Mr Peter Rozen QC
Reviewer
Independent Agent Review
Service Delivery Reform, Coordination and Workplace Safety
Department of Justice and Community Safety
Level 30, 121 Exhibition Street, Melbourne VIC 3000

21 September 2020

By email: agentreview@justice.vic.gov.au

Dear Mr Rozen,

RE: VICTORIAN WORKERS' COMPENSATION SYSTEM - INDEPENDENT REVIEW

HACSU Victoria No.2 Branch welcomes the opportunity to make a submission to the independent review into the Victoria workers' compensation system.

HACSU represents around 10,000 members working in the Mental Health, Intellectual Disabilities and Drug and Alcohol industries within both in the public and private sectors.

HACSU wholeheartedly agrees with comments of the Victorian Trades Hall Council as part of its submission to this inquiry, being.

'Occupational health and safety is core work to unions. No worker should be injured at work. Unions are committed to ensuring employers provide and maintain safe systems of work. Where a worker is injured at work, the main priority must be providing them with support and appropriate treatment and rehabilitation. A compensation scheme for workers injured in the course of their employment must reflect this'.

'Being injured at work can be an extremely traumatic experience, even before accounting for the inadequacies present in the system which serve to push workers off compensation and cause them to feel responsible for their injury'.

'Victoria's workers' compensation scheme must have as its main goal the caring for and effective treatment of injured workers, so they can return to work at the appropriate time. Injured workers with complex claims report that this is rarely how they are treated'.

To this end, on 1st June 2020, HACSU as the pioneer organisation, launched the inaugural Injured Workers Day as an online event and website www.injuredworkersday.org.au, in order to give Injured Workers a voice and opportunity to be seem, rather that suffering out of sight, out of mind.

HACSU endorses the VTHC submission below, which addresses the 28 questions posed by the Review's Discussion Paper, finding that the Ombudsman's definition of a 'complex claim' is lacking, that authorised agents should have no role in the workers compensation system and that a public administration of WorkCover would serve the needs of injured workers and the community in the most fair and effective way. HACSU has added to this the VTHC submission denoted by *an* * as required.

1. For individuals, please explain your experience of the workers' compensation scheme if any.

N/A.

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[1] *Workplace Injury, Rehabilitation and Compensation Act (Vic)* 2013, s 10
[2] WorkSafe Claims Manual, '1.1.1 Objectives of the Victorian WorkCover Scheme', http://www1.worksafe.vic.gov.au/vwa/claimsmanual/Claims_Manual/1-the-scheme/1-1-overview-of-the-scheme.htm#1.1.1
[3] Collie, A. et al. (2019) "Injured worker experiences of insurance claim processes and return to work: a national, cross-sectional study," BMC Public Health (2019) 19:927
[4] Ibid, p 7

2. For organisations, please describe your organisation.

VTHC is the peak body for Victorian Unions. Unions across the state stand up for worker's OHS rights, and in the event a worker is injured or harmed at work, ensure they are treated fairly. VTHC's OHS unit coordinates a collective response to issues of workplace health and safety, including working in partnership with the Injured Workers Support Network to to fight for fairer treatment by the WorkCover system and provide peer support as members of the network navigate the challenges of workers' compensation and living with a debilitating injury.

VTHC also houses Union Assist (UA), a workcover advisory service. UA was established over twenty years ago as a response to the behaviour of authorised agents and self-insurers, and the need for Victorian union members to access a fair go under a no-fault workers compensation scheme.

In the past twelve months, UA has assisted over 1,500 injured union members. UA has helped workers at the Accident Compensation Conciliation Service (ACCS), spoken to union delegates, assisted with training health and safety representatives (HSRs) as part of VTHC Occupational Health and Safety Training, and provided a general WorkCover enquiry line for all Victorian union members.

> ***HACSU represents around 10,000 members working in the Mental Health, Intellectual Disabilities and Drug and Alcohol industries within both in the public and private sectors.*

3. What are the features of a claim for worker's compensation that make it complex, or at risk of being complex?

The Ombudsman's report, while important in shedding light on the poor state of the WorkCover scheme, is limited in its definition of an injured worker's complex claim. The understanding, and definition, of what makes a complex claim needs to be expanded to ensure all workers are treated fairly and given the support they need to move forward.

An injured worker's claim for compensation and treatment may be complex for several reasons, regardless of the length of time they are away from work, including:

- The injury may be so severe, or the circumstances of the injury may be such that at the time it occurs, it causes psychiatric trauma or damage to the injured worker,
- The injury may lead to a secondary claim (sequelae injury),
- The injury may be severe, for example, it may be an injury to the worker's head or spine,
- The age of the injured worker, or
- The behaviour of the employer or agent may render managing the claim complex.

The complexity of a claim does not only manifest at the 130 week mark.

A claim can be complex from the beginning, or it can become complex during the course of the claim; well before the 130 weeks. In fact, many of the claims UA and affiliated unions deal with that fall into

the Ombudsman's definition of a 'complex claim' are relatively simple to resolve.

In other cases, the degree of complexity of the claim at the 130 week mark has been influenced by the poor treatment of the injured worker by the WorkCover system, and consequently, a secondary psychiatric injury is sustained and forms part of the claim.

Recommendation 1: the Independent Review adopts a definition of a 'complex claim' that encompasses all the areas of complexity that may be associated with an injury at work, and that encourages managing the claim in a way that does not lead to further injury and therefore further complexity.

A definition of a complex claim should encompass complexity resulting from:

- The nature of the injury itself, including the measures and extent of rehabilitation;
- Whether it is a psychiatric injury, or has a psychiatric element to it;
- Whether the injury has led to a secondary injury, including injury to mental health;
- The circumstances surrounding the time the injury was sustained;
- The employment of the injured worker, such as the industry in which they are employed, their relationship with their employer, how the employer has handled the injury to date, and their type of employment (i.e. permanent - full-time, part-time, casual or labour hire);
- The personal circumstances of the injured worker, such as whether they are in secure housing, their financial circumstances, whether they have been subjected to family violence;
- How the injured worker has been treated by the WorkCover system to date; and
- The length of time the injured worker has been unable to work.

4. How, and at what stage, should claims for worker's compensation be assessed as being complex, or at risk of becoming complex?

As explained above, a complex claim must not simply relate to the time period in which an injured worker has been off work or receiving compensation.

There needs to be criteria developed against which a worker's claim can be measured to determine if it is, or is at risk of becoming, complex. If the claim is assessed as having one or more of the criteria listed above in response to question 3, it must be deemed complex.

An injured worker and their representative must also have the right to challenge their claim's status if it has not been deemed complex and they believe it should be so treated.

Recommendation 2: an injured worker's claim is measured against criteria to be developed to determine if it is, or is at risk of becoming, complex. Once it meets this criteria, the claim must be presumed to be complex.

Recommendation 3: injured workers and their representatives must have rights to challenge the status of their claims and whether it should or should not be treated as 'complex'.

While the 130 week definition is limiting, the 52 week mark should be a critical time in an injured worker's claim as, at this time, the employer's obligation to provide suitable employment ends. If the worker's employer withholds modified duties or terminates the employment at this stage, the likelihood that the claim will become complex dramatically increases. If this does occur, the ability of the injury to worsen increases, as does the need for ongoing treatment.[5]

> *[redacted], a young chef, tripped on a pallet and fell backwards in [redacted] 2017. His workcover claim for lower back injury was accepted. He continued modified duties at reduced hours until about July 2018 when the employer withdrew duties. In October 2019, [redacted]'s friend offered him administrative work for 15 hours a week. The agent agreed to make up the difference until he had been receiving 130 weeks of weekly payments. At that time, the agent determined that the worker could work full-time regardless of the duties he was undertaking and terminated his claim on this basis. He challenged this decision and had it successfully overturned by the Medical Panel. He will now receive back pay to [redacted] January 2020 and more importantly, continuing ongoing top up by the agent.*

Recommendation 4: the employer's return to work obligations are present for the life of the claim, and not solely limited by the 52 or 130 week mark.

5. Are current case management practices able to support and treat the individual needs of injured workers with complex claims?

No.

The current case management system is flawed and unable to support and treat workers with complex claims. Deficiencies include, but are not limited to:

- A lack of consistency between individual case managers.
- Poor overall case management,
- Resolute focus on the initial injury and reluctance to consider subsequent injuries,
- Inability to accommodate the specific and individual needs of workers from diverse cultural and linguistic backgrounds, and
- Lack of timely responses when an injured worker faces issues relating to the complex claim.
- Financial incentives to terminate the claim and transfer the cost of supporting injured workers to the public welfare system.

[5] Grey et. al (2019) "Association between workers' compensation claim processing times and work disability duration: Analysis of population level claims data" *Health Policy* 123, 982–991

** There should be minimum levels of training for claims managers and RTW officers in workplaces.*

** At 13weeks all claim should the subject to the development of Mental Health Welfare Plans, as it is commonly at this point the Injured Worker may come to the realization of the complexity/severity of their claim. Ironically at this time of heightened anxiety and stress, that WorkCover payments are reduced to 80% of pre-injury levels.*

**On the issue of payments being reduced, HACSU is strongly of the opinion this should not occur, as it punishes the Injured Worker and detrimentally impacts on their Mental Wellbeing and overall recovery processes. Injured Workers themselves view this as financial coercion to return to work and terminate claims prematurely.*

6. If your answer to question 5 is yes, describe how current case management practices respond to the individual needs of injured workers with complex claims.

N/A.

7. If your answer to question 5 is no, describe what needs to change in the case management practices of complex claims so that injured workers are better supported and treated.

Complex health conditions can often result from the accepted injury, however poor management of the claim by the agent or self-insurer can lead to sub-standard medical treatment and poor outcomes for injured workers. This is particularly the case if the claim has not been managed in a timely manner.

Research has found that delays in processing claims have led to chronic disability among some workers, longer disability durations, increased anxiety and depression, and overall lower quality of life for up to six years post injury.[6] It also found that Victoria had the longest medium lodgement time.[7] In many instances, where injured workers have been strung along and decisions about their claim made in such a way that timely medical intervention is not possible, their condition worsens to the point where the initial treatment claimed is no longer effective.

There have also been many cases where best practice regarding decreasing and ceasing treatment is not implemented and the agent or self-insurer decides, without clinical justification, when treatment will cease.

An injured worker's treating medical practitioner has an ongoing relationship with the injured worker and stronger ability to understand and manage the injury. However, this is too often neither recognised nor appreciated by the system. UA notes that in most instances the return to work officer, claims officer, occupational therapist, authorised agents and self-insurer medical advisors all default to the position of the independent medical examiner.

This poor decision is compounded by other factors such as authorised agents or self-insurers failing to inform the independent medical examiners (IME) of the injured worker's job description and therefore putting the IME in a position of providing advice with no understanding of the tasks that were or will be undertaken. Workers also report IMEs who do not spend enough time with the worker, and they do not have the objectivity that reflects the true nature of the diagnosis or the

ability of the worker to attempt their pre-injury duties. This can further exacerbate the injury.

[6] Grey et. al (2019) "Association between workers' compensation claim processing times and work disability duration: Analysis of population level claims data" *Health Policy* 123, 982–991
[7] Ibid

Further, there is serious concern about the independence of several independent medical examiners. This is another failure of a privatised system motivated by profit. As identified by the Ombudsman, the structure of the scheme encourages insurers to favour IMEs they perceive are more likely to make decisions or findings in their favour rather than in favour of injured workers. UA is aware of IMEs that receive up to $900 from the agent per assessment of an injured worker and their capabilities. They are inherently incentivised to meet the agent's expectations, so they can gain further work. Both Ombudsman's reports from 2016 and the 2019 found that agents were guilty of 'doctor shopping' and favoured IMEs that recommended the outcome they sought.[8]

However, there are some very good IMEs within the system, and VTHC is cognisant that IMEs form part of an important oversight purpose, and that if they are to be brought into the public system as it currently stands, remuneration should be kept at current levels to ensure there is no incentive to return to private practice.

The importance of removing authorised agents and returning the whole scheme to public hands is paramount.

Recommendation 5: a greater weight be given to the injured workers' primary medical practitioner when making decisions on treatment plans.

Recommendation 7: if authorised agents form a view that treatment is no longer needed and this opinion is disputed by the worker and their treating health practitioner, then ongoing treatment must continue as scheduled until the matter can be resolved at conciliation and beyond.

Recommendation 8: the services of IMEs, along with the entire WorkCover scheme, must be brought back into public hands.

Key to fixing issues with case management must be the removal of private insurers where a claim is deemed 'complex' (encompassing the definition contained above at Question 3). Private insurers are primarily motivated by profit and for this reason, they are not equipped to handle complex claims with the care and respect injured workers deserve. Indeed, they are financially incentivised to remove injured workers with complex claims from the system.

[8] Victorian Ombudsman (2016) Investigation into the management of complex workers compensation claims and WorkSafe oversight, and Victorian Ombudsman (2019) WorkSafe2: Follow-up investigation into the management of complex workers compensation claims

Recommendation 9: where a claim is deemed complex, private insurers must be removed from the process of managing the claim.

Injured workers are consistently made to feel like they are a burden on the system - rather than being reassured that the system there to help them. The psychological impact of this cannot be overstated. For example, agents are perpetually managing claims by prioritising the insurance aspects which maximise profits. This is driven by the corporate nature of agents and the structure of financial rewards and penalties. The care and flexibility needed in order to support an injured worker is practically non-existent.

UA and affiliated unions also report that agents have a very high level of turnover amongst case managers. This results in little consistency, with injured workers being forced to retell their story repeatedly and often, further delaying the resolution of issues. This is extremely frustrating and impedes progress.

> *John, a plumber, has complained to Worksafe, his agent and the Ombudsman but still finds his agents behaviour unacceptable. His medical records have been incorrectly forwarded to other parties by the agent and his occupation and rehabilitation officer has been pushing him to undertake work that is unrealistic for his capabilities. There had been some delay with treatment assessments which has contributed to his poor mental health and frustration. His initial claim was for a knee injury but it has led to a further foot and back injury and now recently a mental health injury.*
>
> * A *status quo should be applied to ACCS disputes e.g. when an agent seeks to terminate treatment, the claimant should have the provision of services until such time as a conference has an outcome.* *

8. What role do the current financial incentives for agents have in the agent's management of complex claims?

Financial incentives are one of the core inadequacies of the current WorkCover scheme, particularly when it comes to complex claims (encompassing the definition of complex claims proposed above at question 3). The precise details of these financial incentives are kept confidential as commercial secrets, but this merely reinforces the opacity of the system.

The objectives of the Workcover scheme include "to make provision for the effective occupational rehabilitation of injured workers" and "establish incentives that are conducive to efficiency and discourage abuse."[9] The current remuneration scheme fails to deliver the objectives.

Instead agents are offered financial incentives to push injured workers off the statutory scheme and onto publicly funded welfare such as unemployment or disability benefits. While this is a well known

[9] WorkSafe Claims Manual, '1.1.1 Objectives of the Victorian WorkCover Scheme', http://www1.worksafe.vic.gov.au/vwa/claimsmanual/Claims_Manual/1-the-scheme/1-1-overview-of-the-scheme.htm#1.1.1

occurrence, Australia, the data reflecting this is lacking. One study referenced the fact that in the United States, 37% of social security disability recipients were injured at work and unable to access employment based insurance schemes. This study also found there is a high degree of movement between people who are injured at work and the Australian social safety net.[10] This is cost shifting resulting in profiteering off the back of injured workers. It is nothing short of unconscionable.

The WorkCover system needs to be radically overhauled. Private agents must be completely removed and have no role whatsoever in Victoria's workers' compensation scheme. It must be rebuilt by placing best practice, care and a stronger emphasis on the injured worker returning to work on the advice of their treating practitioner, at its centre.

Recommendation 9: Private agents and the associated financial incentives must be removed from the WorkCover scheme entirely.

9. Do the current financial incentives for agents support prompt, effective and proactive outcomes for injured workers with complex claims?

No.

10. If your answer to question 9 is yes, describe:

- **a. how the current financial incentives for agents maximise outcomes for injured workers with complex claims.**
- **b. any different or additional measurements which could be linked to financial incentives to promote quality decision making by agents.**

N/A.

11. If your answer to question 9 is no, describe:

- **a. The ways in which the current financial incentives for agents could be changed to maximise outcomes for injured workers with complex claims.**
- **b. Any different or additional measurements which could be linked to financial incentives to promote quality decision making by agents**

[10] Insurance Work and Health Group Faculty of Medicine, Nursing and Health Sciences, Final Report: T*he Cross Sector Project: Mapping Australian Systems of Income Support for People with Health-Related Work Incapacity* (2018)

As above, the financial incentives for authorised agents fail to deliver positive outcomes for all injured workers, but particularly for those with complex claims (encompassing the definition of complex claims above at question 3), and instead result in harm and further injury.

Part of the issue is that employers have the choice of agent. This creates a strong financial incentive for authorised agents to meet the needs of their client, the employer, rather than looking objectively at the injured worker's required level of care. It undermines the no-fault system by placing employers at a greater advantage, which in turn implies the worker is 'at fault' if a quick return to work is not possible.

Another part of the issue is that agents are incentivised to prolong the dispute as they are reimbursed for costs. UA has assisted many workers who have had to appeal decisions of agents at ACCS multiple times and whose claims have been delayed with no real purpose, other than to wear the injured worker down and make them abandon their claim.

> *Susan was injured in [redacted] 1989. She has submitted many appeals over her WorkCover claim with the majority resolving before conference. Each conference is stressful and difficult for her. Most recently, her appeal included very reasonable requests, such as medication to improve her bone density, an appointment to an endocrinologist, and a customised seat. Many of Susan's requests are to keep her as mobile as possible and maintain her independence. It is only after frequent submissions that she receives anything her treaters' request.*

This, in addition to the financial rewards authorised agents receive to keep costs down, results in perverse outcomes. These publicly funded financial rewards are eroding the purpose of a public system, established to support and rehabilitate injured workers.

Recommendation 10: remove authorised agents entirely from the WorkCover scheme and bring the system back into public hands.

Failing this, VTHC makes the following secondary recommendations:

> *Recommendation 10 (i): remove authorised agents entirely from the management of complex claims as defined above, and have these claims managed in the public system.*
>
> *Recommendation 10 (ii): separate entities should make decisions regarding the care and costs of injured workers, and the cost of the overall insurance scheme.*
>
> *Recommendation 10 (iii): penalties be introduced where agents are found to acting against the best interests of injured workers. This may result from complaints raised or negative*

satisfaction ratings. Patterns of such behaviour should result in the agent having their ability to act as an authorised agent revoked.

Recommendation 10 (iv): financial incentives for removing people from the system, no matter what stage their claim is at, be abandoned.

12. Describe any non-financial mechanisms by which agents could be encouraged to promote quality decision making.

A key issue that must be addressed is that the WorkCover system is structured so that agents can gain financially. This results in disadvantage to injured workers. In addition to removing financial incentives, non-financial mechanisms must be established for the purpose of increasing the power of injured workers within the system.

Victorian unions are critical of the role WorkSafe plays in regulating its agents. The 'health checks' referenced in the Discussion Paper do not address the overall root cause of the poor treatment of injured workers. The Ombudsman's 2016 and 2019 reports also focus heavily on the lack of oversight by WorkSafe. This needs to be rectified urgently.

VTHC strongly encourages the Independent Review to adopt a model where authorised agents are removed from the WorkCover scheme entirely.

A public entity should be established to act as an umbrella entity with three arms:

1. The first arm should be responsible for making decisions about injured workers' claims and case managing their claims. Their purpose should be to provide workers with best practice support and rehabilitation, prioritising a timely and appropriate return to work.
2. The second arm should be established for the purpose of reviewing complaints generated from the first arm, including disputes and internal appeal processes.
3. The last arm should assess the overall viability of the scheme, including its financial stability and sustainability, and broader public accountability functions of the scheme.

Victorian unions believe with expansion, WorkSafe could adopt these responsibilities and administer the scheme effectively, with the three arms operating with insulation walls so there can be effective separation. Importantly in this model, there is no role for authorised agents.

No injured worker should miss out on care because of an accounting ledger. WorkCover must be funded to meet the medical needs of injured workers. Funding must be associated with demonstrated need rather than experimenting with how little cost can be associated with the scheme.

Recommendation 11: case management of injured workers' compensation claims be returned to the remit of a public body, which centres best practice and the wellbeing of injured workers.

Recommendation 12: a separate public entity be established and be responsible for financial management of the workers' compensation scheme.

Recommendation 13: a third, related public entity, have regulatory, investigative and complaint handling powers. It should also have the power to compel the case management or financial management bodies to undertake certain actions.

Failing this, managing the claims of injured workers with complex claims must not be undertaken by private insurers. It is of utmost importance that there are no financial rewards for removing claims from the system by the 130 week mark.

13. Are WorkSafe's processes for overseeing agents' management of claims achieving prompt, effective and proactive outcomes for injured workers?

No. See above at 12.

14. Do the new mechanisms implemented by WorkSafe in response to the Ombudsman's 2019 report address any limitations in WorkSafe's oversight of agent decision making?

Mostly no - see below.

15. If your answer to question 14 is yes, describe how.

The Workers Compensation Independent Review Service (WCIRS) is the only new mechanism that UA or affiliated unions have had any positive interaction with. It has introduced some oversight for injured workers where they have been subjected to poor decision making by agents.

While the service has not been in existence for long enough to give a thorough assessment, so far it has played a positive role. For example, previously injured workers needed to go to Court to challenge a decision after a Certificate of Genuine Dispute was issued, and this was a significant financial and psychological barrier. In the financial year 2018/2019 under 20% of matters where a genuine dispute certificate was issued proceeded to Court.[11] This fact is well understood by authorised agents who have used it to pressure injured workers to accept subpar compromises at conciliation. The introduction of WCIRS has made challenging these decisions more accessible for injured workers by giving them a low cost and quick avenue to review to have their dispute reviewed.

[11] Internal Data from Worksafe - 887 GDs issued and 177 matters lodged at Court.

However there are 40 self-insurers who represent approximately 8% of the Victorian WorkCover scheme based on remuneration. Injured workers employed by these self-insurers do not have access to internal review with WCIRS, an anomaly requiring statutory reform to rectify.

16. If your answer to question 14 is no, describe why not.

As described above, the oversight needs to be drastically increased. A system that is set up which allows substantial financial gain to private insurers cannot function to make decisions in the best interest of the injured worker, no matter the oversight mechanisms.

17. How could any limitations in WorkSafe's oversight of agent decision making be overcome?

As explained above, the profit motive driving private insurers results in harmful outcomes to injured workers. Resolving injured workers' claims in their best interest by providing the appropriate rehabilitation and treatment must be the primary purpose of the WorkCover system. However, this cannot be the case where a profit motive exists. Removing private insurers from the scheme is fundamental to ensuring better outcomes for injured workers.

Oversight within the WorkCover scheme is lacking. In most instances, WorkSafe only intervenes in cases that have been managed poorly or unfairly once it reaches conciliation. For this to occur, an injured worker has to challenge the decision and have the resolution to prosecute their case. Many injured workers do not have the mental fortitude because overall the system is so demoralising and they are already in a vulnerable state. Instead they simply accept poor decisions. Decisions made by authorised agents should be sound, yet instead the injured worker often has to bring a dispute to try and access even the most basic of treatment.

It should be uncontroversial that agents should be making the right decisions about the well-being and rehabilitation of injured workers, and failing that, rectification should be timely and overseen by WorkSafe. While conciliation and arbitration is a form of oversight, it should not be the only mechanism relied upon, as it fails to account for injured workers who live week to week in reliance of their claim.

> [redacted], *an electrician with* [redacted], *was struggling with his modified duties but told to stay at work 'because that's what your agent wants you to do'. His pain had become significant and prior to reaching 130 weeks, he was deteriorating mentally, even though his claim was based on physical injury. He currently has no capacity and up until recently the agent was demanding he apply for five jobs each week. This was having a marked effect on his mental state and Union Assist advised him to ask his treaters to suspend the job seeking services.*

There is also concern that the claims manual, written by WorkSafe, does not accurately reflect the objectives of its governing legislation. It instead favours authorised agents' current behaviour, in line with their profit objective. This makes it extremely difficult for an injured worker at conciliation, to explain why they have been treated unfairly. The claims manual must be re-written to reflect a purpose that is about care, rehabilitation and returning injured workers to work at an appropriate time.

Recommendation 14: rewrite the claims manual guiding authorised agents and their management of injured workers' claims.

18. To what extent do current measurements of outcomes for injured workers, including return to work rates and worker surveys, accurately measure whether the agent model achieves prompt, effective and proactive outcomes for injured workers?

Affiliated unions have reported that workers' surveys are biased towards those with good English and communication skills, who are knowledgeable about insurance, and workers who understand the WorkCover process in general. Unions also report that surveys are being gamed, as they are only sent to workers that agents know had positive outcomes and a return to work. The dispute resolution rate for Victoria for the period 2018-19 was 9.3%, compared to the national average of 5%.[12]

> *Susan, a manufacturing worker has received a 130-week termination. However, on her union's advice she submitted an 'over the course of employment claim' which was accepted. She will head to court or the Medical Panel for the 130-week termination whilst she continues to have liability accepted for the same injury ongoing but considered a different claim. She accepted the insurance agent and return to work officer's advice to her detriment and now suffers multiple permanent injuries.*

This does not include vulnerable workers who require the support of case management to navigate the system, or workers who have been psychologically impacted by the process and cannot give an adequate assessment, and so these measures are not an adequate reflection of the success of the model.

Current measurements of return to work rates are also flawed. A 2019 study found that almost half of Australian injured workers did not receive a return to work plan, and it questioned whether employers were meeting their obligations.[13]

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[12] Comparative Performance Monitoring Report 21st Edition, published in January 2020 lists Victoria for the year 2018-19

[13] Sheehan, L. et al. (2018) "Factors Associated with Employer Support for Injured Workers During a Workers' Compensation Claim", Journal of Occupational Rehabilitation (2019) 29:718–727

A more realistic reflection of the agent model is whether an injured worker is able to return to work after the 52 week mark. The extent to which this occurs should be the marker for success.

19. Describe any additional or alternative methods of measuring outcomes for injured workers that should be considered?

As outlined above, the key to a WorkCover system that produces effective outcomes for injured workers is one that has no financial incentives and is run by a public agency. This would inherently increase scrutiny and accountability, resulting in outcomes that are measured against the public good and benefit injured workers.

Failing that, alternative methods must incentivise results that ensure better outcomes for injured workers. Agents' commissions and remuneration should be based on satisfaction surveys of workers with complex claims (encompassing the definition of complex claims outlined above at Question 3), rather than whether they can be removed from the scheme.

To ensure the surveys genuinely reflect the handling of a complex claim, they must be amended to be more accessible to injured workers from a variety of backgrounds, and objective. They should be written by and housed at WorkSafe in consultation with unions, so that the agents have no interference with the contents of the surveys or the workers selected to take part.

Recommendation 14: failing bringing workers' compensation back into public hands, agents' commission and remuneration must be based on satisfaction surveys of injured workers.

Recommendation 15: the satisfaction surveys be re-written completely by WorkSafe, with the purpose of being accessible to a range of vulnerable workers and objective so they accurately reflect the standard of care they have received.

20. Does the current agent model achieve prompt, effective and proactive management for injured workers with complex claims?

No.

21. If your answer to question 20 is yes, to the extent you haven't addressed your response in answers to earlier questions, describe how the current agent model achieves prompt, effective and/or proactive management for injured workers with complex claims.

N/A.

22. If your answer to question 20 is no, to the extent you haven't addressed your response in answers to earlier questions, describe

a. **The limitations of the current agent model,**
b. **How the current agent model could be improved to achieve better health and recovery outcomes for injured workers, and/or**
c. **Any alternative models to the current agent model that would be more effective in delivering positive health and recovery outcomes to injured workers.**

In your answer to question 22 b. and c., consider the effect of any change to the current agent model on the financial viability of the scheme.

As stated above, the current agent model is not working. It is failing to care for injured workers. Private insurance corporations are able to turn a substantial profit from this failure.

Another limitation of the current model is the role of independent medical practitioners (IMEs). They play a vital role in claims and their opinion may determine whether a simple claim becomes a complex claim.

An IME can deem that an injury has resolved, thus allowing the agent to terminate a claim, or that the injured worker's capacity is the same as before the injury. In this instance, the injured worker is put in a practical position of having to accept the opinion of the IME, regardless of how they feel their injury has progressed or the opinion of their own treating medical practitioners. If they return to work and their injury is not healed, it is highly likely it will be seriously aggravated to the point where they are in the same position or worse than at the time of the original injury, leading to a further and more complicated claim.

UA has encountered many IMEs who do not spend enough time with injured workers or who do not have an objective understanding of the injury, or approach to the claim and the necessary treatment. It is not unusual that IMEs opinions disagree with the injured workers' treating doctors to the detriment of their claim and their rehabilitation, to the benefit of the insurer.

Injured workers have reported that in many cases IMEs have not been given an accurate job description or list of duties by the agent or self-insurer, and so do not understand the tasks that will be undertaken by the worker and the risk to their injury. In other examples key medical reports are not in the IMEs briefing notes. Consequently, the suffering of injured workers is unfairly prolonged including the physical pain and associated psychological impacts.

A 2018 study found that in Queensland 1% of injured workers continued to need support 104 weeks after their injury, whereas in Victoria, this number was 16%.[14] This study also found that Victoria also had the second highest rate of time off work, after New South Wales, due to mental health injury claims, comprising 25.3% of cases.[15]

The psychological effect of chronic pain and its impact on psychosocial abilities are well known.[16] Where a claim based on physical suffering is unfairly prolonged, damage to mental health often results.

However, if the original, accepted injury does not include psychological injury, authorised agents make it extremely difficult for injured workers to receive treatment. Injured workers have reported many instances where authorised agents have encouraged their psychological practitioner to 'wean and cease' treatment.

In other cases, the agent's behaviour is little short of bullying. They force treating practitioners to agree that an injured worker does not need mental health care, by threatening them with the cessation of invoice payment. Ultimately, the injured worker ends up in the public system with a mental health care plan. This is cost shifting onto the public.

The cost of a mental health impairment that results from a physical injury or is associated with case management, must be borne by the workers' compensation system. Instead injured workers are failing to get the care they need and are having to find it elsewhere.

Again, the failings of the privatised, profit driven system is laid bare. It is injured workers, and their mental health and physical injuries, that suffer. If the system fails entirely to provide the treatment an injured worker needs, the system and its purpose must be questioned.

Recommendation 16: a standardised framework for medical treatment be developed, including evaluation and review be adopted for complex claims which require long-term care.

Recommendation 17: the standardised framework include a much greater emphasis on treating mental injury, either as the foundation of the claim or resulting from the management and ongoing operation of the claim.

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[14] Gray, S. & Collie, A. (2018), "Comparing time off work after work-related mental health conditions across Australian workers' compensation systems: a retrospective cohort study",*Psychiatry, Psychology and Law,* VOL. 25, NO. 5, 675–692

[15] Ibid, p 681

[16] Salazar, A. et. al. (2013) "Undiagnosed mood disorders and sleep disturbance in primary care patients with chronic muscuoskeletal pain" *Pain Medicine,* 14, 1416-1425.

For example, UA has also seen that in many complex claims, the agent or self-insurer will only pay for one component of rehabilitation, such as a gym or pool pass. They will not pay for an accompanied medical practitioner to oversee treatment such as an exercise physiologist or physiotherapist; the crucial component of the rehabilitation. In most cases, the worker's ordinary GP does not have the expertise or training to attempt this review, and the injured worker does not obtain the intended benefit of the gym pass.

> [redacted], *previously a residential care worker, has been self-managing his injury with a swim pass, which is continuously cut off after three months. He seeks conciliation each time, but the agent refuses to consider a swim pass longer than three months, despite the considerably reduced cost of an annual membership. UA continues to assist him at ACCS, but he believes this poor process is contributing to a deterioration of his mental health.*

Agents are willing to spend many times the proposed treatment cost, to dispute through conciliation and review common sense and beneficial interventions.

Recommendation 17: all complex claims and associated treatment plans undergo an occupational therapy review, and plans mandatorily include services that can assist the injured worker to become more independent.

> **As part of the minimum levels of training for claims managers and RTW officers in workplaces, there should also be a minimum complexity of Return to Work Plan design. As much as RTW plans are guided by Certificates of Capacity, they should display more detail than, times and dates for attendance work. Such plans should act as a road map to new skill attainment and work role transition as required.*

23. Are there practices or procedures used by other compensation schemes, in Australia or overseas, that maximise outcomes for injured workers that the Review should examine?

As established, the Victorian WorkCover scheme must be brought back into public hands, with the health and well-being of injured workers as its priority. To meet these aims, the Review should consider the principles of restorative justice.

A restorative justice approach, typically used in criminal law settings, focuses on the harm caused by a crime or other violation, rather than the legal duty itself. It seeks to repair the harm by restoring relations and including those with a stake in the wrongdoing in its resolution. As injured workers have primary needs such as medical treatment as well as needs associated with justice, such as to access information, have their voice heard while maintaining their employment relationships, a restorative justice approach would be most appropriate to handling these claims.[17]

A restorative justice approach to workers compensation would centre the needs of injured workers, while having them direct or be heavily involved in the decision making for their claim. It would

[17] Dedes, P, Winford, S & Polis, M (2017) "Exploring a role for Restorative Justice in Workers'

Compensation", presentation to the Actuaries Institute, 12-14 November 2017, accessed https://www.actuaries.asn.au/Library/Events/%20InjuryDisabilitySchemesSeminar/2017/6dPDavisSWindfordMPolis.pdf

prioritise their relationships, particularly their employment relationships and their access to return to work rights.

Currently, process and meeting financial aims is the focus of the system, leading to an adversarial and unsupportive experience for workers with compensation claims. Instead, injured workers must become the central priority of Victoria's workers' compensation scheme. VTHC understands WorkSafe has access to research that considers a restorative justice approach to workers compensation, but is yet to publish it.

The Transport Accident Commission (TAC) is an example of a model that centres the needs of the injured person, through a public case management system. It is a Victorian Government owned organisation that was established to pay for treatments and benefits for people injured in transport accidents, promote road safety and help Victorians get their lives back on track.[18]

The TAC states it identifies as a social insurer, because its outcomes are about people. They aim to "help those [people] who are injured on the roads to get their lives back on track and live a life of dignity."[19] TAC states clearly in its annual report that its role is about putting the injured person first.[20] This informs much of their case management protocols.

After much research the TAC moved towards a model that centred the needs of the injured people in order to return their lives to normal as the focus. Ultimately, it was found that this approach was not only good for the injured person as it returned them to their life quickly and treated their injuries in line with best practice, but it was successful in minimising the long term liabilities as it meant early intervention meant injuries were contained and treatment costs rarely blew out.[21]

The TAC has what is essentially a triaging approach when an injured person first makes contact. They seek to categorise them as 'rapid recovery', 'independence' and 'supported recovery'.[22] In the case of rapid recovery, injured people almost universally have their treatment approved. These injuries are relatively minor or simple to fix - it may be a case of requiring a handful of physio appointments

[18] TAC Strategy 2020, accessed: https://www.tac.vic.gov.au/__data/assets/pdf_file/0009/192753/TAC_Strategy2020_UPDATE_WEB.pdf

[19] TAC Annual Report 2018-19, accessed: https://www.tac.vic.gov.au/__data/assets/pdf_file/0018/402417/11129_TAC-Annual-Report_WEB-accessible.pdf

[20] Ibid

[21] Sunita Bayyavarapu, Dr Katharine Gibson, Dr Beth Costa & Dr Andrea de Silva, "Primary Care Models of Care - A scoping meta-review: Models of primary care for clients with chronic complex conditions," Evidence Review for TAC, accessed: https://www.tac.vic.gov.au/__data/assets/pdf_file/0019/270226/172_REP_ER_R02-Primary-Care_11052017_final.pdf

[22] TAC Strategy 2020, accessed: https://www.tac.vic.gov.au/__data/assets/pdf_file/0009/192753/TAC_Strategy2020_UPDATE_WEB.pdf

to treat whiplash, or a simple procedure to treat an injury so that their lives can return to normal. In these cases, it is simply a matter of the injured person accessing the treatment and logging it into an app, which links to an automated approval process. This app and automated approval process again reflects an attitude of prioritising the system around the injured person's needs. Approximately 80% of TAC's clients fall into this category.

Those in the independence category make up approximately 1% of claims. These are people who are severely injured and who are unable to recover. These require long-term treatment, provided by the TAC.

The last category is supported recovery and it includes injured people with complex needs, which is analogous to, and informs the definition of, complex claims provided above in Question 3. If, when an injured person first contacts the TAC, they also meet another criteria, such as having a pre-existing mental health condition, unstable accommodation, insecure work or low income, low socio-economic, have a disability or are a migrant community member, they are automatically placed in this category. Here, injured people receive one on one, more dedicated case management, which seeks to extend any services required in addition to ensuring they get the treatment needed.

The TAC model is flexible, and in cases where an injured person is placed into the wrong category, they are often moved into the correct category quickly with little, if any, resistance. As a model, it also separates those who make the broader decisions about the scheme's management and viability, and those who manage the injured persons cases. Case managers do not report on profitability.

Disputes are handled in house, and if a poor decision has been made, it is usually picked up by a review before the injured person needs to raise a complaint. Of course, as a system it is not perfect, but its most recent iteration seems to have struck the right balance by placing the needs of the injured person as its central focus.

VTHC strongly encourages the Review to recommend a model for WorkCover that has a similar structure to the TAC.

The ability of the NDIS to meet the needs of people with disabilities was also considered. While the model itself was championed by disability groups for its focus on participants and their outcomes, it has unfortunately been plagued by funding issues, and issues of expertise.

There is a real delay in the NDIS processing eligibility. There is also a lack of expertise amongst those writing the treatment and care plans for people with significant disabilities. Further, the review processes of NDIS are severely lacking, and there is no real robust external review or accountability mechanism, and as a consequence, there is little internal motivation to make the right decision the first time. These factors, coupled with the lack of funding has resulted in a disconnect between what

the client requires and the work that is undertaken internally by the NDIS. These are lessons that WorkCover would be wise to acknowledge and avoid.

Having said that, these are issues of execution rather than the model itself. Disabled people across Australia advocated for this model as they were desperately seeking choice and control. If instead, a model that allowed private corporations to profit by managing the claims of people with disabilities was adopted, there would have been outcry across the community.

Just as people with disabilities deserve choice and control, people who gain a disability or injury at work also deserve the same choice and control over the management of their claim, and to have a system that is purpose-built for supporting them.

Despite the differences in execution, both the NDIS and TAC have at their core the prioritisation of outcomes that benefit the client. In the Victorian workers' compensation scheme, it is the inverse. Authorised agents have their premiums paid for and are chosen by the employer, and so their obligations are inherently towards the injuring party. It is the only market driven system in operation that does not place its obligations towards the client, and undermines the no-fault system.

The TAC model in particular, but also the NDIS which centre the needs of the client, must form the basis for wholesale structural change of the WorkCover scheme.

24. Have you observed any changes to (i) agent decision making and (ii) the oversight of agents by WorkSafe since the 2016 Ombudsman report? Please describe.

No. The behaviour of agents continues to be unfair, unreasonable, illogical, uncaring and absent of best practice. Many injured workers continue to receive poor and unfair treatment.

25. What are the root causes of the problems identified by the Ombudsman in her 2016 report?

As established above, the major problem with the system, which was identified by the Ombudsman in 2016, is that agents are financially rewarded for removing expensive cases - 'complex cases' - from the system. Injured workers do not deserve to be treated as a tick box for being booted out of a scheme that should be designed to help them. The current system is manifestly unjust.

Many injured workers have reported to UA that they have been actively discouraged from submitting a worker's compensation claim by their employer, GP or sometimes even their family, due to how frustrating and demoralising the system is, and the effects it has on their future employment prospects.

These injured workers end up relying upon the public health system, or in a few cases their private health cover, to pay for medical treatment, and their sick or annual leave to cover time off work.[23] Ultimately, they unfortunately have no other option than to take-up medical resources that should be allocated for the public, and drain their leave entitlements that should be used for rest and recreation. It forces workers to lose in all facets of their working and social life.

For casual workers who are injured at work, they have no sick or annual leave and are inevitably denied access to most practical avenues for time off work for treatment.

> [redacted], *a regional supermarket worker, has an accepted workcover injury and though she was contracted for 15 hours per week has always worked up to 30 hours per week. She has had to use her savings and the public health system as the self-insurer has accepted treatment for one wrist but rejected the injury to the other wrist as work-related.*

The financial incentives rewarding this behaviour need to cease immediately. The WorkCover system must be brought back into the public domain.

Another critical element of the Ombudsman's report is the impact of psychosocial conditions. Claims for psychological injury must be accepted earlier and treated with the same level of seriousness as physical injuries. This would lead to fewer complex claims developing from these conditions.

The Victorian Government has already accepted this reasoning and acted on it in the form of the Provisional Payments Scheme. This scheme assists emergency service workers who have compensation claims to access funds for medical treatment and services mental health injuries while their claim is determined.[24] This approach already recognises that injured workers should not have to wait for treatment, and immediate treatment leads to fewer long term complications.

By implementing the recommendations contained in this submission, the Provisional Payments Scheme would essentially be rolled out across the board to every worker. The need to intervene quickly and treat injured workers early is already accepted. There is no reason to delay prioritising the needs of injured workers and reforming the system. WorkCover must be brought back into public hands, and agents removed from the scheme.

26. Do you think the implementation of the recommendations 3–9 in the 2019 Ombudsman report will address those root causes? If so, how will that occur?

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[23] Insurance Work and Health Group Faculty of Medicine, Nursing and Health Sciences, Final Report: T*he Cross Sector Project: Mapping Australian Systems of Income Support for People with Health-Related Work Incapacity* (2018)

[24] Victorian Government, Provisional Payments Pilot Fact Sheet, accessed https://www.vic.gov.au/sites/default/files/2020-06/Provisional-Payments-Pilot-Fact-Sheet-June20.pdf

No.

27. If you do not think the implementation of recommendations 3–9 in the 2019 Ombudsman report will address those causes, explain why not.

With respect to the important work of the Ombudsman and their investigation into complex claims, the recommendations do not go far enough to address the problem.

The cost of the scheme increases when authorised agents string injured workers along with inadequate treatment that exacerbate the injury which leads to further injury or psychological impacts, and ultimately unnecessarily prolongs the claim period. Then suddenly, the injured worker is kicked off support, expected to go back to work, and is re-injured and having to rely on the scheme again. While the cost from this unscrupulous behaviour is high, that is secondary to the unfair treatment of injured workers. Many injuries could be resolved more quickly and efficiently if the agent model was disbanded.

Any public scheme must be accountable, meet expectations and be sustainable. It is understood that the overall operation of the scheme must be a factor of consideration. However, Victorian unions strongly believe that injured workers and their claims must be managed by best practice with a priority of their rehabilitation and treatment, prior to reaching the 130 week mark. This will greatly impact on whether the worker needs to remain in the scheme at all. The aim of the scheme must not be to generate profit to pay annual dividends and the executive bonuses of insurance executives but to serve the interests of the Victorian workers. A public scheme is by far the best placed to meet this criteria.

There is also a greater need for research into rehabilitation and best health practice, rather than relying on the bullying and harassment of workers that is perpetuated by the WorkCover scheme. Further training for those administering the scheme is also desperately needed. Presently, a return to work officer only requires one day of training, but they can be the main reason why a worker does not make a successful return to work.

> [redacted], *a cleaner with over twenty years experience at* [redacted], *has attended ACCS on numerous occasions as her agent disputes her significant injuries, their psychological impact and refuses to pay for straightforward medical expenses. Unfortunately, because of delayed responses by the agent her conditions have become permanent which will result in an increased impairment claim and resulting greater amount for pain and suffering. If the return to work officer had worked with her in the first place her injuries may not have developed to their current extent. She may never work again.*

Recommendation 18: an approach that is best practice health be adopted for the WorkCover scheme, including funding established for the purposes of rehabilitation research and evaluation.

Recommendation 19: greater and more comprehensive training of agents, self-insurers and return to work staff.

28. Are there any other matters the Review should consider in meeting the Terms of Reference?

Importantly, the whole WorkCover system needs holistic change. Its structure disadvantages injured workers. Additionally, there are four matters the Review should also consider: self-insurers, surveillance, reasonable management action in a reasonable manner, and smaller claims.

Self Insurers

Victorian unions have identified a significant gap in WorkSafe's oversight; that of self-insurers. Self insurance schemes were established for large employers to be able to manage and bear costs for their own workers' compensation schemes. The stated purpose of self insurance schemes are to improve OHS, increase the likelihood of workers returning to work, and ensure workers are treated fair and equitably.[25]

However affiliated unions have reported self-insurers are increasingly gaming the system by outsourcing their insurance obligations back to insurance agents, who are often one of the five authorised agents acting directly on behalf of WorkSafe. Unions report that, amongst others, Woolworths subcontracts to EML, as does Food Investments Pty Ltd, and the Municipal Association of Victoria subcontracts to JLT.
Self-insurers are not subjected to the same rules and obligations as the five agents, and affiliated unions report that they are significantly more difficult to deal with when advocating for the rights of injured workers. Self-insurers use their position as both the employer and insurer to leverage outcomes that favour the employer and disadvantage the injured worker.

For example, at conciliation self-insurers often make offers contingent upon the injured worker resigning from their employment, effectively absolving the employer of their obligation to find suitable, alternative employment up to and beyond the 52 week mark. Comparatively, it is rare for authorised agents to conflate the issue of ongoing employment with resolving the claim.

Self-insurers also rarely settle a claim without medical and like expenses being finalised, even in cases where these expenses do not form the main issue in dispute. This results in increasing the settlement

[25] https://www.worksafe.vic.gov.au/whats-self-insurance

time as medical expenses may remain unresolved for years. Again comparatively, authorised agents do not commonly withhold resolution of settlement on the finalisation of medical expenses.

Where injured workers are covered by the same agent through self-insurance as those under the public scheme, they are being subjected to poor treatment with limited access to recourse. For example, these workers do not have rights to review at Workers Compensation Independent Review Service.

These self-insurance schemes ultimately disadvantage the injured workers they cover by virtue of their employer, and results in their diminished access to compensation and entitlements. These tactics displace the cost of workplace injuries from the employer and onto the individual and the social safety net.

This is a huge oversight.

Recommendation 20 (i): self-insurance schemes must be phased out. All Victorian workers should be covered by the same system.

Recommendation 20 (ii): in the alternative, regulation of self-insurance schemes must increase to ensure they cannot contract out their insurance obligations. Where self-insurers no longer wish to manage their own claims, they must default back to the public scheme.

Recommendation 21: appeal and complaints processes and obligations must be extended to self insurers.

<u>Surveillance</u>

The Review should also consider the issue of the surveillance of injured workers undertaken by the authorised agents. The very notion of an injured worker being surveilled reinforces the idea that they are to blame for their injury and that they do not deserve treatment or compensation.

Its existence is the antithesis of a no-fault system which should be about care and rehabilitation. The reliance on extremely expensive surveillance, often costing between $4,000 - $5,000, is further called into question when considering that treatment plans are often inadequate and IMEs are not given adequate information about the worker when forming an opinion in pursuit of 'cost minimisation'.

The information a private investigator needs to obtain could very well be gained by consulting with the injured worker genuinely about what they need, and then carrying out their treatment plan with the proper resources.

The so-called aim of financial consistency is disingenuous considering the willingness of agents to use expensive private investigators for surveillance, yet terminate 'complex claims' due to the so-called cost on the system.

The over-reliance of surveillance is inappropriate and blames injured workers for accessing the compensation and treatment they deserve. Its use must be curtailed substantially.

If it is to remain as part of the WorkCover system, agents' use of surveillance mechanisms must be overseen with rigorous and expanded compliance measures. The agent should have to apply to an independent body that is part of WorkSafe to use surveillance. To be successful in their application, they must be able to meet a high bar and demonstrate a genuine suspicion that some form of fraud is occurring, and this can only be verified by surveillance and not some other form of investigation. The independent body should have the power to authorise or deny the use of surveillance, and where it is approved, it should be recorded and regularly reviewed.

Recommendation 23: the over-reliance on surveillance must be substantially curtailed. Agents must apply to an independent body and meet a test that is set at a high bar to demonstrate surveillance is needed on a genuine suspicion of fraud.

Reasonable management action in a reasonable manner

The Review should also consider the impact of section 40 of the *Workplace Injury Rehabilitation and Compensation Act (Vic)* 2013. The operation of this section has the dual effect of undermining the status of psychological injuries as compared to physical injuries, as well as undermining the no fault system. Workers who were injured through a process of undue disciplinary action or where a supervisor has bullied or harassed the worker, can have their claim nullified where managers claim they were acting in a reasonable manner. This is extremely unfair and damaging to the injured worker.

Recommendation 24: repeal s 40 of the Workplace Injury Rehabilitation and Compensation Act (Vic) *2013.*

Small Claims

Lastly, the Review should consider why low cost appliances such as aids that can contribute to a injured worker's independence and improve their quality of life are routinely rejected. UA has found no justification for this practice, yet note it occurs far too regularly and costs the scheme in terms of hours spent fighting the decision far more than the cost of the aid sought.

Recommendation 25: aids and appliances should form a mandatory consideration for treatment plans.

Conclusion

Thank you again for the opportunity to make a submission to this important review. HACSU and Injured Workers are encouraged with this significant first step in marking a turning point and that injured workers may finally access the treatment and be treated with the humanity and dignity they deserve.

If you have any questions please do not hesitate to contact myself at [redacted]@hacsu.asn.au or on [redacted]

Kind regards,

Paul Healey
State Secretary,
HACSU Vic No.2
Branch