Submission
No 52

INQUIRY INTO PERSONAL INJURY COMPENSATION LEGISLATION

Organisation:

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Subject:

Summary

Submission to GPSC1 Inquiry on Personal Injury Insurance

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Key Points

1. The market model has failed in the public liability and workers compensation area in NSW.
2. The government should re-enter the insurance market in areas where NSW has a key need for insurance as a social function, such as public liability, workers compensation and home building.
3. This insurance should be directly linked to a database. This database would be used to research accidents and identify preventive actions, legislation and regulation that could lessen both accidents and premiums.
4. The key aspect of this system is the safety management function. The lessening of all accidents is likely to be cost-effective, and cases where there is likely to be a large payout could be tendered to the Treasury Managed Fund.
5. The current assessment system has also failed. It gives good financial results, but this is because it does not pay people with significant injuries. In effect the payout is for only some serious injuries. The system does not even adequately identify some serious injuries. People are unable to work, yet are assessed as below compensible level.
6. The accreditation system for doctors in the American Medical Association or Workcover system is too narrow for a real assessment of the injuries. People who have spent a lifetime assessing injuries have been excluded and consideration should be made in the system to assess the bona fides of such practitioners.
7. There needs to be a grandfathering of workers compensation medical assessors until the panel described in (9) below is functioning. Certification in the American Medical Association or Workcover guidelines should not be the only criteria of the right to practice.
8. The assessment of injuries should not use the American Medical Association guidelines, nor the WorkCover guidelines that are substantially derived from them.
9. The assessment of injury should be by a panel constituted with 3 elements:
    a. A medical assessment of the injury and its prognosis
    b. A rehabilitation assessment of the alternative work possibilities of the person and
    c. A financial assessor who would give a view of the costs of the injury and its restitution.
10. The panel's finding should be in the form of the principal brief of medical expert evidence which would advise the court.

Insurance is seen either as a financial problem or a lottery. This is because insurance and the funding thereof is seen as a black art where the actuarial assumptions are critical. Because of their compounding effect different assumptions come up with hugely different assessments of solvency and in consequence payments and premiums. These have considerable economic and thus political relevance. They are also newsworthy as such.

The assumption is that in a market model that insurance is kept honest by competition from other insurers. Given that it is a highly segmented market, there are often few players in a niche, as was shown when there was only one Home Owners warranty insurer. In this situation where the premiums should have been totally unaffected by September the 11th, (as the chance of a builder going broke in western Sydney was in no way related to the global terrorism threat), premiums rose hugely and builders were unable to commence work, or went bankrupt. The premiums should have related to the number of shonky builders, but as statistics on this were poor, there was no check on the insurance companies, and no capacity or willingness in government to take over that role. Legislation was passed to guarantee profitability of the company involved and to try to get others into the market, without any effort being made to monitor the situation, or even to regulate builders more strictly. Perhaps this was due to the political power of both the insurers and the building lobby. The story is included in this submission as it illustrates:

1. An example of market failure in another segment of the insurance industry
2. The lack of willingness of governments to collect information systemically about industries and their costs,
3. The lack of willingness of governments to regulate to lessen the problems created by poor practice in an industry and
4. The lack of willingness of governments to act for the public interest when there is a systemic failure that suits a vested interest.

In the climate that sees insurance as a financial and political problem, the basic function of insurance gets lost. This is further worsened by the current political view that the government has no place in any marketplace where the private sector could function. Hence if there is a global disaster or event such as Sept 11, which makes a huge demand on funds, there is a tendency for the global industry to either to try to recoup its losses, or to 'reassess its risks in view of recent current events and the financial ramifications of this'. The result of either of these approaches is the same- premiums go up.

It was stated at the time of the Home Owners Insurance guarantee legislation that as Australia was such a fraction of the world insurance market, its premiums could not be accurately gauged and so we were in with the rest of the world and had better pay up. It is frankly outrageous that Australian governments were so

disinterested in our welfare as to accept such arrant nonsense. If there were a credible insurer in Australia making its money from the local trade, it could have been largely unaffected, and if local offshoots of global firms did not behave as such it should have been up to our governments to take action. As it was there were no statistics of price changes even to make the changes known and quantifiable to allow a regulator to demand the insurers show cause. Industries that are subsidised greatly by being tax-deductible are unobserved but generally hugely profitable. What is not profit is accumulated as reserves. There is no reason that such reserves, which have as their original aim the maintenance of economic stability of the general population could not be in the public system and being invested in infrastructure or other worthwhile projects for those who made the contributions, rather than being merely another subsidised system of transferring wealth from the populace to an industry group.

In public liability, the risk of major injury to the public at shows and in public halls is not great, and there is an important public benefit in having small communities and groups able to use infrastructure. The rise in premiums has seen people unable to use community facilities, to put on demonstrations to protest against the war in Iraq, and unable to run stalls in shopping centres at weekends. There is pressure on community groups to sell their halls to developers, who will either demolish the hall to maximise capital return on the land, irrespective of the public good of having a hall, or, at best, retain its current use, but at hugely greater cost because of meeting the insurance costs. It must be noted that insurers are not concerned with the degree of risk, as if competition or transparency of premiums is poor, which it almost invariably is, the costs can merely be passed on.

Australia lacks a good inspection system for infrastructure, and standards are at times not even developed. As an example: In many industries slips and falls are a very high percentage of lost time accidents. Yet much of Sydney's footpaths were paved with granite for aesthetic reasons, despite the fact that it has a lower coefficient of friction than the concrete or asphalt that it replaced, and that this difference is more marked in wet weather. When asked about this aspect in Parliament[1] the reply was:

> The Minister has advised that the Department of Infrastructure, Planning and Natural Resources has had no specific involvement with policies that regulate for the slip resistance of "footpaths". The department's only involvement is with slips, trips and falls in buildings, through the Australian Building Codes Board (ABCB) and Building Code of Australia (BCA).

In short, the government had not thought about it at all, and did not plan to do so. It was happy to reduce compensation liability for people injured while it made footpaths more slippery and had no standards, no assessment programme, no monitoring and no database to even record the number of injuries occurring. This would not be tolerated in industry. Why should it be tolerated in public policy?

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[1] The full text of the question is in Appendix 1.

Why should the government leave public liability to market forces, which merely means allowing costs to be passed in with no preventive strategy at all? It is simply appalling! The only alternative at present is for each local council to develop and enforce its own standards of footpath slipperiness- hardly likely!

The idea of 'cost-effective insurance' tends to be confused with 'cheap' insurance. This is because insurance is seen as primarily a financial problem. The role of insurance is to spread losses from an individual affected to the wider group who were exposed to the same risks, but did not have an adverse event. Phrases like 'individual responsibility' are often used to give a philosophical cloak to a very cynical exercise of unwillingness to pay. An individual who does not wear a seat belt has been foolish because the risks were predictable if one considered the physics of hitting a dashboard at 100kph. Yet the probability of having an accident is low, and there is an (albeit lower) probability of being 'thrown clear'. So the consequence of not wearing a seatbelt, which is being in a vegetative state with no insurance, is too great a penalty for the 'crime' of not wearing the belt. The idea of 'taking responsibility' in this case means 'accepting the consequence of being a vegetable as punishment for not wearing a seatbelt' and the corollary is 'with the insurer paying less than the cost'. This is poor policy outcome, as in reality the person is taken care of by the state and the relatives. This is perhaps a flawed example as in practice, a vegetative state would be covered by NSW Insurance schemes, but many accidents that are not covered have the same component of blame and the same disproportionate penalty for wrongdoing. Insurance is a social good and a risk sharing exercise, not system of moral blame and retribution. If there are penalties for acts or omissions, this is a separate system, not a function of insurance. In other words, there should be quite high fines and penalties to encourage seat belt use, but this is a separate issue from insurers gaining immunity from paying.

In that insurers in much of the public liability do no prevention and keep their statistics as commercial secrets so that they have no incentive to act to reduce costs and merely pass them on. This is a strong argument for a single insurer and a database of accidents and near misses. It must be noted that all risk and insurance managers in industry regard a register of accidents and incidents as the major starting point in their efforts to prevent injuries. The system of private insurance keeps a register of only accidents that are sufficiently severe to produce claims that people think may be able to be won. So not only is the register unavailable, its data is seriously flawed from a preventive perspective. The State should have such a register, and actively manage it to research the cause of injuries, then set up standards and preventive activities to reduce accidents backed up with inspections and penalties for lack of improvements by Councils or whatever other body is responsible for the facility or practice that contributed to the incident or accident.

Dr Chesterfield-Evans opposition to the concept underlying the American Medical Association guidelines has been spoken about many times in the Legislative Council. It was the subject of his first speech and a list of the bills in which this was involved is in Appendix 2. The fact that so much legislative change has been needed in the areas of Workers Compensation and public liability is because the whole concept on which the current legislation is based is badly flawed and the and administration of claims has been so poor. An historical perspective on the situation is given below in extract from the speech of 23/9/1998 on the Vaughn Standing Committee on Law and Justice Workplace Safety Interim Report. This warned against using the American Medical Association Guidelines and derivatives therefrom. The inequities and manifest injustice of introducing this system has been borne out and is probably responsible for the current inquiry.

> The trend both in the United States of America and here is to use a table of maims, which assigns a certain level of compensation to a given injury. The most used table of maims is that of the American Medical Association and injury assessment specialists have expertise in the application of these guidelines. The object is to have a system where every assessor of a given injury would reach the same result. In theory, at the conclusion of this process every injury will have been assessed by the same yardstick and everyone will get exactly the same compensation. However, such a process produces a few problems.
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> To achieve a reproducible table, non-quantifiable items like pain must be eliminated. Thus a joint able to be moved over its full range but which produces pain in that movement would be judged to have no disability. If the same joint had half its range, the statutory amount of compensation would be reduced by a percentage. This procedure becomes a little absurd in regard to back injuries. Is someone only 100 per cent disabled if he or she is cut in half, becomes paraplegic or cannot bend more than a certain degree? In any of those cases there would be only a few degrees of movement. These questions require answers. I do not believe that these proposed measures address the nature of a disability.
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> The tables do not draw the distinction between an impairment and a disability. If I have poor vision, I have an impairment. If I wear glasses that overcome the impairment and I can do my normal job, I am not disabled. More importantly, my earning capacity may be normal. If a concert pianists loses his little finger he may be unable to play. The same impairment in a labourer may be only a trivial problem. On the other hand, a concert pianist in a wheelchair may be able to continue to play whereas a labourer would have no earning capacity at all.
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> The table of maims has no functional aspect with regard to assessing the disability resulting from an injury. If one loses a hand, that is a percentage of that arm, which is a percentage of both arms, which is a percentage of the whole body and, hence, is a percentage of a compensation sum for total and permanent disability. A worker may suffer a small percentage of disability but be 100 per cent unemployable. The critical aspect is that the level of unemployability will determine the future wellbeing of an injured person. The percentage of disability may be considered an irrelevant figure, but it determines the amount of compensation.
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> Perhaps it is too strong to say that the American Medical Association tables are a nonsense, but it is not too critical. An assessment of injuries is needed that considers the level of impairment, the probability of getting a job and real income changes.

> Perhaps the worker will be asked to take on a level of chance or responsibility for his or her post-injury fate. In some cases a worker, forced to give up a blue-collar job and use brain rather than brawn to earn a living, discovers latent talents and becomes wealthier. That happy little story is commonly heard. Rather, the converse is more the norm.
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> There must be a realistic evaluation of the injured person's situation and life prospects and not merely a determination of a range of joint movements or some other spurious index such as the AMA tables. However, these tables are supported by powerful lobbies. Doctors become specialists in injury assessment and can charge more for their skills, reports become consistent and insurance costs become controlled and predictable. The loser is the injured worker. The amount allocated for total and permanent disability is small, but few people receive it. Many people are disabled to a small degree but are 100 per cent unemployable.

Dr Chesterfield-Evans gave an example of the absurdity of the American Medical Association Guidelines in practice and put the situation into context in his speech on the Civil Liability Amendment (Offender Damages) Bill on 5/5/04:

> Some years ago I was an occupational health and safety doctor with Sydney Water when a man who injured his knee claimed that he could not work because when he tried to squat down to dig a ditch his knee was too painful. I assessed the man's knee according to the American Medical Association guidelines and determined that he had only a 1 per cent disability. Of course, the guidelines could not measure pain. His knee moved over almost the normal range and was only 1 per cent lower than the normal range according to American Medical Association guidelines, which did not mean that this man could not work. He took his injury sufficiently seriously to lodge a compensation claim, but they said to him, "Look, mate, if you go through with this compensation claim you will not get nearly as much money. You're only in your fifties. You've got to get through to 60 and get your pension retirement. This is going to cost you a fortune." He said, "Well, my knee hurts. I can't work."
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> Even though the range of movement in this man's knee was reduced by only 1 per cent according to the guidelines, he was sufficiently disabled to be unable to work. This Government has made the threshold 15 per cent—practically no one could reach it unless he or she was badly damaged—consequently the number of lawsuits for damages has fallen. If the Government wants to stop people from suing to get redress for their injuries it should propose an alternative solution. Tort law is an old-fashioned thing that has evolved over thousands of years from Britain, and it is much admired. But it does not deal with the modern idea of injury prevention which is, as any person who has studied safety management theory will tell you, looking at the factors involved, identifying what accidents and incidents occur, and trying to prevent them. To make everyone scared of being sued, pay loads of insurance companies money and then introduce laws to stop everyone from suing until they are badly injured is not the way to solve the problem of compensation for injury in our State.

It is further the case that just as the American Medical Association guidelines and the WorkCover ones that derive from them are a retrograde step in assessment of disability, it is very retrograde to create a new elite of doctors, who are the only ones able to give evidence in medical liability cases. The expertise in assessing injuries exists quite separate from and arguably completely differently from the ability to apply the absurd formula that is the American Medical Association/Workcover guidelines. Hence to simply destroy the livelihoods the lose the expertise of this generation of practitioners is foolish in the extreme. Hence the recommendation to try to retain those experts by a panel, perhaps convened by the Medical Board to grandfather in that expertise. It may need to get rid of the AMA/Workcover

guidelines, but this is recommended in any case. It might be noted that there has been a changing of the guard and a huge change in the expertise of the medical compensation professionals. Previously most assessors were older orthopaedic surgeons or general surgeons, who had a lifetime of experience in treating these cases, and often had the time as their practices wound down to spend time in courts. The new guardians of this expertise are the American College of Disability Evaluating Physicians, or clones thereof. This is effectively a degree in the application of the American Medical Association guidelines. The idea that they are 'specialists' in this area was stated by the Minister as important and accepted as a good thing by unions, and even the Greens. This deference to expertise might not have been so universal had those deferring been more aware of the narrow nature of that expertise and the mistaken paradigms on which it is based. As stated above, it is desirable that public liability, motor accidents and workers compensation be restructured as if the state were an industry looking at its accident record. This would involve getting a database to compile accidents and incidents, to use this on a risk management basis, and to manage claims in a far better way. In the end competent claims management is what has been missing. But simply having a patently unjust system of compensation so that profits can be maintained and premiums kept low by not paying those who are injured is not an acceptable policy outcome. The dogma that this has to be by private insurers also needs to be re-examined.

The reason that the insurance costs are so high was as stated frequently in the house and inter alia in the speech on the Workers Compensation Amendment (Insurance Reform) Bill on 19/11/2003:

> As I have said in every speech I have given on WorkCover since I came here, I believe that the reason WorkCover is in trouble is that its claims were extraordinarily poorly managed. Many were managed by a computer. When, according to actuarial calculations, it appeared that it was unlikely that a person would get better, the computer would decide that WorkCover should deny them benefits, force them to go to court and pay them a settlement rather than rehabilitate them. The quality control of the medical system was very poor.
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> When I studied workplace absence and quality control in medicine on a public service fellowship in 1984 I saw that those who were monitoring the progress of injured workers knew exactly what the patients were doing. They knew which doctors they were seeing, what treatment they were receiving and how they were going. They monitored it systematically to keep costs to a minimum and get people back to work. But here nothing would happen for weeks. I believe that the insurance company would pay out without thinking for six months, and when the costs reached a certain amount the computer would kick in and the company would begin to take an interest.

Dr Chesterfield-Evans described his alternative concept of the Expert Case Assessment Panel, with expert staffing in the Motor Accidents Compensation Bill on 26/6/99 in the Motor Accidents Compensation Bill Committee stage:

> The concept of an expert case assessment, as provided for in my amendment, is that the doctor basically makes the diagnosis, a person who is experienced in rehabilitation decides what effect that will have on the person's ability to earn a living - in other words, his or her degree of disability - and a third person determines the degree of disability and compares the person's pre-injury job prospects with his or her post-injury job prospects. It is possible to determine compensation that is realistic for each case.
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> Clearly there is some challenge in achieving uniformity between assessment teams, but the basic concept is to remove the adversarial aspect by conducting a broadly based,

holistic assessment by a
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team of people who have three different types of expertise. One may say that that is more expensive than using the services of one doctor - and that may be right because the assessment method uses three people. However, it is a lot cheaper than having a legal system conduct the assessment, and it is a lot fairer than the arbitrary American Medical Association guidelines. I have tried to find the middle road between an adversarial system that is very legalistic and a single doctor. I believe that this is a middle road for fairness. There is an appeal mechanism to which I will refer in later amendments. The basic concept of the assessment process is that it involves not just a doctor but an expert case assessment team.

Further details of the concept can be read in the committee debate in Hansard of 24/6/99. In essence the concept was for a team to make an assessment of an injured person's situation in an expert role. Pleading could be heard as to why this was in error and the judge would decide. So the primary role is for an expert group, but the conclusion is tested in open forum. This is an attempt to minimise the adversarial role, but still allow a hearing. The concept has not gone beyond the discussion stage. It might be noted that the suggestion was criticised on cost grounds in the debate in the committee stage on 28/6/99. Clearly to have a doctor, a rehabilitation expert assess the case is more expensive than a doctor, though the financial assessment would likely have a cost in any case. The slight increase in the fees for the rehabilitation expert and a possible increase in the financial assessors fee in that it is personalised to the injured person is a small amount compared to systems which involve expert witnesses, and has the advantage that the system is more holistic, and looks at each individual case, rather than merely applying the AMA/WorkCover formula. The idea that this small difference in the cost of assessment is a big factor in the decision, when a whole person's life is at stake is actually almost offensive, particularly as the compensation or the welfare benefits that the person will get for years dwarfs that total.

It is clear that the limiting of benefits to injured people must have prevented many people who are unable to work from being compensated. No doubt these people would now be on some form of government welfare, usually Federal. There may be some winners from the lower premiums, if these have in fact materialised. There is no knowledge of the profits of the insurers as the government does not want to know this. Proof of this is in the Chesterfield-Evans amendment that would have mandated this information was negatived by the government in the Motor Accidents Compensation Bill 1999. It may be that some public liability insurance is cheaper on public halls or events are cheaper, but if the risks were known, the government could meet these risks and costs and allow the population to enjoy our facilities without the influence of world pressures on insurance premiums. It is to be hoped that the government will act on this important issue.

Appendix 1
Text of Question and Answer re Granite Paving in Sydney 24/2/04

*804 PLANNING—FOOTPATHS IN SYDNEY—Dr Chesterfield-Evans asked the Minister for Transport Services, Minister for the Hunter, and Minister Assisting the Minister for Natural Resources (Forests) representing the Minister for Infrastructure and Planning and Minister for Natural Resources—
(1) Is the Government aware that the changes to the paving of Sydney's footpaths with □ **granite**□, bricks terrazzo or other materials in place of concrete or asphalt has lessened the coefficient of friction of the footpaths, especially in wet weather?
(2) Is the Government further aware that this slipperiness makes slips, falls and injuries more likely?
(3) (a) Has the Government any standards re: the coefficients of friction of footpaths?
(b) If not:
(i) Why not?
(ii) Will they get some standards?
(c) If so, what are the standards and what inspection and enforcement practices exist?
(d) Have these failed in that footpaths are more slippery than they were?

Answer—

The Minister has advised that the Department of Infrastructure, Planning and Natural Resources has had no specific involvement with policies that regulate for the slip resistance of "footpaths". The department's only involvement is with slips, trips and falls in buildings, through the Australian Building Codes Board (ABCB) and Building Code of Australia (BCA).

Appendix 2

Speeches by Dr Chesterfield-Evans on the Fallacies of the American Medical Association Guidelines for the Assessment of Permanent Impairment, and the Workcover Guidelines derived from them.

Standing Committee On Law And Justice - 14/10/1998 - NSW Legislative Council Hansard

Motor Accidents Compensation Bill - 1999 - NSW Legislative Council Hansard

Workers Compensation - 05/09/2000 - NSW Legislative Council Hansard

Glenbrook Rail Accident Compensation - 14/11/2000 - NSW Legislative Council Hansard

Workers Compensation Legislation - 19/06/2001 - NSW Legislative Council Hansard

Workers Compensation Impairment Assessment Guidelines - 04/07/2001 - NSW Legislative Council Hansard

Workers Compensation Legislation Amendment Bill (No 2) -2001 - NSW Legislative Council Hansard

Workers Compensation Legislation Further Amendment Bill - 2001 - NSW Legislative Council Hansard

Workplace Injury Management and Workers Compensation Act: Disallowance of Chapter 11 of the Workcover Guides for the Evaluation of Permanent 9/4/02

Civil Liability Bill - 2002 - NSW Legislative Council Hansard

Workers Compensation Amendment (Insurance Reform) Bill - 2003 - NSW Legislative Council Hansard

Workers Compensation Legislation Amendment Bill - 02/07/2003 - NSW Legislative Council Hansard

Workers Compensation and Other Legislation Amendment Bill - 2004 - NSW Legislative Council Hansard

Civil Liability Amendment (Offender Damages) Bill - 05/05/2004 - NSW Legislative Council Hansard

Special Commission of Inquiry (James Hardie Records) Bill - 20/10/2004 - NSW Legislative Council Hansard