Submission
No 137

INQUIRY INTO NSW WORKERS COMPENSATION SCHEME

Organisation: Allianz Australia Workers' Compensation (NSW) Ltd

Date received: 17/05/2012

Submission from

Allianz Australia Workers' Compensation (NSW) Ltd

To

Joint Select Committee Inquiry on the NSW Workers Compensation Scheme

TABLE OF CONTENTS

- **BACKGROUND 3**
- **EXECUTIVE SUMMARY………………………………………………………………….. …4**
- **ALLIANZ'S EXPERIENCE OF THE NSW WORKERS' COMPENSATION SCHEME.... 5**
- **OPTIONS FOR CHANGE………………………………………………………………….…6**

  A- Proposed changes that are underpinned by a change in the Scheme philosophy…………………………………………………………………………..6

  B- Proposed changes that will provide Agents with tools to enable them to become more effective in managing claims……………………………………..8

- **ADDITIONAL AREAS OF REFORM………………………………………………...13**
- **CONCLUSION…………………………………………………………………………….14**

Thank you for the opportunity to provide a submission to this very important and timely inquiry. The submission relates to the inquiry terms of reference as follows:

> *That the committee inquire into and report on the New South Wales Workers Compensation Scheme, in particular:*
> *(a) the performance of the Scheme in the key objectives of promoting better health outcomes and return to work outcomes for injured workers,*
> *(b) the financial sustainability of the Scheme and its impact on the New South Wales economy, current and future jobs in New South Wales and the State's competitiveness, and*
> *(c) the functions and operations of the WorkCover Authority*.

Background

Allianz's submission draws on its significant expertise in claims management and, in particular, its experience of Workers' Compensation Schemes in NSW as well as other Australian States and Territories. Allianz's overriding interest in the inquiry stems from its desire to see reforms to the Scheme that will improve outcomes for injured workers, in particular, to the greatest extent possible, their early return to health and work.

Allianz is clearly aware that the Committee is undertaking its inquiry in the context of the Government's understandable concerns about the Scheme's current large funding shortfall. However, it is worth emphasising that, unlike NSW, the Schemes in some other States and Territories are underwritten by private insurers using capital provided by their shareholders. In those jurisdictions, any insurer's funding shortfall would be required to be ultimately made up through a combination of higher premiums for business (to the extent that premium regulations and competitive conditions would allow) or, more particularly, through capital injections by, and/or lower dividends to, that insurer's shareholders.

The NSW Scheme, on the other hand, is publicly underwritten by the Government of NSW, on which rests the ultimate responsibility for any underfunding of Scheme liabilities. Insurers' role as Agents in the NSW Scheme is limited to the collection of premiums and the management of claims on behalf of WorkCover, based on guidelines set down by WorkCover and relevant legislation/regulation. Agent remuneration under the NSW Scheme, therefore, is essentially based on a 'fee for service' model, with key performance indicators focused on operational efficiency and, most importantly, positive outcomes for injured workers (eg time to return to work).

In preparing this response, our focus has been on changes that will determine :

1. Better outcomes for injured workers in terms of their return to health and, preferably, return to work;
2. Greater operational efficiency;
3. Improved financial outcomes for the Scheme overall.

Executive Summary

We agree in principle with all the proposed changes outlined in the Issues Paper[1]. We believe that the reforms can be categorised into two streams and we have structured our response accordingly. The two streams are :

A. Proposed changes that are underpinned by a change in the Scheme philosophy. These include, in the main, the nature of claims to be allowed or disallowed under the NSW Scheme.
B. Proposed changes that will provide Agents with tools to enable them to become more effective in managing claims.

Allianz believes that the key changes that are fundamental to ensure the future success of the Scheme are:

(i) Step downs in benefits;
(ii) Introduction of work capacity testing; and
(iii) Capping of benefits.

In addition, we submit that:

(i) Assessment of injury for the purpose of determining access and entitlement to Scheme benefits should be based on binding assessments provided by a panel of accredited medical assessors.
(ii) Benefits should be provided to Injured Workers in respect of their primary workplace injury only.
(iii) The Statute of Limitation should apply in respect of the notification of 'frank'[2] work related injuries
(iv) A comprehensive operational procedure model that is unambiguous, enforceable, and consistently applied by all parties needs to be implemented

[1] WorkCover NSW, *NSW Workers Compensation Scheme Issues Paper*, April 2012

[2] Injury as a result of a discrete event

Allianz believes that the above reforms will have a fundamental impact on claim management and *Return To Work* performance, leading to substantially reduced Scheme liabilities.

Allianz's experience of the NSW Workers' Compensation Scheme

As an Agent of the Scheme, Allianz agrees that fundamental reform of the NSW Workers' Compensation Scheme is essential. While most of the injured workers whose claims we manage achieve a sustainable return to work, there is a considerable percentage that do not. We operate within a legislative framework that is supported by an extensive operational structure comprising of over 300 different documents. While there are guidelines and procedures available to Agents to return workers to full health and back into the work place, they are far from effectual as they are :

- Ambiguous and open to variable interpretation
- Not enforceable
- Inconsistently applied
- Not used by all parties involved in decision making regarding claims

As a direct consequence, practices have emerged over several years that enable claimants to remain within the Scheme for a considerable period.

In our experience, many claims are extended beyond the treatment of the original injury and regularly encompass related physical conditions, pre-existing or degenerative conditions, and secondary psychological conditions (such as depression and anxiety). It is our contention that debilitating as they are for the individuals, management of these goes beyond the intention of the Workers' Compensation Scheme principles.

Further, while there are penalties associated with Agent performance and Employer premium due to both increased claim duration and higher medical cost of claims, there is little incentive for employees with significant work capacity to exit the Scheme. We also recognise that there are many injured workers with significant injuries who are disadvantaged financially as well as physically due to the current benefits structure.

Options for Change

As identified previously, we agree in principle with all changes outlined in the Issues Paper. We believe that the reforms can be categorised into two streams, as follows:

A. Proposed changes that are underpinned by a change in the Scheme philosophy
B. Proposed changes that will provide Agents with tools to enable them to become more effective in managing claims.

We refer to the suite of options presented in the Issues Paper and respond to each individually within the above headings as follows:

(A) Proposed changes that are underpinned by a change in the Scheme philosophy

Severely injured workers

We agree that a key plank of any reforms should be to improve the benefits for severely injured workers. It has been proposed that reforms should provide for severely injured workers, who have an assessed level of whole person impairment (WPI) of more than 30%, to receive improved income support, return to work assistance where feasible, and more generous lump sum compensation.

In principle, we support the provision of additional benefits for severely injured workers. We submit, however, that consideration needs to be given to the following:

- A strict definition as to what constitutes a severe injury needs to be prescribed because to date Scheme Agents have not been provided with a definition and this will invariably give rise to inconsistent application of any reform across the Scheme. We submit that the definition needs to be two-fold - prescribing not only the WPI percentage, but also the type of injuries.

- At present, Injured Workers are able to make claims for permanent impairment on the basis of assessments from multiple assessors. However, Scheme Agents are not empowered to require that a claimant be assessed by either an accredited treating specialist(s) or the qualified accredited assessor(s) who has provided the previous assessment. In circumstances where a claim is being made for more than 30% WPI, we believe that such an assessment should be made by an Approved Medical

Specialist via the Workers Compensation Commission[3] to ensure a singular and consistent assessment by appropriately qualified and accredited assessors.

Removal of coverage for journey claims

The object of the Workers' Compensation legislation is to provide income support, medical assistance and rehabilitation support for workers injured during the course of their employment. It has been suggested that the removal of coverage for journey claims would provide a closer connection between work, health and safety responsibilities through eliminating Workers' Compensation costs arising in circumstances over which employers have limited control.

We support this reform in principle, and it will bring NSW in line with other jurisdictions, but we do note analysis would need to be undertaken regarding cost implications for the CTP Scheme.

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

We agree that the removal of the ability of relatives or dependants of deceased or injured workers to make nervous shock claims 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.

We support this reform in principle, noting that workers who witness the workplace death of a colleague and suffer psychological injury would still able to make a claim under the legislation.

Strengthen work injury damages

We agree that there is no reason to exclude Workers' Compensation common law claims from the principles of the law of negligence which apply to other damages claims and we support the application of the Civil Liability Act provisions dealing with the law of negligence to those claims.

The application of the Civil Liability Act to Workers' Compensation common law claims may provide employers in appropriate circumstances defences that may not otherwise have been

[3] by way of application similar to applications for assessment of threshold issues for the purposes of Work Injury Damages

available to them under the general laws of negligence and enable them to better defend work injury damages claims.

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

We agree, in principle with the exclusion of strokes/heart attacks unless work is a significant contributor. This exclusion 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.

Conclusion

Adoption of the above proposed changes to the Scheme philosophy would:

- Provide a closer connection between work, health and safety responsibilities through eliminating Workers' Compensation costs arising in circumstances over which employers have limited control; and
- Increase benefits to severely injured workers.

B. Proposed changes that will provide Agents with tools to enable them to become more effective in managing claims.

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

The definition of pre-injury earnings and adjustment of pre-injury earnings is a significant issue for Scheme Agents. Presently, pre injury earnings are calculated by taking the workers average earnings over a period of 12 months including regular overtime and allowances. As there is no clear direction as to the meaning of "regular" overtime and allowances, calculation is subject to interpretation.

Changes to the definition of earnings in relation to weekly benefits would remove the ambiguous provisions that currently exist to determine the amount of weekly benefits that an injured worker would receive and thereby reduce disputation over weekly benefits.

Accordingly, we have no objection, in principle, with the proposed simplification of the definition of pre-injury earnings and adjustment of pre injury earnings.

We do submit, however that there needs to be strict requirements in place for self employed injured workers to verify their income. Currently, Agents have no authority to obtain company financial records and tax return statements to establish what the workers' earnings

are, which contributes to an inability to prove the income of a self employed injured worker and manage section 40 (top up) entitlements.

Incapacity payments-total incapacity

We support aligning weekly benefit payments/step down provisions more closely with other jurisdictions. To be effective, this has to be supported by capacity testing.

It is suggested that the rationale behind the step downs in other jurisdictions is that the majority of compensable injuries are resolved within three months (based on medical evidence[4]) and we support a review point consistent with other similar jurisdictions.

We submit that injured workers should continue to receive benefits for total incapacity after a defined period only if they have no work capacity and are likely to have no immediate work capacity.

Incapacity payments - partial incapacity

We agree that the NSW arrangements for incapacity payments for partial incapacity means that there is no financial incentive to reduce an injured workers dependence on weekly benefits by increasing hours worked. We support the principle of other jurisdictional benefit arrangements where long term dependency is discouraged through the step down provisions.

Work Capacity Testing

In NSW, there is currently no provision for specific work capacity tests at defined points of the claim. We are supportive of workers undergoing work capacity tests at specified points throughout the claim and agree that work capacity testing could also assist injured workers on long term weekly benefits in transitioning from weekly benefits back into paid employment. To ensure consistency and correct application, the binding work capacity testing should be undertaken by an accredited WorkCover Injury Management Examiner (IME).

In the Victorian Scheme, IMEs are used to assess a workers capacity to work where there is evidence that a worker may have a greater capacity than certified. We understand that the use of IMEs to assess capacity in Victoria has been successful in providing clarity of a worker's capacity to work.

[4] *WorkCover SA Annual Report 2007-08 Solomon L, Warwick DJ, Nayagam S, Apley's System of Orthopaedics and Fractures, 8th Ed (2001) Russell RCG, Williams NS, Bulstrode CJK, Bailey and Love's Short Practice of Surgery, 23rd Ed (2000) Presley Reed, The Medical Disability Advisor. 2nd Ed (1994)*

This assessment is then used in conjunction with vocational assessments and treating provider information to determine whether the worker will have an entitlement to weekly benefits beyond a defined timeframe.

Cap weekly payment duration

In the NSW Scheme, weekly payments are available (subject to continuing incapacity) until 12 months after reaching the Commonwealth retiring age.

We support the application of a cap on those claims falling outside the severe injury claims category, but recommend differing capping consideration depending on the nature of the claim. For example, there are a significant number of claims in the Scheme where an injured worker is back to work at their pre injury hours but in receipt of a top-up of benefits. In such cases, we submit that a short time period cap is applied to the duration of top ups, to encourage that injured worker to return to their full pre injury duties. In instances, where an injured worker is partially incapacitated but has not returned to pre-injuries hours, we submit that the period of ongoing weekly payments is extended, but nonetheless capped after a defined period of time has elapsed.

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

Currently the amount of s67 "pain and suffering" is based on subjective negotiation. We agree that the incorporation of this provision into lump sum payments for injuries with Whole Person Impairment greater than 10% would reduce disputation and reduce administration costs[5]. Such changes would also ensure that statutory lump sum compensation aligns with an objective measure of the worker's physical impairment following a workplace injury rather than a subjective measure of the worker's loss.

Only one claim can be made for whole person impairment

Lump sum experience has been deteriorating across the NSW Scheme with an increasing proportion of S66 claimants reaching the 15% WPI threshold. At present, Injured Workers are able to make multiple claims for permanent impairment based on assessments from multiple assessors, making it possible for claimants to reach WPI thresholds based on cumulative percentages of WPI, pursue claims for work injury damages and reactivate previously dormant claims. Under the present legislative framework, Scheme Agents are unable to prevent multiple or "top up" claims, claims for work injury damages or demand that a claimant be assessed by an accredited treating specialist or the same previously qualified accredited assessor. To enable Scheme Agents to better manage the increase in lump sum payment frequency (both S66 and work injury damages), we submit that one *payment,*

[5] The amount will need to be fixed to avoid disputation

(being a single and final payment based on a binding assessment of a panel of accredited medical assessors) be made for whole person impairment when an injured worker has reached Maximum Medical Improvement. A table of timeframes should provide a guide as to suitable timeframes in line with injury type and medical literature.

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

For the reasons outlined above at point 10, we agree that one single and final assessment of impairment for statutory lump sum, commutations and work injury damages is optimal for the Scheme. This may reduce the scope for new disputes about the level of whole person impairment and "top up" claims reducing medical, legal, red tape and administrative costs in the Scheme.

Cap medical coverage duration

We note that the most recent national data available[6] shows NSW has the highest expenditure on "services to workers" which encompasses medical treatment, rehabilitation, legal costs, return to work assistance, transportation, employee advisory services and interpreter costs.

It is submitted that all parties will be motivated to work more actively to achieve return to health and return to work goals where it is understood that there is a defined timeframe to achieve treatment outcomes. Outcomes would be achieved through improved and strategic targeting of treatment with an increased focus on active rather than passive treatment. Suggested capping rules would apply to all claims as per the below:

- Medical expenses over life of claim - Unless a worker meets the criteria for a Severe Injury Claim, all medical expenses will cease at a specific timeframe following the date of injury.
- Passive treatment - Only one physical treatment modality to be provided at a time with a cap of a maximum of a defined number of weeks post date of injury or surgery unless supported by an Independent Consultant in the relevant field. Home based exercise programs may be established following this period (capped at a certain point post cessation of treatment).
- Medical expenses following return to pre-injury capacity for work - Once a worker has returned to work full time, medical expenses will be paid to a maximum of a defined duration from the date a full return to work is achieved.

[6] The Comparative Performance Monitoring Report (CPM) for the 2009-10 financial year

Strengthen regulatory framework for health providers

We support the strengthening of the regulatory framework for health providers to ensure that Scheme resources are directed to evidence-based treatment with proven health and return to work outcomes for injured workers rather than on treatments that maintain dependency.

We suggest adopting a model similar to the Victorian model, where there is more control over treatment provision and a capacity to address over-servicing. The 5 key principles in the framework are supported by a thorough suite of policies around the provision of medical and like services which reduces requests for excessive treatment. Further support in the form of a WorkSafe clinical panel is available in situations where treatment is excessive. This panel reviews treatment and provides binding advice on the reasonable and necessary nature of treatment and on billing practices.

Targeted commutation

Presently, Scheme Agents submit claims for commutations, if all prescribed criteria are met. It is then a matter for WorkCover NSW to approve the commutation submission. We support the relaxation of commutation thresholds for specific classes of claim on a time limited basis and the continuing adherence to the current WorkCover approval mechanism. To help reduce tail Scheme liability, workers with ongoing injuries should be allowed the flexibility to exit the Scheme on a voluntary basis (in respect of defined claims) whether or not they meet the 15% WPI criteria. Examples of claims that may meet this criteria include:

- Workers in receipt of court awards;
- Partially fit workers who have returned to work on full hours, however, remain on weekly benefits;
- Non-English speaking workers and workers in regional locations where employment options are limited;
- Workers who have returned to work in self employment;
- Mature workers in receipt of ongoing weekly benefits;
- Claims in receipt of ongoing reasonable and necessary medical treatment only.

Conclusion

Implementation of the suite of reforms directed at providing Agents with tools to become more effective in managing claims would result in a number of outcomes including the following:

- Support less seriously injured workers to recover and regain their financial independence;

- Strongly discourage payments, treatments and services that do not contribute to recovery and return to work;
- Implementation of simplified and objective measures, facilitating consistency in understanding and application of key definitions;
- Reduction in inappropriate WPI, weeklies and medical spend, thereby positively impacting Scheme liability;
- Facilitation of commutations in defined cases, where such is in the best interests of the injured worker and the Scheme.

Additional areas of reform

In addition to the suite of proposals identified in the issues paper, we also believe that consideration needs to be given to the following:

1. Determining access and entitlement to Scheme benefits should be based on binding assessments of injuries provided by a panel of accredited medical assessors ensuring a skilled and objective assessment process.

2. Benefits provided to Injured Workers should be limited to their primary workplace injury. Where the primary injury is a physical issue and resolves, benefits are to cease in line with capping provisions. There has been an increasing trend in NSW where an injured workers primary physical incapacity has resolved, but the injured worker continues to receive ongoing benefits (for example, as a result of a secondary psychological condition). In circumstances where there is a manifestation of a psychological injury, support and counselling should be provided as soon as possible (but capped in terms of spend/duration.)

3. Statute of Limitation provisions need to be applied in respect of the notification of 'frank' work related injuries. Hundreds of claims, allegedly sustained more than 3 years ago are received by Allianz on an annual basis. The time lag in lodging such claims makes it exceedingly difficult to investigate and determine the claim on its merits. We accept that the Statute of Limitation provision should not apply to latent disease type claims.

4. A comprehensive operational procedure model that is unambiguous, enforceable, and consistently applied (by all parties, including the Workers Compensation Commission (WCC)) is necessary to ensure that decision making based on appropriate application of the legislation is supported and upheld.

Furthermore, in respect of the WCC, we submit that a medical qualification is essential to assess any medical related component of a claim. Presently, an arbitrator with no medical background is in a position to make a determination on a medical issue. (For example, in expedited assessment matters.) This avenue does not facilitate determination of a matter on its merits.

Conclusion

Thank you for the opportunity to provide a submission to the Committee. We reiterate our support for this inquiry and are encouraged by the approach adopted. We submit that any solutions need to strike the right balance between providing injured workers with the support, assistance and encouragement needed to recover and return to work as quickly as possible, and premium levels which do not undermine the ability of NSW employers to compete and provide jobs. We believe that reforms such as step downs in benefits, introduction of work capacity testing, capping of benefits and legislating that assessments are provided only by a panel of accredited medical assessors will go a long way to addressing current issues within the Scheme.