Women's Experience of the Workers Compensation System

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Abstract

A phenomenological study was undertaken to understand women's experience of the workers compensation system. Eleven women were interviewed. They ranged in age from twenty-five to sixty-five years and represented diverse socio-economic and educational backgrounds. All women were from a non-indigenous background. The initial question to women was "Can you tell me what it is like to be involved in the workers' compensation system?" The narratives were analysed and interpreted using Hycner's (1985) phenomenological guidelines.

The knowledge embedded in the interviews, expressed through core stories and themes, was essential to making women's voices visible and provide insight into service delivery based on women's experiences and needs. Four core themes were found: negative versus positive experiences, the workplace response and role in the process, women's experiences of payouts, and reasons why women may not claim workers' compensation. The women indicated that the workers compensation process was a disincentive to making a claim. WorkCover was viewed as siding with the employer, bureaucratic in nature and lacking values associated with empathy, sympathy and caring.

Recommendations for improvements to the workers compensation system included to establish legal obligations and enforcement of occupational health and safety responsibilities to injured and to ill workers; adoption of occupational health and safety values by employers; change the attitudes of employers (recognising women as breadwinners and that workers are not disposable); a single case manager to advocate for injured or ill workers; recognition of mental and emotional consequences of an injury or illness; provision of rehabilitation that recognises mental and emotional factors as well as the importance of family participation; greater involvement of employers and employees in the rehabilitation process; and finally, improved service delivery that involves consistency, ethics, clarity (regarding the WorkCover process for injured workers and employers), accountability and involvement of all parties.

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Introduction

Published literature revealed that not only has occupational health and safety issues for women been neglected but studies of workers' compensation and workplace injuries and diseases have largely ignored women's experiences (Bale 1989; Cameron 1994; Cooper & Faulks 1999; Quinlan 1996; and Shackelford, Farley, & Vines 1998). A research study was completed in 2003 to seek to help redress this problem by focusing on women's experiences with the workers' compensation system. In addition to highlighting women's experiences, the research aimed to assist in making women visible to service providers, policy makers and the wider community.

In Queensland, Australia the workers compensation system began in 1916. It was not until 1996 that the Kennedy Inquiry brought about the first comprehensive look at this system. The impetus for this inquiry was due to the workers' compensation system being in the red for two hundred and ninety million dollars (Kennedy, 1996). The major response to the inquiry was the introduction of the WorkCover Act 1996 and the tightening of the eligibility criteria. Examples of reductions in the availability of financial support to claimants included: The definition of a worker was narrowed to exclude non-PAYE employees (PAYE tax payers are those whose employer deducts PAYE tax from the amount paid under the Commonwealth Income Tax Assessment Act 1936) and journey claims were downscaled. This alone was estimated to save thirteen million dollars per year. Kennedy did recommend that negligent employers be made responsible for injuries (in terms of payments) and recommended an increase in the lump sum payment from one hundred thousand dollars to one hundred and thirty thousand dollars.

The Legal and Accounting Management Seminars (1997) adopted the view that this narrowing of definitions was used to reduce the number of people who could claim workers' compensation. Glaser and Laster (1990) supported this view when they declared that individual worker's are scapegoats for the costs and rorts of the workers compensation scheme. The cost saving strategies throw into question whether reasonable levels of benefits for injured/ill workers can be maintained at the same time. To some degree this is also dependent upon what one believes the workers compensation role is.

WorkCover provides financial support for injured workers (such as medical and treatment costs, hospitalization costs, traveling expenses and weekly compensation payments), lump sum payments for permanently injured workers, insurance for employers, oversees employers who self-insure and observes the 1997 Regulations for the WorkCover Act of 1996. Although WorkCover is the organisational body within Queensland it also operates within the workers compensation system or processes. This system includes such factors as the legislative framework, the organisation (WorkCover), the employees and agents of the organisation, and the processes established by the legislation (as interpreted by WorkCover).

Inherent within the workers compensation system is values and assumptions. WorkCover is not a neutral institution. Under the Queensland system workers receive eighty-five percent of their normal weekly earnings for the first twenty-six weeks. After this time the rate decreases. Why are individual's compensated at a lower rate? The Industry Commission (1994) indicates that compensation is less than pre-injury earnings to provide an incentive for workers to return to work, to encourage rehabilitation and to encourage workers to behave in a safety conscious way at work. These assumptions demonstrate the belief that workers are responsible and in control of workplace accidents (rather than employers). WorkCover presupposes that individuals will eventually return to work. It acts as a safety net until such time as individuals can either resume work or pass onto welfare benefits. It does not cope well with individuals with permanent, long-term or multiple disabilities/illness.

Other Australian States are being asked to consider adopting for their Workers Compensation management the Queensland WorkCover Model (Flint, 2004). On the topic of workers compensation systems the Employment and Consumer Protection Minister in the Western Australian State Government is quoted as saying "the Queensland System was certainly one of the better, if not the best system in Australia" (Flint, 2004: 29). This consideration makes the findings of this research about women's experience of the workers compensation system in Queensland very valuable.

A literature search revealed a multitude of studies that focused on reducing the costs associated with workers compensation. Sass (1999) states that "In an economic society, what dominates our thinking about occupational health and safety is workers' compensation. Today, occupational health and safety is driven by workers' compensation costs rather than by prevention" (p.130).

This desire to reduce costs has shaped the focus of the existing literature and research. However, the following three topics (Prediction of return to work, Rehabilitation and Women and workers' compensation) include views that may differ from the traditional cost saving focus.

Prediction of return to work

Research indicates that women are less likely to return to work than men, blue collar workers are less likely to return to work compared to white collar workers, and age and receipt of workers' compensation affect return to work returns negatively (Camona, Faucett, Blac, and Yelin, 1998; Crook, Moldofsky, and Shannon, 1998; Gluck and Olieinick, 1988; and Kenny, 1994). Studies that focused on patients' recovery from specific conditions found workers' compensation directly affected patient's recovery in a negative way. For example the workers' compensation process resulted in a decrease in coping, an increase in perceived pain and lowered perceived mobility (Katz et. al 1998; Mont, Mayerson, Krackow, & Hungerford 1998; and Parker, Murrell, Boden, & Horton 1996).

Further research has found that the workers compensation process acts as a disincentive to claims. Stewart (1994) discovered that workers compensation failed to cover some injuries, there were delays and even illegally terminated payments (Blackett-Smith & Rubinstein 1985) and the adversarial nature of workers compensation was found to lead to a loss of personal identity and status for injured workers (Keaney 1998). Unfortunately, the above research looks at the effects of the workers compensation system on individuals but there is a failure to describe the actual workers' compensation 'process' that creates these outcomes. The present research attempts to address this issue.

Rehabilitation

There is a great deal of research that illustrates the benefits of rehabilitation. The predominant service delivery model is the medical model, whereby rehabilitation is based on clinical predictions of recovery time based on types of diagnoses. The problem with this research is that it fails to acknowledge the role of psychosocial and behavioural factors on work disability (Clarke, 1998). According to Legal and Accounting Management Seminars (1997) the incentive to provide rehabilitation is related to a quick return to work by employees, which in turn leads to the cessation of benefits, minimisation of claims and ultimately the reduction of premiums.

The literature reveals that there is some debate over the reasoning behind rehabilitation and the types of services provided. However under WorkCover Queensland Act 1996 rehabilitation is a compulsory condition for workers' to receive benefits and employers are legislatively required to take reasonable steps to provide rehabilitation. Unfortunately there is no clarification as to what constitutes reasonable steps.

Research that has focused on rehabilitation service delivery has found that light duties were not made available for most workers, there were no incidences of modifications of the work place and work hazards were often not removed or changed (Casey and Charlesworth, 1984). The question is what are women's experiences of rehabilitation? The few studies that have been undertaken (Clapham, 1994, Quinlan, 1996) have focused on women's access to rehabilitation.

Clapham (1994) and Quinlan (1996) both found women have less access to rehabilitation than men do. Clapham revealed that women from non-English speaking backgrounds did not receive rehabilitation because rehabilitation provider felt that it was less cost-effective to provide services to these women due to cultural differences and language difficulties. Quinlan (1996) found that lack of access to rehabilitation was due to a lack of transport and family commitments. The third and final section looks at research that has focused on women and workers compensation.

Women and workers compensation

Women, the research revealed, were less likely to use and receive workers' compensation. Quinlan (1996) found that although women make up

forty percent of the workforce they only represent twenty-seven percent of compensation claimants. Stewart & Doyle (1988) disclose that female migrant workers were almost six times as likely as Anglo-Saxon men to have their claims rejected. Furthermore, Blackett-Smith & Rubinstein (1985) discovered that women received significantly less compensation than men did. In terms of money the median received for women was $15,000 compared to $25,000 for men. Two-thirds of women received less than $20,000 compared to only one-third of men. It is critical to note that the researchers controlled for type of injury, dependents and unskilled workers and concluded that men still received more compensation than women did.

Lippel (1995) looked at whether women had fewer claims than men did. It was found that women claimants were less likely to succeed before review boards that were predominantly composed of male decision-makers. Furthermore they found that women Type A personalities were denied compensation compared to male Type A personalities and that personal difficulties have a positive effect for male claimants but a negative effect for female claimants (Lippel, 1995).

O'Donnell and Hall (1988) indicate that women may be less likely to claim or be granted compensation because of the lack of credibility given to them by doctors and insurance personnel as well as the long-term nature of women's occupational illness/disease. These findings allude to the underlying values and beliefs held by institutions. Acker (1992) uses the term 'gendered institutions'. This is where "gender is present in the processes, practices, images, and ideologies and distributions of power in the various sectors of social life" (Acker, 1992: 567). This theory can be demonstrated by Casey & Charlesworth (1984) findings that male workers were able to claim additional benefits for dependents (such as spouse and children) whereas females had to prove that they were the sole providers in order to receive the same entitlements. Graycar (1985) showed that women were unable to claim for loss of domestic working capacity yet men were able to claim it as a secondary loss. The implication for women is that "Under compensation and benefit exclusion add up to greater personal cost burdens for women as a result of employment injuries" (Stewart & Doyle 1988: 16). Furthermore, this research generates the following questions: Do women perceive any discrimination? If so, how is this presented?

Sass (1999) indicates that over time, the initial language expressed by workers about their working conditions has been lost in the social ideas, publications and models developed by academics and occupational health experts. This loss has been particularly paramount for women as ideologies and power structures are dominated by patriarchal realities. This research was in part generated by the need to better understand female realities of workers compensation and the actual process as described and experienced by women. It is hoped that by providing a platform for the establishment of female realities of workers compensation a dialogue will open up between women consumers and service providers of workers compensation. The greater the visibility of women – the harder it is to ignore them.

Research Methodology

In order to develop an understanding of the experience of women using the workers compensation system, a phenomenological research approach was used. "The purpose of phenomenological reflection is to try to grasp the essential meaning of something. Insight into the essence of a phenomenon involves a process of reflectively appropriating, of clarifying, and of making explicit the structure of meaning of the lived experience" (Van Manen, 1990: 77-78).

Approval was granted by Edith Cowan University's Ethics Committee to conduct this research. An advertisement was placed in a Queensland newspaper asking for women who had claimed workers compensation to contact the researcher to be part of a research study into the workers compensation system. This method of selecting subjects may have biased the results as only women who were willing to talk about their experiences were part of this research study. Agreement to participate and a signed consent form were obtained from all research participants prior to their interview. All participants were given a pseudonym and identifying names were removed from historical documents and transcripts. Participants were told that they were being asked to describe their experience of the workers compensation system.

Eleven women, ranging in age from twenty-five to sixty-five, were asked the following central question in an open-ended interview: Can you tell me what it is like to be involved in the workers' compensation system? All of the initial interviews were taped and the researcher took notes. Depending upon the participant's responses, initial interviews lasted from one hour to three hours in length. Interviews ended when participants requested it or saturation had occurred (saturation was indicated by the repetition of information and no new information was given). Of the eleven participants, ten provided the researcher with historical documents. These included diaries, letters to and from WorkCover, doctors and medical specialists reports, tribunal documents, grievances and communications from their workplaces.

In the second interview, transcriptions of interviews were returned for verification to ensure internal validity and the reliability of the information obtained. A summary page of the data was utilised by the researcher to check for accuracy, to clear up any misperceptions and to complete any missing data. The third and final interview was dedicated to discussing the draft copy of each participant's story. This was carried out either in person or over the telephone. Interview data and documentation were analysed using Hycner's (1985) phenomenological guidelines. Themes were identified, categories developed, links and emerging patterns elaborated. Cases were compared for both general and unique themes from the context in which they emerged.

Research Findings

From the women's experiences six themes were developed. Each theme is presented under its own heading and direct quotes from the women are used to highlight particular issues. In theme one, four women's experiences are defined

as positive. Factors (or sub themes) include medical experiences, WorkCover personnel and workplace support. Theme two identified seven women's negative experiences of the workers compensation process. Subthemes identified are the bureaucratic nature of WorkCover, WorkCover personnel, experiences of doctors and specialists and the adversarial nature of WorkCover. In theme three the aim was to compare these two experiences and to ask – What makes these different? The remaining three themes look at the response and role of the workplace, reasons why women may not claim workers compensation and finally the women's experience of payouts.

The overriding theme that emerged from the data was the positive versus negative nature of the women's experiences of the workers compensation process. In particular, how were these opposing processes experienced by participants and in what way did they differ?

Theme One: Positive Experiences

Four women expressed their experience of the workers compensation process in positive terms. For example, one woman stated:

> It was a good experience in comparison to what you hear some people saying. If I wanted something I rang them up and it was done – it was no hassles. It was good. There was never really a time that I was disappointed with the system.

Another stated:

> There was no problem with WorkCover. They were supportive of me.

There were two women, although their experiences were predominantly negative, who acknowledged that the availability of WorkCover provided them with an opportunity to heal. One woman stated:

> I was highly suicidal, and WorkCover really enabled me to be able to take the time off I need to get better, without the added stress of financial concerns.

Another talked about the positive aspect created by delays in the processing of her claim due to her challenging the investigator's findings:

> And in hindsight if things weren't as drawn out as much as what they were, I would still be in a mess I'd say. It gave me time to get better. Or a little bit better.

The data reveals three factors that contribute to these positive experiences. The first relates to medical factors. Women described their ability to determine their own medical personnel as a positive contribution to their experiences as well as prompt arrangement of medical services (such as surgery) and payment to specialists (for example physiotherapist, occupational therapist). This was facilitated via good communication between all parties and having one case manager throughout the duration of the claims process.

The second factor is the positive description of WorkCover personnel (such as case managers). Demonstrated characteristics of politeness, empathy, sympathy and support from WorkCover employees were identified by the participants. However two women noted that female WorkCover employees were nurturing and sympathetic as opposed to male employees who tended to be rude and controlling. One woman stated:

> The male whom I did make contact, left a lot to be desired for the role in which he was employed. The thought of speaking with him would leave me feeling intimidated, insulted, abused and violated… The women handling the case were very supportive. I did find the females more supportive and empathetic. I felt it was a huge gender polarisation, generally speaking.

The third and final area that assisted in providing women with a positive experience of WorkCover was the presence of support from their workplace. This was demonstrated by the maintenance of contact between injured workers and their workplaces, the provision of information, support from workplace personnel (for example a supervisor), organisation and provision of services (such as seeing a psychologist) and assistance with the compensation process (such as filling out forms).

Theme Two: Negative Experiences

Seven women described their experiences of the workers compensation process in negative terms. In one narrative a woman uses descriptive words to express "the biggest nightmare" of her life – WorkCover:

> The words which come to mind when I think of WorkCover are – Obstructive, destructive, bullies, hostile, uncooperative, antagonistic, grandiose, dictatorial, authoritative, fractionalised, unprofessional, egotistical, ill-prepared, poorly educated or prepared for the position, unsympathetic, unobjective, and blatant sympathisers of the employer.

The four main factors that contribute to the women's negative experiences are the bureaucratic nature of WorkCover, WorkCover personnel, experiences of doctors and specialists and the adversarial nature of WorkCover. Each of these sub themes / factors is discussed.

1. The bureaucratic nature of WorkCover

Women reported some degree of frustration in the process of claiming workers compensation due to bureaucratic red tape, delays in payments, lack of information and a lack of co-ordination of services. It should be noted that this was not limited to the seven women but was expressed by all (eleven) of the participant's. One participant stated:

> But I had to keep ringing up the whole time because WorkCover is just too slow. It took four to six weeks before they sent you your first money. But you're ringing up and they're saying "Oh this department's

> handling it" or "You've got to get in touch with them"… I had that much stress.

Another woman stated:

> In an effort to make the processing of my claim more efficient I asked WorkCover what my next step would be or what I needed for further WorkCover needs. I was often told to leave it and 'all would be revealed' approach. Then when I would submit my next claim, I would be informed that it was not valid or couldn't be processed under normal practices because I had neglected, omitted or forgotten to include relevant documentation. This was after I had requested what was needed for the next stage. It was a constant struggle and battle to try and comply with the next stage before it occurred. The process appeared to be deliberately made difficult with obstacles. WorkCover were obstructive. Their attitude was 'how dare you ask us for information'.

Stewart (1994) investigated the personal costs of occupational injuries on workers and found that not only was income support inadequate but many individuals were in debt. The women in the present study indicated those delays in payments meant bills, rent and mortgages went unpaid. Some women were scared and worried as they are the primary income earners for their family. One woman stated:

> I was forever fighting to get fortnightly payments. WorkCover's attitude was if you want five cents, prove it. Payments were always delayed. I was the breadwinner of the family and we had no income. It wasn't a game. I was scared to go to the bank. I couldn't make any payments and I was scared they would foreclose on my home. There were delays in payments, part payments, for all sorts of weird and wonderful reasons.

Casey & Charlesworth (1984: 31) were scathing when they stated that delays and stops in payments by insurance companies (such as WorkCover) are practices "so common it would appear to be a deliberate policy on the part of many insurance companies."

2. WorkCover personnel

Women expressed concerns about the lack of neutrality of WorkCover personnel. They felt that WorkCover was siding with the employer to not only discredit them but in some cases to make the process so difficult that they would drop out of the workers compensation system. One woman described a meeting between herself, a representative of her employer and a WorkCover staff member to discuss her re-entry back to work:

> At the end of the meeting I was left speaking to the person from WorkCover. I felt quite intimidated with what she was saying. Which was that if I did not get better or I was unable to do the work that I had been doing, that my employer would leave me out in the cold.

> They had no responsibility to help me, or if I had to transfer I would not automatically be in line for one and that I would have to stay at this job even if it meant I could hurt myself more… I didn't expect that. That was a shock. My workplace wasn't supportive. It was as though the whole thing was preplanned...

The women in this study also expressed concerns with regard to the lack of training and inadequate staffing levels at WorkCover. One woman stated:

> However there appeared to be significant staff turnover numbers and I never knew just who was my case manager whenever I rang up because they changed so regularly and without negotiation or notice. It was a constant case of repeating my story over and over again to each and every new manager because on many occasions they hadn't had time to read my file or were new to the position and at times didn't seem to care one way or the other if I had a file or not, or my case manager was unavailable for me to speak with.

Casey & Charlesworth's (1984) study of workers' compensation settlements for Liquor Trade Union members found that there was inadequate training and staffing levels with regard to workers' compensation service delivery. The Industry Commission (1994) acknowledged that governments often try to create low-benefit, low-cost workers compensation schemes to attract business to their state and that often leads to poorer services.

3. Women's experiences of doctors and specialists

Experiences were identified as negative due to a lack of competent and fair treatment, excessive charges for services, a failure to look at the individual's work environment and job tasks, dissatisfaction with investigations and conflicting findings. One woman stated:

> But the way people spoke to you and the body language of so called doctors. It was just so degrading in some ways. I used to sometimes go out of the doctors and cry. They never even listened to you. They never even wanted to know. This is the so-called professionals, not so much my medical practitioner. The specialists pissed me off.

Blackmur, Fingleton & Akers (1992) noted that women tend to be under more scrutiny by doctors with regard to their illness or injury. Moreover, Casey & Charlesworth (1984) found that claimants received insensitive and rough handling by doctors requested by the insurance company to carry out medical examinations.

The Industry Commission (1994) also found that there was a lack of knowledge and training for doctors with regard to occupational injuries and/or illness and doctors were required to judge a worker's ability to perform certain tasks at work. Burry's (1990) medical perspective acknowledged that doctors have to act as decision-makers, often on social decisions and with a lack of training with regard to industrial accidents and rehabilitation issues.

WorkCover (1997a: 2) state that "In some instances the treating medical practitioner may need to visit the workplace to assess the work tasks." This poses a logistical nightmare for doctors. Without the implementation of resources and the time needed to carry out such tasks doctors are forced to make decisions based on workplace observations. This was supported by the women's experiences where no doctor carried out a workplace visit. WorkCover (1996) acknowledge that workers compensation claims management is a team process. Thus doctors are able to request an assessment by a suitably experienced occupational therapist or physiotherapist. Only two women discussed meeting with their workplace representatives (such as occupational health and safety officers), at their request. The women in this study indicated that not only does the team continually change but also they were often unaware who constituted their team.

Three women expressed their concern with regard to excessive charges for services. For example one woman stated:

> One thing that did surprise me was the price, the fees that the physiotherapist charged. For the money that they charged, I think it was overvalued for the service I received. I felt I needed massage more. The physiotherapy put me back [in terms of aggravating the injury].

This quote expresses the sentiments of the other two women with respect to their inability to determine what intervention would best suit their recovery. The Industry Commissions (1994) report into workers compensation in Australia found that medical practitioners and hospitals not only over service workers compensation patients but they also charge higher fees. Moreover, Cooper & Faulks (1999: 3) state "We are constantly coming up against the grim face of self-interest. There now exists a legion of 'experts' who make a comfortable living from injured people." Two women described situations in which conflicting medical opinions and reports created replication of services thus increasing costs and delays in the process whilst increasing the frustration felt by these women. However, it must be noted that the women in this study did not lay the blame solely with doctors and specialists but also attributed these problems to WorkCover. One woman stated:

Can't WorkCover believe one doctor or one neurosurgeon? I mean I went to three neurosurgeons and god knows how many general practitioners…it's as though they keep on trying to get a doctor who will say 'No, it is not work related'.

4. The adversarial nature of WorkCover

Three women described situations whereby WorkCover investigations were performed in an unprofessional and non-neutral way. They described the willingness of WorkCover to accept information from employers, co-workers, and doctors and specialists without checking for accuracy of the allegations, of the stacking of information on files in a negative way, adding irrelevant information to files and of a lack of consultation with the women themselves. One woman stated:

> Information was ambiguous and it wasn't discussed with me… I had blatant lies entered into my personal file without my knowledge and which WorkCover chose to believe without checking for allegations with me to be true or even accurate.

All three of these women obtained their files under Freedom of Information Act. This was the only way they were able to discover what was occurring under the workers compensation process. It is also essential to note that all three women were claiming for stress due to workplace harassment and bullying. One woman stated:

> There needs to be legislation regarding bullying and harassment. WorkCover can't handle the issue. There is an ongoing culture here that needs to be addressed. I am a 'victim' of the culture in this workplace. But I felt that was beyond workers compensation's comprehension… WorkCover can't afford to do the right thing by the consumer because if they did they would have to acknowledge the disgusting state of workplace bullying in the workplace and their own contribution and the destructive impact it has on productivity, the community, the individual and their loved ones.

Messing (1997) acknowledges that the compensation system is ill adapted to situations where the relationship between aggressors and occupational illness is complex and multifaceted. Additionally, these three women had expectations that WorkCover would be a neutral party that would provide them with assistance. Instead, two women felt that "*WorkCover is blatantly with the employer*" and "*…they certainly aren't there for the claimant*".

Seven women expressed concerns with regard to being treated as dishonest and as though they were not a person. One participant stated:

> Instead of feeling supported or protected or believed by WorkCover, I felt the exact opposite. I felt I had to prove I wasn't a fraud, lying and cheating the WorkCover system.

Nevertheless, WorkCover (1999) indicate that their goal is to develop a customer focus as an impartial regulator and that workers compensation is based on a no-fault characteristic whereby employees do not have to prove fault on the part of the employer. Lippel (1995) contends that in the case of workers compensation, the onus to establish the legitimacy of the claim lies with the worker. Blackett-Smith & Rubinstein (1985) acknowledge that injured workers are often subjected to inadequate compensation and harassment via the workers compensation system.

Theme Three: Positive Experiences Versus Negative Experiences – How did they Differ?

The eleven women's experiences establish two overriding differences that are attributable to an experience being either positive or negative. The perception of having someone that cares and is on her side is the predominant factor

attributable to a positive experience. This advocate could be from the workplace, a medical practitioner or specialist, or from WorkCover.

The second factor is related to how complicated the injury/illness is. A complicated injury/illness may be one that is an invisible disability (such as nerve damage, carpal tunnel syndrome). These types of injuries tended to be described by the women in negative terms with regard to WorkCover's ability to process their claims. These women indicated that the onus was on them to show that their work caused an injury/illness. One woman stated:

> Instead of feeling supported or protected or believed by WorkCover, I felt the exact opposite. I felt I had to prove I wasn't a fraud, lying and cheating the WorkCover system.

WorkCover (1997b: 2) acknowledge that "some applications are more complicated than others and may take longer to decide". Furthermore, WorkCover (1997e) indicate that although there are some illnesses that do relate to events in the workplace, compensation will not be payable. For example action to transfer, demote, discipline, redeploy, retrench or dismiss the worker and decisions not to give a leave of absence or provide a benefit in connection with the worker's employment will not be payable. Yet, three women in this study demonstrated that these exact same behaviours were used to uphold workplace values, beliefs and actions that supported and sustained harassment and bullying. This caused psychological illness for these women. It is interesting to note that WorkCover (1997e: 5) explain that compensation will not be provided for an illness that has arisen as a result of "action by WorkCover, or a self-insurer in connection with the worker's application for compensation". Does this mean that WorkCover are aware that the workers compensation process creates inordinate amounts of stress for some claimants? One has to wonder, particularly when they have stipulated that they will not provide coverage for this.

The women in this study predominantly perceived WorkCover in negative terms. Their perception is that it is a system that is impersonal, complicated, and highly adversarial. Although some complications such as delays in medical reports and delays by workplaces to fill in forms for WorkCover may not be directly due to WorkCover the women in this study once again demonstrated that they take a holistic view of the compensation process. They look at doctors, specialists, investigators and the workplaces as part of the whole WorkCover system which impacted to create and form a cumulative experience.

Theme Four: Workplace Structures and the Workers' Compensation Process

The women in this study talked about their work not being safe. The predominant contributing factors were work practices and tasks. Women performed tasks that were physically demanding and repetitive (such as manual handling of people). This may have occurred in a work environment that lacked equipment (e.g. hoists) and failed to provide best practices (such as training in

the use of equipment and teamwork). In addition, once an injury had occurred, workplaces failed to reduce or eliminate the risk factors. One woman described a situation whereby management still allowed her to work even though she had a medical certificate to the contrary:

> Because when the Human Resource Manager found out that I'd worked when I was on a medical certificate she went ape shit. And both guys [referring to her managers] got a revving from her about it. They should've let her know, they should've arranged to get someone in – you don't have anyone working on a medical certificate!… And so I ended up being off work for three months whereas if I had just taken the two weeks off… But if I had of stopped then, it might not have been so bad.

Due to this lack of prevention by employers women attempted to prevent injuries from occurring by refusing to undertake tasks or activities that they thought may cause an injury/illness. Sass (1999: 130) acknowledges that "rarely is there any acknowledgement or expression of moral obligation or acceptance of responsibility by employers once an accident has occurred". These women's experiences show that although recommendations are being made to change unsafe work environments there is a failure to enforce preventative measures. It is interesting to note that WorkCover Queensland (1999: 2) state that the workers obligations are to "also work with your employer to modify work practices to reduce the risk of a similar injury happening again". The women's experiences not only show how out of touch this statement is with the reality of experiences of women but it also assumes that individuals are able to control their workplace and that they are responsible for their injury.

One woman (a nurse) indicated that she was blamed for her injury:

> Some people do a lot of blame because they say it as if it was your fault – because what happened was a man fell out of bed and I tried to stop him.

Langford (1991) found that not only were nurses told if an injury occurred it would be their own fault but when a nurse was unable to do any heavy lifting they were not only treated poorly by their peers but they were told that they were no longer a nurse.

Although the women in this study revealed that a preventative approach to workplace injuries/illness was absent in their work situations they also illustrate the absence of a reactive approach. This can best be illustrated by the women's experiences of rehabilitation.

The literature reveals that the predominant service delivery model is the medical model – with rehabilitation based on clinical predictions of recovery based on type of diagnoses. It suggests that there are positive benefits of rehabilitation for the employer, employee and the community. These benefits include reduced claims costs, reduced training costs, reduced absenteeism and shortage of skilled

workers, fast recovery and reduced suffering, job and financial security and minimal disruption to family, social and community life.

The WorkCover Act 1996 (WorkCover, 1997f: 1) requires all employers to "take all reasonable steps to help or provide their workers with rehabilitation or suitable duties while they are being paid compensation". Not only is there a failure to define reasonable steps but this requirement only extends to workers who are on compensation. Once this is removed there is no requirement. The question is – although the 1996 Act states that rehabilitation is compulsory, what is the reality? The women in this study revealed that rehabilitation was either non-existent or inadequate. One woman stated:

> Rehabilitation – there's none. WorkCover said they were going to do things, like send someone in for rehabilitation, and they didn't! Which I reckon is something that needs to be addresses because you need your rehabilitation to get back into work, emotionally and physically, especially when you've been off for awhile… I suspect that I could have been rehabilitated back into the job that I worked at.

The question is – What are WorkCover's obligations under the 1996 Act? WorkCover (1997f: 1) define their obligation in terms of "ensuring that workers who are entitled to compensation have access to rehabilitation and early return to suitable duties". How is the obligation measured? It is met through the provision of approved workplace rehabilitation training courses for employers and a statewide network of rehabilitation counselors that provide help to workers and employers to develop rehabilitation programs. As a result, WorkCover does not have to ensure that rehabilitation occurs. If WorkCover is reliant upon injured workers reporting the failure of workplaces to provide rehabilitation it has not made this known to the injured worker.

The women in this study showed that if rehabilitation was provided it focused on providing women with physical intervention in an attempt to get them to pre-injury performance levels and failed to treat the individual as a whole. They acknowledged that the psychological impact of an injury/illness and the role that co-workers play in the rehabilitation process (such as attitudes to injured/ill workers) were ignored. Although light duties were assigned to injured/ill women, in reality, this failed to occur because workplaces still expected women to carry out pre-injury tasks, they were not given enough time to heal and accommodation of work hours did not occur. This lack of accommodation or adaptation was evident when women with long term disabilities had to step down from their current position, be re-deployed or resign. One woman stated:

> And despite having a doctor's clearance to be able to go back to work, at the organisation – the organisation won't allow me back in another area. Their words were "I had to go back to my delegated duties". So basically what they were refusing is to rehabilitate me anyway. And at no time has the organisation taken into account my disability. They haven't provided me with a chair; they haven't provided me with a desk… They refused the Functional Capacity Evaluation Report.

> They didn't act on the two medical officers that they made me go and be examined by. They didn't act on their reports, which stated that I needed to be rehabilitated – I could work with rehabilitation, with modification of my workplace and the hours of my duties. And the organisation is now stating that my request for any rehabilitation is unreasonable, under reasonable adjustment.

In Kenny's (1995) study of employer and employee perspectives of occupational rehabilitation it was found that employers may withhold information to injured workers, delay the processing of claims, discriminate against the injured worker (such as threatening them with job loss), require consultation with numerous doctors and specialists and provide inappropriate duties.

One woman did have a positive rehabilitation experience. This was due to the involvement of a strong advocate – her case manager. For example the case manager organised retraining and specialist visits, liaised with the employer and provided adaptive equipment.

Finally, women acknowledged that their workplace failed to carry out WorkCover procedures (such as filling out forms) which resulted in hardship for the women themselves. One woman talked about the financial ramifications:

> Because of the delays in payments I had no money and ran out of food. A friend brought me some food and she made me cry…

All eleven women describe the effects of a workplace injury/illness as both physical and emotional. They all experienced stress. It must be noted that because the women viewed their experience as a whole, they did not always separate their workplace and WorkCover experiences. In particular, they described their experience of stress in relation to both factors. Many of these women found the WorkCover process to be an added burden and in some cases as directly detrimental to their wellbeing. One woman indicated that during the WorkCover process she felt "stress, anger, frustration, depression and suicidal". The resulting effects for this person are that she has a permanent disability and "continual low grade pain" and

> The scan I had [a MRI] left me scarred for life. I am now claustrophobic. I know it is not important, it is just another trauma I suppose.

Another woman went to WorkCover due to workplace harassment and bullying and stated:

> Well I survived WorkCover – that is how I think of myself… WorkCover left me feeling like I had been EMOTIONALLY RAPED and left for the wolves to devour.

This participant experienced insomnia, dramatic weight loss, anxiety, violations of privacy and loss of confidence in her nursing practices. Due to the stigma she was forced to leave her family, home and friends for four years to seek employment elsewhere. This precipitated her marriage break up.

Due to a failure on the part of workplaces to accommodate injured/ill workers eight of the eleven women had to step down from their current position, be re-deployed, or resign. Of these, five women went on to describe their resultant experiences of payouts from WorkCover.

Theme Five: Women's Experiences of Payouts

Five women received payouts from WorkCover due to an injury or illness. They indicate that the payouts were inadequate when taking into account the long-term consequences of their occupational injury/illness. Women indicated that they had no recourse but to accept the one and only final offer from WorkCover. The reasons for the lack of choices in their decision making was due to WorkCover's stipulations (such as an injury assessed at twenty percent or below means that individuals can only accept the offer or sue the employer), the cost and risk of failure in suing an employer, and the desire to end the stressful and long process.

Although WorkCover provide financial compensation for an occupation injury/ illness, the women in this study indicated that they not only wished to receive monetary compensation but they were seeking to get well, be safe at work, prevent further injury/illness and receive recognition from their workplaces regarding their role and responsibility in creating, maintaining and being able to prevent workers injuries/illnesses.

Due to the women's negative experience of WorkCover they indicated that compensation was inadequate for the amount of time and energy that was wasted on a process that was at times frustrating, demoralising and stress inducing. Compensation was not seen as providing restitution for the emotional and social consequences of an injury or illness, loss of income, pain and suffering, loss of future employment opportunities and/or career path and the affects on family and significant others. One woman stated:

> The payout I received was really an insult and a very small paltry compensation indeed.

In documenting the women's experiences it has been revealed that they view the whole experience as a system or process. They do not view each aspect (such as WorkCover, the workplace, specialists, etc) as unrelated. All factors are interrelated and effect and affect one another. This is demonstrated in the sixth and final theme which looks at reasons why individuals may not claim workers' compensation.

Theme Six: Reasons for Not Claiming Workers' Compensation

The Commonwealth Department of Health, Housing, Local Government and Community Services (1993) indicate that women are less likely (than men) are to claim compensation and simply withdraw from the paid workforce. Blackmur, Fingleton & Akers (1992: 35) state that "Unions are aware that workers, particularly women, can be actively discouraged from making a claim." The question is why? There is very little research to point to why or how this

phenomenon occurs. O'Donnell & Hall (1988) indicate that women may be underrepresented in the workers' compensation statistics because they may be less likely to claim or be granted compensation. Suggested reasons include difficulties in understanding the process for claiming compensation, lack of credibility to (mainly male) doctors and insurance personnel and a failure to recognise and/or gain acknowledgement of the work relatedness of injuries. Besides these factors the women in this study have demonstrated that the workers compensation process is not user friendly, is not perceived as neutral and is highly adversarial. The following statements from five women illustrate their experience of the adversarial nature of WorkCover:

> I went to WorkCover and it got worse… I felt that if they made it hard enough I would go away. If WorkCover hadn't been so obstructive and destructive I would have stayed and battled on.
>
> I just found WorkCover was an added stress that was almost unbearable at times.
>
> They just want to get you off the system.
>
> They would leave it hoping you'd disappear and go away! They would make it so stressful as if to put you off.
>
> I feel that the way WorkCover have been in contact with the workplace they certainly aren't there for the claimant. They are a government organisation. They work with the organisation. And that became very apparent in my case.

In addition, the women discussed the stigma of having a WorkCover claim. Four women stated the following:

> I have always lived in fear of taking out a WorkCover claim. For the stigma that's attached to any WorkCover claim, but especially back injury and stress.
>
> I have found as soon as you say you are on WorkCover some people treat you like you are a second class citizen.
>
> I think it's just the way they treat people – like they are bludgers, and they aren't.
>
> I felt I had to prove I wasn't a fraud, lying and cheating the WorkCover system.

The women in this study indicated that they tend to use their sick days and entitlements rather than apply for compensation. The predominant reasons for this included the complexity of WorkCover, the delays in processing claims, the amount of paperwork to be dealt with and disputes about investigators findings which created further delays in the process. Stewart (1994) also found that people preferred to use up sick days or leave entitlements due to delays in payments. One woman stated:

> I mean there are times when incidences happen and it didn't go through WorkCover… I took a sick days because it was easier to deal with rather than all the red tape, the paperwork, and also because you don't know what the affects are going to be.

To conclude, figure one has been provided to the reader to summarise the complexity and interrelatedness of identified variables that may affect the outcome for women with an occupational injury or illness.

Figure One: A model of variables that may affect the workers' compensation process as identified by eleven women (adapted from Kenny 1995).

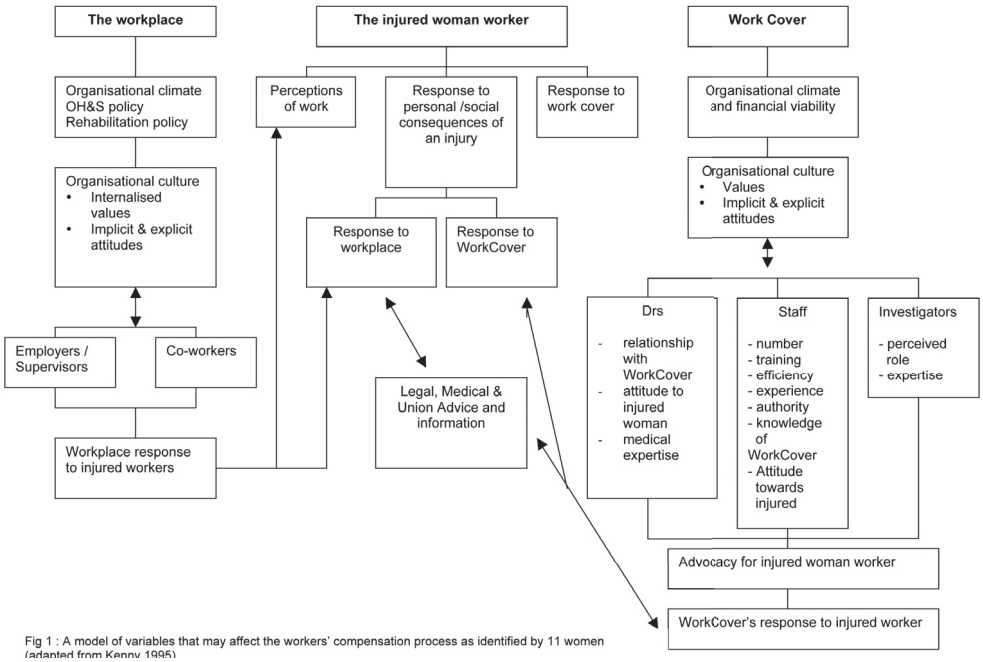

Fig 1 : A model of variables that may affect the workers' compensation process as identified by 11 women (adapted from Kenny 1995)

Implications and Recommendations

WorkCover Queensland (1999) identified one of their goals as the development of a commercial customer-focused operation not only as an insurer but also as an impartial regulator. Values to achieve this goal include excellence, integrity, respect, and responsiveness. The women in this study have shown that there is a dichotomy between WorkCover's goals versus consumer reality.

The women indicate that they want to be treated as an individual with compassion, understanding and empathy. This not only requires adequate staffing but also the recognition and need for training of WorkCover staff in dealing with people under extraordinary conditions and who may be experiencing stress, depression and trauma. One woman talks about the role of both trained staff and management:

> Management are the rudders. They condone or don't condone what happens…If you can't do your job, then get out and get someone that can do it. They need to make sure the people they recruit have above average people skills. People who have a psychological base of understanding about the impact of not working.

During the study one of the participants recommended looking at why WorkCover personnel have a high turnover rate? This warrants further research, along with investigating and evaluating WorkCover's training and development programs for employees.

One defining factor that creates the difference between a negative versus a positive experience is having an advocate for the injured/ill woman. Each compensation recipient requires a consistent and trained case manager to explain and provide information with regard to the process throughout the process. This may also alleviate the delays experienced with regard to paperwork and consequent payments. Until WorkCover's lack of neutrality has been addressed, it would be appropriate to provide a case manager outside of the organisation – from an agency that would advocate on behalf of the compensation claimant.

Although WorkCover (1997c) place an emphasis on the role of the treating medical practitioner in the compensation process, the women reveal their need for a single consistent treating physician, trained in the area of occupational injuries/illnesses. This would also entail the physician visiting worksites to perform assessments and evaluations. In this study no treating physician visited a worksite and this maybe an unrealistic expectation due to the time and costs involved. Alternatives may include monetary incentives for doctors to visit worksites, the provision of doctors who specialise in the area of occupational injuries/illnesses, a case manager who advocates and liaises on behalf of the individual and enforces workplace assessments and obligations (including rehabilitation and work related injury and ill-health prevention).

Due to their occupational injury/illness, women indicated that they want prevention of future injuries/illnesses as an outcome. This requires the education of employers. For example, change the attitudes of employers so that they recognise women as breadwinners, to value a safe workplace (e.g. link increased safety with increased productivity) and change the attitude that workers are disposable. The women's experiences have demonstrated that although the workplace health and safety act provides legal obligations there is a need to look at the enforcement of occupational health and safety and responsibilities to injure/ill workers (such as rehabilitation). Although this area requires further study suggested enforcement activities may include regulators having greater powers, greater consequences for non-compliance (such as fines) and increases in staff numbers to carry out enforcement. Kennedy's (1996 Vol II) inquiry into workers compensation found that if employers had caused extreme or recurring negligence then there were no consequences for that employer. Kennedy recommended that employers should be directly responsible for payments for all damages.

The final recommendations are from two of the women who participated in this study. These are direct quotes and the researcher has not changed or added to these in any way as they are comprehensive and succinct.

One woman stated the following:

- WorkCover needs to be accountable. The ombudsman didn't want to know about it. It's too big. People are frightened to challenge them because they control their lives. When you're finally emotionally and physically able to face them, which may be five to ten years down the track, it's too late, the time frame has passed. And WorkCover thinks that the lack of challenges means that they are doing a good job.
- It's not user friendly, the way the process and system is at the moment. They need to look at the processes. It's difficult to understand and there were no guidelines for me to follow. Bilateral guidelines. You need to know that B will follow A, and what B means, right down to Z. The staff at WorkCover didn't seem to know what the process was. The left hand didn't know what the right hand was doing. Yet a person who is trying to get money for their next meal is supposed to know what is required three weeks down the track. It's an adhoc process.

  I had to hand write reports every fortnight to justify my payment. So it is based on written communication. It discriminates against people who can't articulate verbally and written. Disadvantaged groups are further disadvantaged due to the requirements made of its victims.
- WorkCover need to be consistent. I know that I was getting conflicting information. WorkCover have a long way to go. Nothings changed really. Nothing seems to have changed much.
- WorkCover should employ some of their victims onto their recruitment panel. They should have six of them on each panel. They need to stack it favorably on each local panel so they know what they do and don't want in that geographical area.

Another woman stated the following with regard to WorkCover:

- They need some ethics. They need a code of conduct and protocols. I asked to see them and WorkCover couldn't supply them to me. I wanted guidelines on how investigating psychologist operates. They didn't have that either.
- They need to act on something straight away. For example the waiting list to see the psychologist and psychiatrist is too long.
- Need to address the ongoing psychological problems of victims.
- WorkCover needs to be a neutral organisation not a government one. That is what is causing victims to be revictimised again. They have no ethics and neither do the people that work for them. For example psychologist's ethics and parameters. What do they work to?
- Need competition for workers compensation services.

- The office is very formidable and alienating – you can't see any workers and have to ring a bell to get someone to come out.

These women's recommendations have generated an important question – How are WorkCover's services evaluated? Cameron (1994: 44) states that "The emergence of institutions such as WorkCover, which co-ordinates all these activities, raises questions about who scrutinises and reviews the procedures". Apparently there are three major sources of data for evaluation. The first is a complaints and compliments register via the minister's office. The second is an internal evaluation carried out by internal divisions via surveys. The third and final method is via an external survey that is sent to employers and employees once a year. Unfortunately the researcher was unable to evaluate the internal or external surveys from WorkCover as WorkCover would not release these forms. However, WorkCover do publish the results from their external survey in an annual report.

The Annual Report (WorkCover Queensland, 2002) does not provide enough information to allow for an extensive evaluation of their research methods and findings. When looking at the measures of customers and WorkCover employees two problems are presented. Firstly, WorkCover Queensland (2002: 1) state that "The index scores are weighted so the most important satisfaction attributes have a higher impact and each attribute is scored from the survey results". The reader is not told what these important attributes are or how they were initially identified and weighted. The second problem is related to the satisfaction index. WorkCover Queensland (2002) report that in 2002 injured worker satisfaction was 71.4%, employer satisfaction was 68.8%, impartiality of Q-Comp was 81% and WorkCover and Q-Comp people reported 66.7% satisfaction. WorkCover Queensland (2002) indicates that any movement in the indices from year to year may be considered statistically significant. The problem is that the reader is unable to determine how much movement has to occur for it to be considered significant. For example employee satisfaction was 66.4% in 2000 and 66.7% in 2001, is a 0.3% increase statistically significant? Is an increase in an index an adequate measure of performance? Particularly when the initial baseline of an attribute may be low (for example is 66.7% satisfaction of employees adequate?). The Annual Report does not provide any information with regard to who judged the impartiality of Q-Comp. Was it employers, injured workers or both? Consequently this area requires further exploration.

Overall the recommendations made by the women in this study point to an organisation that requires a shift in its paradigm – from a cost-saving focus to a focus on caring for the people it is serving – the injured or ill worker.

Questions Generated from the Research

So far the research has asserted that there is a need to investigate and evaluate WorkCover's recruitment, training and development programs and to investigate why WorkCover may have a high turnover rate of personnel. In addition, there is a need to examine how WorkCover evaluate their service delivery? Is it adequate?

It was significant to note that although existing research acknowledges the link between the added stress of home/family and work demands, the women in this study did not talk about this factor. This leads the reader to ask – Why don't women perceive this as an issue? The women in this study acknowledged the impact on the family and significant others as including financial concerns, having to cope with changes in their partner/wife/mother due to the trauma or stressful event and increased work load and pressure on families (such as daily chores) and in one case, marital breakdown and family dissolution was experienced. One woman acknowledged that she did not really know if or how her experience may have affected her family. This raises an important issue – the need for further research to look at the impact on the family and significant others from their perspective.

One participant highlighted an interesting idea when she stated that:

> Something's wrong with the system when doctors say you are better off on your private health scheme. I have had many a professional say that "if you were going through your medical fund everything would be fixed up". I wish that I was two people – One could go through my private medical fund and one that could go through the system… Now I would love to see what happened in the end.

This quote generates some interesting ideas and questions for future research. For example do people opt to go onto their private health insurance rather than workers' compensation? If so how many and why?

Finally, now that women's experiences of the workers' compensation system have been revealed, it would be interesting to explore men's experiences of workers' compensation and how it compares or contrasts with women's experiences?

Conclusion

The women's experiences revealed that the workers compensation system is an added burden that they have to cope with. The women in this research study have indicated that the current state of workers compensation service delivery creates disincentives to claiming workers compensation. There is a need to address this, look at alternatives and improved modes of service delivery. The following diagram presents a summary of the implications and recommendations from eleven women's experiences in the present study.

The predominant focus of figure two is a consumer focus based on women's needs. This form of service delivery is represented in the central box. It is supported by the factors radiating from it. To provide a user friendly system intervention would have to address both micro-level changes (that look at WorkCover) and macro-level changes (which address the system as a whole). The women in this study indicate that the system includes themselves, the workplace, WorkCover and society as a whole – which affect and effect one another. Changes not only include service provision but also must address attitudes and values associated with women and work. These ideas are compatible with Acker's (1992a) observation that organisations are often defined

through metaphors of masculinity (such as lean, mean, aggressive, goal-oriented, competitive and efficient) but rarely are they supportive, empathetic and caring.

Figure 2: Consumer focused service delivery model – based on eleven women's experiences of the workers' compensation system

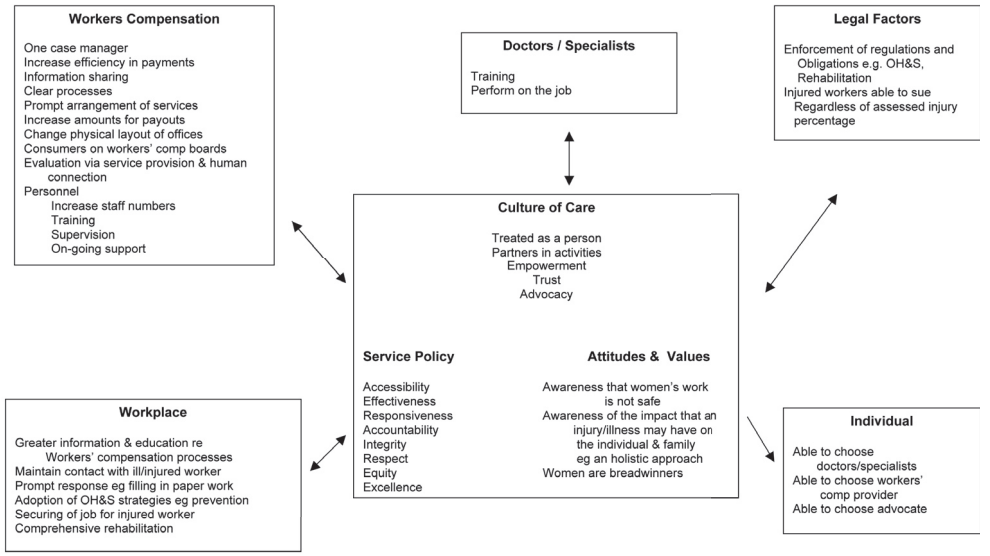

Fig 2: Consumer focused service delivery model, based on 11 women' experiences of the workers' compensation system.

Acker (1992a) indicates that systemic changes must occur as well to look at a fundamental reorganisation of both production and reproduction.

> Long-term strategies will have to challenge the privileging of the 'economy' over life and raise questions about the rationality of such things as organisational and work commitment as well as the legitimacy of organisations claims for the priority of their goals over the broader goals (Acker 1992: 260).

Overall what do women want? The women in this study expressed the desire and need to work, to be safe at work, to be well and healthy and to be treated like a person.

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