

WorkCare and the RSI Epidemic

John Hyde

Documents tabled in the Victorian Parliament reveal that the Victorian Treasurer, Mr Jolly, doctored WorkCare's 1986-87 Annual Report---yet another example of a State Government trying to subvert established accountability procedures. Why, however, should Mr Jolly be so ashamed of WorkCare's failures that he should want to cover them up?

His problem arises because of incompatible promises---a mistake to which politicians are prone. The Victorian Government is caught between pledges to the union movement to provide almost open-ended work-related injury compensation and to the business and taxpaying public to control the cost of this. We must presume that the Government got into its bind because whoever costed WorkCare for the Labor Party made inadequate allowance for the increased incidence of compensable injury which WorkCare itself would induce. This sort of mistake is also common.

To understand what WorkCare, and schemes like it, are up against, we might recall Repetitive Strain Injury (RSI). RSI was predominantly an Australian phenomenon, known to the irreverent as "kangaroo paw". It evolved from a similar condition known to doctors and compensated as "tenosynovitis", known to laymen by such names as "rock miners' hands" and "shearers' wrist".

It is hard to say where the epidemic started. But it manifest itself early in the Melbourne office of the Department of Taxation among people using EDP keyboards. It spread rapidly throughout tax-office staff in Victoria but did not infect NSW staff for some time. Once it was established across the border, however, it spread as rapidly in NSW as it had done earlier in Victoria. Like most epidemics, after the first onrush, it subsided---perhaps as levels of immunity developed; perhaps for other reasons. At its height it significantly depopulated some Commonwealth departments. For instance, one section was so denuded of staff that the procedures for paying pharmacists had to be suspended. In that office replacement staff quickly succumbed to the condition, while other offices were almost unaffected.

An article by David S Bell in the September 4 issue of the *Medical Journal of Australia* freely admits to the 'iatrogenic' nature of RSI. (I admit to looking up "iatrogenic". It means: "caused by process of diagnosis or treatment".) The article is written for doctors, and naturally concentrates on the doctors' role in the epidemic, but it contains equally important lessons for public administration.

Throughout the epidemic, RSI lacked clear causal definition. "No serious approach to a definition of the degree of repetition to cause tissue damage appeared in the many reports, guide-lines, manuals and practice codes that were issued to the end of 1988." "...the distribution of RSI did not correspond with the relative frequency of the repetitive movements that were needed for specific keyboard tasks; some of the occupations with the highest prevalence of RSI required relatively low rates of activity."

Throughout the epidemic, RSI also lacked clear clinical definition, although in 1988 two researchers published a pathology of RSI. By then, however, researchers could not find new cases of RSI in Australia and "in other parts of the world the experience was disbelieved". Diagnosis had, most often, been based on the patients' claim to be experiencing pain.

Bell notes that the decline of the epidemic coincided with three circumstances:

- | television documentaries featuring scenes of organisations in the USA with large numbers of videoscreen operators who did not have RSI, and Australian workers discussing the way compensation had been exploited;
- | legislation that limited the rights of workers to obtain compensation; and
- | test court cases which used the absence of the condition in overseas workers with identical work conditions.

The complaint was eventually recognised as "occupational neurosis", but by then an RSI industry had grown up, and the cost, in terms of lost production and compensation, was already enormous. Occupational (or craft) neurosis has long been recognised by the medical profession with recorded epidemics as long as 100 years ago. In each case, the neurosis was first attributed to an injury that was as a result of work, but time proved otherwise.

RSI has been summarised as "abnormal diagnosis behaviour, which leads to abnormal illness behaviour in the patient, which leads to abnormal treatment behaviour". That summary is pretty hard on the doctors involved, who were fed what proved to be diagnostic and curative nonsense by such as the "Occupational Repetition Strain Injuries Advisory Council", and who often merely gave the patient the benefit of the doubt.

Doctors ought to engage in professional self-criticism, but it seems to me that the root cause of the epidemic was not abnormal diagnostic behaviour, as much as a combination of them-and-us attitudes in the work places and compensation for work-related disorders. During the RSI epidemic, unions advertised success in gaining compensation, claimants turned up for medical assessment accompanied by trade union officers, and some ideologically inclined people fostered a climate of mistrust. Even the poor old multinationals were accused of dumping obsolete keyboards on us.

The real explanation was more simple. We all suffer aches and pains, and in such a climate it was inevitable that those people who were prone to neurosis should convince themselves that every ache was serious.

The RSI epidemic is an extreme but typical example of the sort of problems faced by all compensation schemes. The human animal is the most adaptable species the world has ever known. Turning the like of WorkCare to our own perceived advantage is second nature. More generally: subsidise anything, including illness, and more of it will be recorded. It is not in human nature that a benefit that lacks adequate financial, legal or moral disincentives will not be nipped off.

None of this excuses Mr Jolly's doctoring of the WorkCare report, but it does explain why the original report was politically unpalatable.

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