Submission No 118

INQUIRY INTO NSW WORKERS COMPENSATION SCHEME

Organisation: NSW Worker's Compensation Self Insurer's Association

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N.S.W. Workers' Compensation
Self Insurers Association Inc.

Employers Managing Their Own Risk
ABN 69 780 464 009

SUBMISSION

Inquiry into the NSW Workers Compensation Scheme

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Introduction

This submission is made by the New South Wales Workers Compensation Self Insurers' Association Incorporate (NSW SIA) and encompasses the general views of the members, being Self Insured Companies, Specialised Insurers and Companies seeking Self Insurance. The NSW SIA welcomes this opportunity to provide a response to the Inquiry into the NSW Workers Compensation Scheme and is available to provide further information or evidence if required

The NSW SIA is a non profit Association of New South Wales Employers who is licensed to manage their own risk for workers compensation. The Association commenced in 1979 and has grown to have a membership of 62 full member companies, 6 associate members and 24 provisional members. In all, the Association represents a very large number of businesses varying in size from national multi state employers to single state entities. Many of our members are top ASX listed companies and employ Workers in a range of different Industry Sectors. Also included through legislation (WCA 211B), as a Deemed Self Insurer, is the State's Treasury Managed Fund, whose state public entities are not able to self manage their claims, but come under Scheme Agent management.

Self and Specialised Insurers are in a unique position within the Scheme, as they do not contribute to or participate in the current WorkCover deficit. Section 211 of the Workers Compensation Act 1987 allows The Authority to grant a self insurance license. This licensing requires substantial prudential requirements and securities to safeguard the liability from adverse circumstances. Self and Specialised Insurers possess an intimate understanding of the true risks and cost drivers involved in workers compensation as they are responsible for both direct and indirect costs associated with the management of their own workers compensation risks.

Unlike Scheme Agents who are influenced by remuneration, Self and Specialised Insurers have their Company and Workers' best interests at heart. The ownership of performance and cost rests with the Self and Specialised Insurer who manage their workers compensation risk with the best possible resources, normally experienced in-house staff. Self and Specialised Insurers have outperformed Scheme Agents in claims management, return to work and overall costs over many years.

WorkCover NSW

A concern of all Members has been the ever increasing restrictive regulatory oversight by WorkCover NSW on Self and Specialised Insurers over the past ten years. WorkCover NSW has increased Self and Specialised Insurers annual workload by requiring a number of unnecessary compliance audits. Workplace, Health & Safety Audits and Case Management Audits have been introduced and incorporated in licensing conditions and have added immeasurable layers of bureaucratic cost to our businesses. Diverting staff resources and time to non value adding activities has reduced our ability to concentrate on value add safety and risk initiatives. Our Members ask why they are under such a high level of scrutiny when they are already subject to the same legislation and regulation as every other employer in the state and when they have a higher level of incentive than all other employers to promote safety. Indeed, it could be argued that Scheme based employers, who impact on the overall financial health of the Scheme should be subject to a higher level of scrutiny than self insurers (e.g. OHS Audits).

Last year WorkCover NSW imposed new data management requirements on Self and Specialised Insurers entitled 'CDR and Project Concordance' which has created duplicity of administration. The effects of the CDR data requirements has been the doubling of data inputting and repeated system error report corrections due to increased data error fields. For all companies this has caused a substantial increase in workload. This continues to require data inputting for it's own sake, with no benefit to Self Insured organisations. The reason given has been the need to identify over servicing by providers. Self and Specialised Insurers manage the provider when over servicing is identified and require that treatment is reasonably necessary for the injury or illness and is beneficial to an injured Worker. We do not benefit from WorkCover's investigation of service providers.

Our members also have significant concerns with the large volume of Guidelines and Regulations issued by WorkCover which unnecessarily constrain our management of claims. WorkCover have over 50 documents, totalling over 700 pages, of Guidelines and Regulations that specifically relate to Self and Specialised Insurers, which we are required to adhere to. Many of these Guidelines are inconsistent with the legislation and provide confusion and inconsistency in workers compensation processes and have the overall effect of stifling innovation whilst being questionable in the value they add in a self insured context.

We understand that there is a current review by WorkCover of these processes however the information received to date provides us with little confidence that change will eventuate.

Self and Specialised Insurers are large companies who take the responsibility for their workers compensation risk seriously and are transparent in their adherence to the legislation. Although the Association acknowledge the need for a limited governmental oversight, we recommend that WorkCover's attention be directed to the management of Scheme Agents, rather than Self and Specialised Insurers.

We would strongly recommend that WorkCover's oversight of Self and Specialised Insurers be limited to prudential matters only, in line with the Workers Compensation Act 1987.

Issues Paper Addressed

In regard to the various options advanced for change in the Issues Paper, the Association makes the following submissions:-

1. **Severely injured workers**

The Association accepts the general proposition that entitlements to workers compensation benefits for severely injured workers should be maintained, however the Association does not believe that benefit levels for seriously injured Workers should be improved or added to in the present circumstances where the provision of benefits to other injured workers maybe removed or reduced.

The Association is also of the view that the determination of who constitutes a severely injured Worker should be by reference to an injured Worker who has an assessed level of whole person impairment of more than 50%. It is beyond doubt, in this regard, that impairment does not necessarily reflect capacity. The Association has, for example, experience of incidents where workers claiming for disfigurement consequent upon sun damage to the skin have been assessed as having 50% Whole Person Impairment, but have nevertheless retained a substantial (if not unrestricted) capacity for work. It is therefore the Associations view that the threshold for determining a category of severely injured Worker should be set at a sufficiently high level to ensure that it does not also cover injured Workers who retain a very substantial capacity for work.

2. **Removal of coverage for journey claims**

The Association supports the removal of coverage of workers compensation for journey claims and says further that coverage for 'recess' claim should also be removed.

One of the main benefits of self insurance to an Employer is that it provides a direct and immediate correlation between work, health and safety and workers compensation costs. This provides an immediate and substantial benefit to an employer in improving workplace health and safety and inevitably results in better work safety outcomes.

There is however no real opportunity for an employer to directly improve safety outcomes in areas where there is no connection with the workplace, such as in journey claims and in recess claims.

It is also the Association's view that any scheme reforms should be specifically directed at improving levels of consistency between jurisdictions. Journey claims are not covered in Victoria, Western Australia and Tasmania and are not covered under the Commonwealth Scheme and excluding coverage for journey claims in New South Wales will improve the level of consistency between jurisdictions.

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

The Association supports the removal of any provision of any entitlements for injuries to relatives of deceased or injured Workers. It is clearly a significant anomaly that an injured Worker's entitlements to certain types of compensation for secondary psychological injuries are limited or excluded, but no such limitation or exclusion applies to family members.

It is the view of the Association that entitlements should only be paid to injured Workers, except where additional benefits are payable to direct dependants of the injured Worker (for example in the rate of weekly compensation).

It is also the view of the Association that the current allowance for the payment of lump sum death benefits to the Estate of a deceased Worker in circumstances where the Worker does not leave dependants, should be removed. It is, in the view of the Association, clearly inappropriate for lump sum benefits to be paid to an Estate in circumstances where those who benefit from the Estate were not otherwise dependant upon the deceased at the time of death. The requirement for the payment of lump sum compensation benefits where a Worker dies leaving no dependants amounts to the imposition of a significant penalty on an Employer even in circumstances where the death of the Worker did not result from any act or omission on behalf of the Employer (for example in journey claims).

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

The Association strongly supports any amendments to the Legislation which results in a simplification of the definition of pre-injury earnings and a simplification to the adjustment of those pre-injury earnings. Indeed the Association is of the view that efforts should be made to simplify all elements of the calculation of entitlements to weekly compensation in respect of total incapacity, deemed total incapacity and partial incapacity.

The amendment to the means by which pre-injury earnings are calculated should specifically exclude, from that calculation, any payments made in respect of matters which are related to attendance at work (such as tool allowances and related loadings). Where a person is absent from work by reason of incapacity, allowances of these kind should be excluded as those matters which they are directed at have no, or limited application to an incapacitated Worker.

The Association is also of the view that the recent amendments to the Legislation which remove the cap provided under s.35 of the Workers Compensation Act, 1987 from the calculation of entitlements under s.40 for a Worker who has returned to some suitable work, should be reversed. The removal of this cap provides a specific disincentive to an injured Worker in the resumption of full pre-injury employment and also operates to provide a disincentive to the provision of suitable employment by an Employer.

The experience of Members of the Association is that a large number of disputes are generated by reason of uncertainty and inconsistency associated with the calculation of the extent of any entitlements to weekly benefits and the determination of those matters which go into that calculation. A simplification of this process would have very substantial benefits in reducing the level of disputation in this regard.

5. **Incapacity payments – total incapacity**

The Association supports the introduction of a step down in benefits for the payment of weekly compensation to a totally incapacitated (or deemed totally incapacitated) Worker for the purpose of encouraging recovery and earlier return to work. The introduction of progressive step downs in payments in these circumstances would firstly provide improved consistency across jurisdictions.

The Association's view is that payments of weekly compensation should be reduced to 80% of pre-injury earnings after thirteen (13) weeks (consistent with the current provision in s.38(3)(a) of the Workers Compensation Act, 1987) and then again reduced to either the current statutory rate or 70% of pre-injury earnings (whichever is the lesser) after twenty-six (26) weeks.

6. **Incapacity payments – partial incapacity**

The Association supports the suggestion that incapacity payments for partially incapacitated Workers should be specifically structured in such a way as encourage return to suitable employment and also return to pre-injury employment levels and earnings

As has already been stated the recent amendment that removed the s.35 cap in the calculation of partial incapacity benefits in New South Wales has had precisely the opposite effect and has rather discouraged partially incapacitated Workers from resuming pre-injury duties in many circumstances.

7. **Work capacity testing**

The Association supports, in principle, the introduction of work capacity testing at least to the extent that this allows for greater consistency between the New South Wales Scheme and other jurisdictions. The implementation in New South Wales of work capacity testing should however be part of a broader range of amendments for payments to partially incapacitated workers if it is to provide any real benefit.

The Association notes that in New South Wales there is already the opportunity for Employers to obtain reports specifically addressing work capacity and vocational opportunities, however it is the experience of many members of the Association that these reports are not accorded sufficient weight when disputes regarding incapacity are determined in the Workers Compensation Commission.

8. **Cap weekly payment duration**

The Association supports the implementation of a cap on the period during which weekly payments can be received for a partially incapacitated Worker. It is the view of the Association that payments to a partially incapacitated worker should be limited to one hundred and thirty (130) weeks so that the provisions in New South Wales are, in this respect, consistent with those that apply in Victoria.

It is beyond doubt that the return to work rates for partially incapacitated Workers who are in receipt of weekly benefits for in excess of six (6) months are extremely poor and one of the factors that contributes greatly to the poor return to work outcomes for these injured workers in New South Wales is the availability of ongoing weekly payments of compensation for a period of up to one (1) year past retirement age. Providing a clearly defined cap on the period during which such weekly compensation is available provides certainty for employers and insurers and also provides a specific timeframe by which a partially incapacitated Worker needs to secure a return to work.

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

The Association supports the removal of a separate payment of lump sum compensation for pain and suffering as currently provided for in s.67 of the Workers Compensation Act, 1987.

This separate lump sum compensation payment had been provided for in the Workers Compensation Legislation as a trade off for the abolition of rights to common law damages which rights had been available under the 1926 Act. The reintroduction of access to common law damages without the concurrent removal of a separate entitlement to lump sum compensation for pain and suffering represents an anomaly that should, in the view of the Association, be corrected.

If separate entitlements to lump sum compensation benefits are to be retained then any such entitlement should be determined by reference to s.66 of the Workers Compensation Act only. It should be noted however that at the present time, guidelines issued by the WorkCover Authority currently preclude Employers from negotiating a settlement of an impairment claim in circumstances where the assessment of that impairment relied on by an injured Worker exceeds any assessment obtained on behalf of the Employer. Those guidelines require either that the Employer pay the impairment as claimed by an injured Worker or alternatively offer to pay the impairment assessment obtained by the Employer only.

It is the view of the Association that, concurrent with removing the availability of a separate lump sum for pain and suffering, the restriction on negotiating resolution of lump sum claims on the basis of a mid point between the Workers assessment and an Employers assessment should be removed.

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

The Association supports the general principle that an injured Worker should be restricted to one (1) claim being made for the payment of lump sum compensation in respect of a whole person impairment. Inherent in such a claim for lump sum compensation is the requirement that the impairment be 'permanent'. It is self evident that where multiple claims can be made over a protracted period of time for increased levels of impairment, this must be inconsistent with the suggestion that the first such claim constituted one for 'permanent' impairment.

On the other hand the Association acknowledges the possibility that where a whole person impairment entitlement is determined and paid, there may be circumstances in which the level of that impairment increases at a later date (for example by reason of operative treatment). It is the view of the Association that any further claim for whole person impairment by reason of a deterioration in the Claimant's condition should only be payable (if at all) when such deterioration is substantial. For the purpose of determining whether the deterioration is substantial, it is the view of the Association that the extent of any deterioration should be required to be not less than a 50% increase in the level of impairment before any additional impairment compensation is payable.

11. **<u>One assessment of impairment for statutory lump sum, commutations and Work Injury Damages</u>**

The Association does not support the suggestion of the introduction of one (1) impairment assessment only unless this is specifically on the basis that the one (1) impairment assessment to be obtained is that obtained by or on behalf of the Employer. It is the experience of the Association that assessments of impairment can vary substantially, even though impairment assessments are all carried out by medical practitioners who are WorkCover trained assessors of impairments.

If claims are submitted on behalf of an injured Worker for payment of impairment compensation it is, in the view of the Association, imperative that Employers retain the right to obtain their own independent objective assessment of impairment prior to responding to any such claim.

The Association notes further that at the present time, Guidelines issued by the WorkCover Authority substantially restrain Employers from obtaining their own independent medical evidence in respect of impairment claims (and in respect of claims generally). The Association is strongly of the view that those constraints need to be removed for all purposes.

12. **<u>Strengthen Work Injury Damages</u>**

The Association supports the application of the provisions of the Civil Liability Act to claims for Work Injury Damages so far as issues relating to primary liability are concerned only.

It is however also the view of the Association that one of the factors that is driving an increase in attempts by injured Workers to secure the payment of Work Injury Damages relates to the onerous restrictions placed on the availability of commutations to injured Workers. In particular the Association is of the view that if the onerous restrictions were removed from the availability of Commutations, this would inevitably result in a substantial decrease in the number of Work Injury Damages claims, particularly if there were concurrent improvements in the overall management of workers compensation claims.

13. **Cap medical coverage duration**

The Association supports the imposition of cap on the period during which medical and related treatment expenses are paid.

In Victoria and Tasmania, the cap applicable to the payment of medical and treatment expenses relates to the period during which weekly benefits are paid and the Association is of the view that, for the purpose of consistency medical and treatment expenses should only be payable in New South Wales in the period during which weekly compensation is payable (as exists in Tasmania) or for a maximum of one (1) year after the period during which weekly payment are available (as in Victoria).

It is also the view of the Association that the cap on the availability of medical and treatment expenses should apply to both totally incapacitated and partially incapacitated Workers. If it is considered that this restriction should not apply to seriously injured Workers, then the Association is of the view that the category of injured Workers considered to be seriously injured should be limited to those who are assessed as having in excess of 50% whole person impairment.

14. **Strengthen regulatory framework for health providers**

While the Association agrees, in principle, that improvements can be made in the regulation of health service providers, this is not currently a matter which represents a significant issue so far as self insured companies are concerned.

The Association is however of the view that more information should be available to health service providers regarding what is best practice, evidence based treatment and that further education of health service providers in these areas would provide improved health and return to work outcomes for injured Workers.

15. **Targeted commutation**

The Association is strongly of the view that commutations should be available in an unrestricted form. The Association does not support the suggestion that commutations should only be available on a targeted or time limited basis. In this regard the Association does not agree with the reservation expressed by the scheme actuary regarding risks associated with removing the restrictions on commutations.

Issues associated with the appropriate use of commutations in specified circumstances are matters that should be entirely in the discretion of the Employer and its representative and they are matters specifically related to proper case management. It is open to the WorkCover Authority to put in place principles by which commutation should be considered so far as its scheme agents are concerned. However it is completely inappropriate for any such restrictions to be imposed on self insurers or specialised insurers.

The Association is also of the view that there should be no requirement for the intervention of the WorkCover Authority or the Workers Compensation Commission in the approval process for commutations. The only requirement to enable an injured Worker to give effect to a resolution by way of a commutation, should be the requirement that an injured Worker first have the benefit of legal advice. An injured Worker who is properly advised should be at liberty to agree to the commutation of any statutory workers compensation benefits in an unrestricted way should that Worker (and the Worker's legal advisor) consider it to be appropriate.

16. **Exclusion of strokes/heart attack unless work a significant contribution**

The Association certainly supports the proposition that conditions such as strokes and heart attacks that have nothing more than a tenuous connection with employment should be excluded from workers compensation coverage. The particular concern of the Association is however, that the current provisions of the Legislation should already operate to preclude the recovery of compensation benefits in these circumstances by reason of the application of s.9A of the Workers Compensation Act, 1987 which requires that employment be 'a substantial contributing factor' to injuries.

A series of decisions from the Workers Compensation Commission and the Supreme Court have adopted an interpretation of this provision which significantly limits the circumstances that it was introduced to be applied to.

It is the view of the Association that s.9A of the Workers Compensation Act, 1987 should be amended so that it requires that employment be 'the substantial contributing factor' rather than 'a substantial contributing factor'.

The provision of workers compensation benefits should be limited to conditions that are a direct consequence of employment activities and should not extend to conditions where employment is not the substantial cause of an injury.

17. Other Matters

a) Injury and disease

The Association considers the definition of injury requires revision when it comes to the concept of disease to exclude constitutional or age related degenerative processes where the link between employment or work and progression of the disease is tenuous at best. Moreover, if injury based on work aggravation (etc) of disease is to remain compensable, there should be a deduction in the nature of a section 323 adjustment applicable to claims for weekly compensation and medical costs identical to what is available for impairment claims.

The allegation of injury based on the nebulous concept of "nature and conditions of employment" should be disallowed or, alternatively, tightened up to oblige the Worker to define the injury mechanism by reference to particular work activity and how the work activity has resulted in pathological change or deterioration to a body part or system over a defined period of time.

The arbitrary fixing of an injury date in disease cases based on date of claim, incapacity or death with the limited and cumbersome ability to obtain contribution from earlier employers/insurers is worthy of reform. The Association is of the view that a "time on risk" approach to adjusting liabilities in disease cases as between employers who have contributed to the disease or its progression ought to be implemented. This would also apply to industrial deafness claims.

b) Impairment

The Association considers section 323 of the 1998 Act should be reformed to delete the concept of a one-tenth impairment deduction by reference to subsection (2). Too many medical assessors of impairment rely on this provision, often in a somewhat lazy fashion, to make a nominal impairment deduction for previous injury or pre-existing condition or abnormality where a thorough review of the evidence would warrant a more substantial deduction.

Generally, the Association is very troubled by claims being recycled or brought in piecemeal fashion, particularly multiple and creative impairment claims aimed at overcoming thresholds and burdening insurers with multiple sets of legal costs. It is not unusual for Workers to bring three or four sets of proceedings making different claims for the same injury over short periods of time. Disturbingly, our members have also experienced the factual basis of an injury or claim changing where earlier claims have failed or have not entirely succeeded. Finally medical evidence submitted to support such claims invariably contains incorrect or incomplete history.

All self insurers should also have access to a data base containing details of all past impairment and common law settlements, which is currently only available to WorkCover agents. If a self insurer is confronted with an impairment or WID claim by a Worker, as a matter of fairness, it should be able to find out whether the Worker has previously been paid impairment compensation or damages in respect of the same body part or system following an earlier injury. This will prevent "double-dipping" and assist with the payment of correct entitlements.

c) Industrial Deafness

Industrial deafness claims affect many Association members (and WorkCover scheme employers) in epidemic numbers. Claims are "recycled" many times over and often brought in a piecemeal fashion to "milk" legal costs.

Moreover, the WorkCover Impairment Guidelines have severely compromised the operation of the section 69A threshold by permitting an allowance for tinnitus which is then used to satisfy the threshold.

The Association is of the view the frequency of such claims should be limited, available legal costs should be reduced, all claims should proceed to a binding AMS assessment in the first instance, and liability ought to be fixed on a "time on risk" basis rather than the current section 17 methodology which imposes liability on the last noisy employer who then has limited or no ability to obtain contribution from earlier noisy employers.

d) Psychological Injury

During the 1970s and 1980s, RSI claims were fashionable and prevalent. They are not so much a problem these days. Instead members of the Association are now burdened with stress or psychological injury claims.

The Association does not disagree with the notion that a worker who has suffered psychiatric illness through a traumatic event at work such as a robbery or violent assault should be compensated. Our members are, however, troubled by the increasing frequency of claims based on alleged bullying and harassment.

The experience of our members is that such claims are often not based on genuine injury. On the contrary, claims are frequently submitted in retaliation to legitimate employer action concerning the Worker or its business.

Although the legislation provides a "defence" to such claims by virtue of section 11A, this provision has been ineffectual in practice. It is too limited in its terms and the onus of proof imposes an unreasonable burden on employers. Moreover, there has been too much of a willingness on the part of the Workers Compensation Commission to actively find fault with the actions of the employer, thereby side-stepping or nullifying the application of section 11A.

The Association calls for substantial reform in this area including: application of a threshold for all benefits claimed in respect of psychological injury (not limited to impairment claims), requiring evidence of a psychiatrist to be presented in support of a claim based on injury allegedly caused by employer action, requiring the Worker to present the complete clinical records of treating doctors to expose non-work contributors to the injury, extending the scope of section 11A to cover all legitimate employer action and reversing the burden of proof in the application of section 11A. In this regard, the onus currently falls on the employer to establish the requirements of the section, thereby disentitling the Worker. As with all claims for compensation, the onus should fall on the claimant asserting an entitlement. Claims based on unsubstantiated, perceived or fictitious work events should be excluded.

Psychological impairment should be viewed as a special category. Under the current regime, calculation of the impairment relies largely on the subjective presentation of the Injured Worker which cannot be tested. This, in the experience of the Self Insurers, has resulted in an inordinate number of cases producing large impairment assessments, on this basis the threshold for psychiatric impairment in Section 65A should be raised to 25%.

e) Weekly compensation – redundancy, failure to rehabilitate or return to work

There should be no weekly compensation available in cases where the Worker ceases employment by voluntary redundancy.

There should be no weekly compensation available in cases where the Worker fails to comply with injury management including failure to return to work on suitable duties, failure to reasonably upgrade to normal duties or failure to job seek on the open labour market. The current provisions permitting suspension of benefits in these circumstances are ineffectual, too onerous to implement and suspensions are summarily overturned in the Workers Compensation Commission.

The section 38 process has been another spectacular and costly failure of the 1987 Act. It should have been an encouragement for partially unfit workers to return to work. It has turned out to be a windfall to workers. It triggers considerable expense for insurers in terms of costs associated with work capacity and vocational assessments, rehabilitation providers required to monitor "job-search" activity. Compliance by the worker often occurs in a perfunctory fashion. A modest level of "job-search" or purported "job-search" is sufficient to remain entitled to benefits. Policing compliance is virtually impossible. When all is said and done, the section effectively delivers higher benefits to workers for an additional year before they drop down to the applicable statutory rate of weekly payments. The operation of the section lacks a genuine mutuality between Worker and insurer.

Section 52A of the 1987 Act is perhaps the most cumbersome provision in the legislation. Aside from cases where the Worker flagrantly fails to look for work and obstructs the efforts of the insurer to facilitate a return to work on the open labour market, the section has been almost completely unsuccessful in achieving its objectives. That is, termination of payments where the partially incapacitated unemployed Worker after two years is not looking for work, has unreasonably rejected employment or cannot obtain employment by reason of the poor labour market. The section in its earliest form was introduced in 1998. Fourteen years later, there have only been a handful of decided cases in the old Court or the current Commission, most of which have been decided against the employer.

The section is too complicated and costly to implement. The evidence required to establish its application can take years to assemble. The onus of proof in its application is also an unreasonable burden on employers. It should be reversed. If the section is to remain, the onus should fall on the Worker to prove he/she is genuinely looking for work if still unemployed after two years of partial incapacity in order to retain weekly benefits.

f) Serious and Wilful Misconduct

The Association calls for an amendment to Section 14 of the Workers Compensation Act to delete the word "solely" which will render non-compensable, any injury occasioned through serious and wilful misconduct, except where there is significant compliance with the employers' directions. An employer should not be visited with liability in misconduct cases.

g) Limitation Period

Except for latent work injuries or diseases, there should be a strict limitation period of three years from the date of injury for the bringing of all claims for workers compensation with no ability to extend time. It is not reasonable to expect employers to respond to claims decades after the injury, particularly where the injury was not reported in the first place. This is the experience of some Association members, particularly in the context of claims brought after retrenchment or voluntary redundancy.

h) Provisional liability

Provisional liability is a concern for self insurers. It has not resulted in early and durable return to work outcomes. Anecdotally the regime has been productive of abuse and cost. Self insurers are locked into liability early with little or no ability to challenge the asserted entitlements.

This is particularly galling where the alleged work injury is suspect. There is little ability to refuse provisional payments. The available reasonable excuses do not reflect all possible defences to claims. For example, it is not a reasonable excuse (and therefore a reason to avoiding commencing payments) to assert section 11A in response to a psychological injury notification.

The seven day time period within which to make decisions offers little opportunity to assemble and consider evidence to ensure sound decisions are made. The process encourages a default in favour of making payments without questioning the entitlement.

In cases where provisional payments are refused, an insurer can be dragged into the Workers Compensation Commission via the expedited assessment process and its decision is given short shrift.

Where there is no work injury and no entitlement, and the necessary evidence to prove that is unavailable in the first seven days, the provisional liability regime facilitates a gifting of compensation to the worker which can never be recovered. In this manner the insurer starts to be locked into an ongoing liability.

If provisional liability is to remain, reporting of injury within 48 hours must be a mandatory requirement to trigger an entitlement. Moreover, the seven day period should be extended to 14 days and the range of reasonable excuses should be expanded.

The Association, however, advocates the removal of provisional liability to streamline the system and remove administrative red tape. The claim liability regime, which requires payments to commence within 21 days in any event is sufficient.

i) <u>Section 74 Dispute Notices</u>

Section 74 dispute notices have proven to be too onerous for insurers to implement. This applies to all insurers in the system. The notices contain too many technical requirements, tend to be prolix and unclear and are productive of paper warfare.

With due respect to case managers at insurers, there is a shortage of skilful proponents of section 74 notices in the system. Decisions of the Workers Compensation Commission regularly criticise the drafting and content of dispute notices. To fulfil the legislative and guideline requirements of a valid and effective notice, the drafter has to employ the mindset of a hybrid case manager, doctor, lawyer, worker and arbitrator.

The Association considers the difficulties posed in drafting valid section 74 dispute notices encourages the acceptance of claims which would ordinarily be challenged.

The Association urges the government to streamline and simply the requirements for dispute notices.
The Association also believes there should be no obligation to comply to Chapter 3 of the 1998 Act, where primary liability and/or a dispute have not been determined.

j) WorkCover Guidelines

The Association and its members believe WorkCover Guidelines impose unnecessary obstacles and complexity to the management of claims. There are too many guidelines. It is difficult to determine which guidelines are current and which are obsolete. Many guidelines are inconsistent with the legislation or go beyond the requirements of the law. Overall they are productive of red tape and costlier claim outcomes.

The IME guidelines are the most glaring example of a misconceived approach to the management of claims by the regulator. In effect these guidelines prevent insurers from properly investigating injuries and claims. In the view of self insurers, the implementation of these guidelines has been a key driver of the escalation of impairment claims leading the growth of work injury damages claims.

The Association suggests all guidelines should be revoked. If there are to be any guidelines, they should be limited, consistent with the legislation and contained in a single document or manual for easy access. Additionally all guideline requirements should apply equally to Workers.

Summary

The NSW SIA understands the urgency of the current financial situation in New South Wales and believes our recommendations on the Issues Paper and Regulatory Oversight would improve the current Workers Compensation Scheme for all Insurers and provide clarity to Injured Workers.

It appears the major cost drivers to the current Scheme are wage payments which are overly beneficial and inconsistent with other jurisdictions, and also the non-accessibility of adequate mechanisms for resolution of disputes. Clear and reasonable timeframes for incapacity payments and the provision of adequate commutation arrangements would provide immediate improvement.

Self and Specialised Insurers comply with Legislation, but are impacted by costly and excessive Regulatory Oversight and Guidelines. It is hoped that this Inquiry will be provided with an understanding of the requirements of New South Wales Businesses and recommend constructive change for New South Wales.

Denise Fishlock, Chairperson
On behalf of all Members of the
NSW Workers Compensation Self Insurers Association Inc.