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INQUIRY INTO NSW WORKERS COMPENSATION SCHEME

Organisation: Kenny Spring Solicitors

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Submissions from

Kenny Spring Solicitors

To

The Joint Select Committee on the NSW Workers Compensation Scheme

Kenny Spring Solicitors

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RESPONSE TO NSW WORKERS COMPENSATION SCHEME ISSUES PAPER

A. Introduction

1. Kenny Spring Solicitors is a regional law firm established in 1954, serving Bathurst, Oberon and central western New South Wales. The firm has an extensive personal injury and workers compensation team, with 3 solicitors working in this area. The two principals of the firm have more than 20 years experience between them, and have experienced a number of changes to the workers compensation legislation.

B. The Current System

1. Background

Currently, if a worker is injured in New South Wales they have the following entitlements:

- An entitlement to lump sum compensation provided that they have suffered a permanent injury that translates into a percentage of whole person impairment pursuant to s.66 of the *Workers Compensation Act 1987* ("the Act")).
- An entitlement to compensation for pain and suffering provided that their injury has been assessed as being in excess of 10% whole person impairment ("WPI") pursuant to s.67 of the Act.
- An entitlement to payment of weekly benefits whilst they have a total or partial incapacity to work due to their injury pursuant to s.36, s.37 and s.38 of the Act.
- An entitlement to have their past and future medical expenses paid provided that the expense is reasonable and necessary for the worker's rehabilitation and treatment pursuant to s. 60 of the Act.
- An entitlement to make a Work Injury Damages claim should their injury be assessed as exceeding 15% WPI.
- An entitlement to make an application for commutation if certain legislative preconditions are met.
- An entitlement to make a claim for workers compensation if their accident occurred during the course of their journey to or from their place of employment. This is often referred to as a "journey claim".

2. Lump sum compensation

The Act provides a scheme for the provision of lump sum payments under s.66 and s.67 where an injury produces a permanent impairment or permanent loss of use of the injured part of the body. These lump sum payments are paid in addition to any other benefit and do not curtail nor bring to an end an injured worker's compensation rights or entitlements.

The injured worker must be assessed for permanent impairment and stability by a Trained Medical Assessor trained by the WorkCover Authority in making the impairment assessment. That doctor will determine a percentage of whole person impairment (WPI) attributed to by the injury with reference to the WorkCover Guides to the Evaluation of Permanent Impairment. That percentage equates to a dollar sum under s.66 of the Act.

Currently, the compensation payable under s.66 is as follows:

Benefits payable for permanent injuries received on or after 1 January 2007
(Notes 10 & 11) (Section 66 of the *Workers Compensation Act 1987)*

Maximum amount payable for multiple injuries (Note 12)				$220,000			
Maximum amount payable for spinal impairment (see Notes 10 & 11)				$231,000			
Degree of permanent impairment	**Benefit**	**Degree of permanent impairment**	**Benefit**	**Degree of permanent impairment**	**Benefit**	**Degree of permanent impairment**	**Benefit**
0%	$0	19%	$28,600	38%	$79,750	57%	$150,700
1%	$1,375	20%	$30,250	39%	$82,500	58%	$154,550
2%	$2,750	21%	$33,000	40%	$85,250	59%	$158,400
3%	$4,125	22%	$35,750	41%	$89,100	60%	$162,250
4%	$5,500	23%	$38,500	42%	$92,950	61%	$166,100
5%	$6,875	24%	$41,250	43%	$96,800	62%	$169,950
6%	$8,250	25%	$44,000	44%	$100,650	63%	$173,800
7%	$9,625	26%	$46,750	45%	$104,500	64%	$177,650
8%	$11,000	27%	$49,500	46%	$108,350	65%	$181,500
9%	$12,375	28%	$52,250	47%	$112,200	66%	$185,350
10%	$13,750	29%	$55,000	48%	$116,050	67%	$189,200
11%	$15,400	30%	$57,750	49%	$119,900	68%	$193,050
12%	$17,050	31%	$60,500	50%	$123,750	69%	$196,900
13%	$18,700	32%	$63,250	51%	$127,600	70%	$200,750
14%	$20,350	33%	$66,000	52%	$131,450	71%	$204,600
15%	$22,000	34%	$68,750	53%	$135,300	72%	$208,450
16%	$23,650	35%	$71,500	54%	$139,150	73%	$212,300
17%	$25,300	36%	$74,250	55%	$143,000	74%	$216,150
18%	$26,950	37%	$77,000	56%	$146,850	75% and over	$220,000

If the injured worker is assessed as having greater than 10% WPI then they are entitled to a further lump sum payment for pain and suffering under s.67 of the Act, the maximum for which is $50,000.00. However, an injured worker is likely to recover only a proportion of $50,000.00 as the maximum is only paid in a *most extreme case*, examples of which are quadriplegia, paraplegia and total blindness.

For *psychological* or *psychiatric* injuries, such as Major Depressive Disorders and Post Traumatic Stress Syndrome, the injured worker must have a minimum impairment of 15% WPI to claim a lump sum under section 66 of the Act. In addition, there is an entitlement to lump sum under s.67 of the Act for pain and suffering once this threshold has been exceeded. It is rare for workers who have sustained a psychological or psychiatric injury to exceed the 15% WPI threshold.

The legislation prevents an injured worker from claiming both a physical injury and a psychological or psychiatric injury within the one claim. When this situation arises, an injured worker must elect which of their compensation claims they wish to maintain.

Further, an injured worker is unable to combine the WPI that they receive for their physical injuries with the WPI that they receive for any psychological or psychiatric injury in order to exceed the 10% WPI threshold and obtain a payment of compensation for pain and suffering pursuant to s.67 of the Act.

3. Weekly benefits payments - total incapacity for work

If an injured worker is certified as unfit to work as a consequence of their injury then they are entitled to receive their current weekly wage rate pursuant to s.36 of the Act. The current weekly wage rate is calculated as:

- for workers paid under an award, industrial or enterprise agreement, 100% of the rate of remuneration for one week of work (excluding overtime, shift work, payments for special expenses and penalty rates) or
- for workers not employed under an award, industrial or enterprise agreement, 80% of average weekly earnings (including regular overtime and allowances).

In order to receive this weekly payment, the injured worker must present themselves to their Nominated Treating Doctor (usually the injured worker's General Practitioner) who conducts an examination of the injured worker and provides a WorkCover NSW Medical Certificate stating their medical opinion of the injured worker's fitness for work.

The rate of weekly pay that an injured worker can receive is capped pursuant to s.35 of the Act. Currently, the maximum that an injured worker can receive is $1,838.70 gross per week. This means that if an injured worker was earning in excess of $1,838.70 at the time of their accident then the most that they can recover is $1,838.70 gross per week.

After 26 weeks of incapacity the weekly payments are reduced and will usually be the lesser of the statutory rate or 90% of average weekly earnings. However, the total weekly benefit cannot exceed the worker's current weekly wage rate.

The statutory rate is the amount specified in s.37 of the Act and is indexed twice a year. Most injured workers end up receiving the statutory rate if they find themselves still unfit to work after 26 weeks from the date of their injury.

The statutory rate is currently $432.50 gross per week. If the injured worker has dependants, such as children and/or a spouse who does not work, to care for then they are entitled to an additional payment. The additional payments are summarised as follows:

Dependant Spouse	**1 Dependant Child**	**2 Dependent Children**	**3 Dependant Children**	**4 Dependant Children**	**Each additional child in excess of 4**
$114.00	$81.50	$182.20	$301.80	$424.60	$122.50

As is the case with the statutory rate, the above rates are indexed twice a year.

4. Weekly benefits - partial incapacity for work

If a worker is partially incapacitated following a workplace injury and returns to work on suitable duties the worker will earn income for the hours worked while undertaking those duties. If this income is less than what the worker earned before the injury, for example if the worker is working part-time or the suitable duties are at a lower pay rate, then the worker may also receive a weekly workers compensation payment, often referred to as "make-up" pay.

"Make up" pay is usually calculated based on the difference between the worker's pre-injury earnings (including overtime, shift work, payments for special expenses and penalty rates) and the amount the worker earns while on suitable duties. Under the legislation, the amount of "make up" pay cannot exceed the amount the worker would receive if the worker was totally incapacitated. For the first 26 weeks after the worker first received incapacity payments, this would be the worker's current weekly wage rate and for any later period, the statutory rate. This

means that after 26 weeks if the worker has returned to work on suitable duties and is still earning less than their pre-injury wage, the insurer is only obliged to pay the injured worker "make up" pay up to the statutory rate. This means that even when a worker has returned to work on suitable duties they remain out of pocket.

If a worker is partially incapacitated and fit for suitable duties but no suitable duties are provided by the worker's pre-injury employer, the worker may be entitled to receive a weekly s.38 payment. To be eligible for a s.38 benefit the worker must be undertaking rehabilitation, or undertaking retraining approved by the insurer or job seeking. Section 38 benefits are paid for a maximum of 52 weeks.

For the first 26 weeks of incapacity the worker may receive the worker's current weekly wage rate. The first 26 weeks of incapacity includes any period of total incapacity already taken. Therefore, if the worker has been totally incapacitated for the first 10 weeks following the injury and the worker then becomes fit for suitable duties but no duties are available, the worker will be paid the worker's current weekly wage rate for a maximum of 16 weeks.

For any remaining period up to a total of 52 weeks, the worker may receive 80% of the worker's current weekly wage rate or the statutory rate, whichever is the greater.

After this, if the worker remains fit for suitable duties, the worker may be entitled to weekly "make-up" pay. This payment will be based on an assessment of the worker's capacity for work and most probably be at the statutory rate.

An injured worker is entitled to receive weekly benefits payments up to 12 months after they have reached the age of retirement pursuant to s.52 of the Act.

5. Medical expenses

Injured workers are entitled to have all reasonable and necessary medical or related treatment, hospital treatment, ambulance service or occupational rehabilitation services paid for.

Furthermore, they are entitled to receive reimbursement for related travel expenses which includes fares so long as they can maintain that they are expenses necessarily and reasonably incurred in obtaining treatment or being provided with the service.

All claims for medical expenses and related travel expenses must be properly verified by the production of an account and/or a receipt.

Once received, each claim for medical expenses is scrutinised by workers compensation insurers to ensure that it has been properly incurred pursuant to s.60 of the Act. Insurers can, and often do, decline to pay medical expenses that they decide do not comply with the Act.

Injured workers who reside in central western New South Wales are often required to travel to Sydney in order to obtain medical treatment as medical specialists are not located in the area. Without insurers funding treatment and travel expenses, regional workers would simply be unable to afford the specialist medical treatment that they require to treat their injuries.

6. Work Injury Damages Claims

Claims for common law damages for workers no longer exist in New South Wales. They were abolished in 2001 by the State Government following the last overhaul of the workers compensation scheme in New South Wales. What we now have in New South Wales is an entitlement for workers in limited situations to make a claim for Work Injury Damages.

In order to be entitled to make a claim for Work Injury Damages an injured worker must meet the following preconditions:

- The injured worker must be able to prove that their employer's negligence caused their work related accident.
- The injured worker must have received their lump sum compensation pursuant to s.66 and s.67 of the Act.
- They must have been assessed as having greater than 15% WPI pursuant to s.151H of the Act.
- They must make their claim within 3 years from the date of their injury. Leave of the Court is required for any claim made after this 3 year limitation period has expired.
- The only entitlement that such workers can claim is that of past and future wage loss pursuant to s.151G of the Act.

The moment that such a claim is made, the injured worker will lose their right to have their future medical expenses paid. They will lose any right that they had to have domestic assistance provided. The injured worker will also have to repay the weekly benefits that they received from the workers compensation insurer to date.

Whilst the State Government made these changes in 2001 to apparently benefit seriously injured workers, this category of injured worker rarely benefits from a Work Injury Damages claim as

they simply cannot afford to lose their rights to have their medical treatment continued to be paid. Seriously injured workers require ongoing medical treatment for their injuries. Further, seriously injured workers are often unable to work and in receipt of statutory rate of pay, therefore they are not in a position to fund such treatment themselves.

7. Commutations

A commutation is an agreement between the injured worker, employer and Scheme Agent or insurer to pay all of the injured worker's entitlements to weekly benefits, medical, hospital and rehabilitation expenses as a lump sum.

By agreeing to a commutation the injured worker's entitlements to weekly payments and all other expenses will no longer be paid and the Scheme Agent or insurer will not be liable for further claims with regards to the injury.

WorkCover must also certify the commutation meets all the criteria set out in Section 87EA of the Act. A commutation is only available when the following preconditions have been met:

- the injured worker must have a permanent impairment that is at least a 15% whole person impairment;
- compensation for permanent impairment and pain and suffering must have been paid;
- it must be 2 or more years since the worker first received weekly payments for the injury;
- all opportunities for injury management and return-to-work must have been fully exhausted;
- the worker must have received weekly benefits regularly and periodically throughout the previous 6 months;
- the worker must be entitled to ongoing weekly benefits;
- weekly benefits have not been stopped or reduced as a result of the worker not seeking suitable employment.

As soon as one of the above pre-conditions have not been met the commutation cannot proceed.

Prior to receiving a commutation:

- the worker must receive independent legal and financial advice;
- the Scheme Agent or insurer, employer and worker must agree with the commutation;
- WorkCover must approve the commutation;

- all agreements must be registered with the Workers Compensation Commission.

It is extremely difficult for injured workers to meet the above preconditions of s.87EA and successfully enter into a commutation. For this reason commutations are a rarity under the current scheme.

Prior to amendments in 2001, commutations were generally available requiring court approval to proceed. A worker could "buy out" future rights by way of lump sum for a fraction of the actuarial value of a claim, and dispensing with the administration costs of ongoing claims. This change has adversely impacted on the WorkCover Fund and calculation of liabilities.

8. Journey Claims

Journey claims are governed by s.10 of the Act. According to s.10 (3) of the Act the types of journeys that are compensable under the workers compensation scheme include:

> *"(3) The journeys to which this section applies are as follows:*
>
> > *(a) the daily or other periodic journeys between the worker's place of abode and place of employment,*
> >
> > *(b) the daily or other periodic journeys between the worker's place of abode, or place of employment, and any educational institution which the worker is required by the terms of the worker's employment, or is expected by the worker's employer, to attend,*
> >
> > *(c) a journey between the worker's place of abode or place of employment and any other place, where the journey is made for the purpose of obtaining a medical certificate or receiving medical, surgical or hospital advice, attention or treatment or of receiving payment of compensation in connection with any injury for which the worker is entitled to receive compensation,*
> >
> > *(d) a journey between the worker's place of abode or place of employment and any other place, where the journey is made for the purpose of having, undergoing or obtaining any consultation, examination or prescription referred to in section 74(3),*
> >
> > *(e) a journey between any camp or place:*
> >
> > > *(i) where the worker is required by the terms of the worker's employment, or is expected by the worker's employer, to reside temporarily, or*
> > >
> > > *(ii) where it is reasonably necessary or convenient that the worker reside temporarily for any purpose of the worker's employment,*
> > >
> > > *and the worker's place of abode when not so residing,*

(f) a journey between the worker's place of abode and the place of pick-up referred to in clause 14 of Schedule 1 to the 1998 Act,

(g) a journey between the worker's place of abode and place of employment, where the journey is made for the purpose of receiving payment of any wages or other money:

(i) due to the worker under the terms of his or her employment, and

(ii) which, pursuant to the terms of his or her employment or any agreement or arrangement between the worker and his or her employer, are available or are reasonably expected by the worker to be available for collection by the worker at the place of employment.

Injured workers who are entitled to make a workers compensation journey claim are also generally entitled to make a motor accidents claim pursuant to the motor accidents legislation of New South Wales. In the event that a CTP claim is made and the injured worker receives a payment of compensation under that scheme, the workers compensation insurer is entitled to receive a payback of the workers compensation benefits that it paid to the worker as a consequence of the accident pursuant to s.151Z of the Act. In such situations, the workers compensation insurer is able to recover a large proportion of the payments that it made to the injured worker from the CTP insurer of the vehicle at fault in the accident.

C. The Proposed Changes to the System

1. Lump Sum Compensation

It is noted that reference has been made within the NSW Workers Compensation Scheme Issues Paper that other schemes generally have higher thresholds for whole person impairment and do not have separate awards for pain and suffering. For instance, in South Australia and Tasmania the threshold is 5% and in Victoria and the Commonwealth Comcare scheme the threshold is 10%.

Before leaping to increase the percentage of whole person impairment from 1% to 5% or 10%, regard must be had for the types of injuries that such an increase would exclude from a payment of lump sum compensation. The following injuries would not be compensated under such a scheme:

- Right shoulder injury sustained after a fall onto wet tiles at work – 5% WPI resulting in payment of lump sum compensation of $6,875.00.

- Right elbow injury and left knee injury sustained after the worker fell whilst carrying 20kg bags of cement – 3% WPI resulting in payment of lump sum compensation of $4,125.00.
- Back injury suffered by a cabinetmaker installing a kitchen – 6% WPI resulting in payment of lump sum compensation of $8,662.50.
- Compound fracture of the lower third of the right tibia with adjacent mid shaft fibular fracture sustained by a worker at a greyhound track who was struck in the leg by the mechanical hare that was travelling at speed – 9% WPI resulting in payment of lump sum compensation of $11,250.00.

The above claims were claims actually made under the current scheme.

Whilst the above injured workers were entitled to make lump sum compensation claims they were not eligible to receive pain and suffering compensation because their injuries were not assessed as being greater than 10% WPI. It cannot be suggested that the above injuries did not result in pain and suffering to the injured worker.

Further, it should be noted that a different method of medical assessment applies to injured workers under the Comcare Scheme. An injured worker under the Comcare Scheme is assessed according to the Comcare guidelines, not the AMA Edition 5 guidelines and WorkCover Guidelines. Put simply, we are not comparing "apples with apples" when suggesting that a blanket 10% WPI threshold be applied to injured workers in New South Wales.

It is submitted that any scheme that does not include a separate payment for pain and suffering compensation would be unfair and detrimental to injured workers in New South Wales. The compensation payable pursuant to s.66 of the Act is not, and never has been, intended to compensate injured workers as a pain and suffering payment. As can be seen from the table above, it would be inadequate compensation for injured workers if the current figures were used for such a purpose.

Pain and suffering payments are made after having regard to the following factors which arise from the statement of Commission Wright in *Tyler v Marsden Industries* (2001) 22 NSWCCR 644 at 650:

"There are a number of factors and principles to take into account in determining an appropriate amount under s67:

- *Pain and suffering awards under s.67, unlike the objective criteria in s.66 awards for physical loss impairment, must take into consideration the actual individual experience of the claimant, as to his or her past and future pain and suffering.*

- *The measure of the most extreme case must be compared with the measure of **a** most extreme case and does not need to make a comparison with **the** most extreme case.*

- *The pain and suffering must result from the loss or impairment not merely the injury* (s67(1A)): see *Scrimshaw v SAR Wood Pty Ltd* (1997) 14 NSWCCR 335.

- *Pain may be compensated even if the extent of the loss and its effects are not assessable until a later date:* see *Selimovic v Airfoil Registers Pty Ltd* (1999) 18 NSWCCR 143.

- *Pain and suffering is compensable from the date of the compensable injury and not merely from the date on which the loss or impairment is crystallized:* see *Rico Pty Ltd v Road Traffic Authority* (1992) 28 NSWLR 679; *Corporate Ventures Pty Ltd v Borovac* (1995) 12 NSWCCR 84; *Bohanna t/as Anscot Partnership v Bohanna* (1996) 13 NSWCCR 724; BC9605483.

- *There is no necessary relationship between the loss or impairment and the intensity and duration of the pain and suffering. If an award is excessive upon review of all the circumstances, an award may be overturned on the basis of falling outside the range of a sound discretionary judgment:* see *Ainsworth Nominees Pty Ltd v Crouch* (1995) 11 NSWCCR 640.

- *The age of the claimant is relevant. In Regal Paints Pty Ltd v Wasson* (1993) 9 NSWCCR 301, *the Court of Appeal observed that the younger a person is at the time of injury (loss) the greater is the chance that the worker would get into an extreme case category but each case has to be looked at on its own merits due to the potential for the same injury to affect different workers differently. The Court of Appeal reiterated in Ainsworth Nominees Pty Ltd v Crouch* (Kirby A-CJ at 652F) *that age was a relevant consideration because age at injury had implications for the expected duration of any pain and suffering.*

- *Distress caused by interference with social activities (Department of School Education v Boyd* BC9603267) *or by the effects of the compensable injury on a worker's relationships including marriage (Pacific Dunlop Ltd v Krivec* (1996) 13 NSWCCR 353) *can be relevant.*

- *Objective factors may include the type of surgical procedures undergone, the nature of the convalescent process and any complications flowing there from as well as the need for medication and difficulty with sleeping (Dubbo Base Hospital v Harvey* BC9604829)."

Further, regard is had to the reasoning of Candy ADP in *NSW Police Service v Westling* [2008] NSW WCC PD 99 being that while there is no automatic correlation between impairment found in relation to s66 and the proportion of the award under s67, the impairment under s66 is a factor to take into account in determining the award under s67.

Westling also contains a detailed analysis of the case law relating to awards under s67.

Roche DP in *New South Wales Police Force v Cursley* [2010] NSWWCCPD 66 considered principles relevant to an award under s67 and noted at 46-48 that each case must be considered on its own facts, that determining quantum under s67 involves a value judgment and also considered the concept of a most extreme case.

There is far more to calculating pain and suffering compensation then the Issues Paper would have us believe and an award of maximum pain and suffering compensation is a rarity.

The scheme makes an allowance for injured workers to make further lump sum claims for WPI. This reflects the fact that the worker's injury deteriorates over time and therefore attracts a higher percentage of WPI. However, it is extremely difficult for such a deterioration to be reflected as an increase in WPI. For this reason, such claims are often made over 5 years after the first award of lump sum compensation has been received. Furthermore, as the current scheme has now been in effect for 11 years and it is impossible to exit the scheme, injured workers who made claims after its commencement are only now preparing and submitting further lump sum claims.

Whilst it is technically possible for an injured worker to make further lump sum claims until they exceed the 15% WPI threshold to make a Work Injury Damages claim, it should not be assumed that this is in fact what workers choose to do. As discussed above, there are many preconditions to bringing a Work Injury Damages claim and even if a seriously injured worker happens to meet them, that worker may choose to remain in the scheme in order to continue to receive payment of their medical expenses. These are medical expenses that they would otherwise be unable to afford to meet themselves.

Further, workers would not need to make further lump sum claims if they were able to exit the scheme earlier, such as via a commutation or redemption of their workers compensation rights.

2. Weekly benefits - total incapacity for work

It is noted within the Issues Paper that the following notion is entertained to change the weekly benefits scheme in New South Wales:

- For the first 13 weeks of total incapacity an injured worker receives 95% of their pre-injury wage.
- After 14 weeks of total incapacity, the injured worker receives 80% of their pre-injury wage.
- After 130 weeks of total incapacity, the injured worker can only receive ongoing payments if they have no work capacity and are likely to have no work capacity for an indefinite period.

The above strategy is apparently adopted "to encourage injured workers to return to work". This statement assumes that injured workers do not want to return to work. Those who are involved in working with injured workers and providing them with legal advice know that injured workers frequently demonstrate a willingness to return to work as soon as possible. Injured workers do not arrive at their workplace each morning with the express intention to injure themselves and enter the scheme for as long as possible.

Adopting a scheme that reduces an injured worker's weekly benefit payment whilst they are totally incapacitated for work does not "encourage" them to return to work, it forces them back to work in circumstances where they may not be medically fit to do so. Such a situation places the injured worker at risk of re-injury. It also places the injured worker's colleagues at risk of being injured themselves as they rely upon the injured worker to perform pre-injury duties when they may not be medically fit to do so, for instance in environments such as underground mining where each worker would need to rely on the other in a rescue or evacuation scenario.

Further, whilst an injured worker's weekly benefit is reduced by 95% and more, their incoming bills and mortgages are not reduced by the same percentage. The reduction of weekly payments for incapacitated workers will simply cause more hard working families in New South Wales to fall below the poverty line and default on their mortgages as they would be unable to meet their continuing obligations and become homeless.

In addition, the current scheme in calculating an injured worker's current weekly wage disregards any overtime, shift bonuses or penalties that the injured worker was earning before their injury. The injured worker's weekly benefits are already reduced under the current scheme as they are

only entitled to receive their base wage for a period of 26 weeks. In other words, injured workers already have more than enough incentive to return to work as quickly as possible following their injury.

It is noted that the Issues Paper makes an assumption that the injured worker is not currently subjected to regular capacity tests. This is completely inaccurate. Injured workers must present themselves to their Nominated Treating Doctors for regular examination to assess their capacity for work. That capacity for work is then reflected in a WorkCover NSW Medical Certificate which is provided to the employer and insurer to inform them of this situation. If the insurer and/or employer are not satisfied with the injured worker's medical progress then they can participate in a case conference with the injured worker and their Nominated Treating Doctor to discuss the situation and any proposals for a graduated return to work program to be implemented.

3. Weekly benefits – partial incapacity for work

It is noted that the Issues Paper makes recommendation in relation to partial incapacity benefits to injured workers such as:

- For the first 13 weeks of partial incapacity, an injured worker receives 95% of their pre-injury average weekly earnings less the amount that they are actually earning.
- From 14 weeks to 130 weeks of partial incapacity, an injured worker receives 80% of their pre-injury average weekly earnings less 80% of what they are actually earning.
- After 130 weeks of partial incapacity, an injured worker can only receive benefits for partial incapacity if they have returned to work, is working at least 15 hours per week and is earning at least $166 per week. The injured worker must also demonstrate that because of their injury, they are likely to remain physically and mentally incapable of working beyond their current level, in any job.

The rationale behind making such a recommendation is to apparently coax injured workers to return to work. Again, this makes a presumption that all injured workers do not want to return to work which is completely inaccurate and made without any foundation.

Injured workers who have a partial incapacity for work want to return to work performing their pre-injury duties. Often their employers are not as enthusiastic to have the injured worker return to work as they are perceived to be a liability and prone to re-injury. Furthermore, some employers still respond to partial incapacity medical certificates by informing the worker that no

suitable duties are available or that they cannot return to work until they are fit to perform pre-injury duties. Under the above proposal, an injured worker would be partially incapacitated but still unable to return to work through circumstances beyond their control and left being ineligible to receive a weekly benefit for partial incapacity.

4. Medical expenses

It is noted that the Issues Paper recommends that a cap be placed on medical and related treatment expenses. This recommendation is made with little regard for how medical expenses are currently regulated under the scheme.

In order to be reimbursed or paid by the insurer, medical and treatment related expenses must fit the criteria of s.60 of the Act which provides:

*"**60 Compensation for cost of medical or hospital treatment and rehabilitation etc***

(1) If, as a result of an injury received by a worker, it is reasonably necessary that:

> *(a) any medical or related treatment (other than domestic assistance) be given, or*
>
> *(b) any hospital treatment be given, or*
>
> *(c) any ambulance service be provided, or*
>
> *(d) any workplace rehabilitation service be provided,*

the worker's employer is liable to pay, in addition to any other compensation under this Act, the cost of that treatment or service and the related travel expenses specified in subsection (2).

***Note:** Compensation for domestic assistance is provided for by section 60AA.*

(2) If it is necessary for a worker to travel in order to receive any such treatment or service (except any treatment or service excluded from this subsection by the regulations), the related travel expenses the employer is liable to pay are:

> *(a) the cost to the worker of any fares, travelling expenses and maintenance necessarily and reasonably incurred by the worker in obtaining the treatment or being provided with the service, and*
>
> *(b) if the worker is not reasonably able to travel unescorted-the amount of the fares, travelling expenses and maintenance necessarily and reasonably incurred by an escort provided to enable the worker to be given the treatment or provided with the service.*

(3) Payments under this section are to be made as the costs are incurred, but only if properly verified.

(4) The fact that a worker is a contributor to a medical, hospital or other benefit fund, and is therefore entitled to any treatment or service either at some special rate or free or entitled to a refund, does not affect the liability of an employer under this section.

(5) The jurisdiction of the Commission with respect to a dispute about compensation payable under this section extends to a dispute concerning any proposed treatment or service and the compensation that will be payable under this section in respect of any such proposed treatment or service. Any such dispute must be referred by the Registrar for assessment under Part 7 (Medical assessment) of Chapter 7 of the 1998 Act, unless the regulations otherwise provide."

Medical expenses must be reasonably necessary before they will be paid by the insurer. Medical expenses must also be properly verified meaning that they need to be supported by a tax invoice, receipt and even a medical report supporting that the expenses are reasonably necessary in certain circumstances. It is not a case of "open slather" on payment of medical expenses as the Issues Paper would have us believe.

Further, it is important to consider the whole context within which medical expenses are being paid for injured workers. If injured workers require medical expenses to be paid they are generally receiving a weekly benefits payment at the same time. This means that their income is significantly reduced. With this in mind, injured workers simply cannot afford medical treatment such as continued physiotherapy, chiropractic treatment and surgery if it is not funded by the insurer.

In addition, injured workers who reside in central western New South Wales are placed at a further disadvantage to their metropolitan cousins as they often cannot afford to travel to Sydney to receive medical treatment let alone fund the cost of the medical treatment itself.

By placing a restriction on medical expenses, injured workers will be forced into the already overflowing and under resourced public health system. This will mean a delay in injured workers receiving their medical treatment and protract the time that an injured worker will be unfit to work as they await receipt of such treatment.

It is noted that a recommendation has been made whereby medical expenses would only be funded by insurers for a period of 9 years following the injured workers injury. Such a recommendation, if implemented, would have a detrimental effect upon injured workers. Often medical professionals recommend that injured workers delay having significant surgery as long as

possible, particularly if the injured worker is of a relatively young age. By placing a timeframe on when an injured worker can have their treatment funded, an injured worker's rehabilitation and treatment could be seriously compromised.

5. Work Injury Damages claims

It appears from the Issues Paper that it is suggested that because negligence, as it has been enshrined in the *Civil Liability Act,* has not been similarly adopted by the workers compensation legislation that this somehow translates into a difficulty for insurers and employers to defend such claims. This is nonsense.

Work Injury Damages claims are difficult for insurers and employers to defend because of the timeframes and volume of legislative procedure required to be followed. One only needs to have regard to Division 4 of the *Workplace Injury Management and Workers Compensation Act 1998* to evidence this. For instance:

- Insurers must request particulars of such a claim within 2 weeks of receiving it.
- Insurers must determine a claim within 2 months of particulars being received.
- Insurers must make an offer of settlement after receiving the claim.
- Insurers must inform the injured worker within 7 days of receiving a Pre-Filing Statement whether they are of the view that it is defective.
- Insurers must respond to a Pre-Filing Statement within 28 days from it being received.

The abovementioned timeframes are inadequate for an insurer and employer to properly consider a Work Injury Damages claim, particularly when the quantum of such claims often exceeds $500,000.

Further, Work Injury Damages claims are a rarity because of the preconditions that must be met by an injured worker before commencing such a claim.

6. Commutations

It is noted that the Issues Paper recommends targeted commutations to be implemented to relax thresholds for specific classes of claim on a time limited basis. The Issues Paper further notes that the Scheme Actuary and industry experts advise against broadening access to commutations.

If the scheme deficit is to be rectified then commutations will have an important part to play in reducing it. Currently the legislative preconditions that must be met for a commutation to be approved are too onerous. Injured workers and insurers have no means by which they can reach

an agreement for a lump sum to be paid with the end result being the exit of the injured worker from the scheme and a cessation of the insurer's obligations to continue to make payments in relation to the claim.

Restoring commutations to allow workers to have their claims bought out for a small amount of the actuarial liability of the fund would bring indefinite weekly payments to an end and prevent further increases to lump sum impairment payments. This crystallises the amount of a claim. Injured people prefer this to allow them to get on with their lives and escape the WorkCover Scheme. It also means that the claim requires no further administration by WorkCover or scheme agents.

7. Journey Claims

It is noted that the Issues Paper recommends that journey claims be abolished. *"It has been suggested this would provide a closer connection between work, health and safety responsibilities and workers compensation premiums through eliminating workers compensation costs arising in circumstances over which employers have limited control."*[1]

As detailed above, it is extremely difficult to prove that an injured worker was injured on the journey pursuant to s.10 of the Act. It is erroneous to assume that such claims are easily made and readily accepted by insurers. By removing the rights of injured workers to make such claims, there will simply be an increased reliance on the CTP scheme for compensation. Further, not all motor vehicle accidents lend themselves to CTP claims being able to be made meaning that injured workers will be left without any remedy for compensation.

D. Summary

There are a number of positive changes which could be made to the workers compensation legislation, providing fairness for workers, and ensuring the cost to employers remains reasonable and affordable. The common objective of workers and employers is for the injured worker to return to work as soon as possible and maintain financial security.

The legislation needs reform however such reform should not take the guise of reduced rights and benefits for injured workers. Further, any changes made to the legislation should not be made retrospectively to prevent injured workers being further disadvantaged.

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[1] NSW Workers Compensation Scheme Issues Paper, at p22.