

Australian Government

**SAFETY, REHABILITATION AND COMPENSATION
AMENDMENT (EARLY AND EFFECTIVE
REHABILITATION) BILL 2017**

**REGULATION IMPACT STATEMENT
CONSULTATION DRAFT**

Department of Employment

2017

TABLE OF CONTENTS

Background	3
Overview of this Regulation Impact Statement	5
Description and scope of the problem	6
Objectives	8
Evidence based medical treatment	9
The Problem.....	9
Options	12
Impact Analysis	14
Consultation.....	16
Conclusion	17
Household and attendant care services — tiered system of services and support	18
The Problem.....	18
Options	20
Impact Analysis	22
Consultation.....	23
Conclusion	24
Medical treatment and legal costs	26
The Problem.....	26
Options	28
Impact Analysis	29
Consultation.....	32
Conclusion	33
Income Replacement	34
The Problem.....	34
Options	35
Impact Analysis	35
Consultation.....	37
Conclusion	38
Costing	39
Regulatory Burden and Cost Offset Estimate Table	40
Stakeholder Consultation	41
Engagement Methods	41
Consultation Process	41

BACKGROUND

The *Safety, Rehabilitation and Compensation Act 1988* (SRC Act) provides rehabilitation and workers' compensation arrangements for the Commonwealth, the Australian Capital Territory (ACT) Government and 35 licensees comprising current and former Commonwealth authorities and eligible private sector corporations.

Australian Government agencies and statutory authorities and ACT Government agencies and authorities pay premiums to Comcare under the SRC Act (premium payers). Former Commonwealth authorities and private sector corporations who can demonstrate that they are carrying on business in competition with a current or former Commonwealth authority, and who have been declared by the Minister to be eligible, can apply for a licence to insure for and manage workers' compensation claims under the SRC Act (licensees). Comcare determines and manages claims made in relation to the employees of premium payers. Licensees determine and manage claims made in relation to their own employees, or otherwise engage a claims manager for this purpose.

Comcare's workers' compensation insurance is largely funded through premiums paid by agencies covered by the scheme. Comcare receives, via the Department of Employment, annual and special appropriations for pre-1989 workers' compensation claims. All expenses associated with post-1989 Comcare-managed claims are fully cost recovered through premiums paid by Commonwealth and ACT Government agencies.

A licence provides eligible corporations with the ability to manage and bear the costs and risks of workers' compensation claims made in relation to their own employees. The arrangement for private sector corporations to have coverage for workers' compensation under the SRC Act was introduced to provide competitive neutrality for those corporations competing in the market with government business enterprises – such as Optus competing in telecommunications business with Telstra and TNT Australia competing in the freight business with Australia Post.

For the purposes of the SRC Act, determinations, decisions or requirements under specific sections of the Act are made by Comcare and licensees and they are variously referred to as relevant authorities, determining authorities and responsible authorities.

As at the end of the 2015-16 financial year, about 55 per cent of all employees covered under the SRC Act were employed by premium payers and the remaining 45 per cent by licensees.¹ This proportion of employees employed by licensees is significantly higher than other jurisdictions, which range from 25 per cent in New South Wales to under ten per cent in Victoria and Queensland.²

There have been no significant changes to the rehabilitation or medical treatment provisions of the SRC Act since it was enacted in 1988 and it no longer reflects current best practice. In 2012-13, reviews of the SRC Act were undertaken by Mr Peter Hanks QC and Dr Allan Hawke AC. Mr Hanks reviewed the SRC Act's workers' compensation benefit structures, rehabilitation and return-to-work provisions. Dr Hawke reviewed the performance of workers' compensation under the SRC Act, in particular the governance and financial frameworks.

Mr Hanks and Dr Hawke consulted extensively and engaged with participants in the workers' compensation process under the SRC Act to assist in the development of their recommendations.

¹ Comcare Compendium of WHS and Workers compensation Statistics, 8th edition, p. 12

² Comparison of Workers compensation Arrangements in Australia and New Zealand, October 2016, p. 174

The participants consulted included employer associations and employers, employee organisations, medical practitioners, rehabilitation professionals, lawyers and other professionals, government agencies, licensees and workers' compensation administrators. Stakeholders were extensively involved in the identification of issues, through to the development of recommendations and consulted again post-publication of the recommendations. The Report on the Review of the SRC Act was released in March 2013 (the Review).

Following the 2013 election, the Government consulted widely to develop a package of reforms based on the recommendations made by Mr Hanks and Dr Hawke. This work culminated in the introduction of the Safety, Rehabilitation and Compensation Amendment (Improving the Comcare Scheme) Bill 2015 (the Improving the Comcare Scheme Bill) on 25 March 2015. This Bill sought to make significant amendments to the SRC Act to ensure a stronger focus on rehabilitation and return to work and limit access to, and levels of, workers' compensation benefits for some employees.

The Improving the Comcare Scheme Bill was referred to the Senate Education and Employment Legislation Committee for inquiry. Premium payers and licensees supported the proposals, but the Opposition, the Greens, most independents and unions expressed strong opposition to the proposed reforms. The Bill lapsed when Parliament was prorogued on 15 April 2016.

Since 2014, the financial performance of the Comcare Scheme has significantly improved due to actions taken by Comcare and Australian Government agencies. However, there is scope to build on these improvements through reforms to the SRC Act.

To complement the recent improvements in performance of the Comcare scheme, the Government has developed a new approach to reforming the SRC Act. This new approach focuses on facilitating early and effective rehabilitation for employees to help them return to work sooner, improving claims management and reducing the number and length of disputes. The proposed measures are designed to help injured employees get earlier and better treatment and support so that they can return work sooner. This will reduce costs for Comcare, premium payers and licensees, since the cost of compensating employees for time off work is the single biggest driver of claim costs in the scheme (55 per cent of claim costs paid).³

³ Comcare's Scheme Overview: http://www.comcare.gov.au/the_scheme | "overview, accessed 10 July 2017

OVERVIEW OF THIS REGULATION IMPACT STATEMENT

This Regulation Impact Statement (RIS) examines the Government's new approach to reforming the SRC Act.

The reforms examined in this RIS have been categorised into four themes:

- medical treatment
- household and attendant care services
- medical and legal costs, and
- income replacement.

The RIS treats each of these areas as a discrete problem, with its own options and impacts. Given the complex linkages and interdependencies of the reform package, the regulatory impact of the options cannot be assessed individually, but are considered as a whole. The overall regulatory impact is the impact of the preferred options implemented together. The primary goal of the reforms is ensuring a stronger focus on rehabilitation and return to work by providing early access to rehabilitation and medical treatment.

Consistent with the Australian Government Guide to Regulation, this RIS examines the amendments that are likely to have a significant regulatory impact. The remaining elements of the proposed reforms have no significant regulatory impact, such as those that concern government processes. These matters are not specifically examined in the RIS.

DESCRIPTION AND SCOPE OF THE PROBLEM

The environment has changed significantly since the SRC Act was designed 28 years ago. Now, instead of solely covering the Australian Public Service, 45 per cent of all fulltime equivalent employees (167 700 employees) covered under the SRC Act are employed by licensees.⁴ These licensees are engaged across a broad range of industries including, information, media and telecommunications; financial and insurance services; transport, postal and warehousing; professional, scientific and technical services; manufacturing and, construction.⁵ The shift in the employment profile, combined with medical and scientific advances, means that the SRC Act has become out of step with expert thinking and best practice in medical treatment and vocational rehabilitation. It no longer effectively incentivises employers to facilitate early return-to-work or employees to return to work as quickly as possible.

The current legislative framework for medical treatment does not align with modern regulation of health practitioners in Australia and limits Comcare's ability to have appropriate oversight and influence over treatment being funded. No formal training is required for providers of in-home care. This can result in injured employees not being provided with the best possible chance of recovery. Care is not linked to the level of impairment and this can result in less injured employees receiving similar treatment services to catastrophically injured employees. Furthermore, noting contemporary evidence on the benefits of work, there are limited incentives for injured employees to return to work as quickly as possible.

The nature of workers' compensation schemes influence the type of disputes that arise. As a 'no-fault' workers' compensation scheme, disputes tend to arise from questions of access to, or the extent of, coverage. These include whether an injury is related to employment and the nature and severity of the injury, which determines access to, and level of, entitlements.⁶ While there is no recognised benchmark settlement period, disputes under the Comcare scheme generally take more time to resolve than disputes in other jurisdictions. In the Comcare scheme only 9.9 per cent of disputes are resolved within three months; this compares to 88.4 per cent in Queensland, 79.8 per cent in Western Australia and 68.7 per cent in Tasmania⁷.

Compared to licensees under the SRC Act, premium paying employers are less successful with achieving early and sustained return-to-work for their employees. Over a nine-year period, return-to-work rates for premium payers have fallen from the mid to high eighties (reaching 89 per cent in 2005-06) to plateau at 80 to 81 per cent over the last four years. Return to work rates for licensees have generally been higher but less consistent.⁸

⁴ Comcare Compendium of WHS and Workers compensation Statistics, 8th edition, p. 12

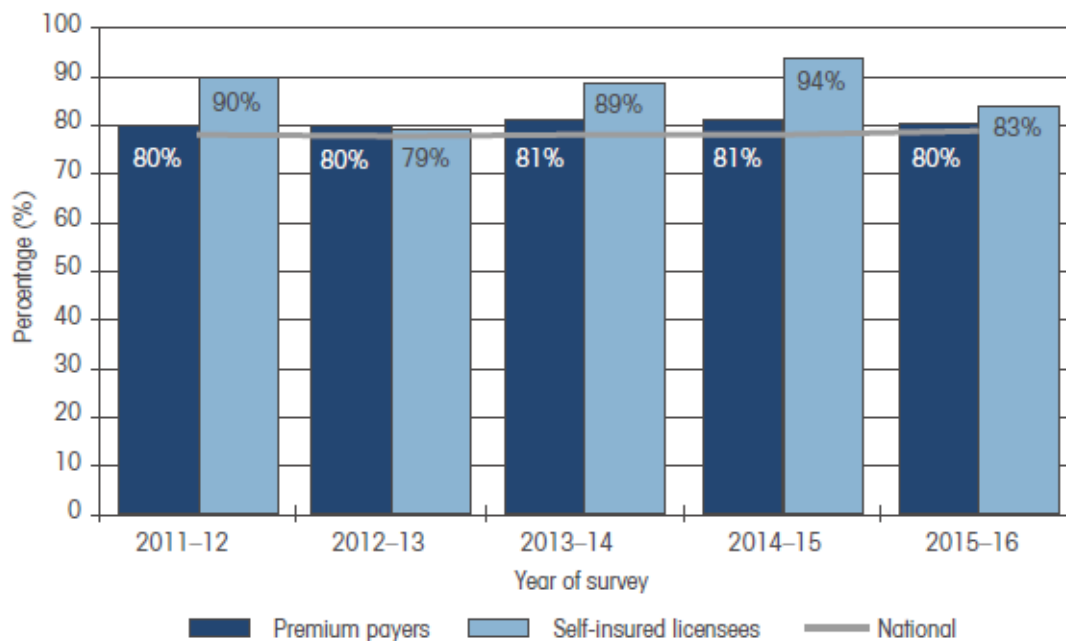
⁵ Comcare Compendium of WHS and Workers compensation Statistics, 8th edition, p. 10

⁶ National Workers compensation and Occupational Health and Safety Frameworks, Productivity Commission Inquiry Report, No. 27, 16 March 2004, p. 365

⁷ Safe Work Australia's Comparative Performance Monitoring Report, 18th Edition, Revised July 2017, p. 34

⁸ Comcare Compendium of WHS and Workers compensation Statistics, 8th edition, p. 45

Current return to work rates in the Comcare Scheme⁹



In the four years to 2014-15 premiums for Australian Government agencies in the Comcare scheme increased by 77 per cent largely due to injured employees being off work for longer periods.

Since 2014, Comcare and Australian Government agencies have undertaken a range of initiatives to improve early intervention and rehabilitation for injured employees in order to better support these workers and better target claims. In 2014, a Working Group of Department Secretaries from several Australian Government agencies, including Comcare was established to oversee a number of trials on ways for the APS to improve the performance of the Comcare scheme. Actions taken by the agencies in the working group focussed on injury prevention, early intervention, targeted rehabilitation and return to work as drivers of costs that were within employer control. A number of departments also trialled management of their own claims, while Comcare commissioned an external review of its claims management practices.

The actions taken by Comcare and Australian Government agencies led to significantly improved performance. The overall premium rate for agencies has reduced from 1.93 per cent of payroll in 2014-15 to 1.23 per cent in 2017-18, saving agencies \$87 million in annual premiums. Comcare’s liabilities are now fully funded and it had an operating surplus in 2016-17.

This package of reforms builds on the successful actions of Comcare and Australian Government agencies to improve the financial performance of the Comcare scheme. The amendments are designed to build on the recent improvements by legislating an evidence-based approach to assessment and management of workers’ compensation claims, with a strong focus on early intervention and effective rehabilitation to return injured employees to work as quickly as possible.

⁹ Comcare Compendium of WHS and Workers compensation Statistics, 8th edition, p. 45

OBJECTIVES

The objective of these reforms is to modernise the SRC Act to improve return to work outcomes by aligning medical treatment, home help and attendant care provisions to modern health care standards and to reduce the number, length and cost of claims disputes that progress to the Administrative Appeals Tribunal (AAT).

EVIDENCE BASED MEDICAL TREATMENT

THE PROBLEM

The framework in the SRC Act for the provision and monitoring of medical treatment is not clearly defined or aligned with current best practice across state and territory workers' compensation schemes. Best practice medical treatment in workers' compensation is widely considered to be evidence based medical treatment that empowers injured employees to manage their injury and recover at work wherever possible. These are the principles that underpin the Clinical Framework which has been endorsed by most Australian workers' compensation bodies. They reflect the well-recognised view of experts that being at work provides significant social and health benefits that will aid recovery.

The lack of a clearly defined, modern framework for regulating the provision of these services under the SRC Act is a barrier to timely and effective recovery and return-to-work and is increasing costs.

STANDARD OF MEDICAL TREATMENT

Under the SRC Act, a 'relevant authority' is required to compensate injured employees for the cost of reasonable medical treatment relating to their injury. However, the relevant authority has no control over an injured employee's choice of medical or therapeutic practitioner and limited influence over medical or therapeutic treatment that it is compensating the employee to obtain.

There have been many legal cases over the years that have considered what 'reasonable' medical treatment is, as it is not defined under the SRC Act. In each case, what is 'reasonable' has been determined by reference to the employee's individual circumstances and perspective.

This has resulted in the AAT, in certain circumstances, approving payment of medical treatment under the Comcare scheme that provides questionable benefit for the employee or at disproportionately large cost, for example:

- approving the continuation of massage therapy payments as part of a broader treatment plan, despite no evidence of any curative effect associated with the massage therapy in this case.
- finding it was reasonable for an injured employee living in Alice Springs (who had 'generalised anxiety disorder and adjustment reaction with brief depressive reaction') to attend a Buddhist meditation retreat in Queensland, because he identified as a Buddhist.
- finding it was reasonable for an employee to be flown from Canberra to Townsville to receive psychoneuroimmunology treatment after the only clinical nurse psychotherapist providing this new and unique treatment in Canberra relocated.

In June 2012, Comcare and the majority of state and territory workers' compensation bodies, endorsed the Clinical Framework for the Delivery of Health Services (the Clinical Framework), which is based on a framework published in 2005 by WorkSafe Victoria and the Victorian Transport Accident Commission. The Clinical Framework is an evidence-based policy framework that outlines a set of five guiding principles for the delivery of allied health services to injured employees. The guiding principles of the Clinical Framework require:

- measurement and demonstration of the effectiveness of treatment;
- adoption of a bio-psycho-social approach¹⁰;
- empowering the injured person to manage their own injury;
- implementing goals focused on optimising function, participation and return-to-work; and
- basing treatment on best available research evidence.

The current provisions in the SRC Act do not contain guidance on what medical treatment is ‘reasonable for the employee to obtain in the circumstances’. While relevant authorities may choose to have regard to the Clinical Framework principles when determining whether a particular medical treatment is ‘reasonable for the employee to obtain in the circumstances’, the AAT does not need to have regard to the Clinical Framework when reviewing those determinations.

MEDICAL TREATMENT PROVIDED BY HEALTH PRACTITIONERS

According to the Australian and New Zealand Consensus Statement on the Health Benefits of Work, employees attempting to return-to-work after a period of injury face a complex situation with many variables. Health practitioners exert a significant influence on work absence and in promoting the health benefits of work¹¹. Good outcomes are more likely when employees understand the health benefits of work and are empowered to take responsibility for their own recovery.

State and territory workers’ compensation schemes maintain a level of oversight and control over the medical treatment they are funding in different ways:

- In Victoria, service providers such as chiropractors, dentists, psychologists and physiotherapists must be registered with WorkSafe Victoria to provide services to injured employees. Providers must complete a ‘WorkSafe Application for Registration to Provide Services to Workers’ form and must also satisfy the relevant provider eligibility requirements. Medical practitioners registered under Medicare are not required to register separately with WorkSafe.
- In New South Wales, allied health providers must be approved as WorkCover providers and follow administrative procedures developed by WorkCover in conjunction with the relevant professional association.

The SRC Act does not define standards of medical treatment, whether provided in Australia or overseas. It also does not require that health providers’ qualifications be accredited by a relevant professional body or by Comcare. Registration standards, such as those in Victoria and New South Wales, provide an extra layer of risk control that is currently lacking under the SRC Act.

Although the definition of ‘medical treatment’ under the SRC Act refers to eight types of treatment, some of which is required to be delivered by, or under the supervision of, legally qualified medical practitioners, it does not prescribe a level of national accreditation required for these practitioners

¹⁰ This approach explains how, in general, work is good for health and wellbeing. ‘Bio’ describes the impairment, body structure and function elements; ‘psycho’ describes the activity, support and relationship elements; and ‘social’ describes the participation elements

¹¹ Australian and New Zealand Consensus Statement on the Health Benefits of Work, p. 7

in line with current protocols under the National Accreditation and Registration Scheme for health providers.

In March 2008 the Council of Australian Government decided to establish a single National Registration and Accreditation Scheme for 10 health practitioner bodies which was introduced on 1 July 2010 and is administered by the Australian Health Practitioner Regulation Authority (AHPRA). Fourteen health professions are now regulated by National Boards supported by AHPRA. The primary role of the National Boards is to protect the public and set standards that all registered health practitioners must meet.

Because the SRC Act does not require medical treatment to be provided by accredited practitioners, medical treatment that is not regulated by AHPRA and is not subject to national standards for quality of treatment may be compensable. Injured employees in the scheme may therefore receive compensation for medical treatment provided by poorly qualified providers that may do nothing to improve, or may even exacerbate, their medical condition. Comcare currently has no legislative power to prevent such treatment if it is under the supervision of a legally qualified medical practitioner.

In its current form, the SRC Act's definition of medical treatment does not enable Comcare to maintain an adequate level of oversight and control over the medical treatment it, and the agencies that pay premiums, are funding, both within Australia and overseas. The current framework is out of step with best practice in health management because it can allow compensation for treatment that is not evidence based or provided by trained health professionals.

The SRC Act is also out of step with current regulatory practice in the states and territories as it has not adopted the National Registration and Accreditation Scheme and its registration and regulation requirements.

For injured employees who seek medical treatment whilst overseas, there is no provision in the SRC Act for relevant authorities to review the qualifications of overseas health care providers or the standard of treatment provided. Compensation for medical treatment overseas must be paid if the need for the treatment is considered reasonable, no matter the standard of treatment provided or the qualifications of those providing it.

The SRC Act also has no provisions to enable relevant authorities to refer health practitioners to the appropriate professional regulatory body where there are concerns about the adequacy, appropriateness or frequency of treatment.

PROVISION OF MEDICINES

The definition of 'medical treatment' under section 4(1) of the SRC Act allows for the provision of 'medicines ... whether in a hospital or otherwise'. The definition of what constitutes 'medicine' under the SRC Act has been compromised beyond the common understanding of that term by court decisions between 1996 and 2006, where 'medicine' has been deemed to include packaged dietary foods, vitamin and mineral supplements and non-prescription medicines such as analgesics. Compensation for the cost of 'medicines' under state and territory schemes is restricted to medicines recommended or prescribed by a medical practitioner or dentist.

Some prescription medicines, such as drugs that are addictive (schedule 8 opioids and schedule 4 sedatives), are subject to misuse and abuse that may result in significantly worse health outcomes for employees that can jeopardise their ability to return to work.

The current SRC Act does not limit the number of medical practitioners that can prescribe drugs of addiction to injured employees. Where it is identified that an employee is being prescribed a schedule 4 or 8 drug Comcare requests on an individual basis that drugs of addiction be prescribed by only one medical clinic and dispensed through only one pharmacy, but it has no legislative authority to enforce these controls. There is a risk that some injured employees may visit multiple practitioners in order to obtain more prescription medicines than is clinically necessary or safe for the treatment of their condition (doctor shopping). Unregulated payment of compensation for these treatments and prescriptions finances these behaviours.

The pharmacist on Comcare's Clinical Panel screens (direct billed) pharmacy invoices and letters are sent to prescribing doctors to ensure that Schedule 8 (opioids) are prescribed on the Pharmaceutical Benefits Scheme. This is to ensure the dispensing of addictive medications has some oversight and the risks of misuse and dependence are minimised. In 2013-14 Comcare sent around 200 letters regarding these issues.¹² While there has been some improvement in this matter over the last two years, with only 56 letters needing to be sent to prescribing doctors, the risk of abuse of drugs of addiction through doctor shopping remains.

Other workers' compensation schemes in Australia, such as Victoria, require prescription medicines to be dispensed by a registered pharmacist on the request of a legally qualified medical practitioner or legally qualified dentist.

OPTIONS

The department has considered three options to address this issue. Option Two is currently the department's preferred option for inclusion in the Bill.

OPTION ONE — MAINTAIN THE STATUS QUO

Under the current provisions, injured employees can receive compensation for non-evidence based treatments that are provided by untrained health practitioners, or by health practitioners who are not meeting accepted standards or are not subject to national standards in their treatments. There is little recourse for restricting compensation for these treatments so long as a medical practitioner has referred an injured employee to them. There is also no recourse to report health practitioners to their professional regulatory bodies if a practitioner is found not to be adhering to standards set by the Clinical Framework in the provision of treatment.

For those injured employees who are overseas, treatment providers and the provision of treatment will continue to be compensated no matter the standard of treatment provided or the qualifications of those providing it.

Relevant authorities are also required to individually assess each claim to determine whether medical treatment provided is reasonable. As each determination is influenced by the employee's individual circumstances, this process is administratively inefficient and poses additional costs.

¹² Information provided by Comcare

OPTION TWO — IMPROVED REGULATION FOR PRESCRIPTION MEDICINE AND MEDICAL TREATMENT

Under this option, the definition of ‘medical treatment’ in the SRC Act will be amended so that, in order to be compensable, medical treatment must meet objective standards, such as those in the Clinical Framework which will also be adopted, and must be provided by health practitioners who are accredited and registered under the National Registration and Accreditation Scheme. This option will also enable Comcare to consider and accredit those not registered under the National Registration and Accreditation Scheme for eligibility to provide medical treatment under the SRC Act. This will ensure that medical treatment is measurable and outcome focussed and provided by suitably qualified practitioners.

In addition, the SRC Act will be amended to include treatment provided outside Australia only where the relevant authority is satisfied that the quality and cost of that treatment is comparable with treatment available in Australia.

Relevant authorities will also be able to report practitioners to the appropriate professional regulatory bodies where treatment falls outside the principles of the Clinical Framework or where there are concerns about the adequacy, appropriateness or frequency of treatment.

This option will also amend the definition of ‘medical treatment’ in the SRC Act to restrict compensation for ‘medicines’ to medicines recommended or prescribed by legally qualified medical practitioners or dentists (or under some circumstances a legally qualified optometrist or nurse) and provided by a legally qualified pharmacist. In addition, compensation for drugs of addiction will be restricted to those prescribed by the employee’s nominated legally qualified medical practitioner.

The employee will nominate a specific legally qualified medical practitioner at the start of their claim. They will be able to change the nominated practitioner throughout the life of the claim but can only have one nominated practitioner at any one time.

This option is consistent with the recommendations put forward by Mr Hanks in his review of the SRC Act in 2012.

OPTION THREE - CAP ON THE LIFETIME MEDICAL COSTS OF A CLAIM (BASED ON WA MODEL)

This option is based on current practice in Western Australia and has several similarities to Option Two presented above. Like Option Two, this option will require medical treatment to be provided by health practitioners who are accredited and registered under the National Registration and Accreditation Scheme in order to be compensable. Comcare will also have the ability to consider and accredit those not registered under the National Registration and Accreditation Scheme for eligibility to provide medical treatment under the SRC Act.

The Clinical Framework will also be adopted and compensation for ‘medicines’ will be restricted to prescription medicines only.

The difference between this Option and Option Two is the introduction of a cap on the lifetime costs of a claim. Once medical costs claimed by an employee reach the cap, no further medical costs would be compensated by the relevant authority. The cap amount will be indexed for inflation and can be reconsidered in cases where the whole person permanent impairment ratio is greater than

15 per cent, or if the worker's social or financial circumstances justify it, or both. This would be expected to stabilise and reduce costs from medical treatment in the Comcare scheme.

IMPACT ANALYSIS

This impact analysis considers the impact of the changes beyond the status quo.

OPTION TWO — IMPROVED REGULATION FOR PRESCRIPTION MEDICINE AND MEDICAL TREATMENT - PREFERRED

IMPACTS ON RELEVANT AUTHORITIES

Relevant authorities, including licensees, will notice a minor reduction in regulatory burden as they will no longer be required to interpret whether medical treatment is reasonable in every situation. Instead, they will be required to ensure that medical treatment is provided by registered or accredited health practitioners and in accordance with objective standards such as those in the Clinical Framework. Each relevant authority will be able to determine how they assess whether medical treatment meets objective standards; for example, by requiring the provision of a treatment plan. Where treatment is provided outside the principles of the Clinical Framework, or where there are concerns about the adequacy, appropriateness or frequency of treatment, relevant authorities will be able to report practitioners to the appropriate professional regulatory body.

As the party responsible for reimbursing the cost of medications, relevant authorities are exposed to risks, such as injured employees doctor shopping, illegally selling or overusing medications, exacerbated injuries or even potential fatalities. Legislating restrictions for reimbursement of medications will reduce these risks for injured employees and relevant authorities.

Under this option, an employee will be required to nominate a legally qualified medical practitioner for the purpose of prescribing medications classified as drugs of addiction. Relevant authorities will need to ensure that compensation is only paid for drugs of addiction prescribed by the employee's nominated legally qualified medical practitioner.

IMPACTS ON HEALTH PROVIDERS

Health providers registered under the National Registration and Accreditation Scheme are regulated by 14 National Boards that set the standards that practitioners must meet and manage complaints about the health, conduct or performance of practitioners. Each National Board has also set a code of conduct and ethics that seek to assist and support practitioners to deliver appropriate, effective services within an ethical framework. Practitioners have a professional responsibility to be familiar with their relevant code and to apply the guidance it contains.

The ability of relevant authorities to improve accountability in regards to treatment outcomes, for example, by requiring the development of a treatment plan, will place an additional reporting burden on health professionals. Reporting professionals who are not meeting appropriate standards to the relevant National Board or professional regulatory body will also place an additional reporting burden on health professionals. However, any additional reporting burden should be minimal for providers registered under the National Registration and Accreditation Scheme due to existing responsibilities under their relevant code of conduct.

Health providers who are not registered under the National Registration and Accreditation Scheme will need to apply to Comcare to be assessed and accredited. National bodies not subject to the National Registration and Accreditation Scheme may seek accreditation on a national basis, rather than individual providers applying to Comcare for accreditation.

Medical treatment costs totalling \$60 million were incurred by injured employees during 2016-17. Legally qualified medical practitioners provided 66 per cent of this treatment, 20 per cent was provided by allied health professionals and 4.5 per cent by other service providers such as masseurs etc. It is estimated that the practitioners providing 90 per cent of acupuncture, health and fitness and massage services, as well as 50 per cent of practitioners providing diet/nutrition, hypnotherapy and pain management services, may need to seek accreditation.¹³

As a minimum, this would mean that practitioners who were paid 5.7 per cent of treatment costs (\$3.4 million) during 2016-17 will need to seek accreditation from Comcare for future claims.

Those health providers, for whom Comcare is required to independently assess the nature and standard of their qualifications and the treatments they provide, will experience an additional administrative burden during the accreditation process. However, this is a once-off activity and any burden will not be significant.

The proposal to require injured employees to nominate one provider to prescribe medications will not create additional regulatory burden for health providers.

Any additional regulatory burden for health providers is justified in that it is part of ensuring best practice in treatment standards. Costs will be reduced over time as higher standards are met and injured employee's return-to-work more quickly.

IMPACTS ON INJURED EMPLOYEES

Amending the definition of 'medical treatment' will ensure that injured employees will receive evidence based, effective treatment which meets the standards established by the Clinical Framework from registered or accredited health practitioners. This will ensure that expected treatment standards are met and result in an improvement in the health and return-to-work outcomes of injured employees.

Employees will be required to ensure that medical treatment is obtained from registered health practitioners or by health providers recognised and accredited by Comcare. The requirement for employees to nominate one practitioner only to prescribe medications will also reduce risks of misuse and abuse of drugs of addiction, improving health outcomes and return to work prospects for injured employees.

OPTION THREE - CAP ON THE LIFETIME MEDICAL COSTS OF A CLAIM (BASED ON WA MODEL)

The key difference between Option Two and Option Three is the introduction of a cap on lifetime medical costs. The impact analysis below discusses the impacts of this proposal.

¹³ Information provided by Comcare

IMPACTS ON RELEVANT AUTHORITIES

Relevant authorities will only be liable to compensate injured employees for medical treatment up to a defined cap. This will reduce their costs and give them greater certainty regarding their workers' compensation liabilities, in particular their liabilities for medical treatment. However, it may negatively affect their ability to help long-term injured employees to recover and return to work.

IMPACTS ON HEALTH PROVIDERS

A lifetime cap on medical costs will have flow on effect to some health providers. A cap will limit the amount of medical treatment injured employees may obtain from health providers. Employees with serious injuries that are likely to have high medical costs may forgo non-essential treatment.

IMPACTS ON INJURED EMPLOYEES

Employees will no longer have access to unlimited compensable medical treatment over the life of their claim. This could result in additional costs for some employees from having to bear the costs of their own medical treatment and/or worse health outcomes from not continuing with medical treatment after the cap has been reached or not obtaining sufficient treatment in the first instance. However, it could help other employees to return to work more quickly by encouraging them to focus on essential medical treatment, rationalise non-essential treatment and recover and return to work prior to reaching the cap.

CONSULTATION

Feedback was received from a number of sources on the proposed amendments.

RELEVANT AUTHORITIES

Relevant authorities, such as Comcare and Transpacific Industries supported the amendments stating that incorporating the Clinical Framework '... would allow injured employees, their medical providers and relevant authorities to assess whether the treatment is improving, worsening or not changing the effects of the compensable injury'¹⁴. TPI also noted the successful impact adopting the Clinical Framework has had on medical treatment management in Victoria.¹⁵

TREATMENT PROVIDERS

Treatment providers generally supported the proposed change with the Australian Psychological Society noting that the adoption of the Clinical Framework would address the issue of long term "maintenance" treatment and require an active partnership between the scheme, its providers and employers.¹⁶

One of the medical experts consulted by the Review (who asked for anonymity) submitted¹⁷:

¹⁴ Comcare, Submission to the Safety, Rehabilitation and Compensation Act Review 2012, p. 33

¹⁵ Transpacific Industries, Submission to the Senate Inquiry into the Safety, Rehabilitation and Compensation Amendment (Improving the Comcare Scheme) Bill 2015

¹⁶ Australian Psychological Society, Submission to the Review, pp. 3–4.

¹⁷ Safety, Rehabilitation and Compensation Act Review Report—February 2013, Peter Hanks QC, p. 128

‘Evidence indicates that compensation patients have a worse clinical outcome when matched for injury. Although not fully understood why, research indicates that a closer monitoring approach of treatment delivery by providers is required to drive best treatment outcomes in the compensation population.

One factor that is understood in the compensation patient cohort is the unique three way value transaction. The compensation client receives treatment and services, but makes no financial outlay and has reduced outcome leverage in the service provision. This results in a low financial risk for the patient and potentially reduces the tension over the cost benefit or cost effectiveness of treatment. The consequence is reduced accountability in the client – provider relationship for measurable health improvement and outcomes....’

CONCLUSION

The current approach to compensating injured employees for medical treatment does not adequately ensure they receive evidence-based treatment provided by appropriately qualified and accredited providers, which would help them recover and return to work more quickly. Retaining the status quo will result in relevant authorities continuing to incur costs from compensating employees for non-evidence based medical treatment and/or medical treatment provided by health professionals who are not qualified and that does not assist them to recover and return to work.

The department prefers Option Two on the basis that it introduces a framework for the provision and monitoring of evidence-based medical treatment by appropriately qualified health practitioners, both in Australia and overseas. Option Two is anticipated to produce a significant improvement in treatment outcomes and reduce the cost of medical treatment under the SRC Act. Key benefits of Option Two are as follows:

- Ensuring all medical treatment is provided by registered health practitioners or by health practitioners whose qualifications and experience have been accredited by Comcare.
- Ensuring that treatment provided adheres to the Clinical Framework and where it does not, enabling relevant authorities to report the treating practitioner to the appropriate professional regulatory body to query the standard of the treatment.
- Providing that all medications compensated for under the SRC Act are recommended or prescribed medications only - and where they are classified as drugs of addiction in particular - they are prescribed only by a ‘nominated legally qualified medical practitioner’ to ensure their use is monitored.

Option Two is preferable to Option Three because medical treatment is an essential part of recovery from injury and supporting an injured employee to return to work. Option Three may provide greater savings for relevant authorities however it has the potential to leave long-term injured employees and those with high medical treatment costs worse off. Once these employees reach the cap for medical treatment, they would have to fund their own treatment. Those that could not afford to continue their treatment would be less likely to return to work.

The majority of those who responded to the Review agreed that the proposals outlined in Option Two would, if implemented, provide significant improvements in treatment outcomes. The regulatory cost impact of these amendments is minimal for licensees and health providers. However, the improvement in treatment outcomes should produce savings in claims costs.

HOUSEHOLD AND ATTENDANT CARE SERVICES — TIERED SYSTEM OF SERVICES AND SUPPORT

THE PROBLEM

There is no clear framework for the provision and monitoring of household and attendant care services, nor any means to ensure that those providing these services are, where necessary, appropriately qualified.

Under the SRC Act, household services are defined to mean services of a domestic nature (including cooking, house cleaning, laundry and gardening services) that are required for the proper running and maintenance of the injured employee's household. Attendant care services are services that are required for the essential and regular personal care of an injured employee (other than household services, medical or surgical services or nursing care) and may include assistance with mobility, personal hygiene (bathing and toileting), grooming, dressing and feeding.

Compensation for attendant care and household services is currently capped at \$464.43 per week for each service, regardless of the nature or severity of injury. Recent changes to the SRC Act aligned household and attendant care provisions with the minimum benchmarks for workplace accidents under the National Injury Insurance Scheme (NIIS) for catastrophically injured employees. These amendments lifted the monetary caps on compensation for employees who are catastrophically injured¹⁸.

In 2014-15, relevant authorities paid \$6.7 million for 1622 accepted claims for household and attendant care services. This is an increase of approximately 70 per cent from 2008-09, when \$3.2 million was paid by relevant authorities for 900 accepted claims.

COMPENSATION FOR SUPPORT SERVICES PROVIDED IN THE HOME

Compensation for support services provided in the home is currently available to all injured employees provided it is 'reasonably required', regardless of the nature or extent of the impairment sustained. There is no limit on the period and total cost for which compensation for these services is payable. Feedback from consultations and evidence from Comcare indicates this can disempower non-catastrophically injured employees by not encouraging them to reduce their dependence on these services over time, which would assist injured employees to return to work.

Household and attendant care services should support non-catastrophically injured employees to participate in rehabilitation by temporarily relieving the employee of household responsibilities or providing them with services required for essential and regular personal care. Participating in activities at home, remaining active and managing an injury as independently as possible are key methods for empowering an injured employee to manage their injury and to promote recovery.¹⁹

¹⁸ 'Catastrophic injury' will be based on the NIIS definition which covers; spinal cord injury, traumatic brain injury, multiple amputations or major single amputation, major burns and/or permanent traumatic blindness. The Department is currently in consultation with stakeholders in the development of the legislative rule that will define 'catastrophic injury' for the purposes of the SRC Act.

¹⁹ [Clinical Framework for the Delivery of Health Services](#), Transport Accident Commission, P. 9

ATTENDANT CARE SERVICES

In 2014-15, relevant authorities paid \$1.2 million for attendant care services. This is an increase of approximately 78 per cent from 2008-09.

Comcare data indicates that since 1989, 70 per cent of claims for attendant care services were made within three years of the injured employees' date of injury; 25 per cent were made five or more years after the injured employees' date of injury; 13 per cent were made ten or more years after the injured employees' date of injury; and five per cent had been compensated for attendant care services twenty or more years after the injured employees' date of injury.

Twenty per cent of injured employees did not make their first claim for attendant care services until after three years from the date of their injury.

HOUSEHOLD SERVICES

There have been sustained increases in household services over the last seven years. In 2014-15, relevant authorities paid \$5.6 million for household support services, compared to \$2.7 million in 2008-09.

Comcare data indicates that since 1989, 60 per cent of claims for household services were made within three years of the injured employees' date of injury; 33 per cent were made five or more years after the injured employees' date of injury; 17 per cent were made ten or more years after the injured employees' date of injury; and four per cent had been compensated for household services twenty or more years after the injured employees' date of injury.

Nineteen per cent of injured employees did not make their first claim for household services until after three years from the date of their injury.

Evidence from Comcare and consultations indicates that delays in accessing household and attendant care services and the unlimited time for which employees can receive these services make it increasingly unlikely they will return to work.

PROVIDERS OF SUPPORT SERVICES PROVIDED IN THE HOME

Injured employees may engage providers to deliver household and attendant care services if their treating practitioner has deemed these services necessary. It is up to injured employees to source and engage providers of these services directly, while a number of employees will engage providers through professional agencies. There are also a number of employees in the Comcare scheme whose attendant care services are provided by family members.

Under the SRC Act an injured employee is eligible to receive attendant care services if they are recommended by a legally qualified medical practitioner, however, there is no requirement to ensure that attendant care services are being provided by qualified providers to ensure the injured employee is receiving appropriate care. There is also no requirement to ensure that the services are actually delivered or that the provider has appropriate insurance or qualified back up in the case of injury or illness. This lack of regulation limits control of costs and prevents assessment of the type and quality of care delivered.

Further, while the practice of having a family member provide attendant care services is convenient, the family members who provide it are often unqualified, have limited relevant training and have no access to support mechanisms, such as workers' compensation/personal liability insurance or relief providers, that come from being part of a professional organisation. These risks leave both the employee and the family member providing attendant care in a position of vulnerability.

The issue of qualifications and training for attendant care providers was considered in the Disability Care and Support, Productivity Commission Inquiry Report. The Productivity Commission noted that, "staff in the disability sector require a diverse range of skills, knowledge and personal attributes, with tiered degrees of specialisation."²⁰ In this regard, the Productivity Commission recommended:

"a 'horses for courses' approach should be adopted. Where a worker needed to perform manual handling, specialised communication or administer medicine, it would be important for the worker to be trained in these tasks. Similarly, there are areas of disability support, absent the right skills and experience, could be dangerous for the support workers and people with disability."²¹

WorkSafe Victoria only pays for attendant care services "delivered by an attendant carer who is employed by an attendant care agency registered by...WorkSafe to provide attendant care services to workers." These agencies are expected to employ staff with appropriate skills and knowledge to meet the needs of workers e.g. "knowledge of care for people with quadriplegia and acquired brain injury."²²

One of the medical experts consulted during the Hanks Review (who asked for anonymity) submitted:

"The interpretation is that the injured employee is the employer for the recruitment and provision of services. This is unfair that this burden is placed on an injured employee to source and provide governance to a service provider as well as manage their own injury. Reasonably, they cannot be expected to understand the minimum standards of an attendant care or household services program such as duty statements, care plan, standards of service delivery and industry wages. They also cannot reasonably be expected to undertake quality review and audit of the services provided to them."

A lack of training for carers may compromise the quality of the care. An injured employee may receive assistance that does not meet their needs and therefore does not help them to recover and return to work.

Relevant authorities have a responsibility to protect the health and wellbeing of vulnerable injured employees receiving compensation. However, the mechanisms provided by the SRC Act are insufficient to allow for the effective management and regulation of attendant care services funded under the SRC Act.

OPTIONS

²⁰ Disability Care and Support, Productivity Commission Inquiry Report, Volume 2, No. 54, 31 July 2011, p. 736

²¹ Disability Care and Support, Productivity Commission Inquiry Report, Volume 2, No. 54, 31 July 2011, p. 742

²² WorkSafe Victoria, Policy for Attendant Care, [Guidelines for providing attendant care services to injured workers](#), October 2014.

The department has considered three options to address this issue. Option Two is currently the department's preferred option for inclusion in the Bill.

OPTION ONE — MAINTAIN THE STATUS QUO

Maintaining the status quo will result in injured employees receiving compensation for unlimited support services provided in the home regardless of the nature or extent of the injuries sustained. Injured employees will continue to be responsible for the engagement (though costs are borne by relevant authorities) of household or attendant care service providers. Combined, these costs were \$5.6 million in 2016-17.

OPTION TWO — TIERED SYSTEM FOR SUPPORT SERVICES PROVIDED IN THE HOME, FORMAL FRAMEWORK FOR IN-HOME SERVICES ASSESSMENT, ACCREDITATION SYSTEM FOR ATTENDANT CARE SERVICES

This option proposes a tiered system for the provision of support services provided in the home that limits long-term access to these services for non-catastrophically injured employees. For non-catastrophically injured employees, household services will be provided for three years from the date of injury. Attendant care services will be provided for three years from the date of injury and for an additional six months after specific events, such as the employee is admitted into hospital.

To ensure that injured employees receive quality household and attendant care services tailored to their needs, Comcare will establish a formal framework for the assessment of need for support services provided in the home. The need for services will be assessed by an independent party such as a registered occupational therapist. Comcare will also be empowered to accredit attendant care providers and issue a list of approved providers, which injured employees can use to source an approved provider. The Department of Veterans' Affairs has established lists for ex-service men and women that could be used as the basis for the Comcare list.

There are situations in which it may be appropriate for a family member to provide attendant care services. Comcare will still have discretion to approve family members to provide attendant care services in special circumstances.

OPTION THREE - HOUSEHOLD AND ATTENDANT CARE SERVICES PROVIDED FOR A MAXIMUM OF 6 HOURS PER WEEK AND NOT LONGER THAN THREE MONTHS. ATTENDANT CARE SERVICES PROVIDED BY AN APPROVED PROVIDER AND AN 'ATTENDANT CARE PROGRAM' MUST BE DEVELOPED.

This option is a hybrid of the household and attendant care services provided in New South Wales and Victoria. In order to be compensable, household and attendant care services must be requested by a medical practitioner and supported by an occupational therapist after completing an in-home assessment of the injured worker.

Attendant care must be provided by a person or organisation certified by Comcare as an approved attendant care provider. Paid attendant care services cannot be provided by friends or family members unless under exceptional circumstances.

An attendant care program must be developed for each injured employee specifying the goals of the program; description of the care and services to be provided; specific duties of the attendant carer;

other support services to be involved; hours recommended; regular review intervals; and program duration.

Household and attendant care services will be provided on a temporary basis of not more than six hours per week and for a period that is not longer than, or during periods that together are not longer than three months.

IMPACT ANALYSIS

The impact analysis considers the impact of the changes beyond the status quo.

OPTION TWO — TIERED SYSTEM FOR SUPPORT SERVICES PROVIDED IN THE HOME, FORMAL FRAMEWORK FOR IN-HOME SERVICES ASSESSMENT, ACCREDITATION SYSTEM FOR ATTENDANT CARE SERVICES

IMPACTS ON RELEVANT AUTHORITIES

Comcare will be required to assess and accredit household and attendant care service providers and issue a list of approved providers. The impact of this task on Comcare could be reduced by basing the list on an already established list of approved providers, such as that issued by the Department of Veterans Affairs. Licensees will not be required to establish their own lists of approved providers.

The improvement in the quality of care for injured employees and limiting the time that they can access household and attendant care services is expected to reduce claim costs over time for relevant authorities.

IMPACTS ON ATTENDANT CARE PROVIDERS

If Comcare does not base its list of approved attendant care providers on an already established list, providers will be required to produce documents and show evidence of experience in order to provide services under the SRC Act. This would result in some regulatory burden depending on the manner in which Comcare chooses to regulate providers.

Care providers may experience a reduction in demand for their services as a result of the SRC Act imposing limits on the length of time that injured employees can access care services following their injury.

IMPACTS ON INJURED EMPLOYEES

Injured employees who do not have a catastrophic injury will not be able to claim household or attendant care services after three years from the date of their injury, unless they claim attendant care services as a result of a specific event.

According to Comcare's analysis, three years provides sufficient time for most employees to recover from their injuries and be rehabilitated to return to work. Limiting compensation for these services to three years (and attendant care to a maximum of six months following a specific event) will ensure that employees receive necessary care so that they can focus on recovering from their injuries and preparing to return to work, while encouraging them to learn strategies to reduce their dependence on care services over time which will assist them to return to work.

Injured employees will not be able to continue to receive compensation for attendant care services provided by family members unless they are approved by Comcare. This will improve health and return to work outcomes for employees by ensuring that care is provided by suitably qualified providers and it will also mitigate the moral hazard risk of families becoming financially dependent on compensation and payments received for caring for an injured employee.

OPTION THREE - HOUSEHOLD AND ATTENDANT CARE SERVICES PROVIDED FOR A MAXIMUM OF 6 HOURS PER WEEK AND NOT LONGER THAN THREE MONTHS. ATTENDANT PROVIDED BY AN APPROVED PROVIDER AND AN 'ATTENDANT CARE PROGRAM' MUST BE DEVELOPED.

The key differences between Option Two and Option Three are the requirements for relevant authorities to develop an 'attendant care program' for injured employees and the shorter time that household and attendant care services will be compensated. The impact analysis below discusses the impacts of this proposal.

IMPACTS ON RELEVANT AUTHORITIES

The impact of Option Three on relevant authorities is similar to that of Option Two. There will be some additional regulatory burden on relevant authorities from the requirement for them to develop an 'attendant care program' for injured employees. However, there will be a greater reduction in claim costs for relevant authorities as a result of a significant reduction in time, three months instead of three years, that injured employees can access household and attendant care services.

IMPACTS ON ATTENDANT CARE PROVIDERS

The impact of Option Three on attendant care providers is similar to that of Option Two, although care providers will likely experience a greater reduction in demand for their services due to the shorter time that employees can access care services.

IMPACTS ON INJURED EMPLOYEES

The impact of Option Three on injured employees is similar to that of Option Two.

The requirement for relevant authorities to develop an 'attendant care program' for injured employees will ensure they receive better targeted and effective care services. However, limiting compensation for household and attendant care services to a maximum period of three months will significantly reduce the time available for injured employees to recover from their injuries in circumstances where attendant care is part of the recovery process. Employees who are not able to recover from their injuries in this time and continue to need household and attendant care services will therefore be less likely to recover and return to work.

CONSULTATION

Feedback was received from a number of sources on the proposed amendments.

RELEVANT AUTHORITIES

Relevant authorities supported the implementation of a tiered system of household and attendant care services and the establishment of a formal framework for the assessment of need for household and attendant care services.^{23,24}

PROFESSIONAL BODIES

Professional bodies, such as Assessments Australia, strongly agreed with recommendations to establish a framework for assessment of need for services provided in the home.²⁵

UNIONS

The Australian Manufacturing Workers' Union supported a tiered approach for home services, but did not believe this should be time-limited²⁶.

LEGAL BODIES AND REPRESENTATIVES

Legal professionals generally supported amendments to household and attendant care services. The Australian Lawyers Alliance believed some discretion should be allowed, in appropriate cases, to exceed the maximum hours per week for attendant care services²⁷.

The Law Council of Australia agreed that it is reasonable for household services and attendant care to be reviewed periodically and more critical scrutiny placed on its provision, but did not support the recommendations. They believed the problem has been the lack of regular review of these services rather than the model of delivery itself²⁸.

CONCLUSION

The department prefers Option Two as it will improve the quality of care services by ensuring they are provided by appropriately qualified persons, while also making these services more cost effective by limiting them to the time that they are most needed.

The increased regulatory impact on attendant care providers and relevant authorities is significantly outweighed by more equitable, effective, transparent, evidence-based and targeted provision of services and the savings in claims costs.

While Option Three would provide some of the same benefits as Option Two, it is not preferred because of the negative impact it would have on the return to work prospects of some employees. Option Three risks removing eligibility for household and attendant care services from some employees when they are still required, which would make it more difficult for them to return to work. Option Two better balances the need to provide household and attendant care services for a

²³ Telstra, Submission to the Review

²⁴ Australia Post, Submission to the Review, pp. 4.

²⁵ Assessments Australia, Submission to the Review, pp. 2.

²⁶ Australian Manufacturing Workers' Union, Submission to the Review, pp. 9 and 12.

²⁷ Australian Lawyers Alliance, Submission to the Review, pp. 7.

²⁸ Law Council of Australia, Submission to the Review, pp. 9.

sufficient period of time to assist employees to recover from their injury and return to work with the need to manage the cost of these services.

MEDICAL TREATMENT AND LEGAL COSTS

THE PROBLEM

The Comcare scheme has characteristics of a ‘principle-agent problem’ since the injured employee, the party that receives services, does not bear the cost of those services. This creates the potential for over-servicing and over-charging of injured employees, since health providers know they will be reimbursed for whatever services they provide and fees they charge.

Workers compensation schemes in other jurisdictions include mechanisms to limit compensation for injured employees for medical and legal costs, to control scheme costs. Comcare’s current limited ability to control the cost of medical and legal services affects the financial integrity of the scheme.

Comcare has a responsibility to the Commonwealth agencies that pay premiums to ensure that it receives value for money for the health services that it purchases on behalf of injured employees and to ensure that legal costs recompensed are reasonable.

MEDICAL TREATMENT COSTS

The SRC Act currently allows for compensation of medical treatment costs ‘of such amount as Comcare determines is appropriate for that medical treatment’. In practice, Comcare has limited ability to determine the ‘appropriateness’ of the cost of treatment. Comcare is not permitted, under the SRC Act, to have any involvement in, or control over, an injured employee’s choice of medical or therapeutic practitioner or treatment.

As at 31 March 2017 Comcare had 9,173²⁹ open claims. Medical costs are approved on a case-by-case basis, with reference to non-legislative medical services rates. Medical and rehabilitation costs currently represent 21 per cent of the total costs of claims liabilities under the SRC Act. This figure has reduced slightly (from 25 per cent) over the last five years but still represents a significant proportion of total claims liabilities.

Injured employees may appeal decisions on medical costs to the AAT, which may vary the amounts paid by Comcare. This can create inequitable outcomes for injured employees where those who appeal a decision by Comcare to pay a certain amount for a certain type of medical treatment may end up better off than injured employees who do not appeal.

MEDICAL REPORT COSTS

The cost of reports provided by legally qualified medical practitioners has significantly increased in recent years. A workers’ compensation medical report will generally relate to events or injuries that occur in relation to causation, capacity for work, treatment or assessment of permanent impairment. These reports provide detailed information about an injured employee’s condition and are not only used to determine liability, but may also be requested to assist decision-making at any stage of the claims process where existing information is inadequate.

²⁹ As supplied by Comcare. Note: “Open claims” is an administrative term used by Claims Management to determine if a claim requires ongoing management. As a general rule, claims which haven’t had any activity in the past two months will be closed. Activity is quite broad in its definition and includes the payment of an account/invoice, the creation of a diary on the claim or when correspondence is sent to the employee.

Since 2012-13 the average cost of medical reports has increased by 34 per cent from \$1,406 to \$1,886 in 2016-17.³⁰ There is concern that the cost of medical reports does not accurately reflect the required reporting complexity. A standard report can involve assessment of a single event or injury, or a simple permanent impairment assessment. A complex report can involve an assessment, including assessment of multiple injuries and, in complex instances where the report is being prepared by an independent medical professional, the need to examine the employee and consider documentation from other sources will contribute to the cost.

Currently, there is nothing to prevent a practitioner producing an overly complex report when a standard report would have sufficed, or a standard report where a more complex report is needed. The relevant authority is then obliged to pay for either sub-standard or over-priced reports.

LEGAL COSTS

Following an initial determination of a claim, either party to the claim may request an internal 'reconsideration' by the determining authority. If either party disagrees with the reconsideration, they can have the matter reviewed externally by the AAT. Up to this point, costs of legal representation are not payable by the relevant authority.

Relevant authorities are liable for their own legal costs in all matters brought before a tribunal (or court, if a matter proceeds to the Federal Court). If the matter is found in favour of the employee, the relevant authority may also be liable for a portion of the employee's legal costs.

Legal costs directly correlate to dispute resolution timeframes. In the last financial year, the number of reconsiderations increased by five per cent, although there was a four per cent decline in the number of matters proceeding to the AAT. The Comcare scheme has the lowest resolution rate for disputes resolved within nine months (41.5 per cent) of all Australian workers' compensation schemes (by comparison, Queensland resolves 96.1 per cent of disputes within nine months)³¹. The more protracted a matter in the AAT, the greater the legal costs.

There is limited provision under the SRC Act by which to curtail payment of excessive legal costs arising from disputation of claims. Once a case has proceeded to the AAT, the AAT cannot order an employee to pay the relevant authority's costs. In practice, and in the current legal climate of 'no win no pay', there is little to discourage the employee progressing a claim to the AAT when they are not required to meet the respondent's costs. This is not the case for the respondent, who may be required to meet the employee's costs, no matter how complex the matter is or how protracted the proceedings are.

Taxation of legal costs is available to parties under the SRC Act to recover legal costs. This refers to the process by which a court may fix the amount of costs it orders one party to pay to the other. Alternatively, a taxing officer may assess the amount of costs by reference to the relevant scale of costs. Taxation is generally designed to regulate the level of legal costs and shield participants from excessive charging. However, parties are generally reluctant to proceed to taxation as it incurs a cost in itself and is typically seen only as a tool for managing costs in extreme circumstances.

³⁰ Data supplied by Comcare

³¹ Safe Work Australia's Comparative Performance Monitoring Report, 18th Edition, Revised July 2017 p. 34

In limited circumstances, relevant authorities can also employ Calderbank offers.³² However, because the AAT cannot order an employee to pay a respondent's costs, Calderbank offers have only a limited impact on workers' compensation cases, particularly as relevant authorities must still pay their own costs, regardless of whether or not the matter may have settled pre-trial.

OPTIONS

The department has considered three options to address this issue. Option Two is currently the department's preferred option for inclusion in the Bill.

OPTION ONE — MAINTAIN THE STATUS QUO

Retaining the status quo will result in relevant authorities continuing to have limited ability to effectively regulate medical compensation costs and services. They will continue to be liable for medical treatment costs that result from treatment prescribed without regard to consistency, suitability or financial cost. They will also continue to be liable for costs of medical examination reports and legal costs (from matters where the AAT finds in favour of the injured employee) that bear no relationship to the complexity of the report or matter before the AAT, respectively.

OPTION TWO — DEVELOP A SCHEDULE OF COSTS FOR MEDICAL SERVICES, MEDICAL REPORTS AND LEGAL SERVICES

MEDICAL SERVICE FEES AND MEDICAL REPORT COSTS

This option will allow Comcare to develop a Schedule of Medical Service Fees. This list of regulated fees will be used to pay medical practitioners and suppliers for medical and rehabilitation services under the SRC Act. These fees will be set by Comcare, in consultation with relevant professional associations, and will have legislative authority as the rates at which relevant authorities are liable to pay compensation for medical treatment under the SRC Act. This amendment was recommended by Mr Hanks in the 2012-13 Review of the SRC Act.

Pricing levels for medical reports will also be set by Comcare and will have legislative authority as the rates at which determining authorities are liable to pay for medical reports under the SRC Act.

LEGAL COSTS

Under this option, Comcare will be empowered to develop of a Schedule of Legal Costs, similar to those that apply in state and territory workers' compensation schemes. The schedule of legal costs could be based on similar existing state schedule or the AAT costs model and would have legislative authority as the rates at which relevant authorities are liable to pay for legal costs under the SRC Act.

The schedule will provide guidance for relevant authorities, injured employees, employers and legal representatives as to what constitutes reasonable amounts of time and/or expenditure on prescribed workers' compensation issues. It would set parameters as to compensable legal costs for

³² A Calderbank offer refers to the process by which an employee refuses a pre-trial offer, proceeds to trial and then receives a trial offer that is less favourable than the terms of the original offer. In this case, the determining authority can then apply to the AAT to exercise its discretion not to award all or parts of the costs to the injured employee.

all parties to a dispute, providing certainty about what costs may be awarded, and provide further incentive to parties to resolve disputes in a timely manner.

OPTION THREE — UTILISE STATE MEDICAL SERVICES AND MEDICAL REPORT SCHEDULES WHERE THEY EXIST AND REFER APPEALS TO MEDIATION AND ADVOCACY SERVICES

MEDICAL SERVICE FEES AND MEDICAL REPORT COSTS

This option is similar to option two, except that Comcare will use the relevant state or territory medical fee and medical report schedules, where they exist, to reimburse medical expenses in the state or territory in which they were incurred, rather than developing its own schedules.

New South Wales, Victoria, Queensland, Western Australia and South Australia currently have fees schedules which could be utilised. These could also be applied to the remaining jurisdictions (Tasmania, Northern Territory and the Australian Capital Territory) based on a combination of proximity and similar economies. For example, Western Australia's cost schedules could be applied to the Northern Territory as they both have similar cost pressures of remoteness; and South Australia's cost schedules could be applied to Tasmania and the ACT as they have similar cost pressures of a relatively small economy.

LEGAL COSTS

Comcare will establish an alternative dispute resolution service, in the form of mediation or an advocacy service, that could be accessed following a reconsideration and as an alternative to legal proceedings through the AAT. If mediation or advocacy was unsuccessful, the claim would proceed to the AAT on appeal.

IMPACT ANALYSIS

This impact analysis considers the impact of the changes beyond the status quo.

OPTION TWO — DEVELOP A SCHEDULE OF COSTS FOR MEDICAL SERVICES, MEDICAL REPORTS AND LEGAL SERVICES

MEDICAL SERVICE FEES AND MEDICAL REPORT COSTS

The implementation of a structured pricing approach to the provision of medical compensation services under the SRC Act is consistent with the approach in state and territory workers' compensation jurisdictions. It will provide greater transparency and certainty for providers and employees about the costs of medical services that are compensable under the SRC Act. It will enable Comcare to more effectively manage medical costs and maintain sustainable financial outcomes for the scheme. The regulation of medical report costs will ensure medical reports more accurately reflect the complexity of an employee's injury.

Impacts on Relevant Authorities

Under this option, there will be a decrease in the time and compensation costs for relevant authorities associated with disputation of medical compensation payments and unnecessary or

excessive medical reporting. This option will also improve administrative processes by ensuring greater consistency in medical service fees paid and medical report costs.

There will be associated establishment and enforcement costs for Comcare to prepare and issue a schedule of medical service rates. These costs could be reduced if the schedule is based on an existing schedule, such as rates prescribed by the Australian Medical Association (AMA). Relevant authorities will need to check payments against the medical service rates.

Impact on Health Providers

This option will reduce incentives for health and medical practitioners to over-charge and over-service injured employees, but is not expected to have a significant overall impact. Health and medical practitioners will be able to charge rates that they consider appropriate, which may be above the schedule rates. This reflects general practice, where medical practitioners may charge above rates recommended by the AMA.

There may be some pressure for practitioners to keep their rates within those outlined in the cost schedule, particularly where employees have choice over their practitioner. If practitioners charge above the schedule rates, employees may be less likely to seek out their services in order to minimise out of pocket expenses.

Impacts on Injured Employees

Injured employees will retain the right to choose their treating practitioner. Where treatment costs exceed the prescribed schedule, these costs will be borne by the employee rather than the relevant authority. Relevant authorities will have discretion to pay above the schedule rates for medical treatment where reasonable (for example, because of a lack of choice of service providers where the employee lives).

This amendment, implemented in isolation, may be seen by employees as a reduction in benefits under the scheme. However, the package of proposed reforms will improve the delivery of medical services and outcomes under the SRC Act. The adoption of the Clinical Framework will ensure that treatment is reasonable and highlights the need for the provider to deliver value (or a functional outcome) to the injured worker.

LEGAL COSTS

Several state and territory jurisdictions have legislated legal costs, fixing maximum costs or the number of hours, for legal services provided in connection with workers' compensation matters. The main objective of having a schedule of legal costs is to ensure that costs are proportionate to the complexity of the subject matter in dispute.

Impacts on Relevant Authorities

There will be administrative costs for Comcare from developing a schedule of legal costs. These could be reduced if the schedule is based on an existing schedule, such as the AAT or Federal Court costs schedule.

This option will give relevant authorities greater certainty over the legal costs that may be compensable in any given matter. It will also likely result in some reduction in costs for relevant authorities by limiting the potential for large costs to be awarded against them.

Impacts on Injured Employees

Introducing a schedule of fees would not limit an employee's right to pursue legal action, but it would limit relevant authorities' financial liability for such actions. Employees whose legal costs exceed those outlined in the schedule of fees would not be reimbursed for those excess costs.

In workers' compensation matters, the personal nature of the subject matter can sometimes lead to excessive time and money being spent on matters that are relatively straight-forward according to the law. A formalised schedule of legal costs will limit the incentive for individuals to spend significant amounts of money engaging law firms to litigate relatively straight-forward matters.

OPTION THREE — UTILISE STATE MEDICAL SERVICES AND MEDICAL REPORT SCHEDULES WHERE THEY EXIST AND REFER APPEALS TO MEDIATION AND ADVOCACY SERVICES

MEDICAL SERVICE FEES AND MEDICAL REPORT COSTS

The main benefit of using state service fee schedules is that Comcare would avoid the costs associated with establishing its own schedule. State schedules would also be more closely aligned to the living costs and standards of each state and avoid the standardisation of medical costs that must arise from a national schedule of fees.

Impacts on Relevant Authorities

The use of established fee schedules may create some implementation costs for relevant authorities. It would be administratively inefficient and confusing, with claims staff required to reference and check medical services fees against multiple schedules and payment systems from state and territory workers' compensation schemes.

Impact on Health Providers

The impact of this option on health providers would be similar to the impact of Option Two. However, with the use of state-based medical services fee schedules, it would be more likely that schedule fees would reflect the fees charged by local health providers. It would also decrease the administrative burden for health providers as they would not need to consider a schedule separate to the one that operates in their state.

Impacts on Injured Employees

The impact of this option on injured employees would be similar to the impact of Option Two. With the use of state-based medical services fee schedules, it would be more likely that schedule fees would reflect the fees charged by local health providers, which would limit the potential for out-of-pocket expenses for employees. However, varying levels of reimbursement for the same medical treatment for injured employees between jurisdictions (including for employees working for the same employer in different jurisdictions) may be perceived as being unfair.

LEGAL COSTS

A less adversarial approach to dispute resolution could result in less disputes progressing to the AAT, thus avoiding the resulting legal costs.

Impacts on Relevant Authorities

There would be costs for the Government to establish a mediation service. These costs would likely be borne by Comcare.

The mediation service would add another layer to the dispute resolution process and impose new costs on relevant authorities. When the mediation service is effective, it would provide savings for relevant authorities by resolving the dispute quicker than current arrangements and avoid disputes progressing to the AAT. However, when not effective, it will impose additional costs and increase the time taken to resolve disputes compared to existing arrangements.

Impacts on injured employees

The impacts of a mediation service on employees are the same as those on relevant authorities. A mediation service would add another layer to the dispute resolution process that, compared to current arrangements, would save employees time and costs where effective, but would add time and costs when it does not resolve disputes.

CONSULTATION

Support for setting medical services rates and legal costs has been mixed.

RELEVANT AUTHORITIES

Licensees generally supported the introduction of fee schedules for medical and legal costs, suggesting that it would address excessive fees being charged by some service providers and bring the Comcare scheme into line with many state workers' compensation schemes³³. However, one was opposed to the introduction of a medical fees schedule, raising concerns that it would negatively impact on an employee's ability to access appropriate care in a timely manner³⁴.

HEALTH PROFESSIONALS

In discussions with the Department, health and medical practitioners indicated general support for fee schedules, although this support was predicated on the assumption that fee schedules would reflect market pricing. They noted that the AMA's list of fees could be used to guide Comcare's fee schedule. Health and medical practitioners also raised concerns that low fees could limit choice of practitioner and quality of treatment that injured employees could access.

³³ Safety Rehabilitation and Compensation Licensees Association Inc., Submission to the Inquiry into the Safety, Rehabilitation and Compensation Amendment (Improving the Comcare Scheme) Bill 2015, p. 2

³⁴ John Holland Group Pty Ltd, Submission to the Inquiry into the Safety, Rehabilitation and Compensation Amendment (Improving the Comcare Scheme) Bill 2015, p. 2

LEGAL BODIES AND REPRESENTATIVES

Legal practitioners did not support the introduction of legal fee schedules³⁵. They indicated this would lead to many injured workers not being able to afford legal representation, with those not able to afford representation either forgoing their review rights or representing themselves³⁶.

CONCLUSION

The insurer, as the third party payer, takes on a greater accountability for outcomes by the provider as it manages the financial transaction. Contemporary compensation legislation needs to take into account the financial risks of increasing medical and legal costs on scheme viability.

Some state and territory workers' compensation jurisdictions use fee schedules to regulate medical treatment costs. The AMA also prescribes suggested rates for medical practitioners.

The department prefers Option Two. The regulation of medical and legal costs would give Comcare the authority to implement measures that would improve certainty, for all parties, as to the compensatory limits for medical treatment and legal costs, which is necessary to ensure the long-term financial sustainability of the scheme. It will reduce disputation over what are reasonable costs of medical treatment and discourage injured employees from excessive litigation of disputes.

For medical costs, Option Three would achieve similar outcomes to Option Two, but the use of state-based schedules could be potentially confusing for determining authorities, particularly licensees who have decided to join Comcare as it is a national workers' compensation scheme. With respect to legal costs, the potential success of Option Three would depend entirely on the ability of the mediation service to resolve disputes. If unsuccessful, this option could actually increase the time taken, and costs incurred, to resolve disputes.

³⁵ Australian Lawyers Alliance, Submission to the Inquiry into the Safety, Rehabilitation and Compensation Amendment (Improving the Comcare Scheme) Bill 2015, p. 15

³⁶ Slater and Gordon, Submission to the Inquiry into the Safety, Rehabilitation and Compensation Amendment (Improving the Comcare Scheme) Bill 2015, p. 16

INCOME REPLACEMENT

THE PROBLEM

Return to work rates in the Comcare scheme have fallen from the mid to high eighties (reaching 89 per cent in 2005-06) to plateau at 80 to 81 per cent over the last five years. The level of benefits, conditions of access and the manner in which a benefit is paid affect the incentives for injured employees to remain off work or return to work.

All Australian workers' compensation schemes reduce the proportion of income replacement over time, which is known as a 'step-down'. Step-downs provide an incentive for injured employees to return-to-work as quickly as possible, as well as helping to manage compensation costs.

Under the SRC Act, income replacement benefits are paid at 100 per cent of pre-injury normal weekly earnings (NWE) until the equivalent of 45 weeks of normal hours, after which they reduce to 75 per cent of pre-injury NWE for as long as income replacement is payable. The long period where income replacement is paid at 100 per cent reduces incentives for injured employees to return to work as quickly as possible. The evidence is clear that the longer employees are away from work, the less likely it is they will return-to-work³⁷.

A sizeable body of empirical work has accumulated over the past 40 years (particularly over the last decade) in which epidemiologists and multi-disciplinary researchers have investigated the possible link between the recovery and health outcomes of an injured person based on whether or not they are potentially eligible to pursue compensation. The majority of studies and, indeed, systematic reviews of such studies, find a link between various measures of an injured person's compensation status and worse health outcomes.³⁸

Under current provisions, where an employer is undergoing a partial return-to-work, the time elapsed until the step down applies varies according to the number of hours worked. This operates to extend the 45 week period before the step-down is applied. For example, a full-time employee who has had a compensation claim accepted and is unable to work for one day per week over the first ten weeks of incapacity would be considered to have offset ten days (two weeks) against the 45 weeks. This would allow access to a further 43 'weeks' of incapacity entitlements at 100 per cent of NWE. If the employee continued to work for four days per week, the step-down would not apply until 225 weeks (over four years) after compensation commenced. This is undesirable as it reduces the effectiveness of the step-down arrangements, reduces incentives for employees to return to full pre-injury working hours as soon as possible and risks entrenching reduced working hours.

This approach is inconsistent with that taken in the states and territories, which counts weeks on the basis of time since compensation commenced, regardless of any hours that the employee returns to work. Under the states' arrangements, the same employee who is unable to work for one day per week over the first ten weeks of incapacity would have ten weeks counted towards the next step-down.

³⁷ Johnson, Fry. Factors Affecting Return to Work after Injury: A study for the Victorian WorkCover Authority. P. 12.

³⁸ Appendix J, Productivity Commission Inquiry Report: Disability Care and Support, July 2011 Volume 1, p. J. 1

OPTIONS

The department has considered three options to address this issue. Option Two is currently the department's preferred option for inclusion in the Bill.

OPTION ONE — MAINTAIN THE STATUS QUO

Under this option, no changes would be made to the definition of “maximum rate compensation week” in section 19(2A) of the SRC Act. An injured employee's 45 weeks of compensation at 100 per cent of their normal weekly earnings would continue to be calculated based on the total hours they receive incapacity payments for. This reduces the effectiveness of the step-down arrangements and acts as a disincentive for early return-to-work.

OPTION TWO — STREAMLINE INCAPACITY PROVISIONS AND CHANGE THE DEFINITION OF A WEEK

Under this option, the definition of “maximum rate compensation week” in section 19(2A) of the SRC Act would be amended so that the 45 week period is 45 consecutive calendar weeks from the date of first incapacity.

Incapacity payment provisions would also be streamlined by repealing section 37(5) of the SRC Act. Section 37(5) makes provisions for payments for employees undertaking “full-time” and “part-time” rehabilitation programs, but does not define what is meant by these programs and is redundant since payments are currently made under other sections of the SRC Act (sections 19 and 31).

These measures were recommended in the Hanks Review.

OPTION THREE — THREE LEVEL SYSTEM FOR STEPPING DOWN INCOME REPLACEMENT BENEFITS

The 2012-13 Hanks Review of the SRC Act went further than recommending changes to the way a week was calculated for the 45 week step-down. It also recommended changes to the structure of step-downs and payment of income replacement benefits, as outlined below.

Weeks incapacitated	Percentage of normal weekly earnings received
0-13	100 %
14-26	90 %
27 +	80 %

This option involves implementing Option Two plus the remaining Hanks Review recommendations outlined above.

IMPACT ANALYSIS

This impact analysis considers the impact of the changes beyond the status quo.

OPTION TWO — STREAMLINE INCAPACITY PROVISIONS AND CHANGE THE DEFINITION OF A WEEK

IMPACTS ON RELEVANT AUTHORITIES

This option will provide benefits for relevant authorities through reductions in income replacement benefits and improved return to work outcomes, since earlier reductions in income replacement benefits will encourage affected employees to return to work sooner. Relevant authorities will be required to increase their focus on providing suitable employment for employees looking to return to work sooner.

This option will lead to a small amount of downward pressure on premiums for premium payers.

IMPACTS ON EMPLOYEES

Step-down provisions are an effective incentive to encourage injured employees to return-to-work. Implementing the current step-down from 45 calendar weeks from date of first incapacity will enhance incentives for affected employees, which will include those who have returned to some work from 45 weeks after injury but have not fully returned to work, to return to normal working hours sooner to avoid a reduction in their income replacement benefits. This change will not affect injured employees who have returned to full working hours within 45 calendar weeks of first incapacity, nor those who have been seriously injured and are not able to return to work at all in that time.

There is compelling evidence that, for most individuals, working improves general health and wellbeing and reduces psychological distress. Returning to work sooner and, where appropriate, recovering at work, will result in better health and financial outcomes for injured employees.

OPTION THREE — THREE LEVEL SYSTEM FOR STEPPING DOWN INCOME REPLACEMENT BENEFITS

IMPACTS ON DETERMINING AUTHORITIES

The impacts of Option Three on relevant authorities are the same as those of Option Two, except that expected reductions in claims costs would be greater as a result of the earlier step-downs in income replacement benefits.

This option will lead to a small amount of downward pressure on premiums for premium payers.³⁹

IMPACTS ON EMPLOYEES

This option shifts the balance of expenditure on income replacement benefits from short-term injured employees to long-term injured employees.

³⁹ Taylor Fry Actuarial Costings requested for Review of the Safety, Rehabilitation and Compensation Act 1988 Summary Report, 8 February 2013, Appendix C of the Safety, Rehabilitation and Compensation Act Review Report - February 2013, pp. 219-230.

Around 85 per cent of employees receiving income replacement return to work within 13 weeks⁴⁰ and are not affected by the proposed changes in this option.

For those continuing to receive income replacement compensation after 13 weeks, benefits would be reduced sooner compared to current arrangements. Benefits would be reduced to 90 per cent of normal weekly earnings after 13 weeks and then to 80 per cent after 26 weeks (these employees currently receive 100 per cent of normal weekly earnings). This would provide significant incentives for them to pursue rehabilitation and return-to-work at an early stage when rehabilitation has the best prospects of success.

On the other hand, under this option, long-term injured employees who receive income replacement for longer than 45 weeks would receive a higher percentage of their normal weekly earnings than is currently the case. After 26 weeks, they would receive 80 per cent of their normal weekly earnings for the duration of their incapacity. This is less than the 100 per cent of normal weekly earnings they currently receive up to 45 weeks of incapacity, but greater than the 75 per cent which is paid thereafter.

CONSULTATION

Extensive stakeholder feedback has been received on amendments to the incapacity provisions.

RELEVANT AUTHORITIES

Relevant authorities supported earlier step downs in compensation payments.

INDUSTRY BODIES

The Ai Group supported the new approach to accruing weeks as it aligned Comcare with most other jurisdictions and simplified the process. It also noted earlier step downs would incentivise earlier return to work.⁴¹

LEGAL BODIES AND REPRESENTATIVES

Feedback from legal bodies and representatives on amendments to incapacity provisions was mixed. Slater& Gordon claimed earlier step downs would have a disproportionate financial impact on seriously and permanently injured employees⁴², whereas the Law Council identified that it favoured national consistency and felt that having the first step down at 26 weeks was fairer than 13 weeks.⁴³

UNIONS

Unions were generally opposed to any changes to the way incapacity benefits are calculated. The ACTU noted that reducing incapacity payments after only 13 weeks will not allow people with

⁴⁰ Data provided by Comcare on return to work performance for 2012-13

⁴¹ The Australian Industry Group, Submission to the Senate Inquiry into the Safety, Rehabilitation and Compensation Amendment (Improving the Comcare Scheme) Bill 2015, p. 10-11

⁴² Slater and Gordon, Submission to the Senate Inquiry into the Safety, Rehabilitation and Compensation Amendment (Improving the Comcare Scheme) Bill 2015, p. 12

⁴³ The Law Council of Australia, Submission to the Senate Inquiry into the Safety, Rehabilitation and Compensation Amendment (Improving the Comcare Scheme) Bill 2015, p. 9

serious injuries enough time to recover and would cause additional stress in what is already a difficult time.⁴⁴

CONCLUSION

Both Option Two and Option Three better align income replacement provisions under the SRC Act with state and territory workers' compensation schemes. Both options will increase incentives for employees to return to work sooner and reduce overall costs in the scheme. There is compelling evidence that, for most individuals, returning to work improves their health and financial outcomes.

The department prefers Option Two over Option Three. As 85 per cent of injured employees return to work within 13 weeks under existing arrangements, there is limited evidence that current arrangements do not already adequately incentivise employees with less severe injuries to return to work as quickly as possible. The step downs proposed in Option Three may result in injured employees returning to work before they have fully recovered from their injuries, which may increase their risk of further injury.

⁴⁴ ACTU, Submission to the Senate Inquiry into the Safety, Rehabilitation and Compensation Amendment (Improving the Comcare Scheme) Bill 2015, p. 12

COSTING

The Office of Best Practice Regulation requires the calculation of costs associated with the regulatory burden of each option to be tabled in a Regulation Impact Statement (RIS). However, the regulatory costs of all options provided in this RIS relate mostly to updating IT systems and training staff on new methodology. As these costs relate to the fact there is a change rather than the quantum of the change, the regulatory burden is the same across all options.

Most claim management functions are completed with the use of specialised software and any significant changes to claims management processes, such as those that are analysed in this RIS, will require a re-design of system software. Relevant authorities will be required to purchase updated software and train their claims management staff on the changes.

There are currently 20 organisations that perform claims management services for the 35 licensees. This is because some insurance companies and corporate groups of licensees provide claims management services for a number of individual licensees.

IT and training costs have been applied to current licensees only. Costs for new licensees entering the scheme after the introduction of these amendments will be establishment costs for them and will be no greater than the establishment costs under existing arrangements.

There are some regulatory costs beyond updating IT systems and associated staff training, such as accreditation costs for attendant care providers and health practitioners not registered under the National Registration and Accreditation Scheme. Accreditation costs for attendant care providers include undertaking a course with a tertiary institution, while health practitioners' costs are associated with the time it takes to complete application requirements.

Taylor Fry Actuaries conducted costings on the proposed package of changes in August 2017. The proposed changes are estimated to save both premium payers and licensees between 4 per cent and 12 per cent annually, with the largest savings arising from proposed changes to rehabilitation arrangements helping injured employees to return to work sooner. The estimated savings equate to between \$9 million and \$27 million for premium payers and between \$6 million and \$18 million for licensees.

REGULATORY BURDEN AND COST OFFSET ESTIMATE TABLE

Average Annual Regulatory Costs (from Business as usual)				
Change in costs (\$million)	Business	Community Organisations	Individuals	Total change in cost
Income replacement	\$0.003			\$0.003
Evidence based medical treatment	\$0.040			\$0.040
Household and attendant care services	\$0.350			\$0.350
Accreditation of attendant care providers	\$0.169			\$0.169
Medical treatment and legal costs	\$0.012			\$0.012
Other changes in submission	- \$0.173			- \$0.173
Total by Sector	\$0.401			\$0.401
<p>Are all new costs offset?</p> <p>No, costs are not offset. The Employment portfolio's net regulatory target will be met by the end of the 2017-18 reporting period.</p>				
<p>Total (Change in costs - Cost offset) (\$million) \$0.401</p>				

STAKEHOLDER CONSULTATION

The issues raised in this RIS have been discussed, reviewed and consulted on extensively over the last four years. The consultation sections of this RIS outlines feedback received from stakeholders on amendments to the SRC Act, including the amendments currently proposed, during the consultation processes outlined below.

This RIS will be updated to include feedback received from Government and non-government stakeholders during the current consultation process prior to finalisation.

ENGAGEMENT METHODS

The department has engaged in extensive and ongoing consultation with participants in the scheme to:

- inform the content of the SRC Act Review and its recommendations;
- gauge stakeholder responses to the SRC Act Review recommendations; and
- inform the second stage of the proposed reforms to the SRC Act.

Engagement methods included:

- targeted consultation groups
- meetings
- public submissions tenders
- workshops
- cross agency working groups

CONSULTATION PROCESS

The Department of Employment conducted the following stakeholder consultation sessions between July 2012 and July 2017.

CONSULTATION STAGE 1

The review of the SRC Act in 2012-13 was a broad review that looked at a range of legislative and operational areas, including scheme governance, performance and access to self-insurance.

Consultation was conducted in three stages by Mr Peter Hanks QC and Dr Allan Hawke AC and consisted of:

1. initial meetings with targeted participants to develop a preliminary list of issues and possible recommendations;
2. publication of an issues paper to stimulate and encourage public submissions to the review;
3. focus workshops with select participants and participant groups to explore particular issues and matters arising in the submissions; and
4. acceptance of written submissions.

Approximately 44 workshops, meetings and other consultations were held between July and November 2012. Written submissions for the Issues Paper closed on 25 October 2012 and 45 submissions were received.

CONSULTATION STAGE 2

On publication of the SRC Act Review report in March 2013, a series of consultations were conducted in April 2013 with key stakeholder groups in Canberra, Sydney and Melbourne. The purpose of the consultations was to gauge stakeholder response to the SRC Act Review and to inform future implementation of the recommendations.

The consultations included feedback sessions held by the department and written submissions regarding the recommendations in the final report. Forty written submissions were received by the department during April and May 2013. Stakeholders who made submissions and participated in workshops and consultations included employees, employer organisations, unions, insurers, Comcare, Commonwealth government agencies, current licensees, premium payers under the scheme, health practitioner bodies and legal practitioners.

CONSULTATION STAGE 3

The purpose of the consultations was to inform the second stage of proposed reforms to the SRC Act and advise stakeholder groups of the proposed content of the SRC Act reform package.

A series of confidential consultations were conducted with key stakeholder groups in Canberra, Sydney and Melbourne during May to June 2014.

Details regarding the stakeholders involved in the consultations are detailed in the table below.

Key Stakeholder Group	Number of consultation sessions	Number of Stakeholders
Unions	2	10
Licensees	3	18
Legal Practitioners	2	11
Rehabilitation Providers	1	5
Health Service Providers	1	9
Commonwealth Agencies <i>Including Comcare, Military and Rehabilitation Compensation Commission, Department of Veteran Affairs</i>	6	14
ACT Government	1	1
Total	16	68

Confidential consultations were conducted to assist in the development of the Government's response to the Review's recommendations and the proposed reforms not addressed by the Review. Participants were also invited to submit written responses to the recommendations.

SENATE INQUIRY INTO THE SAFETY, REHABILITATION AND COMPENSATION AMENDMENT (IMPROVING THE COMCARE SCHEME) BILL 2015

On 26 March 2015, the Senate referred the Improving the Comcare Scheme Bill to the Senate Education and Employment Legislation Committee for inquiry and report. Thirty submissions were

received from various stakeholders including industry groups, unions, plaintiff lawyers and legal bodies, licensees and Commonwealth agencies.

The Committee handed its report down on 16 June 2015 and recommended the Senate pass the Bill. Labor and the Greens both issued dissenting reports recommending the Bill not be passed.

OTHER CONSULTATION – CROSS AGENCY WORKING GROUPS

The purpose of the consultations was to inform the second stage of proposed reforms to the SRC Act and stimulate policy discussion.

During December 2013 to May 2014, representatives from Australian Government Agencies, Comcare and the Department of Veteran’s Affairs were invited to attend a series of workshops conducted in Canberra. Meetings were held on a fortnightly basis to present research on issues pertinent to the recommendations. Participants were encouraged to provide comment or written feedback, including presentation of their own research.

The Department of the Prime Minister and Cabinet, Australian Public Service Commission, Department of Finance and Treasury were represented at the working group meetings:

ALTERNATIVE DISPUTE RESOLUTION – CROSS AGENCY WORKING GROUP

Between September 2015 and February 2016, representatives from Australian Government Agencies, Comcare and the Department of Veterans’ Affairs were invited to join a cross agency working group to look at non-legislative options to reduce disputes in the Comcare scheme⁴⁵.

Members were invited to contribute to the development of a paper on alternative dispute resolution options for the Comcare scheme. Feedback and ideas gained from this process has informed the development of a number of reforms targeted at reducing disputes in the Comcare scheme.

ONGOING CONSULTATIONS

The department has consulted with Australian Government stakeholders on proposed amendments to the SRC Act. The department will seek further feedback from non-government stakeholders on the proposed reforms prior to finalising a package of amendments to the SRC Act for consideration by the Government.

⁴⁵ Agencies represented included Attorney-Generals’ Department, Department of Finance, Comcare, Australian Public Service Commission, Department of Veterans’ Affairs, Department of Prime Minister and Cabinet, and the Administrative Appeals Tribunal