THE LAW SOCIETY
OF NEW SOUTH WALES

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Dear Ms Walsh,

**NSW Workers Compensation Scheme Benefits Reform**

The Injury Compensation Committee ("Committee") of the Law Society of NSW thanks you for the opportunity to participate in discussions regarding investment of additional solvency funds at the invitation of Mr Vivek Bhatia, Chief Executive Officer of Safety, Return to Work and Support Board. Following the meeting on 30 June 2015 with WorkCover and Law Society representatives, the Committee now provides these comments.

## 1. Background

The NSW workers compensation system is designed to establish a 'workplace injury management' and compensation scheme. "Compensation" means compensation under the Workers Compensation Acts, and includes any monetary benefit under those Acts.

Pursuant to section 154D(2) of the *Workers Compensation Act 1987* ("the 1987 Act"), the assets of the Workers Compensation Insurance Fund are subject to a statutory trust to be held on trust for the purposes to which assets of the Insurance Fund are authorised or required to be applied by or under this Act and for the benefit of workers and employers as provided by the Act ("1987 Act").

The objectives of the system are defined in section 3 of the *Workplace Injury Management and Workers Compensation Act 1998* ("the WIM Act") as:

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

(b) To provide:

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

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

(c) to provide injured workers and their dependants with income support during incapacity, payment for permanent impairment or death, and payment for reasonable treatment and other related expenses;

(d) to be fair, affordable, and financially viable;

(e) to ensure contributions by employers are commensurate with the risks faced, taking into account strategies and performance in injury prevention, injury management, and return to work; and

(f) to deliver the above objectives efficiently and effectively.

Section 9(1) of the 1987 Act states:

> A worker who has received an injury (and, in the case of the death of the worker, his or her dependants) shall receive compensation from the worker's employer in accordance with this Act.

The Scheme in its current form now provides only limited compensation to injured workers in the following benefit categories:

- Weekly payments for 'incapacity'
- Medical and treatment expenses
- Permanent impairment lump sum payments
- Death benefits
- Work Injury Damages
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Access to certain categories of benefits is limited by means of impairment thresholds and only accessible as follows:

- Weekly payments – greater than 20% impairment after 5 years.
- Medical Expenses – greater than 20% impairment if the claim was made before 1 October 2012 and greater than 30% impairment if the claim was made after 1 October 2012.
- Permanent Impairment lump sum compensation – greater than10% impairment .
- Work Injury Damages – 15% impairment (note access restricted to where negligence can be proved on the part of the employer, only limited 'damages' accessible)

Following the 2012 reforms to the NSW workers compensation scheme a $4.1 billion deficit has been transformed into $2.4 billion surplus. Funding ratios are expected to be between 90% and 110% but are currently at approximately 120%. The Government has announced that it will restore about $500M to workers and employers.

Section 154D(4) of the 1987 Act provides that employers are entitled to participate in the distribution of any surplus in the Insurance Fund and are responsible for meeting any deficit in the Insurance Fund by means of the fixing of premiums, levies and contributions as provided by the Act. In 2012 employers were not made responsible for meeting the deficit but instead workers' benefits were significantly reduced. Within 12 months of the reform legislation employers received distribution of the surplus by reduction of premiums and have subsequently received further distribution of the surplus in the Insurance Fund (which is growing) by means of further premium reductions. Since the reform legislation, workers have not received the benefit of any surplus funds, other than the limited extension of medical benefits for existing claims pursuant to the *Workers Compensation Amendment (Existing Claims) Regulation 2014.*

Since 2012, workers' benefits have been reduced further through legislative interpretation of certain provisions of the Acts by the Courts.

Given the level of surplus and diminishing benefit levels as a consequence of further legislative interpretation, the Committee considers there should be measured restoration of benefits to workers commensurate with the expected funding ratio.

## 2. Medical and Treatment Expenses

The Committee submits that the return of medical benefits to injured workers should be a high priority of any reform package that may be introduced by the Government. Medical and treatment expenses are at the core of the workers compensation system and the key to achieving return to work objectives. The Committee considers that injured workers should receive prompt and appropriate treatment of injuries to enable the worker to return to work, where appropriate, as soon as possible.

The Committee submits that the current arrangements do not achieve the goals intended. The issues involved have been raised extensively and are well documented, including in the Statutory Review of the *Workers Compensation Legislation Amendment Act 2012* and the Review of the Exercise of the Functions of the WorkCover Authority by the Standing Committee on Law and Justice.

As you would be aware, section 59A of the 1987 Act is based on the concept that payments for medical expenses cease 12 months after a worker ceases to receive weekly payments. Three years after its introduction it still remains enormously difficult for a worker and the insurer to determine a worker's entitlement to medical expenses as impacted by section 59A.

Because of the way section 59A operates, members of the Committee are now starting to see evidence of behavioural changes of injured workers, insurers and their legal representatives directed at mitigating the unreasonable consequences of this provision.

Injured workers and their treating medical practitioners are making decisions about medical treatment based on when compensation coverage is to expire as opposed to what is the best treatment for them. The Committee has, for example, observed that many injured workers are now looking for surgery as an early treatment option as opposed to an option of last resort. This is likely to lead to increased costs to the scheme as workers elect to undergo surgery which may have been avoided by longer term conservative treatment. In the long run this may lead to poorer health outcomes and a reduction in the workers' ability to return to work early.

Section 59A also builds in an incentive to stay off work in an attempt to ensure that medical expenses are covered. For example, if workers return to work the current system "penalises" them by having their medical expenses cut in 12 months' time. If they do not work, and continue to receive weekly compensation benefits, they are "rewarded" by continuing to have their medical expenses paid.

It should be noted that those injured workers who have had their benefits cut under section 59A are resorting to the public health system to have their treatment funded. This has some significant impacts. First, there are long waiting times in the public system. As such the workers' ability to have required treatment is delayed and their return to full work is delayed. Secondly, in terms of costs shifted to Medicare, the tax payer pays for the treatment out of general revenue rather than the scheme funding it out of revenue raised from premium collection. Alternatively, treatment provided in a NSW public hospital is met ultimately out of

consolidated revenue. The Committee notes that this results in an underreporting of the true cost to the Government in the operation of the current workers compensation scheme.

The reforms have created great uncertainty, unnecessary litigation, and, potentially significant hardship. The harshness of these provisions cannot be understated. In order to address this and return benefits to injured workers it is recommended that:

1. Section 59A be repealed.

2. In the event that the Government is not minded to repeal section 59A, the Committee submits that the section requires substantial amendment to provide a simple test that applies to all (excluding exempt workers and those with over 20% impairment). For example, the Government might consider payment of medical expenses for a fixed period, for example, of six calendar years after the claim was first made.

3. Section 60(2A)(a) be repealed.

4. A number of injured workers are excluded from accessing prompt treatment in circumstances where provisional liability is not accepted and/or liability is declined at an early stage. This issue could be addressed by providing a fund administered by the WorkCover Authority for the provision of medical treatment to this category of claimant subject to an appropriate monetary and duration cap.

### 3. Weekly payments

The Committee submits that there is no evidence that the current duration of the entitlement periods encourages early return to work, which is a primary tenet and objective of the system. A limit of 2.5 years of compensation for the great majority of injured workers (including seriously injured workers) is unfair, particularly when the test for receiving weekly compensation beyond 2.5 years is considered. In 2012 the Joint Select Committee recommended that a time cap of:

> no less than five years for seriously injured workers with a more generous time cap for an intermediate category of injured worker and ultimately no time cap (except the Commonwealth retirement age) for the most seriously injured workers.

The Committee considers that the following reforms are consistent with early return to work and fair compensation:

1. Increase the first entitlement period or first 13 weeks of benefits to 100% of pre-injury average weekly earnings.

2. Remove the 52 week "step-down" in the calculation of pre-injury average weekly earnings.

3. Where an employer refuses to provide suitable employment for an injured worker, double the weekly payments entitlement period (to 5 years).

4. Remove the unreviewable subjective discretion of an insurer to determine capacity in section 38 (2) and (3) of the 1987 Act.

5. Recast the 'suitable employment' test to reflect actual labour markets.

6. Ensure that aged workers injured shortly before retirement age receive weekly compensation benefits consistent with those who are injured over retirement age.

## 4. Permanent Impairment

The erosion of permanent impairment compensation in the 2012 reforms was profound. The amending legislation removed 'pain and suffering compensation' without incorporating that payment into the section 66 permanent impairment lump sum scale. It also introduced two restrictions: a greater than 10% impairment threshold, and a 'one claim' policy.

The 'one claim' and determination of what constitutes a claim for the application of section 66(1A) of the 1987 Act has been the subject of judicial scrutiny for three years (*ADCO Constructions Pty Ltd v Goudappel* [2014] HCA 18, *Caulfield v Kartaway Pty Ltd* [2014] WCCPD 34 and most recently in the Court of Appeal in *Cram Fluid Power Pty Limited v Green* on 30 June 2015). While the 'one claim' has been interpreted to date to mean 'one further claim' after 19 June 2012, the decision of the Court of Appeal in *Cram Fluid* may further restrict that interpretation to one claim only, even if this one claim was made before 19 June 2012 when the claimant was not even aware of any restrictions on the number of lump sum claims that the claimant was entitled to pursue. The judicial scrutiny and uncertainty surrounding the lump sum compensation amendments has made it very difficult for lawyers to advise their clients on their lump sum entitlements for the last three years and, unless checked, this uncertainty will continue for the foreseeable future.

The Committee considers that the reforms were unduly onerous and recommends the following:

1. The benefits scale be increased to implement Recommendation 11 of the Joint Select Committee (June 2012) to reflect the non-economic loss scale in the other personal injury jurisdictions in NSW.

2. The threshold for permanent impairment claims be lowered to greater than 5%.

3. Workers be permitted to bring second and subsequent claims for permanent impairment lump sum compensation where there is a deterioration (increase) in their impairment of 5%.

4. The 'one assessment' provision in section 322A of the WIM Act be removed to permit workers to access benefits of differing kinds where an assessment of permanent impairment is required to qualify for benefits.

## 5. Seriously injured workers

The 2012 reforms were said to benefit seriously injured workers, creating a specific category of worker ("seriously injured workers" with greater than 30% impairment). However, despite various recommendations of the Joint Select Committee, seriously injured workers are not relieved of the onerous requirements or eligibility tests for benefits (see 4 and 5 under 'weekly payments' above). Further, there are now two categories of seriously injured worker:

- those with a greater than 30% impairment;
- those who lodged claims before 1 October 2012 with a greater than 20% impairment.

In June 2014 Minister Perrottet announced:

> A sustainable scheme has also enabled the NSW Government to increase weekly income for seriously injured workers by up to 70 per cent over the amount previously paid under the old system.

However, seriously injured workers remain subject to various restrictions introduced by the 2012 legislation. Seriously injured workers are not relieved of the step downs at 13 weeks, 52 weeks and 2.5 years nor the onerous discretionary tests in sections 38(2) and 38(3) of the 1987 Act to qualify for weekly benefits beyond 2.5 years. There is nothing in the legislation that mandates a seriously injured worker being treated any differently than a less seriously injured worker in terms of satisfying the capacity tests to receive weekly payments. While a seriously injured worker is not obliged to attend a work capacity assessment this does not stop the insurer making a work capacity decision which reduces or stops benefits.

The Committee considers that:

1. The threshold for seriously injured worker should be lowered to 20%.

2. For the purpose of eligibility to be treated as a seriously injured worker, impairments from separate injuries (for which claims have been made and not resolved by final determination) should be permitted to be aggregated.

3. Seriously injured workers should be relieved of all work capacity assessments and should not be made subject to a binding work capacity decision.

4. The time cap for weekly benefits should not apply to seriously injured workers (except for Commonwealth retirement age).

**6. Dispute Resolution and settlement**

The Committee considers that the current dispute resolution process in respect of claims involving statutory workers compensation benefits has become unnecessarily complex and disjointed.

The process by which disputes were notified prior to the 2012 amendments was problematic and this has been substantially worsened by the imposition of additional notification requirements in respect of work capacity decisions.

An insurer is required to give notice of a dispute in accordance with Section 74 of the WIM Act and in the related regulations. Notification is also required where weekly payments of compensation are to be reduced or terminated, in accordance with the requirements of Section 54 of the 1987 Act.

While a notice issued in accordance with Section 74 of the WIM Act needs to be concise and understandable, the formal requirements of a Section 74 Notice have been read as requiring a high degree of detail and particularisation as well as requiring that all relevant documents be attached to that notice (whether or not they support the decision).

The consequence of a Section 74 Notice being defective or deficient is often that an insurer is precluded from disputing liability before the Workers Compensation Commission ("Commission") on a basis not accurately particularised or detailed in such a notice whether or not such a basis has merit. In addition, an insurer may be precluded from relying on material or documents not provided with the Notice.

Following the amendments to the legislation the extent of a Claimant's entitlement to weekly compensation is determined by means of a work capacity decision (as defined in Section 43 of the 1987 Act).

While Section 43 itself does not contain any specific requirements that an insurer notify a worker of a work capacity decision, Section 54 of the 1987 Act requires that notice be given to a worker where the amount of weekly compensation is to be discontinued or reduced and a series of guidelines issued by the WorkCover Authority in respect of work capacity impose significant obligations on insurers regarding the manner in which work capacity assessments are conducted and the manner in which work capacity decisions are notified. Those guidelines are not only onerous but, in many circumstances, incapable of being complied with by an insurer.

More importantly, the Commission has now been deprived of any jurisdiction in a dispute involving the work capacity decision and is unable to make a decision in respect of a dispute before the Commission that is inconsistent with such a decision.

The consequence of this is that the disputes about primary liability for the payment of statutory compensation are dealt with by an Arbitrator at first instance in the Commission and disputes about lump sum compensation (where liability is not disputed) are dealt with by an Approved Medical Specialist through the Commission.

On the other hand disputes about weekly compensation are now dealt with by a complex and convoluted review process involving, at first instance, an internal review by an insurer followed by a "merit review" by the WorkCover Authority and a "procedural" review by the WorkCover Independent Review Officer. Injured persons are expected to navigate this complex system without the benefit of legal advice given the prohibition contained in section 44(6) of the 1987 Act.

The summary set out above does not fully capture the complexity of the dispute notification process nor to the disjointed process by which disputes which have been notified are resolved. For example, the liability part of a dispute needs to be determined by the Commission whereas the determination of the assessment of the weekly benefits component of any liability finding needs to be made by the insurer and then, if challenged, by the complex review process mentioned above. The requirement for different forms of notification applying to different entitlements to statutory compensation benefits and the requirement that different forms of disputes are subject to different dispute resolution processes is unsatisfactory and is not conducive to the objects of the legislation.

The Committee considers that this process needs to be simplified and rationalised. The starting point should be that there is only one form of notification required to be given to a worker dealing with the nature and extent of any entitlements to statutory compensation benefits and dealing with any dispute as to whether those entitlements exist and the extent of them. The requirements for such a notification should be simple, concise and understandable. In essence the notice need only properly identify the nature of any dispute and the reasons for it. Further, such a notice should not be found to be invalid or of no effect simply by reason of a deficiency in its form or content.

Once a dispute is notified all disputes should be referred to one dispute resolution system. The forum for that single dispute resolution system is not of primary importance although it remains the view of the Committee that such disputes should be dealt with by independent, properly trained and experienced judicial officers. It is accepted that the process by which these disputes are resolved should be effective and efficient in properly identifying the nature of any issues which legitimately need to be resolved and the documentation and information relevant to the resolution of those issues. Small claims or claims involving single or limited issues should be dealt with on an expedited basis (where those claims cannot be conciliated) and complex claims or those involving multiple issues should be determined in a manner which affords justice and procedural fairness to the parties to a dispute.

Importantly the dispute resolution process should allow all parties access to legal representation and legal representatives should be reasonably remunerated.

An important part of the dispute resolution process is that parties will also have available to them reasonable avenues by which claims can be resolved including, if necessary, on a final basis. The WIM Act presently requires that disputes before an Arbitrator cannot be determined without the Arbitrator first using the Arbitrator's best endeavours to bring the parties to a dispute to a settlement acceptable to all of them (Section 355(1)). However this requirement has been frustrated by the fact that flexible settlement options have not been available.

The Committee submits that the restrictions placed on the party's ability to commute a liability for the payment of statutory compensation benefits set out in Section 87EA of the 1987 Act should be removed so that parties can agree to a commutation of statutory compensation entitlements. This should be subject only to the requirement that a Claimant first obtain legal advice concerning any such commutation.

One of the critical objects of the legislation is to assist injured workers in returning to work. In the majority of cases this will involve an injured worker returning to employment with the employer at which the injury was sustained. There are, however, a large number of injured workers who are unable to return to employment with the same employer for a variety of legitimate reasons.

The ability of injured workers in this category to return to employment with a different employer is often compromised simply by reason of the fact that they remain within the workers compensation system. In those cases the ability of injured workers to reach an agreement concerning a settlement on a final basis (whether described as a commutation or otherwise) would enable them to regain financial and practical independence. They could properly pursue a return to employment without the constraints of remaining within the workers compensation system.

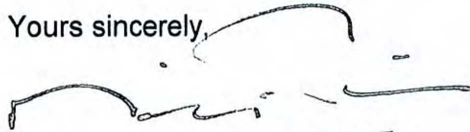
Removal of the restrictions that currently apply to commutations is entirely consistent with the Minister's stated objective of supporting injured workers and getting them back to work.

In summary, the Committee recommends that:

1. The dispute notification process be simplified with only one form of notification required.
2. The dispute resolution process be simplified with one dispute resolution system.
3. All parties should have access to legal representation.
4. The restrictions that currently apply to commutations be removed.

If you require any additional information or have any questions please contact the policy lawyer for the Committee, Leonora Wilson on (02) 9926 0323 or leonora.wilson@lawsociety.com.au.

Yours sincerely,



Michael Tidball
**Chief Executive Officer**