AFEI
Australian Federation of
Employers & Industries

25 May 2012

Joint Select Committee on the NSW Workers Compensation Scheme
Parliament House
Macquarie Street
SYDNEY NSW 2000

For the attention of: The Hon. Robert Borsak, MLC

Dear Mr Borsak,

Re: AFEI Submission to the Parliamentary Inquiry into the NSW Compensation Scheme – question on notice

Thank you for the opportunity to provide the Committee with our members' views on the operation of the NSW Workers Compensation Scheme.

Question on notice from Mr Michael Daley MP

AFEI has taken on notice a question from Mr Michael Daley MP concerning the "watering down" of assessments to attain a level of 15% impairment.

The level of impairment severity is a medical question. The key issue is whether the assessed level of impairment is correct. This depends on the validity of the impairment assessment system. The assessment system is subject to WorkCover operational instructions to agents and guidelines.[1]

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[1] For example on 1 May 2009 revised WorkCover Independent Medical Examinations and Reports Guidelines came into effect, stipulating that if the insurer has sufficient information to make a decision about ongoing claim liability, including permanent impairment, there is no need to ask an injured worker to fill in a claim form or attend an independent medical examination.

The 2009 Guidelines stated that referral for an independent medical examination is only appropriate when information from the treating medical practitioner(s) is inadequate, unavailable or inconsistent and where the referrer has been unable to resolve the issues related to the problem directly with the practitioner(s).

If an injured worker submits a report from an assessor of permanent impairment regardless of whether they are the worker's treating medical practitioner and questions regarding that assessment arise, they are to be posed to the assessor in the first instance. If the response from the assessor is inadequate, unavailable, inconsistent or not received within 10 working days, a referral to an independent medical examiner may proceed.

New guidelines were issued on 23 March 2012.

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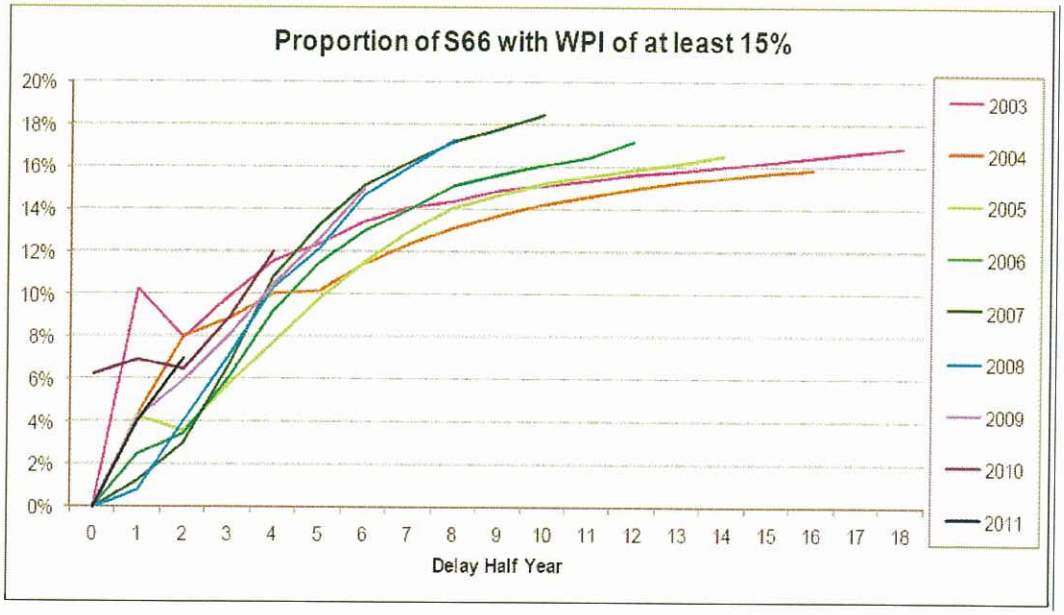
Currently there is wide variation in assessments of the same worker and in practice a weakening of the whole person impairment threshold. We have seen the Employers Mutual submission to this Inquiry and specifically its Appendix C. Attached is Table 1 which reproduces the Employers Mutual Appendix C and demonstrates the variability in assessed impairment levels.

In particular, we draw your attention to those assessments in excess of 30%, which in terms of the inference in the Inquiry's questioning of AFEI that at 30% *"You would be dead".* In this sample, 14 workers were assessed to be at levels of impairment 30% or higher. We also draw your attention to the disproportionate number of psychological injuries assessed at 15% or higher.

PwC's actuarial valuation of the Scheme as at 31 December 2011 estimates that work injury damages benefits liability had increased by $148 million in the previous six months and the liability in respect of future workplace injury damages benefits has reached $1,771 million.[2] This marked increase is a clear indication that the current approach to assessing impairment levels for work injury damages under the scheme is in need of review.

Further evidence of bracket creep in impairment assessment is provided on page 18 of the PwC actuarial valuation which provides a graph which makes it clear that:

- S66 claimants from the more recent accident years are reaching the 15% WPI thresholds more quickly
- The 2006 and later accident years are likely to reach a higher ultimate proportion of s66 claims with a WPI of at least 15%.



[2] PwC, WorkCover NSW: Executive Summary: Actuarial valuation of outstanding claims liability for the NSW Workers Compensation Nominal Insurer as at 31 December 2011, 12 March 2012 page 16

This outcome has occurred in a period of declining workplace injury claims.[3]

Another means of additional compensation may be obtained by re-opening the original claim and seeking additional payments for further deterioration. These are referred to as "top up" payments under s66 and appear to be more widely accessed in recent years.

We further note the risks and recommendations identified by Ernst and Young's external peer review that "*WorkCover should robustly challenge the assessments of the WPI.*"[4]:

Risk Recommendation identified by Ernst and Young at current and previous valuation:[5]

Risk	**Recommendation**
Lump sum payment experience (WID, S66 and S67) – a shift in the Scheme towards a "lump sum" culture	1. Review the guidelines to Scheme Agents to question medical assessments 2. Introduce more rigour in applying the threshold tests to establish entitlement to claim WID and defending matters 3. Review legal cost guidelines
Medical payments – continued deterioration in medical payments may have a negative impact on the rest of the Scheme	WorkCover should revisit the 2009 investigation of Medical costs to improve medical management of claims. Areas that we believe urgently need focus from WorkCover include but not limited to: 1. WPI assessment including WorkCover guidelines around AMA5 2. Other WorkCover guidelines that may impact the WPI assessment and Medical issues 3. How doctors are undertaking WPI assessments 4. Agent's management of medical issues
WID – continued deterioration in the number of intimations results in continued deterioration in the Scheme	WorkCover should implement a strategy in relation to unknown WID claims – the key part of the strategy is to implement improved claims management of the potential WID claims. For known existing WID claims, WorkCover should robustly challenge the assessments of the WPI. WorkCover should also analyse the relationships between doctors and lawyers in the scheme, identify the doctors that are commonly used on these claims and develop strategies around those doctors and lawyers. This is a potential quick win for WorkCover.

[3] WorkCover Annual Report 2010-11 page 26

[4] Ernst and Young External Peer Review of Outstanding Claims Liabilities of the Nominal Insurer as at 31 December 2011 page 8

[5] op cit pages 6 and 8

Question on Notice from Mr Rob Stokes MP

A question was asked of AFEI by Mr Rob Stokes MP relating to general practitioners supplying medical certificates based on the worker's view of their fitness for work or supplying insufficient information to assist in the provision of suitable duties and return to work.

In response, we direct the Inquiry's attention to statements by employers on pages 25-36 of our submission. This small sample reflects our long term experience with members reporting that claims are accepted by some general practitioners with little or no information about the work relatedness of the alleged injury or the availability of suitable duties.

The other point raised by AFEI in response to Mr Stokes' question was that many nominated treating doctors (along with many employers until they see their premium notice following a claim) appear to think that workers compensation is simply another form of insurance which covers all costs of the claim for employers. It does not.

In response to Mr Stoke's initial question concerning the "conflicted" role of general practitioners, Mr Brack identified the key issue as being the multiplier effect of claims costs in premium calculation and the consequences of doctors declaring there is a work related injury based solely on the worker's assertions:

> *.....we know that the multipliers built into the insurance premium formula are so great that there are very significant problems associated with the declaration that there is an issue, and the failure to get them back to work quickly.*

To assist the Inquiry understand the impact of claims costs on premiums and the pivotal effect of the general practitioner on claims costs we submit the following data by way of example:

The cost of the claim includes what WorkCover estimates that they may have to pay, not actual claim costs.

Calculating the Premium (P)
P = (T x (1 – S)) + (E x S) (Note: we have removed certain components of the calculation formula to simplify the example. The resulting impacts are not distorted by this omission)

Tariff Rate = 5.54% (this Rate is assumed to have been unaltered from the previous year)

Industry Claims Cost Rate (ICCR) Estimate = 1.0374

Industry Claims Cost Rate (ICCR) Adjustment = 1.2205

Wages Estimate 10/11 = $1,562,500
Wages paid 09/10 = $1,562,500
Wages Paid 08/09 = $1,562,500
Wages Paid 07/08 = $1,562,500

Assume one claim in 09/10 for $50,000:

Estimate Premium for the 2010/2011 year
WITH the $50,000 claim= $101,738

Estimate Premium for the 2010/2011 year
WITHOUT the $50,000 claim= $68,355

The difference = $33,383

Adjustment (or "hindsight premium") for 2009/2010
WITH the claim = $87,271

Adjustment (or "hindsight premium") for 2009/2010
WITHOUT the claim = $68,355

The difference = $18,916

It needs to be remembered that this impact will continue for a further two years. Assuming absolutely no alteration to the calculation components (i.e. wages paid and estimated, claims cost paid and estimated, tariff and ICCR rates) the expected premium impact would be $52,299 in the second year and $18,916 in the third year.

Therefore, total premium impact of a $50,000 claim in the above scenario would cost the business an additional $123,514 (or $2.47 for every $1 of claims expenditure).

Example of escalating claims costs when unable to achieve a successful return to work: (Note: these calculations are based on 2006-07 data however the process and impact is unaltered)

- Male, with a dependent wife and 3 dependent children
- Award Rate of Pay - $600 per week
- Injury – Broken forearm (radius)
- Initial treatment indicated – does not require surgery, injury site to be immobilised by forearm cast
- Total incapacity for the duration of the claim

Initial Estimate

Wages = 8 weeks @ $600/week =	$4,800
Possible S66 (Lump Sum) =	$6,250
Medical/Rehabilitation Costs =	$4,500
Investigation Costs (Medical/other) =	$2,000
Legal and other costs =	$3,000

Total Claim Estimate = $20,550

Despite clinical norms for such injury it is not uncommon for " incapacity" to continue for much longer periods which means there will be new estimates at each review point where the worker has not returned to work:

12 Week Review

Wages:

26 weeks @ $600/week =	$15,600
26 weeks @ $567/week =	$14,472
Possible S66 (Lump Sum) =	$6,250
Medical/Rehabilitation =	$5,000
Legal and other costs =	$3,000

Total Claim Estimate = $44,322

26 Week Review

Wages:

26 weeks @ $600/week =	$15,600
104 weeks @ $567/week =	$58,968
Possible S66 (Lump Sum) =	$6,250
Medical/Rehabilitation =	$5,000
Legal and other costs =	$3,000

Total Claim Estimate = $88,818

52 Week Review

Wages:

26 weeks @ $600/week =	$15,600
286 weeks @ $567/week =	$162,162
Possible S66 (Lump Sum) =	$6,250
Medical/Rehabilitation =	$5,000
Legal and other costs =	$3,000

Total Claim Estimate = $192,012

These examples demonstrate the crucial impact the treating doctor's assessment (usually the general practitioner) has on the effectiveness of rehabilitation, return to work and workers compensation costs for employers.

A system of independent, properly accredited occupational physicians should be utilised with employers having the right to an independent medical examination immediately in matters of causality, treatment and reasonable injury management plans and particularly wherever return to work is dubious.

Erratum

There is an error on page 22 of the AFEI submission. The last sentence of paragraph 68 on page 22 ends with "greater". This should be replaced with "smaller".

Yours faithfully,

Garry Brack
Chief Executive