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INQUIRY INTO NSW WORKERS COMPENSATION SCHEME

Organisation: Australian Federation of Employers and Industries

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AFEI Submission to the Joint Select Committee on the NSW Workers Compensation Scheme

NSW Workers Compensation Scheme Inquiry

17 May 2012

Australian Federation of Employers & Industries

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Australian Federation of Employers and Industries (AFEI)

The Australian Federation of Employers and Industries (AFEI), formed in 1904, is one of the oldest and most respected independent business advisory organisations in Australia. AFEI has been a peak council for employers in NSW and has consistently represented employers in matters of industrial regulation since its inception.

With over 3,500 members and over 60 affiliated industry associations, our main role is to represent, advise, and assist employers in all areas of workplace and industrial relations and human resources. Our membership extends across employers of all sizes and a wide diversity of industries.

AFEI provides advice and information on employment law and workplace regulation, human resources management, occupational health and safety and workers compensation. We have been the lead employer party in running almost every major test case in the New South Wales jurisdiction and have been a major employer representative in the award modernisation process under the Fair Work Act.

AFEI is a key participant in developing employer policy at national and state (NSW) levels and is actively involved in all major workplace relations issues affecting Australian businesses.

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Introduction

1. We understand that the Inquiry is concerned to be presented with evidence to assist its deliberations. This submission reflects the views of our members as expressed through:

    - our intensive contact with them in consulting, training and advisory capacities on workers compensation issues – AFEI receives around 80 requests per month for assistance on workers compensation matters;
    - consultation specifically on this Inquiry and the Issues Paper;
    - responses to our surveys undertaken to ascertain, on an aggregate basis, member experiences with the scheme and the operation of WorkCover.

2. Unsurprisingly, employers do not want premium increases. The Inquiry must give careful consideration to the impact of premium increases, of any magnitude, on business competitiveness and employment in NSW. Workers compensation costs are but one component of labour costs, and for those employers who are experience rated, the most significant cost after direct wages.

3. The state of the labour market in NSW could not be described as robust and able to withstand increases in price. To the contrary most economists, including the Reserve Bank have drawn attention to the poor performance of the non mining sectors of the economy.[1] In its recent statement on monetary policy the RBA noted that *"outside of the mining industry, growth in labour demand remains subdued"*.[2]

[1] See for example: Developments in the Mining and Non-mining Economies Philip Lowe Deputy Governor Address to the ADC Future Summit Melbourne - 14 May 2012; ComBank Global Markets Research Economic Update May 2012; National Australia Bank Monthly Business Survey April 2012; ANZ Research Quarterly Issue 7 Q1 2012

[2] RBA, Statement on Monetary Policy, May 2012, p. 33.

4. The Issues Paper points to a cumulative 33 per cent reduction in average workers compensation premiums since 2005.[3] While this may imply cost reductions for employers, a reduction in the average premium rate overall does not translate to a cost reduction for experience rated employers or employers in those industries with higher than average WIC rates. Our experience rated members report premium increases, not reductions, over the past three years (see paragraph 67).

5. Employers are particularly concerned with these premium increases given that injury incidence rates and numbers of claims have been falling for well over a decade yet the cost of claims continues to escalate.[4]

6. It is clear that the quest for fair and effective solutions to improve the operation of the scheme have not progressed since the last Parliamentary Inquiry in 2002.[5] Many of the same problems raised in that Inquiry (and earlier inquiries) persist. Likewise the reform strategy introduced in 2000 and subsequent implementation of reviews focusing on scheme operation including agent performance and remuneration, have not produced durable positive outcomes. This demonstrates that to remedy deficiencies in the scheme and its administration, radical and concerted measures are necessary to cure these endemic problems.

7. AFEI surveyed members in February 2007 in response to the high level of member concern with the operations of WorkCover and their difficulties in achieving good return to work outcomes. In May 2012 we resurveyed members. The results of these surveys provide evidence to the Inquiry that the concerns expressed by employers five years ago remain and have been exacerbated.

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[3] Issues Paper page 13

[4] WorkCover Annual Report 2010-11

[5] New South Wales Parliament Legislative Council, General Purpose Standing Committee No. 1, NSW Workers Compensation Scheme, Final Report, September 2002

8. Significantly, in both 2007 and 2012 just over half of respondents considered workers compensation to be a "major" concern for their organisation and rated the impact of workers compensation costs on their organisation as 'major' or 'unsustainable'.

9. In 2007 just under one third of respondents reported that they were more rigorous in screening new employees. This proportion has jumped to 85% in 2012, reflecting employer caution in hiring and the impact of workers compensation in the hiring process, decision making and ongoing employment costs. The number of employers who have actually reduced their employee numbers as a consequence of workers compensation costs has increased from 9% to 15%.

10. At both points in time the main problem areas for members arose from:

- the costs to their organisations
- the performance of their agent
- the role of the nominated treating doctor (usually the general practitioner)
- the shortcomings of the heavily regulated (for employers) return to work and rehabilitation process in which the actual outcome is driven primarily by the insurer and the rehabilitation provider
- the inability of employers to challenge decisions of the agent, WorkCover and the Workers Compensation Commission.

Key employer messages to the Inquiry on the need for reform in the functions and operations of WorkCover

Premium determination

11. Experience rated employers are critical of the scheme's premiums because they are impossible to understand and disproportionately large, compared with both the cost of claims and premiums paid in other states. Frequently they can be more than three times the amount of an employer's claims costs, and it is not uncommon to be much higher than this.

12. This is particularly unacceptable when the claim has been poorly managed by the agent. Experience rated employers see their premiums escalate unreasonably through inflated estimates of the cost of the claim by agents who work in accordance with WorkCover's directives and operational instructions. No part of that premium increase is refunded when the claim subsequently costs less than the estimate, or there has been some error in calculation or benefit payment.

13. Employers want transparency and accountability in premium determination. The premium calculation system must have credibility and be readily understood. Incomprehensible formulas and an unclear and unreasonable linkage between claims experience and premium costs are unacceptable if we are to have a scheme which is credible. This is particularly the case where the employer has little or no control over the claim management process, and no means of adequately challenging the decisions of their agent or WorkCover.

14. Employers consistently report that they are excluded from the claims decision making process, with little or no information about how or why a claim was determined. Many report claims being accepted with no investigation and based on the nominating treating doctor's opinion which is not informed by the factual circumstances of the job or work

environment. Others report claims acceptance for ex-workers more than three years after the claimed date of injury or ceasing to work for the employer where the claim was not investigated and the worker's claims not substantiated. It appears WorkCover interpretation of the legislated time limits and the circumstances in which claims can be made is very fluid.

Premium Dispute management

15. Employers have very limited ability to challenge any aspect of WorkCover's operations. WorkCover confines its investigatory role to matters of premium calculation only (s 170 of the *Workers Compensation Act 1987*). This entails only a limited investigation of the actual calculation and not the assumptions that were made in the assessment of the claims costs.

16. For a compensation scheme to be credible it must have a simple, fair and independent process for the appeal and review of disputed premium issues. This process should be independent of the regulator and the scheme agent.

17. Workers' compensation is a major cost for most medium to large employers. Regulators must make available the data relied upon to justify changes to premium levels and the reasons for changes.

18. Scheme financial information should be published in a timely and accessible manner, capable of showing premium revenue and scheme expenditure details in an easily comprehended format. Whilst WorkCover will argue that these are available in annual reports, this is only "high level" information on overall scheme performance and importantly, gives little detail on scheme expenditure, particularly on agent performance and payment. There should be published information on all sources of

revenue; premiums, investments, fines and all expenditure. This should be detailed, not a broad grouping of costs.

Provisional Liability

19. Employers do not support a system that provides for the automatic acceptance of all incapacity or injury as work related because it was reported to be so and the claim is subsequently inadequately investigated, or not investigated at all.

20. WorkCover steadfastly insists that fraud is extremely rare, almost non existent. Whilst this may depend on one's definition of fraud, there are clear means of readily accessing benefits and frequent instances of ineffective claims management which readily escalate claim duration and cost. The euphemism of "exaggeration" of symptoms/incapacity is used as tacit acceptance that fraudulent behaviour is tolerated. There should be better mechanisms to protect employers and workers against abuse of the system, and to ensure that there is thorough initial investigation of all the circumstances surrounding a claim. Claims should be managed with more involvement than the claims manager simply following the operational guidelines by ticking boxes at particular intervals. This is particularly important in so called stress claims.

21. Provisional liability is even more unreasonable where there is no avenue to appeal the decision of the agent to accept the claim. Disputes about claims can only be taken to the Workers Compensation Commission on the decision of the agent, and this decision will be "guided" (ie constrained) by WorkCover's operational guidelines.

Work Relatedness and access to the scheme

22. Work relatedness is an important issue for the viability of the scheme. A demonstrable level of work contribution must be identifiable*. An injury is compensable if work is '**a** substantial contributing factor'.* Courts and the WCC have interpreted this exclusion extremely narrowly. The test of *"a substantial contributing factor*" should be replaced with "*the major contributing factor"*. Courts will still interpret this to benefit claimants, so the objects of the Act and other provisions need to be fully expressed. A foundation element of a credible and fair scheme is the critical examination of whether the injury or illness was *caused by* work.

23. Employers should not have to bear the cost of an incapacity which was not incurred in the course of employment. The legislative framework must be clear as to the extent of scheme coverage, to provide certainty and to address the expansion of threshold conditions by the judiciary. In no fault schemes, the most tenuous of connections between work and injury is accepted, yet this causal link is fundamental to the legitimacy of any scheme, and to its acceptance by employers. The unreasonably inflated cost consequences have contributed to the uncompetitiveness of NSW employers, to job losses, and to the general malaise in the NSW economy.

Psychological Injury Claims (stress claims)

24. The most frequently occurring occupational diseases are industrial deafness and mental disorders, together accounting for 14 per cent of all claims and 65 per cent of occupational diseases.[6]

25. The need for a more rigorous work relatedness test is clearly evident in psychological injury claims. According to the most recently published WorkCover data these claims cost are above the average for both physical injury and occupational disease; have on average 20 weeks absence from

[6] WorkCover NSW Workers Compensation Statistics 2008-09

work compared to 10.4 weeks for a physical injury.[7] For employers, the actual cost of these claims is even greater than the heavy workers compensation costs. They are exacerbated by the extensive management time committed and organisational resources needed to prevent these claims in the first instance, and in damage control once they arise. The dubious nature of many of these claims points to the failure of the workers compensation scheme, of WorkCover and its agents to exercise any kind of reasonable discipline in vetting, challenging and properly managing claims.

26. Currently the exclusion of psychological injury claims where the condition is due to the reasonable actions of an employer include the words *'wholly or predominantly'*. These words should be removed. At the very least the current exclusion which covers reasonable management action should be properly applied and the onus of proof should not fall to the employer to demonstrate that their actions were reasonable and undertaken in a reasonable manner.

27. Members consistently report that as soon as they have initiated performance management or counselling with a poorly performing employee, instigated some form of disciplinary action or made some change in work arrangements a worker's compensation claim is made. Attempts to challenge acceptance of the claim with the agent are declined with the response (even following investigation) that the worker can claim compensation because they suffered the injury in being told they were underperforming, or were in breach of company policy or practice.

28. While the legislation ostensibly precludes claims in such circumstances, there is a high level of acceptance of these claims in NSW with the insurers' investigator inevitably identifying some contributing factor in the workplace. Invariably this factor is a matter of dispute, with the investigator and agent electing to accept the employee's interpretation of events. Additionally, typically there is no attempt on the part of the

[7] op cit

treating doctor or psychologist to ascertain the facts of the matter at the workplace before diagnosing the employee with anxiety or similar disorder allegedly caused by work. By way of example, employees who do not like the idea of change in their work arrangements are diagnosed with "adjustment disorder", an ostensibly medical but specious translation of "they don't like it" designed to provide access to compensation without scientific or medical rigour.

29. There will be no abatement in stress claims until reform is also made in WorkCover's approach (and directives to claims agents) to ensure a more rigorous and even handed investigation of stress claims. Irrespective of the actual nature of their work environment, it remains open to employees to see work as the cause of their unhappiness/dissatisfaction/ill health with a compensatory outcome unless reforms are made.

30. The implications for productivity in NSW workplaces from the misuse of the scheme is significant. It has the effect of removing management's ability to use fair and reasonable process to manage work performance and efficiently run the workplace. Underperforming and problem employees have to be retained, at considerable additional cost, on a workers compensation claim. This is to the detriment of the enterprise and those replacement workers who would otherwise have the opportunity to work productively. In addition to the direct financial cost, the opportunity costs of dealing with these claims is also considerable with wasted time and resources which could have been expended more productively. It also places employers in double jeopardy as they are required by the Fair Work Act to manage poor employee performance in a manner which is not harsh, unjust or unreasonable.

31. Such claims continue to arise even in workplaces with the resources to put extensive preventative strategies in place to avoid stress claims. This is an unnecessary drain on scarce resources.

Industrial Deafness Claims

32. There were 4,755 (so called) industrial deafness claims made in Australia in 2009-2010.[8] Of these, 3,285 or 70% were made in NSW.[9] This vastly disproportionate share of the NSW scheme has improved only marginally since 2001 when 78% of all deafness claims in Australia were made in NSW.[10] NSW employs around one third of the national workforce and only 20% of the NSW workforce are employed in the so called "noisy" industries of mining, construction, manufacturing, agriculture and electricity/gas/water.[11]

33. Many employers who have been subject to patently unfair industrial deafness claims would like to see the removal of industrial deafness claims. Their sense of injustice is entirely understandable given the dubious work relatedness of many claims and the ease with which they are accepted.

34. An industrial deafness claim is typified by the following scenario:

- Worker is assessed at 6% impairment
- Worker obtains legal advice and a further medical impairment assessment at 8%
- Agent disputes further claim and engages legal advisers
- Legal costs of claim exceed cost of compensation.

35. This outcome could be avoided by introducing the use of an independent panel of assessors to whom the worker is referred for a binding decision as soon as the claim is disputed to avoid additional medical and legal costs.

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[8] Compendium of Workers Compensation Statistics Australia 2009- 2010 Safe Work Australia page 30
[9] WorkCover Statisitical Bulletin 2008- 2009 page 38 (most recent available)
[10] Work-Related Noise Induced Hearing Loss In Australia April 2006 Australian Safety And Compensation Council
[11] ABS 6291.0.55.003 Labour Force Australia Detailed Quarterly Feb 2012

36. WorkCover should undertake acoustic surveys of specific operations before defining which industries/operations constitute a 'noisy' employer and automatically accepting claims accordingly. The WHS regulations require employers to undertake audiometric testing if they are using hearing protection to reduce exposure to noise and this should also be taken into consideration. Employers should not be automatically attributed a "noisy" status because of their industry, eg manufacturing. Noise levels vary greatly between different establishments because of the multiplicity of contributing and offsetting factors.

37. Once identified, re-assessments should periodically occur so that changes in operations can be factored in to a revision of the list of noisy employers.

The role of the general practitioner and the need for an independent panel of medical examiners

38. Medical practitioners play a crucial role in injury management and return to work. WorkCover dismisses employer concerns about the role of gatekeeper played by the nominated treating doctor, and has consistently put in place measures to ensure that the opportunity to challenge medical opinion is circumscribed. Measures should be instituted to ensure medical practitioners are genuinely assessing and reviewing medical treatment and the return to work goal, and these measures should be readily demonstrable.

39. The prevalent current practice of nominating treating doctors supplying medical certificates with no information about the worker's condition other than "unfit for work" or reiterating the same medical restrictions over lengthy periods of time is costly and unworkable. WorkCover medical certificates should be explicitly used to assist rehabilitation and return to work.

40. WorkCover's detailed return to work guidelines envisage a key role for the nominated treating doctor's role in participating in this heavily prescribed process. It envisages the nominated treating doctor participating in the development and implementation of an injury management plan; advising on the suitability of duties, providing information for injury management and return to work plans and being involved in this process at the outset and throughout the life of the claim. This is aspirational, not the practical reality of the working of the scheme.

41. If an NTD does not have the information or the practical resources to make and informed opinion on the worker's capacity in relation to their work environment and the availability of suitable duties, then the NTD should not be permitted to state an opinion. They should be required to make this known to the employer and the agent to gather the necessary information. It is understandable that many general practitioners do not have the time or resources to fully participate in this process; this is an important practical issue which must be addressed.

42. The scheme currently operates to allow the nominating treating doctor's view to be accepted over the opinions of independent medical examiners. WorkCover's administration of the scheme and operational instructions to agents have also acted to limit both access to and reliance on independent medical opinions.

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

44. In this, and other areas of dispute within the scheme such as WPI, there should be access to a panel of independent (of WorkCover) medical examiners which is well managed and controlled and can make binding assessments.

Employers and the Workers Compensation Commission

45. Employers have very limited ability to challenge any aspect of WorkCover's operations and the agent stands in the employer's stead in the Workers Compensation Commission.

46. It is essential to have a simple, fair and independent process for the appeal and review of disputed issues. This process should be independent of the regulator and the insurer. Even a cursory scan of Workers Compensation Commission Arbitration Reports reveals the endemic lack of balance in dispute resolution. In 2009, 261 matters were found in favour of the worker, with 47 found in favour of the employer.[12]

47. Reform of the current dispute resolution and appeals system is needed. At the very least, measures which provide employers the same access as workers to the Workers Compensation Commission to resolve disputes. In the no fault scheme employers' rights are subrogated to Scheme Agents who make decisions as to whether to dispute a claim for compensation, often with little or no regard to whether an employer has reasonable cause or evidence to prove a claim is either exaggerated or fraudulent. This operates unfairly in practice to exclude employers from the dispute resolution process where they have legitimate objections. Mechanisms need to be introduced that provide effective avenues for employers' grievances to be heard where they believe their claims history will be affected by a vexatious or fraudulent claim.

48. Such exclusion from the dispute resolution process must be contrasted with workers' almost unrestricted ability to contest an Insurers' decision regarding a claim, to challenge a medical assessment or to re-open a decision awarding lump sum compensation. The stated purpose of the Workers Compensation Commission Access and Equity Service Charter (the Charter) is to provide "an accessible and equitable workers compensation dispute resolution service to all members of the

[12] AFEI research

community".[13] However, this purpose appears to only pertain to claimant employees. In practice, 'all members of the community' refers to all *employees* in the community. The Charter itself evidences this approach with a single passing reference to employers as 'a key interest group'[14] compared with extensive policies and resources to assist unrepresented claimants, workers with poor English language faculties and outreach services.

Service Providers

49. Employers observe, first hand, when contracted services are not being performed satisfactorily. One infamous claim reported to us involved over 300 physiotherapy treatments in less than two years, in addition to other treatment including pain management counselling for a condition which had no observable physical cause.

50. While WorkCover insists that there are clear performance standards for claims managers' service providers, these are not observable. Transparent performance measures must be available, and employers should be able to feel confident that claims expenditure is being managed in the most efficient manner for the worker's recovery and return to work.

51. Again, the use of independent medical opinion should be available to curtail excessive or inappropriate use of service providers.

Worker Obligations

52. Worker obligations are clearly specified in the legislation and in WorkCover guidance material. The worker is expected to participate and cooperate in

[13] "Access and Equity Service Charter," Workers Compensation Commission, Part 1, p 3.
[14] Ibid, p 17.

the establishment of the initial and subsequent injury management plans and make all reasonable efforts to return to work as soon as possible.

53. For the scheme to be fair and balanced, and to avoid unnecessary expenditure these key provisions should be adhered to. Their importance has been considerably diminished in the approach to claims adopted by WorkCover in recent years.

Deemed Workers

54. Coverage of the scheme should be evident to both workers and employers, with a clear and reliable definition of who is included.

55. WorkCover has devoted substantial resources to attain 100% coverage of all workers in NSW, including contractors and partners in businesses. It has sent auditors into the field to declare every contractor an employee.

56. It has not been demonstrated that the actual level of non-coverage for compensation justifies the assertion that those in self employment are wrongly excluded from the scheme. Whilst underpayment may be seen as a problem across the scheme as a whole, there has been no data put forward to suggest it primarily arises from contractors or those engaging contractors. In the absence of data justifying a cost and coverage problem of such magnitude employers do not support the strategy to ensure the self employed are covered by the scheme, given the significant consequences for those whose businesses have been affected.

57. WorkCover has lost all credibility with large numbers of employers in industries with high proportions of partnerships and contracting arrangements who have witnessed the winding up of business by WorkCover and its agents because they have been unable to meet the cost of their premiums following audits which have deemed contractors as workers.

WorkCover initiatives

58. WorkCover, acting in its capacity as the work health safety regulator, promotes initiatives which are not seen by employers as genuine efforts to reduce harm actually likely to occur at work, but "make work" programs for regulators and other interested parties such as academics and consultants. These policies and programs too often have the intent of making the workplace responsible for every conceivable human condition. For example, work health and safety has been broadened to encompass "wellness", "well being" and responsibility for a worker's emotional quality of life and their lifestyle health outcomes. These have come into prominence as the incidence of actual, and traumatic injury declines. They also have accompanied the industrial relations agenda for "work life balance" campaigns in the workplace.

59. The problem with these initiatives is that they are presented as solutions but the solution is unlikely to work as the problem, if there is one, frequently has its cause elsewhere. Further, while individual employers may instigate such programs in their organisation's interests independently of WorkCover, this is entirely different to the regulator promoting work health and safety programs and campaigns with the inevitable link back to WHS legislation and the workers compensation scheme.

60. Manual handling and stress initiatives are two examples of WorkCover programs designed ostensibly to reduce claims rates but which have had the effect of widening the opportunity to readily make claims.

AFEI Workers Compensation Surveys 2007 and 2012

61. AFEI surveyed members in February 2007 and again in May 2012 to ascertain their views on workers compensation and its impact on their operations. These results reflect the views of over 400 respondent members.

Concern over workers compensation

62. Our members reported a high level of concern with workers compensation. The results of the survey show over half regard workers compensation as a major concern for their organisation:

Level of concern	2007	2012
Major	52%	53%
Moderate	23%	26%
Of some concern	18%	16%
Not a concern	7%	5%

Workers compensation costs

63. The survey results show clearly that there is a divide between the rhetoric of the regulator and the reality experienced by business people.

64. In 2007 the then CEO of WorkCover, Jon Blackwell, announced on the WorkCover NSW website that:

> *… ongoing improvement in the Scheme's performance has enabled the NSW Government to provide a 20 per cent rate reduction ($560m) since November 2005.*

65. The WorkCover Annual Report 2010–11 states average workers compensation premium rates were reduced by up to 2.5 per cent from 30 June 2010 which reduced premiums paid in 2010–11. The Issues Paper refers to the cumulative drop in average premium rates of 33% since 2005.

66. However, the surveys reveal that the majority of our respondent members have not had reduced premiums in the survey periods 2003–2005 and 2009–2012:

- More than eighty five per cent of respondents said their premium had not decreased
- Over sixty percent reported having premium increases:

Premium changes	**2003/04**	**2004/05**	**2005/06**	**2009/10**	**2010/11**	**2011/12**
Unchanged premiums	23%	14%	17%	26%	13%	11%
Increased premiums	69%	71%	58%	60%	73%	71%
Decreased premiums	7%	15%	25%	13%	15%	18%

67. In 2007 half of these premium increases were reported as due to a higher wages bill and an increased WorkCover Industry Classification (WIC) rate, around a quarter had increased premiums because of claims costs. This situation had changed by 2012 with around 40% reporting premium increases due to increased claims costs:

Premium increases	**2003/04**	**2004/05**	**2005/06**	**2009/10**	**2010/11**	**2011/12**
Increased tariff (WIC rate)	18%	11%	11%	11%	9%	5%
Cost of claim(s)	23%	25%	19%	37%	43%	46%
Increased wages bill	46%	45%	39%	49%	49%	41%
New experience premium formula	4%	6%	10%	–	–	–
Reclassified into a different WIC rate	3%	6%	7%	3%	0%	5%
Grouping of your businesses/operations	5%	5%	12%	0%	0%	0%
Audit	1%	2%	2%	0%	0%	0%
Other	–	–	–	0%	0%	3%

68. For those reporting a decrease in premiums, in contrast to the 2007 survey when most decreases were attributed to reduced cost of claims, tariff rates, and lower wages bills, the 2012 survey showed a minimal impact of reduced WIC rates and the much larger influence of reduced claims costs. If there had been actual reduction in premiums the overall cost for employers would have been greater.

Premium decreases						
	2003/04	**2004/05**	**2005/06**	**2009/10**	**2010/11**	**2011/12**
Reduced tariff (WIC rate)	11%	24%	31%	20%	0%	20%
Reduced cost of claim(s)	22%	35%	38%	40%	88%	50%
Lower wages bill	22%	29%	19%	40%	13%	30%
New experience premium formula	34%	12%	6%	–	–	–
Audit	11%	0%	6%	0%	0%	0%
Other	–	–	–	0%	0%	0%

The impact of workers compensation costs

69. Just over half of survey respondents rated the impact of workers compensation costs on their organisation as 'major' or 'unsustainable':

Cost Impact		
	2007	**2012**
Unsustainable	10%	12%
Major	43%	49%
Moderate	34%	30%
Minor	13%	9%

70. Defensive measures and restrictions on business activity *because of workers compensation costs* were:

Restrictions on business activity		
	2007	**2012**
Changed business activities	7%	15%
Not expanded activities/operations	13%	18%
Moved activities interstate	0%	3%
Downsized scale of business	6%	3%
Reduced employee numbers	9%	15%
Not taken on work because of possibility of workers compensation claim is too high	9%	13%
Substituted labour with technology	8%	10%
Outsourced tasks/product	18%	25%
Imported rather than produced product	3%	15%
More rigorous employee screening when hiring	27%	85%

Insurer performance

71. For both time periods, 2012 and five years earlier the highest levels of dissatisfaction with insurers was consistently with getting workers compensation costs down. For this category, over half of respondents were either 'dissatisfied' or 'very dissatisfied'. The proportion of employers reporting dissatisfaction with managing claims has increased significantly in 2012 to 44%:

Dissatisfaction with insurers										
	2007					**2012**				
	Very Satisfied	**Satisfied**	**Neutral**	**Dissatisfied**	**Very Dissatisfied**	**Very Satisfied**	**Satisfied**	**Neutral**	**Dissatisfied**	**Very Dissatisfied**
Advice to you about workers compensation	8%	20%	42%	22%	8%	0%	33%	31%	19%	17%
Explaining how your premium is calculated	3%	29%	36%	18%	14%	2%	26%	40%	21%	12%
Managing claims	7%	29%	40%	14%	10%	3%	24%	28%	22%	22%
Getting workers compensation costs down	2%	10%	36%	29%	23%	0%	12%	31%	24%	33%

72. In the area of agent performance in claims management from the employer's perspective, the survey results show poorer outcomes over the past five years, with the exception of investigating the claim where an employer had objected to its acceptance:

- In 2007 52% reported having a claim that they considered should not have been accepted. This proportion increased to 67% in 2012.
- 58% responded that the agent did not investigate the circumstances of an accepted claim in 2007. This proportion dropped to 41% in 2012.
- When asked what reasons were given by the agent for accepting claims, explanations ranged from "all claims have to be accepted"; "the employee was at work so therefore the claim was accepted regardless"; to "we will have to seek legal advice to answer your query, and it will be added to the cost of the claim". A common response was that if WorkCover had reviewed the claim, it would have made them accept it.
- In 2007 46% per cent said their agent did not disclose adequate information about the employee's fitness for work, including suitable duties. This proportion had increased to 55% in 2012.
- Just under 60% in 2007 said that their agent did not provide regular claims reviews or keep them informed of costs as the claim progressed. This had increased to 66% in 2012, an alarming proportion in terms of achieving a good return to work outcome.
- In 2007 around half reported that the agent did not take appropriate action to deal with any problems concerning employee compliance or the performance of doctors and rehabilitation providers. In 2012 this proportion had increased to over 60%.

- Of those who used a rehabilitation provider, 65% were not able to use a provider of their own choosing in 2012 (67% in 2007), and most were not satisfied with the providers' services. 64% reported that the provider did not assist with the return to work process in 2007, a proportion which had increased to 71% in 2012.

- Not surprisingly, over 90% of respondents agreed that they have very limited ability to ensure that employees, insurers, doctors and rehabilitation providers do the right thing in the claims management process.

Attitudes to WorkCover

73. Almost universally, employers' opinion of WorkCover and claims management was negative, with members very robust in their criticisms. Some examples of employer responses when asked what was their main reason for concern with WorkCover and the NSW Scheme are as follows:

> *We pay a hefty premium yet have no control over the claims. If a person submits a Workers Compensation Medical certificate our insurance company accepts it, even when we make it clear that it's questionable. Recently we have tried to have a claim declined on the basis that the individual stated it was a personal injury for some 2 months before they ran out of sick leave and then it became a claim. It's an outrageous abuse of the system. We used to be able to ask for an Independent Medical Examination in the event of questionable claims to at least get a second opinion. Now it appears that WorkCover has made it impossible to get one.*
>
> *WorkCover appears to punish insurance companies when they don't accept a claim. Our insurance company appears to be terrified of WorkCover as whenever you question a decision they always say it's in the WorkCover guidelines or that if WorkCover reviewed it*

they would make them accept it. It appears that they live in fear of WorkCover

Doctors are the main problem in abuse of the system. They have no investment in the scheme so they're quite happy to write unfit certificates for their patient even though it's contradictory to getting people back to work. If they were more accountable for their actions then they might be more focussed on the outcome rather then indulging their patients. We recently had a worker who used their doctor to avoid having to do certain parts of their job despite them telling all and sundry that they never felt better. In addition their physio and exercise physiologist were both saying they were fit for pre-injury duties but the GP kept writing suitable duties certificates specifically nominating the work activity the person was not allowed to do.

There is no recourse on the worker or their GP if they defraud the system. If some miracle were to occur and we had a claim overturned then we don't either get out premium back nor can we recover costs from the worker or the GP. There are certainly penalties for fraud but no one is ever charged. In fact in my experience, the system rewards the people who set out to abuse the system.

Have a look at WorkCover's website and see if you can find the last time someone was prosecuted for defrauding the scheme. The only thing I could find was the following from 2 years ago – http://www.workcover.nsw.gov.au/aboutus/newsroom/Pages/WorkCoverfraudprosecutionofWyongwoman.aspx. In that apparently unique case (as someone actually was prosecuted) it took 9 years of abuse before anyone did anything. But of course there's no mention that the employer was reimbursed for the additional premium paid.

So, in conclusion, to make this scheme work there are three simple conditions that need to exist:

First, there needs to be an independent assessor of claims to determine their merits. WorkCover is clearly not that body, nor are the insurance companies.

Second, doctors need to be financially accountable for their actions.

Third, if people abuse the system then they need to be punished rather than rewarded.

As an employer we are very restricted. Grounds for excusing a claim are limited and insurers are reluctant to support this action. Once a claim is accepted employers are again constricted by the legislation. I have had two fraudulent claims but have been unable to make any progress with them. One employee has been on weekly payments for eighteen months and her NTD continues to ignore specialist reports stating her injury has ceased. We have spent considerable sums of money on these reports and our premium has been badly affected. Claimants are able to shop for NTD's and specialists at our expense until they get the answers they want. One employee recently had surgery at our expense to repair her ankle, the outcome was poor and we will undoubtedly have to pay for further treatment even though we have done all that could reasonably be expected. As a responsible employer we support the scheme but increasingly we find it is being abused by those seeking treatment for non work related injuries because their family GP has deemed work a significant contributing factor. I think there needs to be a time limit on the length of time an employee can remain on weekly benefits, particularly if they are refusing appropriate treatment.

Hearing Loss claims are borne by the last known noisy employer. We are a noisy employer and it means that we cannot employ anyone that returns over 6% hearing loss for fear that if they claim for hearing loss whilst employed (even for a short period of time) or after they leave before starting a new job that we will be burdened with the cost of the claim.

Employers are insisting that new employees lodge a hearing loss claim before starting employment so that a base line of their hearing loss can be established.

It should be available to establish a base line with a hearing test and not have to make a claim so that a new employer does not risk a hearing loss claim that has been suffered in a previous role !!!!

We are labour hire blue collar industrial. We will always have claims & are very proactive in managing these. However all premium calculations are heavily weighted against our claims costs & this effects all manufacturing/construction sectors increasing business costs reducing job opportunities sending jobs overseas. Even when a claim is denied the maximum estimate is put on the claim & this is included in our cost of claims for calculation of premium. This is applied for 3 years renewal.

I have a claim where the IME says it is not work related. The worker has been extradited to QLD is on bail. I have offered suitable duties he hasn't accepted. Under the workers comp system the situation is this if I deny the claim I still get maximum wage estimate. If I don't deny I have to keep paying weekly benefits. There is no way to reduce my workers comp cost of claims experience.

The medical profession see this as a good way to make money by continually over servicing workers comp cases writing unfit cert without proper treatment or diagnosis. Why can they charge more for a service because it is workers comp than is for the same service for an individual. I have come across many doctor "shops" who generate the majority of their business from this. Historically WorkCover does not wanted to address this issue & it is getting worst. Physio's get an automatic approval for 8 treatments from WorkCover before they have to submit a treatment plan.

Employers being ripped off by the scheme. We had a claim this year from an employee who twisted her knee (no one saw it) who regularly plays netball – 6 mth claim, operations, physio, reduced hours – a total rort and I have to pay the cost.

Unresponsive GP's and specialists who were simply obstructionist did not help.

We are a proactive employer and I had rehab on the case as soon as we were notified of the claim.

As employers we have absolutely no control over what claims are accepted. All claims are accepted regardless of their merits or our concerns.

It's a joke. The system is so open to rort that when talking to WorkCover staff, they admit it also. Doctors give out medical certificates without accountability so in my opinion the medical certificates aren't worth the paper they are written on. I had a case where an employee worked over the weekend paving his home. Then came in on Monday and said he got a bad back and went on compo. The problem is that all the other staff knew this was happening and WorkCover knew also. Yet it was allowed to proceed. Workers Compensation is a financial nightmare growing and growing that is going to end up being a huge money burden. It needs a massive amount of checks and balances and employees need to fear making false claims. I think the lack of accountability and the ease with which employees can claim workers comp makes this a very bad and costly system.

The main reasons:

Workers compensation being no fault insurance – The lack of personal responsibility of an injured worker when an employer has done everything reasonably practicable to minimise risks.

How easy it is to accept claims e.g. Claim put through, employer provides extensive evidence to dispute the claim, an independent doctor concludes injury has occurred from doing "normal things" and is solely work related, claim accepted.

The industrial relations laws, and therefore workers compensation laws do not make employees take any responsibility for their own negligence. The concept of "on the journey" claims is risible.

Poor claims management by an Insurer we were forced to move to by the State. This poor claims management has in turn seen a substantial rise in our premium. We have even had claims accepted that should have been denied.

The insurance and rehabilitation providers merely go through the motions of claim substantiation and verification along with RTW status benchmarks. The compulsory reporting requirements, merely list claims, scrutiny of claims seems non-existent and provision of light duties is virtually impossible in the construction industry. The cost of claims appears to be increasing and the experience factor in the renewal formula keeps the premiums high. Their now appears to be a whole new service industry hanging off the W/C scheme and it comes back to the employers to pay. The insurance industry should take some of the risk instead of passing it all on into the policy renewals. Claims some be categorised low, med, high and a cost cap imposed for each category to limit the employer liability so the insurance companies and service providers have a motivation to limit costs. At the moment the service providers see it as growth industry.

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1. Claims not managed equally between different case managers ie we currently have two claims the same with two separate case managers and yet one was reasonably excused and the other provisionally accepted.

2. Insurance company not willing to challenge legitimacy for fear of legal battle and then weighing this judgement on the costs associated with legal battle versus costs of claim acceptance.

3. GPs not understanding Workers Compensation responsibilities/ Act and/or completing WCMCs correctly. They need a greater understanding for what they're doing. An example of lack of understanding can be seen in psychological injury claims where I find they only write 'bullying and harassment' as the cause of injury because it is the easiest option. Such a case recently happened in our workplace where an employee was undergoing disciplinary proceedings and the employee claimed anxiety due to the proceedings being stressful. I've seen far worse too, such as an Health Education Officer having a slightly bruised elbow resulting in them being off work for 2 weeks. In this instance the employee could have returned to work on restricted duties (if necessary as their usual role would not have impacted) but the GP refused to talk about it. Education for GPs is obviously lacking.

Its been a nightmare dealing with the whole system. In fact we've had to hire a broker to be an intermediary between us and our insurer to manage our claims. The insurers are terribly slow at following up actions and do not keep us informed. We constantly have to prompt them to consider alternative actions and they're not interested at all in helping us to reduce our premiums. The most frustrating part of the whole process is that we have to manage our claims to the best of our ability and yet have no legal right to interact with the doctors and other medical providers etc.

Really frustrated with the whole system. As the employer, we have to manage our claims with no legal rights. We have had to employ a broker to manage our relationship with our insurer and even then we are continually fighting for information to be given or action to be taken.

We are deemed responsible without the chance to substantiate our side of a claim unless the insurer (GIO) finds the claim to be of a large enough amount. We have had 2 false claims against us in the last 2 years. One lied on his Application of having had a prior claim, and therefore we were denied the opportunity to provide suitable duties. Of course this person put his second back claim in against us. This put our insurance to it's maximum. We had to pay a $63,000.00 premium adjustment in January on top of our monthly premiums doubling for the next 3 years! It is crippling our business in the economic downturn. It should not be classified as "insurance" as the employer reimburses everybody at some point. The 2nd claim was an employee who was on his final written warning and the very next day "slipped on a wet path" & hurt his back! We are nervous of handing out warnings as this potential for a claim is very real. Unfortunately it makes us very cynical even when there is a genuine claim.

Main Reasons:

No fault insurance - There is no self responsibility. An employer has done everything reasonably practicable, given the employee training, provided the tools required for the job and the employee has chosen to disregard this. Alternatively anything outside of work is not taken into account in determining liability and ongoing liability, should an aggravation occur outside of work.

Ease of claim acceptance – For example, an employer provides extensive evidence to dispute a claim, one doctor states the injury

is caused by doing "normal things" but is solely work related – claim accepted.

Relatively minor injuries seem to become large problems. We had an employee fall off a ladder, he wasn't supposed to be on and injure his knee. That was 2 years ago, he is still in treatment, unable to work because he can't travel to work. The comment was that you can't expect him to take public transport from the central cost He was travelling from there when he was working for us. He is still on our books because if we let him go we have to find him a position of equal or better than the one he had with us!!! We can't afford to keep the position open and after all this time really don't want him back. Our insurance company deals with him now and we have not heard from them as to what is happening for over 9 months. Not impressed, seems the whole process is prejudiced against the employer. If you make every effort to keep your staff safe and through their own stupidity they have an accident, it's you fault. When you try to arrange work for them to do while they are recuperating, road blocks are put in your way. When you've had enough and want to let them go, so they can gain employment to suit their medical problem, you are penalised.

We are worried sick about the rising costs of our premiums and the lack of say we the employer have in the handling of the case as to what claims are accepted.

Premiums going through the roof. We had a claim recently with costs in excess of $80k for one year which doubled our premium. We have no control over the $80k that got spent on medicals etc.

The whole system seems to favour the employee and it is extremely hard and frustrating for the employer to move fast to get

employees back to work. There is too much "red tape" involved in the process of a workplace injury, from reporting the incident to the employee returning to work.

We currently have two long term injured employees (one case is 3yrs old and the other is 18ths old). We seem to have to "jump through a number of hoops" in relation to getting definitive answers on whether the employee are likely to return to work. Meanwhile the cost of our premium is sky rocketing as the costs of claims keeps increasing with every doctors bill. One of these employees has also received a payment for a permanent disability yet they still remain employed and their case is not closed. This does not make sense to us as an employer because if the employee has a permanent disability from the injury that precludes them from returning to work, then why are their more hurdles to get over for the termination of the employee.

Employers seem to be at the mercy of the hands of the insurer particularly in relation to cases where there is no rehabilitation happening for the employee and it becomes very time consuming for follow up for small businesses who only have 1–2 administration employees to do this type of work.

There is also a lack of communication from the insurer to the employer and one case can have a number of cases workers which makes continuity of the claim hard to manage.

We had a case of a worker going off on workers compensation for a sprained ankle and not returning to the organisation. It cost the organisation $1000's in increased insurance costs. The system appeared to be set up not to assist the organisation and the insurance company were happy to take our money but not follow up our concerns in regards to the worker who clearly had no intention of returning to work. The case went on for three years.

Seems too easy for claims to be accepted and ongoing for years without any real "rehabilitation" being insisted upon. Employees seem to have the say in how long that want off work and what treatments they agree to. Independent Medical Examiners not used often enough.

The unwieldy system plus you get no advice from your INSURER unless you keep asking.

The Doctor can unjustly extend the claim and there appears to be no help to change this.

We need transparency instead of WorkCover dictating to the Insurer and they rubber stamp. The Legal Profession loves Claims and Insurers only make money. IF there is a claim. So every one except the Employer who is TRYING to get the person back on the job, has too many hurdles to jump. He cannot win it seems. Nor does he have time in a small business to keep the pressure up.

Direct impact of premiums on our business

The scheme is open to rorting and WorkCover and insurers do not do enough in regard to fraudulent claims. Provisional liability is a joke and the period in which insurers have to decide liability is far too long. Employer access to medical information also makes it extremely difficult sometimes to manage employees back to work when the insurer will only release "excerpts" of specialist reports to the employer. WorkCover's management of the scheme is incompetent and has been for years costing employers far more than it should. KPI's for insurers are also inadequate meaning that if you don't have a good Case Manager who manages claims well from the insurance end, the employer can also end up paying far more on a claim than it otherwise would if they were being managed effectively. Insurers don't appear to be very accountable

for their claims management or mismanagement as the case may be. The worker's compensation scheme in NSW is akin to asking employers to have an open cheque book or write blank cheques. The factors used for premium calculation penalise employers in higher risk industries. The basis of premium calculation should be changed to reflect organisational performance which would also incentivise employers to do a great deal more in Workplace Health and Safety to prevent injuries in the first place. If you have an industry sector with a dozen bad employers who don't give a toss about WHS and a couple of good employers who do, the good ones end up paying more because of the bad ones. The system really falls down when it comes to claims like "workplace stress". The number of employees who lodge a claim as a result of a performance management process because they are not performing their jobs properly is incredible. The fact they lodge a worker's compensation claim for stress in these circumstances then makes it all the more difficult to manage that situation with that employee, particularly if the insurer takes weeks and weeks to decide liability. It is a complete joke! Finally, lawyers add significant cost to the scheme. Eliminate lawyers from the process and the scheme costs would reduce.

Regular increases in charges. Only started in July 2010 but jumped 50% in the second year.

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74. We note the observation from the actuarial valuation of the scheme that:

> *The particular risk to the Scheme is the apparent move towards a "lump sum" culture. We believe it is important for WorkCover to:*
>
> ☐ *Review the guidelines to Scheme Agents to question medical assessments*
>
> ☐ *Introduce more rigour in applying the threshold tests to establish entitlement to claim WID (i.e. WPI greater than 15%, proof of negligence, three year statute of limitations and demonstrated economic loss) and defending matters*
>
> ☐ *Review legal cost guidelines*
>
> *WorkCover may need to also consider the need for legislative reform in order to correct the significantly deteriorating lump sum experience.*[15]

75. We share this view as reflected in our response to the measures proposed in the Issues paper. However, it is clear that more will need to be done.

1 Severely injured workers

76. Part of employer dissatisfaction with the NSW scheme stems from their concern that it is unfairly used for claims which are not work related or didn't happen at all and allow claims of a minor nature to become a costly and long term drain on resources which are then not available for more severely injured workers.

[15] PwC WorkCover NSW Executive Summary: Actuarial valuation of outstanding claims liability for the NSW Workers Compensation Nominal Insurer as at 31 December 2011 Page 16

77. If there is greater discipline in the administration of the scheme to weed out bogus, and exaggerated claims, and get workers back to work in a reasonable clinically appropriate period, we agree that severely injured workers, who have an assessed level of whole person impairment of more than 30%, could receive improved income support, return to work assistance where feasible, and more generous lump sum compensation. However, we caution that any such measures will depend upon the quality of impairment assessment. Given the problems evident in obtaining reliable and consistent impairment assessment within the scheme and the problems identified with management of high severity claims a great deal more rigour must be utilised to justify this change.

Removal of coverage for journey claims

78. We agree with this proposal. This would eliminate workers compensation costs from circumstances over which employers have limited – if any – control. The object of the workers compensation legislation should be to compensate for injury during the course of employment. The boundaries of journey claims are widening, eg: inside the front gate. This invites rorting and a reduction in the discipline of the whole scheme.

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

79. We agree with this proposal.

80. A further change to the 2008 death benefits amendments *(Workers Compensation Legislation Amendment (Benefits) Bill 2008)* is required. Those amendments provided that when a deceased worker leaves no dependants the lump sum death benefit is payable to their estate. It is not appropriate to pay into an estate where there are no dependents. The purpose of workers compensation should be to provide financial

assistance to worker and dependents, not a windfall gain to an estate. Work Health Safety legislation provides punitive measures to be taken against employers in the event of a workplace fatality.

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

81. Injured workers on weekly benefits are currently paid their award rate or if a non award worker, average earnings. The Issues Paper argues that calculation of pre injury earnings is complex, there are fewer permanent employees (more casuals) and there is a disparity between award and non award workers. We question this rationale for change from the award rate of pay to actual earnings.

82. The move to modern awards expanded their coverage of the workforce. Most workers are readily classified under a modern award, whether permanent or casual. The view that casual workers are an ever expanding proportion of the workforce is propounded by unions and supporting academics but it does not accord with labour force facts.[16] The difficulty is not determining casuals' award coverage but in establishing their average earnings over the past 12 months particularly where they work for multiple employers. This complexity would not be remedied by moving all workers to actual earnings. It would in fact make calculation of pre injury earnings more complex for all workers as all relevant wage components will have to be calculated, not just the more readily identifiable award rate.

83. In addition to introducing greater complexity this change has the clear potential to increase claims costs, estimations and impact on

[16] ABS Forms of Employment 6359.0 November 2011: *Generally, the number of casuals in the workforce is increasing, however it is increasing at a rate lower than that of all employed persons. In 1998, there were 8.3 million employed persons of whom the number of casuals was 1.5 million (18% of all employed persons). The proportion of casuals reached a peak of 21% of all employed persons (2.2 million casuals and 10.4 million employed persons) in 2007, and now sits at 19% of all employed persons (2.2 million casuals and 11.4 million employed persons) in 2011.*

premiums. The cost impact of the higher benefits on scheme may be mitigated if earlier step downs are introduced but only if there is greater rigour in claims acceptance and management procedures. Further this change may also encourage higher numbers of pre step down claims as there is no loss of earnings involved for the worker in the initial payment period. Before this path is followed, there would need to be a clear procedure for managing claims by agents, WorkCover and the dispute resolution system to ensure there is transparent certainty about the management of the whole process.

5 Incapacity payments-total incapacity

84. We agree with an earlier step down with capacity testing aligned with clinical recovery patterns. However this must be accompanied by more rigorous use of capacity testing by an independent examiner (not the nominating treating doctor) as proposed earlier in this submission. We assume this proposal would not apply to severely injured workers with long term treatment needs.

Incapacity payments - partial incapacity

85. The detail of what this proposal actually may entail needs to be clarified, particularly as any increased benefit payable cannot exceed the worker's pre injury earnings rate when combined with the suitable duties rate.

86. Workers' return to work obligations in the legislation should be used more effectively – many workers adopt the view that they are no longer employees and do not have any workplace obligations at all while on workers compensation, including being in communication with the employer. This is particularly evident in psychological injury claims.

7 Work Capacity Testing

87. We agree with capacity testing at specific points and appropriate rehabilitation to make workers as work ready as possible. However. there must be changes in the scheme to ensure that the capacity testing must be independently and properly done.

8 Cap weekly payment duration - lower level permanent impairment

88. We agree with capping weekly payment duration to within a certain time frame and then ceasing weekly benefits. The absence of any time frame for recovery and the widespread practice of nominating treating doctors to issue repetitive medical certificates without challenge is costly for the scheme and makes employers' stringent return to work obligations difficult to manage. It would also give workers an indication of recovery time frames and assist them focus on achieving work readiness. This is consistent with the fundamental principle of workers compensation to support workers to return to work.

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

89. We agree that pain and suffering should be incorporated into lump sum payments for injuries with Whole Person Impairment greater than 10%. This would remove an area of significant dispute and cost.

90. The current separation between compensation for permanent impairment (Section 66), and compensation for "pain and suffering" arising from permanent impairment, is outdated and artificial. AFEI supports the removal of Section 67 compensation for "pain and suffering" and

considers this will reduce compensating workers multiple times for loss arising from a single injury.

91. Currently, the exposure to expensive disputes on the basis that a worker has been inadequately compensated for "pain and suffering" is too great. A survey of recent determinations from the NSW Workers Compensation Commission reveals disputes surrounding s 67 are frequently brought before the Commission. The recent dispute between Yvette Boustani v Onbeck Holdings Pty Ltd (in liquidation)[17] is emblematic of the inefficient double-handling that occurs when damages for pain and suffering are sought alongside claims for permanent impairment. Whilst a settlement on additional WPI was reached at 22 per cent, the issue prolonging the matter surrounded the quantum of compensation payable for pain and suffering alone. Determining the matter required a review of 6 medical assessments conducted by 6 Medical Practitioners dating from November 2006 to September 2009 in an effort to resolve what associated depression resulting from permanent impairment. The compensable injury was to her back in August 2006 when, at age 38, she lifted a box weighing 10 kilograms. She received $32,500 in respect of 22% permanent impairment, $21,000 for pain and suffering, plus costs.

92. As in that case, overwhelmingly the cause of comparable disputes concern the subjective assessment of the individual's reaction of their permanent impairment.[18] As a result, consistent and fair treatment of claimants is difficult to achieve. It is more appropriate that compensation for pain and suffering be taken into account when a determining, objectively, compensation for permanent impairment.

93. This will alleviate many of the inefficiencies associated with responding to two claims for damages and reduce double-handling by medical practitioners, lawyers, insurers and the Workers Compensation Commission.

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[17] [2012] NSWSCC 105.

[18] The findings of Commissioner Wright in *Tyler v Marsden Industries* (2001) 22 NSWCCR 644 at 650 have been consistently applied in this respect.

Limit on 'top-up compensation'

94. AFEI supports removing access to further, 'top up' compensation payments under Section 66 where further deterioration in permanent impairment is argued and compensation has been awarded. Lump sum compensation payments made to workers in respect of less serious injuries must be determinative in order reduce the risk and associated costs with ongoing claims and disputes.

95. Decisions delivered by Arbitrators in NSW Compensation Commission suggest these are avenues used by workers who are not seriously injured to gain additional extra compensation. In the recent case of Diane Butler v Hunter New England Health Service[19], the Applicant claimed additional compensation under Section 66 and Section 67 for a further 2 per cent permanent impairment for an injury sustained in April 2002 and for which she received lump sum compensation in December 2004. The Applicant received a further $3000 for further deterioration and $5,000 for associated pain and suffering, plus costs, for re-opening a matter settled 7.5 years previously.

Only one claim can be made for whole person impairment

96. We agree that only one claim should be able to be made for whole person impairment.

[19] [2012] NSWWCC 106.

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

97. AFEI welcomes most of the reforms suggested in the Issues Paper to the statutory lump sum payments framework. In particular, we endorse the removal of "pain and suffering" as a separate category of compensation, and limiting the number of claims that can be made for WPI to a single claim. We believe these reforms are necessary to reduce the number of disputes, reduce medical, legal, and administrative costs, and reduce the risk surrounding lump sum compensation payments.

98. At this stage we do not however, support having one impairment assessment for both lump sum compensation payments and claims for Work Injury Damages (WID) at common law. If these assessments actually met the objective tests clearly enunciated in the WorkCover guidelines and could be relied upon for all purposes we may support this proposition. The intent of the legislation was that a WPI could only occur once the injury had stabilised. However there is wide variation in WPI assessments and until some rigour is introduced in this process once assessment for all purposes may not be sufficient.

99. There is another consideration. The proposal that only one WPI assessment is necessary for the purposes of determining compensation payable for permanent impairment and meeting the statutory threshold to access WID at common law inappropriately conflates two WPI relating to separate claims that are often separated by a substantial period of time. Work injury damages claims give rise to different considerations and have significant financial consequences hence the different treatment of the threshold issue when it comes to a damages claim.

100. If workers are permitted to rely on an initial assessment for WPI conducted closest to the date of injury, at a later date, this may not reflect the actual WPI they were originally thought to have suffered. Employers, through their insurers, should not be bound to rely on a WPI

that may have improved since the original claim under Section 66 was made. It is important that in such circumstances, a recent WPI determination is admissible to dispute a finding that the statutory threshold is met.

Strengthen work injury damages

101. We are opposed to any measures which may widen the opportunity to make work injury damages claims. We consider that the Civil Liability Act provisions dealing with the law of negligence should apply to those claims.

13 Cap medical coverage duration

102. We agree that there should be a cap on medical benefits. Many workers have access to medical treatment many years after their date of injury. This has been one of the contributors to the escalating costs of the scheme. However, the cap must be structured so that those seriously injured workers who require ongoing medical treatment receive this for as long as there is a genuine clinical need.

103. As the Issues Paper notes NSW has the highest national expenditure on services to workers – medical treatment, rehabilitation, legal costs, return to work assistance, transportation, employee advisory services and interpreter costs. Caps should be introduced to contain all such costs and not confined to medical benefits duration.

14 Strengthen regulatory framework for health providers

104. We agree that there should be greater discipline and regulation in the use of providers to ensure that their efforts are focused on worker recovery and return to work.

15 Targeted commutation

105. We agree with the proposal to introduce limited commutation. There is a clear need to be limited to very specific classes of injury/claim within specific time frames. However, more detail is needed to understand the implications of what is to be proposed for the scheme.

Exclusion of strokes/ heart attack unless work a significant contributor.

106. We agree and support any measures which eliminate workers compensation costs in circumstances over which employers have limited, if any, control.