Submission No 122

INQUIRY INTO NSW WORKERS COMPENSATION SCHEME

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Lawyers for the People

AUSTRALIAN LAWYERS ALLIANCE

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SUBMISSION TO THE JOINT SELECT COMMITTEE ON THE NSW WORKERS COMPENSATION SCHEME

1. Introduction

1.1 The Australian Lawyers Alliance ("ALA") thanks the Honourable Robert Borsak MLC for the opportunity to provide submissions in relation to the inquiry into the NSW Workers Compensation Scheme and for allocating our representatives time to give evidence at the inquiry on 21 May 2012.

1.2 Should the Joint Select Committee ("the Committee") require background information on our organisation, the Committee is invited to review our website at www.lawyersalliance.com.au.

1.3 The ALA agrees that the NSW Workers Compensation Scheme ("the Scheme") requires a careful and thorough review. Such review must include a comprehensive analysis of the WorkCover bureaucracy, its framework and its micromanagement of the Scheme. The inquiry should at all costs avoid applying a "quick fix" by resorting to the further reduction of benefits to vulnerable injured workers as its first port of call. What is required is principled reform rather than ad hoc amendments. The latter exercise failed at the last major review of the Scheme before General Purpose Standing Committee No 1 in November 2001. The very same issues that were raised in November 2001 are again being raised in May 2012.

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2. Executive Summary

2.1 A fair, effective and affordable Scheme in NSW is essential.

2.2 The problems with the Scheme lie not with the quantum of benefits available to injured workers but in the poor management of the Scheme by WorkCover and the Scheme Agents.

2.3 The Scheme requires a comprehensive and principled review only after a truly independent actuarial report on the Scheme is delivered.

2.4 Following the completion of the Scheme's comprehensive and principled review referred to above, the following measures should be taken, in addition to any new matters raised by the review:

(a) Review the Scheme framework, the WorkCover bureaucracy and its micromanagement of the Scheme with a view to limiting the same and simplifying the process.

(b) Review claims management protocols with a view to simplifying and improving same.

(c) Review guidelines with a view to simplifying and improving same.

(d) Review of Scheme Agent remuneration arrangements.

(e) Review claims handling by Scheme Agents with a view to simplifying and improving same.

(f) Consider a return to private underwriting or at least, provide Scheme Agents with a better incentive in the system to reward them for good performance or to penalise them for bad performance.

2.5 Pending the completion of the Scheme's comprehensive and principled review referred to above, the following measures could be taken to assist in ameliorating the alleged projected deficit:

(a) Reintroduce unrestricted commutations without the requirement to obtain WorkCover approval.

(b) Review the protocols for Scheme Agent management of return to work with a view to simplifying and improving same.

(c) Simplify the definition of pre-injury earnings.

(d) Offer incentives to employers to assist in getting the injured back to work.

(e) Give the Workers Compensation Commission ("the WCC") power to enforce the obligation of employers to provide suitable duties to injured workers and a means of penalising recalcitrant employers.

(f) Abandon whole person impairment ("WPI") and reintroduce the Table of Disabilities as the measure for lump sum compensation and allow the parties to negotiate between assessments of percentages. Alternatively, retain WPI and allow the parties to negotiate between assessments of WPI percentages.

(g) Review and consider the effectiveness of the Claims Advisory Service ("CAS") versus the expense of maintaining it.

(h) Review section 151Z(2) so that common law damages are not reduced by the amount which could have been recovered against the employer but for the prohibition and threshold. It is unjust to workers. It is also unjust to employers and the Scheme because without this provision, workers injured by third party would simply sue that third party and not their employer, reducing the liabilities of the Scheme.

(i) Repeal the 2008 amendments in relation to death benefits so that the death benefit is only available in circumstances where the deceased worker leaves full or partial dependants.

3. Terms of Reference

3.1 The Terms of Reference for this inquiry require the Committee to inquire into and report on the Scheme particularly focusing on:

(a) the performance of the Scheme in the key objectives of promoting better health outcomes and return to work outcomes for injured workers,

(b) the financial sustainability of the Scheme and its impact on the New South Wales economy, current and future jobs in New South Wales and the State's competitiveness, and

(c) the functions and operations of the WorkCover Authority.

3.2 The Terms of Reference for this inquiry also require the Committee to note and examine the PWC actuarial valuation of outstanding claims liability for the

Scheme ("PWC Report") and the Ernst & Young external peer review of the PWC actuarial valuation ("E&Y Review").

3.3 The reason for the inquiry is the actuary's calculation of a $4 billion deficit attributed to outstanding claims liability.

3.4 The NSW Workers Compensation Scheme Issues Paper is notably silent on the contribution of WorkCover's operation and management of the scheme and the contribution of the scheme agents and insurers to the deficit.

3.5 The ALA's primary submission is that the problems with the Scheme are not a product of the number of claims or the benefits paid under claims but rather, on ALA experience, a product of the Scheme's management by WorkCover. The current state of the Scheme arises from poor management by WorkCover and the Scheme Agents. This is supported by the commentary within the PWC Report and the E&Y Review. Scheme management needs to be addressed well before any consideration should be given to cutting the benefits of those who need it most; those injured at work. Cuts to workers' benefits should be an absolute last resort.

4. The Cause of the Alleged Projected Deficit

4.1 The PWC Report identifies[1] half the deficit as being due to poor investment strategies, partly due to the GFC. The other half of the alleged projected deficit is due to claims management experience including:

(a) WorkCover in its many roles as regulator, insurer, prosecutor, auditor and claims handler;

(b) Benefits and entitlements available under the Scheme; and

(c) Actual management of claims.

4.2 It is imperative that the Committee properly consider the PWC Report and carefully look to the assumptions that have been used in arriving at the alleged projected deficit. The assumptions and appendices to the PWC Report (the latter of which have not been made available to us) require close examination.

4.3 The ALA submits that a proper examination of the PWC Report reveals that $1.5 billion of the alleged deficit is due to a change in the "inflation assumptions and discount rates" applied by PWC. Page 264 of the PWC

[1] PWC Report page 288

Report shows that over the last 2.5 years, the Scheme results have changed by $1.5 billion merely due to the change in the assumptions applied. This amounts to 37.5% of the current total projected deficit. One could term it as a "stroke of the pen" increase in the alleged projected deficit.

5. The Need for Independent Actuarial Advice

5.1 The ALA urges the Committee to engage independent actuarial advice on the proposals in the Issues Paper. The PWC Report and the E&Y Report were both commissioned by WorkCover.

5.2 The E&Y Review states at page 55 that reliance is placed solely on the Scheme's actuarial report and information provided to it by WorkCover and PWC. Therefore, the review is not independent or impartial. The appendices to the report have not been provided and one would have thought them essential to the understanding of both reports.

5.3 PWC are the same actuaries who failed to predict the current alleged blowout and yet they have been engaged again to report. WorkCover or others on its behalf provided the actuaries with assumptions upon which to base their report. In the past, the Government has acted upon the actuarial report commissioned by WorkCover. The Scheme finds itself in difficulties again. Therefore, WorkCover's position has been compromised and it is essential that the Committee obtains truly independent actuarial advice prior to making any recommendations for changes to the Scheme.

5.4 "*Actuaries are curious creatures. They are actually quite intelligent so most people cannot understand what they are talking about. However, depending on the assumptions and the various discount rates, you could come up with a report that would throw up a materially different result... You have to try to understand what methodologies they have used to come up with a number, and you will probably fail if you try to do that... You will get different views from different actuaries.*"[2]

[2] Richard Grellman, Report of Proceedings before GPSC No.1 on NSW Workers Compensation Scheme on 21 November 2001 at page 9

6. Benefits Available under the Scheme

6.1 Before any consideration can be given to changing the benefits structure under the Scheme it is necessary to understand the current structure.

6.2 The *Workers Compensation Act NSW* 1987 ("the 1987 Act") broadly provides for three sets of benefits for an injured worker. They are weekly payments of compensation during periods of economic incapacity, payment of reasonably necessary treatment expenses and the circumstance where an injury results in permanent impairment, the payment of a lump sum. There are also provisions which modify entitlements to claim damages where injuries are caused by the fault of the employer. Provision is also made for death benefits. Further details of the benefits available in the scheme are summarised in Appendix 1 to this submission.

6.3 In real terms, benefits have not increased in a long time. The Committee's attention is drawn to the following figures which are extracted from a number of reports[3]:

(a) There has been one increase in lump sums in over a decade (which equated to an increase of about 10%) whereas the increase in CPI over the same period is about 25%.

(b) The number of major injuries are down by about half (62,469 to 30,133).

(c) The number of claims are down.

(d) The number of disputes are down from approximately 23,000 in 1996 to 8,800.

(e) Medical payments have decreased by $117 million[4].

(f) Death payments (projected) have been reduced by $4 million.[5]

(g) Legal costs have decreased significantly.

6.4 Legal costs are fully regulated within the Scheme by the operation of Schedule 6 and 7 to the Workers Compensation Regulation 2010. There has been no increase or change in regulated costs since 2006 when the Schedules were first introduced despite other service providers fees having

[3] WorkCover Annual Reports 1997 to 2010; WCC Annual Reviews 2002-2009, DIR Annual Reports 1997-2002 and NSW AG's Department Report 2002

[4] E&Y Review at page 4 and PWC Executive Summary at page 24

[5] PWC Executive Summary at page 24

been indexed according to inflation and other factors (see Medical and Examination Report Fee Orders).

6.5 By comparison:

(a) Claims handling expenses have increased significantly – the public cost of managing the Scheme has increased from $70 million in 1999 to $630 million in 2009.

(b) The Scheme cost per dispute has increased sixteen fold from 1999 to 2009.

(c) Tribunal costs per dispute have gone up four fold from 1999 to 2009 despite the significant decrease in the number of claims.

(d) Investigation costs have increased by $15 million.[6]

6.6 Payments to scheme agents and insurers to manage claims has increased year upon year since 2001 despite the number of major injuries (categorised as those claims which require management) reducing by almost half over that same period.[7]

6.7 The cost of managing the Scheme appears to be completely disproportionate to the benefits provided for injured workers.

6.8 The logical conclusion is if there has been relatively no increase to the level of benefits and significantly less claims of all types being made over time then benefits are not the cause of the deficit.

7. Scheme Management

7.1 In the Terms of Reference the Committee is also asked to inquire and report into the functions and operations of WorkCover. This has been completely ignored in the Issues Paper, which predominantly focuses on cutting injured workers' already modest benefits, rather than getting to the root of the problems with the Scheme.

7.2 The E&Y Report at page 5 states that "*it is possible to arrest deterioration and improve the claims experience by improving claims management and WorkCover guidelines*". As this issue has been identified as a major

[6] PWC Executive Summary at page 24

[7] WorkCover Annual Reports 1997 to 2010; WCC Annual Reviews 2002-2009, DIR Annual Reports 1997-2002 and NSW AG's Department Report 2002

contributor to the current state of the Scheme, we respectfully submit that the Committee should be focussing first and foremost on this clearly identified and important issue before any cuts to workers' modest benefits are even considered.

7.3 The appendices to the PWC Report have not been provided to the ALA and so, we cannot comment or contribute in relation to detail contained therein. What we know from an analysis of WorkCover Annual reports is that payments to Scheme Agents have increased, there has been an increase in staff at WorkCover itself, the costs of WorkCover and the Workers Compensation Commission have increased despite only having to deal with almost half the number of claims, and yet return to work outcomes have either stagnated, not improved or worsened. The key objectives of the Scheme and WorkCover are clearly not being met.

7.4 At WorkCover's request, E&Y excluded from the scope of their review[8] the very matters that are a major contributor to the deficit – "claims handling expenses" and "Estimate total claim costs (including expenses and levies) for each policy renewal year from the inception of the Managed Fund/Nominal Insurer Scheme in 1987".

7.5 Yet Cameron Player, the Acting General Manager of the Workers Compensation Insurance Division of WorkCover NSW, announced on 5 April 2012 that an immediate operational review of the Worker's Legislative & Contractual Framework is being commenced. Greg McCarthy has been engaged as an independent consultant to address wholesale changes to the operation of WorkCover. Mr Player states: "*The Review Program approach will prioritise, consolidate, rescind and update relevant guideline and instruction material to ensure processes adopted by system participants are directed at the delivery of system wide outcomes and improved service delivery standards. The outputs of this Review Program will act as key conduits to continue to manage performance and influence behaviours driving positive Scheme and wider system outcomes.*" The ALA submits that the outcome of the Review Program ought to be assessed before embarking upon legislative change.

[8] E&Y Review, page 2 under heading "scope of review"

8. Scheme Agent Remuneration

8.1 The E&Y Report at page 8 identifies agent remuneration as a problem and suggests a thorough review of remuneration arrangements. The primary recommendation in the E&Y Report is a review of WorkCover's overall approach to management of the Scheme and in particular the management of Scheme Agents (including their remuneration). The ALA strongly supports this recommendation.

8.2 WorkCover reports show that Scheme Agents are receiving three times the amount in payments per claim from WorkCover to manage claims in 2009 as they were in 2001.[9]

8.3 "*I suppose at the highest level what we found was that there is not enough incentive in the system at the moment to reward insurers for good performance—or to penalize them, for that matter, for bad performance. At the same time there is not enough strength in the tools available to WorkCover to ensure that insurers make that commitment.*"[10] The ALA submits that nothing has changed in this regard since 2001.

9. Privatisation of the Scheme

9.1 Self-insurers are able to appropriately manage claims and remain profitable and yet WorkCover cannot. The costs structure and payments to Scheme Agents do not involve any degree of risk and the Scheme Agents receive the same reward regardless of the manner in which they handle each claim. The fee structure should involve some degree of risk for the Scheme Agents. The current funding scheme does not promote proper management by Scheme Agents or any incentive for them to do so.

9.2 The ALA strongly encourages the Committee to consider a return to genuine competitive insurance in the Scheme. Privatisation of the risk. Currently, the Scheme Agents are "*spending someone else's money and with the best will in the world and with all of the protocols and monitoring, if someone or an entity is spending someone else's money, you do not have quite the same interest*

[9] WorkCover Annual Reports 1997 to 2010; WCC Annual Reviews 2002-2009, DIR Annual Reports 1997-2002 and NSW AG's Department Report 2002

[10] John Walsh, Report of Proceedings before GPSC No.1 on NSW Workers Compensation Scheme on 21 November 2001 at page 12

in where it goes as if it is your own. It is just human nature, really. It is not that they are being naughty or inefficient. It is just very hard to keep an organisation focused when it is not their own capital that is going out the door.... At the moment, under the current system, I do not think that there is much incentive for the insurers, given the role that they are playing, to reach for best practice in rehab activities."[11] ALA submits that nothing has changed in this regard since 2001.

9.3 The ALA submits that private underwriting is one of a range of initiatives to get the Scheme back on track.

10. Claims Management Protocols

10.1 Since 2001, we have seen changes to the claims management protocol, the claims handling guidelines and the future estimates protocols. The public cost of managing the Scheme has increased almost tenfold since 1999. The Workers Compensation Commission costs about twice as much to operate as the old Compensation Court of NSW and it deals with less than half as many disputes as the old Court did.

10.2 The introduction of multiple processes in respect to claims management are bureaucratic and confusing. They require service providers to abide by constantly changing codes and protocols, which are essentially a waste of time.

10.3 There must be a removal of the overregulation, oversight or micromanagement by WorkCover. The entire process requires simplification.

11. The Failure of WorkCover to Meet its Objectives

11.1 WorkCover, in its many roles, is failing to meet objectives particularly, return to work outcomes. It has developed into an expensive bureaucratic nightmare.

[11] Richard Grellman, Report of Proceedings before GPSC No.1 on NSW Workers Compensation Scheme on 21 November 2001 at page 6

THE ISSUES PAPER: OPTIONS FOR CHANGE

The ALA makes the following submissions in respect of each of the proposed Options for Reform identified in the Issues Paper.

1. Severely injured workers

The ALA supports the improvement of benefits for severely injured workers. However categorising "severely injured" as only those with greater than 30% WPI is opposed. 30% WPI is too high. Many workers who are very seriously injured will not reach a 30% WPI threshold. Effectively, the introduction of such a threshold will reduce benefits to over 95% of injured workers and is unjust.

The only injured workers who would be assessed at greater than 30% are those with severe multiple injuries, paraplegics, quadriplegics and those with severe psychological and/or psychiatric illness.

Measures of impairment are in some cases an inappropriate measure of serious injury and thus it would be not appropriate to rely on the assessment of WPI to categorise workers as "severely injured". Pain, for instance, is excluded but it can be totally disabling in some circumstances. There are many serious injuries which would not meet 30% whole person impairment including:

(a) Severe back and neck injuries, including those who have had multiple or failed surgeries;
(b) Pain disorders;
(c) Moderate brain damage;
(d) Some amputations.

2. Removal of coverage for journey claims

The ALA does not support the removal of coverage for workers injured on their way to or from their work. There is no principled reasoning to distinguish those workers injured on their way to or from work from those who are injured on a journey during the working day.

A perfect example of the need for journey claims is Heidi Edwards, the young woman who was interviewed on Channel 10 on 16 May 2012. Heidi was catastrophically injured on her way to work when a tree fell onto her car. Without the journey claims provisions Heidi would have not had access to weekly benefits, medical expenses or the lump sum benefit that allowed her to pay her mortgage and keep her home. She was injured through no fault of her own on a journey to her place of employment.

The PWC report identifies that of the $4 billion alleged deficit only $70 million is made up of journey claims. Workers who have been injured on a journey as a result of the negligence of another driver can bring a claim under the Motor Accidents Compensation Scheme. Approximately $35 million is recovered against third party insurers.

In the ALA's experience, third party recoveries are not pursued by WorkCover as vigorously as they could be. Rather than removing journey claims and leaving injured workers, such as Heidi Edwards, without benefits and support, WorkCover should more actively pursue recoveries against third parties which would further reduce any liability of the scheme in relation to these types of claims.

3. Prevention of nervous shock claims from relatives or dependants of deceased or injured workers

The ALA does not support the prevention of nervous shock claims by relatives or dependants of deceased or injured workers.

The number of work related deaths is on the decrease. There is no evidence to suggest nervous shock claims are a considerable financial cost to the Scheme or if they contribute in any substantial way to the alleged deficit. The death benefit payment under section 25 of the 1987 Act is deducted from any nervous shock claim brought by a dependant of a deceased worker and accordingly, many claims are not worth pursuing.

In relation to the death benefit, its proper purpose is to compensate the dependants of a worker killed at work. The 2008 amendments broadened the availability of the

death benefit so that where a deceased worker leaves no dependants, the lump sum benefit is paid to his/her estate. The ALA concedes that this may be an unnecessary expense to the Scheme. The ALA would support the death benefit only being available in circumstances where the deceased worker leaves dependants, whether fully or partially dependant.

4. Simplification of the definition of pre-injury earnings and adjustment of pre-injury earnings

The ALA supports the simplification of the definition of pre-injury earnings and this issue is addressed below.

5. Incapacity payments – total incapacity

During the first 26 weeks of total incapacity for work, a worker is entitled to receive what is termed the "current weekly wage rate" as set out in Appendix 1.

Workers are rarely paid in accordance with awards in the current era and injured workers suffer significant financial hardship when in receipt of weekly compensation. Awards are rarely updated. As the Issues Paper rightly identifies, NSW is the only State that does not take regular overtime and allowances into account when calculating total incapacity payments. This means that those workers who work shift work, such as nurses, or workers who work substantial overtime to supplement their meagre ordinary weekly earnings are severely financially disadvantaged if they suffer injury at work.

The ALA submits that injured workers ought be entitled to payments during the first 26 weeks of total incapacity at their average weekly earnings as defined in section 43 of the 1987 Act – that is, the amount the worker was being remunerated over the previous 12 months unless that is impractical having regard to the shortness of duration of employment.

The Issues Paper suggests that an earlier "step down" should be introduced as in other states. Such suggestion fails to take into account that other jurisdictions with

an earlier step down, such as Victoria, provide for much greater benefits during the first 26 weeks, even with a step down after 13 weeks. Thus the step down is from a much larger figure. Other States, such as Victoria, also have much greater access to common law rights and significantly better entitlements to damages. Victoria has had the 13 week "step down" since 2002. The return to work outcomes in Victoria are relatively no better than NSW, hence there is no evidence to suggest that an earlier step down would promote better return to work outcomes.

There is no rationale for reducing payments after 13 weeks, other than arbitrary costs saver, which involves taking money from those who need it most – people who cannot work as a result of injury in the workplace. If early return to work is the primary goal of the scheme, then it is imperative that workers in this early period of incapacity for work are properly supported, including being properly compensated for their wage loss during this time.

All injured workers have financial commitments based on their pre-injury level of remuneration. Inadequate levels of weekly compensation promotes financial hardship and makes a difficult time of dealing with an injury even more difficult. This, in turn, can lead to financial stress, the development of secondary psychological injuries and breakdowns of families. All of these result in additional treatment costs and longer periods of absence from work.

The suggestion in the Issues Paper that a step down will provide an incentive to return to work carries with it an underlying suggestion that people want to stay off work on payments. The Scheme should be based around the prima facie principle that people are genuine. It is certainly the experience of the ALA that injured workers in the scheme are genuine. The Annual Reports from WorkCover disclose that the incidence of fraud is extremely low.

With the extremely low statutory rate for total incapacity beyond 26 weeks incapacity for work (currently $432.50 gross per week for a single person less tax), there is absolutely no incentive for an injured worker to stay off work. In fact, the opposite incentive is built into the scheme in section 40 of the 1987 Act through "make up" payments if the injured worker returns to the workforce on suitable duties.

An early "step down" in NSW would not "harmonise NSW arrangements with Victoria, South Australia and Western Australia" as those state schemes have a more appropriate compensation regime during the first 26 weeks of incapacity for work; their injured workers being entitled to receive much closer to their proper average weekly earnings than NSW workers.

6. Incapacity payments – partial incapacity

The ALA strongly opposes the automatic termination of benefits after a certain period of time. All this will achieve is condemning injured workers to severe financial hardship. Two-income families have financial commitments that rely on both partners/parents earning an income. Cutting off compensation or support to injured workers due to an artificial time limit imposed by statute will cause an inability to meet financial commitments. All too often members of the ALA who act in this jurisdiction have seen injured workers and their families having to sell their family home due to inability to meet ongoing mortgage commitments following an injury at work. A statute imposed cessation of payments to injured workers will result in the destruction of family units, financial autonomy and create a greater reliance on Commonwealth benefits.

A significant number of injured workers cannot return to their pre-injury work. Many do return to full-time work but on modified duties which are more suitable to their disabilities and they lose income compared to their pre-injury earnings. Many injured workers cannot find work because of the state of the labour market and a reluctance on the part of other employers to take on an injured worker. The reluctance of new employers to take on an injured worker is largely due to the fear of being the subject of a claim if the worker is to re-injure themselves. The ALA submits that any aggravation of an injury that results from earlier injury should be the liability of the earlier employment. This would in the main overcome the reluctance of employers to employ someone who was injured.

The ALA submits that the Issues Paper fails to recognise that the current Scheme has built into it an incentive to return to work. Those who return to work are entitled to claim the difference between their pre-injury earnings and their post injury

earnings (capped by a statutory rate). This can be greater than the amount paid to those workers who are partially incapacitated for work and not suitably employed.

The ALA strongly recommends that incentives should be offered to employers to take on injured workers. Further, greater power needs to be given to the Workers Compensation Commission to order an employer to take an injured worker back to work and punish a recalcitrant employer who does not comply with section 49 of the 1998 Act. All available mechanisms in the current legislation to facilitate early return to work must be properly utilised, monitored and enforced.

It has long been the experience of ALA lawyers that the overwhelming majority of injured workers want to get back to work. It is demoralising for people to be out of work, not to mention the financial stress. Money currently spent on rehabilitation would be better spent on offering incentives to employers to assist in getting the injured back to work. Unfortunately, rehabilitation can often be largely ineffective.

7. Work capacity testing

Work capacity testing is already provided for under section 40A of the 1987 Act, which requires a worker to submit to a vocational assessment at the request of the Scheme Agent at any time. Failure to attend may result in a suspension of benefits.

Workers should be supported and encouraged to return to work. However, work capacity testing is predominantly used as a method of terminating weekly payments, rather than identifying appropriate employment prospects and assisting injured workers to locate such prospects. Many injured workers with a capacity to work cannot find work because of the nature of the labour market and the reluctance of potential employers to employ injured workers.

There are already mechanisms in place in the legislation and guidelines and these should be properly monitored and enforced rather than introducing new mechanisms which add to the cost of the scheme.

The suggestion that ceasing payments will "assist injured workers to move forward from their workplace injury to focus on their future employment prospects" is as

offensive as it is misconceived. It is prefaced on the unsubstantiated assumption that injured workers do not want to return to work.

8. Cap weekly payment duration

The ALA repeats what has been stated in paragraphs 6 and 7 above. It is absurd to suggest that upon the automatic termination of their weekly payments after a specified period of time after the date of injury, a worker with an injury will just walk into a new job.

The 1987 Act already adequately provides for the termination of weekly payments in appropriate cases under section 52A.

9. Remove "pain and suffering" as a separate category of compensation

Compensation for pain and suffering under section 67 of the 1987 Act is the only part of lump sum compensation that differentiates between injured workers having regard to their age and impact an injury has had on their lives. Under section 66 of the 1987 Act, injuries of the same percentage are worth the same dollar amounts regardless of whether the worker is 60 years of age or 20 years of age and having to suffer from the injury and resultant impairment for the rest of his/her life.

The maximum payment for pain and suffering is $50,000. It is not a significant amount and has not been increased since 1996. Only those assessed at 10% WPI or greater are entitled to claim lump sum compensation for pain and suffering. Significant injuries involving a great amount of pain, suffering and restrictions on activities of daily life do not reach the 10% threshold.

The ALA submits that the better way to deal with lump sum compensation would be to reintroduce the Table of Disabilities as the measure for lump sum compensation. The Table of Disabilities was based on the permanent loss of efficient use of specified body parts and takes better account of personal suffering.

The Issues Paper refers to reducing administrative costs. A significant cost of administration of lump sum claims is not due to the lump sum payment itself but the

introduction of the inability to negotiate section 66 WPI percentages. Currently, WorkCover can only pay a claim based on a percentage contained in a medical report. The idea behind the introduction of the WorkCover Guidelines to Permanent Impairment and use of the American Medical Association Guides 5th Edition was to reduce disparity between assessments. It was suggested that any doctor should come up with the same assessment of WPI. This has not occurred. The Guidelines provide for a great amount of clinical discretion and have resulted in significant disparity between doctors trained in the Guidelines including Approved Medical Specialists (AMS's appointed by the Workers Compensation Commission). When there is a dispute about the level of WPI of an injured worker, the dispute can only be resolved by the preparation of an Application to Resolve a Dispute lodged in the Commission, the filing of a Reply to the Application, referral of the worker to an AMS examination and reporting by an AMS. The administrative cost of this process is significant. A standard AMS fee is $1,099.00. Where a review of an AMS is required this requires the compilation of an medical panel which costs $2,500 for each dispute solely in the cost of the medical panel.

The ability to negotiate between assessments of whole person impairment would significantly reduce the administrative costs involved in these disputes.

The Grellman report, upon which the idea of not being able to negotiate between percentages was based, was a much better design in that the AMS did not perform a fresh WPI assessment. The AMS had to pick between one doctor's opinion over the other. This resulted in workers and insurers arranging medical opinions from "middle of the road" doctors and there was a progression towards the mean.

10. Only one claim can be made for whole person impairment

Permitting only one claim for whole person impairment is fundamentally unfair and fraught with difficulty. If an injured worker only has one opportunity at making a claim for lump sum compensation, this will result in significant delays in workers bringing their claims for lump sum compensation. Take, for instance, a back injury, most people will try conservative measures before turning to surgery. A decision to undergo surgery is often not made until say, 4 years post accident. An injured

worker considering surgery would need to wait a significant period before being able to bring their claim for lump sum compensation.

Another example is where a worker has undergone a partial meniscectomy. Any prudent lawyer would have to advise the worker to wait until undergoing a total knee replacement before making a claim for lump sum compensation.

Significant deteriorations in an injury ought be compensated and often cannot be predicted.

The suggestion that this proposal may reduce the ability of fraudulent or exaggerated injuries to meet the thresholds indicates a lack of understanding of the method of WPI assessment. The Guidelines already make provision for exaggeration and inconsistent presentation to be taken into account by the medical assessor.

11. One assessment of impairment for statutory lump sum, commutations and work injury damages

If what is meant by this proposal is that an assessment of WPI, either agreed or assessed, is to be used for the assessment under section 66 in considering whether the threshold for Work Injury Damages (in s151H, 1987 Act) and for the threshold in section 87EA, 1987 Act then the ALA agrees this is appropriate. A decision in *JC Equipment Hire Pty Ltd –v- Registrar of WCC*[12] created difficulty in that the Court held that an assessment for the purpose of section 66 of the 1987 Act was not binding for the purpose of whether a worker exceeded the threshold in section 151H of the 1987 Act. This was overcome by a WorkCover directive to Scheme Agents that they were not to create a dispute about section 151H where a worker has already been assessed at least at 15% WPI for the purpose of section 66 of the 1987 Act.

[12] (2008) 70 NSWLR 704

12. Strengthen work injury damages

The Issues Paper describes the NSW Workers Compensation Scheme as one of the most generous benefit systems in the nation. This is far from true particularly in respect to work injury damages claims. Changes to the Workers Compensation Scheme that came into effect on 27 November 2001 restricted the circumstances in which an injured worker can claim damages from their employer by imposing a threshold and significantly restricting the amount of damages that can be claimed once that threshold has been met. Before an injured worker can make a claim for damages, an injured worker has to demonstrate a severe injury so as to meet the impairment threshold and once a worker does so, they are restricted to claiming only economic loss capped at a weekly compensation. Worse still, they forgo any other benefits in the no-fault scheme, such as treatment expenses and domestic assistance. A seriously injured worker who relies on ongoing medical treatment and care would be ill-advised to pursue a work injury damages claim and more commonly will remain in the system, even though they have been assessed as exceeding the impairment threshold of 15% and can establish that the work injury resulted from the negligence of their employer.

The main provisions of the *Civil Liability Act NSW 2002* dealing with negligence largely reflect the common law hence, it is not correct to say that the principles used to determine negligence in work injury damages matters diverge from the general law. It is a long established principle at common law that employers owe a non-delegable duty of care to their employee.[13] It is the duty of a employer to take reasonable care to avoid exposing employees to unnecessary risks of injury. The common law duty is not inconsistent with the principles of negligence now enshrined in the *Civil Liability Act*.

The ALA cannot understand the suggestion that work injury claims being excluded from the *Civil Liability Act* "compromises the ability of insurers and employers to defend work injury damages claims".

There are a number of provisions of the *Civil Liability Act* that are inconsistent with the duty of care owed by an employer to an employee for instance, sections 5F, 5G

[13] *Stevens v Brodribb Sawmilling Company Pty Ltd*

and 5H which deal with obvious risks; sections 5L and 5K which deal with dangerous recreational activities and section 5M which deals with risk warning.

As the main focus of the Inquiry is to reduce the alleged deficit, the ALA fails to see how bringing work injury damages within the *Civil Liability Act* sections dealing with negligence will have any impact on the deficit.

13. Cap medical coverage duration

The aim of the Scheme is a safe, durable and quick return to work. Appropriate, reasonably necessary, medical treatment is a significant factor in driving return to work and maintaining an injured person's capacity to remain at work. The legislation provides that treatment is payable so long as it is reasonably necessary, assists return to work and maintains a level of capacity. The ALA does not support a change in the legislation framework.

The need for treatment must be assessed on a case by case basis and not by some arbitrary cut off point after a particular period of time. A cap on the duration of medical treatment assumes that all people have the same pain threshold. This proposal is clearly misconceived.

By capping the availability of medical treatment, those with ongoing permanent disability but who have been able to return to work, are likely to be unable to remain at work without ongoing "maintenance" treatment.

The E&Y Review at page 5, correctly identifies that deterioration in medical expenses can impact weekly, section 66 and section 67 and work injury damages payment types.

14. Strengthen regulatory framework for health providers

The Issues Paper suggests that the Scheme should only be liable for evidence-based treatment that improve return to work outcomes. If the Scheme only pays for treatment that assists return to work, then this would result in a quadriplegic being

unable to obtain payment of treatment for the obvious reason that they are never going to return to work. Ongoing treatment helps workers stay at work.

S297 of the WIM Act which relates to interim payment directions for medical expenses compensation states that the direction is warranted if satisfied "*that the treatment or service to which compensation relates is reasonable necessary: (a) to prevent deterioration of the worker's condition, (b) to promote an early return to work, or (c) to relieve significant pain or discomfort..*" The ALA supports that this adequately sets out which treatments should be paid for. Treatment that prevents deterioration and allows a worker to stay in suitable employment is scheme resources well spent, given the aim is to return injured workers to work and enable them to continue to be able to work.

15. Targeted commutation

If the focus of WorkCover is to reduce weekly benefit liabilities of the scheme, an obvious solution is to reintroduce unrestricted commutations of workers' entitlements.

In 2001 WorkCover advised that the average commutation figure was $45,000, which was one third of the average estimate on a file commuted.

The ALA submits that there should be no threshold for commutations and no requirement for approval by WorkCover. Commutation is only available by agreement with the insurer. The ability to commute one's rights is controlled by the insurer. The Nominal Insurer can issue directives to control the types of claims that can be commuted. Where the value of the commutation exceeds the projected value of entitlements to a worker the insurer, in the exercise of its role, would simply not agree to the commutation. To protect the worker, there should be certification by a lawyer that the sum is appropriate.

Making commutations more readily available achieves the following:

(a) Reduces weekly benefit liabilities of the Scheme;
(b) Reduces the medical and treatment related expense liabilities of the scheme;
(c) Brings "tail claims" under control;
(d) Reduces the significant ongoing administrative cost of claims;

(e) Reduces the incidence of lump sum top up claims;

(f) Provides an overall saving to the Scheme through the discounted buyout of a worker's continuing entitlements to benefits;

(g) Allows workers to get on with their lives by providing them with the option of removing themselves from the Scheme with dignity rather than remaining on the "slow drip feed" of weekly benefits from the Scheme.

The actuaries are generally opposed to commutations – their argument being that it will encourage more people to pursue small claims. The current threshold of 15% WPI for commutations is too high. Such threshold does not enable the very claims that are a long-term expense to the Scheme to exit the Scheme. For example, chronic injuries to necks and backs causing permanent disability are assessed at between 5% to 8% WPI. Those are the very types of injuries that require long term treatment and prevent people from finding work. Commutation of those types of claims are the very claims that would significantly reduce the ongoing liabilities of the Scheme.

At this point it would be appropriate to refer to the adverse reference to "lump sum culture" which surfaced unsubstantiated in the last major review of the Scheme before General Purpose Standing Committee No 1 in November 2001 and again in recent months leading up to this inquiry. The concept of "lump sum culture" has not been defined by those bandying it about. No clear argument has been articulated as to why the payment of lump sum benefits is problematic. Access to lump sum benefits is wholly consistent with Article 3(a) of the Convention on the Rights of Persons with Disabilities, which mandates respect for the inherent dignity, individual autonomy including the freedom to make one's own choices, and independence of person with disabilities. The opponents of lump sum payments appear to advocate a system that removes the ability of injured workers to get on with their lives. The implication being that injured workers are either not capable of, or cannot be trusted to, make decisions in core areas of self determination such as health outcomes, vocational choices and financial certainty. Are these people seriously suggesting that a micromanaging bureaucracy (WorkCover), that has demonstrated it cannot keep its own house in order, is somehow best placed to make decisions as to the needs of injured workers?

One of the principal reasons espoused to justify the significant Scheme changes in 2001 was that a lump sum culture existed and that it was creating a "*financial blow out*". The legislative changes that followed, including substantially reduced access to common law rights and significant restrictions to commutations, have not constrained the financial blow out. What is clear, however, on the available data is that the number of common law claims and commutations in the system have substantially reduced, as have the sums paid, when compared to claims prior to the 2001 changes. Taking the aforesaid into account, logic dictates that there must be other explanations for the cause of the Scheme's alleged projected deficit.

16. Exclusion of strokes/heart attack unless workers' employment a significant contributor

This proposal is unnecessary. Section 9A of the 1987 Act provides that the employment must be a substantial contributing factor to the injury or illness. If in an individual's case the employment has been a significant contributing factor to the stroke or heart attack then the injured worker should be entitled to compensation, as with any other injury where work has been a substantial contributing factor. The Act already adequately provides the requisite legislative controls for these types of claims.

CONCLUSION

The starting point for the inquiry must be a comprehensive analysis and review of WorkCover's management of the Scheme. Cuts to benefits and workers' rights should be an absolute last resort. Any reform of the scheme must be fair, effective, affordable, principled but not ad-hoc.

AUSTRALIAN LAWYERS ALLIANCE

APPENDIX 1

BENEFITS AVAILABLE UNDER THE SCHEME

Weekly Benefits - Total Incapacity

Total incapacity occurs when, as a result of a compensable injury, a worker is unable to perform any work at all in the labour market reasonably available to him having regard to his skills, education and other relevant circumstances.

During the first 26 weeks of total incapacity a worker who is totally incapacitated is entitled to receive the current weekly wage rate. If the employment is one to which an award or enterprise agreement is applicable the current weekly wage rate is the rate provided under that award or enterprise agreement for a 40 hour week without including any overtime, shift penalties or the like. If the employment is not subject to an award the current weekly wage rate is 80 per cent of the worker's average weekly earnings. In the case of part-time workers the payment cannot exceed average weekly earnings. This means that an injured worker rarely gets compensation at the rate he was earning being the rate consistent with his or her financial commitments.

Regardless of the amount of wages being lost the payment during the first 26 weeks cannot exceed a maximum prescribed amount which is currently $1,838.70 per week.

After the first 26 weeks, there is a step down in the benefit payable for a totally incapacitated worker. The rate then becomes the lesser of 90 per cent of average weekly earnings or a statutory rate prescribed under the Act. In the vast majority of cases it is the statutory rate that becomes applicable. The current statutory rate for a single worker with no dependants is $432.50 per week. As at November 2011, average full-time adult ordinary time earnings were $1,333.40. The current statutory rate for a single worker is currently less than one-third of average ordinary time earnings.

The statutory rate provides additional amounts for a dependant spouse and dependant children. Those amounts are currently $114.00 for a dependant spouse and $81.50 for a dependant child.

The step down to the statutory rate often results in significant financial hardship. In many families both parents are working in order to meet their financial commitments. People have mortgages which reflect the high cost of property and which are consistent with their level of earnings. Once a totally incapacitated worker is reduced to the statutory rate he or she is often unable to meet their basic financial commitments.

Weekly Benefits - Partial Incapacity

Partial incapacity occurs when an injured worker is unable to perform the duties of their pre-injury employment but is capable of performing some other form of work. During periods of partial incapacity an injured worker is entitled to the difference between what they would have been earning if they had remained in their pre-accident employment performing the same duties for the same number of hours and what they are now capable of earning in some suitable employment. The calculation of what a person is capable of earning makes the assumption that the injured worker makes all reasonable efforts to obtain employment. The assumption is that if all reasonable efforts are made the injured worker will on average earn a certain amount of money per week.

The amount of money that can be paid to a partially incapacitated worker cannot exceed the amount that would be paid if the same worker was totally incapacitated. In most cases this means that the maximum amount payable is the statutory rate.

If the circumstances are such that the amount calculated as above would over compensate the worker then the amount payable can be reduced. This happens in circumstances where it can be shown that it is unlikely that the injured worker would still be working in any event. There is no provision for increasing the payment to an amount greater than the bare mathematical differences set out above.

Young workers are often disadvantaged by the calculation as it currently stands. The calculation is always by comparison to what the worker would have earned if they had continued performing the same number of hours doing the same work.

Generally speaking no account is taken of possible advancement at work as a result of promotion, further training or increased experience. The system is particularly harsh for people who happened to be working part-time when their injury occurred. They are forever pegged to the earnings of a part-time worker regardless of what their intentions may have been.

Weekly payments of compensation continue whilst a worker remains incapacitated until 12 months after the date on which the worker qualifies for an aged pension.

A partially incapacitated worker can lose the entitlement to weekly compensation after 2 years if they do not continue to look for suitable work, have at any time unreasonably rejected suitable employment or are unemployed primarily because of the state of the labour market.

Weekly compensation may be suspended whilst there is an unreasonable failure to comply with an injury management plan or an unreasonable failure to undergo an assessment of ability to earn.

The current system rewards the injured worker who is successful in obtaining employment and exercising the full extent of their residual earning capacity. This is because they get the benefit of their actual earnings in addition to the weekly payment of compensation. For example a worker with an ability to earn $500.00 per week who obtains such employment is $500.00 per week better off then another worker with the same capacity who does not return to work.

Medical Expenses

In addition to but separate from the obligation to pay weekly compensation, an employer is also required to pay for hospital and medical treatment which is reasonably necessary as a result of the injury. An employer is liable for a maximum of $50,000 for medical treatment, $50,000 for hospital treatment and $10,000 for ambulance services unless a direction is given by the Commission or the WorkCover Authority.

Permanent Impairment Benefits

When an injury results in a permanent impairment there are additional amounts payable as permanent impairment benefits. The impairments are assessed using

the American Medical Associations Guides: The Evaluation of Permanent Impairment 5th Edition as modified by the WorkCover Guides for the evaluation of permanent impairment. Whilst the Guides attempt to deal with all body parts they do not take into account all of the consequences of an injury when assessing impairment. An impairment is, in respect of different body parts, assessed only taking certain aspects into account. For example when assessing impairments of the legs there are thirteen ways in which an impairment can be assessed looking at different effects of the injury. Despite the fact that an injury may result in effects that fall within a number of different bases of assessment, in most cases an assessment must be made by choosing one basis to the exclusion of others. It is also significant that an assessment of whole person impairment does not take into account pain nor does it take into account the extent to which an impairment affects the worker's ability to lead a normal life or the duration of that effect.

For example, a 60 year old labourer who loses the last joint of his left index finger receives the same compensation as a 25 year old concert violinist whose whole career is destroyed by the same injury.

Permanent impairment benefits are awarded in accordance with a sliding scale. Whilst the maximum amount payable is $220,000, it does not follow that there is $2,200 payable for each percentage of impairment. For impairments which are not greater than 10 %, which describes the vast majority of compensable impairments, the amount payable for each percentage point is only $1,375. There are many significant injuries which do not exceed 10% whole person impairment. For example, a neck or back injury cannot exceed 8% unless there has been surgery or there is significant nerve root compromise. An injury to the knee requiring a knee reconstruction is 0% impairment unless there is residual ligament laxity. A total meniscectomy is only 3 % and a total patellectomy is 9 %. Injuries such as rotator cuff injuries requiring reconstruction rarely attract impairments of greater than 4% or 5%.

The system currently provides that if an injured worker's condition deteriorates so that there is an additional impairment, then a worker may claim that additional impairment. Many injuries, particularly those involving joint surfaces, often put in train a process which may some years later lead to a very significant impairment.

The current system allows an injured worker, who is usually under financial stress, to gain the benefit of a payment for his current permanent impairment and then to be paid the balance of his full entitlement at a later stage.

Pain and Suffering

If an injured worker has an impairment of at least 10%, he qualifies for an additional payment for pain and suffering. The maximum amount payable for pain and suffering is $50,000. This figure has not been adjusted since 1996, at which time it was reduced from a previous figure of approximately $65,000. The payment for pain and suffering is the only payment that in anyway compensates an injured worker for the impact that the injury has on their day to day lives. The maximum amount of $50,000 is only payable in a most extreme case of pain and suffering. This category usually includes quadriplegic, some paraplegics and other catastrophic injuries. In all other cases, the injured worker receives an amount which is reasonably proportionate to the maximum amount having regarded the degree and duration of pain and suffering and the severity of the permanent impairment. The pain and suffering element is the only offset against the inherent inequities of an assessment of whole person impairment. Because of the way in which the guides are formulated there are many instances where extremely painful and debilitating conditions do not equate to a large whole person impairment. Conversely there are conditions which equate to a significant whole person impairment but which do not involve much pain or interference with daily living.

Death Benefits

The Act currently provides that when a worker dies as a result of work injuries there is a lump sum of $481,950 payable. That amount is payable regardless of whether the worker left any dependants. Where there are no dependants the monies are paid to the worker's legal personal representative. In the latter circumstances, the money will be distributed according to the deceased worker's will or if there is no will according to the laws of intestacy. In some circumstances this would result in a payment being made to the State of NSW.

In addition to the lump sum, there is a weekly payment in respect of each dependant child under the age of 16 or up to age 21 if they are a full time student. That weekly payment currently stands at $120.50 per week per child.

Work Injury Damages

If a worker is injured in circumstances where there is negligence by the employer and the injury results in a whole person impairment of at least 15%, a worker can bring a claim for work injury damages.

The claim for work injury damages is restricted to damages for loss of wages in the past and loss of earning capacity in the future. Before bringing a claim for work injury damages, a worker must have claimed and been paid his entitlements to permanent impairment benefits. The consequence of receiving a payment of damages is that a worker ceases to be entitled to any further workers compensation benefits, including treatment, rehabilitation, care and "top up" impairment claims. There is no separate entitlement to "general damages" or non-economic loss damages. In calculating the amount payable, the employer gets credit for any amounts which had already been paid by way of weekly compensation.