AMIC Australian Meat Industry Council

126

SUBMISSION TO

THE FINANCE AND ADMINISTRATION COMMITTEE

REVIEW OF THE QUEENSLAND WORKERS' COMPENSATION SCHEME

BY

THE AUSTRALIAN MEAT INDUSTRY COUNCIL

September 2012

1. THE TERMS OF THIS REVIEW

The Finance and Administration Committee (the Committee) of the Queensland Parliament has been asked by the Attorney-General to inquire into and report on the operation of Queensland's workers' compensation scheme under the *Workers Compensation and Rehabilitation Act 2003 (Qld)* (the Act).

The review occurs earlier than anticipated. For that, we are grateful.

In particular, the Committee is required to consider:

- *the performance of the scheme in meeting its objectives under section 5 of the Act;*
- *how the Queensland workers' compensation scheme compares to the scheme arrangements in other Australian jurisdictions;*
- *WorkCover's current and future financial position and its impact on the Queensland economy, the State's competitiveness and employment growth;*
- *whether the reforms implemented in 2010 have addressed the growth in common law claims and claims cost that was evidenced in the scheme from 2007-08;*
- *whether the current self-insurance arrangements legislated in Queensland continue to be appropriate for the contemporary working environment;*
- *in conducting the inquiry, the committee should also consider and report on implementation of the recommendations of the Structural Review of Institutional and Working Arrangements in Queensland's Workers' Compensation Scheme.*

Although there have been changes to the Queensland scheme over the last decade, it has been sometime since many employers (and their representative bodies in Queensland) have had to opportunity to voice their concerns publicly, in an open and transparent manner, on the matters listed for the Committee's consideration.

The Attorney-General noted the 'transparency' issue when announcing the review.

THE AUSTRALIAN MEAT INDUSTRY COUNCIL (AMIC)

This submission is filed by the AMIC.

About the AMIC

(i) The AMIC is registered as an employer organisation pursuant to the provisions of the Fair Work (Registered Organisations) Act 2009. It has been registered as an organisation under federal legislation since 1928. The AMIC is divided into Divisions Australia wide including the presence of a long standing Division in Queensland. Until just after the commencement of the Fair Work Act 2009 (Cth.), a branch of the AMIC was registered under Queensland legislation.

(ii) The AMIC represents the substantial majority of employers engaged in or in connection with all sectors of the meat industry across Australia. It is the peak meat industry body in Australia. The meat industry employs in excess of 70,000 persons across the states/territories of Australia.

(iii) The AMIC represents some of the largest meat industry establishments in the country with several thousands of employees as well as many entities that come within the definition of a 'small business' employer. The sectors where members operate include meat processing, meat manufacturing, wholesale, retail and all ancillary activities.

(iv) The AMIC is able to comment on workers compensation schemes Australia wide and provide relevant comments as to the views of employers.

Queensland AMIC members

(v) The AMIC services its members by, inter alia, representing them in courts and tribunals including Queensland courts and tribunals. Regularly, we are called upon to advise members in relation to issues concerning workers compensation and OH&S issues in Queensland. Regularly, we are called upon to deal with WorkCover Queensland on behalf of members.

(vi) AMIC is connected to the Queensland Country Meat Processors Association that regularly meets in regional Queensland representing members.

(vii) In Queensland, AMIC has a number of Queensland based members who self-insure under the workers' compensation scheme.

Note: We do not intend to make detailed comments in these submissions on point (vii) above other than to say that there is a case to be made that restrictions need to be relaxed including the 2000 employee limit. AMIC is aware that various submissions have been received by the Committee dealing with the issue of self insurance under the Queensland legislation compared to other state/federal systems.

3. THIS SUBMISSION – A SUMMARY

The views of AMIC members are important. Those views are the principal reason for this submission. They are 'grass root' views, including from regional Queensland. The views show continued frustration at the functioning of the workers' compensation system.

AMIC has not commented on every issue raised for consideration by the Attorney when establishing the Inquiry. Those we do raise, such as those below, are of serious concern.

1. When a worker submits a claim, the employer must be involved from the outset and totally involved in the process until completion – especially when a claim is submitted after the employment contract is terminated. The involvement must include liaison between the employer and the treating medical practitioner(s).

2. Apart from being reasonably compensated, the claimant (if still employed) must be speedily rehabilitated and be involved in the return to work program. This must be a primary objective of the scheme in these circumstances. In the experience of AMIC members, anyone who submits the scheme is working effectively in this regard is kidding or is so blinded by a vested interest. WorkCover Queensland needs to address procedural issues raised.

3. Other procedural deficiencies outlined need to be addressed.

4. WorkCover Queensland, being the administrator and adjudicator, needs to re-think the investigative process in dealing with claims.

5. Common law issues need to be, once again, addressed probably with the introduction of a threshold. It is unsatisfactory that a claimant has nearly unrestricted access to the courts for damages.

4. OTHER STATE/FEDERAL INQUIRIES

Over the past twelve years there have been public inquiries concerning various workers' compensation systems. On behalf of members, the AMIC made submissions to various inquiries reviewing workers compensation systems at both a national and State level.

Some of those inquiries:

(i) In 2002 the AMIC made submissions and appeared before a House of Representatives Standing Committee on Employment and Workplace Relations. The Committee's role was to inquire into various matters regarding the workers compensation schemes across Australia such as the incidence of fraudulent claims and fraudulent conduct in the systems as well as the adequacy, appropriateness and practicability of rehabilitation programs and their benefits. Many of the issues raised in the submissions remain unresolved and continue to exist. AMIC presented detailed examples in relation to the operation of system in Queensland: see references to AMIC (then known as NMAA) submissions in *Report on the Inquiry into aspects of Australian workers' compensation schemes, House of Representatives Standing Committee on Employment and Workplace Relations – June 2003.*

(ii) In 2003 the AMIC also made a written submission and appeared at a public hearing before the Productivity Commission for Inquiry into National Workers' Compensation and Occupational Health and Safety Frameworks. Again, the issues raised and reported are still relevant 8 years after the release of the final report: see *National Workers' Compensation and Occupational Health and Safety Frameworks, Productivity Commission, March 2004.*

Western Australia

(iii) In 2009 the then newly elected Barnett Government in Western Australia sought submissions on a number of specific issues concerning that state's workers' compensation system. The objective, in considering these issues, was to:

- Improve structure of legislation and readability
- Improve efficiency of legislation
- Address some anomalies
- Address some specific policy issues.

(iv) The AMIC made submissions which were based on a survey of WA members.

(v) Although the inquiry scope was limited, the WA Parliament did enact amendments to the WA legislation in 2011.

New South Wales

(vi) In May 2012 a New South Wales Parliamentary Committee was established to inquire into and report on the New South Wales Compensation Scheme. The Scheme in NSW has been in diabolical trouble for some years, both from an operational viewpoint and financially.

(vii) The relevant Minister published and Issues Paper in May 2012 and it is attached to this submission. We have attached the Paper (marked 'A') because it does make some comparisons between the various state schemes: see especially *section 1.7 - Key differences compared to schemes in other jurisdictions.*

(viii) Under the heading *'Why change is needed'* on page 29 of the Issues Paper the following comments were put forward for consideration:

".....The workers compensation system is a critical component of the NSW economy. It should not hinder productivity but should enhance the growth of jobs.

Workers compensation has to be affordable and efficient and allow New South Wales to be competitive with our most comparable States of Victoria and Queensland.

Employers and workers are entitled to expect a workers compensation system that is efficient, cost effective and offers fair, timely assistance to employers and workers..."

(ix) We emphasise, at this point, that the AMIC believes the quoted comments in paragraph (viii) above are relevant to Queensland.

(x) There were public hearings in NSW and the Committee tabled its final report on 13 June 2012. Amendments to the New South Wales legislation passed in Parliament. Attached and marked 'B' is a Facts Sheet prepared by 'WorkCover NSW' summarising the changes.

(xi) The changes to the scheme in NSW are timely. It is the view of the AMIC that some of these changes adopted in NSW should be adopted into the Queensland legislation. One glaring example needed in the Queensland scheme is a limitation on access to compensation regarding journey claims unless there was a substantial connection between the person's employment and the incident causing the injury.

5. COMMENTS FROM AMIC MEMBERS IN OTHER JURIDICTIONS

The Committee has been asked to consider:

- *how the Queensland workers' compensation scheme compares to the scheme arrangements in other Australian jurisdictions;*

Some comparisons between the NSW system and other systems are to be found in the Issues Paper referred to in paragraph 3(vii) above and attached.

How then do AMIC members view the operation of these other state systems in practice? The AMIC meets with groups of members regularly throughout Australia. Workers' compensation is continually an issue. The most common issues raised by AMIC members in these other states can be listed as follows:

- *The systems create an administrative burden for employers.*
- *Employers pay the premium but are given little say in the process of claims.*
- *Questionable medical decisions are all too common.*
- *Indifference and lack of co-operation of doctors in the claims process.*
- *Medical practitioners (GP's) know little about the workplace yet they make significant decisions affecting the employer.*
- *The ease of employees to obtain medical certificates and then subsequent certificates.*
- *Excessive time taken to assess claims creating rehabilitation problems.*
- *Rehabilitation is only successful if employee fully co-operates.*
- *Little incentives for employees to quickly return to work.*
- *Workers' compensation has created a culture amongst the workforce.*
- *Little deterrent to abusing the system.*
- *Limited investigation and co-operation by insurers of claims for whatever reason.*
- *Limited investigation of pre-existing injuries.*
- *Indifference of the legal system and involvement of lawyers inhibits a proper working of the system.*
- *Common law claims should always be under review.*

The issue is whether these issues arise in the operation of the Queensland system.

1. THE VIEWS OF AMIC MEMBERS IN QUEENSLAND

The Attorney, in announcing the inquiry, stated it was important to 'give the community a voice in how the scheme operates in Queensland.... (and) bring grassroots opinions and issues...to the table'.

When the AMIC was informed of the present Committee Inquiry we sought detailed views of members (both large and small employers of labour).

The views of AMIC members are from persons who deal with workers' compensation matters on a daily basis. The issues raised by members are outlined below and have been collated under specific headings.

Administering & investigating under the Queensland Workers' Compensation Scheme

- *WorkCover Queensland is the body that, essentially, collects the premiums from employers and investigates and processes the claims from employees. In other words, it is the administrator and the adjudicator;*
- *WorkCover Queensland is, essentially, a government run monopoly and there appears a deep-rooted public service culture. The scheme should operate with the same vigour as private insurance companies in processing and assessing claims;*
- *Often, there appears to be a bureaucratic mentality associated with administering and investigating under the scheme;*
- *Confusion and even delay occurs many times in claims with multiple WorkCover staff being involved on a single file;*
- *Investigating officers are sometimes ill prepared on a case or lacking investigative experience resulting in wastage of time and money for the employer.*

Closure of some WorkCover Queensland regional centres

- *The former Queensland government introduced significant organisational changes which ultimately de-skilled vital sections of WorkCover. The government either downgraded or closed WorkCover operations in regional centres. In some cases staff have been reduced and/or transferred to metropolitan offices, which reduced on site visits and face to face meetings.*

Note: AMIC understands budgetary concerns but a lack of network of regional offices of WorkCover creates inefficiency and means local claims staff are not present to assess local claims.

Claims procedure

- *It appears easier to accept a claim rather than giving full consideration to the alternatives. Unfortunately, this is the perception of AMIC members all the way up to Compulsory Settlement Conferences;*
- *Every claim, erroneously investigated, has potentially dire consequences for the premium paying employer;*
- *The perception is to accept a claim rather than fully explore the circumstances and obtain further medical evidence and thoroughly investigate the claim if considered doubtful. The result is insufficient claims examination prior to a WorkCover determination;*
- *When WorkCover does disallow a claim and it is subsequently overruled on review, many times it appears for no apparent valid reason to the employer's knowledge;*
- *Many employers have little or no involvement at the point many claims are submitted and hence no knowledge of the alleged injury at that point - claims should be better managed in these circumstances;*
- *Calculation of compensation should be capped at a reasonable percentage of OTE – average weekly earnings should not be utilised as it is an over inflated figure and not reflective of market forces.*

Medical treatment

- *Many times medical practitioners, such as a GP's, makes key rehabilitation decisions when they have no idea about the specifics of the workplace nor do they inquire of the employer;*
- *There may be too much reliance on treating General Practitioners to make key decisions on whether or not a worker is fully or partially incapacitated and decisions on whether the condition is 'work related' when they have no knowledge themselves of the workplace;*
- *In many cases Occupational Therapists appear more attuned to the workplace conditions for a suitable rehabilitation program;*
- *Experience of many AMIC members is that it is much too easy for the worker to obtain a WorkCover medical certificate and lodge a claim for workers compensation for doubtful reasons;*
- *Too much is there doctor shopping occurring;*
- *With respect to the medical assessment process, there is inconsistency due to lack of processes in place;*
- *The employer should be able to be involved directly with the treating medical practitioners in developing rehabilitation programs which would mean suitable duties could be better identified leading to proper rehabilitation;*
- *Medical practitioners should be required to liaise with employers;*
- *Employer should have the right to send the claimant to another medical practitioner for a second opinion in doubtful circumstances.*

Return to work

- *Doctors and medical providers should be more accountable to try to get the injured employee back to work as soon as possible instead of the 'I'll give you another week off' attitude;*
- *In many instances, the earnings rate while on compensation is so attractive that there is little incentive to return to work;*
- *The problem with the system lies not with the severely injured but the multiple number of small claims that find their way into the system and over which the employer has little control;*

- *Work is supposed to be part of the rehabilitation treatment process and there is plenty of evidence that the longer a person is away from the workplace, the more impact it has on their health and wellbeing as well as the wellbeing of their families.*

Lawyers, common law and related matters

- *With common law, the involvement of plaintiff lawyers means all the disadvantages of adversarial litigation including speculative actions– this hardly benefits a cost effective scheme;*
- *Access to common law has to be further limited to prevent the cost of claims from being artificially inflated through the involvement of legal processes;*
- *Restriction on common law to claims where personnel have received a substantial and life changing injury/illness or a Whole Person Impairment threshold should be introduced or a schedule of settlements that effectively cap common law claims;*
- *Administrative review by Q-Comp should routinely allow for employer representation at the tribunal;*
- *Allow employer to have more 'say' in the settling of common law claims;*
- *Legal fees should be capped to a moderate percentage of the result;*
- *Introduce a tariff for legal fees that discourage 'no win, no fee' lawyers;*
- *A sizeable percentage of all damages awarded ends up in the hands of lawyers, medical profession and expert witnesses.*

Premiums

- *Premium and associated costs are being driven to prohibitive levels for some meat industry sectors and some businesses are giving consideration to closing meaning loss of jobs in regional Queensland;*
- *Average premiums have increased for meat industry sectors such as the meat processing sector where premiums are four and fivefold the settled claims in any given period;*
- *Paying GST and Stamp Duty on an annual premium is like paying tax on a tax;*

- *There is little logic in superannuation being included in the calculation of a premium. It is not an argument to state that it is included in every other government calculation;*
- *Part of the WorkCover premium should be used for industry use such as a mechanism for "screening" workers for pre-existing conditions.*

Employer needs

- *No real penalty system exists for people rorting the system;*
- *Inability of employers to access a worker's claim history – meaning that employers have been on the receiving end of potentially fraudulent employment applications.*
  Note: we cover the last dot point by specific examples later in the submission.

Education

- *Relationship/Interaction with Doctors – this needs much greater development and education;*
- *There is a place for enforcement and prosecutions however, in practice, it must apply to everyone – including employees – and money needs to be allocated to education in this area;*

Some specific industry examples

- *The causality of Carpal Tunnel Syndrome is regarded by Q-Comp as a work related injury, despite overwhelming evidence that it is a genetic predisposition;*
- *Members have experienced situations where injuries such as carpel tunnel/musculoskeletal occurred and the worker fully recovered and still the employer is confronted with common law payouts – this is not isolated;*
- *Introduce limits on some injuries and occupational diseases e.g. carpal tunnel if it can be shown that the job was only "partially" responsible e.g. claimed after 10 days work, or if the worker had a "pre-existing" condition that was exacerbated by the incident or exposure, or if the condition was in part related to aging. Worker's prior health conditions should be regarded as relevant to the compensability of a condition.*

Conclusion

For many AMIC members the scheme is not working effectively and efficiently. There does not appear to be a proper balance.

The concerns from AMIC members are based on daily experiences, including from specialist HR professionals within the service of premium payers.

AMIC submits that there needs to be significant changes to how the system, administratively and procedurally, operates to meet desired objects.

2. THE OBJECTS OF THE QUEENSLAND LEGISLATION

Having outlined the experiences of AMIC members in Queensland it is timely in this short submission to deal with one of the critical Terms of the Inquiry namely:

- *the performance of the scheme in meeting its objectives under section 5 of the Act.*

The relevant sections of the legislation

Sections 4 and 5 of the Act are expressed in the following terms:

*"4 **Objects of Act***

(1) *This part states the main objects of this Act.*

(2) *The objects are an aid to the interpretation of this Act.*

5 Workers' compensation scheme

(1) *This Act establishes a workers' compensation scheme for Queensland -*

(a) *providing benefits for workers who sustain injury in their employment, for dependants if a worker's injury results in the worker's death, for persons other than workers, and for other benefits; and*

(b) *encouraging improved health and safety performance by employers.*

(2) *The main provisions of the scheme provide the following for injuries sustained by workers in their employment -*

(a) *compensation;*

(b) *regulation of access to damages;*

(c) *employers' liability for compensation;*

(d) *employers' obligation to be covered against liability for compensation and damages either under a WorkCover insurance policy or under a licence as a self-insurer;*

(e) *management of compensation claims by insurers;*

(f) *injury management, emphasising rehabilitation of workers particularly for return to work;*

(g) *procedures for assessment of injuries by appropriately qualified persons or by independent medical assessment tribunals;*

(h) *rights of review of, and appeal against, decisions made under this Act.*

(3) *There is some scope for the application of this Act to injuries sustained by persons other than workers, for example -*

(a) *under arrangements for specified benefits for specified persons or treatment of specified persons in some respects as workers; and*

(b) *under procedures for assessment of injuries under other Acts by medical assessment tribunals established under this Act.*

(4) *It is intended that the scheme should -*

(a) *maintain a balance between:*

(i) *providing fair and appropriate benefits for injured workers or dependants and persons other than workers; and*

(ii) *ensuring reasonable cost levels for employers; and*

(b) *ensure that injured workers or dependants are treated fairly by insurers; and*

(c) *provide for the protection of employers' interests in relation to claims for damages for workers' injuries; and*

(d) *provide for employers and injured workers to participate in effective return to work programs; and*

(da) provide for workers or prospective workers not to be prejudiced in employment because they have sustained injury to which this Act or a former Act applies; and

(e) *provide for flexible insurance arrangements suited to the particular needs of industry.*

(5) *Because it is in the State's interests that industry remains locally, nationally and internationally competitive, it is intended that compulsory insurance against injury in employment should not impose too heavy a burden on employers and the community."*

Brief Comments

We make the following comments:

Sub-section 5 (1)

AMIC agrees with many commentators that a common goal of a workers' compensation scheme is to provide fair and reasonable benefits to injured workers. Likewise, a primary purpose in any workers' compensation scheme must be, wherever possible, the effective and proactive management of employee injuries in a manner directed at enabling injured workers to speedily return to work whilst being adequately compensated. If a return to work is not possible then, the scheme should address other adequate compensatory issues.

The AMIC does not believe that "improved health and safety performance by employers" is really a matter best dealt with in clause 1. This issue is best dealt in the *Work Health and Safety Act 2011*.

Sub-section 5 (2)

We make the following comments concerning clause 2:

- If the issue of common law claims is re-visited then 2 (b) should contain the word 'limited' with regard to access to damages (for reasons given in the submissions);
- Similarly, 2 (d) should again contain the word 'limited';
- From the views provided in this submission by members of AMIC, we do not think the provisions of 2(e), 2(f) and 2(g) are being adequately addressed in practice.

Sub-section 5 (4)

Any scheme, in terms of policy, should be fair and equitable, affordable and be financially viable. It should be efficient and effective in terms of the delivery of services. It should not be financially burdensome on employers.

Concerning 4 (a) AMIC comments, on behalf of members, that it does not think that there is a proper balance being met between the competing interests as defined. The system does operate largely in favour of the worker.

AMIC does not believe that 'employer interests' covering claims and/or damages are being adequately protected as stated in 4 (c).

AMIC is not of the view that employer participation is being utilised under 4 (d) and it is not just the 'return to work aspect' where there are deficiencies but in the whole claim process.

3. COMMENTS ON SPECFIC ASPECTS OF THE LEGISLATION

Drawing on the views of AMIC members, we take the opportunity to provide comment on specific sections of the Act and expanding upon the said views by examples.

Journey Claims

The period of travelling between the worker's home and work should not be included for eligibility to workers compensation payments. Section 32 of the Act, defines the 'meaning of injury' as:

(1) *An injury is personal injury arising out of, or in the course of, employment, if the employment is a significant contributing factor to the injury.*

This definition clearly excludes travelling between the worker's home and workplace as such journeys are not work related and are not periods of wage remuneration for the employee. However, section 32 (2) of The Act states:

(2) *However, employment need not be a significant contributing factor to the injury if section 34(2) or 35(2) applies.*

The issue therefore relates to section 35(2) of the Act, particularly paragraph (a), which incorporates the journey between the worker's home and place of employment under the definition of *'an injury arising out of, or in the course of, the worker's employment'*. This paragraph should be removed from the legislation. Section 36 also needs to be amended to cater for the exclusion.

The exclusion of most 'journey claims' has recently occurred in NSW as part of the amendments to that state's workers compensation scheme.

There is an increasing justifiable trend around Australia to exclude 'journey claims'.

Rehabilitation

One of the major problems relating to early return to work of the injured worker is communication between the parties. Members repeatedly contact AMIC stating that they are frustrated with being unable to communicate directly with the nominated treating doctor, which restricts the ability to formulate a return to work plan for the injured worker. On many occasions AMIC members comment that they find that a treating doctor has agreed that an injured worker should remain off work for longer than is necessary without knowing of the availability of suitable duties.

One comment was that there has been little development in the member's regional area in the education of doctors with regard to early return to work and the arrangement for suitable duties.

Too much emphasis and reliance is placed on the treating medical practitioners' diagnoses and recommendations. Insufficient weight is given to the financial impact of excessive time off (total incapacity) for employees where suitable duties exist. Treating medical practitioners are not currently required to justify why an injured employee is 'not fit to work' when suitable duties are readily available.

We think treating medical practitioners should be required to liaise with employers. Some do, but many have no interest in understanding what alternate duties are available in the workplace.

On many occasions, the employer receives the initial and subsequent medical certificates from the employee, which specify that the worker is totally unfit for work for a number of weeks when the injured employee would be able to perform duties at the workplace that do not conflict with the worker's injuries.

Section 40 should contain a legal liability upon all parties, and not just the employer, to participate in the rehabilitation process as early as possible. This is part of the problem why claims are prolonged longer than necessary.

The employer/insurer should both have the right to send the claimant to another treating medical practitioner for a second opinion on the cause of the injury and should have the right to choose the treating medical practitioner or require that the injured worker be "treated" by a specific provider.

There also needs to be a greater flexibility for small business with respect to the return to work process and suitable duties. The reason for this was highlighted in a response from a member who stated the following:

> *"I do believe that the workers' compensation system does need to look at individual cases a little more carefully and to value the difference in small and large businesses. Recently we had a member of our staff off work after injuring the end of his thumb. In larger businesses this particular employee might be able to move from boning out beef into a packing area or something like that. However, in small businesses a suitable rehabilitation duty is impossible."*

It is often found that a treating medical practitioner will draw up the suitable duties program with the assistance of the employee (but not the employer) which imposes unrealistic work limits or restrictions making it difficult at times to find suitable duties. In this regard, the employer should have the right to seek an independent assessment/other medical opinion in relation to the suitable duties.

A member of AMIC recited a situation where an employee was on a suitable duties program for 8 months. He received WorkCover benefits, performed some restricted duties and, through all this, he held down a second job at Sizzlers. WorkCover accepted this claim on the basis that the duties the employee performed at our member's premises were more intense and therefore, our member was responsible for the claim. At no time to our knowledge did WorkCover contact Sizzlers to enquire about the system of work at that workplace.

Treating medical practitioners should be compelled to jointly develop rehabilitation programs with the employer. In many cases, the return to work provisions of the Act are not working effectively. In an age of effective employer rehabilitation programs, total incapacity should be prescribed only in the rarest of cases and the framework around this issue needs to be reviewed by WorkCover.

Definition of Normal Weekly Earnings

The Act should clearly specify in section 106 of the Act that 'Normal Weekly Earnings' is the worker's ordinary hour's rate of pay up to a maximum of 38 ordinary hours. This would bring the legislation in line with the *Fair Work Act 2009 (Cth.)*. Payments for overtime, shift penalties and allowances should not be included in the calculation no matter whether they are regularly paid or not. Paying the base 38 hour weekly rate creates an incentive for the person to return to work as soon as possible. Section 150 of the Act should also be amended in line with this approach.

Another problem for business and for injured workers is that the workers compensation premium that employers pay incorporates the 9% compulsory superannuation contribution but it is not paid in the workers compensation payments. It should be removed from the definition of wages under section 106 of the Act.

A further option for consideration is to provide a discount for employers who have not had a claimable injury for years.

One other member has commented that the calculation of workers compensation payments should be reviewed with a view that companies with incentive payment schemes are disadvantaged with respect to the averaging of payments and that wages should be based on the base rate of pay only.

Calculation of compensations payments to injured employees should be capped at an amount below 100% of their ordinary time earnings because in many cases people on compensation payments are receiving more income than uninjured workers. Average weekly income should never be used to calculate compensation payments because additional hours are not always available.

Taking and Accruing Leave during Workers Compensation

Section 119A of the Act allows an employee to take and accrue annual leave, sick leave and long service leave whilst the worker is on workers compensation. The first issue of concern is the conflict this raises with section 130 of the *Fair Work Act 2009 (Cth.)*. We set out s.130 below in full.

> ***"130 Restriction on taking or accruing leave or absence while receiving workers' compensation***
>
> (1) *An employee is not entitled to take or accrue any leave or absence (whether paid or unpaid) under this Part during a period (a **compensation period**) when the employee is absent from work because of a personal illness, or a personal injury, for which the employee is receiving compensation payable under a law (a **compensation law**) of the Commonwealth, a State or a Territory that is about workers' compensation.*
>
> (2) *Subsection (1) does not prevent an employee from taking or accruing leave during a compensation period if the taking or accruing of the leave is permitted by a compensation law."*

The Bligh government amended the Act [to cover s.130 (2)] so that a worker could receive a double benefit in the week/s they are absent on workers compensation. Others have not taken that course. This situation only adds to the cost and burden on the business as well as having no benefit for the worker in the long term. Sick Leave (now known as Personal/Carer's Leave under the National Employment Standards of the *Fair Work Act 2009 (Cth.)* is a complete contradiction with it being taken during a period of workers compensation. One is personal related and the other is work related.

All leave (other than parental leave) should not accrue during a period of workers compensation because such accrual is only relevant to weeks that are worked (including periods of suitable duties performed during workers compensation) and periods of paid leave other than workers compensation. Therefore, section 119A should be removed.

The right to accrue annual leave is absent from the schemes in New South Wales, Western Australia and Tasmania.

Injuries Caused by Misconduct

Where a person has injured themselves as a result of not taking reasonable care for his or her own safety as prescribed by section 28 and 31 of the *Work Health and Safety Act 2011* this should be prima facia evidence that the injury was caused by *serious and wilful conduct* as prescribed by section 130 of the Act.

The way section 130 of the Act is drafted it is virtually impossible to have a claim rejected on the current wording despite there being a breach of the *Work Health and Safety Act 2011*.

If the elements of section 28 and 31 of the *Work Health and Safety Act 2011* were included in section 130 of the Act there would be fewer difficulties in proving "serious and wilful misconduct" and ultimately (and correctly) exonerate the employer from any liability.

Time Period for Making a Claim

Section 131 of the Act allows for an application to be made up to 6 months after the entitlement to compensation arises. This appears an excessive amount of time, which is not necessary in the vast majority of claims. There have been many examples in the meat industry where workers have resigned from the business and then made a claim for workers compensation weeks or months after leaving. In such cases the worker has indicated the injury occurred during their period of employment, an injury that was not reported to the employer on the alleged date, with no witnesses, and nothing recorded in the injury book. The worker may also have obtained backdated medical certificates that cover the period from the alleged date of injury. This makes a mockery of the notification of injury obligations on the worker.

The legislation should be amended making it obligatory to notify their employer as soon as possible except for when where it there is a satisfactorily reason why the worker did not report it within that required timeframe. (exceptions would be in the case of diseases that could not be detected at the time of the supposed contraction period).

The word 'mistake' should be removed from section 131(5)(a) of the Act. Section 131(5)(c) provides the worker with a satisfactory avenue to explain the failure to make a claim when required.

Lodging a Claim and Reporting an Injury

Sections 132 and 133 of the Act should be amended to clarify that any application for compensation made by a worker be provided to their employer and the insurer. If the worker sends it direct to the insurer only (WorkCover, except for self-insurers) the employer may not be informed of the alleged injury until weeks or months after it allegedly occurred. This makes a mockery of the notification and investigation procedures as well as the requirements to get the worker back to their pre-injury job as soon as possible. In such circumstances costs associated with a claim that is approved would be backdated where (possibly) the claim could have been limited through rehabilitation of the worker and therefore limiting the affect upon the employer's premium.

If it is mandatory for the employee to report the incident immediately it occurs to the employer it would reduce spurious and potentially fraudulent claims, especially claims lodged following the termination of the employment contract.

WorkCover effectively prevents the employer from managing claims by getting doctors to submit direct to WorkCover which immediately sets them up as the first point of contact. Depending upon the case manager, this procedure can almost exclude the employer from being involved in managing the case.

The facility fee paid by WorkCover to the treating medical practitioner for submission of the claim form and medical certificate should be abolished as it indicates that the doctor payment as a higher priority than the employee's rehabilitation. It has an indirect affect upon the employer/employee relationship and erodes the employer's ability to manage the claim.

Insurer deciding on a claim

Section 134 of the Act needs to be amended to reduce the time that an insurer is required to make a decision on a claim (currently 20 business days) where there is no dispute about the claim. If there is a dispute, the insurer should make a decision as soon as possible after

looking at all relevant evidence from both parties. Delay creates problems for both the employer and the worker with respect to payment issues and the rehabilitation process. Where there is evidence of a questionable claim the insurer should reject the claim.

We have made comment in these submissions that the administrator is also the adjudicator of claims and it is much easier to accept a claim than reject it.

Members have commented to the AMIC that there has been frustration over claims where there have been regular changes in personnel managing and assessing claims. The claims management workload of claims managers means that difficult/problematic claims are not always managed effectively. There has also been a lack of consistency in managing claims, which appears to be due to the experience and skills of the case manager rather than the systems and processes.

One member commented that it is often the case that claims managers lack the necessary knowledge and experience to investigate a claim, which ultimately affects the business both financially and in human resources when these claims are accepted. For instance, the method of collecting evidence from the injured worker is, in many cases, predominantly left for the employer to gather in entirety. When WorkCover does obtain information or a statement from the injured worker the level of questioning is often substandard. Again, this is consistent with the views of members that it is easier to accept a claim than reject it.

Another concern raised by members was the limited communication received from the insurer (WorkCover) in which case the employer was not being kept up to date on the progress of the claim and investigations into the claim.

We repeat also that members have highlighted that their inability to do pre-employment checks leaves them at risk of employing dishonest people (because they don't declare previous injuries), who are potentially unsuitable for the job.

Related also is the need to revisit the definition of an injury as prescribed in Section 32 of the *Act* and in particular, the words, *"significant contributing factor"*.

Consideration should be given such that the current definition should be replaced with the former definition, *"the major significant factor causing the injury"* which in essence will make claiming for a pre existing condition somewhat harder. Bearing this in mind, if there were a pre-existing condition, then the employee should be able to revert the claim back to his or her previous employer.

The Act should be amended to preclude a worker from claiming workers compensation if it is found they had alcohol or illegal drugs in their body. Private insurers (in NSW for example) will deny a claim if drugs or alcohol are found in a claimant's body and WorkCover should use the same principle.

More often than not, it is accepted by WorkCover that an injury occurred in the workplace without much investigation or more thoroughly evaluating the doubtful claim. The balance of probability always seems to favour the claimant.

With much emphasis placed on the treating medical practitioner's diagnose and recommendation for total incapacity time periods or suitable duties there is doctor shopping where employees generally know which doctors are most likely to give them a favourable diagnosis. The same doctors happily submit direct to WorkCover leaving employers to chase the insurer or employees for information. Treating medical practitioners should be held accountable.

Time When Compensation is Payable

Sections 141 and 144 of the Act should be amended so that payment for a claim does not commence until the insurer has approved the claim. In the meantime the worker could, if eligible, seek to use accrued annual leave or long service leave, which could be re-credited to them if the claim is approved and not contested.

Section 144A should also be amended to include the situation where the insurer has rejected the claim, and in the case of an appeal, a claim is rejected.

Recovery of Compensation Overpaid

With respect to Section 170 of the Act, there should be an amendment to include a provision that the employer's premium is not affected by the overpayment. If it is, then the premium should be adjusted to cater for the recovered amount.

The reference to recovery from the employer in Section 170 should not apply where the employer has been provided the wrong information from a third party, including WorkCover.

Dismissal of an Injured Worker

Under Section 352 of the *Fair Work Act 2009 (Cth.)* an employer must not dismiss an employee because the employee is temporarily absent from work because of illness or injury.

Under Regulation 3.01 of the *Fair Work Regulations 2009(Cth.)* it is not a 'temporary absence' if the employee's absence extends for more than 3 months, or the total absences of the employee, within a 12-month period, have been more than 3 months, exclusive of an absence on paid personal/carer's leave. Under the same regulation, an employee absent on workers compensation is not considered to be absent on a period of paid personal/carer's leave.

Section 232A, 232B, 232D and 232E of the Act should be amended and reference made to s.352 of the *Fair Work Act (Cth)*. These current clauses restrict the employer in operating their business effectively. It is always open for the injured worker to apply at anytime after their termination and the employer will still be required to comply with the return to work obligations under the Act.

Section 232F of The Act should be deleted as such matters would be adequately dealt with by Fair Work Australia (FWA) under the *Fair Work Act 2009(Cth.)*.

Application for Damages (Common Law Claims)

The Committee has been asked to consider:

- *whether the reforms implemented in 2010 have addressed the growth in common law claims and claims cost that was evidenced in the scheme from 2007-08;*

Irrespective of the 2010 changes problems remain.

The Queensland scheme has been affected by a large number of common law claims, which have primarily been settled before being arbitrated. Although the number of common claims have somewhat decreased in the last 18 months they have still had a major affect upon the scheme. This can be attributable to the various options to claim for damages under section 237 of the Act.

On example of frustration with the common law provisions was with a small business member of AMIC who was subject to two separate damages claims that amounted to almost $600,000. The employer stated that the claimant had serious problems with alcohol and illegal drugs and that his family have had numerous workers compensation claims over the years. The claimant now laughs about how it is "easy money". The same employer has sated that he has just received his latest workers compensation premium notice, which he has to pay by weekly instalment and has done so for years, as he cannot afford to pay a lump sum amount, and " it would be easier to just close the doors".

It would be more appropriate to consider, for example, the Victorian scheme. In Victoria to obtain common law damages, a worker must first be granted a 'serious injury' certificate. There are two ways a worker can obtain a 'serious injury' certificate:

- During the impairment assessment process, be assessed as having a whole person impairment of 30% or more (can combine physical and mental impairments), or
- WorkSafe or the County Court determines that the worker has a 'serious injury' pursuant to the narrative test: see *Accident Compensation Act 1985 (Vic.), s.134AB.*

A worker has the option of having their whole person impairment assessed first or by-passing the impairment assessment process and relying on the narrative test. Either way, the worker must make a serious injury application and have that application accepted or rejected by WorkSafe Victoria before they can proceed to the next step.

The whole person impairment minimum level of 30% should be applied. Also, the access to claim for pain and suffering under common law claims should be removed. This has recently occurred in NSW in amendments to its workers compensation scheme.

The scheme in Queensland needs to be replaced with a more realistic and cost effective structure taking plaintiff lawyers out of the equation. Capping claims will ultimately reduce premiums and produce a much more equitable system. Common law payments could be assessed on the degree of permanent impairment, which would require a review of the definition of *'permanent impairment'*.

One member commented that they have experienced a number of common law claims, especially alleged injuries such as carpal tunnel and musculoskeletal injuries, where the worker has fully recovered, but they have still been subject to large common law payouts, which incorporate future economic loss. If the employee can return to work, future economic loss should not be a component of the payout.

Under the no win-no pay regime, plaintiff lawyers are bleeding employers to death with outrageous settlement claims. Claims in some cases are not pursued vigorously with a great reluctance to take the matter for trial.

To support this statement, one AMIC member had a claim where the claimant stated that he fell into a bone belt in the boning room and subsequently lodged a worker compensation claim. What followed was a common law claim. When investigating this claim, a witness advised the company that the fall onto the bone belt was actually staged. After considering the circumstances of the case, WorkCover declined to take this matter to trial, citing credibility issues with the witness. The company was strongly of the view if there was a credibility issue, let the trial judge decide. In this instance, the Claimant was the one with a major credibility issues as he had lied on his application for employment form to gain employment at our company.

The employer/premium payer does not have sufficient control/input with regard to common law claims. Employer should be present at Compulsory Settlement Conferences as our experience is that WorkCover often start way too high with an emphasis on just settling at any price to close the file and avoid going to court when some cases are clearly challengeable.

Although statutory claims currently operate under a no fault liability system we recommend that where it has been proven that a claimant was negligent bearing in mind the provisions of section 28 of the *Work Health and Safety Act 2011*, an employer be exonerated from such liability.

Fraud and Related Offences

Section 537 of the Act states in subsection (3) that:

> *If, in the proceeding for the offence, the prosecution proves the person obtained payment of compensation or damages by the insurer, by conduct that is the offence, then, whether or not a penalty is imposed, the court must, on application by the insurer, order the person to repay the insurer all amounts of compensation or damages paid to or on account of the person as a result of the commission of the offence.*

In addition to this there should be an automatic requirement on the insurer to make a retrospective amendment to the workers compensation premium paid by the employer in order to not adversely affect their future premium calculation.

It should be noted that the cost to the system as a result of fraudulent activity is greater with respect to the prolonging of claims compared to predetermined fraud by the injured worker. Medical practitioners, service providers and even claims managers have been prosecuted for fraudulent actions for financial gain.

Section 136 of the Act provides that a worker does not commit an offence if they notify WorkCover within 10 business day of a change of circumstances. For instance, if a worker obtains a medical certificate for total incapacitation that worker can work elsewhere if they notify WorkCover of the change of circumstances within 10 business days. Thereupon, no offence is committed.

If a worker is totally unfit to perform their normal duties than they are unfit to perform any work whatsoever. This is highlighted by an AMIC member who had an employee on total incapacitation and was detected driving a taxi. The Company notified WorkCover who advised that there were unable to pursue a fraud claim, as the employee had 10 days to notify WorkCover of a change in circumstance. If that worker was fit enough to drive a taxi, in a sitting position for a shift, then he should have been able to attend work on a suitable duties program. To the member's knowledge there was no follow up investigation by WorkCover on this matter.

Section 543 – Right of Appearance

The Act provides that:

(1) *The applicant may appear before the Authority in person or be represented by another person at the applicants expense with a view to achieving a resolution of the matter.*

(2) The Applicant may also make representation to the Authority by telephone or another form of communication.

The employer affected should be granted rights to make a personal representation to Q-Comp along with the applicant. This particular section needs to be amended.

Access to Particular Documents

One AMIC member recounts a situation where one of their employees instigated a common law injury claim against the employer for an alleged injury. At the same time the employee was offered a lump sum for an aggravation to a pre-existing injury. It appears the employee had other pre-existing injuries and workers compensation claims in the claims history. All this came to the attention of the employer because the employee's legal representatives, in serving the Notice of Claim, were obliged to attach the client's compensation history. Before being offered employment, the employee completed a fairly extensive pre-employment medical questionnaire in which he denied having any previous injuries and workers compensation claims and ticked the boxes. The employer intended for the employee 'show cause' to explain why there had been non-disclosure. The employer was informed by the relevant union they would be relying upon section 572A of the Act if any action was taken including an action to terminate employment.

This is not an isolated incident amongst AMIC membership.

This particular section (572A) was the subject of an amendment by the Queensland Parliament in 2005 in passing the *Industrial Relations and other Acts Amendment Bill.*

Prior to the 2005 amendment, employers seemed to have the right to access from Workcover the prospective employee's work history so far as claims were concerned. In other words, to obtain the best evidence available concerning an employee's past claims history so the employer can undertake a proper assessment. What could be more important to an employer, in undertaking pre-employment procedures, to have the best knowledge available concerning an employees claim history.

Therefore, section 572A should be removed from the Act to allow an employer to access a potential worker's previous claim history. As well, amendments may need to be made to Section 572 of The Act.

9. PROPOSED PUBLIC HEARINGS

We understand that further public hearings are scheduled by the Committee. AMIC would be in a position to attend with a selected number of industry representatives from both large and smaller employers operating throughout regional Queensland. Their experiences, over many years dealing with workers compensation issues first hand, would be invaluable to the Committee in deciding on necessary outcomes.

A

NSW Workers Compensation Scheme

Issues Paper

Purpose of this Issues paper

There are many indications that the current Workers Compensation Scheme is failing the people of NSW, and urgent action is required.

The NSW Government is responding to the deteriorating performance of the Workers Compensation Scheme and is acting urgently to ensure its long term sustainability to provide injured workers with the support they deserve while remaining affordable, fair and competitive for NSW.

The premiums paid by New South Wales employers are estimated to be between 20 and 60 per cent higher than equivalent employers in our competitor states and the scheme actuary projects that the continued deterioration in the scheme deficit will require an eventual increase of up to 28 per cent in premium rates if no changes are made to the scheme. The Insurance Premium Order which sets premium rates is gazetted each year to commence at 4pm on 30 June, therefore decisions about premium rates need to be made at the latest at the end of May 2012.

An increase of this size would impact current and future jobs in NSW, flowing through to reduced state revenues such as payroll tax and would further exacerbate the State's lack of competitiveness as compared to our most comparable competitor States (Victoria and Queensland). Given these risks, increasing premium is not an acceptable solution.

The NSW Government is canvassing a number of suggested solutions to the problems currently being experienced in the NSW Workers Compensation system, with particular reference to other State workers compensation systems.

These solutions for the Scheme deliver effectively on seven reform principles:

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 the 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.

1. Priorities for New South Wales

The NSW Government has set out five priorities for NSW. These are to:

- rebuild the economy;
- return quality services;
- renovate infrastructure;
- strengthen our local environment and communities; and
- restore accountability to Government.

The workers compensation system is a critical component of the NSW economy. Employers and workers are entitled to expect a workers compensation system that is efficient, cost effective and offers fair, timely assistance to employers and workers.

1.1 The need to reform the NSW Workers Compensation Scheme

The NSW Workers Compensation Scheme is a broken system that does not produce good outcomes for injured workers, and without significant improvements it is not financially sustainable:

1. The premiums paid by New South Wales employers are estimated to be between 20 and 60 per cent higher than equivalent employers in our competitor states and if the Scheme continues to deteriorate the difference will increase starkly. The insurance arrangements offered to businesses are not optimal insurance arrangements reflecting risk;
2. The system is difficult to navigate for all participants with a lot of red tape;
3. Payments for seriously injured workers are inadequate, weekly payments in lieu of lost earnings for totally incapacitated workers that bear no relation to the income they have lost. In fact, they are paid a rate barely above the poverty line;
4. 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;

5. Less seriously injured workers are not encouraged effectively through financial incentives and the system to recover and regain their financial independence; and
6. WorkCover has limited power to strongly discourage payments treatments and services that do not contribute to recovery and return to work.

Because the NSW Scheme does not do these things well, it costs far more to get a claimant back to work in NSW than it does in Queensland or Victoria and costs are increasing at an unsustainable rate.

The NSW Government is proposing a suite of reforms that will focus the NSW Workers Compensation Scheme on these critical principles.

1.2 Guiding Principles

As a guiding principle 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.

The best workers compensation systems are 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.

Schemes that align to the above principles are fair, affordable, efficient and financially sustainable. 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.

The premiums paid by New South Wales employers are estimated to be between 20 and 60 per cent higher than equivalent employers in our competitor states and if the Scheme continues to deteriorate the difference will increase starkly.

The Independent Scheme actuary projects that an increase of 28% in premium rates would be required if no changes are made to the Scheme. An increase of this size would impact current and future jobs in NSW, flowing through to reduced state revenues such as payroll tax and would further exacerbate the State's lack of competitiveness as compared to our most comparable competitor States (Victoria and Queensland). Given these risks, increasing premium is not an acceptable solution.

It has been suggested that the goal of any reform package should be to:

- adopt the most effective workers compensation measures from around Australia
- simplify benefit calculation,
- make workers' entitlements more transparent and easier for workers and employers to understand
- workers whose injuries are less serious should have greater incentives and support to return to work, while more seriously injured workers should receive improved weekly benefits and lump sum compensation entitlements.

1.3 Financial Background

The financial sustainability of the Workers Compensation Scheme is deteriorating. An independent valuation of the Scheme's outstanding claim liabilities is undertaken every six months (for the periods ending 30 June and 31 December). The most recent valuation is for the period ending 31 December 2011. The executive summary of the valuation is attached as **Appendix A**. The valuation has been Peer reviewed and the Peer review report is attached as **Appendix B**. A table of jurisdictional comparisons to the current benefit regime in NSW is attached as **Appendix C.**

As at 31 December 2011, the Independent Scheme Actuary calculated the Scheme's deficit at $4.083 billion, a deterioration of $1,720 million in six months. Its funding ratio is 78%, a deterioration of 7% in six months.

This is the worst financial result incurred since the Scheme commenced in 1987.

The Scheme's net outstanding claims liability (inflated and discounted, and including claims handling expenses (CHE)) was $14.378 billion ($16.104 billion when a 12 per cent risk margin is added). The risk margin ensures that, if the Scheme's ultimate liability is greater than estimated, there is a 75 per cent probability that there will be sufficient assets to cover all claims.

Outstanding Claims Liability

	Jun-11	Dec-11	Difference
	$m	$m	$m
Gross claim payments	12,225	13,679	1,454
less Recoveries	-409	-433	-23
Net central estimate (before CHE)	**11,816**	**13,246**	**1,431**
plus Claim handing expense allowance	923	1,132	209
Net central estimate (with CHE)	**12,739**	**14,378**	**1,639**
Risk margin	1,529	1,725	197
Provision	**14,268**	**16,104**	**1,836**

The financial sustainability of the Scheme, at current premium levels, is expected to deteriorate further in future years. This is not good for business or injured workers.

In New South Wales, there are 269,562 policies held by employers and 3 million workers are covered by the Scheme. To provide a view of the quantum of the deficit, the deficit is equal to an amount of $15,146 per employer and $1,326 per every worker that is covered by workers compensation insurance. The growth in the Scheme deficit from June 2011 to December 2011 cost NSW more than $9 million per day. The cost of compensating workplace injury is borne by employers through workers compensation insurance premiums.

1.4 Outstanding Liability categories

Weekly payments, medical treatment and Work Injury Damages liabilities are the largest three contributors to the Scheme's outstanding claims liability. They are also the main contributors to the $2.1 billion increase in claims liability since 2008.

Together they account for:

- 76% of estimated gross Scheme costs in 2012/13;
- 81% of the total gross outstanding claims liability; and
- 95% of the total ($2.1billion) deterioration in claims experience incurred since June 2008.

Estimate of Discounted Outstanding Liability by component, as at 31 December 2011

Benefit Type	Outstanding claims liability	Impact of A v E experience and changed actuarial assumptions	
	$m	$m	%
Commutations	290	5	2%
Weekly	5,912	48	1%
Workplace Injury Damages	1,771	148	8%
Legal Costs	433	-2	0%
Permanent Injury (Section 66)	590	28	5%
Pain and Suffering (Section 67)	237	14	6%
Medical	3,339	-117	-4%
Investigation	383	15	4%
Rehabilitation	236	-11	-5%
Death	81	-4	-4%
Other Payments	143	6	4%
Pre-WorkCover Liability	1	0	-20%
Asbestos	155	14	9%
ULIS - Gross	106	-8	-8%
Total Gross Outstanding Claims Liability	13,679	135	1%

The cost of the Scheme, in adjusted dollars, on current projections for 2012/13 will be $2,601 million, which means that the premium collected at the current rates won't be enough to cover the ongoing cost of the Scheme.

Breakdown of 2012/2013 breakeven premium rate (excl GST)

Benefit Type	PPCI	Annual Cost (Constant $)	Annual Cost (Adjusted $)	% of Wages
	$	$m	$m	%
Commutations	289	24.3	21.0	0.01%
Weekly	12,030	1,013.0	875.9	0.55%
Common Law	3,494	294.2	254.4	0.16%
Legal	1,132	95.3	82.4	0.05%
S66 - permanent impairment	2,023	170.3	147.3	0.09%
S67 - pain & suffering	734	61.8	53.4	0.03%
Medical	7,958	670.0	579.4	0.36%
Investigation	1,035	87.2	75.4	0.05%
Rehabilitation	1,277	107.5	93.0	0.06%
Death	569	47.9	41.4	0.03%
Other payments	454	38.2	33.1	0.02%
Gross cost	**30,995**	**2,609.8**	**2,256.7**	**1.42%**
Excess recoveries	-87	-7.3	-6.4	0.00%
Tax recoveries	-274	-23.1	-20.0	-0.01%
Other recoveries	-1,029	-86.7	-75.0	-0.05%
Net cost (excl expenses & levies)	**29,604**	**2,492.7**	**2,155.4**	**1.36%**
Expenses and Levies	6,117	515.1	445.4	0.28%
Net cost	**35,721**	**3,007.8**	**2,600.8**	**1.64%**

1.5 Workers Compensation System, Insurance, Premium, Benefit and Regulatory Systems

The Scheme operates under the *Workers Compensation Act 1987, Workplace Injury Management and Workers Compensation Act 1998.*

Insurance policies

All NSW employers must have a workers compensation insurance policy if they pay more than $7500 in wages per annum, employ an apprentice or trainee, or are part of a group for premium purposes.

Insurance cover can be obtained in the following ways:

- The Workers Compensation Scheme – provides workers compensation insurance through contracted Scheme Agents to employers operating in New South Wales, and is responsible for underwriting risk, funds management, and premium setting.
- SICorp (through the Treasury Managed Fund) – underwrites workers compensation, administration and financial liability for most public sector employers except those who are self-insurers.
- Self insurers –organisations with enough capital to underwrite, pay and manage their own claims may be licensed to self-insure (there are currently 60 self-insurers).
- Specialised insurers – seven NSW insurers are licensed to underwrite workers compensation insurance risk for specific industry classes. The specialised insurer license category has been closed to new entrants.

The Scheme is funded by the insurance premiums paid by employers. The amount payable is based on a number of factors, including:

- the industry in which the employer operates (the industry premium rate takes into account the costs of compensation claims that have occurred in the industry);
- the amount of wages the employer pays to its workers;
- the costs of any claims made by their workers (for employers with a basic tariff premium greater than $10,000 and with wages greater than $300,000);
- the dust diseases levy, paid by employers whose businesses may expose workers to the risk of contracting a dust disease; and
- the mine safety premium adjustment (for mining industry employers).

Premiums fund financial and medical support to injured workers and cover the costs of dispute management and administration of the schemes.

Benefits

The NSW Workers Compensation system is one of the most generous benefit systems in the nation providing unlimited 'no fault' protection to workers and their employers in the event of a work-related injury or disease.

An injured worker may be entitled to claim a range of compensation benefits. The Scheme's actuary has estimated the total number of claims incurred over the life of the Scheme (as at 30 June 2011) to be 2,600,316.

The amount and type of benefit available to an injured worker broadly depends on the type, nature and severity of their injury, the period they are unable to work, and the date of their injury and claim lodgement.

Types of benefit under the Scheme include:

- weekly incapacity payments in lieu of lost income (including up to 12 months post-retiring age), which:
    - vary depending on: whether the injured worker's level of capacity is total (unfit for any work), or partial (partially fit for work); whether or not the worker's pre-injury earnings are paid under an award, industrial or enterprise agreement; and whether the period is within the first 26 weeks of incapacity or after (at which point a 'step down' occurs in the amount paid); and
    - are also capped (the maximum amount from 1 April 2012 to 30 September 2012 is $1838.70);
- medical, hospital and allied health costs for an indefinite period of cover. The Scheme is liable for all 'reasonable and necessary' medical treatment, with limited power to refuse to meet the costs of treatment;
- lump sum permanent impairment payments for non-economic loss (and pain and suffering, where applicable) – the amount of compensation depends on the degree of impairment[1];

[1] i.e. if the degree of impairment is:

- intensive rehabilitation assistance;
- employer and employee legal expenses;
- death compensation (funeral costs, lump sum and dependency payments); and
- commutation of statutory entitlements to a lump sum.

Injured workers also have limited access to negligence-based, lump-sum damages for economic loss (of past and future earnings) at common law (Work Injury Damages claims), which are made when the injured worker takes legal action against their employer. These claims are heard in the District Court.

To make such a claim, the following legislated criteria must be met:

- the work injury is a result of employer negligence;
- the injured worker must have at least 15 per cent whole person impairment;
- a claim can only commence at least six months after the worker gave notice of the injury to the employer; and
- court proceedings cannot be commenced more than three years after the date on which the injury was received, except with the leave of the Court.

Successful Work Injury Damages claims are paid out of the Scheme.

The worker must have received all statutory lump sum entitlements for permanent impairment and pain and suffering (non-economic loss) to which they are entitled under the Scheme before the Work Injury Damages claim can be settled. The settlement cancels all further entitlements to benefits under the Scheme.

In addition, the amount of weekly compensation that has already been paid to the worker must be repaid out of the amount awarded. The amount awarded can also be reduced if the worker's own negligence contributed to the injury.

- not greater than 10 per cent, the amount is: Degree x $1,375;
- greater than 10 per cent but not greater than 20 per cent, the amount is: $13,370 + [(Degree – 10) x $1,650];
- greater than 20 per cent but not greater than 40 per cent, the amount is: $30,250 + [(Degree – 20) x $3,850];
- greater than 40 per cent but not greater than 75 per cent, the amount is: $85,250 + [(Degree – 40) x $3,850]; and
- greater than 75 per cent, the amount is: $220,000.

WorkCover's regulatory role

WorkCover is responsible for regulating the System by:

- managing the Workers Compensation Scheme on behalf of the Nominal Insurer, which is the public sector legal entity responsible for the management of the Workers Compensation Insurance Fund;
- assisting workplaces to prevent work-related injury and disease;
- promoting prompt and efficient management of work-related injuries;
- licensing self and specialised insurers; and
- oversight of service providers.

1.6 Premium Levels

The cost to employers of premiums in New South Wales does not encourage investment in the NSW economy and is not competitive with other jurisdictions.

The target premium collection rate for the Scheme in 2011-12 is 1.68 per cent of wages, which is:

- less than the rate required to cover the expected cost of claims for the year based on risk free investment returns; and
- marginally higher than the break even rate based on long term expected investment returns.

While there has been a cumulative 33 per cent reduction in average workers compensation premium rates since 2005 (with resulting savings for employers of around $1 billion per annum), NSW premiums remain higher than those in Victoria, Queensland and Western Australia. This has consequences for the costs of NSW businesses, and their competitiveness in relation to businesses in jurisdictions with lower premiums.

1.7 Key differences compared to schemes in other jurisdictions

1.7.1 Scheme Premium Jurisdictional Comparisons

The actual premium paid by an employer in New South Wales varies according to the size and claims experience of the employers.

Premium rates are generally pooled across similar risk profile groups. This allows employers who share a common set of risks to spread the risk across their industry type. Across the schemes, there are hundreds of specified premium rates for industry types.

The examples below compare the basic tariff premium rates for several employers with the corresponding Queensland and Victorian rates.

They also include a projection of the potential increases in premium, being 28% on average that may be required if no action is taken to reduce the spiralling costs of the Scheme.

Employer	Annual wages	NSW current premium	Vic comparison	Qld comparison	NSW if premiums increase by 28%
A wooden structural component manufacturing company	$1,000,000	$42,540 (4.25%)	$23,110 (2.31%)	$35,230 (3.52%)	$54,451 (5.45%)
A residential construction company	$250,000	$12,600 (5.04%)	$2,570 (1.03%)	$6,983 (2.79%)	$16,128 (6.45%)
A regional cafe with 11 staff	$326,126	$8,613 (2.64%)	$1,957 (0.60%)	$4,103 (1.26%)	$11,025 (3.38%)
A regional club employing 467 people	$19,096,377	$595,616 (3.12%)	$206,623 (1.08%)	$361,876 (1.89%)	$762,388 (3.99%)
A road freight transport company	$140,000	$9,138 (6.53%)	$4,361 (3.12%)	$6,927 (4.95%)	$11,696 (8.35%)
A small cleaning company	$151,589	$10,681 (7.05%)	$3,709 (2.45%)	$4,901 (3.23%)	$13,672 (9.02%)

1.7.2 Injured Worker Benefit Jurisdictional Comparisons

NSW benefits regime has not been comprehensively reviewed for over 10 years. The key differences from other jurisdictions are summarised in Appendix C but some of the detail follows:

i) Journey claims

In NSW workers are covered for injuries which occur on their journey between home and work. Victoria, Western Australia and Tasmania exclude such claims. The Commonwealth scheme generally excludes journey claims except in exceptional circumstances. South Australia covers journeys only where there is real and substantial connection between the journey and the industry. Queensland allows journey claims unless there is a substantial delay not connected to employment.

ii) Weekly benefits for total incapacity

Workers in NSW receive 100% of their pre-injury average weekly earnings for the first 26 weeks of total incapacity, if they are paid under an award. Non award workers receive 80% of their pre-injury average weekly earnings. Benefits are capped at a statutory amount.

From week 27 onwards, all workers who have total incapacity receive the statutory rate, plus allowances for dependants. This amount is currently $432 per week. These payments may continue until 12 months after retiring age.

Some jurisdictions have weekly benefit schemes which incorporate 'step downs', or reductions, after 13 weeks, to encourage workers to return to work. This approach is in line with research which indicates the longer a worker is away from work, the less likely they are to return.

In Victoria, the calculation of benefits for award and non award workers is simpler and more consistent. Average weekly earnings are calculated on the basis of the rate paid for the ordinary working hours of the worker. If the worker has no base rate, the calculation is made on the basis of the actual earnings of the worker. Workers receive 95% of their pre-injury average weekly earnings for the first 13 weeks of total incapacity and 80% from week 14 onwards. Workers undergo work capacity tests at specified points throughout the claim, and at least once every 2 years. After week 130, workers receive benefits for total incapacity only if they have no work capacity and are likely to have no work capacity for an indefinite period.

South Australia's calculation method is similar to that of Victoria. Injured workers receive 100% of their pre-injury earnings for weeks 1-13, with step downs to 90% from weeks 13-26 and 80% from week 26 onwards. Like Victoria, South Australia has work capacity tests, once workers have passed or are approaching 130 weeks of benefits. Workers are subject to annual reviews to assess their work capacity.

In Western Australia, workers are subject to a step-down after 13 weeks through a recalculation of their benefit, to exclude payments for pre-injury overtime, bonuses, and regular over-award payments.

Queensland, Tasmania and the Commonwealth ComCare scheme do not have step downs at 13 weeks and do not specifically provide for work capacity testing.

iii) Weekly benefits-partial incapacity

In NSW, a worker who has partial incapacity, who is working at less than their pre-injury capacity or who is looking for work, can receive a benefit up to the amount of the benefit the worker would have received if the worker was receiving benefits for total incapacity. The worker is eligible for this benefit as well as the actual earnings from their employment. This means that the worker's benefit, combined with their actual earnings, can add up to the worker's pre-injury average

weekly earnings. These arrangements apply even if a worker is only working a few hours each week.

These arrangements act as a disincentive for workers to return to their pre-injury employment. Most other jurisdictions provide for injured workers who have partial capacity to receive benefits which, combined with their actual earnings, are up to the amount received by a worker who has total incapacity. These arrangements ensure that workers who have partial incapacity have a financial incentive to return to their pre-injury employment.

For example, in Victoria, workers who have partial incapacity during the first 13 weeks of a claim, receive 95% of their pre-injury average weekly earnings, less what they are actually earning. For the period from weeks 14-130, workers receive 80% of their pre-injury average weekly earnings, less 80% of what they are actually earning.

After week 130, a worker can only receive benefits for partial incapacity if the worker has returned to work, is working at least 15 hours each week and is earning at least $166 per week. The worker must also demonstrate that because of their injury, they are likely to remain physically and mentally incapable of working beyond their current level, in any job.

In South Australia, workers who have partial capacity are paid 100% of their pre-injury earnings, less any amount they are fit to earn in suitable employment. This means they receive the same amount as a worker who has total incapacity from weeks 1-13. From week 14-26 they receive 90% of their pre-injury earnings, less any amount they are fit to earn in suitable employment. From week 27 onwards, workers are paid 80% of their pre-injury earnings, less any amount they are fit to earn in suitable employment. This is the same amount as workers who have total incapacity.

In Tasmania, a worker who is working less than 50% of their pre-injury hours receives the same benefit as a worker having total incapacity, less their actual

earnings. However, if a worker is working over 50% of their pre-injury hours the worker can receive up to 100% of their pre-injury earnings.

iv) Duration

Weekly benefits

There is no limit on the duration of weekly benefits (except the retiring age plus 12 months) in New South Wales and no effective cap on medical and related expenses.

Several jurisdictions limit access to workers compensation based on the length of time benefits are received or a financial cap. Victoria ceases payment of weekly benefits after 130 weeks unless an injured worker has no current work capacity and that is likely to continue indefinitely. Queensland limits payments of weekly benefits to 5 years or a cap of $200,000, whichever arrives first. Western Australia has no cap on duration but does have a weekly benefit cap, which means entitlement to weekly benefits stops once the claimant reaches a total cumulative payment amount of $190,700.

Tasmania has a staggered scheme for the duration of benefits, depending on the degree of whole person impairment of the worker. The duration cap is 9 years for a worker having less than 15% whole person impairment; 12 years for a worker whose whole person impairment is between 15 and 19%; 20 years for a worker whose whole person impairment is between 20% and 29% and retirement age for a worker whose whole person impairment is more than 30%.

v) Medical expenses

In practice, 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.

Most other schemes cap medical and related treatment for work injuries by duration or cost.

In Victoria, the workers compensation scheme is liable for the costs of medical and related treatment provided while weekly benefits are paid and for one year after the cessation of weekly benefits.
In Queensland a cap of 5 years applies to the payment of weekly benefits and benefits for medical and related treatment.

In Tasmania, a cap on the duration of benefits for medical and related treatment applies in the same way as it does for weekly benefits.

vi) Lump sum benefits

The threshold for claiming a lump sum for whole person impairment in New South Wales is 1%. Whole person impairment is medically assessed applying The *WorkCover Guides* are based on the American Medical Association's (AMA) *Guides to the Evaluation of Permanent Impairment,* fifth edition..

Many claims for whole person impairment result in small assessments. Workers frequently make successive, or 'top-up', claims for deterioration following on from the work injury. These claims can increase their overall assessment to 15%, the threshold for a work injury damages claim.

Damages of up to $50,000 are also available for pain and suffering. Pain and suffering damages are not awarded using objective measures but are awarded on the basis of a percentage of a most extreme case.

Other jurisdictions generally have higher thresholds for whole person impairment and do not have separate awards for pain and suffering. In South Australia and Tasmania the threshold is 5% and in Victoria and the Commonwealth ComCare scheme the threshold is 10%.

Other jurisdictions do not have a separate category of 'pain and suffering' statutory compensation. Most jurisdictions have a single table of lump sum compensation for permanent impairment or specific injuries.

Some other jurisdictions, including Victoria, permit only one claim to be made for whole person impairment, rather than allowing successive or 'top-up' claims. The ComCare scheme permits a further claim only if there is a deterioration of more than 10%.

vii) Work Injury damages

Workers in New South Wales can make work injury damages, or common law claims. Common law claims are subject to modified damages provisions set out in the workers compensation legislation.

The general law governing civil liability was reformed in 2002 following the enactment of the *Civil Liability Act 2002*. The Act codifies the principles governing the law of negligence and other specific areas and was enacted following a comprehensive review of the law of negligence, conducted by an expert Panel appointed by Ministers from the Commonwealth, State and Territory Government. The review was in response to community perceptions that the law of negligence as it was applied in the courts was unclear and unpredictable and it had become too easy for plaintiffs in personal injury cases to establish liability for negligence on the part of defendants.

However, the provisions of the *Civil Liability Act* dealing with the law of negligence do not apply to work injury damages claims made under the workers compensation legislation. As a result, the principles used to determine negligence in workers compensation Common Law matters are those which applied to the law of negligence prior to 2002 and now diverge from the general law.

Regulatory framework for health providers

The obligation of the workers compensation scheme to meet the costs of reasonable and necessary medical treatment in NSW means in practice there is virtually no limitation on the liability of insurers to meet the costs of medical or other treatment provided to injured workers.

Other schemes generally also have few effective controls on the provision of medical and related treatment to injured workers. However, the Victorian scheme does exercise more control over treatment provision, especially limitation on treatment with poor evidence base and capacity to respond to over servicing and poor billing practices.

viii) Commutations

The availability of commutations in NSW is limited to workers whose whole person impairment is assessed at more than 15%, who have received lump sum compensation for whole person impairment and for whom return to work opportunities have been exhausted. Commutations can only be made with the agreement of the worker and the insurer.

There are a number of workers who do not meet these criteria, but who would benefit from the commutation of their claims, such as workers receiving small weekly benefits or whose claims remain open in case future medical treatment is required.
Some other jurisdictions have greater flexibility for the commutation (or redemption) of workers compensation claims. These include Victoria, where the criteria for commutations can be related for specified time periods for particular classes of claims.

2. Options for Change

A suite of options for comment have been developed, having regard to the guiding principles set out above. The options are intended to promote recovery and health

benefits for injured workers of returning to work while guaranteeing long term income support and treatment for severely injured workers and ensuring the costs of the workers compensation system are sustainable.

1. Severely injured workers

A key plank of any reforms should to improve the benefits for severely injured workers.

It has been suggested that reforms should provide for severely injured workers, who have an assessed level of whole person impairment of more than 30%, to receive improved income support, return to work assistance where feasible, and more generous lump sum compensation.

2. Removal of coverage for journey claims

It has been suggested this would provide a closer connection between work, health and safety responsibilities and workers compensation premiums through eliminating workers compensation costs arising in circumstances over which employers have limited control.

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

There is recognition of the profound impact of the tragic event of fatality from workplace injury.

In 2008 amendments to the workers compensation legislation increased the lump sum death benefit and made it more widely available. When a deceased worker leaves no dependants the lump sum death benefit is payable to their Estate. The distribution of the lump sum is in accordance with the Family Provision Act and

therefore relatives of the deceased entitled under the Family Provision Act will receive part of the lump sum death benefit.

Legal costs associated with these injuries are not regulated by workers compensation legislation and can be substantial, therefore following the death of a worker the workers compensation scheme pays:

- the lump sum death benefit ($481,950),
- weekly benefits to dependants;
- any common law liability under the Compensation to Relatives Act;
- civil liability for nervous shock to family members, and
- associated regulated and unregulated legal costs.

Arguably an employer's liability for the psychological injuries to family members following the serious injury or death of a worker does not fall within the objects of the legislation and it has been suggested that such claims should no longer be allowed

It has been suggested this would provide a closer connection between work, health and safety responsibilities and workers compensation premiums through eliminating workers compensation costs arising in circumstances over which employers have limited control.

Consistent with the principles of the Act workers who witness the workplace death of a colleague and suffer psychological injury would still able to make a claims under the legislation.

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

It has been suggested the current arrangements should be updated to more closely reflect changes in employment arrangements in NSW.

Stakeholders have argued the existing arrangements for determining weekly benefits are overly complex, anachronistic and fail to deliver consistent outcomes for injured workers.

The current system was designed in an era where employment was characterised by permanency and regulated via industrial instruments, while such arrangements still exist there are an increasing number of workers who are employed under more flexible arrangements. Casualisation is increasing, in 2009 around 20 percent of the workforce in Australia was employed under casual arrangements; this had increased from 17% in 1992[2].

By creating a single measure for pre-injury earnings, the existing disparity between benefits paid to award and non award workers would be removed and administration of benefit arrangements would be simplified.

Changes to weekly benefits would remove the difficult and confusing provisions that currently exist to determine the amount of weekly benefits that an injured worker would receive and thereby reduce disputation over weekly benefits. A new simplified measure more closely aligned to workers actual pre-injury earnings would be welcomed.

In Australia, New South Wales is the only State that does not take regular overtime and allowances into account when calculating a totally incapacitated worker's weekly payment.

Finally, these arrangements would ensure that weekly benefits more closely reflect a worker's actual earnings prior to their injury.

5. Incapacity payments-total incapacity

Step downs feature in all workers compensation jurisdictions in Australia. Currently in the NSW model the first step down occurs at 26 weeks. It has been suggested that consideration be given to aligning weekly benefit payments more closely with other jurisdictions and to an earlier step down with capacity testing

[2] Australian Bureau of Statistics, 1370.0 - Measures of Australia's Progress, 2010, Work, Casual Employees, http://www.abs.gov.au/ausstats/abs@.nsf/2f762f95845417aeca25706c00834efa/08e70c82447487c0ca25779e001c479f!OpenDocument

would align with clinical recovery patterns. This may create more appropriate and effective point for a financial return to work incentive to commence. For example, most fractures have a healing period of within six weeks and the many other injuries have a healing period within 13 weeks.

An earlier step down would harmonise NSW arrangements with Victoria, South Australia and Western Australia.

6. Incapacity payments - partial incapacity

It has been suggested that the NSW arrangements for incapacity payments for partial incapacity do not encourage recovery and return to full employment.

In other jurisdictions, including Victoria and South Australia, financial disincentives are utilised to prevent long term dependency.

This benefit arrangement for partially incapacitated workers would put into practical effect the object of the workers compensation legislation of rehabilitation and return to work. By increasing benefits as workers increase their hours of work, all participants; workers, employers and treatment providers have a clear and simple objective.

7. Work Capacity Testing

It has been suggested that work capacity testing at specific points could assist injured workers on long term weekly benefits in transitioning from weekly benefits back into paid employment. In the lead up to undertaking a work capacity test, injured workers would need to be supported by appropriate rehabilitation to make them as work ready as possible.

There is a concern that continuing to pay weekly benefits for workers' many years after a work place injury reinforces the perception that they are still 'injured'. Ceasing weekly benefits after a certain period for workers with a work capacity would assist injured workers to move forward from their workplace injury to focus on their future employment prospects.

Such a reform as well as the changes to weekly benefits could act together in reducing weekly benefit liabilities of the scheme in therefore improve the overall performance of the scheme. Such changes may be more consistent with the objects and principles of the workers compensation legislation in that they support a workers return to work and rehabilitation.

8. Cap weekly payment duration

There is a concern that paying weekly benefits many years after a worker's workplace injury, for those workers a lower level of permanent impairment, reinforces the perception that the worker is still injured.

It has been suggested that capping weekly payment duration to within a certain timeframe and thereafter ceasing payment of weekly benefits would give workers a fixed timeframe during which they know they need to work toward a certain level of work readiness.

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

The lump sum payment for pain and suffering was a subjective measure of the financial impact of a worker's injury and was originally inserted to replace common law provisions in the 1987 Act. While common law provisions were restored and modified in 1989, the lump sum payment for pain and suffering was not removed. It has been argued that this is an anomaly within the statutory scheme and one that creates significant disputation and legal costs.

It has been suggested that the incorporation of this provision into lump sum payments for injuries with Whole Person Impairment greater than 10% would reduce disputation and reduce administration costs.

Such changes would also ensure that statutory lump sum compensation aligns with an objective measure of the worker's physical impairment following a workplace injury rather than a subjective measure of the worker's 'loss'.

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

It has been suggested that such a measure might ensure that workers injuries are stabilised providing them with appropriate compensation. It may also reduce the ability of fraudulent or exaggerated injuries to meet the meet thresholds.

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

The current Guidelines provide objective criteria for assessing whole person impairment. It has been suggested that there is no reasonable rationale for obtaining multiple reports and it can be distressing for injured workers and contributes to their feeling of being 'injured'. It does not enable them to focus on recovery. Having one assessment of impairment for statutory lump sum, commutations and work injury damages might reduce scope for new disputes about level of whole person impairment in the course of determining commutation applications or work injury damages and thereby reduce medical, legal, red tape and administrative costs in the Scheme.

12. Strengthen work injury damages

The provisions of the Civil Liability Act dealing with the law of negligence do not apply to work injury damages claims made under the workers compensation legislation. As a result, the principles used to determine negligence in workers compensation common law matters are those which applied to the law of negligence prior to 2002 and now diverge from the general law. It has been suggested that this situation compromises the ability of insurers and employers to defend work injury damages claims.

Legislation similar to the Civil Liability Act was enacted in other Australian jurisdictions. These provisions also do not apply to workers compensation common law claims in those jurisdictions. It has been suggested there is no reason to exclude workers compensation common law claims from the principles of the law of negligence which apply to other damages claims and it has been proposed the Civil Liability Act provisions dealing with the law of negligence should apply to those claims.

13. Cap medical coverage duration

There would be the potential for capping medical benefits as they do in other States.

There is currently no cap on benefits for medical and related treatment and many workers have access to medical treatment many years after their date of injury.

The most recent national data available, the Comparative Performance Monitoring Report (CPM) for the 2009-10 financial year, shows NSW has the highest expenditure on 'services to workers' which encompasses medical treatment, rehabilitation, legal costs, return to work assistance, transportation, employee advisory services and interpreter costs that are used to assist employees recover from their injury and return to work.

14. Strengthen regulatory framework for health providers

Increases in medical costs over the last five years have been significant and it may be desirable to strengthen the regulatory framework for health providers to ensure that scheme resources are directed to evidence-based treatment with proven health and return to work outcomes for injured workers rather than on treatments that maintain dependency.

15. Targeted commutation

Targeted commutation would allow commutation thresholds to be relaxed for specific classes of claim on a time limited basis. The Scheme Actuary and industry experts have advised against broadening access to commutations and such a measure would need to be limited to very specific classes of injury/claim

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

It has been suggested this would provide a closer connection between work, health and safety responsibilities and workers compensation premiums through eliminating workers compensation costs arising in circumstances over which employers have limited control.

Covering liability for strokes and heart attacks is arguably inconsistent with the principles of the workers compensation legislation as the principles of the legislation are to provide income support, medical assistance for workers injured as a result of a workplace injury. Whilst tragic for all concerned, causation of strokes and heart attacks are not normally associated with workplace injuries and the factors that impact on rehabilitation and return to work are not typically workplace issues.

Why change is needed

The workers compensation system is a critical component of the NSW economy. It should not hinder productivity but should enhance the growth of jobs.

Workers compensation has to be affordable and efficient and allow New South Wales to be competitive with our most comparable States of Victoria and Queensland

Employers and workers are entitled to expect a workers compensation system that is efficient, cost effective and offers fair, timely assistance to employers and workers.

It has been suggested that the goal of any reform package should be to adopt the most effective workers compensation measures from around Australia, to simplify benefit calculation, to make workers' entitlements more transparent and easier for workers and employers to understand. Workers whose injuries are less serious should have greater incentives and support to return to work, while more seriously injured workers should receive improved weekly benefits and lump sum compensation entitlements.

Glossary

ACS average claim size

actuarial projection – an actuarial estimate - usually an estimate of outstanding claims liabilities, inflated and discounted to a particular date, based on the estimates for future premiums collected, investment returns, and future claims obligations and related expenses.

actuarial valuation – actuarial valuation of outstanding claims liability for the NSW Workers Compensation Nominal Insurer – prepared six monthly (as at 31 December and 30 June)

agent – (Scheme Agent) entities providing workers compensation claim and policy services under contract with the Workers Compensation Nominal Insurer. Does not refer to an agency relationship in the legal sense.

arithmetic average – for Scheme valuation purposes, a method for selecting and testing the continuance rate assumptions

B

breakeven premium rate – the percentage of wages required to be sufficient (together with expected investment income) to meet the expected cost of claims arising during the coming 12 month policy year.

C

CED case estimation development

chain ladder method - the Chain Ladder Ratio (CLR) method is typically used by the Scheme actuary when preparing the Scheme valuation to project claim numbers. It looks at patterns in the development of claim numbers from one development period to the next. The selected ratios of development (the chain ladder ratios) are multiplied with the current level of claim numbers to project future numbers. See also **triangulation.**

claims experience – an employer's claims history, including claims frequency and total payments made.

CHE claims handling expense – an allowance in the Scheme accounts for claim administration costs

common law claim – a claim that has resulted in legal action for negligence being taken against an employer in relation to a work related injury. Referred to as Work Injury damages in NSW legislation.

commutation – the process of settling a claim with a lump-sum payment to buy out future payment streams.

continuance rates –a measure of claim duration or more specifically, how the number of active claims changes from one period to the next

costs of claims all payments made by the insurer in respect of the claims and the estimated costs of all future payments arising from the claims

D

discounted values – Accounting and actuarial standards require the Scheme outstanding claims liability to be paid in future years to be discounted to the valuation date using "risk free" returns on Commonwealth Government Bonds

F

front end claims - workers compensation claims for injuries incurred in the most recent accident years – usually the most recent two years

front end continuance rates continuance rate is essentially the ratio of how the number(s) of active claims change from development period to development period. Front end continuance is the behaviour of claims in the first two years.

fully funded – when a scheme's current assets are sufficient to cover the liability associated with all incurred claims and related expenses

funding ratio Scheme total assets divided by total liabilities - commonly used as an indicator of the Scheme's overall financial position/ funding adequacy.

funding ratio projections - estimate of the funding ratio at future points in time (see funding ratio)

funds management – the investment and oversight of the Scheme's assets.

G

geometric average – for Scheme valuation purposes, a method for selecting and testing the continuance rate assumptions

I

incapacity benefit – the payment made under a workers compensation claim to compensate an injured worker for lost income.

inflated values - The future cashflows projected in the Outstanding Claims Liability valuation are inflated to the expected date of payment based on an assumption about future rates of inflation

J

journey claims - claims for injuries that occur while travelling between the claimants home and place of employment

L

long-tail claims – refers to active claims from over a certain age – usually three years

long term gap assumptions - a set of economic assumptions used by the Scheme Actuary to estimate outstanding claims liabilities. Specifically the difference between the discount rate and inflation rate (the 'real' inflation rate) – projected over the long term. Essential for converting long term liabilities into an as at date value.

loss ratio - the measure of incurred claims cost divided by prerniums earned

M

managed fund scheme - the structure of the current WorkCover Scheme. It is an underwriting structure where a statutory pool of assets exists to fund future claim liabilities

N

net central estimate –The Scheme valuation uses central estimates, in the sense that they represent the actuary's best estimate of the liability for outstanding claims, with no deliberate bias towards either over- or under- statement. They are, however, uncertain and the amount which eventually turns out to have been required to provide for the liability may be more or less than the central estimate. the central estimate of claims incurred is the mean of all possible values of outstanding claims liabilities as at the reporting date

non-economic loss measure of the impact of an injury on a worker's lifestyle, such as pain and suffering, disfigurement and reduced expectation of life, normally associated with permanent impairment

P

PCE - Projected Case Estimates

PPAC - payments per active claim

PPCI – payments per claim incurred

premium - the payments made by an employer to an insurance provider to buy, and maintain, a policy

probability of adequacy – the likelihood that the central estimate will be adequate to meet all future claims payments

projected solvency trajectory projection/estimate of the amount of time required for the Scheme to return to full funding

R

return-to-work management - the process of physical and workplace rehabilitation of an injured worker to enable his/her successful reentry into the workforce. This can also include job modification

risk margin - a 12% risk margin is factored into the Scheme accounts and ensures that if the Scheme's ultimate liability turns out to be greater than estimated, there is a 75% probability that there will be sufficient assets to cover the difference. This 75% probability of adequacy is based on the Australian Prudential Regulatory Authority's requirement for private insurer risk margins and has been applied to the Scheme valuation since 2007. In the absence of a risk margin, the probability of adequacy would fall to 50%.

S

self-insured employer - an employer that is licensed to carry its own workers compensation liability and is responsible for managing its own workers compensation claims

superimposed inflation the tendency for claims costs to increase at a rate that is usually greater than wage inflation

T

top up payments - an informal term, which may refer to:
1 – where a claimant returns to work, but as a result of their injury now earns less, weekly incapacity "top up" payments make up the difference between their pre and post injury earnings. Generally paid under section 40 of the 1987 Act.

2 – claimants who have received a lump sum payment for permanent impairment may subsequently claim additional lump sums for deterioration in their condition. In some cases claimants make multiple "top up" claims over many years. Generally paid under section 66 of the 1987 Act

triangulation - reserving for future claims by comparing the emergence of claims year by year for each underwriting year, the relevant data being set out in triangular arrays.

W

Work Injury Damages NSW legislative term for common law claims – see **common law**

Y

yield curve - accounting and actuarial standards require the Scheme's outstanding claims liability to be discounted to a present value based on observable market yields from Commonwealth Government securities. Where yields fall, claim liability values increase.

4. List of appendices

1. *Executive Summary WorkCover NSW Actuarial valuation of outstanding claims liability for the NSW Workers Compensation Nominal Insurer at 31 December 2011*
2. *External peer review of outstanding claims liabilities of the Nominal Insurer at 31 December 2011*
3. *Table of jurisdictional comparison of current benefit regime in NSW*

'B'

NSW GOVERNMENT | WorkCover

FACT SHEET

Workers compensation changes

Overview

The NSW Worker's Compensation Scheme needed major reform because it was more than $4.1 billion in deficit and was not fulfilling its core responsibilities of rehabilitating injured workers, where possible, and returning them to work, while ensuring those who were unable to return to work were properly supported.

Not only was the Scheme in serious financial difficulty, but NSW employers were paying workers compensation insurance premiums which were between 20 and 60 per cent higher their counterparts in Victoria and Queensland.

The reforms

The State Government sought independent advice about WorkCover's financial position. That advice showed insurance premiums paid by employers would have to rise 28 per cent immediately if the Scheme was to be financially sustainable in five years.

The advice also showed the most seriously injured workers in the Scheme were receiving weekly payments barely above the poverty line.

The Scheme was in massive deficit and failing to properly support those it was supposed to protect.

To address this serious imbalance, the NSW Government released an Issues Paper detailing the Scheme's failings when compared to its key aims, and outlining some options for consideration.

On 2 May 2012 a Joint Select Committee of Parliament was established to inquire into and report on the NSW Workers Compensation Scheme. The Inquiry reported to Parliament on 13 June and, because of the looming financial crisis in the Scheme, the NSW Government subsequently introduced the *Workers Compensation Legislation Amendment Bill 2012.*

The reforms were passed by Parliament on 22 June and assented on 27 June making it law.

The new laws change the way workers compensation benefits claims are assessed and paid.

The changes affect all new and existing workers compensation claims, except for claims from:

- police officers, paramedics and firefighters
- workers injured while working in or around a coal mine
- emergency service volunteers (Rural Fire Service, Surf Life Savers, SES volunteers)
- people with a dust disease claim under the *Workers Compensation (Dust Diseases) Act 1942.*

Claims by these exempt workers will continue to be handled as though the June 2012 changes never occurred.

Some of the changes have already taken effect. Others will come into effect gradually over the next 12 to 18 months.

New definitions

Work capacity assessments

Injured workers receiving weekly benefits will undergo work capacity assessments at specified points throughout the life of their claim, and at least once in every two years. The work capacity assessment will take into account a range of factors including medical evidence, vocational retraining, and the number of hours a person is able to work.

The results of the work capacity assessment will be used to determine the worker's future entitlements to benefits. Seriously injured workers whose whole-person impairment has been assessed at more than 30 per cent will not be required to have work capacity assessments. However, those workers may request an assessment if they wish, for example, to explore return-to-work options.

Journey claims

A journey claim is an injury sustained while a worker is travelling between home and work while the worker is off duty.

The new laws mean coverage will only be available where there is a substantial connection between the person's employment and the incident out of which the injury arose.

For example, if a nurse en route to work stops to assist at a car accident, and is subsequently injured on her way to work, he or she would be covered by workers compensation insurance.

Benefit levels – weekly incapacity payments

Total incapacity

During the first 13 weeks of incapacity, workers who are totally unfit for all work will receive up to 95 per cent of their pre-injury average weekly earnings. From weeks 14 to 130, workers who have no work capacity will receive up to 80 per cent of their pre-injury average weekly earnings.

Workers who are totally unfit for all work for a long period will be better off as they will receive up to 80 per cent of their pre-injury earnings up to week 130 rather than the current $432.50 per week which applies after the first 26 weeks.

Partial incapacity

Workers who have a partial incapacity and are able to work during the 13 weeks after a claim is made will receive up to 95 per cent of their pre-injury average weekly earnings. This amount will comprise the actual wages they are earning and a top-up compensation payment.

Workers who have returned to work for at least 15 hours per week will receive a top-up to up to 95 per cent of their pre-injury average weekly earnings for the first 130 weeks. After that, the rate will be up to 80 per cent of pre-injury average weekly earnings.

Those who have capacity to work, but who are working less than 15 hours per week from week 14 to 130 will receive up to 80 per cent of their pre-injury average weekly earnings. This amount will comprise the actual wages they are earning and a top-up benefit.

If a worker is able to work and is not working at least 15 hours per week by the end of the 130 weeks, entitlement to weekly benefits will cease. However, workers who cannot work will continue to receive benefits of up to 80 per cent of their pre-injury average weekly earnings.

Pre-injury earnings

Pre-injury average weekly earnings will be calculated based on the worker's real earnings in the period prior to injury, rather than the current method of paying either the base award rate or up to 80 per cent of average weekly earnings at the time of injury. For many people this will be a higher level of benefit than provided in the old scheme.

Capping weekly benefits

Continuation of weekly payments after 130 weeks will depend on the person being either totally incapacitated, or (if partially fit to work) having achieved an actual return to paid employment of at least 15 hours per week.

Weekly payments will be limited to a maximum of five years, or on the worker reaching the Commonwealth retiring age (whichever occurs first). At this stage, eligible workers will be able to switch to Commonwealth benefits.

Injured workers with a whole person permanent impairment over 20 per cent will be exempt from this five-year limit and will be eligible to receive weekly payments until reaching the Commonwealth retiring age, provided they have a continuing total incapacity to work. They may be eligible for Commonwealth benefits.

Lump sum payments

Pain and suffering

Payments for pain and suffering under section 67 of the *Workers Compensation Act 1987* are no longer available.

Permanent impairment claims

A threshold of over 10 per cent whole person impairment for physical injury must be reached to access a permanent impairment lump sum, including for hearing loss. The threshold for psychological injury lump sum payments is unchanged (15 per cent whole person impairment).

Assessment of whole person impairment

An injured worker can only be assessed for permanent impairment once .

Medical benefits

Payment for medical and related treatment will end at whichever occurs last:

- 12 months after the claim for compensation is made, or
- 12 months after the last payment of weekly benefits.

The restriction does not apply to workers with a whole person impairment of over 30 per cent. For these workers, medical cover continues.

Diseases, heart attack and stroke injuries

Heart attacks and strokes are only covered by the Scheme if the nature of the employment gave rise to a significantly greater risk of the worker suffering the injury.

For a disease injury, the worker's employment must be the main contributing factor.

Nervous shock and death benefits

There is no entitlement for family members of deceased or injured workers to make nervous shock claims on the NSW Workers Compensation Scheme.

The existing statutory compensation death payments will continue to apply and include:

- an indexed lump sum (currently $481,950) payable to financial dependents, or the deceased worker's estate if there are no dependents
- indexed weekly payments for dependent children (currently $122.50 per child per week)
- funeral expenses ($9,000)

Return to work obligations

Injured workers and their employers need to work together to ensure the best possible return-to-work results. The changes mean a worker who is able to work must, in co-operation with the employer or insurer, make reasonable efforts to return to work in suitable employment, and may request their employer to provide such suitable employment. The employer must comply with this request so far as it is practicable. WorkCover inspectors are now authorised to issue employer Improvement Notices if they believe the employer is not meeting their obligations in this regard. In addition, it is an offence for the employer if they fail to meet their obligations, subject to a penalty of up to $11,000. If a worker who is able to work fails to make reasonable efforts to do so, he or she may have their weekly payments suspended or – in extreme cases - terminated.

Existing Claims

For those already receiving weekly payments immediately prior to commencement of the new arrangements, special arrangements apply. The changes differ depending on the length of time that people have been receiving payments and their level of work capacity.

Some features of the transitional arrangements are:

- seriously injured workers who have been receiving long-term weekly benefits and whose whole person impairment is more than 30 per cent can move from $432.50 per week, to the transitional rate of $725. This will take place as soon as practicable. WorkCover is taking steps to apply the new benefits to these workers as soon as possible;
- during the first 26 weeks of incapacity payments, the amount paid will be the same as under the existing rules;
- claimants who have already received 26 weeks of payments and have an ongoing entitlement will be paid according to the transitional rate that is significantly more than the current basic statutory rate of payment; and
- the existing weekly payment rules will continue to apply until the person has undergone an individual work capacity assessment. Due to the large number of people receiving payments, it may take more than 12 months for all existing claimants to undergo work capacity assessment.

Workers will be given three months' notice of any changes to their weekly benefits due to the new laws. The most seriously injured workers will not be subject to work capacity assessments unless they wish to have one.

Catalogue No. **WC03795** WorkCover Publications Hotline **1300 799 003**
WorkCover NSW, 92-100 Donnison Street, Gosford, NSW 2250
Locked Bag 2906, Lisarow, NSW 2252 | WorkCover Assistance Service **13 10 50**
Website **workcover.nsw.gov.au**

ISBN 978 1 74341 121 6