T R A N S C R I P T

LEGISLATIVE COUNCIL ECONOMY AND INFRASTRUCTURE COMMITTEE

Inquiry into the Workplace Injury Rehabilitation and Compensation Amendment (WorkCover Scheme Modernisation) Bill 2023

Melbourne – Wednesday 13 December 2023

MEMBERS

Georgie Purcell – Chair
David Davis – Deputy Chair
John Berger
Katherine Copsey
David Ettershank
Bev McArthur
Tom McIntosh
Evan Mulholland
Sonja Terpstra

PARTICIPATING MEMBERS

Gaelle Broad
Georgie Crozier
Michael Galea
Renee Heath
Sarah Mansfield
Rachel Payne

WITNESSES

Paul Serong; and

Frank Imbesi, President, Victorian Council of Australian Rehabilitation Providers Association and National Vice President - Australian Rehabilitation Providers Association.

The CHAIR: I declare open the Legislative Council Economy and Infrastructure Committee's public hearing for the Inquiry into the Workplace Injury Rehabilitation and Compensation Amendment (WorkCover Scheme Modernisation) Bill 2023. Please ensure that mobile phones have been switched to silent and that background noise is minimised.

I would like to begin this hearing by respectfully acknowledging the Aboriginal peoples, the traditional custodians of the various lands we are gathered on today, and paying my respects to their ancestors, elders and families. I particularly welcome any elders or community members who are here today to impart their knowledge of this issue to the committee.

To begin we will introduce committee members, starting down this end of the table with Ms Broad.

Gaelle BROAD: Hi, I am Gaelle Broad, Member for Northern Victoria.

Evan MULHOLLAND: Evan Mulholland, Member for Northern Metro.

David DAVIS: David Davis.

The CHAIR: Georgie Purcell, Member for Northern Victoria.

Tom McINTOSH: Tom McIntosh, Member for Eastern Victoria.

John BERGER: John Berger, Southern Metro.

The CHAIR: And on the screen we will go Sarah, Sonja.

Sarah MANSFIELD: Sarah Mansfield, Western Victoria Region.

Sonja TERPSTRA: Sonja Terpstra, North-Eastern Metro.

Renee HEATH: And Renee Heath, Eastern Victoria Region.

The CHAIR: Wonderful. Thank you so much for coming along today. All evidence taken is protected by parliamentary privilege as provided by the *Constitution Act 1975* and further subject to the provisions of the Legislative Council standing orders. Therefore the information you provide during this hearing is protected by law. You are protected against any action for what you say during this hearing, but if you go elsewhere and repeat the same things, those comments may not be protected by this privilege. Any deliberately false evidence or misleading of the committee may be considered a contempt of Parliament.

All evidence is being recorded. You will be provided with a proof version of the transcript following the hearing. Transcripts will ultimately be made public and posted on the committee's website.

For the Hansard record, can you please both state your full name and the organisations you are appearing on behalf of.

Paul SERONG: My name is Paul Serong. I am a retired occupational rehab provider, owner of a firm. I retired about six months ago.

Frank IMBESI: Frank Imbesi. I am currently president of the Victorian chapter of the Australian Rehabilitation Providers Association and National Vice-President of the Australian Rehabilitation Providers Association.

The CHAIR: Wonderful. Thank you. We now welcome your opening comments but ask that you collectively keep them to around 10 to 15 minutes so we have plenty of time for questions.

Paul SERONG: Collectively between the two of us –

The CHAIR: Yes.

Paul SERONG: so 7½ minutes each?

The CHAIR: Yes. We are not strict on it.

Paul SERONG: Okay. We will be able to do that. Just by way of background, my employment history – I have had over 20 years experience in the workers compensation field. I was CEO of Catholic Church Insurance for five years. Catholic Church Insurance, when I was running it, was a national insurance company handling workers compensation in every state of Australia and was a previous WorkCover agent in Victoria. I have been the manager and CEO of a claims agent here in Victoria, a company called Cambridge/Xchanging, which is now DXC – it is one of the agents, about 25 per cent of the market – for five years. For the last 11 years I have owned an occupational rehab company called Counselling Appraisal Consultants. It has been a rehab provider for over 26 years in the state of Victoria. I am also a past president of the rehab providers association, like Frank.

I will just go quickly through what I have called the executive summary; I have got a paper that I will end up putting in probably after you guys ask questions, because I might want to add extra things to it. Let me say, first and foremost, I think this Bill is a very bad piece of legislation. I say that there are two aspects of the bill, two main aspects of the Bill. One is the redefinition of mental health claims, and the second is the 130 -week second entitlement test to get people off the scheme. Now, if the legislation goes through in its present form, there will be about 5400 mental health cases that will not be added to the scheme in a year. So in other words, the mental health cases will reduce from about 6000 a year to about 600.

David DAVIS: They will not get to first base.

Paul SERONG: They will not even be accepted. The agents – you will not be able to lodge a claim. You cannot lodge a claim because it will fall outside the definition. Now, those 5400 people will still be hurt. They will still be injured. They will still be sick. They just will not have a compensation scheme to benefit them, they will not have any income to support them and they will not have any medicals to support them. They will actually go on the public health system. It will overload the public health system, and it will just shift cost out of the workers compensation scheme to the public health scheme.

If I talk briefly about the 130-week second entitlement test, there is an imposition – to stay on the scheme after 130 weeks you have to have greater than 20 per cent whole-person impairment. That is a very, very large test. Frank can talk about it better than me. He is a physiotherapist; he understands it much better than I do. But in my opinion what will happen is 90 per cent of the people that are currently being reviewed at 130 weeks will be terminated off the scheme. Now, when you come to manage those people as they go through the process, there is a review at 130 weeks to say, ‘Are you entitled to the next instalment, the next period?’ That is why they call it the second entitlement test. The WorkCover agents assess things; they have a work capacity test. They use occupational rehab providers to try and get people back into the workforce, but there is no limit on the whole-person impairment. So what will happen is as they farm these people – I call it ‘farm’ – and as they review these at 130 weeks, in the first 2½ years after the Bill is passed there will be 4200 people exiting the scheme.

David DAVIS: Chopped out.

Paul SERONG: Chopped out. They will go on the Commonwealth Centrelink. They will go on NDIS, some of them that have still got disabilities and pass the NDIS approvals. They will be shifted from the state scheme to the federal scheme. Now, WorkCover increased the premium this year by 42 per cent – well overdue. It had not been increased for 10–15 years. Part of the reason the scheme is underfunded is because successive governments never increased the premium. With the redefinition of mental health claims and all those claims not being accepted, the actuaries for WorkSafe, PricewaterhouseCoopers, will do a reassessment of the long-tail liabilities. And WorkSafe could have already done the modelling now, I can tell you. Pricewaterhouse would have been given the job: ‘Tell us how much money we are going to save by exiting

these claims.' I am going to tell you right now that it will generate a saving of about $4 billion, so that will be written back into the scheme. The scheme will automatically go into surplus, and within two years the scheme will have so much money in it that the government will get dividends again from it, which it used to get about 10 years ago. It will probably get about half a billion dollars a year income coming to the government because of these changes. Now, in the meantime, in five years time these 5400 people will end up being 27,000 people not getting mental health assistance. That is why I said right at the start this is bad legislation.

Yours, Frank.

Frank IMBESI: Thanks. I probably will not say a great deal, because I suspect that you probably have questions that you would like to ask. Firstly, I would like to say that having been around workers comp schemes for close to 25 years and having a good understanding of what is going on around the world, sitting on an international vocational rehab organisation and committee, I understand that there is a need for review. Currently mental injury claims are 14 per cent of all claims but are about 50 per cent of the liability, so I appreciate that puts pressure on the scheme and that there is a need for review.

Keeping it to the main points, I understand there is a new definition of mental injury and strengthening of the relationship between the condition and the relationship to work predominantly arising out of or in the course of employment. I understand that. How that is going to be implemented and how that determination is going to be made is of interest, particularly if it is going to delay people getting some care and attention and treatment while the assessment is made of that predominance definition. If those people are rejected – and it has been suggested that there will be increasing numbers of people who will not get a claim accepted based on the way the legislation is currently drafted – I appreciate that they will go onto a provisional payments scheme for around 13 weeks. I think we need to be mindful that the health system is already stretched and the delay to first treatment for people receiving psychological or psychiatric treatment in metro areas is blowing out to anywhere between four and six weeks. So they are not going to get a lot of care and treatment in that first 13 weeks, and then they are going to dovetail onto the public health system, which is already significantly stretched – and I am telling you what you already know – as a result of the post-pandemic world.

David DAVIS: Even prepandemic.

Frank IMBESI: Prepandemic, correct. Then the next part is obviously the entitlement to compensation post that 130-week test, which is around that 20 per cent whole-person impairment based on the primary compensable condition. Internationally that is a pretty high threshold. But I appreciate that the long tail is growing and is probably at the moment around three times what it was five or six years ago, and that is putting financial pressure on the scheme. The questions I have more around that are: what are we doing to positively interact with those people to prevent them becoming people who go onto the tail, and are there opportunities there that we are not realising, as a result of a decision that is encompassed in this Bill? They are my broad comments around that.

The lack of definition of some of the terms around stress and burnout not being defined could potentially be problematic as well, and it is a departure I guess from what is happening internationally, where the World Health Organization has actually defined burnout. I am not entirely sure whether that is deliberate or not, but if burnout arises as a result of chronic workplace stress, then it is interesting that that is being excluded or being a point of exclusion in the Bill as well. From a broader societal point of view if we are taking a humanistic approach to some of these people who are not having claims accepted because they have not passed that test establishing work as being the predominant cause, we are still dealing with unwell people who many not necessarily get the care that they need outside of the compensation system to return to a level of function that we would all like to see, and that potentially is the case for people who come off the 130-week test and have not been given an appropriate opportunity to rehabilitate within the period of time that they did have an active claim – potentially. I will conclude there and leave it to you to ask some other questions.

The CHAIR: Wonderful. Thank you so much for that. We will go to questions now. We have got plenty of time. I will kick off. Our task as a committee is to give recommendations to the government about how this Bill can be improved. What are some of the things that you think are necessary to be done that could reduce the impact on workers that get a mental injury at work?

Paul SERONG: I do not think you can improve the Bill. I think I was fairly clear at the start. It is a rubbish Bill.

The CHAIR: You are not the first person to say that.

Paul SERONG: You cannot exclude mental health injuries, 90 per cent of them, and then say, 'How do we make the Bill better?' The only way to make the Bill better is to shelve it. What you can do is fix the scheme. The scheme can be fixed. We used to work in the industry, but the effective use of occupational rehab will repair this scheme. I spoke to Danny Pearson about this 12 months ago. The State of Washington in America was in the same position that Victoria is in now, 10 years ago. They changed the way they managed workers compensation claims over there. They changed the culture of the Department of Labor and Industries, because it is a state-run scheme there. They use what they call vocational assessment, vocational rehabilitation, and their return-to-work rates have improved dramatically. I have got graphs here that show it off the charts.

The CHAIR: Do you want to share that with the committee?

Paul SERONG: Yes, I am going to send them all through to you.

The CHAIR: We will grab it off you at the end.

Paul SERONG: You can have a look at them later. They saved $2 billion in long-tail liabilities. They got people back to work. They use occupational rehab. The average time it takes to get occupational rehab in the State of Washington is 45 days. Here it is 112 days, and not every case gets OR here. Not every case gets it. What they do in Washington is they look at the case when it first comes in. They have got a triage tool. If it fails the triage test, it goes to rehab. At four weeks they do the same, at 13 weeks they do the same and then every case that gets over 26 weeks goes to rehab. Their return-to-work rate has improved dramatically, and their long-tail liabilities have gone down. That is what needs to be done in this scheme.

David DAVIS: And the earlier the better.

Paul SERONG: And the earlier the better. If you follow that step process – initial, four weeks and 13 weeks – occupational rehab will be on most claims, and people will go back to work. Occupational rehab is very successful on mental health claims when you can get the claim as early as possible.

The CHAIR: Thank you. You mentioned the minister before. Were you consulted at all on this Bill?

Paul SERONG: No.

The CHAIR: Thank you. Ms Terpstra.

Paul SERONG: Danny is actually the Member for Essendon, and I live in Essendon. I got to see him last December.

Evan MULHOLLAND: In my electorate as well.

The CHAIR: Ms Terpstra.

Sonja TERPSTRA: Thanks, Chair. And thanks, Paul and Frank, for your opening remarks. I am just following up from the line of questioning that I think the Chair was raising with you. We are inquiring into this Bill, but one of the aspects of the Bill is about Return to Work Victoria. What I am hearing you say is that the earlier the intervention, the earlier the access to occupational rehab or therapy is a better outcome. As the Chair was saying, we have got to make recommendations to government about how we can improve the Bill. I know you are saying 'shelve the Bill', but wouldn't that be like throwing the baby out with the bathwater? Couldn't we be looking at how we can improve or do work around Return to Work Victoria?

Paul SERONG: But if you change the definition of mental health and do not accept over 5000 claims, there are 5000 people that are not entitled to workers compensation and therefore do not get any rehabilitation.

Sonja TERPSTRA: But isn't that if nothing else changes – so if we keep doing the same thing without perhaps doing work in workplaces to help identify psychosocial risks and those sorts of things? Isn't it true to

say that what you are talking about is if nothing changes in workplaces, there would be people who would not have access under this Bill? But I cannot see that people are not interested, in workplaces in the public sector and other places, in actually working on making their workplaces as safe as possible. Now, those things are happening outside of the Bill. That is not part of the Bill. So I am interested to see what your thoughts are about how we can strengthen that early intervention and access to occupational therapy for those people who might get captured by this Bill.

Frank IMBESI: If I could make a few comments, a late colleague of mine who was an expert in this space in a number of his studies demonstrated that by the time someone in a workplace gets to the point of putting in a claim for a mental injury there has been a gestational period for that condition of around six months, so it has been developing in a workplace. That raises the question around what we are doing about identifying them in the workplace and equally around what we are doing to prevent them. I think that we need to be mindful of the fact that if we are determining that burnout et cetera and work-related stress are going to be exclusions, it sort of follows logically that we are saying that those organisations that expose people to burnout and stress are then acceptable workplaces, whereas we are saying that they are unacceptable psychosocial risks that are leading to injury, so there is an opportunity in that space.

In terms of early intervention we have a system that is based on a period of 28 days for an agent to make a determination on a claim. The research tells us that after 20 days that a person has been off work their opportunity to ever return to the workplace in any job again drops to 70 per cent, at 45 days they have lost 50 per cent of their opportunity to ever return to work and at just 70 days, which is inside of three months, their ability to return to work drops to just 30 per cent. So the concern is that we look at this Bill and work out: how do we determine whether employment was a significant contributing factor, a predominant factor? If we waste time around that we are wasting opportunities to intervene with these people who need care and who can ultimately improve their outcomes. So there is an opportunity to do more with them. The delay to getting treatment or getting occupational rehab services, which is an independent service provided to workers and employers, and it needs to be independent by definition, just so that people know they are getting a fair and impartial view and assistance – that is not currently happening for something like 85 to 90 days. When we had the best return-to -work rates in our industry, that dropped down to somewhere near 50 days, which is very close to what the Washington state research tells us is around 45 days. So there are opportunities to positively intervene on these people and get better outcomes.

Sonja TERPSTRA: What do you think about the 13 weeks of provisional payments, then, that would kick in under this Bill, regardless of whether a claim was accepted or not? So someone makes a claim, they get that 13 weeks – is that useful?

Frank IMBESI: Look, it is better than nothing, but when the delay in getting any treatment for a mental injury is four to six weeks for a psychologist and even longer for a psychiatrist in metro areas – not even talking about regional areas – their ability to get the treatment that they need to improve is very limited, and that is a fact at the moment. Then after that 13 weeks what happens to them is they move onto the public health system, which is already stretched, and do they have –

Sonja TERPSTRA: But some people might have income protection insurance through their EBA and the like. There might be other ways that people can support themselves. Sure, there will be some people who will not have that, but there are income protection schemes that can help in the interim period until a claim is actually worked out. Yes, a number of people have said, even with the 13 weeks of provisional payments, there is an issue accessing suitably qualified treating practitioners – like you are saying, psychologists and the like – but at least that 13 weeks will give people a bit of a buffer where previously that has not been there. People were just waiting – that is about access.

Paul SERONG: Sonja, the provisional payments are there now, in all claims; they are there now.

Frank IMBESI: That is right.

Sonja TERPSTRA: Yes. But it was also about: you had to wait to see if your claim was accepted. So that gives you something where that is going to be useful for you.

Paul SERONG: Look, I support Frank's comments. If you have got a mental health condition, you need a mental health plan to manage that. You probably need at least 10 sessions with a psychologist to manage that

process. You can get into psychologists usually a bit quicker than you can psychiatrists, but it would take at least six weeks to get to see a competent psychologist and then work through the plan over the next 10 weeks, and that is assuming that you can afford to pay the bills and then get reimbursed by the agent. To me the 13-week provisional payment is really – it is nothing. Any of these 5000 people that cannot make a claim – it is not going to make their life any easier.

The CHAIR: Thanks. We will need to move on now. Thanks, Ms Terpstra. Mr Mulholland?

Evan MULHOLLAND: Thank you. I wanted to ask about something you mentioned earlier that interests me. Paul, you said that basically people would be kicked off the scheme. We have heard members of this committee today say that people who have given evidence previously and said that people will be kicked off the scheme are wrong. What is your view on the detail, based on your knowledge of whether people will be kicked off the scheme or not under this Bill?

Paul SERONG: Well, I have read the legislation. The legislation is very clear. It says at 130 weeks there is going to be a test. For anybody to stay on the scheme, they have to have greater than 20 per cent whole-person impairment, right? Frank can explain to you how difficult that is to achieve. And if you have not got that, your claim will automatically be terminated. You will not get your benefits anymore. So you will stop, right? Then as every year goes on, the people that have got a physical injury and have come on the scheme and stayed on for 130 weeks – they get the test; no, they do not pass that 20 per cent, they are off. There will be 1700 of them every year being terminated. And where do they go? The only place they can go – I take Sonja's point that there might be income protection insurance. Not everybody has got income protection. A lot of small businesses have no protection for their staff other than workers compensation. They go onto Centrelink – they have got to get a Centrelink benefit. They will go onto disability benefits under the federal government or, if they can still satisfy the NDIS, they might get the NDIS package, but they are going to be destitute.

Evan MULHOLLAND: Yes. I think that is right. You mentioned before that this Bill will result in the public health system being overloaded. Do you just want to expand on that and how that will happen?

Paul SERONG: Currently for mental health when they get their claims accepted there is an umbrella around them: they have got compensation, they get some part of their weekly benefits paid or their normal salary paid and there is a medical regime in place. If they are fortunate enough to be offered occupational rehab, they have got someone who is an allied health professional helping to manage their claim, getting them to the right doctors and so on. Frank can tell you and I can tell you stories of how we moved someone from this particular doctor because the doctor did not know what they were doing and encouraged them to go to another doctor and they got better medical treatment. That is like an umbrella, or an encased system. With the mental health definition that is being proposed, they will not be part of that; they will be just in the public health system. So they will have to fend for themselves in public health emergency wards or try to go and see a psychologist privately. They have got to pay that out themselves. That is what I said before. I am really concerned.

I was listening when the mental health person was on beforehand. The Victorian government accepted 65 recommendations under the royal commission to do with the treatment of mental health and how they could provide better treatment for people with mental health disabilities. I find this legislation completely goes against those principles. At the moment you have got some protection around a cohort of people that are mentally ill because of work. People could argue that it is not related and they had anxiety disorders when they came to work and all that sort of stuff, but the way legislation is now, they have got some protection. When this goes through, there will be no protection for them and they will be on the public health system. I am fearful for what is going to happen in the future. I am a bit emotive about this, as you can tell, but in five years there will be 27,000 people who will have mental health injuries that have no protection. We are better than that in Victoria. We are an affluent state. We have got money. We do not have to put people on the scrap heap. This Bill, in my mind, is being pushed by the Department of Treasury and Finance to make the WorkCover scheme pay for itself, and they are going far too far.

David DAVIS: And let them take dividends.

Paul SERONG: Well, I will not go that far. All I will say is it will end up in surplus. It will end up with plenty of cash. What happened 10 years ago is it paid about $400 million or $500 million a year to the state government. That is okay; that is a source of revenue for the government. But what we do not want is

5000 people a year damaged because of this. What we do not want is 1700 people turfed off the scheme because we want to save some money.

Evan MULHOLLAND: You mentioned that you had spoken to Minister Pearson about WorkCover issues. Was that before the Bill was –

Paul SERONG: Yes, last December.

Evan MULHOLLAND: Yes. No worries.

Paul SERONG: When the government was re-elected and I found out he was WorkCover minister I made an appointment to go and see him, this time last year.

Evan MULHOLLAND: Would you say that he was aware of the issues then?

Paul SERONG: Yes. He was aware before I got there, but he was clearly aware after I was there. The first thing I said to him was, 'You'll need to increase the premium because the premium rate has not been increased for such a long time and the scheme is underfunded.' He said, 'Yes, we're going to do that.' I gave him a copy of this, and I gave him a copy of the papers I put in to the Rozen inquiry about how to manage complex claims, and he seemed very, very interested. I even said to him, 'I'd like to go on the WorkCover board. Because I know so much about this, I can help the government with the board.' I did not hear from him again. I chased him in February, and his advisor said to me, 'He's got all your stuff. He'll come back to you if he wants any more information.'

Evan MULHOLLAND: Did he come back to you on the Bill at all?

Paul SERONG: No.

Evan MULHOLLAND: So you saw it when it was tabled in Parliament, basically?

Paul SERONG: Yes.

The CHAIR: Thanks, Mr Mulholland. Dr Mansfield.

Sarah MANSFIELD: Thank you. We have heard from a number of people over the day about how the current system often results in a secondary injury because of the process itself. What is your view on the changes and whether they are likely to reduce that risk of secondary injury from the claiming process itself? So for people with stress and anxiety around the claim process, do you think that will reduce, increase or worsen people's outcomes because of these changes?

Paul SERONG: Look, you are not going to have 5000 people being accepted as a claim under the mental health definition. So they will not get secondary psych issues, because they will not even be on a claim. Secondary psych usually applies to claims that have got physical claims, so if a person has hurt his back, his leg or his arms or whatever, the injury takes a while to stabilise and it takes a while to get back to work. It depends on how his employer has embraced him. There are a whole host of reasons why secondary psych comes into play. People fear they are going to hurt themselves, they are not getting looked after by their employer – there are a whole host of reasons. This Bill will do nothing about secondary psych. Secondary psych will still be in the scheme.

Sarah MANSFIELD: Okay. You mentioned before that Washington had improved their return-to-work outcomes. Do you know what that did for the financial viability of that scheme as well?

Paul SERONG: It saved them $2 billion in long-tail liabilities.

Sarah MANSFIELD: Did they have any sort of equivalent changes to eligibility or the sorts of measures that we are seeing in this Bill? You alluded to some of the things that they were doing with a different approach around early intervention. Was that the key driver?

Paul SERONG: What happened was there was a change of chief executive at the department of labour and industry. That person said, 'We need to fix this workers compensation scheme because it's costing the state too

much money. We've got people that aren't getting back to work. We've got families that are destitute. We're going to change it.' So there was a cultural change at the CEO level. It filtered down. They even turned staff over that did not come on board with the new methodology and how things were to be done. Then they went through that step system I talked about before with a triage tool to review it, and they sent every claim that met the tool to what they call vocation rehabilitation. So they had an allied health professional helping to manage the particular claim on an individual-by-individual basis, and the turnaround was absolutely dramatic. It is gold standard in the world for managing workers compensation.

Frank IMBESI: Yes. It is not clear whether they made any changes to eligibility. My understanding is that they did not. At the end of the day there are going to be some people who are injured at work and need minimal intervention to get back to work, and you do not really need to do a lot with some of those people. But there are people's profiles that change along the journey because there are iatrogenic effects of being on a compensation scheme. That is anywhere in the world. If you do not continually review these people to look for those factors, then you are not in a position to know what intervention to give them and when and what is going to be most effective. What was telling about this was that they were triaging them at the beginning and repetitively at certain milestones, then determining who needed that extra care and attention and linking them to qualified people who could do that and linking them to return to work to a functional outcome. There is lots and lots of talk about treatment, but sometimes part of treatment is getting back to work. It is getting back to functional activities in a safe working environment. And sometimes, as much as employers want to help in that space and do the right thing, they are not well versed enough to understand how to interpret medical conditions and medical restrictions in a workplace environment to create the environment that allows someone to return, to be accommodated and to then gradually improve as they prove to themselves that they can function in a workplace environment around supportive people.

Sarah MANSFIELD: Thank you. Frank, I would be interested in hearing a bit more about your view around this 20 per cent whole-person-impairment threshold. I think a couple of times Paul said you might have some views on that. I mean, in practical terms what does that mean for the sorts of clients your providers might be dealing with?

Frank IMBESI: Look, it is an interesting question. It depends really what lens you want to look at it through. It is often helpful to use an example. If someone has an amputation of a limb or part of a limb, it results in a physical whole-person impairment as a result of the loss of function attributed to the anatomic loss of that particular body part. We would all understand that that also has a psychological impact on a human. To make an impairment assessment on the physical injury alone means that they may not get over a certain threshold, whether you put it at 5, 10, 15, 20 or 25 per cent. At some point some of those conditions that we would consider serious do not get over that threshold, but from a functional point of view they have other conditions which impact on their ability to get back into the community and to engage in purposeful activity such as work, so we are effectively excluding that. If you look at it from an impairment point of view, you say, 'Well, this is their physical impairment.' There is a whole bunch of AMA tables that tell you that, but from a humanistic return-to-productivity point of view there is a whole range of other factors you need to look at, and the whole-person impairment, when it is centred only on the primary compensable injury, by design excludes those other factors. So if they are off the system, there may be very strong reasons why they cannot get back to work that have not been considered in the whole-person test.

Paul SERONG: Do you understand the primary cause of injury? If you have got a primary cause of injury – you have lost your leg – but you have got secondary psych that comes into play, and with secondary psych you might be 25 per cent and stay on the scheme, but the loss of the leg is the primary source. That might mean 15 per cent, you go off, right? The other thing that worries me with this part of the legislation is it is going to be virtually impossible to have a proper medical assessment done by each and every one of these people over the 2½ years. There are about 4000 people at the moment in the 2½ year cycle, and currently there are not enough doctors to do the medical assessment, so the Bill provides that the WorkCover claims agent can do the assessment with a desktop review – and WorkCover are past masters at incentivising agents to perform. They give them millions of dollars worth of bonuses to reach targets, so the agents are going to find hardly anybody gets over whole-person impairment and the agents will actually earn millions of dollars in incentive payments because of this particular part of the Bill, because the case manager will be doing the assessment as a desktop review. That is appalling. That is absolutely appalling.

The CHAIR: Thanks, Dr Mansfield. We will move on to Mr McIntosh.

Tom McINTOSH: Thanks, both, for being here – and being here in retirement. You talked about the $2 billion. Is that per annum or a saving –

Paul SERONG: This is –

Tom McINTOSH: Sorry, in Washington.

Paul SERONG: In Washington? It was $2 billion over a four-year period.

Tom McINTOSH: Okay, thank you. We are talking about return to work. I am just hoping to drill down on that a bit. If you just talk a little bit about the current limitations that are in the system that effective return to work can alleviate or can get better outcomes, and what are the pilots or projects that could be delivered to change – you talked about a cultural change. What are the –

Paul SERONG: Well, a cultural change is really at the top of the organisation or even down that path –

Tom McINTOSH: Yes, sorry, so the projects that flow from that. What are the projects or the pilots that could start to see that, to drill down with some examples?

Paul SERONG: Okay. If I start, Frank will add more tangible examples. Currently when a case comes to occupational rehab it is referred by a WorkCover agent. The agent makes the determination, 'We can't get the person back to work, so we'll give them to rehab to try.' We will put on our best consultant depending upon the type of claim. If it is a physical claim, it will be an OT or a physiotherapist. If it is a psych claim, it will be a psychologist on the claim. We work with the person to try and get them back to work as quickly and as safely as possible. The problem is that the industry, the OR industry, only sees about – I do not know – 10 per cent of claims that happen.

Frank IMBESI: A little over that.

Paul SERONG: Right, a little over 10 per cent. So for 90 per cent of claims occupational rehab does not get offered to them. Now, in the current Act – forget about the Bill – there is an entitlement for occupational rehab to injured workers. It is an entitlement. They are entitled to receive it, right, but they do not get offered it because the WorkCover agent just does not give it to them. One of the reasons it does not give it to them is that – and I know this for a fact – one of the incentives WorkSafe do is they pay the agents a bonus for what they call medical management. It is the payment of medical expenses associated with claims. Occupational rehab is seen to be part of the medical management process. So if you send more claims to OR, your medical costs go up and you do not get your bonus. So there is a perverse incentive in there for the WorkCover agent not to send claims to occupational rehab. That did not happen in Washington. In Washington all the claims go to rehab that need to go to rehab. Now, they are talking – sorry, Frank. I am getting worked up here.

Frank IMBESI: You are right. You do!

Paul SERONG: They are talking about this magic Return to Work Victoria division that they are going to have. Return to work is now – we do return to work. When the case comes to rehab, we work on return to work. I do not know what this new magic Return to Work Victoria is going to achieve, because it is actually in place now; it is just not utilised enough. Sorry, Frank. I will shut up.

Frank IMBESI: Look, out of the whole cohort of claims – and it needs to be said because it is fact – some of them do not need intervention. Some people sprain an ankle and see a good physio and have a supportive employer and they will go back to it. They do not need our intervention, because we are a much more specialised service. But some of the facts are that people at the beginning of a claim – around 18 per cent, studies show – who are completely symptom free end up on long-term disability past 130 weeks, across the world, right. At the beginning of the claim you would never pick these people up because you would think all indications are that they are going to get better and go back to work, and they do not. So assessing and reassessing and a triage tool – a lot of the people who are managing these claims at the front end, at the agents, do not have that allied health or medical acumen and sometimes miss those signs.

Now, in our industry we do not see them until they come to us. We have no knowledge of them before that, but there are opportunities to identify the people who are moving to that higher risk profile, and then we can intervene earlier. And the earlier we intervene, the better the outcome is. For mental injury claims, we know

that when we cannot get them back to work with their pre-injury or existing employer because of whatever the reasons may be, 62 per cent of the time we get them a job with a new employer. That is a pretty good strike rate.

Paul SERONG: But if the case does not come to OR –

Frank IMBESI: We have missed the opportunity.

Paul SERONG: we have missed the opportunity. The person stays on the scheme and then gets kicked off.

Frank IMBESI: At 52 weeks the probability that anyone is ever going to return to work is around 4 per cent. They have still got another period of time to stay on the scheme, but we have missed a lot of that opportunity.

The CHAIR: We are just short on time, so we will just try and keep things a bit – go for it.

Frank IMBESI: Yes, sure.

Tom McINTOSH: To my question, what is a practical piece we can deliver? From what you are saying, it is to identify those people from a data perspective –

Frank IMBESI: Correct.

Tom McINTOSH: who would identify as being at high risk to fall into that long-term category that will never go back to work and pick them up and deal with them –

Frank IMBESI: Early, and give them very tailored interventions.

Paul SERONG: WorkSafe designed a scheme called 'better at work' back in about 2018, 2017 – Frank?

Frank IMBESI: It was probably earlier than that.

Paul SERONG: They got all the agents – it was a project – and they worked this predetermined methodology. They got occupational rehab involved in the case at about 20 weeks. And in my paper, when I give it to, you will see the numbers. What happened in 2018 was the WorkCover board told the agents they wanted to reduce occupational rehab costs, because they could, and they did – they saved $20 million, and the scheme viability has jumped out the window.

Tom McINTOSH: Yes. I have just been trying to understand what it is as a recommendation to improve the system now, so I think what you said, I will take that and –

Frank IMBESI: Early identification, early intervention.

Tom McINTOSH: Yes.

Frank IMBESI: Targeted specialists.

Tom McINTOSH: I will stop there. Okay. Thanks to both.

The CHAIR: Thank you. Mr Davis.

David DAVIS: That is exactly where I want to go with some of my questions. There is this return-to-work concept, and I understand it well, having been in this sector once upon a time. But the reality is that at the moment there is just a note up on a website about return to work. It should be – I am asking you some leading questions here – embedded in the scheme and a part of the management. It cannot be out over here.

Paul SERONG: It should not be a separate organisation.

David DAVIS: No, no, no, but this is the way it is being talked about at the moment. It cannot be apart. It will not work if it is a separate scheme over here.

Paul SERONG: It will not work as a separate scheme. But in WorkSafe Victoria right now there is a return-to-work division. Occupational rehab –

David DAVIS: Yes. But if you had a new badge and you called it to Return to Work Victoria, just for the relaunch of it, you would have it in the scheme –

Paul SERONG: Yes.

David DAVIS: and you would have the agents and the authority oversighting this and ensuring that every one of the cases that tripped the assessment tools went to rehab at the earliest possible point –

Paul SERONG: Correct.

David DAVIS: and had the resources – the ergonomic resources, the psychological resources, the OT and 'skills of daily life' resources and so forth – all applied quickly.

Paul SERONG: That is exactly what happened in Washington – it stayed within the whole scheme. Do not pull it out and put it somewhere else.

David DAVIS: And should GPs be able to make that referral for rehab? I am just asking that question because it is a legitimate – I mean, the GPs think they are the centre of the point, and often they are and very good ones.

Frank IMBESI: David, the reality is that the average GP sees, as a proportion of the average case load, 2 to 4 per cent of workers comp patients, so they are not very well versed in the scheme because they do not do a lot of it. You would want to be sure that they knew the scheme well enough to be able to refer people.

David DAVIS: But even company doctors could be involved in the rehab at an early –

Frank IMBESI: The other point, and this is an important one, is that if you embed it within the scheme and within the agents, there is a perception from injured workers that the treatment that they are getting and the service they are getting is in the best interests of the agents and the scheme. Independence of people providing a service is really important in that regard, so that they know that their interests are being considered from an independent viewpoint.

David DAVIS: My final question on this is: should there be some metrics reported on this, on the earliness and the frequency of involvement of rehab?

Paul SERONG: What are you talking about? Do metrics on return to work?

David DAVIS: Well, yes, but on the referral to rehab.

Frank IMBESI: They already do that.

Paul SERONG: They do that.

David DAVIS: They do that.

Frank IMBESI: That information already exists.

Paul SERONG: Well, they do it internally, and they share it –

David DAVIS: None of that is public, though.

Paul SERONG: No.

Frank IMBESI: No, it is not.

David DAVIS: It could be.

Paul SERONG: Yes, it could be. There are sections in the WorkSafe report that actually do report on the WorkCover agents' performance under their contract; it could be in there. But the success of the scheme and

bringing it back and making it work properly and not allowing premiums to increase year on year on year is to effectively use occupational rehab on the cases that need it, and that is not happening at the moment.

Frank IMBESI: Intervening early.

Paul SERONG: I do not think it has happened for so long it is not funny – big fault of the scheme.

The CHAIR: Thanks, Mr Davis. Mr Berger.

John BERGER: Thank you, Chair. And thank you both for your appearance today. Frank, I reckon this one is for you – I think Paul has had a reasonable go today. I am interested in your experiences. You do have a fair bit of experience over many years on a system that needs to be well supported both internally and financially. With what we have got now, our scheme and the schemes around Australia, how they stack up against some of the world trends that you see, notwithstanding the Washington one, which we have heard about – that cannot be the only example that supports and has turned around their issues – what recommendations can you give us from other examples that might be useful?

Frank IMBESI: Look, it is an interesting question. It is really hard to compare apples with apples – and I am not avoiding the question – because different countries have different systems. Canada has a very different system, and every province in Canada has a different way of looking at it. Some people, some institutions, run rehab internally, and Canada has that model. Others outsource it and have it independent. The general consensus is that to have independent people outside gives the injured workers the confidence that there is someone genuinely looking at their interests. That is a perception by them. I am not suggesting that they do not get good care in other ways, but it needs to be specialist care and it needs to be specialist care that understands the medical and psychological aspects and components of an injury, and the connection to a return to safe work and function. That is what we are always talking about. Early accommodation and early intervention is really, really important. Really, really early determination in a case where we know that a return-to-work goal that is aligned to the same employer or the pre-injury employer is no longer feasible lets us pivot and shift very, very quickly and try and get the very best outcome, and often run them in parallel as well. So those are some of the features that work really, really well.

A lot of studies have shown that early education of injured workers and reassurance is as effective as early medical intervention as well. So assuring people that, ‘Hey, you’re not going to go down on the scrapheap. Let’s look after this early, let’s keep you moving, let’s do all these things.’ I have always said, and I still say: the certification of incapacity – medically unnecessary incapacity on a certificate – should be treated the same way as the side-effects of prescribing a medication. If people are off work for too long, you create a belief in them that they actually are unwell, and that becomes a self-fulfilling prophecy. So you need to be very well versed in this, and I think there is an opportunity for some training for all people who are certified to understand that certifying incapacity unnecessarily can be more harmful to people in the long term more than it benefits them. That is a really important point.

Paul SERONG: One of the things occupational rehab does is work with the doctor. We will go and see the doctor of the injured worker and try and convince the doctor to allow the injured worker to come back to work in a graduated return-to-work plan. When that happens, the improvement in the worker and his attitude to get back to work is just absolutely fantastic. If you can convince his doctor for him to come back to work for 2 or 3 hours a week, all of a sudden in three months time he is back full time.

The CHAIR: Thanks, Mr Berger. Ms Broad.

Gaelle BROAD: Thank you very much for your contribution; it has been fascinating. I am just interested, because both of you have had experience with other states, how does Victoria’s current system compare?

Paul SERONG: In what regard?

Gaelle BROAD: You talk about the return-to-work aspect – the rate has been declining in Victoria – and certainly culture you have mentioned. In Victoria the top 10 of our mental health claims seem to be coming from the public health workforce. Are there any approaches being done differently in other states that are a better model to base these changes on?

Paul SERONG: I would say no. They are all pretty bad. New South Wales is a basket case. I think New South Wales will be watching very closely. If this legislation gets passed, then I would say within 12 months they will do the same in New South Wales and exclude mental health cases, because that will correct their scheme as well. The only scheme that seems to run a little bit better than all the others is Western Australia. The Western Australian scheme is a privately underwritten scheme. Insurance companies actually manage the claims and assume the risk, so they have got skin in the game. They tend to do what is called 'buy out the claim'. So if they have got someone who is quite seriously injured, they will work out what that person is going to cost them over the next 20 years and they will make an offer to them – a $400,000 cash settlement – and they write the claim off. But the Western Australian scheme, of those all around the country, would be the one that is running a little bit better than Victoria. Queensland's is a scheme that only has 52 weeks compensation, so you cannot compare it. Victoria's used to be the best run scheme in Australia. When Greg Tweedly was the CEO of WorkCover – you know Greg? – and James MacKenzie was the chairman, the scheme was running the best. It was in surplus. Greg retired, and it just went downhill after that.

Frank IMBESI: It is hard to compare it to other schemes because comparison is guided by what you are focusing on, what you say you are measuring and how you measure it. Everyone in every state – and Victoria – measures return to work, as an example, incredibly differently. So it is almost impossible to compare apples with apples. Western Australia say they have got a return-to-work rate of something like 90 per cent, whereas we measure it as: did they go back to work, and did they sustain that for 13 weeks? That is a much tougher measure. Our return-to-work rates, by extension, are lower than theirs but we have got a much, much tougher test. So it is really hard to compare apples with apples, it really is.

Gaelle BROAD: Claims have tripled, I think, since 2010 in Victoria. Why do you see that? What is causing that rise?

Paul SERONG: Well, you have got a significant rise in mental health claims happening in society. It is okay to be mentally ill now. Years ago it was quite taboo; now it is okay. We have slogans: 'It's okay not to be okay.' So people feel okay and they are comfortable now to put in a mental health claim. I think COVID has had a bit of an effect. I think there is a lag, not to do with the COVID virus but a lag effect – the workforce is finding a new way of doing work, right? But when I started working on my paper and I was trying to get a comparator – when you get to have a look at this – I went through the annual reports of WorkSafe. Sorry, I will find it. I went back to 2017 and then to 2023. The percentage of people on workers compensation claims post-130 weeks – the percentage – was 2.1 in 2017. These are figures out of the annual reports. In 2023 it is 6.2. There has been a 266 per cent increase in people going onto what I call the long tail.

Frank IMBESI: You have also got to qualify the number of claims we are seeing relative to the number of people in the workforce. If workforce is growing and the number of claims are growing and they are growing at the same percentage, then the claims are just reflecting the natural growth in the workplace and people working. So you have got to look at that. If there is a disparity in that – the number of claims is rising at a rate that is higher than the rate of people in the workforce – then you have got a spiking effect and you have got to look for the reasons.

Paul SERONG: You need a circuit breaker. There has to be a circuit breaker. What this legislation will do is it will bring the scheme back into balance and profit, right, but at the expense of people on mental health and people being kicked off the scheme. If collectively the community is prepared to wear that, fine. But, as I said before, I think we are better than that in Victoria.

The CHAIR: Thank you very much. We will have to cap it there. But thank you very much, Frank and Paul, for coming along today and for appearing at such short notice for this inquiry. That concludes the hearing. However, some members might submit further questions to you on notice, in which case the committee staff will reach out. If you just want to share those documents with the staff on your way out, they can send them to us as well.

Paul SERONG: Yes, I will arrange to send them to them electronically.

The CHAIR: Beautiful. Thank you so much.

Witnesses withdrew.