Submission No 24

INQUIRY INTO PROPOSED CHANGES TO LIABILITY AND ENTITLEMENTS FOR PSYCHOLOGICAL INJURY IN NEW SOUTH WALES

Name: Roshana May

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Introduction

My name is Roshana May**.** I am a lawyer and Accredited Specialist in Personal Injury Law with a 40 year career in NSW personal injury law specialising in workers compensation.

I have actively participated in workers compensation reform processes since 1987.

From 2005 to 2011 I was one of four nominated lawyers in the WorkCover Legal and Regulatory Reference Group, a joint Committee to develop a new legal costs regulation. The resulting Schedule 6 of the Workers Compensation Regulation remains today (although no longer fit for purpose due to intervening reforms of the legislation and the dispute relation mechanisms).

I have been heavily involved in the post 2012 reform Taskforces, numerous committees and consultation groups discussing implementation and further reform of the legislation.

I was the Director of the Parkes Inquiry from 2014 until its closure in 2015 and the author of the Discussion Papers to inform the stakeholders participating in the Inquiry.

From 2017 to 2021 I was the Director of the Independent Legal Assistance and Review Service (ILARS) of the (Workers Compensation) Independent Review Office (WIRO) with responsibility for administering the ILARS, including developing the ILARS Funding Guidelines and lawyer approval processes, and managing and facilitating grants of funding for injured workers. In addition, I advised the Officer on policy, assisted in the writing of submissions, and participated in government consultation processes and roundtable discussions.

In March 2021 I became the Director Policy Systems and Support and held that role until I left the IRO in late 2021. My role included responsibility writing and publication of the current ILARS Funding Guidelines and Lawyer Approval process documents.

I have co-authored many submissions to the Standing Committee on Law & Justice reviews of the workers compensation scheme and have given evidence in several inquiries.

I am a former President of the NSW Branch of the Australian Lawyers Alliance and the current NSW Director. I am a member of the Law Society of New South Wales Injury Compensation Committee and sit on the Law Society's Specialist Accreditation Committee for Personal Injury.

I remain an advocate for the rights of workers and a passionate observer and participant in workers compensation law reform.

Executive Summary

Injuries occur in every workplace every day every year and have for thousands of years. The first workers compensation schemes developed during the building of the pyramids. Very early on in civilisation it was recognised that workers could expect a workplace that was protective of their safety and where their safety couldn't be protected and where, as a consequence of a work injury, they were unable to work then they would be supported financially and with medical treatment and assistance.

The "modern" workers compensation system places restoration of health at work at its centre. It embraces many different ways of working and the many different ways in which injuries can occur. It accepts that the worker is at the centre of the system and it seeks to strike a balance between compensation benefits and the amount paid by employers in premium. It does not benefit employers to the detriment of workers.

Our workers compensation system currently embraces all personal injuries sustained in the workplace. No worker is presently precluded from making a claims for compensation arising out of an injury. That does not mean insurers are obliged to accept liability in every claim. Each claim is assessed on its merits and in accordance with the legislation. Workers and insurers can dispute decisions in a dedicated Commission.

Mental illness, mental disorders and psychological injury have been rising in Australia since 2020. The Government recognises an increase in the number of psychological injury claims (particularly in its own workforce) and seeks to deter and prevent psychological injuries from occurring in the workplace.

The Exposure Draft pays no heed to prevention or deterrence. In order to stem the increase in claims, for the first time a worker who sustains a psychological injury at work will be prevented from making a claim unless the injury results from specific incidents or specific behaviours. Thousands of workers who will sustain a psychological injury through circumstances beyond their control will be barred from making a claim, will receive no compensation and be left to fend for themselves under their own means.

The one saving grace is that workers who may be terminated for failure to return to work after injury will still be afforded the protections available under Part 8 of the *Workers Compensation Act 1987* to seek reinstatement to employment in the Industrial Relations Commission of New South Wales. Part 8 is available to all NSW workers.

Whilst the government is to be commended for their renewed holistic approach to workplace health and safety – a whole of government Return to Work initiative enabling public servants to return to work in places other than their original place of work, strengthening SafeWork NSW as an independent agency and expanding the powers and jurisdiction of the Industrial relations Commission – the provisions in the Exposure Draft do not enhance the government's work. By seeking to avoid premium increases and so serve the business community of New South Wales and itself as the major employer, the government has sacrificed the workers of new South Wales.

This Bill is not just about psychological injuries and their "impact" on the 'system. This Bill is about saving money at the expense of all injured workers' rights. It erodes benefits, regardless of the workers employer and regardless of their injury. The changes which affect all workers capriciously reduce access to early and prompt treatment, and remove supports and place onerous burdens on workers which can only lead to increased disputation and increased costs to the system and fractured and unhappy workplaces.

I thank the Committee for the invitation to present to this inquiry.

Up until the release of the Exposure Draft Bill (Bill) I had not been invited to participate, nor have I participated in or contributed to the consultation process concerning the contents of the Bill.

Inquiry Terms of Reference

This inquiry is bound by very narrow terms of reference:

> That the Committee inquire into and report on proposed changes to liability and entitlements for psychological injury in New South Wales, specifically:
>
> (a) the overall **financial sustainability** of the NSW workers' compensation system; and
>
> (b) the **provisions of the Exposure Draft of the Workers Compensation Legislation Amendment Bill 2025** as provided by correspondence to the Committee.

Acknowledgement

I acknowledge the Standing Committee on Law and Justice Report 84 "2023 Review of the Workers Compensation Scheme, December 2023" (SCLJ Report 84). The Terms of Reference reflect the Committee's resolve to focus on the increase in psychological claims in the workers compensation system and seek an explanation for that increase and suggest solutions.

The Committee identified that there was an increase of psychological injury claims over the previous year and that return to work rates for workers with psychological injuries were poor. The Committee opined that there was more to be done by icare, SIRA and the businesses of New South Wales (in particular the largest employer, the NSW Government) to address the issues. The Committee made 18 Recommendations to the new Government (2023) to ensure financial sustainability of the 'scheme' and that "*all injured workers… be given the support and treatment they require*".

Relevant to the terms of reference here, the Committee observed from paragraph 2.59 Report 84 that the financial position of the scheme needed to be addressed through significant improvement to return to work rates and better claims management. This Committee indicated that they would "prefer to see the financial sustainability of the scheme addressed through further administrative efficiencies and operations improvements to icare, rather than an increase to premiums. A key recommendation in this regard was recommendation 3: That SafeWork NSW as the work health and safety regulator collaborates more closely with the State Insurance Regulatory Authority and Insurance and Care NSW to ensure safer workplaces reducing workers compensation claims.

There are a number of submissions made to the 2023 Review of the Workers Compensation Scheme that contain data, information, reports and proposals that are relevant to this Inquiry.

Specifically, the following submissions are in the author's opinion most valuable:

Submission 2	Prof John Buchanan (specifically attachment 3-A report to icare on "Understanding changing return to work (RTW) trends in NSW – First report on progress from the University of Sydney Research Team"
Submission 26	Insurance and Care NSW (particularly paragraphs 7, 21, and 35 – 36)
Submission 31	Independent Review Office 29 July 2022

Those submissions contain relevant information and statistics that may be beneficial to this Inquiry.

As I have not been able to access information relevant to inform the financial *sustainability* of the system this submission will only address limb B of the terms of reference in any detail.

At the time of submitting I have read and endorse and support the submissions to this inquiry of:

Mr Kim Garling

Australian Lawyers Alliance

Law Society of New South Wales

CFMEU, Construction and General Division NSW Divisional Branch.

Addressing the Terms of Reference

I have not been able to access information relevant to the financial *sustainability* of the system this submission will only address limb B of the terms of reference in any detail.

Data sources

Any data referred to in this submission has been obtained from the SIRA open data analytics tool https://www.sira.nsw.gov.au/open-data/system-overview , SIRA reports, the icare annual reports, and the Australian Bureau of Statistics.

The NSW workers compensation system objectives

The objectives of the New South Wales workers compensation system are set in section 3 1998 Act :

> "The purpose of this Act is to establish a workplace injury management and workers compensation system with the following objectives -
>
> (a) to ***assist*** in securing the ***health, safety and welfare of workers*** and in particular ***preventing*** work-related injury,
>
> (b) to ***provide***—
>
> - ***prompt*** treatment of injuries, and
> - ***effective*** and ***proactive management*** of injuries, and
> - necessary medical and vocational rehabilitation following injuries,
>
> in order to ***assist*** injured workers and to ***promote their return to work as soon as possible,***
>
> (c) to ***provide*** injured workers and their dependants with income support during incapacity, payment for permanent impairment or death, and payment for ***reasonable treatment and other related expenses***,
>
> (d) to be fair, affordable, and financially viable,
>
> (e) ***to ensure contributions by employers are commensurate with the risks faced, taking into account strategies and performance in injury prevention, injury management, and return to work,***
>
> (f) to deliver the above objectives efficiently and effectively."

The objectives (quite correctly in the author's opinion) emphasise and can be distilled to:

- immediacy of assistance ("prompt" treatment, "effective and proactive management"),
- promotion of early return to work
- necessary supports (income etc)
- return to work that meets work health and work safety standards,
- prevention of injury
- fairness
- future proofing through affordability and balancing risk to contributions.

In this submission I propose to examine the provisions of the draft exposure bill (Bill) through the lens of the objectives taking into account the stated intent and purpose of the proposals in the Bill.

Fundamental principle of the NSW workers compensation system

In 1926 the *Workers Compensation Act* was enacted with the purposes of amending the law in relation to workers compensation, constituting the Workers Compensation Commission, providing for **compulsory insurance** by employers against their liabilities for workers and for

the regulation and licencing of insurers. In addition, a central fund was established to the meet the costs of administration of the Commission.

The current workers compensation legislation (comprising two Acts - *Workers Compensation Act 1987* (1987 Act) and the *Workplace Injury Management and Workers Compensation Act 1998* (1998 Act). The 'ecosystem' includes a standalone regulator (SIRA), a fund manager (icare), an independent ombudsman (the IRO), a work health and safety regulator (Safework NSW), a tribunal (the Personal Injury Commission (PIC)) and other entities.

The 1987 Act states the fundamental principle of the system:

> **"A worker who has received an injury (and, in the case of the death of the worker, his or her dependants) shall receive compensation from the worker's employer in accordance with this Act.**
>
> **Compensation is payable whether the injury was received by the worker at or away from the worker's place of employment."[1]**

It is therefore a matter for the Government to decide: what injuries are to be covered and what compensation is to be paid?

- **Personal Injury**

The New South Wales workers compensation system has always recognised all personal injuries. Over time, adjusting to the nature of injuries and the nature of claims, the legislation has been amended to impose or relax restrictions on payment of compensation determined **by the extent of the contribution of employment to the injury**.

Some examples of this mechanism, which is used to regulate access to benefits, are:

- Section 4(b) "includes a ***disease injury***, which means—

  (i) a disease that is contracted by a worker in the course of employment *but only if the employment was the main contributing factor to contracting the disease,*

- section 9A 1987 Act "No compensation is payable under this Act in respect of an injury (other than a disease injury) unless the employment concerned was a *substantial contributing factor to the injury.*"

- Section 9B 1987 Act "No compensation is payable under this Act in respect of an injury that consists of, is caused by, results in or is associated with a heart attack injury or stroke injury unless the nature of the employment concerned gave rise to a *significantly greater risk of the worker suffering the injury than had the worker not been employed in employment of that nature*."

- Section 10(3A) 1987 Act "A journey referred to in subsection (3) to or from the worker's place of abode is a journey to which this section applies only if *there is a real and substantial connection between the employment and the accident or incident out of which the personal injury arose.*

- Section 11A (current) 1987 Act "No compensation is payable under this Act in respect of an injury that is a psychological injury if the injury was *wholly or predominantly caused by reasonable action taken or proposed to be taken by or on behalf of the employer with respect to transfer, demotion, promotion, performance appraisal, discipline, retrenchment or dismissal of workers or provision of employment benefits to workers.*

[1] Section 9 WCA 1987 "Liability of employers for injuries received by workers – general"

This 'regulating mechanism' does not in any way declare that an injury does not 'exist' nor give rise to a claim, nor does it say that an injury is not recognised under the legislation. Presently the 1987 Act recognises all injuries but restricts access to compensation for some injury types through the lens of workplace contribution.

The stated intent and purpose of the Bill

The official statement made of the intent and the purpose of the Bill is contained within the Explanatory note and Media Release accompanying the Bill.

The explanatory note released with the bill in titled "Proposed Reforms to the NSW Workers Compensation System" provides statements of intent:

> ***"to address the fact that the NSW workplace health and safety, and workers' compensation laws are failing to prevent psychological injuries and failing to treat those with psychological injuries quickly."***

The purpose of the bill is said to:

- Clarify and update important concepts, such as reasonable management action and thresholds for accessing long-term payments.
- Shift the "workers compensation laws towards *prevention*"
- Expand early intervention powers to support rehabilitation and return-to-work plans *sooner*
- Strengthen anti-bullying protections, allowing workers to bring claims for bullying or harassment through the industrial relations system
- Establish clearer dispute resolution pathways, improving access to timely outcomes
- Modernise benefits and compensation thresholds to better reflect the cost of living and community expectations.

In the Ministerial Statement to Parliament made by the Treasurer on 18 March 2025 it was said that **"The bill is designed to curb the rising number of psychological injuries people are experiencing at work."**

The Treasurer states that 'NSW's workplace health and safety and workers compensation laws are failing to both *prevent* psychological injuries, and *treat* those with psychological injury quickly.' Further, that as a consequence the system is 'becoming increasingly expensive', that businesses are suffering because *the system* "sends staff they've recruited and trained home, and impairs their ability to manage interpersonal conflict and run productive workplaces."

Reference is made the Government's "comprehensive strategy to ensure that the workers compensation system, the workplace health and safety system, and the industrial relations system all work together… And all remain fit for purpose."

Data

- **Coverage**

NSW has the highest population of any state in Australia with approximately 8,500,000 residents.

NSW has the largest workforce in Australia with approximately 4,494,500 people employed as at March 2025.[2]

Table 1 Workforce participation Source: Australian Bureau of Statistics, Labour Force, Australia March 2025

	NSW	VIC	QLD	SA	WA	Tas	NT	ACT
Employed people	4,494,500	3,785,600	2,981,400	963,100	1,646,600	282,400	140,400	272,400

Annual population growth in New South Wales is approximately 1.4 - 2% per annum.

There were 4,528,817 workers[3] covered by the NSW workers compensation system in the 2023-2024 as follows:

Nominal insurer	3,529,013
Treasury Managed Fund	382,133
Specialised insurers	247,151
Self insurers	370,520
TOTAL	**4,528,817**

- **Increase in claims**

The Data reveals that there has been an increase in all claims across the system since at least 2022. (Table 2)

There has also been an increase in psychological injury claims across the system since 2022. (Table 3)

Table 2 All Claims made by financial Source: SIRA OpenData to January 2025

Insurer type	2024 - 2025	2023 - 2024	2022 - 2023	2021 - 2022
Government self-insurers (TMF)	13,359	21,776	22,961	19,341
Nominal insurer	41,503	72,321	68,961	62,205
Self-insurers	7,074	11,655	10,956	11,227
Specialised insurers	4,413	8,122	8,643	7,985
Total	**66,349**	**113,874**	**111,521**	**100,758**

Table 3 Claims made by financial year for 'mental health condition' Source SIRA OpenData to January 2025

Insurer type	2024 - 2025	2023 - 2024	2022 - 2023	2021 - 2022
Government self-insurers (TMF)	3,044	4,572	4,061	3,376
Nominal insurer	3,507	5,305	3,790	2,993
Self-insurers	917	1,414	612	525
Specialised insurers	302	525	488	393
Total	**7,770**	**11,816**	**8,951**	**7,287**

The increase in claims is best demonstrated by the percentage of claims for mental health conditions over all claims by financial year by insurer. (Table 4)

[2] https://www.abs.gov.au/statistics/labour/employment-and-unemployment/labour-force-australia/latest-release#states-and-territories

[3] insurer recovery through Work performance report as at December 24, State Insurance Regulatory Authority https://www.sira.nsw.gov.au/resources-library/workers-compensation-resources/publications/sira-reports/insurer-recovery-through-work-data-reports

Table 4 Percentage of claims for mental health conditions over all claims by financial year by insurer

Insurer type	FY24-25	FY23-24	FY22-23	FY21-22
TMF (Government Self Insurers)	22.79%	21%	18%	17%
Nominal Insurer	8.45%	7%	5%	5%
Self Insurers	12.96%	12%	6%	5%
Specialised Insurers	6.84%	6%	6%	5%
TOTAL	**11.71%**	**10%**	**8%**	**7%**

The Nominal Insurer has experienced a moderate 2% increase in claims from 5% of all claims to 7% in 2023-2024.

The Treasury Managed Fund (the Government) has experienced a 4% increase over the same period. Of note, the number of psychological injury claims in the TMF almost match the number of claims in the NI.

This financial year the TMF is on track to record approximately one quarter of all claims being related to mental health conditions.

Since this Committee's report in 2023 there has been a review of the Treasury Managed Fund by SIRA (TMF Fund Review) examining "the performance of the TMF, particularly in relation to psychological injuries. SIRA conducted a compliance audit and performance review of 100 claims arising in the Corrective Services (less than 2% of psychological injury claims) and reported in April 2024.[4]

The Report records:

> "*the TMF, which represents approximately eight per cent of workers covered by workers compensation insurance in NSW, was responsible for 20 per cent of claims in the 2021/22 financial year. Significantly, the review has confirmed that in the same period, active psychological injury claims in the TMF represent 48 per cent of all active psychological injury claims in the system and of those 48 per cent, Stronger Communities represented over half. Eight out of ten psychological injury claims are from preventable workplace behaviours like work stress, bullying and harassment, and other mental stress factors."*[5]

Between March and April 2023 SIRA conducted an audit of 10 Government employers for compliance with workers compensation **employer** obligations. The TMF Fund Review report identifies that nine of the 10 Government employers **failed to have a compliant return to work program** and 5 government employers **failed to notify all injuries within the required timeframe of 48 hours or did not notify at all.**

These findings reinforce this Committee's concern that the Government has not done enough to ensure the Government employers are meeting their obligations with regard to ensuring the health safety and welfare of their workers, particularly ensuring they receive sufficient support after injury and are returned to work as soon as possible.

- **First responders/'exempt workers'**

Caution must be applied when looking at the number of psychological injury claims within the TMF. That is because public sector workers covered by the TMF include first responders such as active police, firefighters and paramedics all of whom are **exempt** from the 2012 reforms.

[4] State Insurance Regulatory Authority Treasury Managed Fund Review Report April 2024
[5] Ibid page 5

The proposed amendments do not appear to affect their preserved workers compensation rights as there is no amendment to the benefits provisions that affect them. This remains to be seen as there are no savings and transitional provisions available and only media reports that the Police are not affected by the Bill.

If the exempt workers are **not affected** by the Bill then the numbers of workers with psychological injury claims within the public sector (Government/TMF) to whom the bill is addressed is ***significantly reduced*** due to the fact that the largest number of psychological injury claims arise in 'Public Administration and Safety' (Table 5).

I am unable to say what number of claims are attributable to the exempt workers. Regardless, the number of workers making claims for psychological injuries is small compared with the overall number of claims each year.

There are many Public Administration and Safety public sector workers *not exempt* from the 2012 reforms likely to experience psychological injury similar to the police for example, call centre operators (000), nurses, doctors, prison guards, train drivers.

- **Government self insurers**

Noting the TMF Fund Review, which provides information by NSW Government cluster, the Open Data available does not so report on the TMF.

The responsibility for workers in the public sector falls on The Public Service Commissioner and the heads of the relevant departments.

The TMF Report[6] discloses the head count in the Government sector.:

Figure 4: Head count of employees by cluster

Cluster	Head count	% of public sector workforce
Health	202,362	37%
Education	181,121	34%
Stronger Communities	66,459	12%
Transport	37,096	7%
Planning & Environment	18,046	3%
Customer Service	13,607	3%
Treasury	6,909	1%
Regional NSW	6,222	1%
Enterprise, Investment & Trade	5,923	1%
Premier and Cabinet	2,163	0%

Source: Public Service Commission[6]

[6] Ibid page 17, Figure 4 Head count of employees by cluster

The Open Data reports by industry, NOT BY government sector or Government Employer (specific Department /Agency).

The TMF Review Report identifies that the three main clusters with high numbers of claims as at 2021/2022 are Stronger Communities, Health and Education. An analysis of the 2017 financial year and the 2022 financial year discloses that 62% of all claims in the TMF arose from six occupations:

6.3.3. Occupation

Between 2016/17–2021/22, 62 per cent of all claims in the TMF arose from the following six occupations:

Police officers	23,806
School teachers	19,500
Registered nurses	9,809
Prison and security officers	6,863
Fire and emergency workers	5,710
Ambulance and paramedics	5,140

It is recognised that the duties performed by police, prison and security officers, fire and emergency workers, ambulance and paramedics contain inherent risks such as exposure to unpredictable hazards, traumatic events and workplace violence. Despite this, psychological injury claims due to exposure to trauma and workplace violence make up only 25 per cent of psychological injury claims for these workers.

Whilst I appreciate this data is old it gives an indication of the prevalence of claims in the TMF within the workforce **exempt from the 2012 reforms** which is an important consideration for the Committee.

SIRA OpenData reveals that in the last financial year approximately 40% of all psychological injury claims in the TMF arise in Public Administration and Safety, approximately 31% of all in Education and Training and approximately 22% in Health Care and Social Assistance. See Table 5.

Table 5 Mental Health Conditions in the Treasury Managed Fund: Source SIRA OpenData April 2025.

Industry	2024 - 2025	2023 - 2024	2022 - 2023	2021 - 2022
A. Agriculture, Forestry and Fishing	Restricted	6	Restricted	Restricted
C. Manufacturing	Restricted	Restricted	Restricted	6
D. Electricity, Gas, Water and Waste Services	Restricted	Restricted	Restricted	
E. Construction	6	9	Restricted	8
I. Transport, Postal and Warehousing	102	99	42	19
J. Information Media and Telecommunications	37	22	27	Restricted
K. Financial and Insurance Services	Restricted	Restricted		Restricted
L. Rental, Hiring and Real Estate Services				Restricted
M. Professional, Scientific and Technical Services	25	37	27	16
N. Administrative and Support Services	6	20	13	21
O. Public Administration and Safety	1,367	1,931	1,876	1,619
P. Education and Training	800	1,430	1,266	945
Q. Health Care and Social Assistance	670	984	792	721
R. Arts and Recreation Services	18	14	7	9
S. Other Services	Restricted	11	Restricted	Restricted
Total	**3,044**	**4,572**	**4,061**	**3,376**

THE EXPOSURE DRAFT BILL

1. SCHEDULE 1 CLAUSES 1 TO 4 - PSYCHOLOGICAL INJURIES (MENTAL HEALTH DISORDERS)

Schedule 1 clauses [1] to [4] of the Bill insert two new Divisions into Part 1 of the 1987 Act.

Division 1 General now contains existing sections 1 to 7A. New definitions are inserted into section 3 including a definition for "indictable criminal conduct".

Division 2 'Interpretation provisions-psychological injuries' contains sections 8 to 8I. Section 8 provides that the Division provides interpretive provisions relating to psychological injuries and other matters relating to the application of the Workers Compensation Acts to psychological injuries.

To fully appreciate the effect of the proposals on workers who presently can bring a claim arising from a psychological injury, one must have an understanding of how a claim for compensation is initiated or commenced.

- **How is a claim for compensation commenced?**

Currently, a worker after experiencing an event at work would:

1. Perhaps, discuss their feelings with their employer, but more than likely would not. The worker is required to provide notice of injury to their employer as soon as possible after the injury happened and before the worker has voluntarily left their employment.[7]
2. Consult their GP, discuss their feelings, emotional and behavioural state.
3. Receive from their GP a Certificate of Capacity containing a description of the injury ("not stress"), the cause of injury, the likelihood of the worker's employment being a substantial contracting factor to the injury or whether the worker's condition is consistent with his or her employment being such a factor. The certificate will also contain a statement that the worker is not capable of working over a period of time.[8]
4. Provide that certificate to their employer and provide a "notification of injury" if not already provided and remain off work until such time as they have some capacity to return to work.

The employer would provide that notification and certificate to their insurer within seven days of receipt[9]. This is the commencement of the claim. The insurer would commence to consider both liability and commencement of income support and payment of the treatments proposed.

Provision of a GP's certificate of capacity would be sufficient to ground a claim for compensation and allow the worker to access provisional weekly payments (income support) promptly (within 7 days of notification)[10].

[7] Section 254(1) 1998 Act
[8] Sections 260 and 270 1998 Act and Workers Compensation Guidelines.
[9] Section 264 1998 Act
[10] Section 267 1998 Act

The insurer can raise a 'reasonable excuse' which would prevent provisional liability payments from commencing[11].

Provisional liability only covers weekly expenses . medical expenses are to be commenced within 21 days after a claim is made by the insurer determining the claim by accepting or disputing liability.[12]

The effect of the Division 2 provisions

The combined effect of the new division 2 provisions **is that no worker in NSW can access compensation benefits for a primary psychological injury** when they will need them most immediately upon sustaining injury**.**

As will no doubt be discussed by many others making submissions to this inquiry, there is **NO COMPENSATION** payable for a primary psychological injury unless:

- a relevant event or a series of relevant events caused that injury , and
- there is a real and substantial connection between the relevant event and employment, and
- employment is the main contributing factor to the psychological injury.

> **The definition ("Meaning") of psychological injury (being a 'mental disorder') is onerous and requires a diagnosis by a doctor trained in the use of the *Diagnostic and Statistical Manual of Mental Disorders 5th Edition***

The "meaning" of primary psychological injury (section 8A) requires there to be a "mental or psychiatric disorder" that causes "significant behavioural, cognitive or psychological dysfunction". This definition invokes the definition of mental disorder in the *Diagnostic and Statistical Manual of Mental Disorders 5th Edition* (DSM-5.

DSM-5 is a classification of mental disorders with associated criteria designed to facilitate more reliable diagnoses of these disorders. It is a standard reference in clinical practice in Australia and the world.

The definition of mental disorder in DSM-5 is:

> *A mental disorder is a syndrome characterised by clinically significant disturbance in an individual's cognition, emotion regulation or behaviour that reflects a dysfunction in the psychological, biological, or developmental processes underlying mental functioning. Mental disorders are usually associated with significant distress or disability in social, occupational, or other important activities. An expectable or culturally approved response to a common stressor or loss, such as the death of a loved one, is not a mental disorder. Socially deviant behaviour (e.g. political, religious, or sexual) and conflicts that are primarily between the individual and society are not mental disorders unless the deviance or conflict results from a dysfunction in the individual, as described above."*[13]

In the introduction to DSM-5, it is stated "*clinical training and experience are needed to use DSM for determining a clinical diagnosis. The diagnostic criteria identify symptoms and signs comprising aspects, behaviours, cognitive functions, and personality traits along with the*

[11] Section 268 1998 Act
[12] Section 279 1998 Act
[13] Diagnostic and Statistical Manual of Mental Disorders Fifth Edition Text Revision DSM-five-TR, 2022 American Psychiatric Association, page 14

physical signs, symptom combinations (syndromes), and durations that require clinical expertise to differentiate from normal variation and transient responses to stress."[14]

It is practically impossible for a worker to obtain a diagnosis from a doctor trained in the use of DSM-5 immediately upon first consultation following the event or series of events that may trigger a psychological response. Most GPs would not be trained in the use or application of DSM-5.

> Only psychological injuries caused by a very limited set of 'relevant event or series of relevant events' are compensable

In addition to the requirement that employment be a substantial contributing factor than use the 'regulating mechanism' described earlier in this submission (defining the extent to which employment factors must contribute to the injury), the Division provides that only injuries *caused* in a certain way will be compensable.

If an injury is *caused* in any other way other than as specified as a relevant event in section 8E, the injury is **not compensable**.

'Relevant events' are in an extremely narrow compass and split into two categories:

(a) those that are accepted as causative of a psychological injury, (Section 8E(1)) essentially traumatic events: being subjected to an act of violence or a threat of violence, or to indictable criminal conduct or witnessing an incident that leads to death or serious injury or the threat of death of or serious injury, including an act of violence, indictable criminal conduct, a motor accident, a natural disaster, fire or another accident, or experiencing vicarious trauma within the meaning of section 8H [where a worker becomes aware of an act of violence, indictable criminal conduct, a motor accident, a natural disaster, fire or another accident that results in injury to or the death of a person with whom the worker has a close work connection].

or

(b) those where a *finding* is required by a tribunal, commission or court as to the existence of the event *before a notification of injury* will be accepted for the purposes of making a claim under the workers compensation legislation: bullying, racial harassment or sexual harassment.

Whilst there is a provision for further events to be prescribed by regulation (a Henry VIII Clause – see below), the relevant events currently prescribed are extremely narrow.

There is no relevant event of racial discrimination, discrimination by any other means, unreasonable or onerous work conditions, or which captures the experiences of (for example) 000 Call centre operators, nurses and hospital administrative staff, or teachers. Interpersonal conflict (not bullying) is not included and neither is actions by the employer considered to be "reasonable management action'.

I refer to the SCLJ Report 54 paragraphs 3.34 to 3.36 for the only published information regarding the causes of psychological injury across the Nominal Insurer and the TMF.

> Work pressure disorder not considered an injury nor able to ground a claim (Bill Clause [96])

A new part 4A 'special entitlement to expenses for medical or related treatment' provides a new section 148B Work Pressure. The section provides for a worker who experiences a "work

[14] DSM-5 page 5

pressure disorder" to receive a "special work pressure payment" of medical or related treatment expenses for a period of no more than 8 weeks after the worker first commences medical or related treatment.

"Work pressure disorder" is defined in the Bill as "a mental or psychiatric disorder caused by or arising from the pressures placed on a worker in the course of the worker's employment but only if the employment was the main contributing factor to the worker experiencing the disorder". The DSM-5 contains no definition of "work pressure disorder".

However, a special work pressure payment is not a claim for compensation, a work pressure disorder is not an injury and "an application for payment of a special work pressure payment is not a payment for compensation", work pressure is not described as a relevant event..

Whilst I wholeheartedly support workers with psychological injuries arising from work pressure, "special work pressure payments" are potentially ultra vires the legislation. As a special work pressure payment is not a payment of compensation it is difficult to comprehend how such a payment can be made out of the system.

> **Notification of a psychological injury where the cause is sexual harassment, racial harassment or bullying is not notification of a claim until such time as a finding has been made by a tribunal, commission or court.**

A notification is the first step under the legislation to a claim for compensation. Where a worker alleges sexual harassment, racial harassment or bullying is the cause of their psychological injury, they must have first obtained a finding from a relevant tribunal before any notification is accepted as the making of a claim. Until the finding is made, section 8F provides that there is no initial notification of an injury and hence no claim can be made.

For public servants the explanatory note suggests there will be a new jurisdiction in the Industrial Relations Commission of New South Wales similar to the bullying and sexual harassment jurisdiction in the Fair Work Commission. Private sector workers would be required to obtain a finding in the Fair Work Commission before they could notify of an injury and make a claim. As there is no relevant event based on discrimination, workers would be prevented from *making a claim* for psychological injury arising out of racial, gender, religious or other discrimination in the workplace.

I leave it for others to explain the processes currently available to establish harassment and bullying in the existing jurisdictions.

Icare in its submission to the 2022 Review state:

> "35. icare's data suggests that work pressure, and harassment and bullying, are a key causal mechanism in more than half of the psychological injury claims we receive (figure 8 and 9).
>
> 36. Exposure to a traumatic event is less prevalent as the initial cause of a psychological injury, linked to one in five cases in the TMF (21 %), and less than one in 10 cases in the NI (7%). However, we know that proactive and supportive responses to these events can help to reduce the long-term impact on the individual."

This precondition for the most prominent of injury causes (according to icare) will necessarily involve time delay, the amassing and giving of evidence, facing the aggressor, , potential conflict with the employer, cost and potential retraumatising and additional distress. And while the requisite proceedings are taken and until the finding is made and passed across to the insurer the psychologically injured worker is not entitled to income support or medical and treatment supports other than that their own cost.

There is no hint as to whether the worker is entitled to legal advice or representation to navigate the path in obtaining the "finding" and whether such advice or representation will be paid.

The prerequisite of obtaining a finding ***before*** a worker's psychological injury is even recognised by the employer/insurer is so onerous and likely to cause further insult to the worker that it is tantamount to a complete bar to a claim. In the meantime, one can only assume that the bullies and the harassers will continue to pick targets and slowly erode the harmony of the workplace.

> No other circumstances leading to injury are declared causative of an injury

There is no relevant event of racial discrimination, discrimination of any other type, unreasonable or onerous work conditions, or which captures the experiences of (for example) 000 Call centre operators, nurses and hospital administrative staff, or teachers. Interpersonal conflict (not bullying) is not included.

Despite workers sustaining a psychological injury at work they will be unable to notify of that injury and will be unable to claim compensation benefits.

> Reasonable management action

The incorporation of a definition of reasonable manner management action (definition in new section 8D) within section 11A 1987 Act to replace Section 11A(1):

> *No compensation is payable under this Act in respect of an injury that is a psychological injury if the injury was wholly or predominantly caused by reasonable action taken or proposed to be taken by or on behalf of the employer with respect to transfer, demotion, promotion, performance appraisal, discipline, retrenchment or dismissal of workers or provision of employment benefits to workers*.

does not materially change the defence for employers to a claim for compensation arising out of psychological injury.

It remains to be seen whether this defence will have any utility given there is no relevant event related to management actions.

Opinion

The new Division 2 provisions will not stop workers sustaining psychological injury in the workplace. Rather, workers who sustain injuries that do not meet either the definition or fit within a relevant event, or are not successful in obtaining the requisite finding, will be forced to rely on accrued leave (if they have any), work with injury or leave their employment. The only conclusion that can be drawn is that this is a cost shifting exercise to push workers onto other work entitlements or Commonwealth benefits.

The New Division 2 provision are contrary to the fundamental principle stated in section 9 of the 1987 Act, contrary to the system objectives, will not achieve the stated intent of the Bill (unless preventing injury means ignoring injury), do nothing for prevention of injury, do nothing for deterrence of injury and create an even greater burden on employers to find a stable and productive workforce.

Given the combined effect of the meaning of psychological injury and the meaning of relevant event it is hard to conjure up a circumstance where the reasonable management action defence in section 8D can be used by an employer.

We don't know precisely the causes of workplace psychological injury. There is no open data apart from anecdotes or bold statements as to what proportion of the roughly 12,000

psychological injury claims made per year are caused by what mechanism, be workplace/occupational violence, exposure to a traumatic event work pressure, harassment or bullying (there is no current definition of either harassment or bullying in the workers compensation legislation hence caution should be placed on harassment and bullying described as a cause of injury), work pressure stressors within the workplace. Before the Government can sincerely make such drastic changes to the legislation there needs to be a thorough examination of the true cause of workplace psychological injuries.

It is preferable for the Government to use any other means available to restrict the number of claims for psychological injury, than those within Division 2. Given the other proposals in the Bill designed to limit access to lump sum payments for permanent impairment, weekly payments of compensation and medical and treatment expenses, and given that the Government's stated intention of providing a work health safety, industrial relations and workers compensation system that works harmoniously, there must be other ways of managing the increase in psychological injury claims other than by so severely constricting the ability to and lodge a claim for compensation.

The proposed bullying and harassment jurisdiction in the Industrial Relations Commission is welcomed but not as a gateway to a notification or claim for compensation. Just as in the private sector, public servants should be able to raise workplace issues in a forum where pressure can be brought to bear on the Government to adjust and rectify the workplace.

2. SCHEDULE 1 CLAUSE [10] DEATH BENEFITS COMPROMISE

The Bill proposes new sections 32AA. 32AB, 32AC which permit a party to a death benefit dispute to either agree with the insurer or receive a Commission decision as to a compromised resolution of a claim for the death benefit lump sum. These provisions were proposed in 2022 in a bill that did not progress in the Parliament.

Presently section 25 of the 1987 Act provides for a lump sum of $955,950 as a lump sum death benefit. It is an all or nothing provision as there is no ability to compromise the sum where there may be a dispute about liability.

These new provisions are therefore a welcome but long overdue enhancement.

There are no savings and transitional provisions within the Exposure Draft. Previously the savings and transitional provision provided application from the date of assent to the Bill. That would rule out a small number of death benefit claims arising from deaths before assent that have not yet resolved due to the complicating circumstances of the claim.

There are no more than 120 deaths recorded in New South Wales workplaces every year. Claims arising from those deaths are generally advanced within six months of the death and whilst they take some time to resolve (there is no time limit provided for an insurer to respond to a claim for death benefits) at best there would be 20% of outstanding claims that would remain resolved (I can find no data to support this contention and so this stands is an opinion).

My recommendation is that the savings and transitional provisions to commence from **5 August 2015**, date on which the death benefit lump sum substantially amended to $750,000 deaths occurring since that date where a claim has not been resolved for example food delivery driver death claims (or made) due to concerns with liability or other factors. The cost to the scheme of this proposal could be easily assessed by icare.

3. Schedule 1 clauses [29] [18] [97] WHOLE PERSON IMPAIRMENT FOR PSYCHOLOGICAL INJURIES

The bill proposes that in relation to psychological injuries the impairment threshold contained within sections of the 1987 Act permitting access to continuing weekly payments beyond 130 and 260 weeks, permanent impairment compensation and work injury damages should be increased from 15%WPI or 20%WPI (where stated) to "at least 31%".

The accepted tool for measuring whole person impairment related to a psychological injury is the Permanent impairment rating scale" (PIRS) contained within the NSW workers compensation Guideline for the Evaluation of Permanent Impairment. **Annexure A** to this submission is a paper prepared by me "Whole person impairment and the Psychiatric Impairment Rating Scale".

It is readily accepted and is demonstrated in other submissions that by use of the PIRS, an impairment of greater than 30% is virtually impossible to reach. SIRA advises that some of the indicators required to reach the requisite median of 'class 4' under the PIRS are:

- Needs supervised residential care. If unsupervised, may accidentally or purposefully hurt self.
- Never leaves place of residence. Tolerates the company of family member or close friend, but will go to a different room or garden when others come to visit family or flat mate.
- Finds it extremely uncomfortable to leave own residence even with trusted person.
- Unable to form or sustain long term relationships. Pre-existing relationships ended (eg lost partner, close friends). Unable to care for dependants (eg own children, elderly parent).
- Unable to read more than newspaper articles. Finds it difficult to follow complex instructions (eg operating manuals, building plans), make significant repairs to motor vehicle, type long documents, follow a pattern for making clothes, tapestry or knitting.
- Cannot work more than one or two days at a time, less than 20 hours per fortnight. Pace is reduced; attendance is erratic.[15]

These demonstrate the extent to which a worker's function would have to be impaired.

The increase of the impairment threshold will not *prevent* psychological injuries from occurring in the workplace, neither will such claims be prevented from being notified or made.

Whole person impairment of 31% is not a gateway, it is a bar and a very high bar, so high as to be virtually unattainable. If it is the intention of the Government to let significantly impaired workers with psychological injuries have access to the same or similar benefits to equally impaired workers with physical injuries then the threshold should be increased from 15% to 'more than 20%' given that the whole person impairment assessment methodology (impairment of the whole person) is designed to provide injuries of different types to different body parts and systems an equivalent ranking an assessment outcome.

[15] SIRA, Psychiatric and psychological disorders: https://www.sira.nsw.gov.au/resources-library/workers-compensation-resources/publications/health-professionals-for-workers-compensation/workers-compensation-guidelines-for-the-evaluation-of-permanent-impairment/11.-psychiatric-and-psychological-disorders

4. Schedule 1 clauses [18] – [22] CESSATION OF BENEFITS

> Workers with psychological injuries

The Bill carves out psychologically injured workers from workers with other injuries by providing a significantly restricted period of weekly benefits and limited access to treatment expenses once weekly benefits cease. Currently, the psychologically injured worker with no capacity for work is entitled to weekly payments after 130 weeks if they can demonstrate whole person impairment of more than 20%.[16]

New section 39A proposes that unless a worker has at least 31% whole person impairment arising from their psychological injury, they will receive a maximum of 130 weeks of weekly **benefits**.

In addition, whereas currently the psychologically injured worker is entitled to receive either 2 years, 5 or lifetime medical and treatment expenses (lifetime if their whole person impairment is assessed at more than 20%) the bill provides a further limitation on the payment of medical and treatment expenses for a psychologically injured worker to 1 year commencing on the day their weekly payments cease.

In my submission, these provision should be removed. A worker with an injury should receive the same access to benefits based on the same impairment ratings, no matter the injury type.

> No back payment where impairment asserted after cessation of weeklies at 260 weeks (130 weeks for psychological injuries)

New section 39A(4) providing for no back payment of weekly compensation where a worker with a psychological injury subsequently establishes an impairment of more than 31% the 130 week limit, responds to the findings of the NSW Court of Appeal in *Hochbaum v RSM Building Services Pty Ltd; Whitton v Technical and Further Education Commission t/as TAFE NSW* [2020] NSWCA 113, where the Court of Appeal held that a worker who subsequently establishes that there impairment exceeds the section 39 threshold (of greater than 20%) after the maximum 260 weeks of weekly payments has ceased is entitled to receive weekly benefits backdated to the date of cessation. The court found that the liability for a permanent impairment compensation payment arises on the date of injury and not the date when the degree of impairment is determined.

Subsection 39(4) affects workers with psychological injuries only however a similar amendment is made in clause [17] to section 39 in relation to all other injured workers.

5. Schedule 1 Clauses [25] and [26] CHANGING REASONABLY NECESSARY TO 'REASONABLE AND NECESSARY'.

The Bill provides for the omission of the phrase "reasonably necessary" and replacement with the phrase "reasonable and necessary" in sections 60 and 60AA of the 1987 Act.

This proposal goes far beyond the stated intent of the bill. It will affect every single worker in the workers compensation system.

Other than in a brief discussion in the McDougal Review prompted by a submission by icare, there has been no consultation or discussion around this amendment.

Annexure B to this submission is a paper ""Reasonably Necessary" v "Reasonable and Necessary" 2025" authored by me concerning the proposal.

[16] Section 38 1987 Act and definition of worker with high needs in section 32A 1987 Act.

In my submission a change to the test for access to payment for medical treatment will:

- unnecessarily and unfairly reduce benefits
- result in a significant deterioration of worker's outcomes
- result in a significant deterioration delay to treatment and recovery
- increase disputation over medical treatments
- render provisional liability for medical expenses unworkable
- render section 297 1998 Act (interim payment directions for medical expenses) difficult to administer
- result in a significant adverse effect on worker's outcomes by virtue of delay and disputation

  will increase the administrative costs of the scheme.

The more onerous test would permit insurers to arrange IME appointments to test the necessity of any treatment, thereby providing further delays in a system where delay in treatment is already prevalent, with an increase in denials of treatment and consequent increases in disputation.

In order for an Interim Payment Direction to be sought, the test in section 297 1998 Act would need to be reformulated and would likely prevent IPDs being sought by workers.

The knock on effect of delays will impact return to work and the overall costs of the scheme.

The guiding principles and the well-settled formulated tests to determine what is "reasonably necessary" mitigate against harmful treatments. They incorporate a workability component, that is, if treatment assists a worker remaining at work or maintains an equilibrium with the patient then it can be considered reasonably necessary.

There are already restrictions and limitations on access to prompt medical treatment, adopting this recommendation would increase the difficulty in accessing treatment. **There will be delays in treatment provision occasioned by scrutiny of necessity**, the early approval free treatment types in the Guidelines will be significantly reduced, and workers will wait longer for access to treatment. As a consequence, return to work outcomes will deteriorate and the already significant disputation over medical treatments especially surgery will likely increase. A consequent increase in timeliness and cost will also impact the scheme.

There is no data that demonstrates that a change to the phrasing after so many years in use will deliver a significant financial saving to the system.

Restriction on rights and entitlements is very difficult once written into the legislation. Employing a more restrictive test than has existed for over 60 years ought to undergo significant scrutiny before it is adopted.

The' reasonable and necessary test is the antithesis of the objectives of the system and will erode workers' benefits. It should not be adopted without careful consideration and assessment of the impact.

6. Schedule 1, Clauses [75] –[94] COMMUTATIONS

> What is a Commutation?

Division 9 of Part 3 of the WCA 1987 is titled "Commutation of Compensation". There is no definition of 'commutation' therein provided however s87D defines ***commutation agreement*** as meaning "an agreement to commute a liability to a lump sum, as provided by section 87F."

Dictionary definitions vary little with synonyms being 'modification, exchange or substitution'. A commutation is the replacement of a greater amount by something lesser. To commute periodic payments means to substitute a single payment for a number of payments, or to come to a 'lump sum settlement'. Settlement and finality are important considerations in a commutation agreement.

The SIRA Workers Compensation Claims Management Guide[17] contains this definition:

> *A commutation is an agreement between a worker and insurer to commute or **'buy-out' any future liabilities for weekly compensation** payments and medical, hospital and rehabilitation expenses associated with the injury, through the payment of a lump sum to the worker.*

Deloittes described a commutation in 2010 as:

> A commutation is a commercial agreement between two parties, (re) insured and (re) insurer, where, subject to the payment of a mutually agreed sum to the (re) insured, the (re) insurer is discharged of all past, present and future claims arising from the contracts ceded by the insured or reinsured, which form the subject of the commutation.[18]

Icare publishes this definition:

> *Under some circumstances, you can get your workers insurance payments in one lump sum if your employer and insurer agree.*
>
> *The official term is a 'commutation' which means that you accept a single lump sum to cover all of your agreed entitlements including medical, hospital and rehab payments.*
>
> *It also replaces any future weekly payments you may be eligible to receive*.[19]

A **commutation** requires a worker to agree to accept and an insurer agree to pay, a lump sum in exchange for complete discharge of future obligations to make periodic and other payments which are exchanged by receipt of the lump sum. The right to receive further payments of any kind (including work injury damages) is extinguished.

> What is the purpose of commutation or 'commuting one's rights'?

In 1990, a working group of Actuaries reported *"a commutation as "the means outside litigation, arbitration, repudiation or liquidation, whereby both parties to a potential dispute can arrive at an acceptable financial settlement." The report recognised the importance of commutations in resolving issues which might otherwise lead to lengthy and costly legal actions."*[20]

Whilst not clearly articulated anywhere, other reasons for agreeing to a commutation are:

- To bring finality to a longstanding payment arrangement
- To restore financial and medical autonomy and dignity to a worker
- To put the worker in circumstances that they can 'move on'
- To avoid further 'injury' and insult to an injured worker
- To resolve or compromise a disputed claim

[17] https://www.sira.nsw.gov.au/workers-compensation-claims-guide/understanding-the-claims-journey/other-compensation-payable/commutation
[18] 'Achieving Finality: The Commutation Process', Lucy Simpson and Alex Kwa, https://www.actuaries.asn.au/library/events/GIS/2010/GIS10_Paper_Simpson%20and%20Kwa.pdf
[19] https://www.icare.nsw.gov.au/injured-or-ill-people/workplace-injuries/payments/commutation-payments#gref
[20] 'Achieving Finality: The Commutation Process', Lucy Simpson and Alex Kwa, op cit, page 3

- To settle a disputed claim
- To release the insurer from ongoing administration and management of a claim.

> The existing preconditions to commutation

The existing preconditions to commutation are contained in section 87EA(1) of the 1987 Act and are at present a considerable barrier to commutation being used as an effective exit strategy.

They are:

(a) the injury has resulted in a degree of permanent impairment of the injured worker that is at least 15% (assessed as provided by Part 7 of Chapter 7 of the 1998 Act), and

(b) permanent impairment compensation to which the injured worker is entitled in respect of the injury has been paid, and

(c) a period of at least 2 years has elapsed since the worker's first claim for weekly payments of compensation in respect of the injury was made, and

(d) all opportunities for injury management and return to work for the injured worker have been fully exhausted, and

(e) the worker has received weekly payments of compensation in respect of the injury regularly and periodically throughout the preceding 6 months, and

(f) the worker has an existing and continuing entitlement to weekly payments of compensation in respect of the injury (whether the incapacity concerned is partial or total), and

(g) the injured worker has not had weekly payments of compensation terminated under section 48A of the 1998 Act[21].

> Recommendations and suggestions made since 2012

In the 2012 Amending Act, schedule 8 proposed amending section 87EA by inserting two subsections in identical terms to those contained in the Bill at clause [78] save for the Authority being nominated as the approving party rather than the President of the Commission. These proposed amendments to section 87EA were criticised by the legal profession for providing the Authority the responsibility for determining the "classes of cases" (not defined anywhere) that could be considered for commutation outside of the subsection 1 preconditions and for doing so by regulation (beyond the direct scrutiny of the Parliament). Schedule 8 was never commenced.

In 2014 the Report of the Statutory Review of the 2012 Workers Compensation Legislative Amendments conducted by the Centre for Internation Economics provided:

"Addressing barriers to return to work

- **Providing better tools and supports to enable return to work outcomes. This may include:**

– *amending return to work criteria around geographic and career transfers to impose only 'reasonable' requirements on injured workers. This is likely to require some recognition of the costs of relocation and retraining.*

[21] Section 48A deals with failure to comply with the obligations of worker which may result in suspension or termination of payments.

– *removing barriers to commutations where they provide a workable and mutually agreed outcome for employers and injured workers. The existing restrictions to commutations reflect a reluctance to expose the Nominal Insurer Scheme to funding risk, but for self-insurers and specialised insurers these risks are internalised, and if both parties should seek to enter into a voluntary and mutually agreeable commutation arrangement it seems reasonable that they should not be prevented from doing so (as is currently happening under existing workers compensation legislation), so long as workers are protected (receive proper legal advice) and are not coerced into suboptimal agreements."*

The Parkes Inquiry conducted by the WIRO, Mr Kim Garling in 2015 issued a Discussion Paper titled "Settlement and Finalisation of Claims" Discussion Paper which informed the unanimously endorsed Principle that "*Workers should be entitled to exit the Scheme on a fair and reasonable basis with minimal constraints."*

In 2020 His Honour Justice Robert McDougall QC (McDougall) in his independent review of the *State Insurance and Care Governance Act* 2015 (Report dated 30 April 2021) received a submission from icare which identified the benefits of commutation as being voluntary and non-adversarial; providing an opportunity to exit the NSW workers compensation scheme with dignity and choice, and minimises financial distress; and providing an injured worker with control over their future.

Icare identified in paragraph 62 :

> *"In particular, in the case of injured workers impacted by the cessation of weekly entitlements pursuant to section 39 of the 1987 Act, the option to commute their medical entitlements may provide injured workers with greater financial choice. Further, commutation is often a superior alternative to WID disputes, as it encourages a more timely resolution of the claim from time of offer to payment."*

Icare called for reform by the imposition of less stringent eligibility criteria to encourage uptake of commutation by injured workers. Modelling conducted by icare suggested that a relaxation of the 87EA(1)(d) requirement to exhaust all opportunities for injury management and return to work to "no likelihood of return to work" and a reduction in the impairment threshold of 15% to "greater than 10%" (87EA(1)(a)) and alternatively making commutations available to certain classes of claims would on the basis of financial modelling result in significant potential net savings to the system. Icare also expressed the opinion that removing the Authority from the approval process would lead to an increased uptake in commutation.

McDougall made recommendation 40: *"That the legislature give consideration to expanding the powers of commutation and settlement of lump sum death benefits, subject to the approval of the Personal Injury Commission."*

In late 2022 SIRA hosted small group meetings to consult with stakeholders to discuss "expanding access to commutations in the New South Wales workers compensation scheme". Topics for discussion were provided:

- *what your views are on the **benefits** and **risks** associated with broadly opening access to commutations in the NSW Scheme;*
- *whether you think there are **any workers whose claims should not be commuted**;*
- *how we ensure the **"right workers" exit the Scheme** and avoid any shift in focus away from scheme objectives;*
- *what you believe an option or approach is that provides **sustainable, expanded access** to commutations in the Scheme;*

- *your views on **claims (or cohorts of claims)** that would be appropriate for commutation as part of **a targeted strategy** and why; and*
- *your views on appropriate **protections** and **controls**.*

Despite promising feedback and outcome of the consultation, none was provided. However, in October 2022 the *State Insurance and Care Legislation Amendment Bill* 2022 came before the Parliament and in the first print the precise amendments now being pressed were contained in Schedule 2, clause 4. The second print of the Bill omitted the amendments to section 87EA.

In the 13 years since 2012, there have been very few instances of commutations meeting the preconditions and being approved by the Authority. Only very recently is there evidence that claims managers are approaching workers to determine if they are interested in commuting their rights. However, as demonstrated there has been a call for the reinstatement and widening of availability of exit options by way of commutation by successive reviews over the same period.

Opinion

Commutations present an opportunity for significant savings to be made in the system. This has been demonstrated by icare in the McDougall Review.

The proposed amendment to section 87EA does **not** open up commutations sufficiently.

Permitting the regulator SIRA to define "classes of cases" *by regulation*, without defining what a class or a case is, so as to relax the preconditions to commutation does not provide greater opportunity for workers and insurers.

I prefer and endorse the opinion of the Law Society of New South Wales in its letter to the SIRA 2022 Consultation: "*We are of the view that all workers should be given the option to leave the scheme through commutation arrangements. In obtaining the necessary legal advice, workers will be in a position to make an informed and considered decision. It should be borne in mind that agreeing to a commutation is voluntary. Further, if only certain classes and cohorts are permitted to commute, this may result in many workers for whom commutation would be beneficial missing out. A further consideration is that by naming certain classes of claim, some workers may feel pressured to enter a commutation. This is contrary to the notion that a commutation relies on the voluntary participation of the parties."*[22]

The only relevant interested parties to a Commutation are the 'insurer' and the 'worker'. The regulator should not be assigned the responsibility of determining what class of worker can circumvent the preconditions.

The requirement for the provision of independent financial advice is an unnecessary and onerous requirement previously within the Act and removed due to cost and delay.

I support the call for settlement options in the system and note previous suggestions by the Australian Lawyers Alliance, specifically the removal of all the restrictions in section 87EA of the *Workers Compensation Act 1987* so that the parties have the ability to resolve statutory compensation entitlements on a final basis. In the ALA's view, the only restrictions that should be imposed are that the requirement that a claimant obtain legal advice on any such settlement and that such settlement be the subject of approval from the Personal Injury Commission.

[22] Law Society of NSW Letter to Christian Fanker, Director Scheme Design Policy and Performance SIRA dated 5 October 2022 "Expanding Access to commutations in the NSW Workers Compensation Scheme."

> Alternative drafting Recommendation

That either all of the preconditions in section 87EA subsections (a) to (g) be omitted, proposed subsections 2 and 2A be omitted, and the substance of subsection 2A(a) to (d) be placed in subsection (1)

OR

Proposed Subsection (2) be amended to read:

"(2) Despite subsection (1), a liability in relation to an injury may be commuted to a lump sum under this division in a particular case if the President is satisfied the lump sum to which the liability will be commuted is not inadequate and not excessive."

Omit proposed 87F(2A)

7. Schedule 1 Clause [98] DETERMINATION OF THE DEGREE OF PERMANENT IMPAIRMENT AND ASSESSMENT PROCESSES

The Bill inserts a new Part 6 into the 1987 Act 'Determination of degree of permanent impairment' comprising sections 152 to 153O. The provisions **affect all injured workers**.

Part 6 provides a whole new process for the assessment of impairment under the responsibility and to be conducted by the regulator SIRA.

> Current 'assessment process'

Workers seek legal advice and legal assistance to pursue their claims for lump sum compensation or to assert a threshold impairment.

In order to pursue a claim for lump sum compensation or to assert a threshold impairment, a worker has to undergo examination and evaluation by a trained assessor of permanent impairment (an assessor on the SIRA list). The cost of a trained assessor's report is regulated by SIRA in their Independent Examination and Reports Fee Order.

The Workers Compensation Guidelines 2021 in Part 7 provides for Independent medical Examinations and Reports and in Part 8 deals with lump sum compensation setting the procedure to assert a claim.

With the resulting report, the worker will make a claim for lump sum compensation with the insurer. More often than not the insurer will not accept the worker's assessment and will arrange their own assessment by a trained assessor.

Up until fairly recently negotiation and compromise between parties as to whole person impairment percentage has not been permitted by the regulator. The parties can come to an agreement and execute a "Complying Agreement". Where the parties disagree as to the extent of impairment, the worker will lodge an application for consideration and assessment by a medical assessor appointed by the President of the Commission.

The 1998 Act in Part 7 contains the existing medical ***assessment*** processes. Section 322 of

322 Assessment of impairment

(1) The assessment of the degree of permanent impairment of an injured worker for the purposes of the Workers Compensation Acts is to be made in accordance with Workers Compensation Guidelines (as in force at the time the assessment is made) issued for that purpose.

(2) Impairments that result from the same injury are to be assessed together to assess the degree of permanent impairment of the injured worker.

(3) Impairments that result from more than one injury arising out of the same incident are to be assessed together to assess the degree of permanent impairment of the injured worker.

Note— Section 65A of the 1987 Act provides for impairment arising from psychological/psychiatric injuries to be assessed separately from impairment arising from physical injury.

(4) A medical assessor may decline to make an assessment of the degree of permanent impairment of an injured worker until the medical assessor is satisfied that the impairment is permanent and that the degree of permanent impairment is fully ascertainable. Proceedings before a court or the Commission may be adjourned until the assessment is made.

A medical assessment certificate that emanates from an assessment in the Commission is final and binding subject to appeal rights.

Section 327 provides for appeals against medical assessment. An appeal must be made within 28 days of the medical assessment unless the appeal is on the grounds of either:

> "deterioration of the worker's condition that results in an increase in the degree of permanent impairment"
>
> or "availability of additional relevant information (but only if the additional information was not available to, and could not reasonably have been obtained by, the appellant before the medical assessment appealed against)."

The current process is complete and satisfactory and provides an opportunity for workers with deterioration of the condition to appeal from a medical assessment certificate.

Annexure C to this paper is a copy of Part 7 Medical Assessment 1998 Act.

> Proposed principal assessment process to be conducted by SIRA

The new Part 6 provisions mandates a whole new assessment process replacing that contained within the guidelines and section 322 of the 1998 Act for the assessment of the degree of permanent impairment.

The new process which is to be conducted by SIRA permits only one assessment by a single trained assessor of permanent impairment either agreed to between worker and insurer or appointed by SIRA.

Section 153A requires an injured worker to obtain independent legal advice about the full "legal implication of the assessment" including advice in relation to any other entitlement the injured worker may be able to access under any other law and "the desirability of the worker obtaining independent financial advice about the financial consequences of the impact of the assessment". I presume that the cost of independent financial advice is to be borne by workers themselves. There is no indication as to whether the legal advice required prior to assessment will be paid for out of the Fund.

The processes to be managed by SIRA replicate the processes currently utilised in the Personal Injury Commission by the medical assessors.

The SIRA permanent impairment assessment process replicate the processes and conditions contained in Part 7 Medical Assessment 1998 Act. Sections 322 is omitted through the Bill and there is a slight amendment section 322A 1998 Act. Section 322(1) provides that the assessment of the degree of permanent impairment of an injured worker for the purposes of the Workers Compensation Act is to be made in accordance with the Workers Compensation

Guidelines. Section 322(2) and sub paragraphs (3) and (4) are omitted but reproduced and lengthened in the new Part 6 provisions.

New section 153K permits an Assessor to consult with any medical practitioner or healthcare professional treating or who has treated the worker. There is no provision for the worker to be party to any such consultation. The ability of an assessor to discuss a worker with another medical practitioner outside of the worker's presence and without their express consent could constitute a breach of privacy.

In a capricious and unnecessary provision, workers who obstruct an examination by a permanent impairment assessor will have their "right to weekly payments" and their "right to recover compensation in relation to the injury" suspended.

Following an assessment by a SIRA appointed permanent impairment assessor a certificate will issue setting out the details of the degree of permanent impairment, the facts on which the assessment is based and certifying as to the assessment of the degree of permanent impairment with reasons for that assessment.

A dispute about the degree of permanent impairment can be referred to the Commission for review.

I oppose the change to what is a simple, fair and equitable existing process.

Both insurers and workers enjoy the ability to choose their own independent medical examiner and explore resolutions and settlements that benefit the system and the parties. The comparison of two competing opinions can often facilitate resolution or at least identify outliers amongst the trained assessors of permanent impairment. There can be no assurances that this new process will result in fairer assessments, better outcomes for workers or a saving to the system.

Another consideration is the cost of establishing a new process that sits with the regulator. The regulator already has responsibility for the training of assessors and maintaining of a trained assessor list. That list has not been maintained well for at least the last 10 years. The regulator does not currently have the resources to run the assessment process and such a change in process should undergo thorough costing and analysis before it replaces what is a clear and simple procedure.

By taking the "permanent impairment assessment process" into the regulator, there will be a loss of any transparency into the process and an inability to correct any deficiencies.

> Further principal assessments on the basis of deterioration of condition

Section 153N is seemingly in response to requests by workers that they can undergo a further assessment where there is a deterioration in their condition which may lead to an impairment assessment that will permit them to exceed a threshold and pursue further rights,

At present a worker can only undergo the equivalent of a further principal assessment only by bringing an appeal against a Medical Assessment Certificate on the basis of "deterioration of their condition that results in an increase in the degree of permanent impairment". Such an appeal is not limited by time and there is no requirement for the deterioration to be "significant". However, ILARS will not grant funding to a worker for an appeal unless the worker can demonstrate that the deterioration is such that they will either meet or exceed a threshold gain access to for further benefits.

Further assessment will only be made in very confined circumstances. Either the worker and insurer have to agree that "it appears there has been an unexpected and material

deterioration" in the worker's condition. "Unexpected and material deterioration" can only occur if at the time of the original principal assessment there was no reasonable cause to believe the worker's condition would deteriorate, and that deterioration results in an increase of at least a further 20% WPI.

Workers should be entitled to a further assessment for the purposes of asserting a threshold but the bar set is far too high. Firstly, given the constraints on every single benefit contained within the legislation and the imposition of thresholds for access to benefits requirement that there an 'unexpected and material deterioration' in a workers condition is unduly and inappropriately onerous. Secondly, requiring an increase of at least a further 20% WPI puts further assessments out of the reach of most if not all injured workers.

A significant deterioration of at least 5% should be sufficient to justify a further principal assessment.

I maintain, however that the current arrangements regarding medical assessments should remain in place. All assessments should be conducted through the current process in the Personal Injury Commission and not by SIRA

> Why SIRA should not be involved in dispute resolution

In the Law and Justice Committee' s 2014 **Review of the exercise of the functions of the WorkCover Authority**[23] review participants were concerned about a conflict of interest between the functions of the Authority as insurer, regulator, and prosecutor. The Committee stated at paragraph 3.22 – 3.23 of their report:

> *The committee shares the concerns of review participants regarding the potential for conflicts of interest to arise in the current situation of WorkCover undertaking the role of both nominal insurer and scheme regulator. While we note the undertaking by WorkCover to more clearly distinguish between these two roles when communicating with stakeholders, we believe more needs to be done to eliminate any real or perceived conflict.*
>
> *The committee believes that the Minister for Finance and Services, in consultation with WIRO and other relevant stakeholders, should consider the establishment of a separate agency or other administrative arrangements to clearly separate the roles of regulator and nominal insurer in the workers compensation scheme, and implement that model as soon as practicable*.

The Committee made Recommendation 1 "That the Minister for Finance and Services, in consultation with the WorkCover Independent Review Office and other stakeholders, consider establishing a separate agency or other administrative arrangements to clearly separate the roles of regulator and nominal insurer in the workers compensation scheme, and implement that model as soon as practicable."

At the time WorkCover had a role in reviewing work capacity assessments. In the review process of a work capacity assessment there were three tiers of review: firstly, an internal review by the insurer, secondly a merit review by WorkCover and finally a review by WIRO.

During the Inquiry, questions were raised and discussed over independence and impartiality of the merit review process and the inherent conflict in WorkCover's multiple roles. Recommendation 2 was made that the Authority review the segregation of functions and

[23] Report 54 - September 2014 Standing Committee on Law and Justice

delegations around its role in work capacity decisions. In 2018 the role of reviewing a work capacity decision was passed to the Commission.

Various stakeholders expressed an opinion that the Authority should retain responsibility as the licensing and potential regulator with no role in the dispute resolution process. In 2015, WorkCover was disbanded be the enactment of the *State Insurance and Care Governance Act 2015*.

The concerns and arguments remain the same: SIRA should have no role in the dispute resolution process. Permanent impairment assessment is part of the dispute resolution process. There is a distinct perception of conflict of interest if that process is conducted by the regulator.

8. Schedule 2 Clause [19] FUNDING OF ILARS

The proposed amendment to section 3371) are for the regulations to:

- provide for "funding for ILARS" (being the total amount from the Operational Fund to be allocated to the ILARS), and
- provide a scale for the maximum legal and associated costs provided by the IRO, including providing for no costs to be payable for certain matters in certain circumstances

It is not clear what is intended by the proposed amendments other than the Regulator assuming the function of ILARS and potentially imposing a scale of costs for administering by ILARS. This amendment is unnecessary and appears to be interference with the functions of the ILARS and the independence of the Independent Review Officer (IRO).

The IRO is responsible for managing and administering ILARS (including by issuing Guidelines)[24]. The purpose of ILARS (ILARS) "is to provide funding for legal and associated costs **for workers** under the Workers Compensation Acts seeking advice regarding decisions of insurers for those Acts and to provide assistance in finding solutions for disputes between workers and insurers."[25]

The IRO can issue Guidelines with respect to "the allocation and amount of funding for legal and associated costs under ILARS".[26] In addition can revoke and replace ILARS Guidelines and adopt the provisions of other "publications, whether with or without modification or addition and whether in force at a particular time or from time to time."[27] The IRO is given agility through the making of Guidelines. Removal of the ability of the costs or amend their Guidelines is an attempt to fetter the independence and constrain the functions of the IRO.

Any Guidelines issued must be published on the NSW legislation website and can be disallowed by Parliament.

and is a direct interference with the independence of the IRO and the IRO's functions and must be resisted.

The IRO must prepare an Annual Report each financial year which is tabled in Parliament. The Annual Report must provide information on the operation of ILARS and any information as the Minister directs. In addition, any Guidelines (including the amounts paid under a grant of funding) are subject to the scrutiny of Parliament.

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[24] Schedule 5, Part 5, clause 8(d) *Personal Injury Commission Act 2020*
[25] Schedule 5, Part 5, clause 9(2) *Personal Injury Commission Act 2020*
[26] Schedule 5, Part 5, clause 10(1)(b) *Personal Injury Commission Act 2020*
[27] Schedule 5, Part 5, clause 10(2) & (3) *Personal Injury Commission Act 2020*

If the intention is to impose funding envelope for the ILARS then that must be resisted. The total ILARS spend is affected by many factors: the number of workers seeking grants of funding, the number of claims, the numbers of disputed claims, the changing requirements of the legislation.

If the intention is for ILARS to pay under Schedule 6 of Workers Compensation Regulation then that must be resisted. Schedule 6 is simply not fit for purpose and has not been so since the 2012 reforms.

The rationale for this amendment is not apparent and has the proposed amendment has neither been consulted on or subject to scrutiny. There does not appear any justification for making this change to an accepted and valuable service for **workers** which provides them with access to independent legal assistance and advice at no cost to them. Any attempt to disrupt the function of ILARS without evidence as to the need must be resisted.

9. INCREASED DISPUTATION.

Many of the proposed provisions in the Exposure draft provisions if enacted will necessarily increase disputation between workers and employers/insurers and hence the knock on effect is reduced return to work rates, depleted workforces, reduced productivity, delay in treatment, delay in restoration of health, and significantly increased costs to the system.

Increased disputation must be resisted in a system that already encourages disputes and is adversarial by its nature.

10. DRAFTING ISSUES

> Insertion of current rates in existing provisions

the Bill contains amendments to almost every provision within both acts where a dollar amount has increased as a consequence of indexation or other measures. In the context of what is described as very complex legislation which requires a dedicated review, inserting current values into existing provisions adds to the complexity and confusion, both because it is hard to determine whether or not the new rate quoted relates to old existing claims and from when that payment commenced.

It is far preferable that the drafters do not make such amendments as provided for in Shcedule 1 clauses 8, 9, 11, 13, 15, 32 to 41, and 108 to 117.

> Henry VIII Clauses

In its Report 7 – October 2020 the Legislative Council's Regulation Committee "Inquiry into the making of delegated legislation in New South Wales", the Committee reported at Chapter 3 (The potential for executive overreach) that "the chief concern raised in the inquiry with regard to executive overreach centred on the use of Henry VIII clauses, shell legislation and quasi-legislation."

> "*The term 'Henry VIII clause' is generally used to describe a clause in a principal Act of Parliament that allows for the making of delegated legislation and confers the ability for the delegated legislation to amend the principal Act of Parliament*".

Almost every submission to the Inquiry, including from the Parliamentary Counsel's Office, eminent legal experts and members of legal academia, raised concerns with respect to Henry VIII clauses.

The Committee concluded that there is a potential for executive overreach in the delegation of legislative power particularly arising from the use of Henry VIII clauses. In its comment at

paragraph 3.62 it is stated “use of these legislative tools carries with it the risk that the executive may determine significant elements of statutory schemes in ways that the parliament may not have intended. Why does this matter? In our view, it matters because the legitimacy of the laws made by the delegated legislation may be adversely affected if the public perception is that the accepted balance between Parliamentary and executive power has become skewed. At the end of the day, it is in the interests of good government that the potential for executive overreach is managed.”

Henry VII clauses are used throughout the Bill. Those that deserve attention subject to whether the substantive provision remains in the Bill are set out in Table 6.

Table 6 – List of potential Henry VIII clauses

Section	Section title	Words
8D(2)(o)	Meaning of reasonable management action	Another action prescribed by the regulations
8E(h)	Meaning of relevant event	Another event prescribed by the regulations
8G(3)	Primary psychological injuries	The regulations may provide for matters relating to primary psychological injuries, including- (a) The type of matters or circumstances an insurer must take into account when determining whether an injury is a primary psychological injury, and (b) The evidence a worker must provide for a claim in relation to a primary psychological injury
19B(5)	Presumptions relating to certain employment in relation to COVID-19	The regulations may provide for when a worker is incapable of work for subsection (5).
44BB	Regulations	The regulations may provide for the procedures to be followed by insurers in connection with— (a) the making of work capacity decisions, including the adjustment of an amount of weekly payments a result of work capacity decisions, and (b) the making of decisions about pre-injury average weekly earnings, including the adjustment of weekly payments as a result of decisions.
87EA(2)(a)	Preconditions Commutations	Despite subsection (1), a liability in relation to an injury may be commuted to a lump sum under this division in a particular case if the President is satisfied— (a) the case is of a class prescribed by the regulations as a class to which this subsection applies, and (b) the circumstances of the case satisfy the requirements prescribed by the regulations as requirements that must be satisfied for this subsection, and (c) unless the regulations otherwise provide, the lump sum to which the liability will be commuted is not inadequate and not excessive.
87F(2A)	Commutation by Agreement	(2A)The regulations may require the provision of independent financial advice to a worker, at the expense of the insurer, before the worker enters into a commutation agreement and the

		requirement applies despite any other provision of this section.
153N(1)(c)	Further principal assessments	(c) in circumstances prescribed by the regulations

> Consistency

The Bill lacks consistency in drafting with the 1987 Act and the 1998 Act. The Parkes Inquiry held in 2015 by the WIRO drew attention in its unanimous statement of principles and recommendations to the existing discrepancies in drafting within the 1987 and 1998 Acts. The Parkes "Definitions" Discussion Paper (**Annexure D**) identifies the existing inconsistent terminology within the Acts, relevantly the use of "greater than" and "more than" when expressing a threshold of degree of impairment. The drafters of this Bill have added a further expression which only adds to the confusion and inconsistency by the use of "at least …".

In an already confusing and complex matrix of legislative provisions there must be consistency of language and drafting style. The legislation should be clear on its face as to its meaning and intention. Introduction of expressions which further display inconsistency only contribute to ambiguity and may lead to unnecessary disputation.

Closing

I thank the Committee for the opportunity to provide this Submission, albeit in a very short timeframe. Should the Committee require clarification of any of the matters or opinions expressed in this submission I am happy to oblige.

Roshana May

15 May 2025

ANNEXURE A

WHOLE PERSON IMPAIRMENT AND THE PSYCHIATRIC IMPAIRMENT RATING SCALE

Use of 'Whole person impairment' in the NSW workers compensation system

- **Background**

Since 1911 the NSW Workers Compensation Scheme has included a lump sum payment to injured workers to compensation for permanent impairment arising from injury.

Since 1998 the NSW Workers Compensation system objectives have included an objective to "*provide injured workers and their dependants with income support during incapacity, **payment for permanent impairment** or death, and payment for reasonable treatment and other related expenses*".

The 1987 Act introduced sections 66 and 67 which provided in section 66 for a payment of a lump sum for permanent impairment, and in section 67, subject to meeting a threshold[1], a lump sum payment for pain and suffering[2]. The policy behind the introduction of section 67 arose from the abolition of common law rights in 1987. In 1989 common law rights were reintroduced and in November 2001, broad common law rights were abolished and replaced by 'Work Injury Damages', where access to common law damages was limited only to past and future economic losses. Section 66 and 67 lump sum compensation became the 'substitute' for the abolished 'non-economic loss damages' for work injury damages claimants.

Between 1987 and 2002 the method of assessment of impairment was relatively subjective and subject to wide variation in medical opinion. Impairment was assessed by the body part subject to a table of 'disabilities'. Each body part was assigned a proportion of the whole body, with compensation awarded by body part (for example: permanent loss of efficient use of the left leg at or above the knee, permanent impairment of the back).

In 1 January 2002 the method of determining impairment and quantifying the section 66 payment changed. It was at this time the concept of 'whole person impairment' (WPI) was introduced and an impairment evaluation method imposed by Guides[3] (the Permanent Impairment Guides). Impairment was to be measured of the affected body part but evaluated against the whole person in accordance with the Permanent Impairment Guides.

In addition, 'thresholds' for access to benefits were introduced: "*In New South Wales the current thresholds for accessing statutory permanent impairment lump sums are 1 per cent for general whole person impairment, 6 per cent WPI for binaural hearing loss and 15 per cent WPI for psychological injury*"[4].

Between 2002 and 2012 there had been one increase in the quantum of permanent impairment compensation (in 2007) but no increase in pain and suffering lump sum compensation.

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1 The threshold for section 67 compensation was $10,000 of section 66 compensation to 1 January 2002 and thereafter 10% WPI (whole person impairment) to 19 June 2012.

2 From 1987 the maximum payment for pain and suffering was $50,000 paid as a proportion of "a most extreme case"

3 WorkCover Guides for the Evaluation of Permanent Impairment

4 Joint Select Committee on the NSW Workers Compensation Scheme Report 1 – June 2012 paragraph 3.126

In 2012 a major reform package increased the 'threshold' for lump sum compensation for permanent impairment to greater than 10% for physical injuries and hearing loss. This significantly reduced the number of lump sum compensation payments.

Most importantly in 2012, for the first time, impairment was introduced as the threshold for determining access to weekly payments of compensation and ongoing medical treatment. Specifically, workers with an impairment of greater than 20% are said to be able to access weekly payments beyond five years to retirement age and additionally those workers with a greater than 30% impairment are not required to participate in a work capacity assessment (but can be the subject of a work capacity decision). Workers with more than 20% WPI are considered workers with high needs and enjoy certain relief from proving capacity after 130 weeks. Workers with more than 30% WPI are considered workers with highest needs and enjoy special benefits. There are only a relatively small number of workers with greater than 30% WPI in the NSW scheme (compared to the number of workers with significantly lower WPI).

- **WPI as threshold determinant to access benefits**

In NSW, since 2012, an 'assessment' whole person impairment is required to access:

- weekly payments beyond 130 weeks (2.5 years)
- domestic assistance,
- medical expenses and treatment for more than 2 years
- a lump sum payment for permanent impairment
- a commutation of rights and entitlements, and
- determining access to modified Common Law damages (Work Injury Damages).

Read below as to the use of WPI as a measure for 'capacity for work',

The Psychiatric Impairment Rating Scale (PIRS)

The "Psychiatric Impairment Rating Scale" (PIRS) was introduced in 2001 when the workers compensation legislation was amended to include a lump sum payment for impairment acquired through psychological injury.

Previously psychological injury had been evaluated through a subjective measure with no guidance under the table of disabilities issued by WorkCover NSW.

In 2002, with the shift to the adoption of 'Whole Person Impairment" (WPI) as basis for determining permanent impairment lump sum compensation and 'thresholds' to certain benefits and damages, WorkCover first adopted the American Medical Association Guides to the Evaluation of Permanent Impairment Fifth Edition (fourth edition for eyes) (AMA5) for the Principles of Assessment and method of assessment for most physical injuries.

WorkCover issued Guideline for the evaluation of permanent impairment which adopted the assessment principles of AMA5 but modified some of the assessment methodology to NSW employment conditions and set a different method for some Body Systems, in particular ***psychological injury***. The method of assessment adopted by WorkCover NSW was the "Psychiatric Impairment Rating Scale" (PIRS) developed by Doctors Parmigiani, Skinner, Lovell and Milton and adopted by WorkCover NSW in 2001 for the NSW Workers compensation scheme. [The PIRS was originally used in NSW under the Motor Accidents scheme to compensate those with psychological injuries arising in motor vehicle accidents].

The PIRS

The NSW Guidelines for the evaluation of permanent Impairment – Fourth Edition set out Chapter 11 the method of evaluating and assessing impairment as a result of psychiatric and psychological disorders and injury and the PIRS.

The PIRS is repeated at the end of this paper.

Critique and analysis of the efficacy of the PIRS

Most recent critique of the PIRS has been demonstrated by the Parliament in the report 84 **Standing Committee on Law and Justice** report on the 2023 Review of The Workers Compensation Scheme. Recommendation of the Report states "that the State Insurance Regulatory Authority review the use of the Psychiatric Impairment Rating Scale within the workers compensation scheme, to assess whether it is the most effective tool for calculating whole person impairment in relation to psychological injuries."

The committee reported that icare considered that the PIRS tool should be reviewed as to its challenges and to assess whether the PIRS is the best and most effective way of calculating WPI within the workers compensation system (P85 SCLJ Report 84)

- **Davies, G. R. (2008) The Psychiatric Impairment Rating Scale: Is it a valid measure?** *Australian Psychologist*

In August 2008, Dr Gordon Robert Davies first published an article entitled "the Psychiatric Impairment Rating Scale: is it a valid measure?". Republished in 2011 in the publication Australian Psychologist, the Abstract states:

> "The Psychiatric Impairment Rating Scale (PIRS) was introduced as part of the Workcover legislation in NSW and has since been adopted in other States. There has been significant criticism of its validity and structure, but no supporting research. This study was undertaken to examine the validity of the use of the PIRS to assess psychiatric impairment. This study assesses the concurrent validity of the PIRS by comparing it with the Comcare and Social Security scales and the Health of the Nation Outcome Scale, together with two self-report measures. It also examines the relationship between the PIRS subscales. A high level of ordinal concordance was demonstrated between all scales although the ratings obtained had major systematic variations between scales in both level and distribution. The scoring technique in the PIRS transforms normally distributed scores to a skewed distribution with a preponderance of low scores. The PIRS is a valid scale for ordering the severity of psychological disability but it measures disability rather than impairment. The form of scoring does not provide a proportionate or statistically meaningful measure."

- **Davies, G. R. (2013). The reliability of the Psychiatric Impairment Scale (PIRS) in Valuing Psychological Impairment, *Psychiatry, Psychology and Law***

In a further article published in Psychiatry, Psychology and Law, Volume 20, 2013-issue 5, titled "The Reliability of The Psychiatric Impairment Scale (Pirs) In Valuing Psychological Impairment**"**, the Abstract states:

> This study examines the validity of valuations made using the descriptors in the subscales of the Psychiatric Impairment Scale (PIRS). Estimates of the item valuations on a 0–100 scale made by a group of psychiatrists trained in the use of the PIRS and a comparative group of patients with psychiatric disorders were compared. The results are contrasted with impairment ratings resulting from the use of the prescribed valuations of the descriptors. There was good agreement between the groups on the

valuation of classes 1 and 2, but a substantial loss of discriminative ability for classes 3, 4 and 5. Valuations of the degree of disability for each class were, in all cases, much larger than the value obtained using the standard scoring system, **suggesting that the level of impairment measured by the PIRS is undervalued.** Questions are also raised regarding the reliability of the PIRS in use.

- **A Report on the Ratings of Psychiatrists Using the Psychiatric Impairment Rating Scale: Some Australian Data**, James A Athanasosu

Athanasou concludes that the PIRS is not a perfect measure and "It was designed with a specific purpose, namely to assess psychiatric outcomes in a standardised fashion and in a way that is broadly consistent with the medico-legal system of physical impairment ratings." However, it is arguably not the best tool for determining the extent of psychiatric injury in "compensable cases."

Athanasou cites a number of studies or papers which are not available e.g**. Parmegiani, J.** (2009). Psychiatric Impairment Rating Scale. The last ten years and the next ten years. Sydney: Author.

- **The usage of the AMA Guides for the determination of psychological injury within the state and federal workers' compensation systems, Pamela A Warren Published: 25 November 2016, Psychological Injury and The Law Volume 9, pages 313–340, (2016)**

  [USA]

This paper is not accessible due to a firewall and relates to use of the AMA % Guides for the assessment of psychological injury in states and territories of the USA.

Comment

The lack of empirical studies on the PIRS highlights a need for more research to assess its reliability and validity, especially in the context of evolving mental health needs.

There has not been an appropriate evaluative study published in Australia or NSW about the efficacy and accuracy of the PIRS. Commentary so far, including from the author Dr Parmegiani, suggest that the tool is harsh.

The American Medical Association Guides to the Evaluation of Permanent Impairment 5th Edition (AMA5)

The NSW Guidelines adopt the principles of the AMA5.

Chapter 1 of the AMA5 sets out the ***philosophy, purpose and appropriate use*** of the Guides.

AMA5 define *impairment* as "a loss, loss of use, or derangement of any body part, organ system, or organ function". Chapter 1 deals with the features of **impairment.**

> *A medical impairment can develop from an illness or injury. An impairment is considered permanent when it has reached* ***maximal medical improvement (MMI),*** *meaning it is well stabilized and unlikely to change substantially in the next year with or without medical treatment. The term impairment in the Guides refers to* ***permanent impairment,*** *which is the focus of the Guides.*
>
> *…determining whether an injury or illness results in a permanent impairment requires a medical assessment performed by a physician. An impairment may lead to functional limitations or the inability to perform activities of daily living. [Chapter 1.2a]*

The difference between definitions and interpretations of ***impairment*** and ***disability*** (as far as they relate to the USA) are contained in Table 1-1

Table 1-1 Definitions and Interpretations of Impairment and Disability

Organization	Impairment	Disability	Physicians' Role	Comments
Guides to the Evaluation of Permanent Impairment (5th ed, 2000)	A loss, loss of use, or derangement of any body part, organ system, or organ function.	An alteration of an individual's capacity to meet personal, social, or occupational demands because of an impairment.	Determine impairment, provide medical information to assist in disability determination.	An impaired individual may or may not have a disability.
World Health Organization (WHO) (1999)	Problems in body function or structure as a significant deviation or loss. Impairments of structure can involve an anomaly, defect, loss, or other significant deviation in body structures.	Activity limitation (formerly disability) is a difficulty in the performance, accomplishment, or completion of an activity at the level of the person. Difficulty encompasses all of the ways in which the doing of the activity may be affected.	Not specifically defined; assumed to be one of the decision-makers in determining disability through impairment assessment.	Emphasis is on the importance of functional abilities and defining context-related activity limitations.
Social Security Administration (SSA) (1995)	An anatomical, physiological, or psychological abnormality that can be shown by medically acceptable clinical and laboratory diagnostic techniques.	The inability to engage in any substantial, gainful activity by reason of any medically determinable physical or mental impairment(s), which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months.	Determine impairment; may assist with the disability determination as a consultative examiner.	Physicians and nonphysicians need to work together to define situational disabilities.
State Workers' Compensation Law (typical)[5]	"Permanent impairment" is any anatomic or functional loss after maximal medical improvement has been achieved and which abnormality or loss, medically, is considered stable or nonprogressive at the time of evaluation. Permanent impairment is a basic consideration in the evaluation of permanent disability and is a contributing factor to, but not necessarily an indication of, the entire extent of permanent disability. (*Idaho Code* section 72-422)	"Temporary disability" means a decrease in wage-earning capacity due to injury or occupational disease during a period of recovery. (*Idaho Code* section 72-102[10] "Permanent disability" results when the actual or presumed ability to engage in gainful activity is reduced or absent because of permanent impairment and no fundamental or marked change in the future can be reasonably expected. (*Idaho Code* section 72-423)	"Evaluation (rating) of permanent impairment" is a medical appraisal of the nature and extent of the injury or disease as it affects an injured employee's personal efficiency in the activities of daily living, such as self-care, communication, normal living postures, ambulation, elevation, traveling, and nonspecialized activities of bodily members. (*Idaho Code* section 72-424)	Purpose is to provide sure and certain relief to those who become injured by accident or suffer effects of disease from exposure to hazards arising out of and in the course of employment.

AMA5 define **disability as an alteration of an individual's capacity to meet personal, social, or occupational demands or statutory or regulatory requirements because of an impairment.**

> *"An individual can have a disability in performing a specific work activity but not have a disability in any other social role. Physicians have the education and training to evaluate a person's health status and determine the presence or absence of an impairment. If the physician has the expertise and is well acquainted with the individual's activities and needs, the physician may also express an opinion about the presence or absence of a specific disability. For example, an occupational medicine physician who understands the job requirements in a particular workplace can provide insights on how the impairment could contribute to a workplace disability. The*

impairment evaluation, however, is only one aspect of disability determination. A disability determination also includes information about the individual's skills, education, job history, adaptability, age, and environment requirements and modifications. Assessing these factors can provide a more realistic picture of the effects of the impairment on the ability to perform complex work and social activities. If adaptations can be made to the environment, the individual may not be disabled from performing that activity."[Chapter 1.2b]

Importantly, the Guides state:

> ***Work*** *is not included in the clinical judgment for impairment percentages for several reasons:*
>
> *(1) work involves many simple and complex activities;*
>
> *(2) work is highly individualized, making generalizations inaccurate;*
>
> *(3) impairment percentages are unchanged for stable conditions, but work and occupations change; and*
>
> *(4) impairments interact with such other factors as the worker's age, education, and prior work experience to determine the extent of work disability.*
>
> *For example, an individual who receives a 30% whole person impairment due to pericardial heart disease is considered from a clinical standpoint to have a 30% reduction in general functioning as represented by a decrease in the ability to perform activities of daily living. For individuals who work in sedentary jobs, there may be no decline in their work ability although their overall functioning is decreased. Thus, a 30% impairment rating does not correspond to a 30% reduction in work capability. Similarly, a manual labourer with this 30% impairment rating due to pericardial disease may be completely unable to do his or her regular job and, thus, may have a 100% work disability. As a result, impairment ratings are not intended for use as direct determinants of work disability. When a physician is asked to evaluate work-related disability, it is appropriate for a physician knowledgeable about the work activities of the patient to discuss the specific activities the worker can and cannot do, given the permanent impairment.*

The distinction the Guides make between disability and impairment are:

> *"An individual with a medical impairment can have no disability for some occupations, yet be very disabled for others stop for example, severe degenerative disc disease may impair the functioning of the spine of both the licensed practical nurse and a bank president in a similar fashion when performing their activities of daily living. However, in terms of occupation, the bank president is less likely to be disabled by this impairment and the licensed practical nurse. An individual who developed rheumatoid arthritis may be disabled from work as a tailor but may be able to work as a childcare aid a pilot who developed a visual impairment, correctable with glasses, may be able to perform all of his daily activities but is not a longer able to fly a commercial plane stop an individual with repeated hernias and repairs may no longer be able to lift more than 20 kg but could work in a factory where mechanical lifts are available stop the guides is not intended to be used for direct estimates of work disability.*
>
> ***Impairment percentages derived according to the guides criteria do not measure work disability. Therefore, it is inappropriate to use the guides criteria or ratings to make direct estimates of work disability****.[Chapter 1.2b, page 9]*

Comment

In other words, WPI should not be used to determine **capacity *for work*. In the context of the NSW workers compensation system, that means WPI should not be used as a gateway or threshold to determine access to weekly payments.**

11. Psychiatric and psychological disorders

AMA5 Chapter 14 is excluded and replaced by this chapter. Before undertaking an impairment assessment, users of the Guidelines must be familiar with (in this order):

- the Introduction in the Guidelines
- chapters 1 and 2 of AMA5
- the appropriate chapter(s) of the Guidelines for the body system they are assessing. The Guidelines replace the psychiatric and psychological chapter in AMA5.

Introduction

1.1 This chapter lays out the method for assessing psychiatric impairment. The evaluation of impairment requires a medical examination.

1.2 Evaluation of psychiatric impairment is conducted by a psychiatrist who has undergone appropriate training in this assessment method.

1.3 Permanent impairment assessments for psychiatric and psychological disorders are only required where the primary injury is a psychological one. The psychiatrist needs to confirm that the psychiatric diagnosis is the injured worker's primary diagnosis.

Diagnosis

1.4 The impairment rating must be based upon a psychiatric diagnosis (according to a recognised diagnostic system) and the report must specify the diagnostic criteria upon which the diagnosis is based. Impairment arising from any of the somatoform disorders (DSM IV TR, pp 485–511) are excluded from this chapter.

1.5 If pain is present as the result of an organic impairment, it should be assessed as part of the organic condition under the relevant table. This does not constitute part of the assessment of impairment relating to the psychiatric condition. The impairment ratings in the body organ system chapters in AMA5 make allowance for any accompanying pain.

1.6 It is expected that the psychiatrist will provide a rationale for the rating based on the injured worker's psychiatric symptoms. The diagnosis is among the factors to be considered in assessing the severity and possible duration of the impairment, but is not the sole criterion to be used. Clinical assessment of the person may include information from the injured worker's own description of his or her functioning and limitations, and from family members and others who may have knowledge of the person. Medical reports, feedback from treating professionals and the results of standardised tests – including appropriate psychometric testing performed by a qualified clinical psychologist and work evaluations – may provide useful information to assist with the assessment. Evaluation of impairment will need to take into account variations in the level of functioning over time. Percentage impairment refers to whole person impairment (WPI).

Permanent impairment

1.7 A psychiatric disorder is permanent if, in your clinical opinion, it is likely to continue

indefinitely. Regard should be given to:

- the duration of impairment
- the likelihood of improvement in the injured worker's condition
- whether the injured worker has undertaken reasonable rehabilitative treatment
- any other relevant matters.

Effects of treatment

1.8 Consider the effects of medication, treatment and rehabilitation to date. Is the condition stable? Is treatment likely to change? Are symptoms likely to improve? If the injured worker declines treatment, this should not affect the estimate of permanent impairment. The psychiatrist may make a comment in the report about the likely effect of treatment or the reasons for refusal of treatment.

Co-morbidity

1.9 Consider comorbid features (eg bi-polar disorder, personality disorder, substance abuse) and determine whether they are directly linked to the work-related injury, or whether they were pre-existing or unrelated conditions.

Pre-existing impairment

1.10 To measure the impairment caused by a work-related injury or incident, the psychiatrist must measure the proportion of WPI due to a pre-existing condition. Pre-existing impairment is calculated using the same method for calculating current impairment level. The assessing psychiatrist uses all available information to rate the injured worker's pre-injury level of functioning in each of the areas of function. The percentage impairment is calculated using the aggregate score and median class score using the conversion table below. The injured worker's current level of WPI% is then assessed, and the pre-existing WPI% is subtracted from their current level, to obtain the percentage of permanent impairment directly attributable to the work-related injury. If the percentage of pre-existing impairment cannot be assessed, the deduction is 1/10th of the assessed WPI.

Psychiatric impairment rating scale (PIRS)

1.11 Behavioural consequences of psychiatric disorder are assessed on six scales, each of which evaluates an area of functional impairment:

1. Self care and personal hygiene (Table 11.1)
2. Social and recreational activities (Table 11.2)
3. Travel (Table 11.3) } Activities of daily living
4. Social functioning (relationships) (Table 11.4)
5. Concentration, persistence and pace (Table 11.5)
6. Employability (Table 11.6).

1.12 Impairment in each area is rated using class descriptors. Classes range from 1 to 5, in accordance with severity. The standard form must be used when scoring the PIRS. The examples of activities are examples only. The assessing psychiatrist should take account

of the person's cultural background. Consider activities that are usual for the person's age, sex and cultural norms.

Table 11.1: Psychiatric impairment rating scale – self care and personal hygiene

Class 1	No deficit, or minor deficit attributable to the normal variation in the general population
Class 2	Mild impairment: able to live independently; looks after self adequately, although may look unkempt occasionally; sometimes misses a meal or relies on take-away food.
Class 3	Moderate impairment: Can't live independently without regular support. Needs prompting to shower daily and wear clean clothes. Does not prepare own meals, frequently misses meals. Family member or community nurse visits (or should visit) 2–3 times per week to ensure minimum level of hygiene and nutrition.
Class 4	Severe impairment: Needs supervised residential care. If unsupervised, may accidentally or purposefully hurt self.
Class 5	Totally impaired: Needs assistance with basic functions, such as feeding and toileting.

Table 11.2: Psychiatric impairment rating scale – social and recreational activities

Class 1	No deficit, or minor deficit attributable to the normal variation in the general population: regularly participates in social activities that are age, sex and culturally appropriate. May belong to clubs or associations and is actively involved with these.
Class 2	Mild impairment: occasionally goes out to such events eg without needing a support person, but does not become actively involved (eg dancing, cheering favourite team).
Class 3	Moderate impairment: rarely goes out to such events, and mostly when prompted by family or close friend. Will not go out without a support person. Not actively involved, remains quiet and withdrawn.
Class 4	Severe impairment: never leaves place of residence. Tolerates the company of family member or close friend, but will go to a different room or garden when others come to visit family or flat mate.
Class 5	Totally impaired: Cannot tolerate living with anybody, extremely uncomfortable when visited by close family member.

Table 11.3: Psychiatric impairment rating scale – travel

Class 1	No deficit, or minor deficit attributable to the normal variation in the general population: Can travel to new environments without supervision.
Class 2	Mild impairment: can travel without support person, but only in a familiar area such as local shops, visiting a neighbour.
Class 3	Moderate impairment: cannot travel away from own residence without support person. Problems may be due to excessive anxiety or cognitive impairment.
Class 4	Severe impairment: finds it extremely uncomfortable to leave own residence even with trusted person.
Class 5	Totally impaired: may require two or more persons to supervise when travelling.

Table 11.4: Psychiatric impairment rating scale – social functioning

Class 1	No deficit, or minor deficit attributable to the normal variation in the general population: No difficulty in forming and sustaining relationships (eg a partner, close friendships lasting years).
Class 2	Mild impairment: existing relationships strained. Tension and arguments with partner or close family member, loss of some friendships.
Class 3	Moderate impairment: previously established relationships severely strained, evidenced by periods of separation or domestic violence. Spouse, relatives or community services looking after children.
Class 4	Severe impairment: unable to form or sustain long term relationships. Pre-existing relationships ended (eg lost partner, close friends). Unable to care for dependants (eg own children, elderly parent).
Class 5	Totally impaired: unable to function within society. Living away from populated areas, actively avoiding social contact.

Table 11.5: Psychiatric impairment rating scale – concentration, persistence and pace

Class 1	No deficit, or minor deficit attributable to the normal variation in the general population. Able to pass a TAFE or university course within normal time frame.
Class 2	Mild impairment: can undertake a basic retraining course, or a standard course at a slower pace. Can focus on intellectually demanding tasks for periods of up to 30 minutes, then feels fatigued or develops headache.
Class 3	Moderate impairment: unable to read more than newspaper articles. Finds it difficult to follow complex instructions (eg operating manuals, building plans), make significant repairs to motor vehicle, type long documents, follow a pattern for making clothes, tapestry or knitting.
Class 4	Severe impairment: can only read a few lines before losing concentration. Difficulties following simple instructions. Concentration deficits obvious even during brief conversation. Unable to live alone, or needs regular assistance from relatives or community services.
Class 5	Totally impaired: needs constant supervision and assistance within institutional setting.

Table 11.6: Psychiatric impairment rating scale – employability

Class 1	No deficit, or minor deficit attributable to the normal variation in the general population. Able to work full time. Duties and performance are consistent with the injured worker's education and training. The person is able to cope with the normal demands of the job.
Class 2	Mild impairment. Able to work full time but in a different environment from that of the pre-injury job. The duties require comparable skill and intellect as those of the pre-injury job. Can work in the same position, but no more than 20 hours per week (eg no longer happy to work with specific persons, or work in a specific location due to travel required).
Class 3	Moderate impairment: cannot work at all in same position. Can perform less than 20 hours per week in a different position, which requires less skill or is qualitatively different (eg less stressful).
Class 4	Severe impairment: cannot work more than one or two days at a time, less than 20 hours per fortnight. Pace is reduced, attendance is erratic.
Class 5	Totally impaired: Cannot work at all.

Using the PIRS to measure impairment

1.13 Rating psychiatric impairment using the PIRS is a two-step procedure:

1. Determine the median class score.
2. Calculate the aggregate score.

Determining the median class score

1.14 Each area of function described in the PIRS is given an impairment rating which ranges from Class 1 to 5. The six scores are arranged in ascending order, using the standard form. The median is then calculated by averaging the two middle scores eg:

Example A: 1, 2, 3, 3, 4, 5 Median Class = 3

Example B: 1, 2, 2, 3, 3, 4 Median Class = 2.5 = 3*

Example C: 1, 2, 3, 5, 5, 5 Median Class = 4

*If a score falls between two classes, it is rounded up to the next class. A median class score of 2.5 thus becomes 3.

1.15 The median class score method was chosen as it is not influenced by extremes. Each area of function is assessed separately. While impairment in one area is neither equivalent nor interchangeable with impairment in other areas, the median seems the fairest way to translate different impairments onto a linear scale.

Median class score and percentage impairment

1.16 Each median class score represents a range of impairment, as shown below:

Class 1 = 0–3%

Class 2 = 4–10%

Class 3 = 11–30%

Class 4 = 31–60%

Class 5 = 61–100%

Calculation of the aggregate score

1.17 The aggregate score is used to determine an exact percentage of impairment within a particular median class range. The six class scores are added to give the aggregate score.

Use of the conversion table to arrive at percentage impairment

1.18 The aggregate score is converted to a percentage score using the conversion Table 11.7, below.

1.19 The conversion table was developed to calculate the percentage impairment based on the aggregate and median scores.

1.20 The scores within the conversion table are spread in such a way to ensure that the final percentage rating is consistent with the measurement of permanent impairment percentages for other body systems.

Table 11.7: Conversion table

Aggregate score

% Impairment	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30
Class 1	0	0	1	1	2	2	2	3	3																
Class 2				4	5	5	6	7	7	8	9	9	10												
Class 3								11	13	15	17	19	22	24	26	28	30								
Class 4												31	34	37	41	44	47	50	54	57	60				
Class 5																66	65	70	74	78	83	87	91	96	100

Conversion table — explanatory notes

a. **Distribution of aggregate scores**

- The lowest aggregate score that can be obtained is: 1+1+1+1+1+1=6.
- The highest aggregate score is 5+5+5+5+5+5= 30.
- The table therefore has aggregate scores ranging from six to 30.
- Each median class score has an impairment range, and a range of possible aggregate scores (eg class 3 = 11-30 per cent).
- The lowest aggregate score for class 3 is 13 (1 + 1 + 2 + 3 + 3 + 3 = 13).
- The highest aggregate score for class 3 is 22 (3 + 3 + 3 + 3 + 5 + 5 = 22).
- The conversion table distributes the impairment percentages across aggregate scores.

b. **Same aggregate score in different classes**

- The conversion table shows that the same aggregate score leads to different percentages of impairment in different median classes.
- For example, an aggregate score of 18 is equivalent to an impairment rating of
  - 10% in Class 2,
  - 22% in Class 3,
  - 34% in Class 4.

- This is due to the fact that an injured worker whose impairment is in median class 2 is likely to have a lower score across most areas of function. They may be significantly impaired in one aspect of their life, such as travel, yet have low impairment in social function, self-care or concentration.
- Someone whose impairment reaches median class 4 will experience significant impairment across most aspects of his or her life.

Examples: (Using the previous cases)

Example A

PIRS scores						Median class
1	2	3	3	4	5	= 3

Aggregate score						Total	% Impairment
1 +	2 +	3 +	3 +	4 +	5 =	18	22%

Example B

PIRS scores						Median Class
1	2	2	3	3	4	= 3

Aggregate score						Total	% Impairment
1 +	2 +	2 +	3 +	3 +	4 =	15	15%

Example C

PIRS scores						Median class
1	2	3	5	5	5	= 4

Aggregate score						Total	% Impairment
1 +	2 +	3 +	5 +	5 +	5 =	21	44%

Table 11.8: PIRS rating form

Name		**Claim reference number**	
Date of birth		**Age at time of injury**	
Date of injury		**Occupation before injury**	
Date of assessment		**Marital status before injury**	

Psychiatric diagnoses	1.	2.
	3.	4.
Psychiatric treatment		
Is impairment permanent?	☐ Yes ☐ No (Tick one)	

PIRS category	Class	Reason for decision
Self care and personal hygiene		
Social and recreational activities		
Travel		
Social functioning		
Concentration, persistence and pace		
Employability		

Score class

Median

=

Aggregate score

							Total %
+	+	+	+	+	+	=	
Impairment (%WPI) from Table 11.7							
Less pre-existing impairment (if any)							
Final impairment (%WPI)							

ANNEXURE B

"REASONABLY NECESSARY" V "REASONABLE AND NECESSARY" 2025

Note: This paper is written following consideration of the Parkes Inquiry Discussion Paper on Medical and Treatment Expenses (attached) and the McDougall Review 2021

Contents

1. The Legislation

Part 3, Division 3 of the WCA 1987 provides for compensation for medical, hospital and rehabilitation expenses etc.

The phrase "***reasonably necessary***" is contained within section 60 which provides:

> Section 60 **Compensation for cost of medical or hospital treatment and rehabilitation etc**
>
> (1) If, as a result of an injury received by a worker, it is **reasonably necessary** that—
>
> (a) any medical or related treatment (other than domestic assistance) be given, or
>
> (b) any hospital treatment be given, or
>
> (c) any ambulance service be provided, or
>
> (d) any workplace rehabilitation service be provided,
>
> the worker's employer is liable to pay, in addition to any other compensation under this Act, the cost of that treatment or service and the related travel expenses specified in subsection (2).
>
> **Note.**
>
> Compensation for domestic assistance is provided for by section 60AA.
>
> (2) If it is necessary for a worker to travel in order to receive any such treatment or service (except any treatment or service excluded from this subsection by the regulations), the related travel expenses the employer is liable to pay are—
>
> (a) the cost to the worker of any fares, travelling expenses and maintenance necessarily and reasonably incurred by the worker in obtaining the treatment or being provided with the service, and
>
> (b) if the worker is not reasonably able to travel unescorted—the amount of the fares, travelling expenses and maintenance necessarily and reasonably incurred by an escort provided to enable the worker to be given the treatment or provided with the service.
>
> (2A) The worker's employer is not liable under this section to pay the cost of any treatment or service (or related travel expenses) if—
>
> (a) the treatment or service is given or provided without the prior approval of the insurer (not including treatment provided within 48 hours of the injury happening and not including treatment or service that is exempt under the Workers Compensation Guidelines from the requirement for prior insurer approval), or
>
> (b) the treatment or service is given or provided by a person who is not appropriately qualified to give or provide the treatment or service, or

(c) the treatment or service is not given or provided in accordance with any conditions imposed by the Workers Compensation Guidelines on the giving or providing of the treatment or service, or

(d) the treatment is given or provided by a health practitioner whose registration as a health practitioner under any relevant law is limited or subject to any condition imposed as a result of a disciplinary process, or who is suspended or disqualified from practice.

(2B) The worker's employer is not liable under this section to pay travel expenses related to any treatment or service if the treatment or service is given or provided at a location that necessitates more travel than is reasonably necessary to obtain the treatment or service.

(2C) The Workers Compensation Guidelines may make provision for or with respect to the following—

(a) establishing rules to be applied in determining whether it is reasonably necessary for a treatment or service to be given or provided,

(b) limiting the kinds of treatment and service (and related travel expenses) that an employer is liable to pay the cost of under this section,

(c) limiting the amount for which an employer is liable to pay under this section for any particular treatment or service,

(d) establishing standard treatment plans for the treatment of particular injuries or classes of injury,

(e) specifying the qualifications or experience that a person requires to be ***appropriately qualified*** for the purposes of this section to give or provide a treatment or service to an injured worker (including by providing that a person is not appropriately qualified unless approved or accredited by the Authority).

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

Operation of the Section is qualified by limits on payment imposed under section 59A.

1.1 System Objectives

The NSW Workers Compensation system objectives (in section 3 of the WIM Act 1998) include:

(a) to assist in securing the health, safety and welfare of workers and in particular preventing work-related injury,

(b) to provide—

- *prompt treatment of injuries, and*

- *effective and proactive management of injuries, and*
- ***necessary** medical and vocational rehabilitation following injuries,*

in order to assist injured workers and to promote their return to work as soon as possible,

Subsection 60(1) WCA 1987 provides that an insurer is to pay for ***reasonably*** necessary medical or related treatment, hospital treatment, ambulance services or workplace rehabilitation services required as a result of an injury to a worker.

Section 60 meets the guiding principles of the system because in its very heart is early access to treatments that

1.2 Provisos, restrictions and safeguards

1.2.1 Prior approval of insurer

Subsection 60(2C) WCA 1987 restricts payment of such expenses by providing that an employer is *not liable* to pay the cost of any treatment or service if that treatment or service is **given or provided without the prior approval of the insurer** (not including treatment provided within 48 hours of the injury happening and not including treatment or service that is exempt under the Workers Compensation Guidelines from the requirement for prior insurer approval)

1.2.2 The Workers Compensation Guidelines

The Workers Compensation Guidelines:

- establish rules to be applied in determining whether it is reasonably necessary for a treatment or service to be given or provided
- list treatments exempt from prior insurer approval
- place caps treatments exempt from prior insurer approval
- can establish standard treatment plans for the treatment of particular injuries or classes of injury
- specify the qualifications or experience that a person requires to be appropriately qualified to give or provide a treatment or service to an injured worker (allied health service providers)
- can limit the kinds of treatment and service that an employer is liable to pay and the cost thereof (All subsection 60(2C)).

Current Guidelines (2021) provide in Part 4.2 :

"*When considering the facts of the case, the insurer is to understand that:*

- *what is determined as reasonably necessary for one worker may not be reasonably necessary for another worker with a similar injury*
- *reasonably necessary does not mean absolutely necessary*
- *although evidence may show that a similar outcome could be achieved by an alternative treatment, it does not mean that the treatment recommended is not reasonably necessary.*

- *In most cases, the points above should be enough for an insurer to determine what is reasonably necessary treatment*

If the insurer remains unclear whether a treatment is reasonably necessary, than the following factors may be considered:

- *the appropriateness of the particular treatment*
- *the availability of alternative treatment*
- *the cost of the treatment*
- *the actual or potential effectiveness of the treatment*
- *the acceptance of the treatment by medical experts."*

1.2.3 Section 59A WCA limits and thresholds

One must not forget **section 59A** WCA 1987 which serves to limit the payment of compensation by providing for compensation periods during which medical and treatment expenses can be considered by the insurer and outside which an insurer is not required to make payment.

In 2012 the base period during which medical treatments could be paid was 12 months after the last day on which weekly payments of compensation ceased. In 2015 the Government delivered a package of premium relief and "benefits" by extending the base compensation period to 2 years after the day on which weekly compensation ceases for those with a degree of permanent impairment of 10% or less and 5 years for those with a degree of permanent impairment greater than 10% and not more than 20%.

Section 59A is a "difficult" section in terms of drafting and certainty. Firstly, it relies on WPI thresholds for the payment and delivery of medical and other treatments; secondly, efficacy of its operation relies on the insurer dealing with a request for treatment in a timely way; thirdly, due to the way it operates it causes injured workers to consider undergoing invasive treatments well before conservative treatments have been exhausted.

The Parkes Inquiry examined medical and treatment expenses in some detail and unanimous principles and recommendations were made in relation to section 59A that remain valid today (see paper attached).

2. "Reasonably Necessary"

2.1 Formulation of the test for reasonably necessary

The test for reasonably necessary was clarified in the decision of ***Rose v Health Commission (NSW)*** [1986] NSWCC 2. The section of the 1926 Act under consideration was section 10, effectively the equivalent of the current section 60 of the *Workers Compensation Act* 1987.

The dilemma for Judge Burke was to determine what was meant by "reasonably necessary". His Honour formulated the following guiding principles:

> "In determining whether a particular regimen is medical treatment and whether it is reasonably necessary that such be afforded to a worker and that such necessity results from injury, it appears to me some general principles can be stated:
>
> 1. Prima facie, if the treatment falls within the definition of medical treatment in section 10(2), it is relevant medical treatment for the purposes of this Act. Broadly then, treatment that is given by, or at the direction of, a medical practitioner or consists of the supply of medicines or medical supplies is such treatment.
> 2. However, though falling within that ambit and thereby presumed reasonable, that presumption is rebuttable (and there would be an evidentiary onus on the party seeking to do so). If it be shown that the particular treatment afforded is not appropriate, is not competent to alleviate the effects of injury, then it is not relevant treatment for the purposes of the Act.
> 3. Any necessity for relevant treatment results from the injury where its purpose and potential effect is to alleviate the consequences of injury.
> 4. It is reasonably necessary that such treatment be afforded a worker if this Court concludes, exercising prudence, sound judgment and good sense, that it is so. That involves the Court in deciding, on the facts as it finds them, that the particular treatment is essential to, should be afforded to, and should not be forborne by, the worker.
> 5. In so deciding, the Court will have regard to medical opinion as to the relevance and appropriateness of the particular treatment, any available alternative treatment, the cost factor, the actual or potential effectiveness of the treatment and its place in the usual medical armoury of treatments for the particular condition."

2.2 Embracing the test in the Workplace Injury Management and Workers Compensation Act 1998

The guiding principles as formulated by Burke CCJ have stood as the 'test' since the decision. They were enshrined in the *Workplace Injury Management and Workers Compensation Act 1998* in section 297 (first inserted in 2001):

> **297 Directions for interim payment of weekly payments or medical expenses compensation**
>
> (1) When a dispute to which this Part applies concerns weekly payments of compensation or medical expenses compensation, the President can direct the person on whom the claim is made to pay the compensation concerned. Such a direction is referred to in this Part as an interim payment direction.

(1A) Section 298 does not apply to a dispute concerning a decision by the insurer to discontinue or reduce weekly payments of compensation on the basis of a work capacity decision under Division 2 of Part 3 of the 1987 Act.

(2) An interim payment direction for payment of medical expenses compensation cannot be for an amount of more than $7,500 or such other amount as may be prescribed by the regulations.

Note—

The amount of $7,500 is subject to adjustment under Division 6 of Part 3 of the 1987 Act.

…

4) If an injury management plan for the worker is in place or the insurer has accepted that the worker has received an injury (as defined in this Act), the President is to presume that an interim payment direction for **medical expenses compensation** is warranted if satisfied that the treatment or service to which the compensation relates is reasonably necessary—

(a) to prevent deterioration of the worker's condition, or

(b) to promote an early return to work, or

(c) to relieve significant pain or discomfort, or

(d) for such other reason as may be prescribed by the regulations.

(5) Subsections (3) and (4) do not limit the circumstances in which an interim payment direction can be given.

(6) An interim payment direction can be given subject to conditions.

(7) A further interim payment direction or directions can be given after the expiry of any earlier direction.

Since the inception of Interim Payment Directions in the 1998 Act it a little used provision largely because the limitations of maximum cost and the requirement of an IMP being in place. IPDs are not reported by the Commission and only few decisions are available.

2.3 Restatement of the standard test for 'reasonably necessary'

The most recent restatement of the 'test' for 'reasonably necessary' is the decision of Deputy President Bill Roche in ***Diab v NRMA Ltd [2014]*** **NSW WCC PD 72 (10 November 2014).**

The case involved a left knee injury sustained in initially in 2005 by Mr Diab originally as he worked as a road service patrol officer for NRMA Ltd. A second and third insult to the left knee 2012 within the course of employment. Following examination by a specialist including MRI studies surgery to the left knee was recommended. The insurer is specialist did not consider the recommended surgery to be reasonably necessary or related to the 2005 injury, concluding that the injury to be treated by surgery was degenerative rather than work-related.

The worker underwent operation in late 2012. Following surgery he developed deep vein thrombosis which required further hospitalisation and treatment.

When the matter came before the Commission the only issue in dispute was whether the cost of medical treatment was reasonably necessary as a result of the accepted injuries to Mr Diab's left knee.

The worker lost before an Arbitrator who concluded that the surgery was not reasonably necessary as a result of the pleaded injuries. The worker appealed the Arbitrator's determination.

In his decision, DP Roche recited "the standard test adopted in determining if medical treatment is reasonably necessary as a result of a work injury is that stated by Burke CCJ in ***Rose v Health Commission."***

He recited some of the cases in which the test has been applied and noted that in addition, the Commission had been guided by and generally followed the later decision of Burke CCJ in *Bartolo V Western Sydney Area Health Service* [1997] NSWCC 1 where he distilled the 'test' to: "*the question is should the patient have this treatment or not. If it is better that he have it, then it is necessary and should not be forborne. If in reason it should be said that the patient should not do without this treatment, then it satisfies the test of being reasonably necessary."*

DP Roche considered the Arbitrator's approach in following *Bartolo,* and then stated that subsequent appellant Authority suggested that this approach was not strictly correct.

He discussed the judgment of the Court of Appeal in the matter of ***Clampett v WorkCover Authority*** [2003] NSWCA 52 where Grove J considered the dictionary definition of "necessary" and stated: "*the essential issue is what effect flows from conditioning such qualities as 'reasonably'. The consequence is to moderate any sense of the absolute which might otherwise be conveyed by the word 'necessary' if it stood alone."* Roche DP considered that the approach in *Clampett* is consistent with the modern approach to statutory interpretation, which is to construe the language of the statute, not individual words. **Thus, "reasonably necessary" is a composite phrase in which necessity is qualified so that it must be a *reasonable necessity***.

DP Roche concluded the following:

- "Reasonably necessary" does not mean "absolutely necessary". If something is necessary in the sense of indispensable, it will be 'reasonably necessary'. That is because reasonably necessary is a lesser requirement than "necessary".
- Depending on the circumstances, a range of different treatments may qualify as "reasonably necessary" and a worker only has to establish the treatment claimed is *one of those treatments*.
- a worker certainly does not have to establish the treatment is "reasonable and necessary", which is a significantly more demanding test than many insurers and doctors apply.

- In the context of section 60, the relevant matters, (useful heads for consideration[the test]) according to the criteria of reasonableness, include, but are not necessarily limited to, the matters noted by Burke CCJ in *Rose* namely:
  - (a) the appropriateness of the particular treatment
  - (b) the availability of alternative treatment, and its potential effectiveness,
  - (c) the cost of the treatment,
  - (d) the actual or potential effectiveness of the treatment, and
  - (e) the acceptance by medical experts of the treatment as being appropriate and likely to be effective.
- With respect to point (d), it should be noted that while the effectiveness of the treatment is relevant to whether the treatment was reasonably necessary, it is certainly not determinative. The evidence may show that the same outcome could be achieved by a different treatment, but at a much lower cost. Similarly bearing in mind that all treatment, especially surgery, carries a risk of a less than ideal result, a poor outcome does not necessarily mean that the treatment was not reasonably necessary. As always, each case will depend on its facts.
- The essential question remains whether the treatment was reasonably necessary. It is not simply a matter of asking, as was suggested in Bartolo, "is it better that the worker have the treatment or not".

2.4 Provisional Liability and 'reasonably necessary'

After an insurer has received a notification of an injury and a certificate of reduced capacity for work the insurer must commence provisional weekly payments within 7 days unless it has a reasonable excuse not to. Acceptance of liability on a provisional basis provides a worker with access to up to 12 weeks of income support and up to $10,000 for reasonably necessary medical treatment.

Whilst provisional liability is designed to provide insurers with sufficient time to consider acceptance of liability formally, it provides injured workers with immediate and early income support and access to medical treatments to, hopefully, support and early restoration of health and return to work.

Unlike provisional weekly payments, provisional medical expenses cannot be reasonably excused by the insurer however the treatments must either be one of those preapproved in the Workers Compensation Guidelines or approved as "reasonably necessary" by the insurer.

SIRA states that "early medical or treatment support has been shown to achieve better return to work outcomes for the worker".

3. Consideration of McDougall's Recommendation 39: amend 'reasonably necessary' to 'reasonable and necessary'.

3.1 Background

In 2020 the then Treasurer and the Minister for Customer Service announced an independent review of icare and the *State Insurance and Care Governance Act 2015*. The terms of reference described as the matters in scope for review a comprehensive organisational review of icare, review of the Government managed workers compensation schemes (NI and TMF), the statutory review of the SICG Act and any amendments to the workers compensation legislation **to the extent they relate to those terms of reference.** Out of scope for the review was the workers compensation Acts other than to the extent they relate to icare, the TMF, the NI, insurance, funding, or the powers, functions and statutory independence of SIRA.

3.2 Review Report and Recommendation 39

In the Review report McDougall included Recommendation 39:

Medical treatment	**29.3.4**
39	That the legislature give consideration to amending section 60 of the *Workers Compensation Act 1987* to replace the words 'reasonably necessary' with the words 'reasonable and necessary

Within the review there was no direct or open discussion concerning the formulation of this recommendation. The change from '**reasonably necessary' to reasonable and necessary'** was raised by icare in their submission to His Honour. No discussion was raised in any forum before their submission.

Icare stated in their submission:

> In most Australian workers' compensation jurisdictions, the test for determining whether treatment or services are appropriate is based on the concept of that treatment being "*reasonable and necessary*".
>
> 33. The 1987 Act diverges from this test, and uses the "*reasonably necessary*" test. The test in the 1987 Act differs from similar personal injury schemes in NSW, as well as Commonwealth schemes like the National Disability Insurance Scheme (NDIS), which apply a "*reasonable and necessary*" test.
>
> 34. Although the difference in wording in the 1987 Act may appear innocuous, it has had profound and potentially unforeseen consequences for claimants by creating incentives for medical and allied health service providers around fee-for-services, rather than encouraging the system to take a holistic view of a person's ability to 'function and recover'.
>
> 35. The "*reasonably necessary*" test applied by the 1987 Act allows all manner of treatment to be approved, including those considered as being of low value or potentially harmful. This has contributed to the steadily increasing medical spend, and persistent non-improvement in patient outcomes, over the years.

36. A review of case law relating to "*reasonably necessary*" treatment supports this. It is well-established that the "*reasonable and necessary*" test is more demanding than the "*reasonably necessary*" test. In *State Super SAS Trustee Corp Ltd v Perrin*, the Court of Appeal held that the "*reasonably necessary*" standard did not require absolute necessity for surgery proposed. The adverb "*reasonably*" modified the strictness of what was "*necessary*".

37. One example which demonstrates the implications of the "reasonably necessary" test is the number of spinal fusions being approved and undertaken within the workers compensation system for back injuries, despite the evidence suggesting this is not best practice. In some cases, spinal fusion may even result in permanent reduction of function, which may limit future work ability.

38. The current system therefore provides a financial incentive for providers to recommend surgery, rather than consider conservative treatment options that may lead to better health outcomes in the long-term.

39. The Workers Compensation Guidelines (October 2019),161 which expanded the list of pre-approved medical treatments, has relaxed the "reasonably necessary" test even further, as workers are able to access services and incidental expenses with limited scope for denial under the legislation.

40. These changes have a direct impact on the increase in medical expenditure. As an example, if every claim managed by the Nominal Insurer used the allowable $110 per claim for reasonable incidental expenses (such as strapping tape, TheraBand, exercise putty, disposable electrodes and walking sticks), this would add an additional $6.6 million to annual medical expenditure (based on 60,000 claims per year). If applied across all NSW workers compensation claims, this figure alone would exceed $10 million.

Apart from the AMA, no other submission deals with this proposal. iCare's statements stand unchallenged due to no issue having been raised with stakeholders.

The correlation between the definition and rising medical costs (item costs) was not supported by publicly available data. Medical spend increasing due to the definition was not substantiated. Rather, the increase in the cost of medical services was impacting the scheme and had been the subject of much discussion in the 2012 Issues Paper and Joint Select Committee review leading to the 2012 reforms. [Refer Parkes Inquiry Medical and Treatment Expenses Discussion Paper attached].

3.3 Report commentary regarding recommendation 39

3.3.1 Icare submission

McDougall provided the following commentary in the report:

> "icare submitted that there were three difficulties with the reasonably necessary test:
>
> a) it allows for all types of treatments to be approved, including treatments considered to be ***'low value* or potentially *'harmful'*;**
>
> b) it has led to the deemed pre-approval of a wide range of services and incidental expenses, which in turn has led to increased medical expenditure and costs for the schemes; and

c) its use as a test is inconsistent with the use of a *'reasonable and necessary'* test in similar personal injury schemes in NSW, and in Commonwealth schemes such as the NDIS."

The submission may have been misleading. The pre-approved treatments (in the Guidelines) allow for workers to obtain initial treatments likely to prevent time off work or reduce time off work in circumstances where the insurer must approve all other treatments prior to the worker receiving such treatments.

The pre-approval requirement is already onerous in terms of timeliness of delivery of treatment and assistance to a worker. This is recognised and argued by the AMA in their submission to the inquiry (page 274, paragraphs 144-145). The AMA in its submission states: "*The AMA (NSW) is also concerned by reports from medical professionals regarding insurers refusal of treatments despite doctors' recommendations and clinical evidence which supports intervention. Doctors clinical decisions regarding patient treatment should be supported and the role of the nominated treating doctor needs to be recognised and respected.*"

The rise in the cost of medical services had been attributed to the NSW workers compensation rates being in excess of the AMA rates and considered exceedingly generous.

McDougall does not seem to be aware of actions taken by SIRA to control medical expenditure in the system including:

- reduction of the maximum regulated rates for medical treatments and surgeries in line with the List of Medical Services and Fees issued by the AMA.[See Workers Compensation (Medical Practitioner Fees) Order]
- introduction of the Standards of Practice for insurers including standard 15, approval and payment of medical hospital and rehabilitation services
- introduction of Workers Compensation Guidelines for the approval of treating allied health practitioners (2021, amended 2024).

Nor was McDougall directed to the package of benefits and premium relief given by the Government in 2015 (following the scheme delivering a significant surplus) which included extending the limitations in section 59A providing longer periods of treatment.

3.3.2 Delays in access to treatment

In Chapter 8.2 McDougall is drawn to the **delays in access to treatment**. He attributes delays potentially to two matters:

1. the 21 day approval timeframe for treatments in section 279 of the 1998 Act: "it is not unreasonable to conclude that a 21 day period for consideration and approval may be excessive when there is an urgent need for medical treatment"
2. referrals to Independent Medical Examiners (IMEs) where timeframes to consider material, examine and report are lengthy. At Paragraph 196 he

states "*Unfortunately, **that delay is an unavoidable consequence of the need for a resolution mechanism to decide disputes as to what is reasonably necessary medical treatment***".

A partial solution to this is cited as provisional acceptance of liability in section 280 of the 1998 Act.

> *(1) An insurer can accept liability for medical expenses compensation on the basis of the provisional acceptance of liability for an amount of up to $5,000* or such other amount as may be specified by the Workers Compensation Guidelines.*
>
> *(2) The acceptance of liability on a provisional basis does not constitute an admission of liability by the employer or insurer under this Act or independently of this Act.*

McDougall is persuaded by icare that the reduction of the 20 one day approval timeframe I result in "unintended consequences". He opines "Nor do I think that the statutory regime for approval should be modified without very can careful consideration. Such consideration is beyond the scope of this review." [at paragraph 201, page 51]

3.4 Argument for change?

3.4.1 No change to benefits payable to injured workers?

McDougall states in his discussion of Return to Work Rates and the legislative structure of the system/scheme [at 41-42]:

> *I wish to make it clear that **I am calling for a reform of the legislative structure, not of its incidents**. **There should be no change to benefits payable to injured workers**. What is necessary is that the way to realisation of those benefits be made straight. Nothing put to me in the course of my Review provided evidence of a need for any substantial change to benefits. Workers' benefits under the scheme have been subject to significant change over the past decade. There is no present need for further changes.*
>
> *The current balance between benefits and obligations is the result of significant work and negotiation. Apart from some specific matters, neither workers' representatives nor employer groups submitted to my Review that there was need for wholesale change. The important work of simplifying and reconciling the regulatory regime should not be jeopardised by opening up debate on the fundamental balance in the scheme.*

3.4.2 No significant adverse effect on patients' outcomes?

McDougall states **"On my understanding of the two tests, I see no reason to think that the adoption of the reasonable and necessary test would be likely to have a significant adverse effect on patients' outcomes. However, against the possibility that it may, those outcomes ought to be monitored."**

The statement is equivocal, there being no evidence before him that there is an actual problem to resolve; that there will NOT be a significant adverse effect on

workers outcomes; or that there will be an improvement in the financial position of the nominal insurer by adopting the recommendation.

3.4.3 Alignment with the CTP insurance scheme or other 'schemes'?

Although not expressed in icare's submission to the review, a commonly stated reason for changing the definition from 'reasonably necessary' to 'reasonable and necessary' is to bring it in line with the New South Wales motor accidents compensation scheme. There is no reason to bring the two completely separate and distinct schemes into alignment in terms of definitions. The two schemes are funded completely differently and operate quite differently. Most importantly, the return to work imperative in the workers compensation scheme is a paramount consideration and an integral part of prompt return to work is access to medical treatment quickly. Importing a 'necessity' factor into the workers compensation scheme will slow down access to early medical intervention and slow down return to work. Furthermore, there is no such mechanism in the CTP scheme as 'provisional liability'.

Alignment with NDIS is simply not appropriate. The NDIS is not a compensation scheme it is a social security net for which application is based on disability, and in particular intellectual disability and severe physical disability. The Scheme is funded by the Commonwealth. It is not strictly insurance and it is not compensation. There are limited funds available and the terms and conditions of assistance are different.

3.4.4 Financial pressure on the scheme?

One must bear in mind that the recommendation was made in 2021 after a review that commenced in 2020. It is now five years on and there are significantly different financial concerns with the scheme, most particularly in the TMF.

There is no data to support that medical costs are an issue. There are however multiple reasons for increases in the overall spend on medical treatments and rehabilitation spend:

- Section 59A cut offs (based on impairment not capacity or need) bringing treatment decisions early (particularly surgery) before conservative modes are exhausted to ensure they are paid within the (generally) 2 year period.
- Covid 19 delays to treatment particularly surgery (2020 – 2023)
- Rising costs of treatment
- Thresholds based on WPI driving surgery (we have no evidence of this given the restraints on availability of treatments)
- Number of claims increasing year on year. (note, you cannot simply calculate average treatment costs to determine average cost per claim because claims once in the system will attract a spend potentially for many years)

3.5 Commentary

Adopting Recommendation 39 will result in a significant change to benefits for all injured workers in the NSW workers compensation system including those exempt from the 2012 reforms, regardless of the injury sustained.

A change to the test for access to payment for medical treatment:

- **Will** necessarily **reduce benefits.**
- **will** result in a significant deterioration of worker's outcomes
- **will** result in a significant deterioration delay to treatment and recovery
- **will** increase disputation over medical treatments
- **will** render provisional liability for medical expenses unworkable
- **will** render section 297 1998 Act (interim payment directions for medical expenses) difficult to administer
- **will** result in a significant adverse effect on worker's outcomes by virtue of delay and disputation
- **will** increase the administrative costs of the scheme.

The more onerous test would permit insurers to arrange IME appointments to test the necessity of any treatment, thereby providing further delays in a system where delay in treatment is already prevalent, with an increase in denials of treatment and consequent increases in disputation.

In order for an Interim Payment Direction to be sought, the test in section 297 1998 Act would need to be reformulated and would likely prevent IPDs being sought by workers.

The knock on effect of delays will impact return to work and the overall costs of the scheme.

The guiding principles and the well-settled formulated tests to determine what is "reasonably necessary" mitigate against harmful treatments. They incorporate a workability component, that is, if treatment assists a worker remaining at work or maintains an equilibrium with the patient then it can be considered reasonably necessary.

There are already restrictions and limitations on access to prompt medical treatment, adopting this recommendation would increase the difficulty in accessing treatment. **There will be delays in treatment provision occasioned by scrutiny of necessity**, the early approval free treatment types in the Guidelines will be significantly reduced, and workers will wait longer for access to treatment. As a consequence return to work outcomes will deteriorate and the already significant disputation over medical treatments especially surgery will likely increase. A consequent increase in timeliness and cost will also impact the scheme.

There is no data that demonstrates that a change to the phrasing after so many years in use will deliver a significant financial saving to the system.

Restriction on rights and entitlements is very difficult once written into the legislation. Employing a more restrictive test than has existed for over 60 years ought to undergo significant scrutiny before it is adopted.

The' reasonable and necessary test is the antithesis of the objectives of the system and will erode workers' benefits. It should not be adopted without careful consideration and assessment of the impact.

4. Conclusion

There is currently no persuasive argument articulated anywhere to support a change to section 60 of the Workers Compensation Act to adopt the phrase "in place of "reasonably necessary".

Before such a change were to be adopted an examination of the drivers towards rising medical costs in the scheme must take place.

There are alternatives available to the Government to consider which would alleviate pressure on the system:

1. Adopt the recommendations stated within the Parkes Inquiry:

   Replace the requirement that the treatment be provided or given within the 12 months period with a requirement that the '*claim for medical expenses compensation*' is to be made within the 12 months - as an example :

   > *Section 59A(1) "Compensation is not payable to an injured worker under this Division in respect of any treatment, service or assistance* ***for which a claim is made*** *more than 12 months after a claim for compensation in respect of the injury was first made, unless weekly payments of compensation are or have been paid or payable to the worker."*

2. Remove whole person impairment thresholds for the payment or provision of medical or other treatments thereby removing incentives for workers to undergo potentially unnecessary surgical treatment and making decisions to bring that treatment early in order to exceed the threshold.

MEDICAL and TREATMENT EXPENSES

BACKGROUND

In 2012 the Government expressed the concern that the NSW Workers Compensation Scheme was *"a broken system that does not produce good outcomes for injured workers, and without significant improvements is not financially sustainable."* [1] In particular, the Government highlighted that WorkCover had *'limited power to strongly discourage payments treatments and services that do not contribute to recovery and return to work.'* The Government identified that *"recovery and the health benefits of returning to work are not effectively promoted as there are perverse financial incentives for workers to remain off work and there is not effective work capacity testing".* [2]

The Government's Issues Paper set out as a 'guiding principle' that 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.*" [3]

The Paper cited *"International research has consistently found a correlation between early return to work and improved health outcomes. Long term absence and work-disability are harmful to physical and mental health and wellbeing. Recovery and return to work should be the key objects of any workers compensation system."*[4]

The Government (in the Issues Paper) equated fairness, affordability, efficiency and financial sustainability to schemes which were designed to:

"1. enhance NSW workplace safety by preventing and reducing incidents and fatalities;

2. *contribute to the economic and jobs growth, including for small businesses, by ensuring that premiums are comparable with other states and there are optimal insurance arrangements;*
3. *promote recovery and the health benefits of returning to work;*
4. *guarantee quality long term medical and financial support for seriously injured workers;*
5. *support less seriously injured workers to recover and regain their financial independence;*
6. *reduce high regulatory burden and make it simple for injured workers, employers and service providers to navigate the system; and*
7. *strongly discourage payments, treatments and services that do not contribute to recovery and return to work."*

As at December 2011, the second biggest contributor to the outstanding claims liability was medical expenses.

The Government identified as a potential cause of high medical expenses was that in NSW "workers compensation insurers must meet the cost of all medical and related treatment provided to injured workers, with no cap on cost or duration, provided the treatment relates to a work injury. Treatment costs are met after retirement age", recognising that 'most other schemes cap medical treatment and related treatment expenses by duration or cost'.[5]

The Government proposed 2 options for change:

1. Cap medical coverage *duration* – the rationale provided was that there was no cap on medical and related treatment expenses and "*many workers have access to medical treatment many*

[1] Issues Paper Op Cit, page 5
[2] Ibid, page 4
[3] Ibid, page 5
[4] Ibid, page 6
[5] Ibid, pages 18-19

years after their date of injury".[6]

2. Strengthen regulatory framework for health providers – ensure that the resources are directed to 'evidence based treatments with proven health and return to work outcomes for injured workers rather than on costs that maintain dependency'.

The Issues Paper also canvassed the introduction of step downs to the weekly payments regime and capping *weekly payments duration.*

During the Inquiry by the Joint Select Committee[7] concerns were raised about the rising medical costs in NSW resulting in upward pressure on premium costs, continuation of an upward trend in excess of inflation and the high expenditure of the Scheme on medical treatment and rehabilitation for workers. [8]

The absence of a 'cap' was noted by various stakeholder groups and a suggestion was made to the Inquiry that "the ongoing provision of medical treatment without a cap has at times been misused by some service providers who may propagate a slow recovery and return to work".[9]

In response to the proposal to cap medical coverage duration, the Joint Select Committee noted the duration caps on medical expenses in other jurisdictions and that a conservative position 'must be taken at the present time' given the Scheme's poor financial position, and commented:

> *"The WorkCover scheme should provide a level of reasonable coverage of medical and related treatment, but it is not unreasonable that that coverage be proximate to the date of injury and time off work by the worker. Australia has a comprehensive safety net of medical and hospital coverage for all Australians under Medicare. Injured workers whose workers compensation medical benefits expire after a time cap are not suddenly put on the 'scrap heap'. They will enjoy the benefits of the Medicare system like everyone else, including those whose serious accidents were never covered by any accident compensation scheme (e.g. because they were not in a motor accident or they were outside the work place) and those born with serious disabilities."*

The recommendation made by the Committee was:

> **Recommendation 9**
> That the NSW Government seek to amend the *Workers Compensation Act 1987* to cap reasonable and necessary medical and related treatment expenses to those incurred whilst weekly benefits are paid and for one year after the cessation of those payments

The Committee were careful to recommend exclusion of 'seriously injured workers' from the operation of any duration cap on medical expenses.[10]

The Amending Act introduced substantial amendments to the medical expenses arrangements in the 1987 Act by Schedule 4:

- Introducing Section 59A – Limit on payment of compensation (cap on *duration)*
- Amending section 60 requiring pre-approval of certain treatments or services and providing for conditions for pre-approval and service provision and exemptions therefrom.
- Amending section 61 - Rates applicable for medical or related treatment
- Amending section 63A - Rates applicable for workplace rehabilitation services

The second reading speech recorded the following:

> *"Medical expenses have been an area of increasing cost to the workers compensation scheme. Under the bill payment of an injured worker's expenses for medical, hospital and rehabilitation*

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6 Ibid, Option

7 Joint Select Committee Inquiry into the New South Wales Workers' Compensation Scheme 2012, Report No 1 – 13 June 2012

8 Ibid, paragraphs 2.82-2.84, page 24

9 Ibid, paragraph 2.85 and Submission 142, Australian Industry Group.

10 Ibid, Recommendation 2: That the NSW Government ensure that, under the Workers Compensation Scheme, any time cap on payment of weekly income benefits and medical expenses (apart from the Commonwealth retirement age) not apply to appropriately defined severely injured workers.

> *services will be limited to a 12 month period after the claim is made or 12 months after weekly payments cease, whichever is the earlier. However, consistent with the Government's objective of directing workers compensation benefits to the most serious injured workers, workers with a permanent incapacity of more than 30 per cent will not be subject to the new restrictions for medical and related expenses. They will continue to be eligible for benefits for medical and related treatment until retirement age. An employer's liability for medical and related treatment and rehabilitation services will be made subject to preconditions to ensure that the treatment is appropriate and properly provided and approved. WorkCover guidelines will be able to limit an employer's liability for medical and hospital treatment and rehabilitation services."*

The provisions have now been in place for over 2.5 years. The drafting of the legislation (and not the policy) has caused and continues to cause disputes because of the uncertainty about what it actually means.

There was an appreciation by November 2013 that there was an emerging problem as the legislation required treatment to have been undertaken within the time limit. It was apparent that workers who had received approval for medical treatment could not be guaranteed of the treatment being available prior to the first major cut-off point. In recognition, the Government introduced a Regulation on 20 December 2013[11] however that assisted only those workers who were informed about it and were able to take advantage of the change given the time of year.

Further remedial subordinate legislation [12] was introduced in June 2014 affecting only 'existing claims'[13] which exempted such claims from the operation of section 59A by imposing a threshold of greater than 20% permanent impairment and excluding compensation for certain artificial aids and members and compensation payable in respect of modification of a worker's home or vehicle.

This change was also of very limited application because the claim that was exempted from the time limit was one which had to have been made before 1 October 2012 and still be unresolved almost two years later.

The Statutory Review[14] of the Scheme which reported in June 2014 considered that the amendments introduced greater discipline in the system. However, the report identified that the '12 month cap':

- had the potential to impose a challenge to injured workers who required continuous funding of medical expenses beyond the entitlement period particularly where funding in alternative systems was inadequate, and
- had the potential to disadvantage workers who may benefit from conservative treatment where a 'wait and see' approach was more suitable, and with conditions where the natural history of the resolution of the condition indicated a greater than 12 month period.[15]

Further, the report identified a potential 'unintended consequence' of the amendments that workers may be *"**disincentivised** to return to work for the purpose of extending the time in which medical benefits were payable"*.[16] This is of particular concern given one of the specific functions of the WorkCover Authority is to "to **identify** (**and facilitate or promote the development of programs that minimise or remove) disincentives** for injured workers to return to work or for employers to employ injured workers, or both"[17]

The Statutory Review considered that the pre-approval process may lead to potentially costly delays in 'treatment outcomes' particularly where the approval was delayed by the engagement of independent

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11 Workers Compensation Amendment (Medical Expenses) Regulation 2013
12 Workers Compensation Amendment (Existing Claims) Regulation 2014
13 Existing claim means a claim for compensation in respect of an injury made before 1 October 2012.
14 Statutory review of the Workers Compensation Legislation Amendment Act 2012, The Centre for International Economics, prepared for the Office of Finance and services 30 June 2014.
15 Ibid, page 59
16 Ibid
17 Section 23(1)(f) of the 1998 Act: Specific Functions [of the Authority]

medical examiners. *"This is particularly detrimental where early treatment is required to maximise recovery/function and/or minimise treatment costs".*[18]

In the Upper House Review of the Exercise of the Functions of the WorkCover Authority[19] discussion of the fairness of the new provisions was extensive. The cessation of medical benefits after 12 months was described as "unfair", "harsh and unjust", "artificial and arbitrary". The Committee observed the findings of the Statutory Review[20] of the Scheme, particularly that the 12 month cap on duration of medical expenses *"…has the potential to disadvantage patients that may benefit from conservative treatment of certain conditions including spinal, shoulder and some other known regions, where a 'wait and see' approach is more suitable."*

The Committee requested that the Scheme Actuary calculate the cost to the Scheme of removal of the cap for categories of injured worker. Noting that the Government had introduced some changes to the medical expenses regime, the Committee commented:

> *We acknowledge that the Minister for Finance and Services has recently announced the extension of medical benefits for workers with whole person impairment assessments of between 21 and 30 per cent, until retirement age for injured workers who made claims prior to 1 October 2012. We consider that this decision goes some way towards restoring the balance between financial sustainability of the scheme and providing enhanced support for injured workers*.[21]

Regrettably the amending Regulation did not achieve this result.

Notably the Committee did not consider the validity of introducing 'impairment thresholds' for the purpose of distinguishing who is deserving of access to reasonably necessary medical treatment.

In relation to the requirement for pre-approval of all but essential medical services the Committee noted:

> *"The Committee is of the view that requiring insurer approval before the costs of a medical treatment are incurred is not an unreasonable expectation. However, we firmly believe that insurers must provide a decision regarding treatment as soon as practicable to ensure that injured workers are able to promptly access the necessary treatment to assist them in their rehabilitation in most instances. However there are clearly cases where this is not practical or reasonable and there should be some flexibility built into the system to accommodate this… The committee encourages WorkCover to be more vigilant in enforcing this aspect of the workers compensation scheme, and intend to keep a watching brief on this issue."*

The Standing Committee made the following relevant recommendations:

> **Recommendation 6**
>
> That the NSW Government restore lifetime medical benefits for hearing aids, prostheses, home and vehicle modifications for *all injured worker* [emphasis added], noting the actuarial evidence as to the relatively minimal cost of restoring such benefits to the workers' compensation scheme, and that it promptly review the viability of restoring all lost medical benefits for injured workers under the scheme.
>
> **Recommendation 7**
>
> That the NSW Government consider amendments to the WorkCover scheme to allow for the payment of medical expenses where, through no fault of the injured worker, it was not

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18 Ibid

19 Standing Committee on Law and Justice, Review of the Exercise of the Functions of the WorkCover Authority Report 54 – September 2014

20 Statutory review of the Workers Compensation Legislation Amendment Act 2012, The Centre for International Economics, prepared for the Office of Finance and services 30 June 2014.

21 Standing Committee on Law and Justice, Review of the Exercise of the Functions of the WorkCover Authority, OP CIT, at paragraph 4.49.

reasonable or practical for the worker to obtain pre-approval of medical expenses before undertaking the treatment.

Interpretation of the application of the time caps of section 59A remains unresolved. In *Flying Solo Properties Pty Limited v Collett*, Deputy President Roche commented of section 59A:

> *"in the vast majority of cases, where workers' entitlements to weekly compensation are uncertain and disputed, the provision will create great* ***uncertainty****,* ***unnecessary litigation****, and, potentially,* ***considerable hardship*** *while parties fight about whether compensation was paid or payable and whether, and, if so, when, the worker's entitlement to weekly compensation ceased. It is clearly a provision that is in need of urgent reform.*[22]

The Principles

The principles which inform policy on medical expenses compensation appear to be:

- To provide prompt treatment of injuries (Section 3 of the 1998 Act)
- To provide medical assistance and rehabilitation support to restore the health of an injured worker
- To support a quick, safe and durable return to work
- To promote recovery of health at work
- To meet the medical and treatment needs of injured workers with ongoing need for support to return to work
- To discourage payments, treatments and services that do not contribute to recovery and return to work.

Legislation impacted

The 1987 Act provides for medical, hospital and rehabilitation expenses ("etc") to be met in Division 3 of Part 3 "Compensation – Benefits". The Division encompasses sections 59 to 64A.

Section 41 of the 1987 Act contemplates weekly payments for "injury related surgery" in certain circumstances.

The 1998 Act contains certain provisions related to the provision of medical treatment: Sections 50, 279 and 280.

What are 'Medical services'?

Section 60(1) provides that the employer is to pay for:

- Medical or related treatments (other than domestic assistance)
- Hospital treatments
- Ambulance services
- Workplace rehabilitation services
- Related travel expenses and interpreter services[23]

'Hospital treatments', 'medical or related treatments' and 'workplace rehabilitation services' are defined in the Act.[24]

Establishing liability

It has been stated that to establish liability under section 60, three conditions must be satisfied:

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22 [2015] NSWWCCPD 14 at paragraph 77.
23 Section 64A of the 1987 Act.
24 Section 59 of the 1987 Act

1. That the worker received an injury to which employment was a substantial contributing factor
2. That the relevant treatment or expense was 'as a result of' that injury; and
3. That the treatment was reasonably necessary.[25]

Reasonably necessary

Treatments or services must be ***reasonably necessary*.** [26]

What is reasonably necessary has been determined by the Compensation Court of NSW and the Workers Compensation Commission.

Dealing with the precursor section in the *Workers Compensation Act 1926* (section 10, which relevantly incorporated 'reasonably necessary' with medical treatment), Burke J after discussing "*appropriate*" and "*necessary*"[27] stated relevantly:

> *"In determining whether a particular regimen is medical treatment and whether it is **reasonably necessary** that such be afforded to a worker and that such necessity results from injury, it appears to me some general principles can be stated:*
>
> *1. Prima facie, if the treatment falls within the definition of medical treatment in section 10(2), it is relevant medical treatment for the purposes of this Act. Broadly then, treatment that is given by, or at the direction of, a medical practitioner or consists of the supply of medicines or medical supplies is such treatment.*
>
> *2. However, though falling within that ambit and thereby presumed reasonable, that presumption is rebuttable (and there would be an evidentiary onus on the party seeking to do so). If it be shown that the particular treatment afforded is not appropriate, is not competent to alleviate the effects of injury, then it is not relevant treatment for the purposes of the Act.*
>
> *3. Any necessity for relevant treatment results from the injury where its purpose and potential effect is to alleviate the consequences of injury.*
>
> *4. It is reasonably necessary that such treatment be afforded a worker if this Court concludes, exercising prudence, sound judgment and good sense, that it is so. That involves the Court in deciding, on the facts as it finds them, that the particular treatment is essential to, should be afforded to, and should not be forborne by, the worker.*
>
> *5. In so deciding, the Court will have regard to medical opinion as to the relevance and appropriateness of the particular treatment, any available alternative treatment, the cost factor, the actual or potential effectiveness of the treatment and its place in the usual medical armoury of treatments for the particular condition*."

In *Bartolo v Western Sydney Area Health Service* 14 NSWCCR 233 (3 February 1997) then dealing with section 60 (pre 2012 reforms, but in the same terms as the present section) Burke J considered that:

> *"The question is should the patient have this treatment or not. If it is better that he have it, then it is necessary and should not be forborne. If in reason it should be said that the patient should not do without this treatment, then it satisfies the test of being reasonably necessary."*

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[25] Roche DP in *Bielecki v Rianthelle Pty Ltd [2008] NSW WCC PD 53* cited in Mills Workers Compensation, Lexis Nexis, [WCA 60.1]

[26] Section 60(1) of the 1987 Act

[27] *Rose v Health Commission (NSW)* (1986) 2 NSWCCR 32: *"A particular course is "appropriate" when it is expedient, desirable, opportune or meet; where it tends to promote a desired objective; where it is fit and suitable for a particular purpose; where it is proper in all the circumstances. A particular course is "necessary" where it is indispensable, requisite, essential, imperative, mandatory or obligatory; where it cannot be foregone."*

Most recently, Deputy President Roche (in the Workers Compensation Commission) stated:

> "*reasonably necessary does not mean "absolutely necessary"…If something is necessary, in the sense of indispensable it will be "reasonably necessary". That is because reasonably necessary is a lesser requirement than "necessary". Depending on the circumstances, a range of different treatments may qualify as "reasonably necessary" and a worker only has to establish that the treatment claimed is one of those treatments. A worker does not have to establish that the proposed treatment is the "optimal treatment" before it can be held to be reasonably necessary."*[28]

'Causation'

The Australian Medical Association (AMA) have repeatedly raised that 'causation' is an issue which is properly resolved by the medical profession and not the legal profession. The medical profession oft refers to the mal alignment between the Motor Accidents CTP Scheme in NSW and the Workers Compensation Scheme in NSW applauding the Motor Accidents scheme for permitting the medical profession to 'determine causation' and criticising the Workers Compensation Scheme for permitting causation to be determined 'by the legal profession'. For example,

> *Dr GLIKSMAN: That is a separate issue to the causation one. I think if this Committee does nothing else but address the causation issue and bring about an alignment between workers compensation and the Motor Accidents Authority it will have done a great service to the State.*[29]

This illustrates a perceived confusion between the 2 Schemes and also the many concepts of 'causation'.

The AMA5 Guides[30] notes that there are multiple meanings of 'causation' and carefully distinguishes between "medical or scientifically based causation" which "requires a detailed analysis of whether 'the factor could have caused the condition, based upon scientific evidence and, specifically, experienced judgement as to whether the alleged factor in the existing environment did cause the permanent impairment" and" the legal standard for causation in civil litigation and in workers' compensation adjudication" which varies from jurisdiction to jurisdiction and which calls on an independent arbiter to determine a question of fact.[31]

Medical opinion providers are required to express expert opinions applying their expert based on a set of facts. The medical profession are not the 'finder of fact'. This point of view is implicit in the Court of Appeal decision in *Makita (Australia) Pty Ltd v Sprowles [2001] NSWCA 305*: *"so far as the opinion is based on facts "observed" by the expert, they must be identified and admissibly proved by the expert, and so far as the opinion is based on "assumed" or "accepted" facts, they must be identified and proved in some other way; it must be established that the facts on which the opinion is based form a proper foundation for it; and the opinion of an expert requires demonstration or examination of the scientific or other intellectual basis of the conclusions reached: that is, the expert's evidence must explain how the field of "specialised knowledge" in which the witness is expert by reason of "training, study or experience", and on which the opinion is "wholly or substantially based", applies to the facts assumed or observed so as to produce the opinion propounded."*

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28 *Tray Fit Pty Ltd v Cairney* [2015] NSWWCCPD 2, at paragraph 60.

29 Evidence of Dr M Gliksman before the Joint Select Committee Inquiry into the NSW Workers Compensation Scheme, Monday 28 May 2012, page 5 Corrected Transcript (https://www.parliament.nsw.gov.au/prod/parlment/committee.nsf/0/3669d4dd25549a10ca257a0d001e86ba/$FILE/120528%20Corrected%20transcript__1.pdf)

30 American Medical Association Guides To the Evaluation of Permanent Impairment, 5th edition (AMA5 Guides)

31 AMA5 Guides Chapter 1.6, Causation, Apportionment, Analysis, and Aggravation

Pre-approval

Medical treatments or services require the **prior approval** of the insurer[32] otherwise, except in certain circumstances, the employer is not liable to pay. However, treatment provided within 48 hours of the injury happening and treatment or services which are exempt under the WorkCover Guidelines[33] are excluded from the requirement for prior insurer approval.[34]

There is no standardised form for a worker to request pre-approval of medical treatment. As a consequence treatment can be delayed and workers become anxious and traumatised with continued delay. This creates an unnecessary burden on claims officers. A simple process (Request for Medical Treatment form) would assist in reducing time spent in obtaining necessary information from treating doctors and the confusion and anxiety around the approval process.

One of the issues which insurers face is the failure by the medical profession to identify the precise treatment being proposed and the reasons why it should be considered as reasonably necessary. This in turn causes further delay and emotional distress. The implementation of a process through insurers would alleviate much of the delay.

There are instances of insurers delaying approval because of a lack of a proper process by which the insurer is accountable which in turn prevents the worker from accessing paid treatment through the effluxion of time. Delays in approval are often created by insurers seeking medical information from treatment providers or alternatively seeking 'independent medical opinions' as to whether the proposed treatment is reasonably necessary. There appears to be no legislative warrant for the seeking of independent medical opinions in these circumstances.

The Claims Guidelines do not prescribe a process for seeking pre-approval nor do they direct insurers as to how to evaluate requests for treatment. Without such a process it is difficult to ensure quick and prompt treatment to an injured worker.

There are examples where claimants in recent disputes in the Workers Compensation Commission have received a declaration that their treatment was reasonably necessary but by the time the decision is made, they are outside the timeframe during which the insurer can be ordered to pay for the treatment.

Exemptions to pre-approval

The treatments or services exempted from pre-approval are identified in the Claims Guidelines[35] and include services provided within the first 48 hours on injury. The exempted treatments or services include *limited* services provided by:

- General practitioners (nominated treating doctor)
- Specialists
- Pharmacy items (for a limited period and/or limited cost)
- Plain x rays
- Public hospital presentations at emergency
- Physiotherapists, osteopaths, or chiropractors
- Psychology treatment or counselling
- Remedial Massage
- Hearing needs assessments

The exemptions also include treatment or services provided to an injured worker:

[32] Section 60(2A)(a) of the 1987 Act
[33] WorkCover Guidelines for Claiming Compensation Benefits - September 2013, amended 6 February 2015, Chapter 3 ("Claims Guidelines")
[34] Section 60(2A) of the 1987 Act
[35] Claims Guidelines, Chapter 3.

- where liability has been initially declined but where the Workers Compensation Commission 'finds for the worker on liability' and it is agreed the treatment or service provided was reasonably necessary, or
- any treatment or service provided where there is a dispute about whether the treatment or service is reasonably necessary where the Workers Compensation Commission finds that the treatment provided was reasonably necessary.

These exemptions are predicated upon the treatment or service having been undertaken and (presumably) paid for.

More recently, by way of regulation, expenses paid for crutches, artificial members, eyes or teeth and other artificial aids or spectacles (including hearing aids and batteries) and any expenses for home or vehicle modification during the period 1 October 2012 to 3 September 2014 have been exempted from pre-approval (presumably restricted to 'existing claims'). This has limited application.

Notably, what is not excluded from pre-approval are medical treatments or services provided in emergency circumstances (other than within the first 48 hours following injury). This can result in consolidated revenue meeting the cost of medical treatments and services which should properly be met by the Workers Compensation Scheme.

Other restrictions on payment of medical and treatment expenses

Other restrictions imposed on the provision of medical treatment are contained in sub-sections 60(2A)(b), (c) and (d) of the 1987 Act. They provide that the worker's employer is not liable to pay the cost of any treatment or service (or related travel expenses) if:

- the treatment or service is given or provided by a person who is not appropriately qualified to give or provide the treatment or service, or
- the treatment or service is not given or provided in accordance with any conditions imposed by the WorkCover Guidelines on the giving or providing of the treatment or service, or
- the treatment is given or provided by a health practitioner whose registration as a health practitioner under any relevant law is limited or subject to any condition imposed as a result of a disciplinary process, or who is suspended or disqualified from practice.

The WorkCover Claims Guidelines require that an insurer approve the payment of reasonably necessary services "*once the need for treatment has been justified in a report or a treatment plan which specifies the services proposed, the anticipated outcome, duration, frequency and the cost of the service.*"[36]

The Claims Guidelines provide that if there is **insufficient or inadequate information** upon which to make a **soundly based decision**, further information should be requested from the treatment provider. Failing this, insurers/agents are directed to obtain an 'independent opinion'.

Neither 'soundly based decision' or 'independent opinion' is defined in the Claims Guidelines.

Delay in pre-approval

Delay in providing pre-approval for medical treatment or services can result in a number of poor outcomes:

- Treatment not being provided at the *optimal time*
- Delay in return to work whilst treatment is being sought
- slower recovery
- extension of rehabilitation periods

[36] Claims Guidelines Chapter 2.7.2.

- extension of the period a worker is away from work
- Cost shifting to the public purse increased financial burden on an injured worker.

Delay in pre-approval coupled with the delay in making a "claim for medical expenses compensation" may result in an injured worker exhausting a period of at least 12 months in establishing the elements that would lead to the insurer meeting their medical and treatment costs.

Delay in the giving of pre-approval was acknowledged by both the Statutory Review of the Workers Compensation Legislation Amendment Act 2012 and the Upper House Inquiry into the Functions of the WorkCover Authority as detrimental to the operation of the scheme and productive of "outcomes that detract from the spirit of the objectives".

Time frames for claims for medical expenses

Section 279 of the 1998 Act contemplates a period of 21 days 'after a *claim for medical expenses compensation*' is made within which liability must be accepted or disputed.

Provisional Liability

Section 280 of the 1998 Act provides for payment of medical expenses compensation up to $7,500 on the basis of provisional acceptance of liability.

A "claim" for medical expenses compensation

The Claims Guidelines contemplate that a 'claim for medical expenses' can be an injury notification (through the insurer's injury notification system and where provisional liability payments have commenced) or a 'claim form'[37].

The Guidelines require a claim form to be provided if a 'reasonable excuse notice' has been issued (to avoid provisional liability payments), compensation is claimed beyond the provisional liability limit (currently $7,500) or an injury notification is made but there is "insufficient information to determine liability".

Disputes over 'small claims'

A dispute concerning the payment of medical expenses compensation for less than $7,500 can be resolved through the expedited assessment process in the Workers Compensation Commission. Section 297 of the 1998 Act provides that an 'interim payment direction' for payment of the expenses is warranted where the Registrar of the Commission is satisfied that the treatment or service is reasonably necessary:

> (a) to prevent deterioration of the worker's condition, or
>
> (b) to promote an early return to work, or
>
> (c) to relieve significant pain or discomfort, or
>
> (d) for such other reason as may be prescribed by the regulations.

This is a very expensive method of resolving minor disputes.

Disputes generally

A dispute concerning liability for medical expenses compensation falls within the jurisdiction of the Workers Compensation Commission.

[37] Claims Guidelines, Op cit, Chapter 2.1 and 2.2

Section 60(5) of the 1987 Act provides;

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

Section 60(5) was introduced in 2010 to ensure that injured workers, who do not have the financial capacity to pay for medical treatment themselves (and then pursue reimbursement), can approach the Commission for a decision "*about whether treatment requested, but not yet received, is reasonably necessary, medically appropriate and in the best interests of the injured worker*".[38]

The subsection **mandates** referral to medical assessment in a dispute about **future or proposed** treatment.[39] The Court of Appeal per Leeming ACJ said at [22] "*The ordinary literal meaning of "Any such dispute" is that it means every such dispute, and not merely disputes confined to particular issues (such as causation). The grammatical meaning of s 60(5) is unambiguous".*

The time taken to resolve such disputes can result in the resolution and determination being made after the expiry of the 12 month period proposed in section 59A discussed below.

Section 60(5) contains a regulation making power which has not been enacted to cure the difficulties associated with delay in outcomes occasioned by the mandatory nature of the referral and the 12 month cap. Section 60(5) would operate more favourably to provide quick outcomes if the referral to medical assessment was discretionary rather than mandatory.

Medical Assessment

in addition to disputes about future or proposed treatment being referred for medical assessment, section 321 of the 1998 Act provides for other 'medical disputes' to be referred for "medical assessment".

Section 319 of the 1998 Act defines a "**medical dispute**" as:

> *"a dispute between a claimant and the person on whom a claim is made about any of the following matters or a question about any of the following matters in connection with a claim:*
>
> *(a) the worker's condition (including the worker's prognosis, the aetiology of the condition, and the treatment proposed or provided),*
>
> *(b) the worker's fitness for employment,*
>
> *(c) the degree of permanent impairment of the worker as a result of an injury,*
>
> *(d) whether any proportion of permanent impairment is due to any previous injury or pre-existing condition or abnormality, and the extent of that proportion,*
>
> *(e) the nature and extent of loss of hearing suffered by a worker,*
>
> *(f) whether impairment is permanent,*
>
> *(g) whether the degree of permanent impairment of the injured worker is fully ascertainable.*

Part 7, Chapter 7 of the 1998 Act provides the set of rules regarding medical assessments .

There can be only one medical assessment made of an injured workers degree of permanent impairment.[40] A medical dispute about the degree of permanent impairment of worker as a result of an injury cannot be referred for or be the subject of assessment if a medical dispute about that matter has

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[38] The Hon Dr Andrew McDonald, MP, introducing the *Workers Compensation Legislation Amendment Bill 2010* as cited in *Tolevski v Zanardo and Rodriguez Sales and Service Pty Limited* [2013] NSWWCCPD 9 (28 February 2013)

[39] As interpreted by the Court of Appeal in *Zanardo and Rodriguez Sales and Service Pty Limited v Tolevski [2013] NSWCA 449*

[40] Section 322A(1) of the 1998 Act

already been the subject of assessment and the subject of a medical assessment certificate. However, the one assessment for permanent impairment 'rule' does not affect appeals against medical assessments.[41]

The one assessment 'rule' for permanent impairment 'rule' appears to affect an injured worker's ability to assert entitlement to any benefit where there is an impairment threshold imposed, such as exemption from section 59A for seriously injured workers or for existing claims. The assessment conducted for the purpose of the threshold determination may not be appropriate for the claiming of permanent impairment compensation. For example, an injured worker who seeks to be considered as a seriously injured worker for the purpose of being exempted from the 12 month cap on medical treatment may wish to assert that status to access medical treatment but may not wish to pursue permanent impairment compensation until some future time.

The status of a medical assessment conducted under Part 7, Chapter 7 the 1998 Act is that the certificate is conclusively presumed to be correct in relation to medical disputes about the degree of permanent impairment of a worker (section 319(c)) and those disputes outlined section 319 (d), (e), (f) and (g). In relation to medical disputes of any other kind, including disputes about future treatment, the medical assessment certificate is evidence, but not conclusive evidence, in any proceedings taken regarding that dispute.[42]

The 12 month duration cap – the operation of section 59A

Section 59A of the 1987 Act provides**:**

> **Limit on payment of compensation**
>
> (1) Compensation is not payable to an injured worker under this Division in respect of any treatment, service or assistance given or provided more than 12 months after a claim for compensation in respect of the injury was first made, unless weekly payments of compensation are or have been paid or payable to the worker.
>
> (2) If weekly payments of compensation are or have been paid or payable to the worker, compensation is not payable under this Division in respect of any treatment, service or assistance given or provided more than 12 months after the worker ceased to be entitled to weekly payments of compensation.
>
> (3) If a worker becomes entitled to weekly payments of compensation after ceasing to be entitled to compensation under this Division, the worker is once again entitled to compensation under this Division but only in respect of any treatment, service or assistance given or provided during a period in respect of which weekly payments are payable to the worker.
>
> (4) This section does not apply to a seriously injured worker (as defined in Division 2).

Commencement of the 12 months

– **Where no weekly payments are paid or payable[43]**

The 12 months commences when a 'claim for compensation' was first made. The date of the 'claim for compensation' may or may not be the date of injury. [44]

- The 12 months ceases 12 calendar months after the claim for compensation was first made
- The treatment must *be provided* within the 12 month period.

[41] Section 322A(4) of the 1998 Act
[42] Section 326(2) of the 1998 Act
[43] This can be because there is no incapacity for work, or alternatively, there is incapacity but as a consequence of the operation of the weekly payments provisions and calculation of weekly payment entitlements, no weekly payments are payable.
[44] There is considerable confusion already created by the use of the phrase 'claim for compensation' within the Act.

'Claim for compensation' is not defined in the Acts and could be interpreted to be a claim specifically for medical expenses compensation, or a claim for 'any ' compensation or a claim form or injury notification.

- **Where weekly payments are or have been paid or payable**

The operation of section 59A is tied to when weekly payments are '*or have been paid or payable'*. The 12 months commences 'after the worker ceased to be entitled to weekly payments of compensation'.

There is serious doubt about whether the 12 months commences when the worker '**first'** ceases to be entitled to weekly payments, or at some other time, for example at the end of a subsequent period of weekly payments or at the notional end of the second entitlement period (an aggregated 5 years of weekly payments). This has for the time being been resolved by the *Collett*[45] decision which is authority for the proposition that the time commences when weekly payments *first cease* regardless of whether there are numerous sporadic periods of weekly payments or one period of weekly payments.

Argument has focussed on the meaning of 'payable' and whether 'payable' includes future weekly payments, and 'entitled'.

In ***Flying Solo Properties Pty Limited v Matthew Collett*** [2015] NSWWCCPD 14, DP Roche said:

> *"[the] submission that the words "unless weekly payments of compensation are or have been paid or payable to the worker" in s 59A(1) includes potential payments into the future cannot be accepted. That is because the sub-section does not talk about the potential entitlement to weekly compensation in the future. It deals with the period 12 months after the claim for compensation in respect of the injury was first made. Moreover, the entitlement periods defined in s 32A, upon which the Arbitrator relied, only establish periods during which weekly compensation might be "paid or payable". Merely because the entitlement periods have not expired does not establish that weekly compensation is in fact "payable" in that period."*
>
> *"The entitlement periods merely identify periods during which an entitlement to weekly compensation may arise. They direct attention to the method to be used to determine a worker's actual entitlement, if one exists, in each particular period. If a worker's claim for weekly compensation is in the "first entitlement period", that is, the first 13 weeks, one applies one of the four formulas in s 36. If a claim for weekly compensation is in the "second entitlement period", that is, 117 weeks after the expiry of the first entitlement period, one applies one of the six formulas in s 37. Different provisions apply after the expiration of the second entitlement period (see s 38). If the correct application of the relevant formula results in a worker having no entitlement to weekly compensation, no such compensation is "payable".* [46]
>
> "*…[W]eekly compensation is "payable", within the meaning of s 59A, when a worker has an entitlement to actually receive such compensation by reason of a compensable work injury."*[47]
>
> …"*[W]hether a worker is "entitled" to weekly compensation at any particular time, that is, whether weekly compensation is "payable", will depend on the application of the legislation to the particular worker's circumstances. A worker is not "entitled" to weekly compensation just because the entitlement periods have not expired."*[48]

- **Revival of the right to medical expenses compensation: does the 12 months revive?**

Support for the proposition that the 12 month period commences after the worker *first* ceased to receive weekly payments is garnered from Section 59A(3). The section provides for revival of the right to have medical treatment paid but only in respect of any treatment, service or assistance "given or provided during" the period when weekly compensation is "payable" to the worker. Section 59A(3) does not

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45 *Flying Solo Properties Pty Limited v Matthew Collett* [2015] NSWWCCPD 14
46 *Collett* at 57 - 58
47 *Collett* at 59
48 *Collett* at 63

reinvigorate the 12 month period, but merely provides that medical expenses compensation is payable during a period of further weekly payments.

Payment of medical and treatment expenses outside the 12 month 'cap': Section 59(3): chicken or egg?

59(3) provides for treatment expenses to be paid outside the 12 month period and is activated under 2 conditions (which are not mutually exclusive):

- after the 12 month period anticipated in sub sections 1 or 2 has ceased, and
- the worker becomes entitled to weekly payments.

The treatment must be **provided or given** during that period of weekly payments. This is the 'chicken or egg' provision.

The tethering of section 59(3) to weekly payments by requiring the treatment to be 'provided or given' during the weekly payment period makes the subsection practically unworkable. Treatment has to be rendered whilst the worker receives the weekly payments and the weekly payments provision will be enlivened by the incapacity caused by the treatment.

The process is commonly frustrated by workers not taking time off work until such time as their treatment, for example surgery, is programmed. Programming of the treatment requires the insurer to pre-approve the treatment and schedule the treatment to coincide with time away from work.

Essentially, this requires the worker to then seek payment at the cost of the public purse (resulting in further delays) and seek reimbursement for treatment after it occurs. This forces cost shifting and is counterintuitive to the key objectives of the scheme.

Perversely, this section can have the effect of worker not returning to work as quickly as possible in order to preserve their medical treatments for as long as possible. This is particularly so where the injury calls for a conservative treatment plan before a more interventionist or surgical approach (for example, knee and shoulder injuries, back injuries).

'Given or provided'

Section 59A is drafted in such a way that the treatment must be '*given or provided'* within the 12 month period.

This artificially narrows '12 month cap on medical treatment' by virtue of the service having to be given within the 12 months and unfairly restricts the treatment period particularly where a claim for a specific treatment or service is declined or liability is declined.

The requirement that the treatment must be given or provided within the 12 months severely restricts the worker's opportunity for treatment.

There are many instances of insurers delaying approval which in turn prevents the worker from accessing paid treatment through the effluxion of time.

The medical profession have criticised the arbitrariness of the 12 month cap for either forcing workers to rush treatments that would benefit from delay and timing and foregoing a conservative approach to often riskier treatments (for example, spinal surgery), or ignoring best practice clinical protocols in relation to treatment.

Options for treatment where time expires through delay occasioned by declination of liability

Where the claim for medical treatment is declined or liability is declined the worker can either:

- Undergo the medical treatment at their own cost or on the 'public purse' and seek to recover the cost through proceedings in the Workers Compensation Commission
- Not undergo the treatment and seek a determination of the dispute through the Workers Compensation Commission

The tribunal of fact must decide first the issues in contention which may be injury, causation and whether the proposed treatment is (or was) reasonably necessary. Resolution of the dispute may occur well outside the 12 month period. On finding in favour of a worker there then must be consideration of an order to pay under 59A.

If a determination is made favourable to a worker beyond the expiry of the 12 month period, there is no mechanism for the treatment to be paid except that provided for in section 59(3). Compensation is 'not payable in respect of any treatment given or provided more than 12 months after' the claim is made (59A(1) and hence no order may be made requiring payment be made.

Exemptions from the 12 month cap

Exemptions to the 12 month cap in the legislation

Seriously injured workers (those with an impairment of greater than 30%) are exempt from the 12 month cap on the payment of medical expenses *for life*.[49]

The relationship between a need for medical treatment and impairment will be discussed below.

Exemptions to the 12 month cap in the Regulation gazetted in September 2014

The Minister on announcing *"Now that we have pulled the scheme out of Labor's deficit and returned it to surplus, we are in a position to better support the State's workers… we can make meaningful refinements to the Scheme that will better support injured workers"*[50], implemented the 2014 Existing Claims Regulation[51] amending Schedule 8 of the *Workers Compensation Regulation 2010,* which amendments came into force in September 2014.

The amended Regulation provides (retrospectively):

> *28 (1) An existing claim **is exempt** from the operation of section 59A (Limit on payment of compensation) of the 1987 Act in respect of the following compensation until the injured worker reaches retiring age:*
>
> *(a) compensation payable to an injured worker under Division 3 of Part 3 of the 1987 Act if the worker's injury has resulted in permanent impairment **of greater than 20%,***
>
> *(b) compensation payable in respect of the provision of crutches, artificial members, eyes or teeth and other artificial aids or spectacles (including hearing aids and hearing aid batteries),*
>
> *(c) compensation payable in respect of the modification of a worker's home or vehicle.*
>
> *(2) A worker's injury is considered to have resulted in permanent impairment of greater than 20% only if the injury has resulted in permanent impairment and:*
>
> *(a) the degree of permanent impairment has been assessed for the purposes of Division 4 of Part 3 of the 1987 Act to be greater than 20%, or*

[49] Section 59A(4) of the 1987 Act
[50] Minister for Finance and Services, Dominic Perrottet MP, Media Release Thursday 26 June 2014
[51] Workers Compensation Amendment (Existing Claims) Regulation 2014 amending Schedule 8 of the *Workers Compensation Regulation 2010.*

(b) an assessment of the degree of permanent impairment is pending and has not been made because an approved medical specialist has declined to make the assessment on the basis that maximum medical improvement has not been reached and the degree of permanent impairment is not fully ascertainable, or

Note : *Paragraph (b) no longer applies once the degree of permanent impairment has been assessed.*

(c) the insurer is satisfied that the degree of permanent impairment is likely to be greater than 20%.

29 (1) An existing claim is exempt from the operation of section 59A (Limit on payment of compensation) of the 1987 Act in respect of compensation for the cost of ***secondary surgery****.*

(2) Surgery is ***secondary surgery*** *if:*

(a) the surgery is directly consequential on earlier surgery and affects a part of the body affected by the earlier surgery, and

(b) the surgery is approved by the insurer within 2 years after the earlier surgery was approved (or is approved later than that pursuant to the determination of a dispute that arose within that 2 years).

(3) This clause does not affect the requirements of section 60 of the 1987 Act (including, for example, the requirement for the prior approval of the insurer for secondary surgery).

Note. This clause only creates an exception from section 59A of the 1987 Act in respect of compensation for secondary surgery that would have been payable (had it not been for section 59A) as part of the original claim for compensation. It does not relate to surgery for an injury that gives rise to a separate claim for compensation.

'Existing claim' means a claim for compensation in respect of an injury made before 1 October 2012.

This means that the exemption only applies to the particular claim made before 1 October 2012. It does not refer to claims made after that date in respect to an injury incurred before that date.

The amendments operate to create 2 types of exemptions:

- Exemptions based on *type* of medical treatment or service:
    - Exempt existing claims from the 12 month cap on the provision of crutches, artificial members, eyes or teeth and other artificial aids or spectacles (including hearing aids and hearing aid batteries) but only to *retirement age*; and
    - Exempt existing claims from the 12 month cap for 'secondary surgery' upon condition that the secondary surgery is claimed within 2 years after the earlier surgery.
- Exemptions based on impairment threshold
    - Exempt workers injured before 1 October 2012 with a greater than 20% impairment but only to retirement age.

In the matter of *Anderson v Canada Bay City Council* [2014] NSWWCC 424*,* the applicant sought approval for knee replacement surgery outside the 12 month period. The Arbitrator accepted a submission that "*the replacement of the knee does include replacement of part of a limb and in the context of the provision of benefits to the worker for reasonably necessary medical expenses, should be considered to be an "artificial member" for the purpose of cl 28(1)(b).*"

The restriction of these exemptions to retirement age is troublesome given that many surgeries and treatments will be delayed until the 6th and 7th decade, or are considered in best clinical practice terms as better delayed, and many aids require continuous adjustment or replacement over time well beyond retirement age (hearing aids, batteries, prostheses, artificial aids).

Impairment as a determinant for medical treatment

The NSW Workers Compensation Scheme now uses permanent impairment evaluations as a threshold for determining access to various types of benefits. This has been discussed earlier in relation to *Weekly Payments*.

With the 2012 reforms, for the first time, impairment evaluation is introduced as the threshold for determining access to ongoing medical treatment and weekly payments of compensation. Specifically, workers with an impairment of greater than 30% whole person impairment are said to be able to access medical treatment expenses for life. Workers with an impairment of greater than 20% whole person impairment injured prior to 1 October 2012 are able to access medical treatment expenses to retirement age.

In NSW, permanent impairment is assessed for *"the purposes of awarding a lump sum payment under the statutory benefits of the NSW Workers Compensation Scheme and also for determining access to Common Law, domestic assistance and commutation of claims.*" [52]

Since 1 January 2002 impairment has been assessed by application of the WorkCover Guides for the Evaluation of Permanent Impairment (WorkCover Guides), currently in its third edition, which relies in the main on the American Medical Association Guides to the Evaluation of Permanent Impairment 5th Edition ('AMA5' Guides).

The AMA5 Guides define **impairment** as *"a loss, loss of use, order arrangement of any body part, organ system, or organ function*."[53] AMA 5 Guides nowhere indicate that impairment can or should be used as a determinant for continuing medical treatment.

Statements contained within the WorkCover Guides for the Evaluation of Permanent Impairment make it clear that impairment measures are not intended to be a basis for assessing access to medical treatment:

> *1.21 Assessments are only to be conducted when the medical assessor considers that the degree of permanent impairment of the injured worker is fully ascertainable. The permanent impairment will be fully ascertainable where the medical assessor considers that the person has attained maximum medical improvement. This is considered to occur when the worker's condition has been medically stable for the previous three months and is unlikely to change by more than 3%WPI in the ensuing 12 months with or without further medical treatment (ie further recovery or deterioration is not anticipated).*
>
> *1.23 If the claimant has been offered, but refused, additional or alternative medical treatment that the assessor considers is likely to improve the claimant's condition, the medical assessor should evaluate the current condition, without consideration of potential changes associated with the proposed treatment. The assessor may note the potential for improvement in the claimant's condition in the evaluation report, and the reasons for refusal by the claimant, but should not adjust the level of impairment on the basis of the worker's decision.*
>
> *1.24 Similarly, if a medical assessor forms the opinion that the claimant's condition is stable for the foreseeable future, but that it is expected to deteriorate in the long term, the assessor should make no allowance for this deterioration, but note its likelihood in the evaluation report. If the claimant's condition deteriorates at a later time, the claimant may re-apply for further evaluation of the condition.*
>
> *1.40 As previously indicated, where a claimant has declined treatment which the assessor believes would be beneficial, the impairment rating should be neither increased nor decreased.*

[52] WorkCover Guidelines for the Evaluation of Permanent Impairment 3rd Edition, which are based on the American Medical Association Guides to the Evaluation of Permanent Impairment 5th Edition, paragraph 1.4.

[53] AMA 5 Guides To The Evaluation Of Permanent Impairment, Chapter 1.2a

Permanent impairment evaluation as a means of determining access to medical treatment is not supported by the medical profession or the accepted professional methodologies of evaluating impairment and should be discouraged.

Interaction between section 41 ('special compensation) and 59A(3)

Section 41 of the 1987 Act provides that a worker who suffers "incapacity from **injury related surgery**" after the 'second entitlement period', that is, after 130 weeks of weekly payments (aggregated, not consecutive), is entitled to "*special compensation"*[54].

Injury related surgery is **surgery** which is undertaken in the course of medical treatment provided as a result of the **initial injury**.

The provision of special (weekly) compensation is dependent on the surgery being related to the injury. The surgery would have to meet the conditions of being reasonably necessary. The payment of special compensation is not dependent on the payment for the treatment being made by the insurer.

In fact, there may be circumstances where the injured worker will not be entitled to payment for the surgery contemplated by section 41, noting that section 59A(3) provides:

> *If a worker becomes entitled to weekly payments of compensation after ceasing to be entitled to compensation under this Division, the worker is once again entitled to compensation under this Division but only in respect of any treatment, service or assistance given or provided during a period in respect of which weekly payments are payable to the worker.*

Injury Management Plans

Section 50 of the 1998 Act provides that the payment of the cost of treatment of an injured worker can be provided for in an *Injury Management Plan (IMP).*

"Injury management" is defined in the 1998 Act as *"the process that comprises activities and procedures that are undertaken or established for the purpose of achieving a* ***timely, safe and durable return to work*** *for workers following workplace injuries".*

An IMP is a plan for *"co-ordinating and managing those aspects of injury management that concern the treatment, rehabilitation and retraining of an injured worker, for the purpose of achieving a timely, safe and durable return to work for the worker. An injury management plan can provide for the treatment, rehabilitation and retraining to be given or provided to the injured worker."*

Where the cost of specified treatment[55] is provided for in an IMP, for the **purposes of payment** *"it does not matter that the worker has not made a claim for compensation, the insurer has not accepted liability in respect of the injury or the insurer disputes liability in respect of the injury*".

The intent of the section is that workers will be able to undertake treatment to achieve a ***timely, safe and durable return to work*** without the unnecessary continuous intervention of bureaucratic process (reds tape).

The difficulty with section 50 of the 1998 Act is that the opportunity for 'pre-approval of a treatment plan is not referred to anywhere in section 59A of the 1987 Act or in section 60. It must be assumed that if the cost of the treatment and treatment proposal is noted in an IMP then the pre-approval requirements are met. However, the fact that an IMP refers to a specific course of treatment does not excuse that treatment from the section 59A caps.

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[54] Section 41(1) of the 1987 Act

[55] Section 50(1)(b) of the 1998 Act provides for specification by reference to such factors as the kind of treatment, the identity of the health care professional who provides the treatment, and the circumstances in which the treatment is provided.

IMPs are not often used to their full potential to advance the purpose of section 50(1)(b). The IMPs are used more as a 'tracking device' for the progress of a worker meeting their Chapter 3 'Work Injury Management' obligations rather than a short cut to pre-approval of specific medical treatments.

Workplace rehabilitation services

s.60(1) contemplates a workplace rehabilitation service as a medical expense. Rehabilitation services are thus subject to the restrictions in section 60(2A) as to pre-approval. The return to work plan for a worksite can obligate the provision of rehabilitation or vocational retraining as can an injury management plan. The exemptions to pre-approval (expressed in Part 3 of the Claims Guidelines) do not include rehabilitation services prescribed as part of a RTW Plan or IMP. Similarly, rehabilitation and vocational retraining is subject to the s. 59A restrictions (the 12 month restriction).

Aging Workers

Workers who are injured close to retirement age are disadvantaged by the 12 month cap in that their entitlement to weekly compensation ceases on retirement age and therefore the 12 months of medical treatment concludes exactly one year after retirement age.[56]

Summation

The 2012 reforms saw the implementation of new policy on medical treatment in the workers compensation scheme, the introduction of a 12 month cap on the payment for medical treatment and the use of impairment evaluation to determine exemptions from the cap.

These policy initiatives were coupled with the requirement for pre-approval of most medical treatments or services before incursion of the treatment and 'special compensation'.

The unintended consequences of the legislative framing of the cap (section 59A) is that workers with a legitimate need for medical treatment as a result of a workplace injury are being refused treatment. Even when the treatment is proven to meet the requirements of the legislation there is no means of enforcing payment by the insurer.

In turn, this results in workers being prevented from remaining at work or in delays in return to work (often after periods of return to work).

The 2014 regulatory changes do not 'fix the problem' but rather create further problems, most notably reliance on impairment evaluation to justify exemption from the harshness of the cap.

Legislative redrafting can ameliorate some of these unintended consequences. It is preferable that there be further discussion with a view to a reformulation of policy in relation to the scheme meeting medical and treatment expenses for injured workers.

Solutions

Re Section 59A:

1. Extend the operation of the *Workers Compensation Amendment (Existing Claims) Regulation 2014* [especially Schedule 8, Part 2, R 28(1)] to all claims by amendment of the legislation (currently applies to existing claims only: cf definition of 'existing claims' in 1998 Act).
2. Extend the exemption provided in Clauses 28 and 29 of Schedule 8 of the Regulation for 'life'.
3. Clarify 'claim for compensation' or prescribe that time runs from the date the first claim for medical expenses or treatment is made.

[56] *Air Electrical Pty Ltd t/as DJ Staniforth & Co v Mortimer* [2015] NSWWCCPD 18

4. Replace the requirement that the treatment be provided or given within the 12 months period with a requirement that the '*claim for medical expenses compensation*' is to be made within the 12 months - as an example :

   *Section 59A(1) "Compensation is not payable to an injured worker under this Division in respect of any treatment, service or assistance **for which a claim is made** more than 12 months after a claim for compensation in respect of the injury was first made, unless weekly payments of compensation are or have been paid or payable to the worker."*

5. Amend section 59A(2) to clarify from when the 12 months commences:

   *Section 59A(2) "If weekly payments of compensation are or have been paid or payable to the worker, compensation is not payable under this Division in respect of any treatment, service or assistance **for which a claim is made** more than 12 months after the worker **last** ceased to be entitled to weekly payments of compensation."*

6. Delete the words "*but only in respect of treatment… weekly payments are payable to the worker"* from section 59A(3).

7. There should be a general exception to the cap on duration of medical treatment to cover:

   a. Reasonably necessary surgery (to promote return to work)

   b. Treatment required to ensure the worker *remains at work* or is *capable of returning to work*

   c. Essential services to ensure that the worker's health or ability to undertake the necessary activities of daily living does not significantly deteriorate

8. Consider a 6 year ultimate cap on medical and treatment expenses (seriously injured workers and those with an impairment of greater than 20% excluded).

Pre-Approval of medical treatment

9. Provide a defined and easier path for pre-approval of specific treatments and courses of treatment including post-operative treatment plans in accordance with clinical practice thereby avoiding unnecessary and repeated requests for pre-approval.

10. Add to the exemptions to pre-approval those services provided on emergency admission to hospital (outside the first 48 hours after injury).

Generally

11. Amend Section 60(5) to make the referral to medical assessment discretionary rather than mandatory.

12. For the purpose of exempting those with an impairment of greater than 20% and seriously injured workers from the 12 months cap:
    a. Provide an eligibility test permitting impairments from all injuries to be aggregated

    b. Provide that a worker who meets the eligibility test does not impact premiums

    c. Provide that the Nominal Insurer meet the medical and treatment expenses

13. Medical treatment and service providers should be clearly informed of the duration cap (expiry date for payment of medical treatment in advance and the grounds, if any for provision of services beyond that date)

14. Consider a reformulation of policy in relation to the payment of medical and treatment expenses for injured workers particularly the 12 months cap and the reliance on impairment evaluation to determine access to benefits.

ANNEXURE C

NSW legislation

Results: Document Types="*Acts*, *Regulations*, *EPIs*", Search In="*All Content*", Exact Phrase="*provisional*", Point In Time="*01/07/2024*" match 15 of 398 provisions

Workplace Injury Management and Workers Compensation Act 1998 No 86

Current version for 1 July 2024 to date (accessed 14 May 2025 at 12:13)

Chapter 7 > Part 7 > Section 319

Part 7 Medical assessment

319 Definitions

In this Act—

medical dispute means a dispute between a claimant and the person on whom a claim is made about any of the following matters or a question about any of the following matters in connection with a claim—

(a) the worker's condition (including the worker's prognosis, the aetiology of the condition, and the treatment proposed or provided),

(b) the worker's fitness for employment,

(c) the degree of permanent impairment of the worker as a result of an injury,

(d) whether any proportion of permanent impairment is due to any previous injury or pre-existing condition or abnormality, and the extent of that proportion,

(e) the nature and extent of loss of hearing suffered by a worker,

(f) whether impairment is permanent,

(g) whether the degree of permanent impairment of the injured worker is fully ascertainable.

320 (Repealed)

321 Referral of medical dispute for assessment

(1) A medical dispute (other than a dispute concerning permanent impairment of an injured worker) may be referred for assessment under this Part by a court, the Commission or the President, either of their own motion or at the request of a party to the dispute. The President is to give the parties notice of the referral.

(2) The parties to the dispute may agree on the medical assessor who is to assess the dispute but if the parties have not agreed within 7 days after the dispute is referred, the President is to choose the medical assessor who is to assess the dispute.

(3) The President may arrange for a medical assessor to assess the dispute outside the State—

(a) if requested by a party to the dispute, or

(b) with the consent of the parties to the dispute.

(4) In deciding whether to make an arrangement under subsection (3), the President must consider the following—

(a) the interests and wishes of the parties to the dispute,

(b) the nature and complexity of the dispute,

(c) if the arrangement is necessary for the timely and cost effective assessment of the dispute,

(d) other matters the President considers relevant.

321A Referral of medical dispute concerning permanent impairment

(1) The regulations may make provision for or with respect to—

(a) the circumstances in which a medical dispute concerning permanent impairment of an injured worker is authorised, required or not permitted to be referred for assessment under this Part, and

(b) the giving of notice of a referral to the parties to the dispute.

(2) Without limiting subsection (1), the regulations may provide that a medical dispute may not be referred for assessment under this Part if the dispute concerns permanent impairment of an injured worker where liability is in issue and has not been determined by the Commission.

(3) A medical dispute concerning permanent impairment of an injured worker that is authorised or required by the regulations to be referred for assessment under this Part may be referred by a court, the Commission or the President, either of their own motion or at the request of a party to the dispute.

322 Assessment of impairment

(1) The assessment of the degree of permanent impairment of an injured worker for the purposes of the Workers Compensation Acts is to be made in accordance with Workers Compensation Guidelines (as in force at the time the assessment is made) issued for that purpose.

(2) Impairments that result from the same injury are to be assessed together to assess the degree of permanent impairment of the injured worker.

(3) Impairments that result from more than one injury arising out of the same incident are to be assessed together to assess the degree of permanent impairment of the injured worker.

Note—

Section 65A of the 1987 Act provides for impairment arising from psychological/psychiatric injuries to be assessed separately from impairment arising from physical injury.

(4) A medical assessor may decline to make an assessment of the degree of permanent impairment of an injured worker until the medical assessor is satisfied that the impairment is permanent and that the degree of permanent impairment is fully ascertainable. Proceedings before a court or the Commission may be adjourned until the assessment is made.

322A One assessment only of degree of permanent impairment

(1) Only one assessment may be made of the degree of permanent impairment of an injured worker.

(1A) A reference in subsection (1) to an assessment includes an assessment of the degree of permanent impairment made by the Commission in the course of the determination of a dispute about the degree of the impairment that is not the subject of a referral under this Part.

(2) The medical assessment certificate that is given in connection with that assessment is the only medical assessment certificate that can be used in connection with any further or subsequent medical dispute about the degree of permanent impairment of the worker as a result of the injury concerned (whether the subsequent or further dispute is in connection with a claim for permanent impairment compensation, the commutation of a liability for compensation or a claim for work injury damages).

(3) Accordingly, a medical dispute about the degree of permanent impairment of a worker as a result of an injury cannot be referred for, or be the subject of, assessment if a medical dispute about that matter has already been the subject of—

(a) assessment and a medical assessment certificate under this Part, or

(b) a determination by the Commission under Part 4.

(4) This section does not affect the operation of section 327 (Appeal against medical assessment) or 352 (Appeal against decision of Commission constituted by non-presidential member).

323 Deduction for previous injury or pre-existing condition or abnormality

(1) In assessing the degree of permanent impairment resulting from an injury, there is to be a deduction for any proportion of the impairment that is due to any previous injury (whether or not it is an injury for which compensation has been paid or is payable under Division 4 of Part 3 of the 1987 Act) or that is due to any pre-existing condition or abnormality.

(2) If the extent of a deduction under this section (or a part of it) will be difficult or costly to determine (because, for example, of the absence of medical evidence), it is to be assumed (for the purpose of avoiding disputation) that the deduction (or the relevant part of it) is 10% of the impairment, unless this assumption is at odds with the available evidence.

Note—

So if the degree of permanent impairment is assessed as 30% and subsection (2) operates to require a 10% reduction in that impairment to be assumed, the degree of permanent impairment is reduced from 30% to 27% (a reduction of 10%).

(3) The reference in subsection (2) to medical evidence is a reference to medical evidence accepted or preferred by the medical assessor in connection with the medical assessment of the matter.

(4) The Workers Compensation Guidelines may make provision for or with respect to the determination of the deduction required by this section.

(5) (Repealed)

Note—

Section 68B of the 1987 Act makes provision for how this section applies for the purpose of calculating workers compensation lump sum benefits for permanent impairment and associated pain and suffering in cases to which section 15, 16, 17 or 22 of the 1987 Act applies.

324 Powers of medical assessor on assessment

(1) The medical assessor assessing a medical dispute may—

(a) consult with any medical practitioner or other health care professional who is treating or has treated the worker, and

(b) call for the production of such medical records (including X-rays and the results of other tests) and other information as the medical assessor considers necessary or desirable for the purposes of assessing a medical dispute referred to him or her, and

(c) require the worker to submit himself or herself for examination by the medical assessor.

(2) If a worker refuses to submit himself or herself for examination by the medical assessor if required to do so, or in any way obstructs the examination—

(a) the worker's right to recover compensation with respect to the injury, or

(b) the worker's right to weekly payments,

is suspended until the examination has taken place.

(3) This section extends to the assessment of a medical dispute in the course of an appeal or further assessment under this Part.

(4) A medical assessor hearing the appeal or who is assessing the matter by way of further assessment has all the powers of a medical assessor under this section on an assessment of a medical dispute.

325 Medical assessment certificate

(1) The medical assessor to whom a medical dispute is referred is to give a certificate (a ***medical assessment certificate***) as to the matters referred for assessment.

(2) A medical assessment certificate is to be in a form approved by the President and is to—

(a) set out details of the matters referred for assessment, and

(b) certify as to the medical assessor's assessment with respect to those matters, and

(c) set out the medical assessor's reasons for that assessment, and

(d) set out the facts on which that assessment is based.

(3) If the President is satisfied that a medical assessment certificate contains an obvious error, the President may issue, or approve of the medical assessor issuing, a replacement medical assessment certificate to correct the error.

(4) A medical assessor is competent to give evidence as to matters in a certificate given by the assessor under this section, but may not be compelled to give evidence.

326 Status of medical assessments

(1) An assessment certified in a medical assessment certificate pursuant to a medical assessment under this Part is conclusively presumed to be correct as to the following matters in any proceedings before a court or the Commission with which the certificate is concerned—

(a) the degree of permanent impairment of the worker as a result of an injury,

(b) whether any proportion of permanent impairment is due to any previous injury or pre-existing condition or abnormality,

(c) the nature and extent of loss of hearing suffered by a worker,

(d) whether impairment is permanent,

(e) whether the degree of permanent impairment is fully ascertainable.

(2) As to any other matter, the assessment certified is evidence (but not conclusive evidence) in any such proceedings.

327 Appeal against medical assessment

(1) A party to a medical dispute may appeal against a medical assessment under this Part, but only in respect of a matter that is appealable under this section and only on the grounds for appeal under this section.

(2) A matter is appealable under this section if it is a matter as to which the assessment of a medical assessor certified in a medical assessment certificate under this Part is conclusively presumed to be correct in proceedings before a court or the Commission.

(3) The grounds for appeal under this section are any of the following grounds—

(a) deterioration of the worker's condition that results in an increase in the degree of permanent impairment,

(b) availability of additional relevant information (but only if the additional information was not available to, and could not reasonably have been obtained by, the appellant before the medical assessment appealed against),

(c) the assessment was made on the basis of incorrect criteria,

(d) the medical assessment certificate contains a demonstrable error.

(4) An appeal is to be made by application to the President. The appeal is not to proceed unless the President is satisfied that, on the face of the application and any submissions made to the President, at least one of the grounds for appeal specified in subsection (3) has been made out.

(5) If the appeal is on a ground referred to in subsection (3) (c) or (d), the appeal must be made within 28 days after the medical assessment appealed against, unless the President is satisfied that special circumstances justify an increase in the period for an appeal.

(6) The President may refer a medical assessment for further assessment under section 329 as an alternative to an appeal against the assessment (but only if the matter could otherwise have proceeded on appeal under this section).

Note—

Section 329 also allows the President to refer a medical assessment back to the medical assessor for reconsideration (whether or not the medical assessment could be appealed under this section).

(7) There is to be no appeal against a medical assessment once the dispute concerned has been the subject of determination by a court or the Commission or agreement registered under section 66A of the 1987 Act.

(8) Clause 2 of Schedule 2 to the *Legal Profession Uniform Law Application Act 2014* applies to and in respect of the provision of legal services in connection with an appeal under this section in the same way as it applies to and in respect of the provision of legal services in connection with a claim or defence of a claim for damages referred to in that clause.

Note—

Clause 2 of Schedule 2 to the *Legal Profession Uniform Law Application Act 2014* prohibits a law practice from providing legal services in connection with a claim or defence unless a legal practitioner associate responsible for the provision of those services believes, on the basis of provable facts and a reasonably arguable view of the law, that the claim or defence has reasonable prospects of success.

328 Procedure on appeal

(1) An appeal against a medical assessment is to be heard by an Appeal Panel constituted by 3 persons chosen by the President as follows—

(a) 2 medical assessors,

(b) 1 member of the Commission who is a member assigned to the Workers Compensation Division of the Commission.

(2) The appeal is to be by way of review of the original medical assessment but the review is limited to the grounds of appeal on which the appeal is made.

(2A) To avoid doubt, any medical re-examination of the worker for the purposes of the review need not be conducted by all of the members of the Appeal Panel if the members agree for it to be conducted by only some of the members.

(3) Evidence that is fresh evidence or evidence in addition to or in substitution for the evidence received in relation to the medical assessment appealed against may not be given on an appeal by a party to the appeal unless the evidence was not available to the party before that medical assessment and could not reasonably have been obtained by the party before that medical assessment.

(4) When attending an Appeal Panel for the purposes of an assessment, an injured worker is entitled to be accompanied by a person (whether or not a legal adviser or agent) to act as the injured worker's advocate and assist him or her to present his or her case to the Appeal Panel.

(5) The Appeal Panel may confirm the certificate of assessment given in connection with the medical assessment appealed against, or may revoke that certificate and issue a new certificate as to the matters concerned. Section 326 applies to any such new certificate.

(6) The decision of a majority of the members of an Appeal Panel is the decision of the Appeal Panel.

329 Referral of matter for further medical assessment or reconsideration

(1) A matter referred for assessment under this Part may be referred again on one or more further occasions for assessment in accordance with this Part, but only by—

(a) the President as an alternative to an appeal against the assessment as provided by section 327, or

(b) a court or the Commission.

(1A) A matter referred for assessment under this Part may be referred again on one or more further occasions by the President to the medical assessor for reconsideration.

(2) A certificate as to a matter referred again for further assessment or reconsideration prevails over any previous certificate as to the matter to the extent of any inconsistency.

330 Costs of medical assessment

(1) The costs of medical assessments under this Part (including the remuneration of medical assessors) are payable by the employer or insurer, except as otherwise provided by the regulations. The Authority may, for the purposes of meeting those costs, impose fees for the carrying out of medical assessments or make other arrangements for meeting those costs.

(2) If a worker is required to submit himself or herself for examination pursuant to this Part, the worker is entitled to recover from the worker's employer, in addition to any compensation otherwise provided—

(a) the amount of any wages lost by the worker by reason of so submitting himself or herself for examination, and

(b) the cost to the worker of any fares, travelling expenses and maintenance necessarily and reasonably incurred in so submitting himself or herself.

(3) If it is necessary for a worker to travel in order to submit himself or herself for examination but the worker is not reasonably able to travel unescorted, the fares, travelling expenses and maintenance referred to in this section include fares, travelling expenses and maintenance necessarily and reasonably incurred by an escort for the worker provided to enable the worker to submit himself or herself for examination.

(4) If the cost of fares, travelling expenses and maintenance referred to in this section includes the cost of travel by private motor vehicle, that cost is to be calculated at such rate as is fixed for the purposes of section 64 of the 1987 Act.

(5) A reference in this section to a medical assessment includes a reference to a further medical assessment and an appeal against a medical assessment.

331 Commission rules

Medical assessments, appeals and further assessments under this Part are subject to relevant provisions of the Commission rules relating to the procedures for the referral of matters for assessment or appeal, the procedure on appeals and the procedure for assessments.

ANNEXURE D

1 DEFINITIONS

1.1 Background

The 2012 amendments it would be fair to say were in part not considerate of the existing language of the Acts. The amendments (including more recent regulatory reform) in part utilised existing language and terms but also introduced new definitions for existing terminology. This has resulted in the inconsistent use of the same terms, language and expressions, lack of clarity around terminology and confusion leading in turn to unintended consequences of the reforms as the courts attempt to bring clarity to the meaning of the provisions.

As a consequence, the ineffective operation of the amendments has relied on the courts to assign meaning and interpretation to terms and concepts that previously were relatively clearly understood.

The most obvious example is “injury”. There have always been 2 definitions of injury – in the 1987 Act and the 1998 Act. The two Acts are to be read together. The definition of injury in the 1987 Act was amended as part of the 2012 Amending Legislation but was not so amended in the 1998 Act. The 1998 Act takes precedence in the event of conflict. The question to be asked is whether the 2012 amendments to the definition of injury apply?

The word “claim” The 2012 amendments relied on varying assignations of meaning which are not found within the Acts. Judicial interpretation has left 'claim' unresolved. Wherever it is used in the Acts there is now uncertainty as to its meaning in any particular context and ambiguity as to the purpose and intent of the legislation.

The Interpretation Act states simply:

> *“In the interpretation of a provision of an Act or statutory rule, a construction that would promote the purpose or object underlying the Act or statutory rule (whether or not that purpose or object is expressly stated in the Act or statutory rule or, in the case of a statutory rule, in the Act under which the rule was made) shall be preferred to a construction that would not promote that purpose or object.”*[1]

The Act encourages the Courts to consider extrinsic material (material not part of the Act) where that material is “*capable of assisting the ascertainment of the meaning of the provision*.” The material that may be considered includes:

> *(a) all matters not forming part of the Act that are set out in the document containing the text of the Act as printed by the Government Printer,*
>
> *(b) any relevant report of a Royal Commission, Law Reform Commission, committee of inquiry or other similar body that was laid before either House of Parliament before the provision was enacted or made,*
>
> *(c) any relevant report of a committee of Parliament or of either House of Parliament before the provision was enacted or made,*
>
> *(d) any treaty or other international agreement that is referred to in the Act,*
>
> *(e) any explanatory note or memorandum relating to the Bill for the Act, or any other relevant document, that was laid before, or furnished to the members of, either House of Parliament by a Minister or other member of Parliament introducing the Bill before the provision was enacted or made,*

[1] Section 33 of the *Interpretation Act 1987*(NSW)

(f) the speech made to a House of Parliament by a Minister or other member of Parliament on the occasion of the moving by that Minister or member of a motion that the Bill for the Act be read a second time in that House,

(g) any document (whether or not a document to which a preceding paragraph applies) that is declared by the Act to be a relevant document for the purposes of this section, and

(h) any relevant material in the Minutes of Proceedings or the Votes and Proceedings of either House of Parliament or in any official record of debates in Parliament or either House of Parliament. [2]

The High Court recently restated the 'basic' principles around statutory interpretation in *Certain Lloyd's Underwriters Subscribing to Contract No IH00AAQS v Cross* [2012] HCA 56:

> At 23: It is as well to begin consideration of this issue by re-stating some basic principles. It is convenient to do that by reference to the reasons of the plurality in *Alcan (NT) Alumina Pty Ltd v Commissioner of Territory Revenue [2011] NSWCA 136*:
>
> > *"This Court has stated on many occasions that the task of statutory construction must begin with a consideration of the text itself. Historical considerations and extrinsic materials cannot be relied on to displace the clear meaning of the text. The language which has actually been employed in the text of legislation is the surest guide to legislative intention. The meaning of the text may require consideration of the context, which includes the general purpose and policy of a provision, in particular the mischief it is seeking to remedy."*
>
> 24: The context and purpose of a provision are important to its proper construction because, as the plurality said in Project Blue Sky Inc v Australian Broadcasting Authority, "[t]he primary object of statutory construction is to construe the relevant provision so that it is consistent with the language and purpose of ***all*** the provisions of the statute" (emphasis added). That is, statutory construction requires deciding what is the legal meaning of the relevant provision "by reference to the language of the instrument viewed as a whole", and "the context, the general purpose and policy of a provision and its consistency and fairness are surer guides to its meaning than the logic with which it is constructed".
>
> 41: It is not legitimate to identify a legislative purpose not apparent from the text of the relevant provisions (or in this case even expressed in some extrinsic material), to examine extrinsic material and notice that there is nothing positively inconsistent with the identified purpose, and then to answer the question of construction by reference to the purpose that was initially assumed. That reasoning is not sound. It is reasoning of the kind of which Spigelman CJ rightly disapproved in the extra-curial writing set out earlier in these reasons. Statutory *"purpose"* and "*intention"* are to be identified according to the principles that were described earlier under the heading "Some basic principles".

It is telling that in much of the litigation around the confusing terminology in the Acts much time is spent discussing the "rules" of statutory interpretation and their application and exceptions. What was in the mind of the legislative drafters, what was the policy that underpinned the particular provision or term, when is use of one interpretative tool preferred over another?

The extent of the litigation which calls on the courts to interpret the language of the Acts has been profound and the outcomes often not consistent with the assumed 'correct' position: For example *Goudappel*[3].

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[2] Section 34 of the Interpretation Act 1987

[3] *Goudappel v Adco Constructions Pty Limited* [2013] NSWCA 94 (29 April 2013), *Adco Constructions Pty Limited v Goudappel* [2014] HCA 18 (16 May 2014)

For those who seek to exercise the function of insurer or manage claims and for those whose to assist injured workers receive the benefits they deserve the inherent confusion, inconsistency and ambiguity in the text, language and concepts in the Acts is a constant cause of frustration and consternation with the delay in coming to a final resting point and a defined outcome.

1.2 Specific examples

1.2.1 "Injury"

The 2012 Amending legislation introduced a new definition of "injury" in the 1987 Act. As a consequence section 4 of the 1987 Act defines "injury" as follows:

> In this Act:
> **"injury":**
>
> (a) means personal injury arising out of or in the course of employment,
>
> (b) includes a "disease injury", which means:
>
> (i) a disease that is contracted by a worker in the course of employment but only if the employment was the main contributing factor to contracting the disease, and
>
> (ii) the aggravation, acceleration, exacerbation or deterioration in the course of employment of any disease, but only if the employment was the main contributing factor to the aggravation, acceleration, exacerbation or deterioration of the disease, and
>
> (c) does not include (except in the case of a worker employed in or about a mine) a dust disease, as defined by the *Workers' Compensation (Dust Diseases) Act 1942*, or the aggravation, acceleration, exacerbation or deterioration of a dust disease, as so defined.

Section 4 of the 1998 Act defines "injury":

> In this Act **"injury"**
>
> (a) means a personal injury arising out of or in the course of employment, and
>
> (b) includes:
>
> (i) a disease contracted by a worker in the course of employment, where the employment was a contributing factor to the disease, or
>
> (ii) the aggravation, acceleration, exacerbation or deterioration of any disease, where the employment was a contributing factor to the aggravation, acceleration, exacerbation or deterioration, but
>
> (c) does not include (except in the case of a worker employed in or about a mine):
>
> (i) a dust disease, or
>
> (ii) the aggravation, acceleration, exacerbation or deterioration of a dust disease.

The two Acts now have inconsistent definitions of a **disease** injury because of the failure to recognise that the structure of the Acts is such that they are to construed as if they formed part of the 1998 Act[4], and both Acts carried a definition of injury .

This 'error' is compounded by the fact that s.2A of the 1987 Act states "*in the event of an inconsistency between this Act and the 1998 Act, **the 1998 Act prevails** to the extent of the inconsistency".*

[4] Section 2A (2) of the 1987 Act

The 1998 Act (unamended in 2012) definition of a disease refers to contributing factor, whereas the 1987 Act (*amended in 2012)* of a disease refers to employment being the 'main contributing factor'. Section 9A qualifies that for an injury (other than a disease injury) employment must be a "*substantial contributing factor'.*

The new 'disease injury' definition affects 'older' workers whose injuries are predominantly an aggravation of age related processes affecting their spine. They must satisfy the more onerous definition. The definition is leading to more declinature of liability on the basis that the 'injury' can or should be categorised as a disease injury and therefore satisfy the higher onus.

1.2.2 "Claim"

The 2012 amendments make "claim" central. This represents a move away from the use of date of injury as a reference point for the operation of many of the provisions of the Acts. "Claim" is used in many ways and for many purposes. As a consequence of the confusion created by the many uses and interpretations of 'claim' the notion of claim requires recasting. Insert footnote [5]

Previously the 'claims process' described a continuum by which an injured worker could rely on a date of claim to assist in the determination of benefits. Successive reforms have removed any clarity over that process principally because the concept of making a claim has been removed from the 1998 Act and referred to the Claims Guidelines. The 1998 Act now states that *"a claim must be made in accordance with the applicable requirements of the WorkCover Guidelines*". The WorkCover Guidelines may make provision for all with respect to the following matters in connection with the making of a claim:

(a) the form in which a claim is to be made,
(b) the manner in which a claim is to be made,
(c) the means by which a claim may be made,
(d) the information that a claim is to contain,
(e) requiring specified documents and other material to accompany or form part of a claim,
(f) such other matters as may be prescribed by the regulations.

The regulations deal with requirements in notifying the dispute but do not prescribe what is required to "make a claim".

By way of example: Consider what is meant by 'claim' in section 59A: '12 months after a *claim for compensation* in respect of the injury was first made'.

1.2.3 "Existing claim"

In 2014 the Workers Compensation Regulation was amended and another new term was introduced: "existing claim"[6]. The definition of "existing claim" in the Regulation contradicts an existing definition within Chapter 7 of the 1998 Act[7]. There now coexists to competing and inconsistent definitions of "existing claim". Whilst the definition in the 1998 Act will prevail, that definition does not lend itself to the purpose or meaning required of the Regulation.

1.2.4 Disease Injuries/Disease

The amended definition of "injury" in 1987 Act creates "disease injury" and requires employment to be a 'main contributing factor". The definition in the 1998 Act speaks of 'disease' as a sub category under the umbrella of "injury" and does not reflect the amendments to "main contributing factor.

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[5] . See *Ottomen Pty Limited ATF Labour ADM v Serge Ah-Lam Lee Chee* [2013] NSWWCCPD 42 (14 August 2013)
[6] Clause 25 of Schedule 8 of the *Workers Compensation Regulation* 2010, amended 3 September 2014
[7] Section 250(1) of the 1998 Act

1.2.5 Definition of Paramedic & Firefighter

Clause 25 in Part 19 H of Schedule 6 being the savings and transitional provisions in the 1987 act provides that:

> *The amendments made by the 2012 Amending Act do not apply to or in respect of an injury received by a police officer, paramedic or firefighter (before or after the commencement of this clause), and the Workers Compensation Acts (and the regulations under those Acts) apply to and in respect of such an injury as if those amendments had not been enacted.*

Neither Act provides a definition of either 'paramedic' or 'firefighter' hence it is unclear as to the extent of those workers who are exempt from the provisions of the 2012 amendments.

- **Firefighter**

In *Ware v NSW Rural Fire Service [2014] NSWCCPD 33* DP Roche stated:

> *"I have concluded that the legal meaning of firefighter corresponds with its normal grammatical (dictionary) meaning and there is nothing in the context, purpose or policy behind cl 25 that leads to a different conclusion. It follows that firefighter means "someone whose activity or employment is to extinguish fires, especially bushfires". As Mr Ware was employed as a mechanic, not a firefighter, he is only a firefighter, for the purposes of cl 25, when he is engaged in providing support at the fire front during a fire."*

In *The Australian Workers Union New South Wales v Office of the Environment and Heritage [2012] NSWIRComm 133* the union sought declaratory relief that certain employees employed in the Government Service in the Forestry Commission and National Parks and Wildlife be declared firefighters for the purpose of being exempted from the 2012 amendments to the Workers Compensation Acts.

Boland J, in the Industrial Relations Commission of NSW, found that persons employed by the Government of New South Wales who perform firefighting duties as part of their work for various government departments and whose employment is covered by various Crown Employees Awards, are "firefighters" for the purposes of clause 25 of Part 19H of Schedule 6 to the Workers Compensation Act 1987, provided that the Employees are only "firefighters" for such purposes whilst they are performing firefighting duties. His honour provided the definition of "firefighting duties".

- **Paramedic**

In *State of New South Wales v Stockwell [2015]NSW WCCPD 9* DP Roche stated:

> *[118 -] The reasoning in Ware is tolerably clear. In that case, I held (at [42]) that, in the absence of a definition of "firefighter", "firefighter" means, based on the dictionary definition, "someone whose activity or employment is to extinguish fires, especially bushfires". As Mr Ware was employed as a mechanic, not a firefighter, he was only a firefighter, for the purposes of cl 25, when he was engaged in providing support at the fire front during a fire.*
>
> *In the present case, if it is ultimately found that, at the time of the psychological injury, the appellant employed Mr Stockwell as a paramedic, then, regardless of the activities he was performing when he was injured, he is entitled to the exemption provided in cl 25. That follows from the clear terms of cl 25, which do not say that a paramedic is only exempt from the 2012 amendments if injured while administering emergency health care to a person in need of such care, or that a firefighter is only exempt if injured while actually fighting a fire, or that a police officer is only exempt while attempting to apprehend a dangerous offender."*

DP Roche observed that in *Stockwell*, the term "paramedic" was defined in the Ambulance Officers' Award, which the parties appear to have accepted governs the employment relationship between them. In that document, paramedic means*: "an employee who has successfully completed the necessary and relevant training and work experience as determined by the [Ambulance] Service to*

become a Paramedic and who is appointed to an approved Paramedic position. Provided that such an employee shall be required to undertake and successfully complete further instruction/in-service courses necessary for the maintenance of their clinical certificate to practice and the reissue of their clinical certificate to practice every three (3) years."

Absent a definition the anomalous situation arises when a trained paramedic may receive different benefits under a different regime (pre-2012 reform, post 2012 reform) depending on what specific activity he is engaged in at the time he receives injury.

The absence of a definition within the Act provides anomalous situations such as the factual circumstances in *Ware* – a mechanic whose duties are only directly related to firefighting for a very small proportion of the time. Similarly, employed paramedics required to perform purely administrative tasks could be found to not be 'paramedics' for the purpose of exempting them from the 2012 amendments. The anomaly is found in that worker sustaining injury whilst performing a specific duty that determines whether their claim is processed in accordance with the pre 2012 rules or post 2012 rules.

There are many workers who may be injured whilst carrying our firefighting duties but whose direct employment is not as a firefighter, for example forestry workers. Similarly there are many qualified paramedics who are required to perform duties of a purely administrative nature in their employment as a paramedic.

1.2.6 "Date of injury"

More certainty is required around "date of injury" similarly to the certainty required for "claim". Anomalies exist depending on when and injury occurred and when the 'claim was made'.

1.2.7 Definition of a "week"

What constitutes a week for the purposes of calculating pre-injury average weekly earnings and weekly compensation is not clear. "Week" is not defined in either the Acts or the Regulation. What constitutes a week or part of a week must be made clear.

1.2.8 Inconsistent terminology

There are many examples of similar but inconsistent terminology throughout the Acts. This appears to be as a consequence of a lack of rigour on the part of the draftpersons. Regardless, the use of dissimilar terminology to describe or define the same process creates further ambiguity and confusion.

- **'greater than' v 'more than'**

these 2 competing expressions are used to describe the threshold of degree of impairment. The choice of one or other of the expressions appears to be stylistic and not reflective of a different meaning or statutory purpose or intention.

Section 66(1) of the 1987 Act states:

> *A worker who receives an injury that results in a degree of permanent impairment **greater than 10%** is entitled to receive from the worker's employer compensation for that permanent impairment as provided by this section…*

Section 32A of the 1987 Act states:

> *seriously injured worker means a worker whose injury has resulted in permanent impairment and… the degree of permanent impairment has been assessed for the purposes of Division 4 to be **more than** 30%*

In contrast to section 32A, clause 25 of Part 2, Schedule 8 of the *Workers Compensation Regulation 2010,* introduced by regulation in 2014, states:

> *an existing claim is exempt from the operation of section 59A… If the worker's injury has resulted in permanent impairment of greater than 20%.*

The expressions are used interchangeably and one assumes have the same meaning. The expression "more than" is used in other contexts throughout the 1987 and 1998 Acts, viz:

- "more than"[8]
- "more than one…injury"[9]
- "more than one" (other than reference to injury)[10]

- **'At least' v 'Not less than'**

There is some ambiguity created by the use of these two expressions in the 1987 Act where 'not less than' is used as an absolute*: "not less than 15 hours per week*" "*not less than the required period of notice*" "*not less than 7 days*" .[11]

The expression "at least" is used as a minimum threshold: "*at least one of those other injuries*", "*at least $155 per week*", at "*at least once every 2 years*", "*at least 12 weeks*", "*permanent impairment of the worker of at least 15%*".[12]

- **"Lump sum" compensation v "Permanent Impairment" compensation**

Except for amendments to the savings and transitional provisions in Schedule 6 of the 1987 Act, the phrase "lump sum" is used throughout the 1987 Act to describe the manner in which compensation is payable on death or commutation. 'Permanent impairment' is employed in the 1987 Act as a descriptor of a benefit type (section 66 compensation payable in respect of permanent impairment, 'permanent impairment compensation').

The 2012 amendments include introduced into schedule 6 part 19 H in which clause 15, 'Lump sum compensation', employs the term "lump sum" in reference to claims for "permanent impairment compensation"[13].

The 1998 Act also employs the term 'lump sum' interchangeably with 'permanent impairment compensation' by defining in section 4 that "lump-sum compensation" means compensation under Division 4 (Compensation from Non-Economic Loss) of Part 3 of the 1987 Act [the provisions for permanent impairment compensation].

1.3 Harmonisation of the Workers Compensation Acts[14]

A history of successive amendments to the Acts since the 'split' of the Acts in 1998 have resulted in provisions of similar content and purpose being separated and placed in varying chapters and divisions of the two Acts.

A harmonisation process would result in **collocation** of provisions of similar purpose and a more fluid and purposeful order of provisions. A harmonisation process would clearly identify the rules that govern the scheme and present them in a cohesive and comprehensive manner.

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8 Sections 17, 32, 39, 40, 41, 40 4B, 52, 59A etc of the 1987 Act; Sections 4, 42, 40 8A, 261, 297 & Schedule 1 of the 1998 Act

9 Sections 17, 64, 65A of the 1987 Act; Sections 108 & 322 of the 1998 Act

10 Sections 9AA, 20, 150 A, 155, 156, 175, 170 5F, 175O, 175P 202A, 208, 239AG of the 1987 Act; Sections 39, 30 9A, 62, 107, 108 & 255 of the 1998 Act

11 Sections 37, 38, 41, 54, 141 and 239AG of the 1987 Act.

12 Section 22C, 38, 41, 54, 60AA, 65A, 87EA etc of the 1987 Act

13 Schedule 6 part 19 H clause 15: **Lump sum compensation** An amendment made by Schedule 2 to the 2012 amending Act extends to a claim for compensation made on or after 19 June 2012, but not to such a claim made before that date.

14 The *Workers Compensation Act 1987* and the *Workplace Injury Management and Workers Compensation Act 1998*

Issues with the current structure of the two Acts include:

- lack of consistency in drafting style leading to a competing expressions to describe or define the same thing
- anomalies between provisions and between Acts as a consequence of successive amendments to the Acts since 1998
- lack of coherence arising from illogical grouping of unrelated concepts
- scattering of related provisions throughout the Acts and between the Acts
- highly prescriptive provisions making it difficult to adapt to changing circumstances or conditions
- the significant body of guidance material which must be read in conjunction with the Acts to understand important obligations and processes
- a number of spent or obsolete provisions

The interrelationship between the two Acts is although well defined, counterintuitive, in that as a consequence of the subservience of the 1987 Act to the 1998 Act, some of the 2012 amendments may have no application.

The outsourcing of significant aspects of the Act to Guidelines and the complexity of the guidelines made under the Acts cause confusion and frustration for scheme participants

Harmonisation of the Acts may lead to:

- restructured and reordered provisions in a logical sequence (commencing with the most fundamental of issues);
- use of plain language;
- consistency of key terms such as “injury”, “claim”, “claim for compensation”, “existing claim”, and consistency of expressions such as “more than”, “greater than”, “at least”, “no less than”, incapacity and capacity, liability; and
- Removal of redundant and obsolete provisions

1.4 Recommendations/Solutions

1. There should be consistency of language, terminology and drafting throughout the legislation.
2. The legislation should be clear on its face as to its meaning and intention..
3. The structure of the Act(s) should reflect the practical operation of the Scheme.
4. Where possible there should be national consistency or harmony of definitions used in workers compensation legislation.
5. Consolidate terms and expressions used in the legislation to ensure consistency. For example “more than” and “greater than”.
6. Redraft existing provisions of the Acts to provide clarity and where possible, incorporate nationally consistent language.
7. Amalgamate the two Acts into one with the purpose of ensuring that the Act sets out the rules that govern the Scheme in a way that is comprehensive, coherent and readily understood by Scheme participants.