of information to offer, especially when you're in a state of trauma and obviously you life is in a bit of a mess. I generally found that most of the information I found regarding the system, or the next step you were supposed to take, came from people maybe in private practice, the physios, district nurses and the like. The booklet I found very confusing, and when it came to say the insurance company and/or the agent, they're not forthcoming with any information because it's going to go against their basis for being a business.

PROF WOODS: In what sense?

MR SPOONER: They're there to make money and, although they probably have to work within the guidelines of the WorkCare system, I think they tend to put up maybe not brick walls but certainly chicanes to congenially say, "We'll look into it," whether it's a matter of rehabilitation, retraining - virtually every step - or reimbursement for costs incurred - - -

PROF WOODS: I notice you're mentioning that in your submission.

MR SPOONER: It gives more specific details. When I got home and the agent came to our home address, she was very negative regarding anything regarding monetary compensation and, given that I knew that I was up for a few months of rehabilitation, I started to think, "How am I supposed to pay for all this?" to the point - and this is the extreme: I live in Yarra Glen and I've got a wood heater and when I wanted firewood - she said, "I'll have to look into it," and I thought, "How am I supposed to cut wood for the next six months?" It's a ridiculous situation when you have to prove something so trivial. Examples like home maintenance: I needed help with the garden and I assume they do it in quarterly blocks and I understand why they do that, but when I've asked for it to be redone - obviously over the drought there was not much need to come and look after my - - -

PROF WOODS: Sadly, no.

MR SPOONER: Yes. The insurance company would just baulk at every request and say, "We need another doctor's certificate" or "We need a letter from your carer." I thought, "Where is all the paperwork going?" They seemed to have plenty of records on me but nothing when it comes to putting in what I would have thought was a fairly decent claim, and it was always backed by the relevant practitioner. I'd done some surveys with I think the Monash Medical Centre while I was in hospital and this Productivity Commission came to my attention by somebody in my family and I thought, "I think it would be nice to just make the statement from someone that's on the shop floor." I come from a small manufacturing industry where it's not union backed, so you don't have I suppose the union helping you out. So you were continually sort of walking through a forest trying to find your way through the system. At the moment I'm back on light duties, thankfully, but I'm not going to regain the skills to continue as a fitter and turner.

PROF WOODS: Are you back on light duties in the firm that you were with?

MR SPOONER: Yes.

PROF WOODS: What sort of size firm is it in employment terms?

MR SPOONER: About nine people - yes, nine people working there.

PROF WOODS: That's pretty impressive, then, that they've been able to find duties for you. Did they create duties that fitted your need or was there a position there that you could fill?

MR SPOONER: I've taken some of the duties that possibly the manager did, but they're pretty - more often than not it's, "Count this box of stuff," deliveries. I don't mind doing that anyway. I've got no problem with it. There are limitations to what my arm will stand and any work is meaningful as far as I'm concerned, but I don't want to see it as a long-term proposition.

PROF WOODS: No, but it's keeping you engaged - - -

MR SPOONER: Certainly, yes.

PROF WOODS: - - - and they're caring for you in the sense of creating responsibilities and things. That's not the story we get of all firms. In that bit it's a positive story, but that then contrasts with what you're telling us of your treatment by the system.

MR SPOONER: Generally I think the employer is well meaning. In fact, most of the people I've worked for, many and varied, have always been in that situation, and I've worked in big union places as well as small private concerns. I suppose it depends on the size of the company as to how much notice they take of legislation, whether they decide, "We have to do this because we know there's going to be a solicitor knocking on the door if we don't," or a government agent, so to speak. He's been pretty well, as far as I know, right behind me, to the point where you'll get a comment - he went to court for WorkCare negligence a fortnight or so ago, found guilty and came to me the next day and said, "Now we can get on with the business of making you better." I thought, "It's nice that he thought of his situation before he thought of my arm." I've 11 months like this and it's getting better, but it's not going to improve much more now.

PROF WOODS: I don't want to relive any traumas, but in terms of avoidability of accidents - and let's not go through this one and have some sort of litigation things - to what extent can employers at that sort of size business - because they're we're talking sort of small to small-medium businesses - - -

MR SPOONER: Certainly.

PROF WOODS: Presumably they don't want to injure their workers, is the first position you would take, but is it difficult for them to be constantly vigilant to ensure that situations don't arise that could ever lead to an accident?

MR SPOONER: I think it may be difficult, but being safe driving a car is difficult. It's all about how much effort you want to put into it. I suppose like the TAC ads, is it risk management? I mean, quite often small business is in the habit of buying poor machinery. That's common knowledge. You'd know it from any - - -

PROF WOODS: They buy second-hand - - -

MR SPOONER: Exactly. That was the case in my instance. Whether it had been fiddled with before he bought it or he fiddled with it before he told me is irrelevant anyway, but it happens. I know there's legislation and Australian standards on most of the machinery that I deal with anyway, but more often than not small businesses don't have a list of Australian standards. They sort of know common knowledge: you need a stop switch, you need this, you need that.

PROF WOODS: You need a guard, you need - - -

MR SPOONER: You need a guard, yes - both of which were missing in my case. It just happens probably far too often. I've worked in small companies where they go, "Mick, be careful. It hasn't got such and such," but every now and then you don't get told and people get caught out. It's a pretty costly exercise. I'm not there, but I

tell you what, I think I've cost the insurance company a fair swag of money, not to mention the trauma to my family and myself.

PROF WOODS: Yes, and your future and all the rest of it.

MR SPOONER: Yes.

PROF WOODS: It's interesting you raise second-hand machinery because it is something we're conscious of. In those cases the history of the machinery is sort of not known to the employer or the employees either, and so any previous weaknesses or - - -

MR SPOONER: Haven't been brought to attention.

PROF WOODS: - - - repairs that may not have been fully and competently done - there's an uncertainty in that process.

MR SPOONER: I spoke to the WorkCare inspector at my home when they were proceeding with what they thought were going to be criminal charges, and he seemed wise to the manufacturing industry in general. He thought there was a flaw in that so much as you've got Australian standards on the machinery, there doesn't seem to be a licensing system for probably dealers who sell machines - or if there is I don't know of it and I haven't found about it - where they might be accountable and say, "If this machine isn't up to the standards required, it's scrap metal."

Of course, factories are forever shutting down plant, having clearance sales, ringing up people in their competition and saying, "Look, we're selling off A and B. Do you want to come bid on them?" and of course they're not controlled by anything, unlike car yards where the machine is pretty well roadworthy or it's not. That seemed to be a bit of a concern for me because this is the industry I'm in. You think, "Who controls them when they fund a machine is dodgy and decide to sell it off and of course they're not going to tell anybody because they want money for it?" I don't mean that they expect anybody to get hurt. They might it's going to be stripped or sent to scrap.

PROF WOODS: Or just don't care.

MR SPOONER: Or just don't care, yes.

PROF WOODS: There's a whole range of incentives in that process. So we have the second-hand machinery, we have inadequate guards and bits and pieces. In terms of your experience, there are two levels. One is whether the level of benefits et cetera was appropriate versus how the system was administered. You can have all of the rules and regulations and payment dates and levels et cetera, but if, as you say,

the rehab provider or the case manager is part-time and says, "I'll come back to you in - - -"

MR SPOONER: "Such and such a time," yes.

PROF WOODS: "two weeks' time" - because everything we hear is about early intervention, that the sooner you get onto an injured employee, the more you keep the contact between employee and employer, all of those things, then the better the rehabilitation process. I suspect you're agreeing with that.

MR SPOONER: Totally.

PROF WOODS: Totally, not even as a general principle, you're totalling agreeing. That's not then helped if somebody says, well, I'm your case manager and I can fit you in in a fortnight or three weeks or something.

MR SPOONER: I'm not even sure what sort of restrictions you can put on as to their qualifications, I think I mentioned. There's a lot to absorb, I mean, between the legal sense - I thought this person was an occupational therapist. But I think I had an x-ray or something and my arm was in splints when she visited. You got the attitude she thought, "Oh well, it takes six weeks for a bone to mend. You'll be back at work, two or three months." Now, I don't know if that's the company procedure. Whereas, you know, this pushing back to work - - -

PROF WOODS: I mean a simple break, yes, six weeks in a cast is - - -

MR SPOONER: But I don't have to be a doctor to know it was going to take a little bit longer than that, you know.

PROF WOODS: That's right.

MR SPOONER: Bits of metal hanging out everywhere.

PROF WOODS: Yes.

MR SPOONER: Fairly obvious - - -

PROF WOODS: Nerves that need reconnecting and the whole thing, yes.

MR SPOONER: Yes. She may have been poorly trained, maybe they had no-one else for the job, I don't know. I got round that system because I found out - because I had my licence just taken off me, obviously, for the duration - that the person that had to do my licence test said, "You and your employer can pick your case worker and the insurance company doesn't get a say in it." The way the insurance company

baulked considerably I then used this person for - and changed my case management over. There has been a fair improvement in discussion between the parties now because she is obvious to the injury. She is not sitting there going, "You'll be back at work within a week." I'll be back at work when I'm back at work. That is pretty much all I can say because it is governed by surgeons say and physios and so on. So it may have been just a really bad example of this case management. But then who controls them? If they're employed by the insurance companies and they're pushing the back to work principles, which makes sense, then you get the problem where people are probably going back - certainly serious injury, I can't talk about - - -

PROF WOODS: Sprains and strains.

MR SPOONER: - - - sprains and cut fingernails. Maybe there needs to be a level, and I don't like putting levels on anything because then you can say, "Well, I should have been level 3 and not level 2," you know.

PROF WOODS: That - - -

MR SPOONER: That's always going to happen. But yes, with a change of case management my situation has improved remarkably. Had it been there at the start I probably wouldn't be here. I wouldn't have bothered with a submission. I would have said, "Oh well, the system works pretty well."

DR JOHNS: When was your first contact with the boss after the accident?

MR SPOONER: He did visit me - a week after, I think, he came in.

DR JOHNS: Yes.

MR SPOONER: I was still shaking and pretty scared to see him, to tell you the truth, but that was all post-traumatic stuff.

DR JOHNS: Yes. How did the conversation go in the weeks after that? What part did he - - -

MR SPOONER: I suppose he was along the lines of, "How did it happen?" He was obviously worried about litigation.

DR JOHNS: Yes.

MR SPOONER: There was some serious breaches there, you know. Looking back now I can see them all but, you know, it's hindsight, isn't it. I think he was genuinely concerned for my wellbeing but he is probably been 30 years in business and didn't want to see it all go down the drain because he employed a bloke who got hurt.

DR JOHNS: So was there - at some stage would have been a face to face conversation between your employer, yourself and the case manager or case worker?

MR SPOONER: Yes, it probably happened when I went back to work.

DR JOHNS: Okay.

MR SPOONER: Yes, to - - -

DR JOHNS: Was that with your new rehab provider though?

MR SPOONER: With the new rehab provider.

DR JOHNS: So who negotiated the back to work? The conditions of the return?

MR SPOONER: That was partly - I think the surgeon gave some information regarding, you know, weight I could lift. The rehab provider and the employer they just sort of threw a few ideas around and looked at me and wanted the nod. We have since had another one about a month ago. I've been pushing the retraining barrow, as I said. I mean I was lying in hospital a week after the accident thinking, "How long am I going to be here?" I mean you just - - -

DR JOHNS: Want to get out and get on - - -

MR SPOONER: It's amazing it is for me now to be up here looking at Melbourne. I've never done this, you know.

DR JOHNS: It's not bad, actually.

MR SPOONER: It's beautiful. But I was lying in Royal Melbourne, who I owe my life to, and saying, "Well," you know, "I've got to be able to do something. If I'm going to lose all the feel in my hand nobody is going to want a one-handed fitter and turner." Your brain is active and you thought, "Well, the best way to get over it is to move on." I remember mentioning retraining to my wife and to the nurses and to the WorkCare, the inspector. He said, "Get on to it now. It's the way to go." But the first WorkCare provider said to me - and I think I mentioned it in that - she said, "Don't start any retraining without the insurance company's authority because they will say you were going to do that anyway, so we don't have to back you up." Now that to me is just ludicrous but I have been told that since then.

DR JOHNS: Sorry, how long have you been back at work?

MR SPOONER: Five months. I had a break in between for some more surgery.

DR JOHNS: Yes.

MR SPOONER: And I'll probably have another little bit in a month or so.

DR JOHNS: What are your thoughts now? That you still might want to take a retraining option?

MR SPOONER: I have to go that way, yes. I can't do my - - -

DR JOHNS: You've reached your limit.

MR SPOONER: - - - previous duties.

DR JOHNS: You've tested it now.

MR SPOONER: Yes. I mean I used machinery that is the most basic machinery in the trade and it causes me problems. As I said, I mean I tried bumping my hours up and I end up getting swelling and medical problems. Further surgery may negate it to a small degree but it probably won't. Retraining to me is just a sensible alternative.

DR JOHNS: So what rights do you still now have under say, well, I guess, WorkCover to retrain or for further assistance?

MR SPOONER: That's the thing, it's - well, I'm still getting the benefits because obviously they pay me for the hours I work and a reduced rate for the hours you're not there.

DR JOHNS: So it's a top-up but not to your previous pay. It's a top-up to a compensible - - -

MR SPOONER: We're getting into a different area, which I'd like to get to, it's that - - -

DR JOHNS: Deal with that for me, then.

MR SPOONER: Yes, I'll get to that.

DR JOHNS: Yes.

MR SPOONER: The occupation therapist, as I said, re-approached my employer and said, "Well" - you know, to give me a job as a gofer is all well and good, even at a good tradesman's rate of pay. But I don't want to live the gofer's life because that's

why I got a trade certificate. I continue to study in other areas associated with what I do. But it seems now it is being held up because the surgeon is on holiday. So they want to have the surgeon's approval before the insurance company surgeon will okay it. Then they'll look at the options and assess whether they'll give me - let me do this course, that course or whatever. It's disconcerting, 12 months down the track I could have my third - an associate diploma in this time or something, you know.

DR JOHNS: Do you ever feel that part of your life is now in the hands of others?

MR SPOONER: Yes, totally - well, yes, every minute of the day.

DR JOHNS: For somebody who is not as - I'm not sure if "strong willed", I don't mean that in any pejorative sense, but you have a motivation and a direction in your life.

MR SPOONER: Yes.

DR JOHNS: But if somebody didn't have that sense of self-being and worth, would that control by others - could that lead to a sort of - almost a sense of therefore relying on the system for their existence?

MR SPOONER: Certainly, I mean I suffer maybe mild depression. I've got no end of well-meaning friends who sit there in amazement about what I went through and that I still laugh about it. I think, "Well, you don't have an option." But then some people don't have the attitude I have. I think I'm lucky I'm not, you know, suffering the blues big time. But I've got a great family and - but yes, to be single and relying on the system could be, I think, fairly treacherous without a good family backup.

DR JOHNS: Yes.

MR SPOONER: Perhaps because I come from outer suburbs, a regional area, where the district nurses were doing amazing things at finding out information that people just wouldn't tell you. It's a bit like, I suppose - - -

DR JOHNS: Because they didn't know, didn't want to tell you?

MR SPOONER: Well, I'm going to think the worse, because it's an insurance situation, that they won't tell you if they think that you will go away.

DR JOHNS: What sorts of things were the district nurses finding out for you?

MR SPOONER: Just compensation for expenses, two or three trips a week into Royal Melbourne from Yarra Glen was a tank or two of petrol, not a big deal at all, yet they - I was told by the rehab provider that they would supply me with cab

vouchers at $75 a trip when 30 bucks for the petrol would have covered it. So I couldn't work out their - and besides, I'd rather have my wife with me because I was unable to drive and she could be there listening to the doctors' opinions and to make sure that my rehabilitation was on track.

DR JOHNS: That's called support.

MR SPOONER: That was just a minor issue but that was a typical one where you just thought, "Where are they coming from?" They're spending money but they're wasting it, you know.

DR JOHNS: Did you finally get your petrol money?

MR SPOONER: Yes. We put in an account every couple of months. They don't seem to be worried about the little - well, just having said that, I mean I'm still - I've gone to the Australian Conciliation Authority about the garden maintenance. They've booked in a hearing date. I rang the bloke and said, "Is this really necessary" - that when they want to charge $30 to do your lawns, how much is it going to cost to set up a committee and have five blokes sitting around at a table? It's ludicrous. And over winter we wouldn't talk more than a couple of hundred dollars and it would cost more than that to convene a hearing. He said he'd fix it and I haven't heard back but, you know, maybe they're still fixing it.

PROF WOODS: Now, levels of benefits was an area that you were then - - -

MR SPOONER: It's just a little confusing - I understand the reasons that they drop your benefit from 107.95 or 90, whatever it is - I'm not an expert in this - is it they say you don't have to spend money on travelling expenses and lunch money and that and I sort of understand that and then after a period they drop it down to, I think, 70 per cent and I sort of understand that, because there's no point giving people financial - if they can just stay at home - but I went back to work and then was informed that because I had an ability to work my benefits would be 60 per cent and I've calculated it and even the WorkCare people can't explain this to me, that under 25 hours a week you lose money going back to work. When I questioned them, I asked for their supervisor, he said, "You should be happy to be back at work." That had no relevance at all to my question.

PROF WOODS: But not at a financial penalty, thank you.

MR SPOONER: Yeah.

DR JOHNS: So there wasn't a sliding scale, it was just a - - -

MR SPOONER: No, you get paid your hourly rate that you were on pre-injury for

the hours you work and you - and I've got the WorkCare booklet if you want to have a look at it, but it probably gets a bit messy to do that, but yes, it drops down to 60 per cent for the hours you don't work and my calculation is about 25 hours a week, or less, you will lose money returning to work. And I just think that's - and I'm on a 12-hour week and probably a long way before I'm on a 25-hour week, so I've just about halved my pay. My wife's gone back to work to make up the difference and we'll see how we go.

PROF WOODS: And that's not an uncommon event in these situations either, where the other partner - - -

DR JOHNS: Just so that I can get the arithmetic right though, if you're on 60 per cent of - sorry, of a benefit, not of your wages.

MR SPOONER: 60 per cent of your wages - - -

PROF WOODS: No. He gets what he earns plus top-up to 60 per cent.

DR JOHNS: So you've got to be somewhat more than 50 per cent of what you used to earn.

MR SPOONER: Probably, I'm talking - sorry, after tax, I'm probably making - I'm exaggerating.

DR JOHNS: Okay.

MR SPOONER: But, yeah, in your hand you sort of look at it and go - where are we going here? And obviously they say, "Well, you know, you increase your hours you'll make more money." Well, blind Freddy can see that. But as I said, I mean I done some fairly serious physical work this morning and if my physio saw it now she'd be mad at me, because all right I might be doing duties that theoretically I shouldn't be doing, but I mean, it's a small business and I've got to do what I can to fill in the time.

PROF WOODS: And you don't want to just be hanging around anyway.

MR SPOONER: Well, it's not good for anybody, is it? Other employees don't like to see you slacking off and the boss wants something for his money, I understand that.

PROF WOODS: Yes.

DR JOHNS: So at some point though there'd be, presumably, X - six months will be up and 12 months will be up and there will be another conference to say, "Well,

here are your options."

MR SPOONER: It will happen in the near future, as I said, when my surgeon comes back from leave that will get the ball rolling again and, you know, they'll all knock heads and they'll come up with an equation. The insurance company has to approve it. My only worry is that as far as the handbook goes, the WorkCare handbook, it says 24 months and all benefits cease unless special dispensation is made and I don't know whether I'm a - no-one is going to tell you if you're a "special dispensation" case.

PROF WOODS: So there's uncertainty.

MR SPOONER: We're not there, anyway, you know, "You don't need to know that yet," and maybe WorkCare people could probably - but as I said, I could sit there for a day and the more I look at the booklet the more questions I come up - it's almost like, when I tried to get the submission together I just had so many thoughts in my head I didn't know what to put in - - -

PROF WOODS: No, it actually reads quite clearly and lucidly. We will make sure that the staff track down a copy of that booklet so we'll have a look at that ourselves.

MR SPOONER: All right. As I said, I rang the WorkCare to explain to them - because my boss didn't understand the booklet, he had, obviously, an employers copy and they're not much different, just showing you your rights and obligations, but it just seems to - it makes no sense and even he said, "How are you supposed to get by, with reduced rates?" So he was concerned, even though he did ask the rehab provider if he could put me on a lower rate of pay because I wasn't able to do my former duties.

PROF WOODS: Everyone has their own incentives.

MR SPOONER: Most definitely.

PROF WOODS: Where would we look to changes in the system? If it was a bigger enterprise and they were self-insurers, you could have a direct relationship with the employer and work with them and pick your rehab officer and do various things. In this case, clearly small businesses don't have that infrastructure. I mean, he probably has one accident in 10 years or something, so - - -

MR SPOONER: One would hope.

PROF WOODS: Yeah, so it's all new to him. I mean, this is as new to him as it is to you.

MR SPOONER: Certainly.

PROF WOODS: So - and that's as you would expect. I mean, small businesses individually don't have accidents often, but collectively - - -

MR SPOONER: And they can't afford the time to sit there studying the WorkCare legislation.

PROF WOODS: No, just in case in nine years time, in which case it will be out of date and - things anyway, so at what point in time do they make investment in this, obviously after an event. So it's got to be accessible, it's got to be quick, prompt.

MR SPOONER: Accurate.

PROF WOODS: Not the occ health and safety side, that's got to be preventative and all the way through - - -

MR SPOONER: Yes.

PROF WOODS: - - - but in the WorkCover situation, they're not going to invest the time until they need to.

MR SPOONER: I mean, I don't want to look at the - I don't know what they're called now, Centrelink - model and say, "Do you need branch offices where - ", because I think there's one in Dandenong and what have you, but I mean, I'm an hour away from Melbourne, I'm an hour away from Dandenong and when you're not supposed to be driving it's a major drama to sort of travel that distance, apart from the fact that it wasn't good to be in the car for any length of time, you quite often can't get the interaction you want or you come up with other questions. So you need the face-to-face meeting. So whether they need - I don't want huge CES offices or whatever they're called, but maybe they need to be mobile and say, "We'll come out and we'll tell you what your rights and obligations are. Put this to your insurer and tell us if anything goes wrong." Because WorkCare are fine when you've got a complaint, but as I said, in the first couple of months my head was spinning because I'm thinking, "What am I going to do? Am I out of a job as soon as I get better, or - " because that was my initial understanding, like all they had to do was get me back to work 40 hours a week and they just flick me.

I believe that's not quite the case, but it's pretty accurate, it's close to it. I think on the 52nd week, 366th day, if I'm back at 40 hours a week, he could come up with any sort of situation where, say, "We don't have you position any more because you can't carry out your former duties. Sorry to have to let you go." Now, I don't want the world to be covered with legislation and have unions banging down the doors of small factories, they can't afford it. But I just feel there needs - if there were offices

where you could get people in and fill in the dots, everybody would know what they had to do and maybe I would have been back at work a little bit earlier.

DR JOHNS: No, that's very useful, yes, as an insight.

PROF WOODS: Yes, and we will go through that booklet on that. But yes, no, it's helpful to have people who have been through the system and particularly people such as yourself who - you sort of aren't coming with a whole lot of perspective other than, "This is what happened to me. This is where you could make some improvements. This is - - -", so we appreciate - - -

MR SPOONER: Well, I don't see it as a witch hunt, but I just think if you can find ways of - I got the impression what you wanted to do was maybe nationalise the system.

PROF WOODS: We're looking to see whether we can look at the various state schemes and develop a national framework that will apply across Australia, but in so doing it's important for us to understand the strengths and weakness of individual schemes. I mean, this isn't, in itself, a review to reform Victoria or something else, but it's to say what's working, what's not working and what would a national framework look like.

MR SPOONER: I mean, I invited comment from my treaters and I think my physio was the only one that made a comment that said, "I think they get paid a lot more in Western Australia than they do in Victoria," but I don't have any information to back that up.

PROF WOODS: No, that's all right.

MR SPOONER: And everybody else just looked at it and went, "Oh, that sounds scary," they didn't want to come anywhere near this building.

PROF WOODS: We're not all that frightening are we, Dr Johns?

DR JOHNS: Pretty much.

PROF WOODS: Pretty much. Okay. You don't seem to have been intimidated.

MR SPOONER: I didn't like the lift.

PROF WOODS: Yes, it's a long way up, but a good view when you get here.

MR SPOONER: It is.

PROF WOODS: Well, thank you for your time. Is there anything else in particular that you'd like to draw our attention to?

MR SPOONER: I think we covered all the questions.

PROF WOODS: It was helpful the way you wrote this, because you did it under various headings and we could follow through what your points were.

MR SPOONER: Maybe I'll give you a follow up report in a couple of months when I get - maybe retraining happening, I'll be a happy man.

PROF WOODS: Well, our inquiry - no, quite seriously, because our inquiry - we'll be producing a draft report in September. If you go onto our web site at the end of September, early October, have a look at that, have a flick through some bits and see if there's any comment you want to make back to us on where we're heading.

MR SPOONER: No worries at all.

PROF WOODS: It would be helpful. Thank you for your time.

MR SPOONER: Thanks very much for your time.

PROF WOODS: I appreciate that.

PROF WOODS: If we could invite our next participants, the Australian Chamber of Commerce and Industry - gentlemen, if you could please for the record state your name, your position and the organisation you are representing.

MR ANDERSON: Peter Anderson, director of workplace policy, Australian Chamber of Commerce and Industry.

MR SHAW: David Shaw, manager, occupational health and safety, also Australian Chamber of Commerce and Industry.

PROF WOODS: Thank you very much, gentlemen. We have the benefit of a submission from you, and thank you for providing it. There are a few things that we'd like to discuss arising out of that, but do you have an opening statement that you wish to make?

MR ANDERSON: Thank you, commissioner. I have an opening statement. I have it in writing and I'll hand that up. I might make a few oral remarks, but rather than spend too much time reading out an opening statement I'll hand it up as a supplementary part of our submission.

PROF WOODS: Okay, that's fine.

MR ANDERSON: And I also have some further supplementary material on enforcement and regulatory matters which I will hand up as a further supplement to our submission.

PROF WOODS: Thank you.

MR ANDERSON: So if I could start just by making a few opening comments. The Australian Chamber of Commerce and Industry welcomes the establishment of the inquiry and the opportunity that it does present to recommend workers compensation and occupational health and safety reform, particularly reform in the direction of more national focus, which would contribute more directly to our national economic and social objectives. Our submission calls for new approaches that would replace diverse, complex and costly workers compensation and occupational health and safety regulation with a nationally consistent framework in each area. ACCI does not advocate a single national regulator or the Commonwealth taking the field as the sole regulator and legislator for either workers compensation or occupational health and safety. Such a radical move is not necessary. More realistic and less intrusive alternatives exist.

We do strongly advocate nationally consistent standards, regulations and systems managed and administered consistently by the jurisdictions and the creation

of mechanisms to make that happen. The objective should be for cooperative approaches between the Commonwealth and state or territory governments while still leaving primary responsibility for these systems with the states. Such a system would be beneficial to employers, employees and governments alike, for that matter. The lack of a nationally consistent approach imposes significant compliance burdens on business and leads to inequities for injured workers in terms of benefits payable and entitlements to benefits.

Our submission, as you would have seen, is divided into two parts: the occupational health and safety component and the workers compensation component. There is no doubt in our view that both the workers compensation system and the occupational health and safety system, while better than some international comparisons, are letting employers and the community at large down. They are delivering sub-optimal outcomes. They are complex, subject to constant change, open to abuse, create unnecessary business costs, lack proper incentives to drive best practice and are interpreted and administered differently in each of the multiple jurisdictions. I think as we look to some of the possible solutions we really need to identify those problems and identify what some of the causes of those problems are. Both systems need to be redesigned to contribute in a positive way to our economic and social goals.

The key issues that we raise in our submission on the workers compensation front are that premiums are going up despite workplaces being safer and injury numbers falling, there is an absence of nationally consistent arrangements, duplication overlap and excesses in administration feature in each scheme. In some jurisdictions common law is retained in part or in whole and those elements of common law expose employers and employees to the vagaries of litigation in what is becoming a more litigious society. There are loopholes, abuses and excesses which lead to employers paying for non-genuine claims or non-work-related claims or having the industrial relations system top up the safety net standards that are established through the statutory benefits scheme.

Aside from self-managed or self-insured employers, few employers retain any real control over decisions on claims or the cost of claims or management of the employer-employee relationship during the operation of these systems. I think that many of these systems operate to the disadvantage of what are good human resource and workplace relations practices, and I think as employers they are primary considerations in the overall management and administration of occupational health and safety and workers comp schemes but, the way the systems are structured, they become secondary issues.

Finally by way of opening remarks let me just identify in terms of occupational health and safety what we see as the key issues that confront us. Employers, particularly small and medium businesses, are overregulated, with hundreds of pieces

of regulation, codes of practice, regulatory standards and the like, constantly changing. There is some but only limited recognition of nationally consistent standards. There is a substantial degree of unrealism and imbalance in the interpretation by the courts of the duty of care, leading to an almost impossible capacity for employers to ensure their legal compliance. There is abuse of occupational health and safety in both the workers compensation systems and through the industrial relations system, not limited to but a good example being the building and construction industry, where occupational health and safety is used for a range of ulterior purposes - and misused rather used, I should say - and there is imbalance in the required policy mix of education, prevention and enforcement, particularly by a number of state authorities and particularly in recent years.

Our solutions: we've had a look on the workers comp front at some of the ideas raised in the issues paper. There are six possible mechanisms outlined in the issues paper as models for a national framework. The first four of those hold some particular attraction to us and they should be examined because they each have some intrinsic merit: a model for cooperative work along the lines of the current National Occupational Health and Safety Commission and, I might also say, with some similarities to what happens in road transport and also food safety structures; a mutual recognition model; an expanded Comcare model; or a uniform template legislation model. Each of those four models holds some prospects for achieving objectives we advocate.

On the occupational health and safety front, aside from contending for a change in focus by WorkCover, government and some legal authorities to improve the balance between compliance, enforcement and the interpretation of the law, we also argue for greater nationally consistent regulatory frameworks and the work that the National Occupational Health and Safety Commission is doing in that regard should be continued. We contend that there are opportunities for nationally consistent administration and interpretation as a consequence of that and a regulatory approach which seeks to raise awareness, inform and educate, with compliance and enforcement as a last resort.

That is an overview of the key objectives and issues as we see them. I would like to just table now as a supplementary submission some additional material that we have developed and are still in the process of developing, dealing with the level of the regulatory burden and enforcement data. We forward this as additional supplementary material. It is as yet still incomplete in some segments because it is quite difficult to extract from the jurisdictions some of the information we've been looking for, but it does give the commission some guidance. Just by way of a 60-second summary of it, it would demonstrate that in the last five years workplace inspections have increased by 20 per cent, improvement notices have increased by 48 per cent, prohibition notices on industry have increased by 97 per cent, prosecutions of industry have increased by 20 per cent; and court-awarded penalties

and fines have increased in dollar terms by 400 per cent.

We have in that five-year period some 166 amending instruments to occupational health and safety legislation in Australia, with 1796 amendments having been made, or thereabouts, to occupational health and safety laws in the space of simply five years. In terms of the total volume of regulatory materials - and this isn't really total because we haven't included some of the incidental regulatory enactments - in terms of primary OHS and related acts there are about 98 OHS and related acts operating in the Australian jurisdictions, with over 500 underpinning regulatory enactments which bind employers in their compliance activities. That is a picture, I think, of a very heavy regulatory system which is made all the more onerous because of the multiple and differing methods of enforcement and interpretation.

PROF WOODS: Thank you for that. I notice from the data that it does vary significantly from jurisdiction to jurisdiction. Some go up and some go down and some go in cycles and there are no doubt all sorts of reasons for that. We'll study that data more closely. Thank you.

Can I raise a few questions and my good colleague, Dr Johns, will do the same. First of all, you've used the word "consistency", but if we can just clarify quite what we mean there, because in part you talk about "cooperation between jurisdictions"; you talk about "elements of schemes", so maybe it's only in relation to a subset of the total schemes; and then you talk about "as far as possible be consistent"; I'm just not quite sure where you stand or does this reflect your diversity of membership?

MR ANDERSON: I think rather than reflect the diversity of membership, it reflects the fact that there are ideal outcomes, in an ideal world, that we'd be looking for, but there are also practical, realistic outcomes that we also want to be able to achieve. The ideal outcome is one where you have effectively common legislative standards.

PROF WOODS: Uniform.

MR ANDERSON: Uniform legislative standards, that would be ideal, particularly in the key areas, the key areas of regulatory control, the key issues, the key definitions, keys issues of benefit levels, the key issues of the way in which disputes are handled.

PROF WOODS: Benefit levels or benefit structures which you would then apply locally applying average weekly earnings or something too? Do you actually mean the dollar benefit levels or the benefit structures?

MR ANDERSON: Well, the benefit structures to start with.

PROF WOODS: Yes.

MR ANDERSON: Now, as you drill down in those benefit structures you do have differences that can emerge between jurisdictions, you have plenty of them at the moment. Ideally we would advocate a system where those differences, even in terms of levels, are minimised. I mean, there needs to be some objectively valid evidence for differences between jurisdictions as to levels of benefits as well. We don't have a difficulty with the idea that there can be some competitive aspects between jurisdictions in the workers compensation area and I think competition in respect of premium rates and the like is not a bad thing. But what you do find is that a number of the differences between the jurisdictions are accidents of history and not necessarily based on any particularly objective criteria that exists.

PROF WOODS: The outcome of a lot of stakeholders sort of lobbying for their particular position and where that fine balance is at any one point in time can move.

DR JOHNS: Which, I must say, are not accidents of history, but the product of history. It's a big difference, isn't it? I mean, serious people negotiating serious outcomes over a long time arrived at different answers, which is what I'm getting from this inquiry. So I'm accepting a certain amount of difference.

PROF WOODS: Interestingly though, you talked about competition. There has been a small amount, but not an avalanche of evidence to this inquiry that says that firms actively pursue and benefit from variations in workers comp premiums between the states. We haven't found too many who have said, "Our locational decision was based on this versus that." Now, that doesn't deny that the states don't promote their varying premiums, but in terms of then subsequent behaviour of a locational nature by firms, we don't have a lot of evidence or not many firms have come to us and said, "It was because of the workers comp premium that we moved from here to there or expanded there and not here." So I'm just not quite sure in a practical sense how much that competition is actually changing behaviour.

MR ANDERSON: I think as with many of these issues relating to the cost structures that business has to face and the costs business face that are imposed by the state in one form or another, it's generally not one thing that drives a business to make those decisions; there's a combination of factors as to where you may locate your business or move your business to. The level of workers compensation premiums is part of the economic decision, part of the economic judgment. If you don't have competition which could help drive down some of those premium rates, then you are going to minimise the capacity for those economic decisions for workers compensation to be factored into those economic decisions in a way that attracts a particular business to a location. So I think that it's true to say that there may not be a lot of businesses who will say, "Well, I will move into state X or move

from state Y because of the workers compensation cost." But it is equally true to say that businesses will decide to move into state X or state Y because of the total economic cost they face, of which workers compensation - - -

PROF WOODS: Is a part.

MR ANDERSON: - - - is an important component.

PROF WOODS: No, we understand that. Now, does that therefore argue against having one single uniform national scheme, particularly in that scheme doesn't happen to be the best possible scheme, then everybody equally suffers, compared to some sense of competitive federalism where jurisdictions are constantly learning from each other and leap-frogging to better and better practice?

MR ANDERSON: I think it certainly would argue against the proposition that you have "one scheme" for all businesses.

PROF WOODS: Some of your larger members may not want to hear that.

MR ANDERSON: I was just going to say - at the same time, that's not to say you can't have one scheme made available to a nationally operating company who wishes to only operate with one scheme and take the risks that that scheme will deliver them a premium which they have to accept for all purposes.

PROF WOODS: Very well put, Mr Anderson. No, I think we understand your views there. In terms of nationally consistent definitions, you talk about wanting, say, in the course of employment a definition. You then reinterpret that, which is always an interesting challenge when you look at variations on words, because you come up - "or that employment play" - and you say - "a major or significant part in the development of the injury or disease." Now, is that a sort of general form of wording, or is it a deliberate inclusion of the word "a major", ie, that there can be others equally or even more major or significant, or on reflection, would you have rephrased it as "or that employment played 'the' major part in the development of the injury or disease." And we're not looking for the definitive legal interpretation, but there's just a principle lurking in there somewhere.

MR ANDERSON: Yes. I think what we're looking for - what we're trying to convey here is a message that the concept of "arising out of or in the course of employment", which is the traditional concept in the systems, has been interpreted so broadly that there is no sense of significance or materialiality that is really incorporated, that creates the causal connection between the workplace and the injury in any significant way. The courts have really moved, because they've seen workers compensation legislation as beneficial legislation, to apply very broad interpretations so that any even incidental connection with the workplace is seen as arising out of or

in the course of the employment. And so we think there should be some not only common definition, but a tighter definition that involves the issue of significance or major connection.

DR JOHNS: Do you have a preferred set of words?

MR ANDERSON: Our preferred set of words would be for the injury to have "the significant" connection with the workplace, not just "a significant" connection with the workplace. The workplace should have to be "the significant causal factor". But that is an ideal situation and it would still be an improvement on the current interpretation, if the workplace had to be a significant contributor.

DR JOHNS: These words are very important, I know, and I guess by definition that hasn't been tested in a court of law otherwise - well, it may have been, actually. A judge may have - - -

MR ANDERSON: It hasn't in the general sense.

DR JOHNS: - - - considered that.

MR ANDERSON: But in some of these stress-related claims, or the psychosocial claims, it has been because a number of jurisdictions did move during the 90s - - -

DR JOHNS: That's right.

MR ANDERSON: - - - to put some tighter language around psychosocial claims.

DR JOHNS: That's right, those words applied to the stress claims.

MR ANDERSON: That's right. In most jurisdictions now.

DR JOHNS: Do we have material on how successful that has been in limiting those claims?

MR ANDERSON: It has helped. It has helped. There are still significant - there are still considerable problems with the management of those claims, both the ones that get through the gate and into the system and also the management of those claims once they're in the system. So - - -

DR JOHNS: The legal definition is just one little instrument.

MR ANDERSON: Yes.

DR JOHNS: Okay, thanks for that.

PROF WOODS: This even applies to an employee who might be "hasty, careless, inadvertent, inattentive, unreasonable or disobedient."

MR ANDERSON: Correct.

PROF WOODS: Yes. We thank you for the case material - - -

DR JOHNS: Drawing our attention - - -

MR ANDERSON: Well, the judges are very open about the way in which they interpret the law. They interpret it broadly but they also tell us just how confronting the law is for the employer. So we have to protect ourself not just against what are matters that we can reasonably foresee and take reasonable risk assessment against, but we have to effectively try and protect ourself and our other employees against the reckless, against the inadvertent, against the inattentive and really, the absolute duty of care that is imposed on us both through the OHS system and through the workers compensation systems - - -

DR JOHNS: Well, just so long as you know.

MR ANDERSON: Well, the judges are telling us that we effectively have an impossible task. We can't appeal to the judges to rectify that but we can appeal to the commonsense of policy-makers.

PROF WOODS: That was genuinely helpful to have included those attachments to understand the spectrum that you're dealing with.

DR JOHNS: Just while we're on definitional things, unless you've written up elsewhere, but under national consistency your very first point is:

> Access and entitlement, the definition of key terms such as: injury, worker, independent contractor -

but you don't dip your toe in the water and suggest definitions here.

MR ANDERSON: No, we haven't.

DR JOHNS: Or tested any - in case I've missed it.

MR ANDERSON: No, we haven't, commissioner.

DR JOHNS: I guess I should ask why.

MR ANDERSON: Why, yes.

DR JOHNS: You weren't asked to do it but - you know.

MR ANDERSON: They are not easy things to put together.

DR JOHNS: Yes.

MR ANDERSON: We would need a number of months of further consultation given that the range of industry sectors - I mean there are industry sectors which themselves apply different definitions under the current schemes for different purposes.

DR JOHNS: Although it does - I mean it begs the question, doesn't it? You've been in the game for a long time, so you've had these discussions endlessly, and you haven't come up with preferred or singular definitions, which means that - not only that people are wedded to different definitions but again, there are real reasons why these things vary from state to state.

PROF WOODS: Because they represent the outcome of a process at any one point.

DR JOHNS: Yes. Part of a jigsaw.

MR ANDERSON: That is true, and I think that some industry sectors will look at, you know, common definitions and see what trade-off is presented as part of a package of common definitions.

DR JOHNS: Yes.

MR ANDERSON: They may have accepted some broader definitions in their own particular jurisdiction.

DR JOHNS: I guess what I'm - what is eventually slowly turning around in my head is that you won't get a single set of definitions unless you have a massive renegotiation of a whole set of conditions because these definitions arose by a set of negotiations. To have a single set of definitions implies, if you like, your going back around the track amongst all the players across six jurisdictions.

MR ANDERSON: I think that's right. I think that analysis is right in the sense that those multiple definitions, each of them has come into operation in the context of a package of changes that occurred at one time or another where there were certain policy balances. So industry is going to look at the overall policy balance that is presented to it if you come up with single definitions inside that package. But that's not to say that single definitions are not desirable.

PROF WOODS: Worth striving for but they need to be put in context.

MR ANDERSON: There's a price associated with those single definitions and whether the package as a whole - - -

DR JOHNS: That's right.

MR ANDERSON: - - - you know, has sufficient in it to justify that price.

DR JOHNS: Could I just get to the bottom - one of the things, it's a really broad point. But your initial point was that premiums are moving up - that might be just a cyclical thing, I don't know, but they're moving up across all jurisdictions because you're referring to the whole of the country - but that accidents or compensated injuries - or however measure this thing - is heading down. So what is - why is this so?

MR ANDERSON: Well, for us that's the $64 million question. In fact - - -

DR JOHNS: I mean let's say greater cost of regulation, take that aside, what's driving all this?

MR ANDERSON: When we try and look inside that there's a range of things that seem to be driving it and they're almost all outside of our control. Claims, once they are in the system, are more costly. That is a product of three things: that is a product of the way in which those claims are managed, is a product of the cost of the health and rehabilitation industries, and it is a product of the dispute resolution processes that deal with disputed claims. In each of those respects employers feel very much isolated from the process. They have very little control over the decisions to accept or reject claims. Have very little control over the decisions to extend or to use or to invest resources into the management and rehabilitation of claims. They have extremely limited control over dispute resolution processes. It now comes, particularly, within - matters are handled by external parties.

DR JOHNS: You see I just - I mean this is really a subset of a larger question of health care which we're all caught up in, which is that the standard of care is increasing. Why? Because we can, technically; we can, we can do it. We didn't use to worry about soft-tissue injury all that much but now we know you can fix it if you go to physio five times. But that costs 50 bucks a pop, that's $250 that would normally not enter the system. It might be carried by the worker but it wouldn't enter the system. So I guess I'm just reflecting on the fact that standards of care are rising, that's why prices are rising. So it's not all doom and gloom, in the sense that standards of care are rising. But often all players don't even recognise that. They almost think we're going backwards but in fact standards of care are improving; but

it's costing.

MR ANDERSON: It's costing, and in the workers compensation context, you know, the - - -

DR JOHNS: Yours is the assignment of costs, in a sense, isn't it?

MR ANDERSON: It is. But there's also the real - what we see as the human resource aspects here, and that is - you know, the objective is to have individuals come back into the workplace at the earliest possible opportunity. There's lots of medical evidence to indicate that the sooner you come back into the workplace the sooner you're going to deal with some of the issues relating to your injury and prevent overlaying psychological effects and all those sorts of things. So, you know, the idea that we will keep people out of the workplace until there is absolute levels of treatment through the whole range of the health system or the rehabilitation system is not the best way to approach managing a workers compensation claim. Yet the system gives employers very little say in that process. We are subject to some very subjective views and decisions made by claims managers.

PROF WOODS: You mentioned that in your opening statement about, in effect, the system creating a wedge between the employer and the employee. We have heard evidence from a number of employers, some of whom would support that proposition that, you know, "The system took over, the rehab provider said this, the doctor wouldn't give a certificate for return to work," whole range of things. Some other employers have suggested that almost despite the system provided you go and do your visits in hospital to the injured employee and check up on them at home and make sure that the shopping is able to be done and that various things are happening, that they are able to maintain a positive relationship with the employee. So to what extent - and it will vary by different systems. Self-insurers have a different relationship anyway so let's put those aside, but in different systems you either have private underwriters who are the claims managers - in other cases you might have a government underwriter but who then employs a third party claims manager, whether it's an insurance company or whoever. Even in those cases, is it entirely out of the employers' hands or can they actually do something within the system that helps maintain that relationship and promotes a return-to-work attitude?

MR ANDERSON: It's entirely out of the employer's hands to control because the employer is effectively at the mercy of the claims manager and the capacity that the claims manager wishes to give the employer to be involved. As I said, employers are subject to quite subjective views by claims managers about the way in which employees should be approached, whether employers should be in direct contact with them, whether employers should be seeking to activate return to work arrangements in the workplace and the like. So there are third parties involved, and then once you get rehabilitation advisers involved, once you get a range of medical people

involved, then there are further and further barriers, all sorts of issues dealing with patient, client confidentiality and the like and the like and the like, so all of these little barriers get erected through, which just create more distance.

So it is true, as you've said, commissioner, that some employers, through good human resource dealing with the staff member involved, have been able to overcome these problems, but they've tended to do so despite the system. That's the point we're trying to make.

PROF WOODS: Okay. But in terms of reforming of various systems you would be looking for opportunities that required, encouraged, facilitated the ongoing relationship between the employer and the employee, and that these other resources are there to benefit the rehabilitation process, not get in the road of the relationship?

MR ANDERSON: That's right. We would be looking for policy outcomes in that direction. That's not to say that we as employers have all the expertise on rehabilitation; we don't. But it's to say that, unless we are part of the decision-making and part of facilitating those things happening, then there's going to be such a disconnect that there are going to be negative outcomes at the end of the day for the recreation of relationships, particularly on longer-term claims.

PROF WOODS: I understand that point. You mentioned journey to work, and I don't want to spend a lot of time on it. You say that you don't accept that it's part of the matters that are under the control of the employer and therefore shouldn't be part of the system. Financially how important is the journey to work component, or is it more a flag of, "This is clearly and demonstrably outside of the employer's control and therefore shouldn't be part of the process?" Is it a financial issue, an issue of principle or an issue of consistency, that as a matter of consistency it shouldn't be in any of the systems?

MR ANDERSON: It's all of those things.

PROF WOODS: I thought it might be.

MR ANDERSON: It is a very important issue of principle, because when you come to look at definitions you have to deal with some issues of principle. But it is also a financial issue because the journey accidents cost, and the journey accidents - - -

PROF WOODS: Can cost a lot, cost a little.

MR ANDERSON: Can have, I was going to say, very substantial cost impacts in the system. So, yes, it's financial but it's also about having a system which has some sensible boundaries drawn around it, and if you expect employers to pay, we should

be paying for workers compensation arrangements which have some relationship to our capacity to control those outcomes.

PROF WOODS: I understand the principal issue, I understand the consistency issue. I'm getting different feedback on the financial issue, but we'll also get some actuarial advice that just pins that down, because some employers are saying, "It's not a big issue. It's not in our system but in fact we separately provide an insurance cover for our employees," et cetera. So some do, some don't. There's a variation.

MR ANDERSON: I think when journey accidents were taken out of the South Australian scheme, for example, in 1994 the authority was able to identify what that meant in terms of premiums, and there was a discernible impact that it had on the premium levels.

PROF WOODS: Yes, and we'll chase down that.

MR ANDERSON: So it does have a financial component.

DR JOHNS: Under Benefits Structure you've made us aware, and we've become aware of course, of the various EBAs that are negotiated a make-up arrangement to top up where a worker's payments are being stepped down after a while. I guess if you have any evidence as to how common that is - I mean, it will be in certain industries, highly unionised ones et cetera et cetera, I guess.

MR ANDERSON: It is almost inevitable those demands, where that exists, exist as a result of demands in industries where unions have exercised very substantial bargaining power, including the threat of industrial action, as part of a log of claims. So they are not provisions where employers have seen some objective benefit in agreeing to fund accident top-up. Almost without exception the employers who are parties to those agreements are quite satisfied that the workers compensation system provides the appropriate safety net for compensation, but it's effectively the industrial relations context that employers face that has brought them to accept that they will top up and pay higher premiums and higher costs for a higher level of benefit.

DR JOHNS: I think the point for us too is, though, that these schemes exist in an industrial relations context and we're not going to take them out of that context, I guess.

MR ANDERSON: No.

DR JOHNS: The other one, under Duty of Care - I think you're searching for a jurisdiction that doesn't exist but I'll need to ask. You're saying:

> In addition to change in the regulatory approach taken by jurisdictions

there is a need for a legal framework which will recognise and enforce contributory negligence in workers compensation cases before the courts and tribunals based on the concept of mutual responsibility.

I understand the concept. Is there anywhere where that is the common law or that's a statute law in another country? I'm not aware of that balance.

MR ANDERSON: No, not quite in that context but we really talk about two angles here. If we're dealing purely with a no-fault system, then issues of contributory negligence don't have a role because issues of negligence don't have a role. But if you start introducing fault components through common law into a fault system, then what we say is that you equally have to introduce some concepts of contributory negligence into those decisions, and our difficulty with the way in which both our statutory occupational health and safety duties are applies as well as the way in which the courts when they come to consider common law apply negligence principles in these cases is that there is such a heavy discount of issues of contributory negligence that it is almost impossible to discern that the employer is anything but entirely responsible, given where there are clearly now discrete differences in responsibility.

DR JOHNS: Where do we have to go to to find cases of judges assigning responsibility. I suspect back in our own common law 20 years ago.

MR ANDERSON: You have to go back into our own common law systems.

DR JOHNS: Are there any current jurisdictions, I don't know, Canada, UK, that you know of? I'd like to have a look at some current system where assigning degrees of responsibility, how it works out and (1) whether it helps, whether it really solves much.

MR ANDERSON: We wouldn't have much luck going to the European countries - - -

DR JOHNS: No.

MR ANDERSON: - - - and in fact I'd urge the commission to do everything to shy away from the European countries, just given their experiences with their compensation schemes, but - - -

DR JOHNS: I don't know, there might be a US state, a system or - - -

MR ANDERSON: We will have a look at that, see if there's some additional information. The Ontario scheme is one that does come to mind, but we will have a look at that - - -

DR JOHNS: Thanks.

MR ANDERSON: - - - and if there's something more we can provide we will.

DR JOHNS: Yes, thanks. Thank you.

PROF WOODS: On common law, do I detect almost a not quite fatalistic but a resigned set of words here. You say:

> Common law is a feature of some workers comp schemes and if it is to be retained it must be restricted to those seriously injured leading to severe disability or death.

et cetera, et cetera. Is that an accurate interpretation of the view of ACCI, that you would prefer it not to be there, but you accept that in a number of scheme it is, it's unlikely to go away and if so here's how it should be structured.

MR ANDERSON: That's a fair analysis.

PROF WOODS: I thought so.

MR ANDERSON: I mean, our view is, as we've said in that part of the submissions, that common law does not sit within the context of the no-fault system, but we do not want a situation where we wait until we get the ideal outcomes before we get some improvements in this area and we recognise there are some political realities. A number of Australian state governments have been elected, or re-elected, on the basis that they're going to introduce or retain common law and they are unfortunate introductions into the no fault scheme, to say the least. But we're not going to let those governments off the hook and they shouldn't be let off the hook. We're not going to say that until they got rid of common law there are other things they shouldn't be doing to make their workers compensation systems more acceptable in terms of economic and social policy.

DR JOHNS: But the amazing thing is you can get elected or unelected picking one or the other. It can go either way, promising to knock it off or bring it in, which is, you know, these things have swings and roundabouts, don't they? Or swings and swings.

MR ANDERSON: Yes. I think I'd rather not make any comment about it.

DR JOHNS: Maybe they're just a pendulum.

MR ANDERSON: That angle.

PROF WOODS: All right. In self-insurance - I don't think we need go any further on common law, I think we understand your view. Self-insurance: you talk about "all schemes should provide for self-insurance of suitably credentialled employers," and then you go on, "Mechanisms should be developed to allow nationally consistent self-insurance licences or a national insurance coverage." Well, let's deal with that in its two parts. (1) you're saying that if it's going to scheme by scheme, then those who are suitable credentialled should be allowed in. What sort of criteria should there be and what sort of criteria might there be at the moment that there shouldn't be, or are you happy to let the self-insurers speak on that?

MR ANDERSON: I think I'd make some general remarks. Self-insurance carries with it some objective evidence, some objective experience that we can point to which would demonstrate lower injury rates, much greater connection between prevention and injury, a much more efficient method of managing claims and a much better return to work rate. So there's some very strong social and economic benefits that accrue in self-insurance, that is why we say it ought to be part of the framework of each scheme or, if you're going to have some national mechanisms, a national structure.

The criteria which apply are tricky, because when you introduce self-insurance components or self-managed components even, into workers compensation schemes, you have to look to the impact on the scheme as a whole and there are certain trade-offs. Because if you accept the proposition, as we do and as the objective shows that the self-insurers tend to be the better performing employers, with lower cost structures, then you're taking good performing employers out of a scheme and you're leaving a scheme to be funded by employers who would have a proportionally larger number of claims and potentially higher claims costs and that impacts on premiums for those that remain in the scheme. So there are some trade-offs.

I think that by and large the jurisdictions have dealt with the self-insurance issue pretty well. They've tended to look at self-insurance avenues for employers who have been able to establish objective evidence that they are able to administer, financially justify self-insurance arrangements and to do so in a way that doesn't prejudice or threaten the total operation of the schemes. I think self-insurers still pay some administrative costs for components of the administration of state schemes. So I don't think that the criteria that are used by the states are the real problem, as a general rule. I mean, the self-insurers will come to you and they will have much more specific points of view to put and they will understandably, I think, argue that some of that criteria is too inflexible and probably in some respects it might be.

PROF WOODS: Like headcounts of a very large size in some states.

MR ANDERSON: And some - I think one of the problems that I think they very

fairly point to is to the almost paternalistic way in which some of the authorities want self-insurers to effectively justify to authorities that self-insurers can do all these things and meet these standards, and yet some of those authorities themselves, when they were managing workers compensation, claims themselves had such a poor record, so much poorer than the self-insurers, that one wonders why they would be asking the self-insurers to justify their performance in such specific terms. But having said that, we have to have some interest and the authorities do have to have some interest to the impact on the scheme as a whole, but they shouldn't be the overriding factors. These are balancing factors and if we are looking primarily at schemes which produce the economic and social objectives we want, then self-insurance is right up there as a category of businesses who we give a big tick to.

PROF WOODS: Okay. Then you talk about allowing nationally consistent self-insurance or a national insurance coverage. Again, is that an area where you want to make any points?

MR ANDERSON: I think that one of the key opportunities that presents itself and really what we have to grapple with, is how we will provide a mechanism for nationally operating companies to operate systems across state boundaries in a way that they can manage claims on a consistent basis and the like, and it does seem that self-insurance mechanisms across state boundaries need to be established. The mechanism of using something like the Comcare scheme is one of them; the licensing arrangements under the Comcare scheme. They are limited to companies that are in competition with public authorities and they are discretionary decisions made by ministers of the crown. I think that if some of those rules were made more flexible, some of those legislative requirements made more flexible, then we might see a greater attraction for national companies to use mechanisms under the Commonwealth Safety and Rehabilitation Act. That might be one mechanism in which you could also introduce components of self-insurance.

PROF WOODS: A lot of these members are at the big end of town and are members of ACCI, aren't they? The self-insurers.

MR ANDERSON: A lot of those companies are larger companies, obviously we're talking here about nationally operating companies, companies with large financial profiles and they would be members of ACCI, ACCI being a peak employer organisation.

PROF WOODS: And do you represent them at things like the National Occupational Health and Safety Commission forums?

MR ANDERSON: Yes, we do. We represent industry generally in those forums. So we wouldn't - specifically we're wearing one hat but would be representing industry generally, yes.

PROF WOODS: I could ask you whether they felt adequately represented on that forum but, as I know the answer and you don't, that's probably an unfair question.

DR JOHNS: Read the transcript - prior to lunch, wasn't it?

PROF WOODS: Yes. Okay, moving on. Dispute resolution; you've given us two lines. Your membership to ACCI is across all jurisdictions. Are there some that report to you better dispute resolution mechanisms in their jurisdictions than others?

MR ANDERSON: We've left a lot of the work on dispute resolution to be presented through the individual members because they are really dealing with their experiences in their state systems.

PROF WOODS: Yes, sure.

MR ANDERSON: What we've identified here are a number of key principles. There are differences between the state systems and the experiences that are being reported, no question of that. As a matter of common message though the dispute resolution processes fail their test of really allowing employers to manage that relationship they want with their staff members. The inability of almost being able to talk directly to the employees - employee involved through the dispute resolution process. That in itself is an inhibitor to resolving a dispute and returning to work. You're talking through various agents, various representatives, mediators, conciliators and the like.

On the positive side there have been a number of changes in some jurisdictions to dispute resolution where there have been more informal mechanisms introduced. Those informal mechanisms are designed to try and reduce costs and involve less legal expense, particularly. But the way in which all of these dispute resolutions operate they are subject to administrative overview, the whole process of administrative law, principles of natural justice. So lawyers do get involved even when you try and limit the involvement of lawyers in these processes. The processes still become quite formalised even if the statutory policy was to make them informal.

PROF WOODS: Thank you. I then move on to occ health and safety. Have you got anything further - - -

DR JOHNS: No.

PROF WOODS: You are an active member of the national commission. You say that the commission is now recognised by the stakeholders as having a central role to play in the implementation of a nationally consistent framework et cetera et cetera; they produce guidelines and standards and various things. Yet you quite rightly

point out there are still issues of inconsistent adoption once it gets down to state level. In fact, your sub-membership then is often on tripartite bodies at the state level where there is yet again the argument re-run and some variations on a theme negotiated out, which comes back to Dr Johns' earlier point about much of this is the result of a process of negotiation within an industrial relations environment at the national level, not in a sub-national level.

What's the way through? A lot of employers come to us and say, "We want to have one safety management culture. We want to have one set of standards across our various enterprises that we are confident meets all of the minimum requirements in the various jurisdictions but we are constantly having to monitor eight systems" - presuming they're not caught under Comcare or the Seafarers, and most aren't - "and we can never be certain that we have actually captured all of that. What is more, if we have got a shortage of staff in the Perth office we can't immediately send someone from the New South Wales office to go there until we have retrained them in the differences between the two, to make sure that, you know, we don't inadvertently get ourselves into trouble by doing something that's not permissible in that jurisdiction." Is there any way through? I mean you're well-versed in the politics of NOHSC, and let's not pretend it's anything but a political environment, not in a party political but in a sense of parties with interests coming together. Talk to me. What's the answer?

MR ANDERSON: We are, obviously, one of those parties.

PROF WOODS: I know.

MR ANDERSON: It is not an easy environment because it is a tripartite environment which is trying to bring forward differing interests and converge them into a common position. So it's quite a difficult objective NOHSC sets itself. I don't think we should expect it to be otherwise. It is not an easy task. Having said that, there is considerable progress that has been made in the development at the NOHSC level of key nationally - or key standards which are seen as the ones which should be the subject of national consistency.

PROF WOODS: So we're talking about heavy lifting, we're talking about hazardous - - -

MR ANDERSON: Dangerous goods, hazardous substances and the like. I mean these are - these have been developed through the NOHSC process. Quite a tortuous process but one that I actually think needs to be quite tortuous because it needs to have rigour in it, before you get to the idea of recommending any standards. It is true that then you have a whole process that operates at a state level. That cannot be avoided. But there was a decision made in the mid-1990s by what was then the labour relations minister's council which I thought was a good one because what it

said was that before NOHSC goes ahead and develops a standard on a particular issue there should be some political ownership or some governmental ownership of that process. So government should say, ministers should say, "Yes, we think there ought to be a standard in this area. We've got some preliminary information that objectively justifies that. Go ahead and develop it." So NOHSC then goes and develops it in the knowledge that - - -

PROF WOODS: It has got the backing of - - -

MR ANDERSON: That it has got the backing of ultimate decision-makers, at least in principle. That, I think, has been a good thing because the last thing you want is for NOHSC to go off and go through its tortuous process of developing standards only to find that it simply gets thrown off the table, not even considered seriously; at the decision-making level states - in one sense. So is there a simple way through? No, I don't think there is a simple way through. At a NOHSC level, certainly from an industry point of view, we are not saying that the way in which you implement a national standard ought to be identical. We are saying on the key standards there should be national consistency.

Some jurisdictions implement a standard through a regulatory mechanism, through its regulations in one of its underpinning regulatory enactments to its primary OHS legislation. Others may use codes of practice. Others may use guidance material. Others may use codes of practice which are called up as mandatory codes. Others may use voluntary codes. They are all options which from our point of view, industry's point of view, are quite acceptable as open options for the jurisdictions. They are matters which our affiliates at the state level quite properly can and should negotiate with state governments and other interest groups in the states. What is unfortunate is if the substantial elements - - -

PROF WOODS: Yes.

MR ANDERSON: - - - are re-negotiated, as I say - - -

PROF WOODS: Yes, it's not so much the form in which - their issue but it's the substantive content.

MR ANDERSON: Yes.

PROF WOODS: That if the railing height gets changed or the load level gets changed then - - -

MR ANDERSON: Now that is, I think, where the system can really go around in circles. I think that's what we have to try and avoid. The way to avoid that, I think, is to make sure we have this political ownership in the first instance of the NOHSC

process; secondly, for the governments that are involved in the NOHSC process to be working in that NOHSC process not just at an intellectual level but on the basis that it is a process that is going to deliver to them something which there is an expectation that they will implement. So the government representatives on the NOHSC are not just there for their contribution, their intellectual contribution to the process, but their contribution to the process as being people who will have to take and implement what is happening, rather than just take and implement something - just take something that is happening and then review it all over again.

I think I've seen a little bit of evidence that government contributions on the NOHSC process is at an intellectual level but is not necessarily at a level where there is actual ownership of the issue and I think there needs to be some improvement in that regard at the NOHSC level.

PROF WOODS: Is the possible consequence of that though that when each good state official trundles along to NOHSC knows that by agreeing to it they're committing their government to its full and complete implementation that you might even get less agreement at the national level because of that?

MR ANDERSON: I don't think we would be expecting, you know, full and complete commitments, you know - water-tight commitments under a seal. I think what we're looking for is an involvement in the process where they have undertaken through their involvement in the process the consultations that they would be wanting to occur at a state level.

PROF WOODS: Okay, so more certainty but not guaranteed.

MR ANDERSON: More certainty but not guaranteed. I mean, I think if you ask governments to guarantee then, you know, you would probably be unlikely to get those guarantees and therefore you may not get them participating actively in the NOHSC process and that would be a negative.

PROF WOODS: That would be the down side. I think that's probably all that I have. Are there matters that we haven't dealt with that you would like to draw to our attention?

MR ANDERSON: We haven't spent much time on the issues of enforcement on the OHS front but our submission says quite a bit about that and - - -

PROF WOODS: Yes, I've read it but I didn't have it any questions on it. It was quite self-evident.

MR ANDERSON: I think I would just draw your attention to that as it's based on the data we've presented again today, there's we say quite a significant imbalance in

the way in which jurisdictions are approaching the - - -

PROF WOODS: Yes, and you go through chapter and verse on numbers of regulations and acts and, I mean, yes, we've got that information. The message is clear. Thank you.

MR ANDERSON: I appreciate the opportunity to address you.

PROF WOODS: Thank you. We appreciate the time before and now in the build-up to this submission and today, ACCI's involvement in the Productivity Commission's various inquiries is always very welcome and very helpful. We look forward to your ongoing cooperation with us in this one. Thank you very much.

PROF WOODS: Now, we welcome Multiple Sclerosis, MS Australia, Victoria. Could you please for the record state your name, position and organisation that you are representing?

MR BLACKWOOD: Alan Blackwood, manager of policy and community partnerships at the MS Society of Victoria.

PROF WOODS: Thank you very much. Are you the only one who's going to be speaking?

MR BLACKWOOD: No, I'm actually - the MS Society of Victoria is part of a state consortium of other organisations dealing with the issue of people in nursing homes so we have here a representative from the Transport Accident Commission and Headway Victoria.

PROF WOODS: Do they wish to come forward in case they wish to speak or are you happy to just - your choice. But if you change your mind let me know. We have a short submission from you but as I detect the light beaming over my shoulder you also have a presentation so do you want to proceed through that?

MR BLACKWOOD: Yes, okay. This kind of follows the same theme as the submission. The young people in nursing homes consortium has been around for a couple of years working on an issue that's been around for more than two decades. I think given we've just had a national conference last week and one of the major themes was the differences in funding and service availability across different states for people with disability and catastrophic injury. So what we experience here in Victoria is very different to what our - as you would know - what our counterparts have in other states. Our consortium represents over 6000 people nationally under 65 who live in nursing homes. We've got 1500 in Victoria and it's mostly acquired disability. I guess for us it represents kind of a systemic failure; the care and funding arrangements for disability are such that the aged care system has to work as a safety net.

Systemically across the country there are 6100 people from numerous different funding sources and causes of accidents. Nationally 5 per cent of aged care beds are occupied by younger people which means that they're inaccessible to older people. In Victoria there's nearly 600 people who are stuck in hospital waiting for aged care placement which costs this state about $280,000 a day; Western Australia it's about $90,000 a day - - -

PROF WOODS: Is that after allowing for the fact that if they are classified as, what, after 35 days as a nursing home type patient the state can charge a component, contribution from them?

MR BLACKWOOD: I'm pretty sure this might be pre that time.

PROF WOODS: Gross or net?

MR BLACKWOOD: This would be gross I would think. But I suppose it just highlights the inefficiency of the system. In Victoria that means that a hospital the size of the Monash Medical Centre is out of action permanently because it's filled with people that don't need the acute care and the people with disabilities who are living in nursing homes don't necessarily want to be there either, which has not got a huge amount to do with compensation but that's kind of what the system throws up. Our main sort of contention in regard to this inquiry is just the inequities that exist across the system around disability.

PROF WOODS: I presume you are also making a submission to our inquiry into the Disability Discrimination Act?

MR BLACKWOOD: I think our organisation separately may well have done so.

PROF WOODS: Yes, we're running them in parallel purely coincidentally but there is that body of inquiry that's happening.

MR BLACKWOOD: Yes, and we've seen people nationally who either fall just outside compensation schemes or whose compensation schemes are just so inadequate in their cover that they basically end up in the public system. Here we've got the comparison about someone with a disability who is fully funded, which means that they get government funding, they're non-compensible. They may grow up with a disability. They can get - you know, I suppose if they're fully serviced as an adult it can cost somewhere between 85 and 120,000 for their service. If you're a person with MS or a person with acquired brain injury, spinal cord injury, who ends up in a nursing home it is not compensable for the amount that you attract. It's about 37,000. You might have very similar needs but what happens basically is a safety net service; you get very little.

It doesn't mean that you don't consume $85,000 worth of service but that within the facilities that comes from other residents' funding so it's a lot of cross-subsidisation within facilities.

PROF WOODS: I was going to say, things like therapy does happen in aged care facilities but it's done from within the resources - - -

MR BLACKWOOD: It's done from within the resources. It might be half an hour a week so if you're someone who needs sort of a full rehabilitation program after a brain injury to sort of get back to strength and you don't get it then you end up contracting and needing a huge amount more care. So it's not much of a saving.

These figures are around what it costs other schemes to look after people with severe disability. These ones came from the New Zealand Accident Compensation Commission but looking at figures the TAC would provide they're probably fairly comparative. A quadriplegic with full care would cost you around $145,000 a year with rehab costs, rehospitalisation. They sort of estimate the cost at about 15 million over a lifetime. That actually includes loss of earnings payments. So that's for someone obviously who has a very severe disability.

Look at someone who's a paraplegic who obviously doesn't need quite as much care and is relatively independent, it's still going to cost the scheme about five to six million over a lifetime. You can compare that with people who - this is the sort of a no-fault system as you would be aware. Where there's a fault-based system, we've had recent press from public liability and medical indemnity schemes and obviously the lump-sum workers comp schemes, you know - payouts of 2 to 3 million are excessive. So if you look at someone who's a quadriplegic who may attract 10 to 15 million dollars of care in a no-fault scheme may attract 2 to 3 million in a fault scheme. Obviously it won't last them their full life. They'll end up in a nursing home. If they happen not to have a common law claim and they've got nothing - - -

PROF WOODS: But they'll go onto the disability pension and I mean - - -

MR BLACKWOOD: In terms of their income they'll get the disability pension.

PROF WOODS: I mean part of what - almost, what, at least two-fifths of that is compensation so if they go onto a disability pension then - I mean, it may not equate to that level and in fact it doesn't equate to that level but - - -

MR BLACKWOOD: No, I guess it's just that what we see is that basically what people get in aged care and again if it's entering the system later in life when the system is not prepared to absorb you, you would sort of bypass the disability services system completely.

PROF WOODS: Now, those costs per year, does that include accommodation costs?

MR BLACKWOOD: No, that's really just whatever is in their scheme paying for things like attendant care, equipment, that kind of thing. In Victoria - this is just the Victorian - you would be aware of what exists in other states with fault-based and mixed schemes. For workers compensation and CTP you've got no-fault schemes but very different arrangements when you get to the fault component. In Victoria we've got a crimes compensation scheme that offers you maximum of $7500 regardless of the injury that you receive and limited medical and wage replacement. Clearly if you fall off your roof, dive into a shallow dam, contract multiple sclerosis, you get nothing. You've basically got to queue up with everyone else. There's no set

system.

Regardless of cause severe disability is treated very differently. This is an example of a particular case that falls into the crimes comp jurisdiction. It's a young woman who spoke at our national conference. She's 17 years of age and living in a nursing home after being beaten last year by her boyfriend. She's basically got no compensation. She's going to be ending up in the public system. She's got very little opportunity for alternative accommodation other than aged care nursing home but had she been bashed at work, had she been in a car accident, had she been in New Zealand, she would have a much better opportunity both for rehabilitation and for lifestyle. So we see that people like Angela are kind of indicative of those that - you know, her family would have paid CTP charges, private health insurance charges, whatever - workers comp, but she can't claim on any of it. So it's sort of like the cover that she's paid for is just inadequate and the community response to her is also inadequate.

As I said, our major issue is inequity and we see this inquiry as an opportunity to sort of raise the issue of how the community or how nationally we deal with catastrophic injury because with over 30 different schemes which include federal and state governments and the various insurance schemes it's just a lottery about how you come by your disability, and in effect we insure for the cause of disability, not the effect. I think we're much more interested in setting premiums for cause, not for effect. When you can see the different outcomes of the various schemes; Queensland that basically tips you out after a number of years; Western Australia, which is an awful scheme. I think there's a good rule of thumb that if you're ever interstate make sure you rent a Victorian hire car, because you'll be much better. I mean, I squirm every time I go to Western Australia or New South Wales and get driven around, just sort of, you know, try and be a passenger because it makes all the difference that you've someone to sue if you are injured.

Equally, you look at the nonsense that's gone on with medical indemnity, you know, where we insure the practitioner rather than the individual. The cost of premiums have got very little to do with the risk that you're insuring against. And regardless of what happens, the community pays. I mean, someone who is not compensable and ends up - someone like Angela - the community will pay for her. There'll be not only the nursing home costs, but there'll be the upstream blockages in acute care, lost wages from her and her family. And a lot of it is hidden costs and I think as we point out in here, the non-compensable group who have substantial amounts of unpaid care from family is just a huge bubble coming through the system, very similar to the aging of the population. There just doesn't seem to be a great will within the federal sphere to fix this problem, so we've looked to the minister for aging and also the minister for family and community services to address this as a national problem and they seem to be a little unwilling, they want to push back to the states. Perhaps the minister for workplace relations that I think referred this matter to

you guys may have more interest in it, so this could be the thin edge of the wedge, just to have a decent response to this issue.

DR JOHNS: You can buy insurance for catastrophic accidents, can't you? I know someone was - a paraplegic I knew some years ago was actually selling me an insurance which would give me, in a catastrophic situation, quite a reasonable coverage for a particular period until - sort of greater life insurance or something kicked in, I forget what it was. Anyway, it raises a question of the extent to which you have a national scheme which covers all, regardless of cause of whether people look after themselves.

MR BLACKWOOD: Whether they can look after themselves and I think salary insurance is a product that seems to be bridging a bit of a gap and it's again - - -

PROF WOODS: Continuity of income.

MR BLACKWOOD: But the thing is that there is the money in the system, nationally, but it's kind of not being used very efficiently. And particularly where we're over-insured. If you consider that we all pay - if we pay private health insurance, CTP, workers comp, salary insurance, we can be spending two to three thousand, four thousand dollars a year for insurance and we still may end up like Angela. So in that sense you can't - - -

PROF WOODS: There are some gaps.

MR BLACKWOOD: There are some huge gaps and I think where and how you come by your injury and the cost of it just should be - and there's a whole lot of social issues as well as just the economic ones. In terms of the cost to the community, again, to try and explode the myth that the size of common law payouts to victims are increasing and crippling the insurance industry, the Supreme Court of Victoria, which holds funds in court for awards in Victoria, has kept records over a 12-year period and there's only been three awards of over $5 million in that time. They were all for quite young people who will never have any chance of working. So you compare that to the other people that we saw in New Zealand and the costs that they will incur. If you get an average, you know, you might get a couple of million, it's going to run out and we're certainly aware of a number of people who are looking down the barrel of going into an aged-care nursing home because their lump sum is running out and they're only 35 years of age.

And again, with taxation, superannuation, there's a whole lot of other Commonwealth areas of law that severely limit people's ability to use that money for disability and I think in the recent budget the federal government is looking at imposing further taxation on the loss of earning capacity payment, rather than being treated as an asset, it's now going to be treated as an income stream and taxed. And

again, you know, that's often used for things like home modifications, vehicle modifications and cost of care. So you lose that in tax, the fund will just run out sooner and you'll end up with more people queuing up for public services.

Again, the problem with common law systems is that if fault can't be found, the disability remains. It's just, again, the problem for the victim and their family to find the best option and clearly if we've got over 30 insurance schemes for disability and personal injury in Australia, it's just not good enough that there are the sort of gaps that there are. But as I said, it's the problem with transition from one scheme to another. Like in Queensland; we've been aware of a number of people coming from Queensland back to Victoria, like the people that head for the sun and work for a little while, have a severe injury and then need to come home, it takes agencies like ours a huge amount of effort to try and get them onto the Victorian schemes and generally the governments aren't that happy about, you know, taking refugees from other states. It's just cost-shifting, really, and that's one of our major problems with younger people in aged care is that it's clearly just a cost-shifting exercise between the Commonwealth and the state and between two Commonwealth departments. So if anything could be done to fill some of those gaps and use some of the money that's already in the system, that would be good.

Also, just some figures from New Zealand. These were actually provided to us by the ACC, so we don't have much comment other than just the initial reaction that the cost of premium does not relate in any way to the value or the effectiveness of the cover. You look at the costs of premiums in New South Wales, Western Australia, they're all sort of fault based systems where you can be injured, turfed out and end up in a nursing home and you've paid a substantial premium. I mean, without taking in regard other income of the ACC from government, it looks like it's a fairly good value for money type of operation.

So we'd like to see that - you know, again, it's probably a sister argument to the one that's running about whether or not we should have a private insurance levy. I mean, buying insurance does not necessarily buy you a good system. So what our consortium would be recommending to this inquiry is that we look at a particular solution to people with catastrophic injury. I think there's a lot of issues that you're dealing with that have really got very little - you know, in our sphere, that clearly there's those people that are injured within workplace accidents that are part of our group that end up in aged care. We would support a no-fault system for that group. Part of the whole of government, which again we're calling on the Commonwealth to provide some leadership around securing a reliable revenue stream for catastrophic injury and disability. It could be across the country, within solutions that are not limited to one state or another and if a disability lasts a lifetime as a result of an accident, then clearly the resources should last a lifetime as well. That's about it.

PROF WOODS: Do you have a copy of those overheads that can be left with us?

MR BLACKWOOD: I can leave you with the CD, if that's going to be of any help.

PROF WOODS: We will turn that into an official submission. You're happy to go on the web site - - -

MR BLACKWOOD: Yes, sure.

PROF WOODS: - - - as a supplement to your other submission. A few years ago I conducted an inquiry into residential aged care and travelled through all the states and territories and travelled to metropolitan and regional and outback centres and came across a few examples of people in their 20s and 30s in residential aged care. I mean, the care they were being given was professional and good in the context, but their life needs, in some respects, were so different from those of the rest of the residential body, that it was tough. It was very difficult, not only for them, but for the carers, who recognised that these are, in all other respects, fit, healthy, 20, 30 year olds who, in other ways, would have been going out and playing the footy or having girlfriends or doing whatever, whatever and yet were unable to care and they were going to be there for 50 or 60 years because physically they were fit and well and were cared for to remain so, no difficulty there, within the limits of what they could do so that they didn't fall over and didn't compound injuries, and all those things, but they were there for a very long time.

MR BLACKWOOD: Yes, we see the aged care providers as being fairly heroic in all of this. They really sort of are the compassionate end. They'd rather not have people like this but there's no option in the system. 37,000 a head doesn't allow them any flexibility in doing other than just exercising their goodwill to the maximum.

PROF WOODS: Yes, well, we certainly didn't come up with any creative solutions other than to recognise the issue and to recognise within the circumstance the high level of goodwill that was made for these people, but it wasn't the ideal solution.

MR BLACKWOOD: It's certainly a tough one. It's been around as long as most of us have been in the sector.

PROF WOODS: Also the age profile of the carer in those environments is at the upper end, and these people were going to go through a multiplicity of carers, so they weren't going to get long-term relationships with their carers because they were all going to be retiring in 10 years or so, as would the next group, as would the next group, and they were going to be there for 40 or 50 years.

MR BLACKWOOD: Yes. We had some feedback from some of the people at our conference that they'd actually make friends with the older residents and their children who would come to visit them, but then once the old person died that was

the last they saw of them so, as you say, they have these sort of intermittent types of friendships.

PROF WOODS: Certainly in terms of being friends with the residents, yes, that's a very short-term relationship in most cases - not all but in most cases. But with the caring staff as well, they were going to outlive them in terms of the working life of the carer versus the resident several times over. I appreciate you bringing the issue to us so that we can be conscious of the broader context as we go through our various deliberations.

MR BLACKWOOD: Thanks for the opportunity.

PROF WOODS: Thank you very much. We'll convert that into a formal submission and post it on the site.

MR BLACKWOOD: Thank you.

PROF WOODS: Our next participants are the Australian Psychological Society. Gentlemen, could you please for the record state your names, positions and the organisation that you're representing.

MR CROOK: We're both from the Australian Psychological Society. My name is Arthur Crook and I am principal policy analyst for the society. I'll let my colleague introduce himself.

PROF WOODS: Thank you.

MR STOKES: My name is David Stokes and I'm the manager of professional issues for the Australian Psychological Society.

PROF WOODS: Excellent, thank you, and thank you for your submission. It's impressively detailed. Somebody has gone to a lot of trouble.

MR CROOK: I am assisted in my role by a national working group on workers compensation that we have in the society. It covers all of the states and territories of the society and they've contributed substantially to do that.

PROF WOODS: It was very helpful. You've pursued a number of issues in a great deal of detail, so it was quite helpful reading. I guess your comment then reinforces that you've also drawn extensively on initiatives in the various jurisdictions, quoting even as recently as the Stanley report in South Australia et cetera. So the currency of the submission is very welcome.

MR CROOK: We made a submission to the Stanley review and have only just, as everybody else has, seen their final report. I'm not sure I've digested all of it.

PROF WOODS: No. We're also monitoring it closely.

MR CROOK: There are some other developments that we've recently become aware of, including in Queensland, and therefore the report is not quite as up to date as it can be, but it's such a dynamic field.

PROF WOODS: It's only up to date as of yesterday, not today?

MR CROOK: Yes, exactly.

PROF WOODS: Okay. We won't admonish you for that at this stage. But certainly as you become aware of matters that are relevant to your perspective you can if you wish - and we would encourage it - make them known to us.

MR CROOK: Thank you.

PROF WOODS: Thank you. Now, do you have an opening comment you wish to make?

MR CROOK: We thought rather than a formal opening comment, and particularly in view of the time, that we'd make the whole time available for discussion of our key issues as well as any questions that you may wish to ask of us arising from our detailed 64-page submission. Can we begin by thanking the commission for the opportunity to discuss these issues, as they are very, very important for psychologists and the clients of psychologists, and we should put some emphasis on this, that it's not just self-interest. There is an element of self-interest but we have great concern also for the welfare of injured people, and the previous speaker I think summarised the attitude of most psychologists about transferability of provisions, a fairer and more just system and so on.

We didn't anticipate or we didn't know what sort of technology might be evident here and we do have the capacity to put on some overhead slides, but if that's difficult I do have some hard copies.

PROF WOODS: Yes, if you could provide us with a copy and we can follow you through.

MR CROOK: Okay.

PROF WOODS: Thank you. Are we able to incorporate these in the transcript?

MR CROOK: Yes, please do.

PROF WOODS: Thank you. Please.

MR CROOK: You already know, of course, that the current occupational health and safety and workers comp systems are not planned. They've developed like topsy and it's no surprise that they're unintegrated and diverse, and in our view they don't have enough links with the other health and welfare systems, although they do have quite tight and sometimes dysfunctional links with the motor accident compensation arena, particularly in regard to some problematic legal definitions and also what we regard as flawed assessment of psychiatric impairment. That came out of the Motor Accident Commission, at least in the short term, although the Motor Accident Commission borrowed it from an earlier version of the workers comp system, so they're a bit interactive.

PROF WOODS: They do tend to leapfrog each other.

MR CROOK: They do indeed. Our submission is primarily aspirational. We've

identified a number of problems, but it wasn't our main intent just to tinker with the current system. We believe that it needs to be changed in some fairly fundamental ways. I don't think our views are novel. Similar suggestions were made by the Industry Commission in 1994 and only some of those recommendations seem to have been implemented. I think it's a shame that there wasn't full implementation of the package of reforms that was suggested as far back as then. One of the suggestions, and one of our main suggestions, is to move away from an adversarial system and to have a better focused and better coordinated system, stronger linkages between occupational health and safety and workers compensation, uniform legislation provisions - - -

PROF WOODS: By "uniform", can I just ask at that point, do you mean uniform within jurisdictions such as you have a common definition between CTP and workers comp or what constitutes a worker between workers comp and payroll tax, or do you mean uniform between jurisdictions in the one area of legislation, for example workers comp across all jurisdictions? There are different ways of slicing it.

MR CROOK: Mainly across regions and within workers comp, but also between workers compensation and occupational health and safety. I know there are legal complexities there. We are not lawyers and, as we said at the outset, I don't think any one professional gets a total understanding of the system because they are very complicated systems. But our preference would be that workers anywhere should have the same benefits, the same entitlements, the same treatment.

PROF WOODS: Across Australia?

MR CROOK: Across Australia and even perhaps including New Zealand, because we do note the link between Australia and New Zealand on that. But we're particularly concerned about better coordination with other health and welfare systems because there's a lot of dysfunctional developments in workers compensation in particular, with the definition of "mental health" and the treatment of people with mental health problems, where there is explicit stigma. The Stanley report and many other inquiries have noted that it is a substantial problem, the stigmatisation of injured workers with mental health problems.

One attempted solution to it has been to establish thresholds, the argument being that because of the difficulties of accurate assessment of mental health problems you can get over that by the use of thresholds. That's confusing accuracy with the setting of thresholds, and in terms of decision-making that is a confounding that ought not to occur.

PROF WOODS: It's a point I was going to bring up later, but why don't we discuss that at the moment, if we may. We've been looking at bodily impairment, putting aside your issue at this stage. It can be used as a threshold for access to common

law, for instance, and even in that area if they set a threshold of say 15 per cent total body impairment on a permanent disability basis, it's surprising - well, maybe it isn't surprising but you do get quite a range of different expert opinion as to whether the person is 12 per cent or 18 per cent, and that is fundamental as to whether they do or don't go through and have access to that particular form of redress. Now, there we're talking about bodily impairment. What's the point of a 15 per cent if you can't accurately gauge at least something plus or minus two points? In your field the diversity seems to be even greater.

MR CROOK: We're not sure that it's any greater in the mental health field than in the physical health field.

PROF WOODS: That would be helpful to clarify for me, because the bits of evidence - and this is why it's useful for you to come directly to us, that others who aren't experts in your field have professed a level of confusion perhaps. So, yes, please give us the evidence.

MR STOKES: I think some of the variability exists because of the underlying different dimensions of impairment that come through, and physical area is not my expertise but if I can use that as a springboard to talk about the mental areas.

PROF WOODS: Yes.

MR STOKES: There is a sense in which a physical injury per se can be measured and can constitute some sort of rating of impairment. But more relevant in so many instances is, of course, that functional impairment or their participation impairment, and the categories have been well elaborated by WHO in the their sort of disability ratings scales. But there's always a tendency for people to be talking in three dimensions at once and not settling on perhaps a fixed way of ascertaining what impairment we're talking about, can cause some of that confusion, because clearly from the medical profession's point of view, they have a strong attachment to that sort of physical impairment in terms of its evident state in the individual's body. But their participation or their functional impairment is not something that's well elaborated by some of the specialists in that field.

PROF WOODS: Actually, your functionality is a good point. I mean, I guess a significant permanent injury to the foot for a cyclist is a very different thing from that of a cellist.

MR STOKES: Absolutely. The situation, if you like, or the purpose is not often taken into account when this impairment is made, as if somehow an impairment stands on its own, but it doesn't really, does it? It stand in an environment.

PROF WOODS: Yes.

MR STOKES: And the same is true in the mental disorder.

MR CROOK: There is a difference too. In the physical area, if you have more than one assessment of impairment where there's differences of opinion, well, there's two ways to assess it. The tradition - and I support it - is to use the higher of the two impairment ratings as a beneficial interpretation. In the mental health arena, unfortunately in the Australian system, there are six ratings of functioning and impaired functioning, but it's then scored by taking the median value, the median being the littlemost point.

Now, that, statistically, is a very savage interpretation. It's certainly a non-beneficial interpretation because in the physical areas, either these matters are combined, the impairment measures are combined in the various ways, or they take the higher of the ratings. We have a document which we'd like to table which looks at the five approaches to assessment that are used and with the notation which is not on here - we certainly have it. Do you want one for yourself?

PROF WOODS: Please. Thank you.

MR CROOK: We could note in regard to this that in the physical areas only methods A, B and C, that is simple addition or addition with a correction to prevent the total exceeding 100 per cent, or method C which is the higher or highest of the ratings. They're the ones applied with physical area. In the psychiatric area method E is applied, and method E is more draconian than method D. Method D is the average. Method E is the median. They're both measures of central tendency of ratings whereas the general principle in impairment assessment is to start with the worst area of impairment as the base for the impairment level and then add the other impairment levels to them, either by straight addition, or in some cases if there's a likelihood that you will exceed a hundred per cent by a correction factor.

Now, our view is that correction factor, while it's arithmetically okay to do it, is not necessary in that anybody who is going to get over a hundred per cent impairment is massively impaired. So there doesn't seem to be any - we would have no concern of having a rating of 105 per cent because it simply is operating in an area of impairment that is so massive that the difference is meaningless.

PROF WOODS: Yes.

MR CROOK: But when you talk about 15 to 20 - - -

DR JOHNS: Sorry, just give me the - what's the distribution of impairment? It's not a nice bell curve. Presumably there's a small number of highly impaired cases

and then a very long tail of low suffering. What's the distribution of all such cases in Australia?

MR CROOK: It's bi-modal, that list, and then in some instances multi-modal, that is that there is no one modal point and it depends on the degree to which the injury leads to a particular cluster of impairments that are always associated with that injury; in which case you'll tend to get just bimodal, or where the injury generates multiple impairments which are not intercorrelated. So it's generating separate distinct impairments, in which case you can get a distribution form that looks like that.

DR JOHNS: Yes.

MR CROOK: That's an issue that can only be resolved empirically whereas some of the approaches taken by law and by governments in writing procedures and so on have made assumptions about the underlying distributions, and those assumptions need to be tested by research. That's one of the reasons we place so much emphasis in our submission on the need for a lot more research in the workers compensation area in particular. The OH and S area could do with more research funding, as could everybody, but the workers comp area is one that is relatively inert in terms of research.

MR STOKES: Can I just draw your attention to the sample column which suggests that, for instance under category A, a person would end up with a 30 per cent rating, but using E ends up with a 10 per cent rating. That has significant implications.

PROF WOODS: Yes.

MR STOKES: Particularly in the sort of medico-legal framework that has been recently released in Victoria and so forth.

DR JOHNS: Yes, but I mean, whether you use mean, median or mode, it's just a means of excluding or including groups of people for the purposes of resources.

MR STOKES: I accept that, yes.

DR JOHNS: So that's why you need to know the distribution of illness or whatever.

MR STOKES: Sure. Point taken.

PROF WOODS: But, you see, he raised that - - -

DR JOHNS: So that someone who's writing up a scheme can say, "Okay. We'll

capture the worst and leave the rest," or whatever they want to do. Yes, you need to know that, don't you?

MR CROOK: You're right to draw attention to that. We've referred to the science of diagnostics and gave a reference to it. It's an article by Swetzidel and we're happy to provide a copy of that to you. That looks systematically at decision-making - medical and other forms of decision-making - where you compare the costs and benefits of faults, positives and faults negatives, and you set your cutting points, your thresholds, in accordance with what the policy-makers determine to be the appropriate ratio of costs to benefits.

PROF WOODS: Yes.

MR CROOK: Now, there's two ways of shrinking the number of faults positives and faults negatives; both misclassifications. One is to improve the accuracy of the system and the other is where you set the threshold. That's why I said before, the accuracy of the system should not be confused with the thresholds.

PROF WOODS: Yes.

MR CROOK: If it had a perfect correlation between the actual impairment and the assessor's measure of it, you would then have no faults positives or faults negatives. Because of the perfect correlation, you get no errors. In an imperfect system - and they're all imperfect - there is a number of both faults positives and faults negatives.

PROF WOODS: And it's where your tolerance level lies.

MR CROOK: Yes, and there are now very useful and advanced statistical methods, not just actuarial but statistical methods such as multiple regression and a variety of forms of multi-varied analysis which can be used to optimise the cutting points. This is done - for example, in the armed services in their selection batteries I used for the navy psychology branch and did all of their selection validation. We carried out these kinds of analyses in very substantial detail. They determine the cutting point on selection tests.

DR JOHNS: So you want to optimise the threshold. You're not necessarily on about a more generous threshold in all cases, although it's important to - - -

MR CROOK: No, it's not - - -

DR JOHNS: Otherwise it sounds like lobbying, you see.

MR CROOK: No, we are not pushing as advocates to have a generous or a lenient or harsh threshold.

DR JOHNS: Right.

MR CROOK: What we are concerned about, first of all, is that thresholds should be transparent and not covert.

DR JOHNS: Yes.

MR CROOK: That they should be properly managed in a scientific fashion, and that doesn't exclude political considerations, but the political considerations ought to be made explicitly, not covertly, by the imposition of these sorts of things.

PROF WOODS: Yes.

DR JOHNS: Yes, that's good.

PROF WOODS: Could I actually follow up on that article? If you could make its details known to the staff, that would be - - -

MR CROOK: I have a copy with me and I'll hand it over to them so they can photocopy it.

PROF WOODS: Excellent. I have a staff member in mind who would devour that and interpret it for me in a way that I might understand.

MR STOKES: Can I take a step back, because we've now gone to what we do with the data when it's collected but we haven't quite finished, if you like, working out what are the dimensions or measures we use to get the data in the first place. If I can go back to the mental health area particularly. Our concern has been that there has been a number of dimensions working in that area too, just like there has been in the physical disability. One has been, if you like, the psychiatric diagnosis line which is very commonly followed in workers compensation. Once again the much more useful ideas of functionality and impact are much more relevant dimensions. I guess from our point of view as psychologists we're interested in assessing that as well as some sort of psychiatric diagnosis. That has been one of our concerns with the current practice in workers compensation, which has relied uniquely on psychiatry and its contributions in that area, which have been very much diagnostically focused rather than impairment focused.

PROF WOODS: We did notice you drawing our attention to the dichotomy between them.

MR STOKES: Thank you.

PROF WOODS: The psychiatric/psychological approaches. Carry on.

MR CROOK: We have made fairly strong reference to multidisciplinary collaboration, and that's not just to get ourselves back into the assessment picture, but it is directly related to that issue we've just talked about. Amongst the professionals not traditionally associated with health and welfare are statisticians, engineers, information technologists and architects. This is for both workers compensation and occupational health and safety. Our view is that the systems for both the workers compensation and occupational health and safety could benefit from much more intensive and planned and coordinated multidisciplinary work. There are good models in multidisciplinary collaboration and there are some poor or unworkable ones which we're prepared to elaborate on, perhaps not at the particular moment.

Our view goes beyond just the health professions. For example, in design in the building industry, in the designs of homes, there's a greater move towards prefabrication or partial prefabrication and so on and one of the frequent injuries is of framers who fall off the top of frames. One of the issues there could well be through architects and others, and through analyses of the sources of injuries, that something more effective is done about that. Some things are done, like the installation of rails and so on, but again it tends to be piecemeal. The power of a multidisciplinary team is that it brings together people with different perspectives who work together in the analysis of problems. They don't come up with separate problems and sometimes separate professionals don't even see the problem because it's not within their ken.

We gave an illustration in our submission - two instances, real life instances - about the fleet air arm and the identification of what was the source of problems. It wasn't pilot error that pilots were killing themselves but faulty cockpit design related to human factors where the controls were set too close together and didn't have distinguishable tops. This is some years ago and pilots landing - at night particularly - but under the stress of landing just don't have enough discriminatory capacity using the elbow - feedback from the elbow, as a way of telling where your hand is. You might be able to do it driving your car but operating an aircraft you don't. So the simple solution was to space them out a little more, which you can do mechanically, and also put distinguishable tops on; knobs on the top. Two simple solutions, but the fact there was a problem there of a human-factors kind wasn't identified for about three years, in which time a number of pilots killed themselves.

The other instance we gave was of organisational arrangements which actually promoted conflict between two supervisors, where the blame was attached to the supervisors whereas in fact it was an organisational problem. Some of the recent research on stress is showing that organisational practices - particularly management philosophies, organisational climate and support - are much more crucial in fact for stress in organisations than are individual stressors. Yet in the occupational health and safety field there has been perhaps an over-concentration on the individual

stressors without taking into account the very strong moderating effects of the organisational climate. Again, that's another illustration of where interaction amongst different kinds of professionals can realise where the problems are and the solutions to them. We're very strong on that issue of multidisciplinary cooperation. It is favoured in occupational health and safety much more these days. I'm sure the penny has dropped years ago in that area.

In the workers compensation area there has in fact tended to be a move in the other direction, towards psychiatric exclusivity in the mental health area, which is highly dysfunctional and contrary to developments in health generally where there is a - - -

DR JOHNS: Sorry, just take us through that; psychiatric exclusivity, meaning you blokes don't get a Guernsey. Is that the - - -

MR CROOK: We've been excluded from the assessment of permanent psychological impairment.

DR JOHNS: I see you've got - under the legislative definition of medical assessors psychologists are excluded.

MR CROOK: In some cases and not in others.

DR JOHNS: In some jurisdictions.

MR CROOK: In South Australia they're included and in Comcare they're included, although in the draft Comcare guide we're now excluded, even though we were recently re-included. So they're all over the place.

DR JOHNS: Just give us the sense of why? What's the debate that has happened there?

MR CROOK: We believe - we have no evidence, not much evidence, of this - but we believe that part of the reason has been there has been active effort by a consulting group to persuade governments of that point of view.

DR JOHNS: Of consulting psychiatrists?

MR CROOK: Yes. A small group of consulting psychiatrists - - -

PROF WOODS: But the psychologists aren't paranoid about this?

MR CROOK: No, there are some - - -

MR STOKES: Not much, no.

MR CROOK: The research evidence in terms of treatment is that psychologists are highly effective and there is a very recent set of research reports which have just been completed under the ACE program. Are you familiar with the ACE program?

MR STOKES: The Commonwealth Department of Health and Ageing set up a committee of eminent epidemiologists, psychiatrists, psychologists and others to look at the whole question of assessing cost-effectiveness in psychiatric treatments. Out of that has come some interesting evidence which certainly broadens the spectrum of those interventions which are as effective, if not more so than the conventional ones. Perhaps the most interesting thing is that the public sector employees were a third of the cost of some of the private sector programs. So a combination of issues there, both in effectiveness and in cost-effectiveness, that's coming out of that study. The results of that have not been published as yet but they're on the final stages of their progress.

I guess that brings us a bit back to that multidisciplinary team because in that context you're getting access to a greater range of interventions, some of which are very evidence-based interventions but not necessarily currently part of everyday practice. I guess it also shifts the focus to rehabilitation rather than compensation, which is something we very strongly endorse in the whole process.

MR CROOK: There are some legal reasons too for the New South Wales government's preference for psychiatrists. There is an interpretation locally about the legislative intent of the previous legislation, or the legislation they were amending, and also of the case law regarding psychiatric impairment. That involves the introduction of the American Medical Association guides for the assessment of permanent impairment. The belief in New South Wales, I understand, was that the term "medical physician" - which is the term used in America - was restricted in America to medical practitioners. That was the assumption; idea. In fact it is not the case because in almost all states in the United States and in the District of Colombia the legal definition of "physician" includes psychologists and that penny hadn't dropped in New South Wales.

By the time we got involved in New South Wales and Tasmanian legislation and found out about it - because the change to the definition of "medical assessor" was made at the last minute without any opportunity for us to have any input - we couldn't identify that was the misunderstanding that had occurred. We've been seeking ever since to have that addressed. The problem with case law is that the use of legal terms is very confused. Sometimes the courts use the terms psychology and psychiatry interchangeably, and they refer to psychologists and psychiatrists in the same breath; at other times they refer to them as different. Some judges have suggested that psychiatric injury is not the same thing as psychological injury. We

had thought there was some improvement in the level of conceptualisation legally until we found a recent judgment which said that every injury had to have an underlying pathological condition - sorry, physiological condition; a patho-physiological condition. We are not medical experts but even our medical colleagues assure us that the notion that underlying - - -

DR JOHNS: That isn't so.

MR CROOK: - - - every mental illness is a patho-physiological condition suggests that whoever invented the term has got some difficulties with the understanding of - - -

DR JOHNS: They're only lawyers after all.

MR CROOK: We have a summary of legal cases with the important implications for those issues, which again we are happy to give you.

DR JOHNS: Thank you.

MR CROOK: We, with that, have got an outline of what the particular case alludes to - - -

DR JOHNS: All right, excellent.

MR CROOK: - - - in terms of the legal matters. So I hope you see that my earlier comment wasn't just paranoia but there is some foundation, which we believe to be a false foundation, in terms of some of the contentious legal interpretations.

DR JOHNS: Yes.

MR CROOK: They do need to be addressed. We've made that point in our submission, that we believe that this is another case for multidisciplinary cooperation; that the legal profession and the other professions need to get together more. There have been some - particularly in the Family Court area there has been a lot more collaboration there and multidisciplinary approaches in the Family Court. Psychologists are much more involved in Family Court matters in terms of assessment and treatment and particularly in the conciliation process. That has had remarkable improvements, as I might also say has been the case in workers comp in Queensland, where the involvement of psychologists in Queensland in early intervention has dramatically improved the rehabilitation process. The head of WorkCover has made comments, very supportive comments, along those lines in some of our publications.

The only other matter that we wanted to draw your attention to was we believe

that there is room for much more collaboration amongst the various professions on getting the decision-making pathway right in workers comp in particular. We have a very partial illustrative decision-making map where we've tracked through some of the decision-making processes. This is based on a spreadsheet about that wide, that we couldn't actually photograph in a way that wouldn't need a microscope to read. So this is just a summary of the - of some of the elements of that. We've excluded all the claims management and most of the case management issues from that. We have just focussed on psychological and psychiatric injury and impairment. We have put it in linear fashion although many of these things can be handled in a parallel fashion.

But we note, for example, that WorkCover Victoria has fairly recently moved towards a system like this where they have been able to identify and focus mostly on multidisciplinary assessment efforts on high-risk cases. Although we have some doubts about some components of that or we could see areas where their approach could be improved, that's the kind of economy of effort that a proper focus on decision-making thresholds and the contrast of benefits to negatives is very powerful. That is, I think, a living illustration of taking an explicit look at decision-making thresholds and what happens if you go one way versus the other.

We don't believe - we don't wish to see judicial review removed from the system. We don't believe that medical or psychological assessors should have final binding powers of determination of cases. We believe that the judicial review process is important but we believe that there is too early activation of it and that most cases, if they are properly dealt with in a conciliatory fashion, can be handled. But a lot of the conciliation processes that have been set in place around the states have been set as part of an adversarial system so that they are not really genuinely conciliatory, even though they have all the form of conciliation with - people go into them expecting an adversarial contest then even the conciliation becomes adversarial. So that we would have a number of views that we would like to express down the track about how one could shift that whole system towards a much less adversarial - - -

DR JOHNS: They're also based on a notion of a settlement and settlement relies on negotiation. Most barristers spend all day negotiating settlement.

MR CROOK: Yes.

DR JOHNS: On the basis that if they walk through the door of the court it will cost another 4000 bucks. So I understand it but a lot of the system is based on negotiation.

MR CROOK: Yes.

DR JOHNS: From my little experience.

PROF WOODS: In that respect you made mention of some material down the track. The clock ticketh in terms of us producing a report by the end of September. If that could come to us sooner rather than later that would be helpful. But also given that members of your society practice across a range of jurisdictions, if they were then able to draw from their perspectives some commentary on the relative merits of the different dispute-settling mechanisms in the various state schemes that would be very helpful to us because the conflict that is generated from the process is an important consideration.

MR CROOK: We'd be happy - they do have a - is the mechanism through one of your project officers?

PROF WOODS: Yes, through our staff, if you can make direct contact. In fact, do that on your way out. But before you go, a couple of further things, if I may. One is that - and you raised it yourself - of pre-existing psychological adjustment problems. I mean in some areas of physical injury if a worker goes to work with a leg that is whole and comes back from work with a leg that is broken it's evident that the event occurred then and there. If there's progressive hearing loss or degeneration of soft tissue in the back over a number of years that becomes very difficult to attribute to particular events, the deterioration. As our workforce age some of that might compound itself over time and become a greater issue than it currently is.

But in your area where you're talking about pre-existing psychological adjustment problems, that problem is there as well, isn't it: that it is a person who comes to work to perform a work function. They're not a worker, they're a person with all of their personality that they bring with them to the work environment and that then interacts with the work environment. Where is your profession heading in being able to carefully tease out the various components and understand what is a work injury versus what is a pre-existing psychological impairment that happens to express itself in a particular moment in a work environment?

MR CROOK: There's a vast array of problems. Some of them are identifiable through good selection techniques.

PROF WOODS: Is this person suited to this particular job.

MR CROOK: Yes. So that the military, for example, and a number of business organisations routinely screen applicants in terms not only of aptitude and abilities but also in terms of psychological adjustment. That's not an uncontentious area.

PROF WOODS: I was going to say it's not necessarily a perfect science.

MR CROOK: No.

PROF WOODS: But at least it's attempting a filter.

MR CROOK: Yes, and because the law really takes the view, as you know, that once you employ someone you take them as they are. You can't throw them out because they're different from what you thought they were when you hired them. So the onus is on the employer to identify some of those things. In the assessment of behaviour of somebody who is injured there are methods of trying to assess pre-morbid functioning psychologically. That's easier to do in the area perhaps of brain injury and David is an expert - is a neuropsychologist with a background in that, and he can speak to that. If you're talking about then personality disorders it is more difficult to tease out the interaction between pre-existing personality traits and the work environment.

PROF WOODS: But the pre-existing may be pre-existing as of that morning because of some function, some event, that occurred prior to turn up to - I mean, we're not talking about just screening somebody when they were 18 and first joined the firm. We're talking about somebody who then is with the firm for 30 years and they have an awful lot of life experience outside of the work environment. So it's not good enough just to say, "Well, they were terrific when they were 18 when we first recruited them."

MR STOKES: There's no fixed position on this. I mean, it is very much a sliding scale as to where you stand in regard to this. Do you allow and accept that this is the risk you take when you take on human factors, that you'll have people with situational and circumstantial environments that make them more vulnerable on the day of the event, or that they carry with them a legacy of other psychological issues either from trauma or from genetics? I mean, how you handle that and whether you say, "Look, we take that risk when we employ somebody with these possibilities," or whether you say, "No, we've got to actually attribute the amount on each occasion" - which of course makes it very, very difficult.

PROF WOODS: So which way is your society leaning in that particular debate?

MR CROOK: Early intervention is part of the solution in that if you get someone quickly enough you prevent it escalating, because escalation is a major problem both for the employer and for the injured person and keeping it low key is crucial on that. This is the current system - particularly, requiring a psychiatric diagnosis encourages exaggeration. For the thing to jump a threshold they've got to establish that they meet a high - what are really false criteria in a way - but they then have to exaggerate to meet the threshold. Whether you regard that as fraudulent behaviour or smart system handling behaviour is a different matter. If you can get in early enough and work with the person and have some very quick treatment the degree to which the

behaviour is resistant to treatment is also giving some information about whether it was pre-existing and long-term.

The sort of person you talk about, who comes in with some turbulence from home then has a work experience, is not likely to suffer such a serious psychological impairment that is not fairly quickly remediable. So that early intervention process, and early assessment and continuous assessment as part of the treatment process, helps you to identify that issue about pre-morbid functioning versus how much it was due to work circumstances. The other matter is confidence. There is a therapeutic alliance between the treater and the person so that you get a full insight into it. It's one reason that we find the notion of independent assessors - although on the surface it sounds good and there is a role, I think, for independent assessors - but most of the independent assessors in this system are not genuinely independent. They're seen as hired guns. The courts regard them as hired guns. More to the point, injured people regard them as hired guns. They don't open up to them so they then give them little information - - -

PROF WOODS: And perhaps sadly, some behave like hired guns.

MR CROOK: Yes, and there's no therapeutic alliance therefore there's no exchange of confidential information. There's no therapy, there's no seeing how the person is actually functioning in the therapeutic setting and so on. So the treating practitioner has got much more insight into those sorts of issues, about pre-morbidity and so on, partly because of that therapeutic alliance. The danger with the treating practitioner's judgment is in becoming too close to the person. But that is something that can be handled, and particularly in a multidisciplinary team assessment. We're not suggesting that every member of a multidisciplinary team does all the assessments and the treatment. In fact, as part of our more advanced model, we suggest that a team of professionals work together. You have a multidisciplinary team but that team assesses these people but treats those people. Then the other multidisciplinary team who assesses those people treats these.

PROF WOODS: So they have the competence and the understanding but they separate the roles, the assessment from treatment.

MR CROOK: Yes.

PROF WOODS: No, I think that's actually - would be quite an advance, because at the moment the two roles do get confused. It's like the service provider and the regulator being the one and the same. We've had micro-economic reform for a very long time that has said, "Separate those roles."

DR JOHNS: Just one other - on page 27, section 4. You've used this term a number of times. At the start here, "A high level of employer default and the much

lower level of employee fraud" - default in what sense? What does that mean?

MR CROOK: Simply that they don't pay the level of premiums that they ought to. Either they don't pay any or they underpay.

DR JOHNS: Why is that default?

MR CROOK: Sorry, that might be my wrong use of a technical term.

DR JOHNS: Well, I don't know. If they are charged $1000 a year or whatever, then that's - you're suggesting they should pay more or there's under-funding of the schemes. Is that the - - -

MR CROOK: No, sorry, deliberate avoidance by the employer by various devices of paying these - - -

DR JOHNS: Of excluding workers from the definition, okay.

MR CROOK: Excluding workers or persuading workers in particular, persuading workers not to make claims but have informal ways of providing for them, saying to them, "We'll pay your doctor's bills. Just don't tell anybody."

DR JOHNS: Some of which work.

MR CROOK: Yes, but then the person has no entitlement down the track. So if the problem recurs down the track then they have no redress, because there's no evidence that they ever had suffered that injury at that time.

DR JOHNS: All right, that clarifies that use of the word.

PROF WOODS: I think that probably covers my questions as well. Yes, I think - are there any matters that we haven't dealt with that you particularly wish to draw to our attention today?

MR CROOK: I think we've had a very full hearing, thank you.

PROF WOODS: Thank you. It has been very helpful to us to have your perspective. You are going to come back to us with some further material.

MR CROOK: I will talk to the - - -

PROF WOODS: Yes, if you address the staff as you leave that would be helpful. Thanks very much again for your submissions.

PROF WOODS: Thank you very much for coming. For the record if you could please state your name, position and the organisation you are representing.

MS EVANS: My name is Gwynnyth Evans. I'm from the Meat Industry Employees Union and I'm the health and safety officer both nationally and in the state of Victoria.

PROF WOODS: Thank you very much. Thank you for coming. I have been presented with your submission but, as you realise, I - - -

MS EVANS: You haven't had time to read it.

PROF WOODS: - - - haven't had time to read it. I suppose I should apologise for that, but there hasn't really been a lot of time.

MS EVANS: Perhaps I should apologise for that.

PROF WOODS: But we will read it after this hearing. But could you take us through the principal points and we can launch off from there, please.

MS EVANS: Okay. The reason that AMIEU is particularly interested in this inquiry is the unfortunate situation that the meat industry is one of the more dangerous industries that there are, that the injuries that occur are both very broad in the range of injuries and illnesses that occur in the industry, and the workers compensation issues are in some areas potentially likely to seriously affect major sections of the industry. The AMIEU has a very long history of raising the issue. We have had claims officers for 30 or 40 years - obviously not me for all that time - and we have a history of having the particularly difficult problem that large sections of the medical industry, going back, were not capable of recognising or identifying zoonotic diseases in particular. So we have a history also of trying to intervene to ensure that there is greater education of the medical profession and, going back to the 1960s, we were actually involved in setting up medical centres where there were doctors who were familiar with particularly the zoonotic diseases. So when you do look at the problems for our members, when you look at the injury rates that occur in the industry, there's a 99.6 per cent chance that every worker will have - - -

PROF WOODS: Over the life of your employment you will have a serious injury.

MS EVANS: - - - a serious injury. Of course for some people that means many serious injuries. So obviously we are extremely interested in the developments in both health and safety and workers compensation. One of the difficulties that we had with the terms of reference of this inquiry is that the focus of it is very much on the economic role of the legislation in both health and safety and workers compensation, and we very strongly believe that both health and safety legislation and workers

compensation legislation are predominantly social legislation, not economic legislation. So, whilst we do recognise the need to have an ongoing framework for compensation that doesn't itself collapse or send governments down, we believe that the social role has to be given the major focus in looking at it.

We haven't attempted to address the question of whether there is the mutual recognition, the federal overriding areas, those sorts of issues. We have not addressed that or been able to address that, but one of the areas that we do believe would be an advantage would be that in the areas of compensation a national process similar in many ways to the National Occupational Health and Safety Commission were addressed nationally in the compensation area. We are aware of the fact that there are the heads of government who meet regularly and the ministers who do, but of course recognising that that actually doesn't give any input for the stakeholders, for either the employers or ourselves, in that we believe that both workers and employers should be able to participate in working on the framework of the best standards.

What we certainly would focus on is that whilst it is desirable to have nationally consistent schemes, we would have a major problem if that were the lowest common denominator, quite simply, so we would consider that any national standards would need to be based on best standards.

PROF WOODS: It's funny, "best" can be interpreted in so many ways.

MS EVANS: Indeed that's true, and that of course is one of the things which would no doubt have a great deal of discussion - - -

PROF WOODS: Yes, indeed it does.

MS EVANS: - - - by a tripartite body. We do believe that there are a number of issues, such as what are more compensable injuries and who are employees and questions like that, where there are obviously good reasons why it would be advantageous if they were consistent across the states.

PROF WOODS: I notice you've gone to the trouble of setting out some principles there to help guide us in our thinking on those.

MS EVANS: We certainly have put a number of principles that we consider should be the basis of the area. There are a number of particular areas where some of the differences between the states certainly can create major problems in some areas, for example, in the area of the definitions of a worker, or of an employee. I should say, in recent decisions in New South Wales where what are described as contractors are not necessarily covered by the workers compensation arrangements. What we would like to point out is that what happens in this industry, but not only in this industry, in

other industries also, where the process of requiring that instead of employing your boner, asking that your boner, who provides all of their services to you full-time and only to you, has to be structured as an independent contractor and that is used as a way of getting out of having to cover them with compensation in New South Wales. Alternatively, in Victoria a contractor who works only for the one employer is deemed to be a worker. So areas like that - and certainly we would prefer the Victorian model on that - need to be something which is addressed.

One of the other major areas where there are problems that do occur and are in the trends that are occurring is with the use of labour hire and casual labour. In particular, one of the trends that is occurring in the meat industry is the use of what is called labour hire, and in some cases that is done by a company setting up another company that is a labour hire company who provides staff to that workplace.

PROF WOODS: To run the processing.

MS EVANS: That not only is used as - well, one of the reasons is, obviously, the attempts which the law so far has in fact roped in both the host employer and the direct employer in terms of health and safety areas and the responsibilities for health and safety. However, what regularly occurs from the compensation end for those workers who are injured, is that first of all one of the reasons for doing it is that labour hire, under most of the compensation legislations, in fact attract a different rate of premiums. The meat industry is always at the top end of the premiums and labour hire firms are at a much lower level of premiums that are paid.

So to avoid responsibility, when he is the host employer, who completely controls the day-to-day activity and the workers' work in the same workplace, they don't move from one workplace to another. They aren't, as labour hire was initially justified as, "We need to have a maintenance person who comes on. They only come in; they work here for a very limited period of time and they go and they are placed somewhere else." It is a way of avoiding both the workers compensation for them - and of course what happens then is that the host employer does not provide, does not have to provide, return to work and the labour hire firm does not provide any return to work elsewhere. So it's one of the ways of making sure that workers who are injured in that industry, quite often in that situation, regularly end up on the scrap heap.

DR JOHNS: I'm just wondering why premiums are supposedly lower for those who are hired out under labour hire when generally they're in construction and meat work and so on and so forth. Everyone knows that - and you know that - they're probably less familiar with the work site in some cases and they're a riskier bet in some ways. Wouldn't the WorkCovers of the world catch up with them and say, "Well, we're going to charge you a fairly high premium because we know who you are."

MS EVANS: Well, one of the reasons is that by labour hire then they will in fact provide into the blue-collar areas, the white-collar areas, and they only make those two separations.

DR JOHNS: Yes, they just don't distinguish, right. They don't take it any finer than that.

MS EVANS: So it's not taken down any further than that; that they do in many cases.

DR JOHNS: Okay, yes.

MS EVANS: In fact, on the point that you just made, yes, there has been work that has been done that in fact shows that the likelihood of injury is far higher for people in that area.

DR JOHNS: Yes, I would have thought so. So why doesn't, I don't know, the insurer or the responsible body not take a finer look at this I wonder, and apportion costs more accurately. Maybe it's too difficult to do.

MS EVANS: It's a good question. I wish I had an answer to it.

DR JOHNS: Maybe it's not one you can answer but it's another way around the issue, isn't it?

MS EVANS: Yes. Well, I mean, one of the issues that we believe certainly should be the case is that - and what does happen in this industry is that a workplace who has a full-time permanent workforce, they will sack the entire workforce and then they will hire the entire workforce through labour hire. As I said, those labour hire workers are there full-time permanently. They're not going around from one workplace to another.

DR JOHNS: Yes.

MS EVANS: I believe, and we certainly consider that under circumstances like that, in fact what should occur is that basically they should inherit the premium record of the employer who has sacked everybody and they shouldn't in fact - I mean, that way, that employer would obviously - well, presumably the labour hire company, if they aren't going to go broke, would charge the host employer more for the provision of labour to meet that.

DR JOHNS: Yes.

MS EVANS: So we believe that it would be possible to address those but only where, yes, it is recognised that in fact there is succession in that.

DR JOHNS: Yes, good.

MS EVANS: That's one of the areas we would recommend.

PROF WOODS: One argument that's being put to us about workers compensation is that by paying premiums employers are getting strong pricing signals about their occupational health and safety. But if they are not able to directly experience those premiums or directly control those premiums because they've now gone through a third, some of that pricing information gets blunted, doesn't it? They're paying for a total package to the labour hire company for their payroll, their workers comp premiums, their payroll tax payments and any other benefits or any other component that makes up the cost of hiring labour. So they no longer see a direct relationship between, "If I improve my safety record, the cost of labour hire company to hire the boner to me goes down."

MS EVANS: That absolutely is one of the problems with that area. One of the things which we actually believe should be the case is that where an employer directly employs their workforce who are, after all, a regular workforce who continuously work there and who do provide long-term employment - I mean, one of the problems that does occur is that there are employers, not all by any means, but there are employers who not only use that subcontracting process of avoiding a lot of the costs from the compensation end - and therefore the pressure on improving health and safety is not there to the same extent - but the employers who do maintain a workforce, and maintain them ongoing, return them to work after they have been injured and particularly employ people for - well, you couldn't say for a lifetime, but for the long-term, rather than taking on a young workforce for a period of one or two years and then turning over the workforce.

That is one of the common practices that employers can and do use to avoid it. So we actually believe that the employer who is prepared to actually maintain a long-term workforce and to take the necessary measures to improve health and safety - I mean, if I can give an example: an employer who keeps workers for 15, 20 years, they work - the workers work in that one workplace. When that employer invests to make dramatic improvements in health and safety and it may be completely retooling the workplace. Then what currently happens - and particularly given the nature of many of the industries where you've got cumulative injuries, they happen over time, they don't - I mean there are traumatic injuries. I'm not saying there aren't traumatic injuries. Obviously knife injuries are one of the traumatic injuries. The hock cutters - all of the extremely dangerous equipment which is in the industry obviously can cause traumatic injuries, but 60 per cent of the injuries are cumulative injuries. They don't happen in an one-off event.

The employer who is prepared to maintain a workforce - when they make those important changes, okay, there are - new technology that has come in. They are prepared to invest in it. It doesn't - it isn't recognised and offset against premiums. So the amount that they have been prepared to take - the steps that they have been prepared to take in health and safety should be able to be offset to reduce premiums.

DR JOHNS: Well, some schemes do, don't they? You can have an audit, it says you have improved your - well, potentially improved your performance, and get some sort of bonus.

MS EVANS: That is certainly the case in New South Wales.

DR JOHNS: Yes.

MS EVANS: It is far less common in any of the other states.

DR JOHNS: Yes.

MS EVANS: So that is one of the areas where yes, we believe that moving towards a national standard on that - - -

DR JOHNS: So we're starting to pick the best bits, of course. So let me take you back to the Victorian definition of "employee" which you preferred. Are there any loopholes in it that you've come across? Any difficulties with it?

MS EVANS: Well, I mean it has been designed so that it does cover outworkers. It does cover, as I said, subcontractors, provided that they are in fact in the position where they are not on the market with - for your contract. It does cover casual employees. It does cover permanent employees. So in most of the major areas would be - well, certainly in our experience so far - does cover - - -

DR JOHNS: But the difficulty with covering the outworker is that the nominal employer - and I do say "nominal" - has no control over the workplace. It's in, you know, the person's home, isn't it?

MS EVANS: Well, in fact they should have responsibility for a number of those areas too.

DR JOHNS: Should but they don't literally, it's not their place. I'm only pointing out the obvious difficulty.

MS EVANS: In the same way as in the area of - an occupier of a building that they don't own, one could argue it was in a similar position. So that responsibility is

there - - -

DR JOHNS: It's a special case, though.

MS EVANS: Yet that responsibility is there as an occupier.

DR JOHNS: You've got your own kitchen and bathroom and bedroom and that determines lighting, airflow - you know, there's not a lot the employer does. It's an old one, we've all looked at it many times.

MS EVANS: Most people don't usually do the - they don't usually have the kitchen as their work area or their bedroom as their work area. No-one is - I mean - and in fact in areas, I mean - and this isn't in the meat industry again - - -

DR JOHNS: No.

MS EVANS: - - - so I'm talking probably much more theoretically.

DR JOHNS: I spent some time down at Footscray looking at these things, believe me.

MS EVANS: But in areas such as local government who provides home help services there actually are ways in which they do accept responsibilities in that.

DR JOHNS: Yes, I think that's a clearer link, in my mind; good. I'm having fun.

PROF WOODS: Are you pursuing that particular - - -

DR JOHNS: No, I want to go on, just a minute.

PROF WOODS: Pleasant chatting, Dr Johns?

DR JOHNS: Your turn.

PROF WOODS: Okay. Your industry is one that is helpful to this inquiry in that it does raise a whole range of issues. I mean some of the facilities at which your members work are in rural and regional Australia. That brings with it issues such as return to work. Quite often the large abattoir will be the main game in town and there aren't too many alternatives in terms of return to work. Also in some cases, although it seems decreasingly so, there can be seasonality, so there will be lay-off periods because there's no stock-kill and the like. So if somebody is on compensation, how do you calculate their level of ongoing compensation if the rest of the workforce is stood down or doing a three-day week or a four-day week. So there are those sorts of issues. I'd appreciate your views on whether collectively

yourselves and the employers are making significant improvements. We have dealt with some occ health and safety issues but on the workers comp and the rehab side. Do you detect a degree of progress, any improvement, as you address each of those various issues?

MS EVANS: One of the issues - I mean one of the issues is looking at long-term sustainable alternative duties for someone who has permanent injuries, yes.

PROF WOODS: Yes.

MS EVANS: That clearly is a major issue and it does actually raise in a lot of cases the importance of recognition of the need where the - two areas. One is that where there is permanent injury that is of a nature that is going to make it very difficult to genuinely provide suitable alternative sustainable duties. With the recognition of that then obviously one of the major things that is required is retraining for other areas. So the whole issue of providing retraining is one of the areas that actually has to be addressed seriously to actually make it possible for a worker to consider returning to anywhere, and that is an issue. I must say one of the difficulties that can occur, it certainly doesn't in all cases but it can occur, and that is that, particularly in a rural area, the existence of the abattoir as the largest employer or the major large employer in an area can lead to workplaces where it is possible to encourage workers that they don't claim and they don't put in their claims. That in fact is one of the major issues and certainly, I mean - - -

PROF WOODS: So recognising that their future employment depends on their relationship with their employer and that there's a culture of discouraging employees to make workers comp claims?

MS EVANS: Absolutely. I mean I would say in fact that from the level of health and safety auditing and enforcement body, in terms of health and safety, in this industry what should be done is that certainly they should learn from the issue - certainly look at workers - where there are high levels of workers compensation claims and go out and have a look and see what needs fixing; absolutely. No question about that. But there also needs to be looking at those who don't have claims and going and having a look at them. There are two potential reasons.

PROF WOODS: Just to admire their best practice.

MS EVANS: One could be they are very good and there's a great deal to learn from them and the other is that there is a great deal of intimidation of workers against claiming and does not show that health and safety doesn't need improving so both end, from either to learn from them or to enforce health and safety, that end should also be subject to the enforcement structures. It isn't always the case.

PROF WOODS: Okay. I can understand that some small business operators who have, say a workforce of less than 10 people and there's a minor accident and they care for their worker and they take them off to the doctor and they make sure they get the cab home and follow them through and they might genuinely think that they're doing the right thing by the worker and saving themselves some paperwork on occupational health and safety on the way through. The down sides of that are twofold: one is that the worker therefore has no record that they incurred a work-related injury should something else happen at a later date and (2), the records don't show that was an injury and that there's a safety issue that needs to be addressed.

Even so, you can understand the mentality of the occasional small business operator who says, "Look, I look after them. You know, they get a bit injured, it's not serious, I take them to the doc, we buy them a nice bunch of flowers, we give them a cab home, we ring them up, take them" - da dum, da dum. But when you're talking big employer there isn't that excuse, is there?

MS EVANS: No, there isn't.

PROF WOODS: They're running large businesses, they've got the overheads to be able to record, you know, process, deal with and - yes, they run out of excuses at that end.

MS EVANS: Yes, and unfortunately it doesn't only happen on the small level.

PROF WOODS: No, exactly your point.

DR JOHNS: Could I just get a sense of how long people remain in the industry? What's the average? Does a worker stay for five years, 10 years?

MS EVANS: Well, large numbers of people stay for their lifetime in the industry.

DR JOHNS: It can't be that too many do because if you have almost a one in five chance of experiencing a serious injury, that's only one in five, right? But if you assume a worker spends his or her whole lifetime working in the industry almost everyone gets a serious injury, so it implies that in fact not many stay a lifetime. So I just wondered if you had a sense of, you know, duration?

MS EVANS: Well, many people start working in the industry when they are quite young and it is certainly not uncommon for people to work 30, at least 30 years in the industry.

PROF WOODS: Particularly if they aren't tied to town.

MS EVANS: Yes, particularly in those areas. But also when eventually - it will be in fact an entire working life but their working life may well be much shorter than other people's working lives so that it is not unusual for workers when they are in their 40s and 50s they have had a number of injuries and a number of relatively serious injuries and they are not able to return to work in that area. Having - and this is one of the difficulties that certainly does occur, is that having worked their entire life in that area whilst it is certainly, you know, not always the case that they could be defined as being totally incapable of performing any kind of work, it is certainly unlikely that anyone else is ever going to employ them because their entire life and their skills have been built in this industry and, I mean, if we look at the labour market per se, trying to start in a whole new industry in your 40s or 50s the odds of you getting a job are pretty slim - anywhere.

PROF WOODS: Particularly if you are carrying some injury and if you're in a location where the range of alternative jobs in itself is limited.

MS EVANS: And in the location of the city unfortunately as well.

PROF WOODS: Well, yes, that's right.

MS EVANS: But yes, certainly worse in other areas, yes. So it does quite often lead to a much - being forced out of the labour force much earlier than they would in many other industries.

DR JOHNS: What's the big meat works just north of Geelong heading back into Footscray? Something Brothers or something? There was a big - - -

MS EVANS: Heading back in towards the city there's Heards, M.C. Heards is down there.

DR JOHNS: Might be Heards. I visited it a few years ago and they had a very impressive sort of - mightn't be so now but a very impressive relationship with their workforce and we sort of sat down with some workers and just amazing number of sort of butchers' paper sheets up around which obviously meant that there was a real dialogue going on between the workforce and the bosses and amongst the workforce about all the safety and health issues. It was very good.

MS EVANS: And in fact they would be a perfect example of a workplace that does in fact have - and I actually did look at their statistics - it's about 16 per cent of their employees who have worked for them for more than 25 years directly in their workplace, continuously.

DR JOHNS: Yes, that I could believe.

MS EVANS: So they do keep the workforce for a long time. They have made major - attempted to continuously improve the health and safety in their workplace and I have to say their premiums have skyrocketed.

DR JOHNS: Yes?

MS EVANS: Yes.

DR JOHNS: What's happening there?

MS EVANS: Again it is that problem of the cumulative injuries. If they decided to sack their entire workforce and start again now with all their - you know, the brand new equipment, the much safer material and things like that, equipment, then yes, it would have an impact but because they have kept on that staff and a lot of those cumulative injuries happened - started to happen and happened over the years beforehand, by the time they occur then that's what happens. I mean, they are in fact probably a perfect example for how the improvements for health and safety should in fact be able to be offset against premiums when they do make - - -

DR JOHNS: But can't because of their ageing workforce.

MS EVANS: But because they have an ageing workforce it's not going to automatically mean that claims don't happen. But it does mean that they are not starting new injuries. So perhaps in 30 years time it might reduce their premiums, if they stay in business that long, whereas the workforce - - -

DR JOHNS: It's a very large employer. I wonder if they are experience-rated?

MS EVANS: Hm?

DR JOHNS: I wonder if they are industry-rated or experience-rated because they're - from memory - a very large employer.

MS EVANS: They are quite a large employer, yes.

DR JOHNS: Would there be some capacity to vary their premium because they employ hundreds.

MS EVANS: They do.

DR JOHNS: Anyway, thanks.

PROF WOODS: That's helpful. Are there other matters that you particularly

would like to draw to our attention while we're all here?

MS EVANS: Well, as I said, in particular the areas that I do believe that is a major issue that has to be looked at is that whole change in the use of the workforce in terms of both labour hire, increase in casualisation, a casual employee; the likelihood of them being taken back on or the return to work, is probably out somewhere on the edges. I mean, obviously those who we know about we actually can intervene and we can actually negotiate with those people; we'll get back there. But we have to know about the individual case to be able to do that. But the changing use of the workforce and particularly that move towards labour hire - - -

PROF WOODS: Not heavily unionised.

MS EVANS: - - - is a big problem. The industry as a whole is still fairly well unionised, compared with most - - -

PROF WOODS: But labour hire companies.

MS EVANS: - - - but it - well, I must say the advice that we get is that there is verbal advice to people that if they want to get a placement then they shouldn't be a member of the union. So they certainly believe that they are certainly - under a great deal of pressure on people in that area. One of the other issues that does occur and that is the use of traineeships. You take on a trainee, you train the trainee and then you don't keep them on afterwards; they're out. Again, that's very useful in terms of the premiums because, you know, you can get a new workforce in two years - - -

PROF WOODS: Brand spanking new.

MS EVANS: - - - not to mention all those kind of financial advantages that you might get, you know, subsidies you get along with your trainees.

PROF WOODS: And then your bits and pieces of cuts or sprains and that go out the door and you get a brand new one.

MS EVANS: Absolutely.

PROF WOODS: What would be helpful to us is to gain some understanding of the role that you actually play in helping the workers comp system - and the occ health and safety system - actually function in accordance with how its intended. That these things are dynamics, they involve parties, all of whom have a set of incentives. Not all of the incentives are perfectly aligned and therefore to gain some appreciation of the active role that you play in helping employees have safe workplaces and get their rights and entitlements and get through the maze that's required. I mean, they're not trained in how to do a workers comp, really, until they have to do a workers comp

and reasonably so, because if you trained them all now and somebody is not injured for 15 years, it would be irrelevant anyway, because the system would have changed, they'd have lost the knowledge - - -

MS EVANS: That's right.

PROF WOODS: - - - and so reasonably and understandably they're not all fully trained in all of its aspects until you actually need it. By then you're also suffering some trauma, your income is in jeopardy, you know, all of those things, so it's not your perfect environment to suddenly learn about a whole new complex system. So we have the rehab providers come in and tell us how they pick up the employee and they look through and we have the employers who come through and say, "They're our employees and we care for them and we look after them." What I'd like is your perspective on that, both now but also if you could do something for us as a bit of a supplement.

MS EVANS: Okay - I mean, both things, two ends of it, both in terms of health and safety. Health and safety: we provide support to the health and safety representatives, we are approved by the governments in most of the states - - -

PROF WOODS: And your members are the tripartite bodies.

MS EVANS: But, no, look - providing training for health and safety reps.

PROF WOODS: All right, yes.

MS EVANS: Training in how to carry out a workplace assessment; how to look at controls; how to actually improve workplaces. So we actually provide support and backup for health and safety representatives and in particular when they do have problem areas they can contact their organisers. Their organisers not only can directly help them with it, but if we don't have the skills we can actually get the information for them, we can get the backup for them. So that they are able to play a very positive role in improving health and safety in the workplace, we are also in a number of workplaces, we sit on - Heards being a perfect example, where their health and safety committees that they have in the workplace are organisers for that area also attend in those meetings, participate in them. We're able to actually take - "Hey, there's this solution that was found somewhere else, you can learn from it," so that we're actually a conduit for information and participate actively, both in cooperation with the management and in particular providing backing for the delegates and for the health and safety representatives and they are union health and safety reps and union delegates in the workplace, so that's one of the very positive areas, on the prevention area, that we can play.

We also train our delegates and our health and safety reps in, "How do you

assist someone who has got an injury on the job?" So if someone gets hurt, I mean, to give you an example - well, it's George Weston, but Don Smallgoods, a very large workplace, very large number of people, the delegates in that place - and also a large number of workers from non-English-speaking background whose English literacy is very limited, it is very much the delegates on the job, the union delegates, who actually assist them through those processes of filling in claim forms. And we do keep up - them trained in what are the changes in legislation. There's newly designed claim forms; this is what's required. We have a web site; we provide information to our members about it; we put out newsletters on, "These are the changes that are happening in these areas; these are those things." We negotiate with the workplace about who are rehabilitation providers who actually know our industry and can actually assist in a much more practical way and a rehab provider who doesn't know the industry.

We provide support to - our organisers and me, we will assist people to do those things like put in claim forms, finding out - getting them to doctors, sitting down and going around in workplaces and looking what are suitable alternative duties. So we particularly, in a number of workplaces, there is a process whereby our representatives, they're on the job, with the support of full-time officials, do actually go around and say, "Okay, hang on, there are these duties, they don't require, you know, these movements." So if the person is not able to use their left hand at the moment, "Yes, it would be possible to have seating in that area." So those sorts of changes that are made, we actually provide assistance to people in that and to employers in that area and obviously where there are unionised workforces.

We also represent - and there is the unfortunate situation that an enormous number of the people who, in the first instance, may have a claim rejected and yet through the process those claims are eventually accepted, we represent them. For example, in most of the states where the initial process is a process of conciliation, before it goes to courts, it is the union who provides assistance in those conciliations. In most of those lawyers aren't involved in it, we do it. So we represent - provide assistance to the members through those processes. Obviously, as well as sitting on all the tripartite bodies, and yes, we do it on that government level, but on that individual level as well.

PROF WOODS: No, it was that that I was wanting to get onto the record, because these are a series of interests that come to bear in very individual situations and what we're looking is scheme designs and alignment of incentives to get the right outcomes, but we need on the record the full range of participation in those processes.

MS EVANS: Yes.

PROF WOODS: So that's been very helpful; that's exactly what I needed. Thank

you.

MS EVANS: That's okay.

PROF WOODS: Appreciate that. Any other - - -

DR JOHNS: No, that's good. Thank you.

PROF WOODS: Thank you for your time and we look forward to your ongoing participation in our inquiry.

MS EVANS: Thank you.

PROF WOODS: Could you please, for the record, state your name, position and organisation that you are representing?

MS ARMOUR: I'm Julie Armour, I'm director of Working Armour.

PROF WOODS: Thank you very much. You have provided us with a submission and we thank you for that. In fact it came in in a very timely manner, which we thank you for also. There are a couple of matters that I would like to pursue arising from it. But do you have an opening statement? Or do you have a summary that you want to draw together the key points of this submission for us?

MS ARMOUR: I guess it was just very interesting listening to the last speaker and the last speaker's comments. I think probably most of the issues that I am really looking at is the way that we've completely forgotten about prevention in this whole equation. The reality of what is happening in the workplace is that workers compensation and injury management is priority and prevention seems to get pushed out - or effective prevention gets pushed right down the ladder.

PROF WOODS: In the sense that she wasn't addressing occ health and safety I'd - - -

MS ARMOUR: No, no, I like the points she was bringing out - - -

PROF WOODS: Yes.

MS ARMOUR: - - - about the fact that prevention isn't high on a lot of priorities, that the workers comp system seems to be driving a lot of what is going on.

PROF WOODS: I didn't quite get the same interpretation but nonetheless. I noticed even, while we're on that point, that you have a statement in here -

> perhaps this is simply a question of priority, even this inquiry places workers comp ahead of occ health and safety -

what is that based on?

MS ARMOUR: I guess that you called it the workers compensation occupational health and safety inquiry.

PROF WOODS: Well, we didn't?

MS ARMOUR: Sorry, that's the title - - -

PROF WOODS: Yes, that's the terms of reference that were given to us. But this

inquiry itself, ie, my learned commissioner colleague and I and the absent Prof Sloan, don't place one ahead of the other.

MS ARMOUR: I guess it was probably more tongue in cheek but the fact that workers compensation was just put in the title before OH and S issues - - -

PROF WOODS: That's a factual, you know, point. Yes, whoever constructed that title for the inquiry did put one ahead of the other. But in terms of the approach of this inquiry I think a read through the transcripts will show that we're actually quite - you know, delving into both. So please feel comfortable that we ourselves as an inquiry don't have a bias one way or the other. Do you want to talk to your submission?

MS ARMOUR: I guess probably it's a very, sort of, personal submission. I get started off - involved in rehabilitation work and I guess saw through that I get - not the futility of it but in the majority of cases we're involved in that it was a very simple preventative action that would have prevented the resulting injury. I guess I sort of made in my own personal career a choice to take on or take into and use my skills in biomechanics and ergonomics in a very preventative way. I think over the years what has become more and more interesting is that it hasn't been prevention that has been driving this whole thing. It has actually been workers compensation injury management. I guess that's probably the main area that comes through.

I guess the tongue in cheek comment I made in relation to the name of the inquiry was more as - this is something that is often the message that has got out there in employers and in the community. Workers compensation is what people know about. Health and safety people know about and are aware of but it hasn't necessarily changed their practices. I think that is probably the big difference. I go places these days and people abuse me when I tell them that I'm involved in health and safety because it has ruined their particular profession or it has put up all sorts of barriers in light of their particular profession. They're more aware of it now than they perhaps were 15 years ago. But the emphasis with most people is definitely on workers compensation and the whole injury management approach.

DR JOHNS: Now, there's an interesting thing, they abuse you for interfering, I suppose, which might answer your question to some extent, does it? Why are they abusing you?

MS ARMOUR: I guess in a way it's human nature. I mean I - one particular situation I can recall with some marine scientists who were saying to me, you know, "It's you OH and S people who have put up all these barriers to our science. You make it difficult for us to go diving and make it difficult for us to do all these things and we now have to go overseas to do our research and it's really complicated."

PROF WOODS: Make it difficult for them to get drowned.

MS ARMOUR: That's right, but then in the next breath, "Well, tell me about the problems that I have from continued formaldehyde exposure and how difficult it is to now cope with that." So it's a really interesting acceptance and again, yes, there's a degree of acceptance in the workforce, without a doubt. I think it's that human nature approach that we all have of perhaps not making informed risk management decisions which makes us our own worst enemies, often.

PROF WOODS: But is occ health and safety all about barriers, limitations, expensive equipment, huge diversion of time or can it be seen more simply as smart design, productive practice? Is there a bias in perception and is that something that the industry can correct?

MS ARMOUR: I think there's definitely a bias in perception and I guess it's usually something that - especially in litigation, which is very to show, after a case of very simple measures that could have been implemented to have prevented an incident to occur. I think that's the disappointing part. Although we have had legislation which is requiring proactivity within workforces they way that framework has been structured the only driver is really workers compensation, not the health and safety preventative aspect. So I'm not saying per se that there's an issue with what the legislation is saying or what the legislation requires. It's how that's applied that has created, I think, many of those barriers. So people are perceiving there's big cost, that to get good health and safety, "It's going to cost us lots, it's going to do all of these other things." But the reality is - is the only reason we're going to do anything about it is we have to get our premium down.

DR JOHNS: Perhaps you could harness that drive though, perhaps that's not a bad thing that at least you've got some lever on them to attract their attention. I mean you could look at it as a positive that - I mean in one sense you say, "But that's where their perception is," but if you can align their interests and then their incentives then maybe that is helpful to you to actually have something to - have a bit of four-by-two to get them between the eyes.

MS ARMOUR: Look, I agree with you. I don't have an issue with that. I guess what I have an issue with is the same, exact same, claims being repeated over and over and over again.

DR JOHNS: Okay.

MS ARMOUR: So that is where my concern is. The workers compensation isn't driving them towards prevention. We're seeing the same injuries occurring over and over and over again and no effective prevention being put into place. So although we bring you back to the workplace and we put you on alternate duties and we do

lots and lots of things that are going to make it look like this claim is not going to cost very much we've done nothing to go back to the root cause of the incident and actually put some effective prevention in place.

PROF WOODS: Are there whole classes of claim though, for which there is no effective prevention?

MS ARMOUR: Look - - -

PROF WOODS: I'm thinking of a lot of - you know, the lower level physio stuff where you hurt your back or your bend this or whatever. You would virtually have to shut the place down to stop them. So in other words there's a level of injury which is, "Hey, that's" - to close this off is very expensive or you might stop living or working.

MS ARMOUR: Yes and no, I guess. I mean one project that I was involved in very recently was with the coalmining industry. To me for an industry that has huge - huge, significant - proportion of their workers comp in manual handling sprain and strain type claims, to go through the injury record books of the best performers and the worst performers in that industry and find no difference in the preventative strategies except for the age of the workforce and the aggression of their injury management when there are very simple issues that need to be dealt with, to try and address some of these issues - no attempt has been made by the industry in many cases to even look at this, especially with the manufacture of the equipment that is being used. We have manufacturers who are designing 200-tonne dump trucks. If we are going to design a dump truck for that capacity we need to design a cabin that is able to allow the worker that has got to sit in it for eight or 12 hours or however long to be able to do that safely. You know, I wish this was much more complicated than that but in lots of cases that is what we are finding. It's not - I mean the amount of - - -

DR JOHNS: So all right, well, I - why not. I mean I'm surprised, why haven't they done that? They thought up that in 1972 or something, so why is it not happening?

MS ARMOUR: Why is that the case?

PROF WOODS: Yes.

MS ARMOUR: I mean I guess - - -

DR JOHNS: Say with the truck.

MS ARMOUR: Why is it that the case? The argument that is often given to me by - - -

DR JOHNS: Because the worker is not buying it, I suppose.

MS ARMOUR: The argument that is often given, for instance in that industry, is the fact that the manufacturers will claim that the Australian market isn't large enough to actually warrant them to redesign that sort of thing and that the markets of Asia are much larger and they have a lot more buying power et cetera, et cetera. I would argue - you know, I said, "We are going to have to get to a stage in this industry where as employers you're going to have to take a class action against the manufacturers to get change." This isn't complicated change. This isn't stuff that engineers are not able to do and it's that type of stuff on the one hand which is no good but equally on the other hand there's a complete lack of attention to the basics: the same sorts of injuries over and over again. What have we got each time there's corrective action that's indicated on the incident report forms? Take more care. Take more care.

This person is working in an underground mine where they can't see, they've got a light that is shining three feet ahead of them, they're wandering around in slush up to their knees. Why are we surprised that this person has lots and lots of knee injuries and tripping injuries when they can't see where they're going? Why aren't we grading these roads and pumping this water out? Comment that comes back, "Pumping out water and grading roads doesn't produce coal."

PROF WOODS: So it's a cost trade-off.

DR JOHNS: Well, there is a cost.

MS ARMOUR: There is certainly a cost but often when you look at that cost benefit in relation to the actual costs of the workers comp it just can't be justified.

DR JOHNS: But that's the debate. I mean someone must be sitting around doing the figures on it. Costs benefit has to measured and if the employer carries all those costs - anyway, you're invited into some workplaces. You must be doing some good work. Who's inviting you in?

MS ARMOUR: A variety. I guess I can perhaps share - I've been invited down to Victoria to look at doing a safety manual report that I've been doing for a large organisation as part of their self-insurer requirements. Now, I guess - - -

PROF WOODS: So you're not based in Victoria?

MS ARMOUR: No, I'm usually based in Sydney. It's just that I was working down here.

PROF WOODS: Yes.

MS ARMOUR: I guess to me the interesting factor of where we've stuffed this up severely is that we're just training companies to perform to audits. The company I went to yesterday had on the wall 2000 days lost time injury free. Two days before one of their drivers had blacked out getting out of his vehicle and he's not yet been medically assessed to check that there's no particular problem, but he's a driver. All he does each day is drive and deliver product. The way they get assessed is on that number of lost time injury free - those lost time injuries, so they're doing a great job. In their warehouse, their warehouse has two tiny smoke alarms that have been bought from a Kmart type operation. I guess they're minor - well, they can be particularly major areas - but this is where we're teaching people to tick boxes rather than get to what is the outcome that we want? What do we want to achieve? We want to stop this happening.

What we've done very, very well with this whole workers comp focus of bringing people back into the workplace is that often in workplaces the OH and S people are just injury management people.

DR JOHNS: Where the injury will occur again, yes.

MS EVANS: And it does. It's continuously occurring. We don't have time to send these people out and say, "What could we do to stop these - our hundredth manual handling or repetitive strain injury that we've had this month from occurring?"

DR JOHNS: Give us some thoughts. I mean, we don't want another bucket of legislation that - - -

PROF WOODS: Creates more incentives to tick different boxes.

DR JOHNS: More of those things. It has to come down to some return I guess to - - -

PROF WOODS: Aligning the incentives.

DR JOHNS: - - - the person who's paying.

MS EVANS: Certainly. I mean, I guess I thought long and hard about - well, you know, it's very easy to criticise all of this but how do we correct it, how do we improve it? I guess something very interesting that I came across recently; Jerry Ellis' comment, now he's been made chairman of NOHSC, that he was astonished to learn that more people die in Australian workplaces than on the roads and he thought that most of his colleagues would be shocked to hear that as well. I thought this goes back to the heart of the Robens original findings, that we need to educate our

employees but what we've done in the education of our employees is concentrate it on those that don't have any ability to make decisions. We haven't considered senior management in that employee group.

Time after time in a lot of the workplaces that I get invited into the emphasis is on training, without a doubt. "We've got a health and safety problem. Let's train them. Let's train people," and that's where it stops. We don't ever actually stop to enforce whether anyone follows any of the requirements of that training. Equally what we're often finding in our senior management levels is that they've not even had the basic training to understand themselves what's required to make a safety management system work. It's not being filtered down. So in most - a lot of cases I'm going into - there's no specific responsibilities for health and safety at any level within an organisation.

The major responsibilities we'll have will be based on a lost time injury frequency rate and - if that. You may get some sophisticated organisations that have a greater number of accountabilities but in nine times out of 10 they're never assessed and people are never held accountable for them and we wonder why we're not getting effective risk management. In most areas that I'm auditing, large companies and small, the two areas that people will fall down, nine times out of 10, is responsibility and accountability for OH and S and risk management.

DR JOHNS: Excuse the pun; fall down.

PROF WOODS: That's very good, for this late at night.

MS EVANS: This time of day.

PROF WOODS: Actually, I notice with interest that you provided a submission to the mid-90's inquiry and I refrained from suggesting maybe that was a high school assignment. I mean clearly you've - this is an area that you've spent a lot of time trying to focus on. As you reflect over that, what, eight years, what are the lessons of getting employers to appreciate the positive cost benefit trade-offs for occupational health and safety? Where has it worked best and what - as we sit here if we felt that we could devise some system incentives that caused employers to say, "Right, let's go tomorrow morning, walk around the place, have a good look at what we do, bring the unions, bring the occ health safety specialists, let's invest a bit of money, let's monitor it, let's work at it," I mean, where do we head? What do we do?

MS EVANS: Well, there's got to be some enforcement of that system requiring that. I was interested in the last speaker's comments in relation to health and safety committees and the whole concept of consultation and it's obviously something that's very crucial and very important to have that present, but one of the issues that I'm constantly seeing is that my management is taking up responsibilities they should

have for health and safety. "Oh, let that health and safety person manage that." The self-regulation model hasn't worked because we've allowed it to become a reactive model, ie we all assume our workplaces are working well if we're not having injuries, not that we're managing risk, but our workplaces must be okay because we haven't had many injuries, when the level of risk can be highly significant.

I think that's a very large concern, the way our whole legislative framework for health and safety is applied is reactively. So what we find out there in the majority of workplaces is that people risk manage by hoping they're not going to have an incident and when they have an incident it's so easy to see all of the things that led up to that and all of the things that could have been done very simply to avoid it. It's not generally just one piece of information that was missing or just one mistake or just one area. It's usually a multitude of information that just points to this inadequacy. Most cases are totally foreseeable.

PROF WOODS: So step 1, up the enforcement and up the penalties?

MS EVANS: I would always much prefer to look at some sort of balance situation but the reality is in many cases, and I've actually been in workplaces where that's what they've wanted to do; they've looked at the cost of the penalty they're going to have, they've said, "The maximum penalty that's been applied for this is X. It's going to cost us more than X to put this in place. Bugger it, let's cop the fine." So I think in a lot of cases those penalties just haven't created - but having said that I would also argue that perhaps my profession has been perhaps guilty of not really being realistic with employers about those penalties and there are lots of these threats constantly, "You'll go to jail for this and you'll go to jail for that."

PROF WOODS: And it doesn't happen so they - - -

MS EVANS: The reality is that most people see that no-one's going to jail. The fines that are being applied are relatively low. So there isn't much of a deterrent. If you were an economic rationalist who wanted to run a good business there's not a great deal of incentive at all there.

PROF WOODS: Presumably there are some professionals also who are there to help the employers meet whatever is the minimum apparent standards of box ticking.

MS EVANS: Sure.

PROF WOODS: "How do you get me through the next occ health and safety audit? Put that cord behind that chair. Put that lot of chemicals back in the storeroom. Open that window" and - "No, that looks pretty good." No doubt all of that happens.

MS ARMOUR: Quite a lot of that happens, yes, and generally it's not driven by OH and S; it will be driven by workers comp, especially in a self-insurer situation. In a lot of the jurisdictions that I've worked in the biggest comment that they often get is, "Well, the most likely way we'll get a health and safety inspector here is if we have a fatality, and even then there's no guarantee we'll get them here." So I guess the threat and the deterrent effect that's supposed to be there just isn't a problem.

PROF WOODS: Okay, but that's sort of one part of the process, and you're saying the price signals aren't working particularly well. What else is there? Where to?

MS ARMOUR: I think there needs to be a lot more balance. I think for a lot of our jurisdictions that are just administrative differences occurring between, for example, health and safety legislation and workers compensation legislation, which means that a lot of expense is going into the administration of those authorities as opposed to actually getting outcomes we're after, making our workplaces safer. I think that's a really interesting trend, especially with the fact that most of our employment status has been changing dramatically over the last 10 years. We've got such a trend that we're spending all of this money on health and safety regulation and workers compensation regulations, and has it given us safer workplaces in Australia? Has it given us less expensive injury management?

PROF WOODS: Some of the stats show a decline in the number of reported injuries, to be precisely correct. Whether it's a decline in the actual number of injuries may be a separate question.

MS ARMOUR: In terms of if you're actually looking at an incident rate as opposed to an incident-free - - -

PROF WOODS: Yes.

MS ARMOUR: Yes, and I guess there's also the changing nature of our workforce, which means that now there are a lot of people who wouldn't be covered under those umbrellas as they previously were.

PROF WOODS: No. That's a good point. I was going to think in the direction of moving from manufacturing to service industry, which also changes the accident rate. But your other point, for those who are self-employed, however defined or undefined - so, yes, if you look at the changing nature of the workforce, if you look at the changing structure of the workforce from manufacturing predominantly into service, it would be interesting to see how much of that can account for the reduction in injuries, let alone what residual might then be a safer workplace. Have you ever done that sort of analysis?

MS ARMOUR: Yes, in the coal industry I did that and, although again - - -

PROF WOODS: Do you have the results of that?

MS ARMOUR: Yes, I have a study that's been - - -

PROF WOODS: Can you make that available to us?

MS ARMOUR: Sure. But one of the things that we found there was that, yes, over the last five years of their workers comp there had been a reduction of certain types of claim, but when you actually expressed that as a number of employees in the industry there was no difference. So in actual fact we're not being effective. Then when we look at the number of administrators - I guess if we're looking at that whole cost-benefit analysis, in Australia we have health and safety authorities but then we're also likely, for example in mining, to have a mines department, and we have in the maritime industry another OH and S group.

PROF WOODS: We've got the seafarer system.

MS ARMOUR: We've got so many of these. The actual administration of running these for the cost-benefit we're getting out of it in terms of making our workplaces safer or making workers compensation cheaper hasn't happened. I guess I was intrigued because as part of this going back to all of the workers comp and the OH and S Acts and looking at the objects of the acts, I wanted to ask myself, "Does any jurisdiction's government actually ever assess these departments against these objectives?" Do they ever actually look to say, "Yes, you've achieved this," "No, you haven't achieved this"?

PROF WOODS: I'm sure the treasuries from time to time peer at the trails of these bodies.

MS ARMOUR: Where would you suspect the treasuries would put most of their emphasis?

PROF WOODS: Cost effectiveness, correctly so.

MS ARMOUR: And which section, do you think? Would it be in the workers compensation side or the OH and S side?

PROF WOODS: I'm not sure that they'd have a particular bias, particularly for the privately underwritten schemes. In the privately underwritten schemes I'm not sure they'd have a bias one way or the other.

MS ARMOUR: I guess though if you look at the objectives of the workers comp acts in each state and the objectives of the OH and S Acts in each state, are we seeing

an assessment that is actually occurring against those objectives to say, "Yes, we're doing this and we're doing a good job at it" or "No, we're not." I guess if we're looking specifically at the framework itself we'd have to ask ourselves right at the level of the legislation, "Are we achieving the objectives of the legislation?" Equally, this has been passed down to the employer, so we've told employers, "You need to have a health and safety policy," so they put up something on a wall that everyone ignores. We never actually relate that policy to a particular plan of action to make any of those objectives be achieved. We then never actually assign specific responsibilities for each of those areas to actually make those achievable. Then we have an injury down here and we start whacking everyone around the head all away along the line, "How come we had that?" We didn't give you specific tasks to do to stop that occurring. We didn't assess you against those tasks and say, "Yes, you're doing that well" or "No, we need to give you more resources or whatever else," so it's really no wonder the system doesn't work. In terms of its application it's incredibly ad hoc.

PROF WOODS: I would encourage you not to be disillusioned, though. When the next inquiry occurs in 10 years' time, I hope you haven't developed any sense of despondency about progress.

MS ARMOUR: It's like anything: there's always room for improvement, but I think the bigger frustration is that it's almost a feeling that we're actually going back.

PROF WOODS: Hang onto your achievements and build on those.

DR JOHNS: Now, this is your study into the coal industry injury rates?

PROF WOODS: Yes.

DR JOHNS: Up to 2001, so it's pretty recent.

MS ARMOUR: Yes.

DR JOHNS: Okay, that's good.

PROF WOODS: Is there anything else that you want to raise with us?

MS ARMOUR: I'll just have a quick look. Just one of the things that is really interesting to me is having been involved in the awful side of litigation - and I really don't like that type of work; I find it incredibly parasitic - one of the things that is always brought home to me in that - - -

PROF WOODS: We won't ask you who are the parasites.

MS ARMOUR: I guess no-one wins, if you like. No-one wins. The event has happened. No-one is really happy as a result of it, but I guess one of the things that I find nine times out of 10 is that at no stage has anyone ever actually really looked at these things which are really obvious after an event, whether that's the employer or whether that's the body that's involved. I remember another litigation case that I was involved in in mining and the actual inspectorate had been there three times and issued three notices before they had a roof collapse and it resulted in a guy's leg being amputated. What else do we have to do to make this stuff change and to make it happen?

PROF WOODS: That's pretty intensive action.

MS ARMOUR: I guess that's the thing that I'm constantly seeing now at that end of the scale. Equally at the front end of the scale, we just don't seem to be actually doing things that are effective. You asked the question previously about what would we do to alter this and what's an incentive. I think the biggest incentive and biggest change to either a workers comp or an OH and S scheme or system would be to put a measure of effectiveness in it so rather than just looking at claims history we'd see, "How many of these claims have you had repeated?" When we have a high repetition of these sorts of claims or no attempt made to actually put any preventative measures into place, that there actually be some sort of - - -

PROF WOODS: Sanction.

MS ARMOUR: Yes, against that, and I think the thing is missing. We're getting people, slowly dragging them kicking and screaming down the path - - -

DR JOHNS: So the days-lost measure is a false measure, you say? It's an incentive for a certain sort of behaviour which is to get the person back to work, but you could use other measures which might be more effective in preventing injury?

MS ARMOUR: Well, you get the person back to work but we do nothing about what caused that injury to start with.

DR JOHNS: That's what I mean. So we've got to think about some other measures that will press buttons.

MS ARMOUR: Where I have worked with companies that I consider have very good activities is where their senior management is actually required to have a number of measures included in their bonuses - not just lost time injury frequency rate but things like the percentage of the safety plan that was actually implemented and deemed effective. That's been very effective at ensuring change actually occurs within the organisation as opposed to ensuring that everyone has gone to a training course even though they haven't - though they didn't listen to it or they don't apply

any of it or practise it. It's actually making people look at that whole total approach. But it's really that effectiveness - the frustration that I'm constantly getting is we just shove them straight back into the same situation and wonder why they get injured again doing exactly the same thing in exactly the same way. I wish there was an industry I could say it doesn't happen in. Even dive instructors, when I audit dive instructors, and tourist operations, still the same sort of complaint. We don't monitor what they do, we just assume, "We've got happy customers. They must be doing their job correctly."

PROF WOODS: Unless you're left on the reef.

MS ARMOUR: Yes.

PROF WOODS: Good. Thank you very much. It's quite helpful, but do remain positive and find the way through. That would be good.

MS ARMOUR: I will.

PROF WOODS: This is the bit I like next. Are there any persons present who wish to come forward for an unscheduled presentation? There being no persons present, I'll adjourn until tomorrow at 9 am.

AT 6.09 PM THE INQUIRY WAS ADJOURNED UNTIL
FRIDAY, 27 JUNE 2003

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