AUSTRALIAN PLAINTIFF LAWYERS ASSOCIATION
LAWYERS FOR THE PEOPLE

99–101 Buckingham St. Surry Hills NSW 2010
PO Box 2348 Strawberry Hills, NSW 2012 Australia
DX 22515 Surry Hills | ABN 96 086 880 499
Phone (02) 9698 1700 Fax (02) 9698 1744
Email info@apla.com.au www.apla.com.au

HOUSE OF REPRESENTATIVES INQUIRY INTO ASPECTS OF AUSTRALIAN WORKERS' COMPENSATION

APLA Submission

---

8 August 2002

Contact:
Simon Garnett
Phone: 03 9238 7878 Mobile: 0418 353 231
Email: Sgarnett@rct-law.com.au

Contents

Executive Summary

Further to the invitation of the Secretary of the Standing Committee on Employment and Workplace Relations, APLA has prepared this submission to the Inquiry into aspects of Australian workers' compensation schemes.

The evidence required to fully address the Inquiry's terms of reference takes time to assemble. It is with regret that APLA's submission is therefore unable to provide accurate and current data on all aspects.

However, APLA investigated claims of fraud in the Australian workers' compensation schemes in 1999 for its annual conference. While we have been able to update some of the data, some statistics referred to herein are not current. The principles underlying APLA's position in relation to the Terms of Reference however, are not altered by this fact.

The presumption is constantly that fraud in our workers' compensation schemes lies with the claimants. This is fuelled by media portrayal of 'cheats' in the system and the presentation of material in the public domain by employer groups and insurers. The evidence, however, is to the contrary. The incidence and cost of fraud in the workers' compensation schemes lie predominantly with employers and service providers.

The detection of fraud in Australian workers' compensation schemes is focused on the more easily identifiable fraud, that of the claimant. Employer and service provider fraud is much harder to detect and there is less incentive to eliminate such conduct as a result of the structure of the various schemes.

Injured workers must comply with the legislation to remain entitled to benefits under their respective schemes. The pressures of being suspected as a fraud do not assist recovery.

This submission does not address the final term of reference in any great detail, as APLA does not have the expertise in risk management or safety audits to answer it in depth.

Incidence and Cost of Fraud in Australian Workers' Compensation Systems

Reported Claims of Claimant Fraud

There is a general perception in the community that claimant fraud in the Australian workers' compensation systems is rife and is a major cost that is ultimately borne by employers and the community at large.

Generally allegations of fraud against workers can be categorised as follows:

- Claiming for an injury that does not exist.
- Claiming for an injury which has not arisen out of or in the course of employment.
- Claiming weekly payments whilst receiving other undeclared earnings.
- Altering medical certificates to obtain compensation or an increased benefit.
- Providing false information in relation to a claim for compensation.
- Substantial activity which contradicts medical certificates/reports.

Statements made by various people in positions of influence as to the nature and extent of fraud in the system have reinforced the perception of the "compo bludger" and "compo cheat". The following statements were all published in the same publication:[1]

> "The insurance industry in general has rules of thumb as to the amount of fraud that occurs," said Comcare Australia's action CEO, Robert Knapp. "But it is the iceberg problem. You just do not know how much is above the surface. Any measurement is more in terms of what we catch with the difficulty being how much gets away."

Garry Brack, from the New South Wales Employers Federation has stated:

> "I do not think that there is any doubt that fraud is a very significant problem but some people say euphemistically that there is not much fraud but there is plenty of exaggeration of injuries. As far as I am concerned, exaggeration is fraud and the euphemism belies the real problem."

Harry Neesham, WorkCover Western Australia's CEO said:

> "Only a very small proportion of people set out to deliberately defraud the system from day one of their claim, the issue is more a

[1] Graham Turner, "Fraud Wars: Workers' Compensation Rip Offs", *Safety News*, National Safety Council of Australia, Issue 4, April 1998, http://www.safetynews.com.news/sn9804/feature1.html (Accessed 16/06/99).

> problem of people who are fit to return to work fabricating their ongoing incapacity so as to remain on benefits for as long as they can maintain their full injury pre injury rate of pay."

Mal Milliken from the South Australian WorkCover Corporation said:

> "Fraud is there but we find it abhorrent to accept it so we are keen to investigate and, if necessary, to prosecute. We are a giving organisation but if you defraud don't scream when we prosecute you."

Queensland WorkCover's Ivor Thomas said:

> "Most of the systems now have a fraud hotline that people can ring up. The callers say they hate doing it but they are just sick and tired of others ripping off a system we are all paying for."

The various compensation authorities, employer and insurance groups regularly publicise the issue of claimant fraud. The *Australian Safety News* published by the National Safety Council of Australia conducted a fraud survey in 1998 with employers.

The South Australian WorkCover Corporation published *Twelve Ways to Spot Workers Compensation Fraud.* It also regularly publishes a fraud newsletter.

WorkCover Queensland also promotes a confidential fraud hotline number and publishes a *Confidential Fraud Advice Form.*

The Insurance Commission of Western Australia advertises their fraud control activities through articles, television and radio. The script for a television and radio advertisements in 1999 read as follows:

> "Some people think insurance companies, workers comp. and third party insurance are fair game. But every time they make a fraudulent claim, your insurance premiums go up. In fact it is probably costing you more than $100.00 a year. Call Crimestoppers. Because when you think about it, it is really you who has been taken for a ride."[2]

The Cooney Report into the Victorian Workers' Compensation System[3] received submissions from interested parties. It was the employer groups who were most trenchant in criticising the honesty and integrity of some involved in the making and prosecuting of injured workers' claims for compensation.

The Metal Trades Industry Association of Australia, in a submission to the Inquiry wrote[4]:

---

2 Insurance Commission of Western Australia, http://www.icwa.wa.gov.au/home.htm (Accessed October 1999).

3 B.C Cooney, *Committee of Enquiry into the Victorian Workers' Compensation Sydney 1983-84*, Government Printer, Melbourne, 1984.

4 Ibid. Ch. 11, p. 13.

> "In the area of Workers Compensation, as in Social Security, taxation and similar other areas there is invariably a section of the community who attempt to obtain benefits to which they are not entitled."

The Association also said:

> "There is an apprehension that the way the system now works, is seen as an opportunistic system, if you want to have a go, go for common law or go through workers compensation claims and you can do pretty well out of it. In fact, we have had examples written across claim forms where this is indicated. On the claim it was rubbed out, but we were able to read it and it said, "This one looks like a bit of a goer." That is from the employees' solicitors. That is the sort of feeling at large in our industry, the system is there to be ripped off and I have put that quite firmly. That seems to be what our members perceive the system provides. There is not a great deal in it for them but there is a lot in it for other people."
>
> "Why would not any employer be concerned about the legal fraternity, about the unions, about employees, when he has just retrenched 30 employees and within a week of their retrenchment 27 lodged common law claims. Why would there not be some apprehension? This is happening every day."

Mr Ken Crompton, who spoke to the Committee of Inquiry on behalf of the Victorian Chamber of Manufacturers, said:

> "I was trying to make the point that there is an impression given to us from enough complaints around that a lot of claims are not genuine. There are no figures or evidence to prove it. If that feeling is about, what is the cause of it?"[5]

The Grellman Report into the New South Wales Compensation System in 1997 commented that:

> "There is a perception among employers that the system is subject to widespread abuse."[6]

Inquiry Findings

Despite the claims of the insurance industry, employer groups and workers' compensation authorities that rorts and fraud by claimants are widespread, all official inquiries into the various workers' compensation schemes in Australia in the last 20 years have found no cogent evidence to support claims of widespread fraud, malingering or malpractice.

The Rowe Parliamentary Committee Report into the Victorian Workers' Compensation System in August 1988 recommended that quantified results of

---

5 Ibid.

6 R.J Grellman, *Inquiry into Workers' Compensation System in NSW: Final Report*, Sydney: KPMG, 1997.

fraud detection should take due account of only reasonably calculated savings. Without such calculation safeguards, inflated monetary savings can be used to justify large and unnecessary increases in fraud investigation staff.[7]

On 21 April 1994, the Commonwealth Industry Commission Report into Workers Compensation in Australia was released and simply stated, "Clear cases of fraud should be subject to criminal prosecution".[8]

The Commonwealth response was:

> "The Commonwealth supports the view that all compensation schemes should maintain and implement balanced fraud control strategies involving prevention, education and detection and prosecution of fraud in order to promote appropriate behaviour in the use of the schemes. Such strategies must ensure that prompt action is taken when fraud is detected, both to stop the fraud and to discourage others who may be inclined to commit similar conduct. The Commonwealth considers that all jurisdictions should maintain or implement, as appropriate, a separate legislative framework for the pursuit, by their compensation authorities, of claimant, employer and service provider fraud and over-servicing."[9]

The 1996 Report of the Heads of Workers' Compensation Authorities to the Labour Ministers' Council[10] believed that there was a strong need for schemes to be able to share information for more operational purposes, particularly those related to fraud control.

> "This involves the exchange of information both between the various workers compensation schemes and between workers compensation schemes and a range of Federal agencies. The inter-jurisdictional exchange would primarily be to ensure that a claimant is not improperly attempting to access benefits from more than one system. On behalf of the HWCA, the Workers Compensation Board of Queensland and Comcare Australia have undertaken discussions with all Federal agencies in order to pursue the prospects of achieving agreement for implementing appropriate information sharing techniques to detect and combat Workers Compensation fraud."[11]

The final recommendation was that state, territory and federal workers' compensation legislation should be amended to allow the exchange of information between jurisdictions relevant to fraud control.

---

7 B.J. Rowe, *Parliament of Victoria WorkCare Committee Final Report*, Melbourne: VGPO, 1988, Vol. 2, p. 480.

8 Full Citation unavailable at time of submission. For further details on this paper please contact APLA.

9 Full Citation unavailable at time of submission. For further details on this paper please contact APLA.

10 Heads of Workers' Compensation Authorities (HWCA), *Promoting Excellence: National Consistency in Australian Workers' Compensation*, Final Report, Melbourne, HWCA, 1996.

11 Ibid. p. 128-9.

It is interesting to note that the HWCA Report was primarily concerned with abuse by workers and no mention was made about employer or insurance company practices. The Kennedy Commission of Inquiry Report into the Queensland Compensation system also stated that it was not possible to calculate the extent of evasion[12] but it failed to investigate the nature and extent of rorting by employers.

All inquiries into the various compensation schemes have addressed the issue of fraud but have found that it is a negligible component of workers' compensation. Not one inquiry has found evidence of significant claimant fraud nor has any of the employer, insurer or workers' compensation authorities been able to produce evidence to any inquiry that there is significant claimant fraud.

Statistics

There are 10 different workers, compensation schemes which operate throughout Australia and which cover approximately 10 million workers. The number of reported claims for the financial years 1995/6 to 2000/01 is as follows:

Year				Vic						SA
1995/96			62,469	32,632		93,008		4,070		37,180
1996/97			60,109	31,809		85,110		4,272		34,350
1997/98			58,604	30,113		79,859		4,334		32,450
1998/99			55,492	31,242		80,089		4,529		30,720
1999/00			53,224	31,592		82,335		4,349		31,200
2000/01			*	32,539		85,340		3,946		*

* Data unavailable at time of writing

Table 1: Numbers of Reported Claims[13]

There are approximately 265,000 reported workers compensation claims per year across Australia. Despite what the insurance industry, employer groups and compensation authorities may allege, according to the Authorities' Annual Reports, the number of fraud prosecutions against claimants is small in comparison.

Year	Vic	Qld	SA	NSW
1995/96	5	*	*	*
1996/97	11	91	21	3
1997/98	11	92	24	5
1998/99	12	94	17	5
1999/00	18	*	7	*
2000/01	1	*	7	*

*Data unavailable at time of writing

Table 2: Numbers of Prosecutions[14]

---

[12] J Kennedy, *Report of the Commission of Inquiry into Workers' Compensation and Related Matters in Queensland*, Vol. 2 p. 121.

[13] Heads of Workplace Safety & Compensation Authorities, *Comparison of Workers' Compensation Arrangements in Australia and New Zealand 2001*, pp.8-9.

[14] Data collated from the Annual Reports of Victorian WorkCover Authority, WorkCover Corporation South Australia and WorkCover Queensland. Data from NSW obtained from a letter from John Grayson,General Manager NSW WorkCover to the author, 31 August 1999.

ACT WorkCover, NT Work Health and the Western Australian Workers Compensation and Rehabilitation Commission were unable to provide any statistical information when we made enquiries in 1999 and again more recently for the purposes of this submission.

Reported Claims of Employer Fraud

The Green Paper on Workers Compensation Premium Evasion[15] and the Review of Employers' Compliance with Workers, Compensation Premiums and Payroll Tax in NSW[16] found that employer fraud in workers compensation requires urgent legislative action.

Employer fraud can consist of:

- Incorrectly informing employees that they are not covered under the legislation.
- Failing to declare remuneration/wages for the purposes of evading or minimising an insurance premium.
- Incorrectly classifying the business to attract a lower premium.
- Failing to have workers' compensation insurance.
- Failing to pass on a full benefit to a claimant.
- Deducting money from an employee's wages for the purposes of contributing to their levy.
- Demanding an employee take sick leave or other leave entitlements for a work injury.
- Failing to submit a claim to the insurer.
- Requesting an employee to enter into a work agreement that does not reflect the true nature of the working relationship.
- Modifying equipment after injury to avoid occupational health and safety prosecution.
- Failing to comply with Occupational Health and Safety Standards.

In 1996 the New South Wales Government conducted an amnesty on underpayment producing a $15 million improvement in compliance.[17]

The CFMEU (New South Wales branch) has recommended a stricter policing of employer premium compliance on building sites. Their investigations discovered many companies do not have workers compensation insurance and many others falsely declare wage levels or provide misleading information regarding industry classification to minimise premiums. According to Andrew Ferguson of the CFMEU, non-compliance was between 30% and 60%.[18]

The Victorian WorkCover Authority has conducted audits of the remuneration

[15] WorkCover NSW, *Workers Compensation Insurance Compliance Green Paper*, October 2001.
[16] Penny Le Courteur and Neil Warren, *Interim Report: Review of Employer's Compliance with Workers Compensation Premiums and Pay-roll Tax in NSW*, Commissioned by WorkCover NSW Office of State Revenue 22 March 2002.
[17] Graham Turner, "Fraud Wars: Workers' Compensation Rip Offs", *Safety News*, Issue 4, April 1998.
[18] Ibid.

declarations and WorkCover Industry Classifications of Victorian employers since 1995. Between 1995 and 1999 the total number of audits conducted was approximately 21,000 of which 9,821 employers complied, 4,225 over-declared and 6,860 employers under-declared, resulting in an underpayment of premium to the amount of $41 million.[19]

In the 1995/6 financial year in Victoria eleven employers were prosecuted for premium/levy offences.[20] Most of these cases involved the failure to obtain a workers compensation policy and pay the premium as well as a failure to pay a levy.

One employer was convicted not only of these offences but also of a failure to forward a worker's claim to the insurer and providing false information.[21]

In the 1996/7 financial year, six employers were prosecuted, four of whom had no workers' compensation insurance policy and in 1997/8, four were prosecuted for failing to register a business.[22]

In 1995/6, WorkCover Queensland identified a total of $1.87million in additional premium income from uninsured and underinsured employers and the Board obtained judgements against 320 employers.[23]

In the 1996/7 financial year, WorkCover Queensland identified $2.65 million in premiums owed by employers who either under-declared their payroll for the purposes of being charged a lower premium or who were completely uninsured. This increased to $5 million in the 1997/8 financial year and to $6.1 million in the 1998/9 financial year.[24]

In the 1995/6 financial year, WorkCover Western Australia contacted 23,500 businesses, 18% of which did not have a workers, compensation insurance policy.[25]

In 1996/7, 16% of 18,000 businesses contacted did not have a workers compensation insurance policy, resulting in the recovery of additional premium of over $500,000. The Compliance Section recorded an average 100 uninsured employers per month.[26]

The report noted:

> "Anecdotal evidence from insurers and employers suggest concern over the possibility some employers may under declare the amount of wages paid in order to reduce their premium. Further investigation of this trend is under way. Trends over the last ten years suggest small businesses who engage part time, casual and contract workers have a greater tendency to be

[19] Letter from Victorian WorkCover Authority to the author, 18 August 1999.
[20] Victorian WorkCover Authority Annual Report 1995/6.
[21] Ibid.
[22] Victorian WorkCover Annual Report for the years 1996/7 and 1997/8.
[23] WorkCover Queensland Annual Report 1995/96.
[24] Ibid.
[25] WorkCover Western Australia Annual Report 1995/96.
[26] WorkCover Western Australia Annual Report 1996/97.

uninsured for workers, compensation."[27]

In the 1997/8 financial year, 16.9% of the 19,432 businesses contacted failed to have a workers compensation insurance policy, which resulted in additional premiums of $450,000.[28]

The Kennedy Report in Queensland states that:

> "Some employers are rorting the system but that it was not possible to calculate the extent of the evasion."[29]

> "Unofficial estimates of premiums evaded by employers is as high as $50 million per annum."[30]

A Performance Audit Report by Des Knight estimates that the value of outstanding premiums is $28.8 million and $3 million is lost each year in bad debts from employers.[31]

In June 1999, Queensland WorkCover Chief Executive, Tony Hawkins confirmed that:

> "Some employers under declare to save or defer on their insurance premiums."[32]

WorkCover NSW reported that for the 30 June 1997 to 30 June 1998 policy year, licensed insurers completed 4,184 audits and recovered $4.9 million in additional premium. WorkCover conducted 499 wage audits and recovered $741,482 for the same period.[33] In 1999/2000, 4,692 audits resulted in additional premium of $7.4 million and as a result of recent investigations; additional premiums for the year ending 30 June 2001 amounted to $14.8 million. Ninety-three investigations were finalised identifying an under declaration of $37.9 million in wages and the billing of an additional $1.3 million in premiums. In addition 203 complaints from unions, inspectors, employers and insurers were also investigated. The 76 matters finalised identified a total under declaration of $17.6 million in wages and resulted in employers being billed $977,851 in additional premiums.[34]

The ACT Legislative Assembly convened the first Parliamentary Inquiry into employer fraud and premium evasion. In view of the loss of premium revenue to most schemes, all governments should consider similar inquiries. Consider the following examples of questionable insurance conduct:

---

27 Ibid. p. 39.
28 WorkCover Western Australia Annual Report 1997/98.
29 J Kennedy, Report of the Commission of Inquiry into Workers' Compensation and Related Matters in Queensland, Vol. 2 p. 21.
30 APLA Commentary on Kennedy Commission of Inquiry. Full citation unavailable at time of submission. For further details on this paper, please contact APLA.
31 Ibid.
32 Queensland WorkCover, *Workers Compensation Report* Issue 352.
33 Heads of Workplace Safety & Compensation Authorities, *Comparison of Workers' Compensation Arrangements in Australia and New Zealand 2001.*
34 WorkCover NSW, *Workers Compensation Insurance Compliance Green Paper*, October 2001.

Example 1: David McCubbin v. MMI[35]

In the Victorian County Court matter of *David McCubbin v. MMI* the worker was a shearer from the age of 18 until he ceased work at the age of 51 in 1990. On 3 July 1990 while shearing a very large ram, its horns locked around his legs causing him to fall. He sustained injuries to his neck, back, left and right arms. His claim was accepted and he began to receive weekly payments until 27 September 1993. On that date, at the invitation of the insurer, he attended a motel in Stawell and signed a document purporting to be a final settlement of his compensation entitlements for the sum of $8,000.[36] The court accepted the worker's evidence that prior to arriving at the motel he had no inkling as to the real purpose of the meeting or that settlement of his claim would be discussed. The two senior claims officers who attended the meeting gave evidence that they had previously attended a meeting with the Victorian WorkCover Authority concerning settlement of these claims and were directed to follow the Victorian WorkCover Authority Guidelines which state that:

> "The settlement must be cost effective and ... Insurers must also ensure that each worker fully understands the terms of offer and a settlement including the non entitlement to future compensation and common law damages and appropriate verbal and written advice is given."

The worker gave evidence that he was told the law had changed and that they were to advise and help him. He was informed that his weekly payments would stop on 30 November 1993 and that he had a chance of signing a piece of paper and getting $8,000 with payments stopping on 5 October 1993 or he would get nothing.

He gave evidence that he was told that he was not entitled to legal advice and if he did go to court he would have a "snowflake's chance in hell" of winning. The worker said he felt depressed and pressured and if he did not sign it there and then he would get nothing. The court found the insurer's conduct to be unconscionable and set aside the agreement.

Example 2: Hill v. FAI[37]

In the Victorian County Court matter of *Hill v. FAI* the plaintiff was assaulted by two men on 6 September 1991 and sustained head injuries and consequential anxiety and depression. His claim was accepted and he received weekly payments. In January 1993 as a result of negotiations with FAI he settled his claim pursuant to Section 115[38] for $6,000. The court found that when the worker attended FAI's offices and signed the document he genuinely believed he was only settling his claim for weekly payments and not any lump sum entitlement. The court found that the claims officer knew the plaintiff was only concerned about weekly payments and made no attempt to disabuse the plaintiff of his mistaken belief or to inform him of other possible entitlements. The agreement was set aside.

---

[35] Unreported, Victorian County Court, 7 November 1997.
[36] Pursuant to section 115 of the *Accident Compensation Act* 1985.
[37] Unreported, Victorian County Court, 4 December 1997.
[38] *Accident Compensation Act 1985* (Vic).

Example 3: Fischer v. Keys Road Clearance Centre[39]

In the Victorian County Court matter of *Fischer v. Keys Road Clearance Centre* an injured worker who developed psychological stress from the intensity of the surveillance that the insurers, FAI, put him under prior to trial, was relentlessly called a liar and a fraud during his trial only to have the defence fail to produce any evidence to support their allegations.

Judge Strong described the tactics used by the Victorian WorkCover Authority as, "amongst the most shameful things he had ever seen." The judge also said, "Workers Compensation cases are to some degree being conducted in a manner more akin to a criminal proceeding where a person before the court stands accused of some serious wrong doing."

Example 4: FAI Workers Compensation (Vic) Pty Ltd v. Brewster[40]

In the Victorian Supreme Court matter of *FAI Workers Compensation (Vic) Pty Ltd v. Brewster,* the worker lodged a claim for weekly payments that was rejected by the insurer on the grounds that the alleged injury did not arise out of, or in the course of, her employment. The insurer was required by law to set out in a notice the reasons for their decision and in doing so "incorrectly" quoted their doctor's opinion to the effect that he had said, "Your employment was not a significant contributing factor."

Counsel for the worker submitted that the notice was fraudulent, tainted by dishonesty and was false.

Counsel for the insurer submitted that it may have been "misleading" but it was not intended as deception. He ultimately conceded that the statement was grossly misleading.

The judge at first instance reached the conclusion that the notice of rejection was "a travesty, it being such a gross misrepresentation of the truth I am not saying there is fraud...it is a big step to go that far..."

The Supreme Court on appeal agreed with the Magistrate's decision and description of what occurred as a "travesty". The Court held that the insurer acted *ultra vires* and therefore the insurer's decision, notice and reasons were invalid.

His Honour, Mr. Justice Smith, also went on to say that:

> "The Scheme imposes on the Authority or self-insurer an obligation to sit in judgment on claims made against it. It was not intended that the consideration of claims be a sham. Rather, the statutory scheme plainly depends upon a careful, reasoned and bona fide exercise of the statutory powers and duties given to and imposed upon the persons authorised to consider claims. It would make a mockery of the statutory scheme for a decision and a notice and reasons, like those in question in this case, to be

[39] Unreported, 11 December 1998.
[40] *FAI Workers' Compensation (Vic) Pty Ltd v. Brewster* [1999] VSC 388 (15 October 1999).

accorded any validity."

Reported Claims of Service Provider Fraud

This type of fraud generally occurs where a provider bills for a treatment that never occurred or over-services. The HWCA Interim Report to the Labour Ministers' Council found that the level of medical costs, as a percentage of total costs, varies between the schemes, ranging from around 13% to over 20% of workers compensation benefit expenditure. The final report recommends that only providers who meet minimum competency standards be accredited to practice in the workers compensation field[41] and that schemes enact legislative provisions giving power to remove the ability of a provider with aberrant performance patterns which continue after review, and following appropriate counselling, to practice within the system.[42]

The Cooney Report stated that the accusation of over-servicing is in effect an accusation of malpractice. The Committee of Inquiry did not pursue any formal investigation in this area. Dr. McCubbery on behalf of the AMA submitted:

> "I believe that it is rather a scurrilous aspersion which has not been accompanied by appropriate documentation to justify it."[43]

In Victoria a medical peer review process began in 1995 that according to the Victorian WorkCover Authority[44] has led to a change in the servicing patterns of some providers. Seventeen physiotherapists, seven chiropractors and four psychologists were investigated regarding the number of services per claim. In the 1996/7 financial year, two providers were prosecuted, one for furnishing false information and the other for obtaining property by deception. In the 1997/8 financial year two providers were prosecuted, one for obstructing an investigation and the other for falsifying 44 invoices for treatment not provided.

Dubious activities of some providers actually resulted in legislative change in Victoria with the introduction of the *Accident Compensation Act (Further Amendment) Act* in 1996. The following is an extract from the Minister's Second Reading speech:

> "The activity of a number of organisations associated with the lodgement of hearing loss claims under the *Accident Compensation Act* 1985 are well known to Parliament. These companies prey on the elderly and those who have difficulty with English offering to lodge a claim for hearing loss for a fee. This Bill introduces provisions similar to those adopted by the New South Wales Parliament late last year which will provide penalties for companies and individuals who come within the definition of an agent for the purposes of the provisions and who engage in

---

41 HWCA, *Promoting Excellence: National Consistency in Australian Workers' Compensation*, Interim Report, Melbourne, HWCA, 1996, p. 30 Recommendation 73.

42 Ibid. Recommendation 74.

43 B.C Cooney, *Committee of Enquiry into the Victorian Workers' Compensation Sydney 1983-84*, Chapter 11 p. 13.

44 Victorian WorkCover Authority Annual Report 1995/6.

prohibited conduct as defined."[45]

The U.S. Experience

Allegations made by the insurance industry, employer groups and compensation authorities against workers are not restricted to Australia. Greg Tarpinian in his article, "Workers Comp Fraud: The Real Story" comments:

> "Dramatic increases in workers compensation premiums throughout the late 1980's and early 1990's fuelled unsubstantiated charges that costs were high in part because workers abused the system, fraudulently collecting benefits for faked injuries or remaining on benefits far longer than their recovery required. The American Insurance Association estimated fraud losses at 10% of the cost of claims paid, or about $3b. The National Insurance Crime Bureau doubled the AIA's estimate to $6b, even though it was involved in only 99 fraud prosecutions in 1994 and 134 in 1995 nation wide. The Coalition Against Insurance Fraud adopted the AIA's estimate. One insurance company president put the cost of workers compensation fraud at $30b a year. These huge numbers grabbed the attention of the public and policy holders. The presumption in the press and the state houses was that fraud was rampant and that most workers compensation fraud was claimant fraud. Since that time more than half of the states have passed legislation on workers compensation fraud, with most of the laws directed primarily at claimants. 33 states currently have active workers compensation insurance fraud units, many of them geared to fighting claimant fraud. In every state some claimant fraud has been discovered, publicity about these cases has created a deterrent for workers who might contemplate fraudulent claims. It has also created an atmosphere that Frederick Hill, California Analyst for Fire Mark Research of New Jersey, describes as the:
>
> 'Unwarranted and anecdotal vilification of the work force.'
>
> In its extensive investigation of workers compensation fraud the Santa Rosa Press Democrat concluded that:
>
> 'the perception that workers are cashing in by faking or exaggerating injuries has created a climate of mistrust in which ever person who is injured and files a claim can become the subject of suspicion by insurance adjusters, doctors and industry lawyers.'
>
> Perhaps most importantly, the fixation on claimant fraud has distracted policy makers, enforcement agencies, and the public from growing evidence of the real problem - millions of dollars in employer and provider fraud."[46]

---

[45] Full citation unavailable at time of submission. For further details on this paper please contact APLA.

[46] American Trial Lawyers Association Journal March 1999.

These views are confirmed by Todd J O'Malley in his article, "Who is Defrauding Workers Comp?" where he comments:

> "The insurance industry and corporate America have waged a media campaign to convince the public that claimants - not insurers or employers - are responsible for most insurance fraud. Insurers and the corporate sector are especially targeting injured workers as guilty parties because annual benefits paid in this area amount to billions of dollars. Insurers and corporate leaders have also sought to persuade legislators that the Government should join the effort to curb claimant insurance fraud. Many states have commissioned special insurance fraud task forces to help catch and prosecute these offenders... However, what these task forces, insurers, and corporations have failed to publicise is that fraud committed by employers and insurers has cost the insurance industry more money than worker fraud."[47]

In summary, there is some degree of claimant fraud in the various workers' compensation systems in Australia, but the nature and extent of it pales into insignificance compared to the cost of employer fraud in the systems.

[47] American Trial Lawyers Association Journal December 1998.

The Methods Used and Costs Incurred to Detect and Eliminate Fraudulent Claims

Most compensation systems in Australia have established fraud detection units and have specific legislative provisions relating to fraud. However, to be more effective an independent body should administer them. There is an overuse of resources, which is directed to the detection of claimant fraud rather than employer fraud. An exchange of information and resources between Australian compensation authorities would assist in the control and eventual elimination of employer fraud that would result in considerable cost savings to the schemes.

The methods and resources employed by the workers' compensation schemes in the detection and elimination of fraudulent claims is largely aimed at the most obvious source of fraud by claimants, rather than the less readily identifiable behaviours of employers and service providers.

There is the potential for employer fraud to go undetected. In some jurisdictions the management of claims is outsourced by the scheme to insurance companies. The insurance companies chosen to be agents have a vested interest in protecting the interests of the employers whose claims they manage as employers have the right to change agents each year. Moreover, some agents are paid bonuses for managing claims. There is therefore an inbuilt conflict of interest for agents in the management of claims on their books.

Factors Leading to Different Safety Records and Claim Profiles and the Appropriateness of Rehabilitation and Their Benefits

Ideally a workers compensation system should provide incentives and bonuses to employers who provide a safe working environment for their employees and penalise those who don't. It should also provide an adequate benefit structure to those who are injured and encourage employers to effectively rehabilitate them. Unfortunately, the Australian compensation systems fail to satisfy these criteria. This is due to political and economic reasons and the entrenched attitude of society to those injured in the workplace.

All compensation schemes in Australia have statutory requirements relating to the provision of suitable employment or rehabilitation programs. However, their effectiveness is questionable. Although Victoria, New South Wales, South Australia, Queensland and the Northern Territory provide incentives to prospective employers to employ injured workers, there is still a major reluctance by employers to do so.

A considerable amount of resources is directed to rehabilitation but it must be implemented at an early stage and in an appropriate manner in order to be effective. Effective sanctions should be imposed against employers who refuse to provide suitable employment to their injured workers. At present there is generally a similar approach taken by all Australian jurisdictions in respect to the legislative provisions and sanctions imposed on employers in relation to the provision of suitable employment and penalties for failing to do so.

Enforcement of non-compliance in this area is virtually non-existent. In South Australia, the legislation provides for an additional premium charge on employers who fail to comply with their obligations to provide suitable employment to injured workers. In Victoria, there has never been a prosecution against an employer for failing to provide suitable employment although the legislation specifically provides for it. There needs to be a financial penalty imposed on employers who fail to provide suitable employment to their injured workers whether that are by way of a court imposed fine or premium penalty.

Consideration should also be given to allowing injured workers the right to obtain additional compensation from their employer if they have failed to provide them with suitable employment after injury.

Safety records in the workplace vary widely depending on the size and resources of the employer and the levels of openness and accountability in allowing access to their premises for Occupational Health and Safety audits.

Information about safety records and claim profiles are not readily accessible outside the systems.

Conclusion

The insurers and the respective workers' compensation schemes largely control the information required to address the terms of this Inquiry. The only way that workers or their representatives can respond without access to this information is to quote anecdotal evidence and statistics that are not current.

Injured workers face many pressures as they recover from injuries sustained in the workplace. To comply with the legislation that entitles them to benefits they must participate in employer and insurer organised rehabilitation, medical checks, retraining and the like. They are also under the constant suspicion of being a fraudulent claimant, and this does not assist their recovery.

If employer fraud and insurer "bad faith" cannot be accommodated within the current terms of reference of this inquiry, APLA would urge the Committee to recommend an additional inquiry into these matters.

Appendix

About APLA

The Australian Plaintiff Lawyers Association (APLA) is an association of lawyers and other professionals devoted to the protection and enhancement of the rights of those injured through the negligence of others and dedicated to injury prevention through safer products, workplaces, roadways, and other environments.

It is a national association with branches in all Australian states and territories.

APLA came into existence in 1993 and has since been invited to participate in all major discussions concerning the rights of the injured, including the following:

Member of the Legal Liaison Group with the Transport Accident Commission, VIC

Member of the Legal Liaison Group with the Victorian WorkCover Authority, VIC

Legislative Assembly Committee inquiry into the Criminal Injuries Compensation Scheme, ACT

Aircraft passengers' compensation issues, Federal

Industry Commission inquiry into Occupational Health and Safety, Federal

Working Group on Open Disclosure in Healthcare with Standards Australia, Federal.

Motor Accident Insurance Act, QLD

Workers' Compensation Act and *Common Law Practice Amendment Act* 1994, QLD

The *Uniform Civil Procedure Rules*, QLD

Founding member of the Structured Settlements Group, National

National Ministerial Summit into Public Liability Insurance, March 2002

National Medical Indemnity Forum, April 2002

APLA has also been instrumental in the "School Bus Safety Campaign" designed to make school buses safer for children.