Submission No 124

INQUIRY INTO NSW WORKERS COMPENSATION SCHEME

Organisation: Workers Health Centre

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Workers Health Centre

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Introduction:

Industrial Health and Research Foundation trading as Workers Health Centre is a not for profit organisation that provides rehabilitation and referral services for injured and ill workers and work health and safety related services to workers, business and the community.
The Centre has been in operation since 1976 and we are a small business. The business is genuinely committed to the fundamental principals of delivering quality rehabilitation services in accordance with the HWCA Nationally Consistent Approval Framework and Principles for workplace rehabilitation providers.

The Foundations objectives are to:

- Provide health related services, rehabilitation and referral services for injured workers.

- Provide education and research into occupational health and safety and injury management, to publish findings and make recommendations to appropriate bodies.

- Provide information and advice about health and safety hazards at workplaces and to conduct research into these and related matters.

- Educate workers and the community in relations to matters referred to in the clauses above and provide related services.

- Encourage self-reliance in occupational health and safety matters through education and demonstration.

- To be an independent, not for profit public policy think tank, dedicated to the preservation and strengthening of legislation pertaining to occupational health, safety and welfare, as well as compensation, injury management and rehabilitation for injured workers and the general community.

The Workers Health Centre welcome the opportunity to make a contribution in our capacity as a NSW Work Cover accredited Rehabilitation Provider in relation to the current review of the NSW Workers Compensation System.

Our role as Workplace rehabilitation providers is an important one - to identify and address the critical physical, psychological, social, environmental and organisational risk factors, which may have an impact on a worker's ability to successfully return to work.

Given the time constraints placed upon interested parties to make submissions, the WHC submission will attempt to comment on the major issues encountered in our day to day functioning as a provider in addition to

some of the issues raised in the NSW Workers Compensation Issues paper distributed by the New South Wales government.
This submission is made on the basis of a genuine commitment on our part to ensure NSW injured and ill workers have an appropriate and sustainable workers compensation system that truly supports and promotes adequate care, positive return to work outcomes, financial stability and compensation for those workers unable to do so.

Any changes to the Workers Compensation Scheme must positively enhance the scheme for all stakeholders; specifically injured workers and their families must be as a minimum no worse off than they are under the current regime.

The medias recent focus on a few isolated cases of injured workers alleged 'rorting' the workers compensation the writer believes is NOT representative of the overall participants in the system.

The view that the current NSW Workers Compensation is "generous" is misguided and from our experiences, factually incorrect.

Our experiences on a day to day basis working within the system with injured workers allows us to take this opportunity share our experiences trusting that a fair and equitable system can result.

The following issues relate directly to the inappropriateness of the Claims Management process.

Provider Experiences:

Service Provider: Scheme Agents:

In NSW there are seven scheme agents employed by Work Cover to:

- Issue workers compensation insurance policies.
- Determine and collect insurance premiums.
- Manage workers compensation claims.
- Provide support for injured workers, including rehabilitation.
- Pay workers compensation benefits to injured workers.

Currently this management accounts for 25 cents in every dollar spent on an injured workers claim compared to just 10 cents in 1997. Coupled with the fact that serious workplace injuries have decreased by 53% for the same period, this represents as an area that warrants further investigation for the purpose of cost reduction.

Lengthy delays in receiving approvals for rehabilitation services causes immediate delays in triaging clients and organisation of return to work programs.
We regularly experience documents being "lost' in the insurers internal systems and unnecessary conflict regarding the clients choice of provider.

Common comebacks from insurers regarding referrals include:

- *"We can't approve the services because you're not on our panel".*
- *"The doctors didn't make the referral so we cant approve services".*
- *"Why has the injured worker has chosen us as their provider –its our (the insurers) job to send them to one".*
- *"This worker doesn't need a provider"..*
- *"We can find a provider closer to where they live".*
- *"They were referred by their Union, not us so we cant approve services."*

There is considerable evidence to support the concept that initial engagement of key parties (worker, employer, doctor, insurer and other providers) in implementing an injured worker's return to work, significantly reduces the duration and associated costs of claims, including improving social and health outcomes for the worker concerned.

Refusal of treatment regimes and aids for injured workers suggested by medical professionals is a common frustration that again requires providers to allocate unbillable time to rectify. It is the view of the Centre, underpinned by the legislation that if a suitably qualified practitioner certifies and requests particular aids or treatment regime that will assist an injured worker, then approval should not be unreasonably withheld.

Most often these life-changing decisions are being made by insurance staff with little or no medical background based purely on cost alone.
A $250 chair to assist in a worker returning to suitable duties vs. additional costs in the working staying at home until fit for pre injury duties, demotivated and isolated from the workplace?

Whilst all other stakeholders in the system are required to acquire and maintain the necessary relevant qualifications for their discipline it appears, in our experience that insurers do not.

A high level of aggression is directed toward the us as the provider from insurance case managers while trying to pursue evidence based outcomes for injured workers. Insurance case managers have complained to Centre staff they are frustrated and overworked,' need to reduce the cost of the claim or close the case to ensure their "targets/bonuses" are reached and are trying to manage over 100 cases.'
This same aggressive behavior from insurance case managers is reported by injured workers and becomes an added stress to their already venerable state.

Providers are subject to stringent application and evaluation processes to become a provider and, once they are approved, must maintain that approval through conformance with the Conditions of Approval. In summary an organization wishing to be approved as a provider:

- Makes an application to the workers compensation authority in which approval is sought. The application outlines how their organisation will meet the Conditions of Approval. If the application is approved, the provider is granted a three year Instrument of Approval.

- Providers in the field of workplace rehabilitation must have the qualifications, experience and expertise appropriate to provide services

- After the first 12 months of approval the provider may be required to undergo an independent evaluation at the discretion of the workers compensation authority.

- During the three years of approval, the provider must complete annual self-evaluations and may be required to undergo a periodic evaluation and/or exception evaluation by an independent evaluator, initiated at the discretion of the workers compensation authority.

Clearly the regime is designed to evaluate and ensure quality participation of the key stakeholders providing service, yet there seems little evidence that that these provisions are a consideration for operating as case manger for an insurer.

These issues prolong providers commencing services in a timely manner, create unnecessary tension amongst the parties, frustrates the injured worker and is often a non-billable cost to the provider.

These delaying tactics are in direct conflict with the Nationally Consistent Approval Framework for Workplace Rehabilitation Providers, Clause 4.1 Service Provision Principles, “Providers are to deliver services to workers and employers in a cost effective, timely and proactive manner to achieve a safe and durable return to work.”

These issues in isolation and on an occasional basis would on the surface not be viewed as insurmountable hurtles.
However these types of issues are being experienced regularly not only by us as a provider but also by injured workers causing mounting pressures and over time become an obstacle to obtaining a safe and durable return to work. And become an additional cost to the scheme.

Current Management of the scheme:

- From 1997 to 2010 major workplace injuries fell by 53%
- From 1997 to 2010 inflation increased by 44%
- From 1997 to 2010 management fees increased by 236% (more than 5 times inflation).
- From 1997 to 2010 benefits paid increased by 43% (less than inflation).
- From 1997 to 2010 management fees per major injury increased by 620% (14 times inflation).
- If private insurer management fees had, like benefits, grown only by inflation then $1.6 billion dollars would have been saved.
- In FY 2010 management fees paid to private insurers accounted for 24% of the value of benefits paid to injured workers compared to just 10% in FY 1997.

Service Providers – Medical :

Injury and return to work is a managed process involving timely intervention with appropriate and adequate services based on assessed need by suitably qualified stakeholders.

The medical practitioner has a key role in the scheme:

- **Medical certification -** outlining diagnosis, management plans, opinion on whether the injury is work related and the capacity for work.
- **Recommending reasonably necessary treatment -** responsible for recommending reasonably necessary treatment and any necessary ordering of appropriate medical investigation.
- **To communicate** with all parties to assist in the development of injury management and return to work plans.

Whilst most practitioners operate appropriately, delays and reluctance in diagnosis of an injury and illness continues to occur. Injured workers referred to 'preferred' employer practitioners who make no diagnosis and subsequently offering no treatment regime for even the most straightforward injuries is a cost to both the injured worker and the scheme. Without a diagnosis and treatment plan injured workers are left to linger with pain and quite probably a worsening of the injury or illness requiring additional medical intervention and time away from work.
An example of this is Injured Worker 1 who sustained a back injury as a result of a serious workplace fall. Referral was made 4 hours after the incident to the company doctor who saw the Injured Workers for 5 months without making a diagnosis or ordering any further investigative tests. When her brother bought her to the Centre 5 months later she was unable to walk, was in pain and suffering incontinence issues due to the a back injury. She now has a long term injury that may have been averted with early diagnosis and adequate medical intervention .

Of equal importance is the growing trend with larger employers for injured workers to be treated on site before diagnosis. Physiotherapy is the most common with several manipulative procedures sometimes being performed before referral to a medical practitioner .The result often being exacerbated before medical diagnosis and treatment is sought.
Again the cost of not receiving immediate diagnosis and treatment is a cost borne by the injured worker and the Scheme.
An example of this is Injured Worker 2 who after a fall at work was directed by her supervisor to the employer preferred physiotherapist. After a week, 4 attendances and continuing pain the worker was taken by a family member to see a Doctor. Following x-rays she was advised she had sustained a broken wrist that now required surgery and an extended recovery period.

Stakeholder Participation – Employers:

Commitment from business to return injured workers to duty/redeployment:

The employer's commitment to provide suitable duties and a sustainable return to work is a fundamental part of the current Scheme.

The *Workers Compensation Act 1987*, *Work Injury Management and Workers Compensation Act 1998* and the *Workers Compensation Regulation 2003* detail the workers compensation, injury management and return to work responsibilities of employers.
The goodwill and intent encompassed in the legislation however are not always replicated in such a positive way on the job.
Employers often create artificial barriers in our attempting to return injured workers to durable long-term employment.
Suitable duties are withdrawn, not because they don't exist but simply because the employer makes a decision to withdraw them with little or no recourse for the injured worker. Forcing the injured worker to rely on the Scheme for payment, often at a reduced rate of pay than they would receive if on a suitable return to work program.
Redeployment within the same business, despite intervention from providers to identify options available to support the return to work, is often met with rejection by employers. Even the largest employers who have a greater ability for retraining and redeployment to alternate duties within their brand are very low.
Termination is often the result of claims greater than 6 months old and often used by employers as a means to 'clean out' unwanted workers from the workforce.
Again adding to the cost of managing the scheme – additional rehab costs, lengthy and costly retraining, extended periods of benefit reliance whilst job seeking in a slow labor market and sometimes additional costs for psychological counseling for depression resulting from long term unemployment.
The cost to the injured worker, in addition to their injury or illness, is often the loss of the family home, breakdowns in family relationships, loss of future income including retirement earnings, psychological breakdown and sadly sometimes suicide. The Safe Work Australia, Cost of work related Injury and Illness Report, January 2012 highlighted that *"In terms of the burden to economic agents, per cent of the total cost is borne by employers, 74 per cent by workers and 21 per cent by the community.*

"The trends over the three iterations of this report are for an increasing proportion of costs borne by workers and a decreasing proportion of costs borne by the community."

Injured Worker 3 was terminated from her employer after 6 months .Her income dropped to the statutory rate and she was unable to meet the cost of her mortgage, lost the family home and is now living with her daughter. She had to sell her car as she could not meet the costs of running a vehicle and is now reliant on using public transport to job seek. Injured Worker 3 is suffering

from severe depression and has contemplated suicide as a result of the injury and subsequent financial implications.

A distinct and enforceable commitment to ensuring injured and ill workers return, where medically possible, to the pre injury employer is crucial in any new reforms.

Private Investigators:

The increased role of investigators under the current Scheme is costly and appears to deliver no added value to any of the stakeholders or the Scheme. Injured workers being 'investigated', mostly for no apparent reason by hostile insurers engaged by Scheme agents hamper rehabilitation. The injured worker becoming extremely anxious creating another barrier in our attempts to return to them to work.
Injured Worker 4 suffering a physiological injury was subject to aggressive questioning by an investigator and suffered a major setback in his treatment as a result. Increased anxiety levels for the worker resulting in delayed return to work and subsequent cost to the Scheme.

A former Allianz Case Manager has provided the following information regarding the insurance industries wide spread use of investigators .

"The main reason for use being to defend a claim, mitigate liability and deny benefits".

Private investigators (and firms) are judged and rated by WorkCover insurance companies on their ability *to "assist in reducing liabilities".* If the chosen private investigator (or the firm) fails to provide -what they call- "*positive results"* on a consistent basis, the private investigator (or firm) will simply be replaced by someone who will provide *"positive results".*

The term, "positive results*",* simply means the documentation that is required to reduce or eliminate claims."

Despite the escalating costs of private investigators to the Scheme over past years there is little evidence to support the public misconception that injured and ill workers are making fraudulent claims.

"*Fraud is an unacceptable aspect of any insurance scheme and therefore requires appropriate audit and fraud detection programs to ensure scheme integrity. In the case of workers' compensation most attention is focused on workers. In Australia this occurs to such an extent that a 2003 federal parliamentary inquiry noted there appeared to be "a general perception that workers are automatically suspected of fraud" (HRSCEWR 2003: xxi). This often has the effect of stigmatising injured workers and the system of workers' compensation itself, despite the fact that worker fraud does not appear to be a significant problem. A review of some 20 government workers compensation*

enquiries conducted by state and federal governments in Australia found no evidence that fraud by workers was rife (Garnett 2000: 11). More recently, the 2003 parliamentary inquiry concluded that "*the level of employee fraud is minimal" (HRSCEWR 2003: xxix). The preoccupation with presumed worker fraud also diverts attention from fraudulent activity by other workers' compensation scheme participants".* K.Purse outlines in his paper titled Provisions of Fair and Competitive Workers Compensation , 2011.

Workers Health Centre comments on the Issues Paper:

The content of the Issue Paper highlights a need for improvement to a '*broken* ' scheme and the need to produce good outcomes for injured workers –there is no doubt this is an agreed view.
The main thrust of Workers compensation Issues Paper appears however to have been devised to appease corporate Australia, and is not centrally focused on the well-being of injured workers and their families.

The Financial viability of the Scheme:

The size of the deficit is in large part due to poor investment returns during the Global Financial Crisis. Therefore the deficit will reduce as the economy improves. Injured workers should therefore not be expected to negatively impacted by factors outside of their control.
It is evident that the workers compensation system has enough money to meet its current liabilities.
The size of the deficit is based on an estimate of future potential claims, which is something very difficult to accurately predict.

From 1997 to 2010 scheme agent management fees per major injury increased by 620%! Refining claims management and in turn reducing the costs paid to insurers in administration would provide substantial and immediate savings.

An analysis by The Greens of Work Cover's annual returns shows a staggering rate of growth in the fees paid to private insurers to manage workers compensation claims. Over the same period injury rates have fallen and benefits paid to injured workers have barely kept up with inflation.

"Payments made to private insurers are to manage claims and encourage those injured to return to work. The $3.9 billion paid to these private insurers since 1996 has not lead to any significant increase in injured workers returning to work. There has been almost no change in the rate at which injured workers have returned to work since 2003.[1]

Management fees paid to the private insurers have grown from just 10% of the cost of benefits paid in FY 1997 to more than 24% of the benefits paid to injured workers in FY 2010.

The simple fact is there has been hundreds of millions of dollars wasted every year on endless reporting and form filling by private insurers. This bureaucratic tangle has been delivered by the agency overseeing the scheme, WorkCover."

Source -$1.6 Billion wasted on paper shuffling by WorkCover- Greens D.Shoebridge May 14,2012

Date	Payment to Private Insurers	Payment to private insurers if limited to inflation of 2.5%	Benefits paid (unadjusted)	Number of Major injuries[1]	Management fee per major injury
1996/97	141,743,000	141,743,000	1,367,805,000	60,109	2,358
1997/98	137,676,000	145,286,575	1,467,737,000	58,604	2,349
1998/99	163,400,000	148,918,739	1,811,025,000	55,492	2,944
1999/00	134,654,000	152,641,707	2,016,000,000	53,224	2,529
2000/01	177,868,000	156,457,506	2,191,847,000	53,797	3,306
2001/02	160,730,000	160,369,194	2,692,423,000	54,674	2,939
2002/03	196,440,000	164,378,424	2,518,760,000	51,000	3,851
2003/04	172,392,000	168,487,884	2,047,690,000	51,551	3,344
2004/05	331,538,000	172,700,082	1,608,936,000	36,150	9,171
2005/06	393,587,000	177,017,583	1,518,437,000	31,613	12,450
2006/07	398,479,000	181,443,023	1,581,846,000	29,326	13,587
2007/08	649,538,000	185,979,099	1,632,507,000	30,077	21,595
2008/09	376,229,000	190,628,576	1,836,039,000	30,133	12,485
2009/10	476,996,000	195,394,291	1,962,418,000	28,056	17,001
Total	$3,911,270,000	$2,341,445,683			

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[1] Defined as an injury causing 5 days or more off work

Employer premiums:

NSW employers have enjoyed reduced premiums in recent years and must not rule out some movement in premiums to assist in supporting the scheme.

In 2010 WorkCover NSW CEO Ms Lisa Hunt reported:

*"Worker's compensation premium rates were reduced by up to 2.5 per cent from 30 June 2010**, the sixth premium rate cut since November 2005.***

“The latest rate cut targeted those industries that showed a sustained improvement in work health and safety, injury prevention and management.

“Businesses operating in more than 240 industry classes had their premium rates reduced as a result.

“The reduction benefits more than 161,000 employers – or 55 per cent of employers covered by the NSW Workers Compensation Scheme – across the state,

Premium rates for all other industries were maintained at the same level as in the previous year.”

There is little evidence to support the past and current threats from businesses to take their operations interstate if premiums increase. In reality premiums represent less than 2% of a company’s operating expenses and NSW employers have enjoyed reductions in the recent past.

In the peer reviewed report titled “Provisions of Fair and Competitive Workers’ Compensation Legislation” by Dr. Kevin Purse of the University of South Australia the following is stated:

“In many respects, workers’ compensation policy in Australia can be characterised as the product of periodic bidding wars between the states. Implicitly, or otherwise, state governments have depicted cut price workers’ compensation arrangements, and the associated reductions in premium rates, as necessary to attract, or retain business, in their respective jurisdictions. Evidence in support of the ‘competitive premiums’ doctrine though remains conspicuous by its absence This is hardly surprising as differences in average premium rates between the states are generally less than 1%, and rarely in excess of 1.5%, of payroll. In South Australia, for example, the average premium rate during the 10 year period to 2007 varied between 2.46% to 3% - the highest of all the states - while in Queensland - at the opposite end of the premium spectrum - the average rate fluctuated between 2.15% and 1.2% ***(ASCC 2007: 20****). Despite this differential there has, as indicated earlier, been no evidence presented to suggest it resulted in an exodus of businesses and jobs from South Australia to Queensland or anywhere else.*

In practice, business relocation decisions tend to be based not on workers' compensation premium differentials of this magnitude but rather on total labour and operating costs as well as a range of other strategic considerations.
*The same conclusion has been reached in the United States where the catch cry of 'competitive' premiums has also figured prominently in the discourse surrounding workers' entitlements in the United States. When subjected to scrutiny by the National Commission on State Workmen's Compensation Laws in the early 1970s it was found, as in Australia, that premium rate differentials between the states for the average employer were relatively small. The National Commission's assessment was that "Surely no rational employer will move his business to avoid costs of this magnitude. For most employers, the costs are relatively insignificant compared to other differences among States, such as wage differentials or access to markets or materials" (**NCSWCL 1972: 124**).*

*The Industry Commission too, in its 1994 review of Australia's workers' compensation arrangements, was highly critical of the 'competitive' premiums doctrine arguing that 'competition' that reduced workers' entitlements in order to lower premiums was 'invidious' competition (**IC 1994: xxxi**). By contrast 'beneficial' competition was characterised in terms of initiatives that sought to improve occupational health and safety, claims management, rehabilitation and return to work outcomes (**Ibid: xxxii)**.*
*The inevitable by-product of the 'competitive' premiums doctrine is cost shifting. Although cost shifting can sometimes be a two way process, the Commission had no hesitation in concluding that in net terms cost shifting occurred on a large scale, and to this effect cited evidence which suggested that in 1991 alone cost shifting may have been in the order of $1 billion (**Ibid: 170-172**). This assessment highlights the fact that state based workers' compensation schemes act as a transmission belt for the externalisation of work-related injury costs from employers to the broader community, particularly injured workers and the taxpayer funded social security system. In effect, employers are subsidised for work-related-injury costs by the community, although the extent to which this occurs can vary significantly between jurisdictions. This in turn, it was argued by the Commission, can undermine the motivation for employers to prevent work-related injury and that of employers and insurers in facilitating early intervention and rehabilitation for injured workers (**Ibid: xxxi-xxxii**).*

*Similar concerns to those raised by the Industry Commission also featured in the findings of the National Commission of Audit, which reported on the issue to the Howard government in 1996 (**NCA 1996: 79-80**), and, more recently, those of the Productivity Commission in its 2004 inquiry (**PC 2004: 268-272**). Additionally, all three Commissions acknowledged the need for policy responses to tackle cost shifting. This was most clearly articulated in recommendations put forward by the Industry Commission which called for a more adequate compensation package for injured workers within a range of 2.5% - 3.0% of payroll (IC 1994: xxxvi), or failing this a concerted effort by the federal government to estimate the full extent of cost shifting and determine the best means by which these costs could be transferred back to the states (**IC 1994: 172-73**).*

In relation to assertions in the Issues Paper that NSW premiums are higher than Western Australia ,this is not correct with NSW target collection rate for 2011/12 1.68% whilst Western Australia have revised their collection rate to 1.69% as outlined below:

"WA WorkCover chair Greg Joyce has reported the average recommended premium rate will increase to 1.691% of total wages for 2012-13, up from 1.569% of total wages for 2011-12."While recommended premium rates have fallen significantly over the last decade, the challenging economic environment and improvements to worker entitlements have led to modest increases in recommended rates in the past two years," he said. Joyce said the 2012-2013 increase was attributed to a moderate increase in claim numbers, removal of age limits on workers' compensation and improved protection for workers employed by uninsured employers. "Reductions in real rates of return have also placed upward pressure on premium rates, offset to some extent by continued wages growth in WA," he said. The increase would not be applied uniformly across all 480 premium rating classifications, Joyce said."

Journey Claims:

The claims account for a small percentage (2.6%) of all workers compensation claims in NSW.
The Issues paper suggests that employers have limited control of such claims and that a journey to work is not considered to be done in the course of their employment. Research however suggests that:

"The principal argument in support of coverage is that journeys to and from work are essential to give effect to the employment relationship. As this activity is of benefit to employers and would not otherwise be undertaken workers should, as a general principle, be covered in the event of injury while traveling to or from work. As against this, it is often contended that employers should only be held accountable for risks which they can control. And since injuries associated with commuting to and from work attributable to negligence by employers is rare, they should not, according to the 'controllable risk' doctrine, have to bear responsibility for the costs involved with this type of injury. The main limitation with this line of reasoning, as indicated earlier, is that it implies that employers should only be held accountable for injuries which they can be expected to prevent.
This may make sense in the context of a tort based compensation scheme, but as applied to workers' compensation it serves to undermine the no-fault principle that underpins compensation for work-related injury. In practical terms it is also worth noting that much of the cost for journey injuries is recoverable from motor accident compensation schemes, thereby reducing their financial impact on overall workers' compensation scheme costs."

Injured Worker 5 is a NSW Police Officer injured in a motor vehicle accident after falling asleep at the wheel of his patrol car , travelling home after a 12 hour shift. The officer received multiple injuries that will continue to trouble him despite his return to duty.
Under the proposed removal of journey claims this officer would not be entitled to compensation. Journey claims must continue to be part of any reforms of the Workers Compensation system.

Weekly Benefits:

Provisional liability under the NSW Scheme refers to a situation in which weekly payments and medicals are granted to injured workers for up to 12 weeks on an interim basis to enable a full and proper determination of their claims for compensation. This provisions needs to remain as an integral part of the Scheme.

According to Mr Kevin Purse in his paper titled Provisions of Fair and Competitive Workers. Compensation Legislation ,2011 he states:

*"The main proponents of provisional liability have been trade unions, sections of the legal community and of the caring professions while opposition has been led by employer organisations (**Hanks 2008: 95-96**).*
*Employer opposition has focused on the potential for rorting and increases in scheme costs. However, on the basis of an analysis conducted by PricewaterhouseCoopers of the New South Wales provisional liability arrangements, the 2008 Victorian inquiry concluded that the limited evidence available did not support these claims (**Ibid: 106**).*
*This made the Brumby government's rejection of the inquiry's recommendation for adoption of provisional liability in Victoria, purportedly on the grounds that .it would put the ongoing viability of the scheme at risk. (**Victorian Government 2009: R.12**), all the more difficult to fathom. On the other side of the ledger, the New South Wales experience suggests that provisional liability facilitates speedier access to weekly payments and medical treatment. In relation to this first point, the scheme's management reported in 2002 that 77% of injured workers received their first weekly payments within seven days compared to 53% in the period immediately prior to the commencement of provisional liability arrangements (**WorkCover NSW 2002: 20**). The PricewaterhouseCoopers report, which examined the period from 2001 to 2007, also found reported provisional liability had significantly contributed to a more timely receipt of weekly payments (**Hanks 2008: 98**). Another advantage of provisional liability is that it facilitates improved claims decision-making and reduces unnecessary disputation over the acceptance of claims. In New South Wales, prior to the advent of provisional liability, 15% of claims were initially rejected but that 40% of these decisions were subsequently overturned on appeal. However, as the claims disputation process is often a drawn out affair it meant that workers with eligible claims were not infrequently subjected to delays of several months before they received their entitlements. Under the provisional liability arrangements, however, only 2% of workers who access provisional liability payments have their claims subsequently denied (**Ibid: 106**).*

There is also considerable scope for provisional liability to improve return to work rates. Historically, the return to work process has been a function of the claims determination process. Consequently, the longer it takes to correctly adjudicate workers. claims, the longer it takes to commence the rehabilitation and return to work process. By removing immediate liability and associated disputation issues from the 83 equation, provisional liability arrangements facilitate an earlier commencement to the return to work process".

Weekly benefits –Total incapacity

Any changes to weekly benefits must be based on improving payments to injured and ill workers . Injured workers MUST receive compensation weekly payments that are no less than their pre injury earnings. The current step-down to the statutory rate of $432 per week after 26 weeks does not financially sustain an injured worker. We reject any notion of step down provisions a these are merely a cost shifting mechanisms that impose economic hardship on injured workers, especially those with serious and ongoing illness and injury.

According to Mr K Purse on this matter he states:
*" A more appropriate approach might be to realign compensation on the principle that injured workers should receive weekly payments no more but no less than their pre-injury earnings. As a former South Australian Minister of Labour and Industry once expressed it, the main purpose of workers. compensation laws should be to ensure workers do not suffer financially because they have been injured in the course of employment. (**SAPD 1971: 4131)**. Depending on their circumstances, this principle already applies to many - if not the majority of - workers in most jurisdictions able to return to work before the operation of step-downs comes into play. Consequently, the adoption, or rather the extension, of this principle would treat, predominantly, seriously injured workers . those most in need - on the same basis as those with less serious injuries, and in the process eliminate the economic hardship occasioned by the imposition of step-downs.*
*There are at least four essential elements required to give effect to this approach. First, weekly payments need to be as closely aligned as possible with pre-injury weekly earnings. This entails the inclusion of payments for shift work, regular overtime and other allowances that normally comprise part of a workers. wages or salary. Second, caps on the maximum amount of weekly payments need to be reviewed, although in practice the current cap in some jurisdictions, such as South Australia and Victoria, of twice that of average weekly earnings (**SWA 2010: 165, WSV 2010: 2**) would probably suffice since the overwhelming majority of injured workers earn less than this amount. Third, weekly payments need to be paid on a timely basis consistent with the pre-injury payment of the workers. wages or salary. Fourth, payments need to be suitably indexed on a regular basis."*
The Centre does not support the use of introduction of further step downs in injured and ill workers weekly payments as one of the key indicators to returning the WorkCover budget to surplus.

Mr Purse goes on to say in his paper the following regarding ‘step-downs’:

“The rationale used to support step-downs in weekly payments is that they provide a necessary incentive for motivating injured workers to return to work. Despite this claim there has been no systematic Australian research that demonstrates this to be the case. What evidence there is has been drawn from North American studies and, on closer consideration, it is apparent that the moral hazard arguments and Econometric modelling on which these studies are based are flawed. It is also apparent that the return to work process is not the exclusive responsibility of injured workers but rather a joint responsibility that includes employers and scheme administrators. The real function of step-downs is not so much one of facilitating return to work but rather that of shifting costs for work-related injury”.

Partial incapacity payments:

The notion outlined in the Issues paper that states the partial incapacity payments are a disincentive are concerning at best. If injured workers were adequately compensated by no less than pre injury earnings this issue would be overcome.

Mr Kevin Purse in his paper titled **Provisions of Fair and Competitive Workers Compensation Legislation, 2011 is clear on this matter:**

“*In the case of total incapacity, weekly payments in New South Wales for workers covered by a collective agreement are equivalent to the injured worker’s award or enterprise agreement pay rate . .the award rate of pay. - subject to a statutory ceiling (of $1739.30 at October 2010), for a period of 26 weeks (**WCNSW 2010:10**).*

*However, allowances such as shift work payments, overtime and penalty rates are excluded from the calculation of weekly payments. Where a worker is totally incapacitated for more than 26 weeks, weekly payments are significantly reduced to a statutory rate. (of $409.10 at October 2010), although if the worker has dependents additional payments are available (**Ibid: 12, 18**).*

*Workers with a residual, or partial, capacity for work fall into two categories . those who are fit for work but not working in suitable employment and those who are working in suitable employment. Those in the former category, covered by a collective agreement, are entitled to weekly payments at the award rate of pay for the first 26 weeks and 80% of the award rate or the statutory rate - whichever is the greater - for a further 26 weeks (**WCA Act 1987: s.38**). Workers in the second category are eligible for make-up pay if they are earning less than their pre-injury average weekly earnings. (**Ibid: s.40**). Make-up pay is the difference between the injured worker’s pre-injury average weekly earnings, including shift work payments etc, and the amount earned from suitable employment. For the first 26 weeks this means a worker can receive a combined payment of their earnings from suitable employment and make-up pay (up to the award rate). Beyond 26 weeks, however, the make-up pay component is limited to the maximum available under the statutory rate*

*(**WCNSW 2010:8**). As make-up pay provides this latter category of worker with a higher level of weekly payments than might otherwise be the case, it is frequently described as providing injured workers with an .incentive. to return to work. A more accurate description is that make-up pay has the effect of softening the impact of an otherwise harsh weekly payments regime on injured workers. As such it falls well short of a best practice approach capable of underpinning the development of fair national workers compensation legislation".*

Capping of weekly payment duration:

If a workers is receiving weekly benefits it is because they have been certified by a suitably qualified practitioner that they are medically unfit for work. If they are a long-term injured worker then provisions must be utilized to exit the Scheme. Placing a cap on weekly payments will not "sharpen" a workers view to returning to the workforce if they are physically or mentally unable to do so.

Medical Costs:

Costs associated with medical and all related treatment must continue to be covered for injured and ill workers. There should be no limits placed on compensation for medical and related expenses 'reasonably' incurred by injured workers. Any alleged rorting by service providers must be dealt with by the Authority. *'Fraud is an unacceptable aspect of any insurance scheme and therefore requires appropriate audit and fraud detection programs to ensure scheme integrity. In the case of workers compensation most attention is focused on workers. In Australia this occurs to such an extent that a 2003 federal parliamentary inquiry noted there appeared to be a general perception that workers are automatically suspected of fraud. (**HRSCEWR 2003: xxi**). This often has the effect of stigmatising injured workers and the system of workers compensation itself, despite the fact that worker fraud does not appear to be a significant problem.' K.Purse 2011*

Caps on cost and duration for medical and related has high potential to see injured workers worse off. Mr Kevin Purse Provisions of Fair and Competitive Workers. Compensation Legislation Paper , 2011 says this on the subject**:**

*"The legislation in most jurisdictions contains wording to the effect that injured workers should be compensated for .reasonable costs. that are incurred. However, some jurisdictions including New South Wales, Victoria, and Tasmania impose limits on compensation for medical costs after which medical expenses are no longer covered. In New South Wales this is achieved through a financial limit on the amount of medical expenses available to injured workers (**WCA 1987: ss. 61-64**).*

*In Victoria, medical payments can be discontinued 52 weeks after their entitlement to weekly payments has ceased. For example, workers who have had their weekly payments terminated as a result of a work capacity review but who still require ongoing medical treatment may find that they no longer have any entitlement as a result of this provision (**ACA 1985: s. 92AD**). A similar provision to that contained in the Victorian statute can also be found in Tasmania legislation (**WRCA 1988: s. 75**).*

Elsewhere, as in South Australia, Queensland, the Northern Territory and the

*Commonwealth there are no such artificial limits on workers. coverage in relation to medical expenses. Jurisdictions also avail themselves of fee schedules, or other methods, that may regulate charges for medical and related services provided, and are justified as being necessary in order to prevent overcharging by service providers. While this is not unreasonable, it is essential that injured workers are not caught in the crossfire between scheme administrators and service providers over the appropriate level of charges for particular services. This has been recognised in some jurisdictions, such as New South Wales and South Australia, where provisions that protect workers from liability for medical and related charges above those contained in fee schedules, or other regulatory instruments, have been given legislative force (**WCA 1987: S. 60A, WCA 1986: s. 32**). As a further safeguard, legislative mechanisms for ensuring adequate consultation with peak trade union and employer bodies prior to fee schedules being prepared are important.*

Recommendations:

- Costs associated with medical and all related treatment should be covered
- for workers compensation purposes.

- There should be no arbitrary limits placed on compensation for medical and
- related expenses reasonably incurred by injured workers.

- Workers who require ongoing access to medical and related treatment
- pertaining to their injury should continue to be entitled to compensation for
- medical and related expenses where their weekly payments have been
- terminated.

- Workers should not be liable for medical and related costs, including for
- charges above those contained in fee schedules, or other regulatory
- instruments.

- Where fee schedules for medical and related expenses are proposed this
- should be undertaken in consultation with representative trade union and
- employer organisations."

<u>Lump Sum Benefits:</u>

The majority of NSW workers who suffer a work-related injury or illness are not left with physical or psychological damage of a level that they are able to reach the already high threshold. Those eligible for permanent impairment payments and benefits must continue to have these provisions exist in any reforms.
"In some jurisdictions, notably New South Wales, there is an explicit provision for lump sum compensation in respect of both permanent impairment and pain and suffering associated with the impairment (A**CA 1985: ss 98C and 98A, WCA**

1987: ss 66 and 67). The inclusion of a specific provision for pain and suffering is of considerable significance because it provides a mechanism that enables consideration to be taken of the impact of the impairment on an individual workers quality of life. It also provides a corrective to the use of the *AMA Guides to the Evaluation of Permanent Impairment* - and assessment protocols based on the *AMA Guides* . which have historically failed to satisfactorily address this issue (**Burton 2008: 21-29**)
There are two main justifications put forward in support of permanent impairment thresholds. The first is that thresholds facilitate more efficient scheme administration in that they ensure that scheme administrators have less permanent impairment claims to administer. The second is that they provide a mechanism for weighting .the payment of lump sums for non-economic loss to the most seriously injured. (**WorkCover SA 2006: 30**). As regards this latter issue, it is undoubtedly the case that higher weightings should be attached to those injuries resulting in higher impairment levels. This, however, does not require that those workers with comparatively less severe injuries should be excluded from entitlement to permanent impairment payments.

Recommendations:

- *"Lump-sum payments should be available for permanent impairment, pain and suffering, gratuitous care and for terminal conditions associated with latent onset injuries." States Mr Kevin Purse*.

Work Capacity Testing:

Work capacity reviews are currently utilised under the current NSW Scheme. The reviews enable scheme agents after 104 weeks of incapacity to terminate weekly payments to an injured worker on the presumption that they can obtain suitable duties.
There is no obligation to prove that suitable is actually available and so in most cases does not provide the injured workers with any result other than continued unemployment with out monetary support.

Provisions of Fair and Competitive Workers. Compensation Legislation, 2011
Mr K Purse Says on the issue of work capacity testing:
"*Suitable employment refers to a range of factors including the nature of their incapacity, pre-injury employment, age, skills, education and work experience required to be taken into account by scheme administrators when making a determination. The fundamental purpose of these provisions is to limit scheme liabilities and, hence, premium costs for employers.*
Arguably the most draconian versions of this scheme design feature are those contained in the Victorian and South Australian schemes, based on the Kennett
government's 1992 legislation. In general, weekly payments can be discontinued

unless scheme administrators determine that a worker has .no current work capacity.
*and is .likely to continue indefinitely to have no current work capacity. (**ACA 1985: s. 93CA, WRAC Act 1986: s. 35B)**. In other words, a worker with any residual capacity whatsoever for work may be deemed capable of securing suitable employment. There is no obligation to ensure that such employment is actually, or reasonably, available to an injured worker. This is most explicitly expressed in the Victorian legislation where the determination of suitable employment is required to be undertaken:*
"regardless of whether" -
(i) the work or employment is available; and
*(ii) the work or employment is of a type or nature of that is generally available in the employment market (**ACA 1985: s. 5**)...*
Due to their inherent unfairness work capacity reviews provisions are highly contentious. The unfairness involved with these provisions has both procedural and substantive dimensions.
Work capacity reviews should continue to be viewed as profoundly inequitable and consequently their inclusion in any national workers. compensation legislation should be rejected."

Exclusion of stroke/heart attacks unless work is a significant factor:

Now more than ever evidence exists that issues such as stroke and heart disease are caused by workplace factors.

With workers spending more hours than ever at work and the known effects on the body of issues such as fatigue ,stress and shift work removal of this provision is inappropriate**.**

Certain hazards at work have long been recognised as exacerbating or even causing cardiovascular disease.

Stress triggers an increase of cortisol, a "stress hormone," which can raise blood-sugar levels and blood pressure. The overproduction of cortisol can lead to a constant state of chemical arousal, which can eventually cause a heart attack.

One study of Belgian workers found that those who reported feeling they had little control of their work life had increased levels of markers of inflammation such as C-reactive protein and fibrinogen, which are linked to heart disease.

"There is strong evidence that shift work is related to a number of serious health conditions, like cardiovascular disease, diabetes, and obesity," says Frank Scheer PhD, a neuroscientist at Harvard Medical School and Brigham and Women's Hospital in Boston. *"These differences we're seeing can't just be explained by lifestyle or socioeconomic status."*

In a 12-year population study of over 10,000 London-based civil servants, Tarani Chandola, D.Phil., senior lecturer in the department of epidemiology and public health at University College London and his colleagues, examined the effects of work stress on heart disease in people ages 35 to 55. At the start of the study in 1985 and then again in 1989, participants were asked to complete the job strain questionnaire, a standard measure of psychological stress involving questions on decision making power, support from colleagues and overall work demands. To determine how the autonomic nervous system (ANS), which regulates your organs and hormones, responds to a prolonged state of stress, researchers checked levels of cortisol, a stress hormone, and assessed heart rate variability, a measure of heart health.
In this study, people who suffered from ongoing work stress had higher than normal morning levels of cortisol, which remained elevated throughout the day. Also, those who reported greater work stress were more likely to have a lowered heart rate variability, indicating strain on the heart. During the 12 years of follow up, researchers found that the individuals who experienced prolonged work stress had a 68% higher risk of coronary artery disease compared with those who reported no stress at work or retired during the course of the study. Finally, 32% of the effect of work stress on heart disease was attributed to metabolic syndrome, unhealthy habits such as over eating, smoking, or a couch potato lifestyle.
"*What's unique about this study is how we were able to demonstrate that **chronic stress is linked to heart attack** indirectly through unhealthy habits, and also directly through its effect on your cortisol levels and heart rate functioning,"* said Dr. Chandola. "*We found that chronically stressed out people had lower heart rate variability and higher levels of circulating cortisol in the bloodstream, which damages the heart and blood vessels and weakens normal body functions like tissue repair."*

Removal of shock claims for dependants of deceased or injured workers:

The issues paper proposes the abolition of these claims.

It is important to firstly realise that as the law currently stands, these claims can only be successful if both:

1. The death or serious injury to the worker has been caused by the negligence or fault of the employer.
2. The relative of the worker suffers from more than just a normal grief reaction - he / she must suffer from a diagnosable psychiatric condition (which often leads to substantial time off work and substantial medical treatment).

If the proposal was to proceed, relatives of deceased or injured workers would be placed in a highly discriminatory position, compared with relatives of persons deceased or injured due to the negligence of someone other than the persons' employer - the proposal would be totally at odds with the

compensation position under both the Civil Liability Act and the Motor Accidents Compensation Act.

The proposal argues that there are now substantial lump sums paid (pursuant to section 25 of the Workers Compensation Act) to the dependants or estate of a deceased worker. These lump sums however do not take into account the psychological effects of a worker's death upon his / her relatives. The lump sums have traditionally only been paid if financial dependency upon the deceased worker can be established. Although section 32 of the Act now provides that the lump sums are to be paid to the estate of the deceased worker if he / she leaves no dependants, this will only assist his / her relatives with psychological injuries based upon their position as beneficiaries of the estate. Put simply, there is no correlation between the amount of the lump sum that would be received and the extent of the psychiatric condition.

The proposal also argues that an employer's liability for psychological injuries to family members following the death or serious injury of a worker does not fall within the objects of the Act. This is a ridiculous argument as the Act has always been considered to be beneficial legislation, and as the argument fails to acknowledge that the only reason for the employer's liability is the fact that the employer has been negligent (generally grossly negligent) in causing the death or serious injury of the worker.

The proposal further argues that it would eliminate "workers compensation costs arising in circumstances over which employers have limited control". This is an even more ridiculous argument, as if an employer has no control over the death or serious injury of one of its workers, it will not be found to be negligent in causing that death or serious injury, and no claim would arise for psychological injuries suffered by relatives. To succeed in a claim for those injuries, the employer will be found to have unreasonably either not done something or done something (within its control) to cause the worker's death or serious injury.

The claims that the proposal seeks to abolish do not regularly occur because of the need to establish not just the negligence of an employer, but more importantly that the relatives of the deceased or injured worker have suffered more than just a normal grief reaction.

XX Solicitors acted for the relatives of a union member, Mr J . He died during the course of his employment with Kellogg's on 22 March 1983, when due to its gross negligence, he suffered fatal burns in one of its ovens. He came from a very close knit family, and as a result of his death, his parents and siblings needed substantial psychiatric treatment, and had varying periods of economic loss. Some of their claims settled for close to $100,000.00 (a substantial amount in the 1980s). His father still has psychological issues to this day.

XX Solicitors are also acting in a current claim (not for a union member) arising out of the death of his wife just over one year ago. As his wife had other dependants, he will probably only receive around one quarter of the

lump sum payable under section 25 of the Act (perhaps $120,000.00). Nevertheless, he has had ongoing psychological treatment since his wife's death and he has been unable to work since that date because of his psychological condition. His treatment expenses and his economic loss already exceed $120,000.00, as prior to his wife's death, he was an architect that generally worked overseas on large projects.

Both of these above cases would not be able to proceed if the proposal went ahead.

Targeted Commutations:

"Commutations are lump sum payments made by compensating authorities to injured workers to finalise liability for their claims. They are often used by compensating authorities as a means to reduce scheme costs. Their use usually occurs in a cyclical fashion. In the initial phase, the policy settings are usually adjusted to make commutations readily available in order to promote their take-up by, mainly seriously, injured workers. In the subsequent phase, as the average cost per commutation increases, their use is eventually restricted; either precipitously or more gradually depending on the prevailing conditions.

Commutations were extensively used in New South Wales during the second half of the 1990s through to the early years of the new century by WorkCover and its agents. During this period, commutation payments increased by over 400%, from $130.7 million in 1997 to $812.5 million in 2002 (NSWWA 2009: 161). Despite the fact that the commutations policy was driven by WorkCover itself, it was injured workers and their legal representatives who were subsequently blamed for creating the ‘lump sum culture’.

Although commutations can be useful as a short term liability management tool, they are no substitute for best practice, front end injury management measures and well designed return to work programs. Any change in the current policy stance, therefore, needs to be carefully considered in conjunction with other scheme changes.

While not opposed in principle to a more strategic use of commutations, the trade union movement would need to be convinced that their use was part of a broader policy package designed to assist injured workers rather than strip back their entitlements. "K.Purse.

Closing comments:

This submission is made on the basis of a genuine commitment on our part to ensure NSW injured and ill workers have an appropriate and sustainable workers compensation system that truly supports and promotes adequate care, positive return to work outcomes, financial stability and compensation for those workers unable to return to work.

Mindless cost shifting exercises must be avoided to ensure injured,ill and disabled workers and the community at large do not bear any additional cost burdens.
The NSW government have not only a fiscal ,but a moral responsibility to ensure this process is conducted in a transparent manner with outcomes that benefits all stakeholders.
Specifically injured workers and their families must be as a minimum no worse off than they are under the current regime.