



FINAL REPORT

Statutory review of the Workers Compensation Legislation Amendment Act 2012

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Summary

This statutory review of the *Workers Compensation Act 2012* was triggered early in the life of what was large scale, fundamental change to workers compensation in NSW.

The trigger was an earlier-than-expected estimation that the Nominal Insurer Scheme would be brought into surplus based on improved investment returns and a larger than expected reduction in claims. Both of these changes have contributed to a financial turnaround in the Nominal Insurer Scheme to date.

Some of the findings on the impacts of the amendments are preliminary, and it is too early to assess whether changes to date are sustainable. There has been insufficient time lapsed to draw robust observations about changes at different stages of a claim, or changes in the cost of claims as new entitlement thresholds are triggered. It is also too soon to see the full extent of behavioural changes due to the new incentives embedded into workers compensation arrangements in NSW.

However, it is not too early to observe gaps and inconsistencies in terms of the alignment with the underlying principles for reform. There are also early signs of potential inefficiencies, emerging inequities, and barriers to return to work as a result of implementation to date.

Several areas are highlighted for further government consideration to:

- redress unintended or undesirable outcomes linked to access thresholds and entitlements, and
- simplify complex processes to better meet the guiding principles for reform in a fair and efficient way.

Key findings at a glance

- **There are early signs of financial success, with a large swing in the financial performance of the workers compensation system in New South Wales (NSW), and notable premium reductions for those under the Nominal Insurer Scheme.**
- **It is too soon to say that the improvement in economic fundamentals is sustainable. Part of the improvement is due to the amendments, which have driven large falls in claim numbers and expenditure, although some of the financial turnaround is linked to rebounding investment returns.**
- **The dip in claiming behaviour is unexplainable by the amendments alone, and there are several risks that claiming patterns will change and benefit payments will rise. There are also new system costs generated by the amendments related to claims management and dispute resolution, not reflected in Scheme liabilities.**

- Moreover, there are also some gaps and inconsistencies in the application of the amendments, and some equity considerations that detract from the spirit of the guiding principles for reform.
- A review of the seven guiding principles finds that some lack specificity and some are unmet. Principles that are deemed most appropriate relate to ensuring optimal insurance arrangements, the competitiveness of premiums, promoting recovery and return to work, guaranteeing long-term support for the seriously injured, reducing the regulatory burden, and discouraging payments that do not contribute to recovery and return to work.
- To better achieve these principles, more needs to be done to address barriers to return to work, reduce the administrative burden and improve the ease of navigation through the system, and improve the fairness and equity of benefits and the process for review.

Time will tell

In many respects, it is too early to determine the impact of the amendments on the financial sustainability of workers compensation in NSW, and the effectiveness of individual amendments on behaviours. For instance:

- it is too early to observe whether additional cycles of medical expenses are generated when injured workers become entitled to them, and
- it is too early to be certain that the insurance operations of the Nominal Insurer Scheme are able to achieve sustained improvement, given a substantive part of the financial turnaround has reflected favourable outcomes of investment operations.

The impacts of large-scale change take time to be properly implemented and observed, according to some stakeholders as long as four, and preferably five years, with at least another twelve months required from now before any meaningful data-driven observations can be made.

The success of the amendments in terms of meeting their objectives should improve over time as the processes and infrastructure to support the new system are bedded down. Hence, it is likely that some of the difficulties highlighted in this review may reflect teething issues which may dissipate.

Large scale, system wide change

The 2012 amendments represent a major shift in the incentive system underpinning the workers compensation system in NSW, designed to incentivise behaviours that support financial sustainability.

Whether the impacts were direct or indirect, the 2012 reforms affected all key parties in the NSW workplace injury management system:

- **injured workers** (unless ‘seriously injured’) typically face financial disincentives for not returning to work where some work capacity exists, and the disincentives grow in line with the period of work absence
- **employers**, albeit indirectly or as a result of concurrent reforms, were incentivised to improve safety and claims management or face financial disincentives (excluding smaller employers), and are required to focus on the provision of ‘suitable duties’ for injured workers in order for work capacity assessments to be effective
- **insurers and agents** gained greater powers to force work capacity into the mainstay of the way that workers compensation benefits are distributed, and
- **regulators** were given new powers and responsibilities, with WorkCover inspectors able to issue legally binding improvement notices to employers not meeting management and return to work obligations with penalties payable. Changes in complaints and dispute resolution processes were also introduced through the merit review function of WorkCover and the new role and powers set out for the WorkCover Independent Review Office (WIRO).

Various exemptions were made, but in the main, the 2012 reforms will be considered alongside large-scale reforms in 2001 and 2006 as representing a substantial change in the intention, function and operation of workers compensation in NSW.

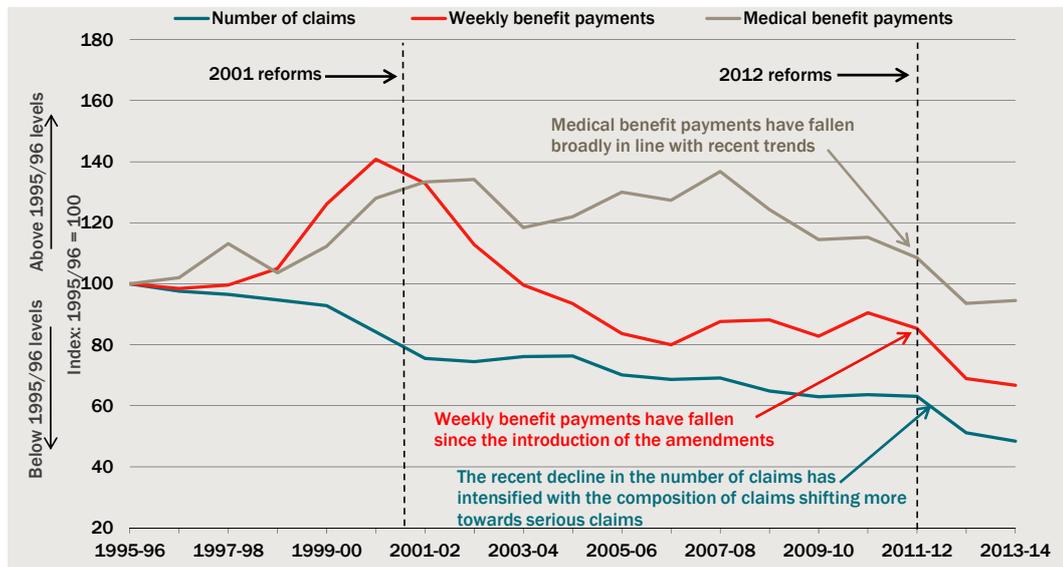
Early evidence shows sizeable financial improvement

The 2012 amendments have contributed to the improved financial performance of the Nominal Insurer Scheme over the 18-month period to December 2013, and the changes underpinning the financial turnaround have also been experienced by self-insurers, specialist insurers, and the Treasury Managed Fund (TMF):

- the \$4.1 billion deficit of the Nominal Insurer Scheme in December 2011 has swung to a \$1.4 billion surplus in December 2013, which partly reflects early evidence on the reduction in gross outstanding claims¹:
 - active compensation claims under the Nominal Insurer Scheme fell 23 per cent over the 18 months to December 2013, with the level of payments down 14 per cent over the period (chart 1)
- the number of active compensation claims with self and specialised insurance schemes has fallen 23 per cent over the 18 months to December 2013, with the level of payments declining by 22 per cent, and
- the number of active claims with the TMF schemes has fallen by 24 per cent over the 18 months to December 2013, with the level of payments declining by 33 per cent.

¹ The risk margin used to calculate gross outstanding claims increased from 12 per cent in December 2011 to 16 per cent in December 2013.

1 Early evidence on the impact of the Amendments on the Nominal Insurer Scheme



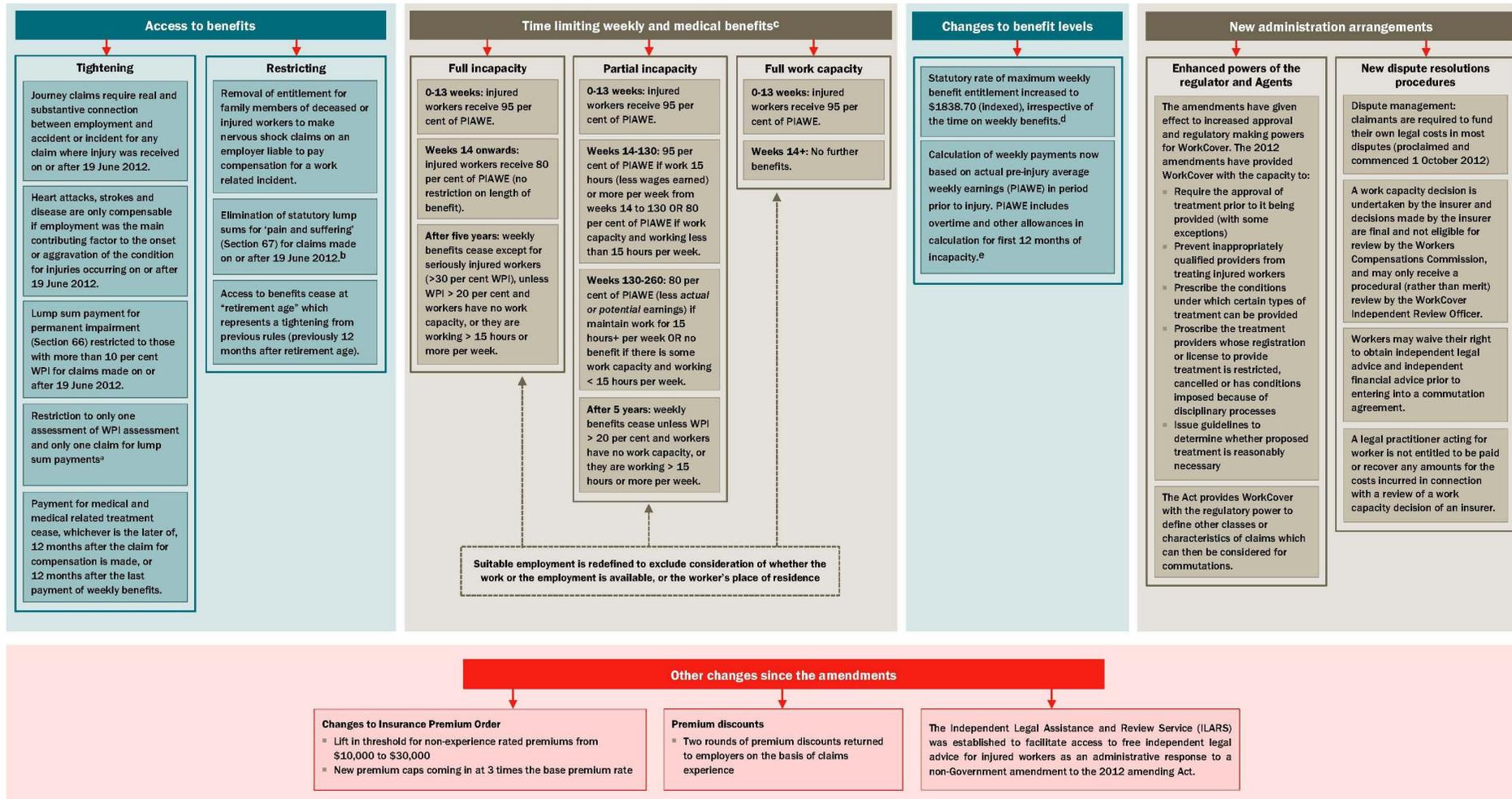
Data source: PricewaterhouseCoopers (PwC), Actuarial valuation of outstanding claims as at 31 December 2013.

Lower benefit payments reflect the fall in claim numbers and the associated value of payments, led by falling expenses for weekly benefits, medical claims, journey claims, and section 66 claims.

The fall in claims reflects both the amendments themselves, such as the introduction of work capacity decisions, tighter access to lump sum (section 66) payments, restrictions around journey claims, as well as changes to claimant behaviour resulting in self-selection of injured workers out of the Nominal Insurer Scheme even where access to compensation has not changed.

A summary of the amendments is provided in chart 2.

2 Summary of the 2012 reforms to the workers compensation system



Notes: ^aThe legal case of *ADCO Constructions Pty Ltd v Goudappel* [2013] NSWCA 94, the High Court found that the 2012 reforms to permanent impairment lump sum entitlements are applicable to pre-June 2012 claimants overturning a Court of Appeal finding, although it is not yet clear what the effect of the High Court decision is in terms of how it applies to different cohorts or workers. ^b The overturning of the legal case of *ADCO Constructions Pty Ltd v Goudappel* [2013] NSWCA 94 by the High Court in 2014 implies that all general claims made prior to June 2012 will no longer receive statutory lump sums for 'pain and suffering'. ^c Prior to the amendments, up to 26 weeks 100 per cent of weekly wage was payable, and after 26 weeks, 90 per cent of weekly wage (less actual earnings) if permanently impaired and 80 per cent of weekly wage (less actual earnings) if partially incapacitated; ^d Previously, the maximum weekly benefit payment after 26 weeks was \$432.50 per week (in April 2012, prior to the amendment) plus additional amounts per week for dependent spouse and children up to a maximum of \$1838.70 (in April 2012); ^e Previously, it was based on the award rate OR for workers not employed under an award or agreement, 80 per cent of average weekly earnings at the time of injury (including regular overtime and allowances)

Source: The CIE, based on PwC, 2013, Markey et al, 2013, and NSW Government, 2012.

Premium reductions and changes to benefits bring NSW more in line with other jurisdictions

Prior to the 2012 reforms, the NSW workers compensation system was in many respects more generous than other jurisdictions, and as a result, premiums were typically higher.

Since the reforms, premium reductions have brought NSW premiums broadly in line with the average premium level across jurisdictions. The benefits structure is also now more aligned with some other systems, particularly Victoria (with respect to restrictions on medical benefits, work capacity assessments, and WPI assessments for lump sum claims), and South Australia (with respect to the treatment of journey claims).

Too soon to conclude that financial outcomes are sustainable

There are several risk factors that suggest financial outcomes may not yet be sustainable.

- **Potential ‘correction’ in the number of claims may be anticipated.** The number of claims have fallen by more than the reduction in access to benefits. There is no robust evidence to suggest injury rates have fallen enough to account for the larger than expected fall. It more likely reflects behavioural change, uncertainty about the new arrangements, and/or publicity about the reforms at the time rather than a lack of entitlement to claim. For instance, since the 2012 amendments, new claims have fallen by around one quarter, with one third explained by the exclusion of most journey claims and the remaining two thirds of this fall difficult to explain because access to workers compensation entitlements (with the exception of journey claims) has not materially changed across the vast majority of other claims.²
- **Average claim costs have increased.** The average payment of all claims, with the exception of commutations, has increased substantially since the amendments indicating that those that remain on benefits generally receive more. If future refinements to guidelines and the Act change impairment thresholds and/or increase claim numbers, total liabilities may increase.
- **Favourable investment returns have partly accounted for improved financial performance** rather than changes in insurance operations. A sizeable proportion of the financial turnaround is unrelated to claims or liabilities and is not relevant to the amendments. In the six months to June 2013, investment returns improved by \$0.40 billion more than expected, without which the Nominal Insurer Scheme would not have been in surplus (and this statutory review would not have been triggered when it

² It is noted that the Nominal Insurer Scheme actuary suggested that prior to the reforms, journey claims may have been inflated because employers were possibly choosing to code motor vehicle claims as journey claims to reduce premiums, as journey claims are excluded from experience premium calculations. See <http://www.parliament.nsw.gov.au/prod/parliament/committee.nsf/0/4E1B55B3597B1EACCA257A0D0026BA40>

was).³ Moreover, changes in investment returns, while positive, are not the core function of the Nominal Insurer Scheme or the TMF, and are likely to fluctuate over time in response to changes in economic conditions. They are not the subject of the objectives of the Act or the seven principles of the 2012 amendments.

- **Future legal challenges could arise affecting interpretation and application of the amendments.** Given the ‘early days’ of the amendments, and the large scale change involved, it is possible, if not likely, that there will be future legal challenges that will impact on the number of claims that can be made. The recent High Court decision with respect to *ADCO Constructions Pty Ltd v Goudappel* is one example with cost implications for the NSW workers compensation system — in this case they were favourable from a financial sustainability perspective, although earlier legal testing suggested otherwise.

Other uncertainties highlighted by the Nominal Insurer Scheme actuary include:

- the extent to which Work Injury Damages may continue to escalate
- the weekly benefit level, which has been higher than expected with many of the transitioned claims being assessed as having little or no work capacity
- the stability of Whole Person Impairment (WPI) assessments as, over time, assessments tend to cluster around new benefit thresholds (referred to as ‘slippage’)
- the future impact of work capacity decisions on the number of continuing weekly active claims, and
- the potential for expenditure on disputes to escalate.⁴

Hence, while the financial outcomes associated with the amendments are positive, it is too soon to confirm that the insurance operations of the Nominal Insurer Scheme have achieved sustained improvement, certainly not of the magnitude experienced to date.

Financial drivers

Despite the more broad ranging principles for reform set out in the second reading speech at the time of the amendments, changes made by the *Workers Compensation Legislation Amendment Act 2012* primarily reflected:

- concerns about the deteriorating financial sustainability of the Nominal Insurer Scheme
- the perceived lack of capacity to fund future liabilities without substantively increasing premiums that were already high relative to other jurisdictions, and
- the desire to improve return to work outcomes.

³ The *Workers Compensation Legislation Amendment Act 2012* included a requirement in clause 27 of Part 19H to Schedule 6 of the *Workers Compensation Act 1987* for the Minister to conduct a review of the 2012 amendments. The Act specified that a review would be tabled within 12 months after the end of the period of 2 years, unless there was actuarial advice that the Nominal Insurer Scheme was projected to return to surplus before the end of the period of 2 years, in which case the review was to be undertaken as soon as possible after that projected date, with the review tabled within 12 months after that projected date.

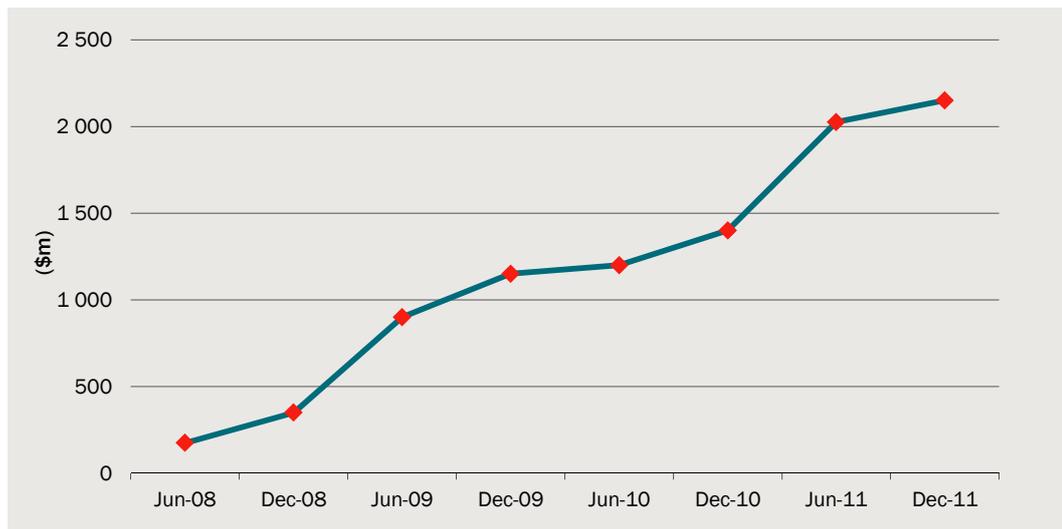
⁴ PwC, 2014. *WorkCover NSW Full Report: Actuarial valuation of outstanding claims liability for the NSW Workers Compensation Nominal Insurer as at 31 December 2013*, p300.

This is evident through:

- the focus on reducing the *duration* of benefit payments, except for seriously injured workers
- new incentives designed to specifically encourage and enable injured workers to return to (and recover at) work, and
- new rules that have prompted the transfer of support for injured workers from workers compensation to other insurance systems (such as private health insurance or CTP insurers if CTP entitlements exist) or the public health and social security system after a defined period. For the Nominal Insurer Scheme, the number of active claims with a weekly benefit payment has fallen by close to 35 per cent, and the number of active compensation claims receiving a medical related payment has fallen by 27 per cent, largely due to Scheme exits.

The focus on financial sustainability is considered to be appropriate, given the consistent increasing trend in the cost of claims over the three years prior to the reforms (chart 3).

3 Increase in Nominal Insurer Scheme liabilities from changes in claims experience/actuarial assumptions



Note: Changes in economic assumptions and investment earnings, which are outside the control of WorkCover, are excluded.

Data source: Ernst & Young, External peer review of outstanding claims liabilities of the Nominal Insurer as at 31 December 2011, 22 March 2012.

Weaker signs of impact on other key target areas

There has been a weaker connection between the outcomes seen to date and principles other than those that support financial sustainability.

This is particularly the case with respect to injury prevention, reducing the regulatory burden, and supporting less seriously injured workers to recover and regain their financial independence, particularly those with a WPI in near proximity to the threshold for a seriously injured worker. There are also some early signs that unintended outcomes have resulted from implementation that detract from the spirit of the principles. These factors have created some barriers to return to work.

Barriers are largely associated with location and training requirements as part of work capacity assessments, the provision of suitable duties, a lack of focus on rehabilitation and

early intervention, the time-limiting of medical expenses for workers with a work-related major impairment and ongoing needs for support to return to work, among others.

Summary of stakeholder feedback

Despite its limited timeframe, this review involved extensive stakeholder consultation. A series of meetings with key stakeholders (36 separate groups) and workshops (six) were held to explore the issues with stakeholders directly. Stakeholders and the general public were able to make written submissions to the review and over 400 written submissions were received and considered.

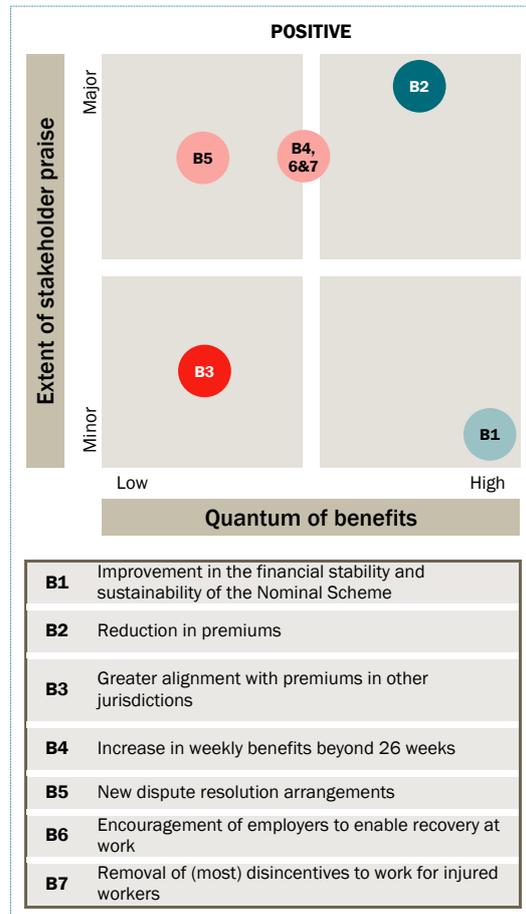
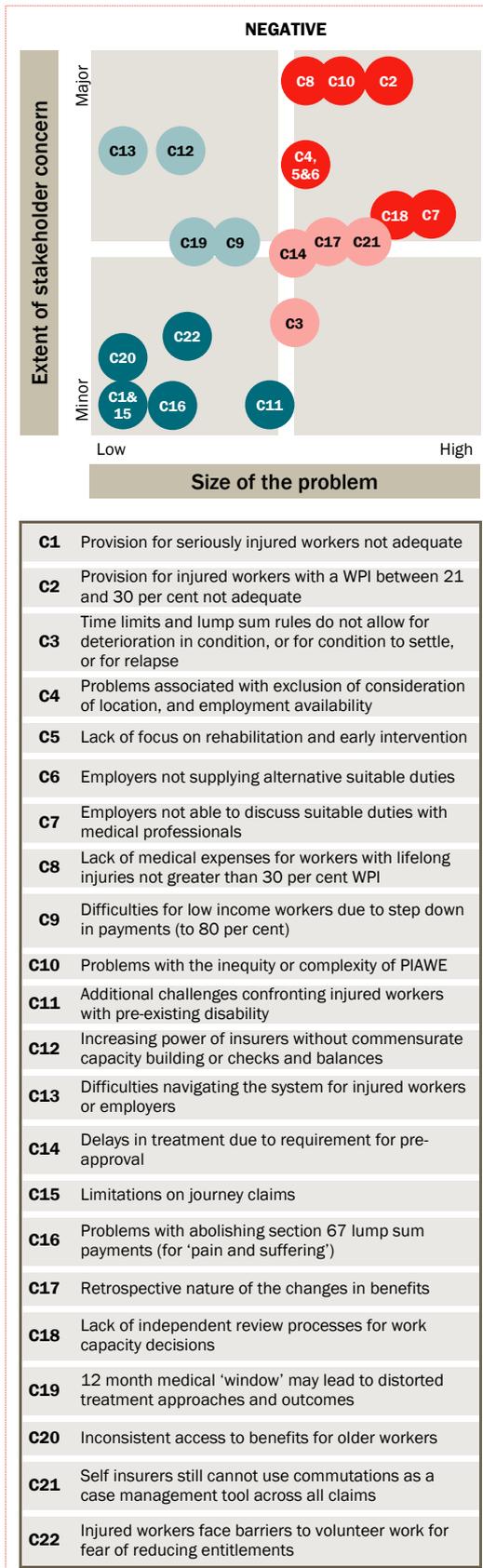
To illustrate the breadth and depth of stakeholder feedback on the perceived issues associated with the amendments, chart 4 rates the major costs and benefits of the amendments *from the perspective of stakeholders*. The most *serious* and *widely held* concerns of stakeholders are those shown in red in the ‘negative’ part of the diagram, which point to the concerns mentioned above, as well as concerns that small employers in particular are unable to support people back to work.

Concerns that affected only a small proportion of claimants and/or were believed to generate more minor costs (relative to other forms of support that were available outside of workers compensation) are shown in dark blue in the bottom left hand quadrant, such as reduced access to benefits for journey claims.

Conversely, the most substantial benefits of the amendments *as perceived by stakeholders* relate to reductions in premiums and improvements in scheme financial sustainability. Benefits that have been at least partly achieved but are not among the most ‘valuable’, include achieving alignment in premiums across jurisdictions.

The mixed performance of the amendments to date highlights the fact that the principles for reform are difficult to achieve simultaneously, in equal measure.

4 Ranking of positive and negative stakeholder feedback on the amendments



KEY

- Lowest costs (LHS) or highest benefits (RHS)
- Second most preferred outcome
- Second least preferred outcome
- Highest costs (LHS) or lowest benefits (RHS)

Despite the stricter benefits regime, the majority of claims remain unaffected by the amendments

While several issues have been raised about the application of the amendments to date, it is acknowledged that the 2012 changes were limited in terms of the number of claims affected. Most were unaffected, and where impacts were observable, in some cases they reflect behavioural change (decisions to not make a claim) rather than simply the tightening of eligibility. For instance:

- **there has been a reduction in the number of new claims** by around 24 per cent since June 2012, with around one third of the change related to tighter eligibility around journey claims and the remaining two thirds likely to be due to behavioural/cultural change impacting the propensity to claim, rather than the change in eligibility to workers compensation benefits
- **there has been no discernable change in the proportion of claimants that leave the Nominal Insurer Scheme within 13 weeks.** Hence, claims relating to relatively minor injuries where workers exit the Scheme within 13 weeks are unlikely to be impacted by the amendments (with the exception of now-ineligible claims like certain journey claims). There is a slight reduction in weekly benefits received as a proportion of average earnings, but average earnings estimates will be higher in many cases and there are various examples where workers on benefits receive more income as a result of the amendments
- **changes to ‘claimable’ injuries affect a relatively small number of claims.** Prior to the amendments, journey claims comprised less than 9 per cent of the total number of active claims and heart attack claims comprised 0.1 per cent of active claims. The number of active journey claims has roughly halved since the amendments. It should be noted that some journey claims have access to a Compulsory Third Party (CTP) insurance entitlement
- **the number of ceased claims for medical benefits linked to the payment of weekly benefits is relatively modest.** Prior to the amendments (2011), 9 per cent of claims were incurring medical benefits beyond 12 months following the cessation of weekly benefits (including where no weekly benefits were received), and
- **work capacity assessments would apply to no more than around a third of claims.** As an upper bound, up to a third of claims would relate to injured workers with a WPI of less than 31 per cent receiving weekly benefits. The proportion of these claimants that incur a work capacity assessment is likely to be relatively small given that, overall, 89 per cent of claimants leave the Scheme (voluntarily, return to work, retire, or for some other reason) within one year.

Achieving balance between the health needs of injured workers and minimising costs

To a certain extent the ‘right’ amount of funding for benefits is an unresolvable question about what is a fair and reasonable level of support for injured workers that should be

funded through employer premiums as opposed to other insurance systems and the broader social safety net.

However, in some respects it would seem that the new system does not work well for some injured workers. This largely results from gaps in coverage, inconsistencies in the application of the new rules, and the creation of unintended barriers to work.

Caps and medical approval of medical expenses

There is scope for the time limiting of medical expenses to give rise to:

- **Potential delays in treatment.** Some of the reasons for delays in medical treatments *highlighted by stakeholders* include:
 - the lack of clinical skills of many case managers resulting in their referral for medical advice from medico-legal firms, which can result in conflicting medical opinions with those of treating doctors and lead to delays
 - the approval process for medical expenses beyond 48 hours after injury, and
 - a lack of understanding on the part of doctors, who are not aware of the intricacies of workers compensation and do not realise that there is a limit to the time that services will be funded, and when various interventions to improve diagnosis and treatment need to be made.
- **Poorer health outcomes.** Access to timely and effective medical treatment at the earliest possible stage is a well-established cornerstone of good medical treatment.

Variation in access to treatment based on threshold of impairment

Most injured workers fall below the greater than 10 per cent Whole Person Impairment (WPI) required to access lump sum compensation.

These workers have at least 12 months entitlement to reasonably necessary medical benefits and income support through weekly payments if they do not have capacity for work, up until they exit the system through return to work, work capacity testing, retiring or reaching the time caps on weekly benefits. Beyond this, injured workers need to rely on the broader social safety net for income and medical payment support.

Most of the concern about the thresholds embedded in the amendments relate to workers with a WPI between 21 and 30 per cent, where injuries are substantial, but not 'serious' enough to qualify for ongoing support for life.

These workers can only access weekly benefits until Commonwealth retiring age if they do not have a decision that they have capacity to work and/or they return to work – in which case they lose medical entitlements after 12 months, creating a clear disincentive to work for this cohort.

Meeting the needs of injured workers with ongoing need for support to return to work

Some impairments that result from workplace injuries require ongoing support to enable return to work, even if they are not necessarily 'serious'. This includes injuries such as those that result in substantial hearing loss, the need for prosthetics, and other life-long injuries.

While the level of available benefits reflects one of the many trade-offs in a workers compensation system, it is undesirable for the amendments to disincentivise injured workers requiring hearing aids or prosthetics from returning to work. In these cases, it is not reasonable to end the entitlement to reasonably necessary medical benefits including the replacement of medical devices.

A similar problem exists for workers that sustain an injury that results in a WPI of greater than 20 per cent, up to 30 per cent, if the time limiting of medical support creates a barrier to return to work.

Inconsistent access to benefits for older workers

Workers approaching the Commonwealth retirement age are unlikely to be eligible to benefits for the full entitlement period, as benefits are only payable up to retirement age, when other forms of community-funded support are available to meet the needs of older Australians.

However, the way that legislative amendments were drafted mean that older Australians can have unequal access to benefits depending on the date of their injury relative to them reaching Commonwealth retiring age. This is considered to be an unintentional anomaly in the drafting of the amendments and is an example of an inconsistency in the application of the amendments.

Removal of journey claims that are not work related whilst recess claims remain

The amendments have excluded claims for journeys that are not work related, but are silent on claims for non-work related injuries incurred during work breaks. It is arguable that the intent of the amendments to capture only work-related injuries in the workers compensation system would equally apply to unrelated-to-work injuries sustained during work breaks.

Unintended disincentives to work

Despite the strong intent of the amendments to promote return to work and recovery at work, this may not always be achieved. For instance:

- **Workers with serious injuries can be disincentivised by the new benefits regime.**
Workers with a WPI of greater than 30 per cent may receive no encouragement to return to work, and are not necessarily supported by the workers compensation system to encourage employers to find suitable duties. Several stakeholders commented that some seriously injured workers would like to return to work, particularly when cognitive capacity is not impaired.

- **Workers with a disability.** Workers with a pre-existing disability face additional challenges in terms of their participation in the workforce. This can make it more difficult to meet the hourly requirements for work when return to work is achieved.
- **Injured workers that cannot meet the *terms of work capacity assessments*.** The bio-psycho-social nature of injuries can often create genuine barriers to transferring workers to locations where suitable duties are available.
- **Potentially higher payments on the transitional rate than return-to-work salary.** Given the way that PIAWE is calculated, it is possible for injured workers to receive higher weekly benefits on the transitional rate⁵ than they would if they returned to work. This directly disincentives return to work.
- **Volunteer workers.** Anecdotal evidence suggests injured workers are reluctant to undertake (or declare) volunteer work, due to fear of being determined as having a capacity to work and putting at risk weekly benefits received. This is an undesirable outcome in many respects, given the demand for volunteer workers, and the importance of volunteer work to improving the positive social engagement and sense of purpose of injured workers, which are both positively associated with return to paid work.

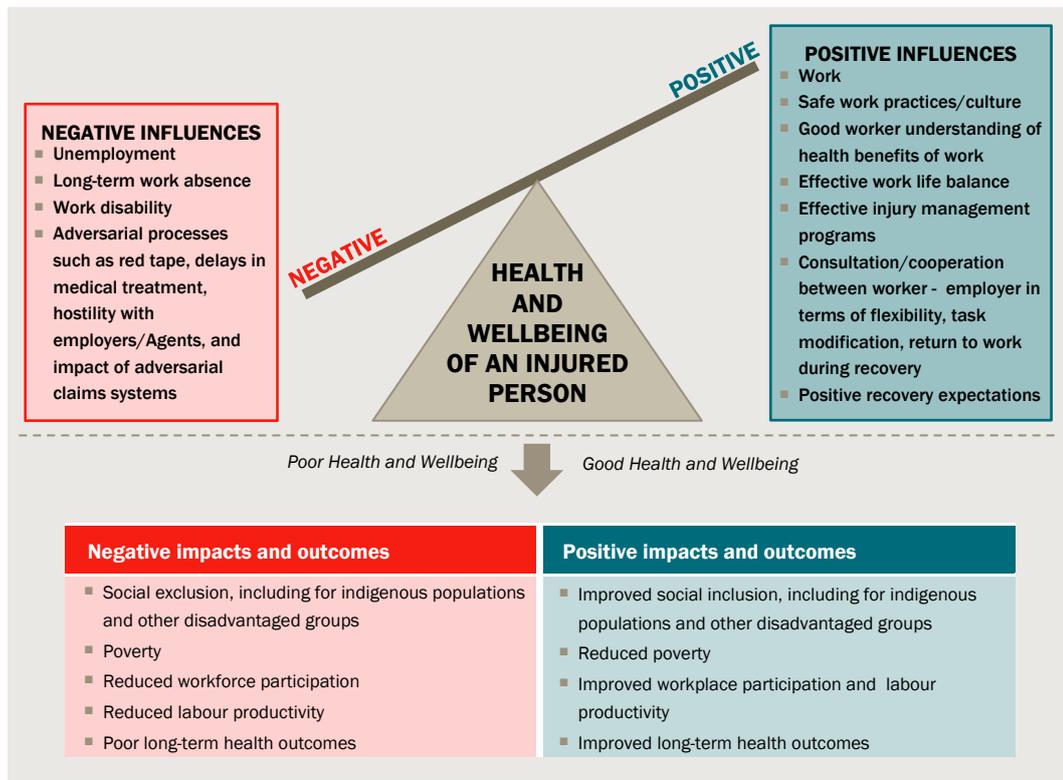
Key areas for future government consideration

It is a finding of this review that several themes warrant further consideration by government to enable the amendments to best achieve the intentions of the Act. These issues span across four domains: the level of benefits, eligibility and access to benefits, the handling of disputes, and the impact of the legislative framework on workplace culture.

Changes to existing arrangements across any of these domains should be aligned with the drivers of good health outcomes, and should minimise scope for outcomes and behaviours that detract from these outcomes. A summary of the positive and negative influences on the health and wellbeing of an injured worker is provided in chart 5.

⁵ The transitional rate only applies to pre-1 October 2012 claimants.

5 What is known about positive and negative impacts on health and wellbeing



Data source: The CIE

Addressing barriers to return to work

- **Providing better tools and supports to enable return to work outcomes. This may include:**
 - amending return to work criteria around geographic and career transfers to impose only ‘reasonable’ requirements on injured workers. This is likely to require some recognition of the costs of relocation and retraining.
 - removing barriers to commutations where they provide a workable and mutually agreed outcome for employers and injured workers. The existing restrictions to commutations reflect a reluctance to expose the Nominal Insurer Scheme to funding risk, but for self-insurers and specialised insurers these risks are internalised, and if both parties should seek to enter into a voluntary and mutually agreeable commutation arrangement it seems reasonable that they should not be prevented from doing so (as is currently happening under existing workers compensation legislation), so long as workers are protected (receive proper legal advice) and are not coerced into suboptimal agreements
 - redressing anomalies that result in injured workers being ‘better off’ without returning to work
- **Engaging health professionals to better achieve return to work. This may include:**
 - improving communication between employers and medical professionals to support work capacity and the provision of suitable duties

- providing more education of medical professionals on the nature of the amendments to offset a ‘natural’ reluctance of practitioners to recommend return-to-work prior to an improvement to pre-injury health status
- reviewing the reimbursement model for medical services to efficiently re-engage the medical community in the workers compensation system
- developing clear mechanisms for encouraging rehabilitation and early intervention.
- **Providing more support and focusing on small business.** There continues to be a large divergence between the preparedness of large and small businesses in the event of a workplace injury. This includes with respect to the policies and processes in place to deal with an injury that reflects an understanding of the requirements of employers, as well as an ability to provide suitable duties. This is particularly the case now that the experience rating threshold for premiums has been lifted, removing the price incentives on smaller employers to reduce injuries and claims, and reduce the size and duration of claims. This could include greater information provision and assistance with allowing for commutations.
- **Improving the efficiency and consistency of work capacity assessments.** Whether as a result of the early days of reform, the remuneration model, or other factors, there is variability in the effectiveness of claims managers to make work capacity assessments, and insufficient tools available to improve the quality of work capacity decisions. This may require capacity building for claims managers to respond to the disconnect between the new powers of insurers and the skills of case managers to fulfil them.

Minimising the regulatory burden associated with implementing reform

- **Minimising complexity and reducing the administrative burden of calculating weekly benefits.** The PIAWE approach is complex and often difficult to calculate, and yet it is still able to generate ‘winners’ and ‘losers’ compared to a more simple averaging calculation that was used previously and is still used by those exempt from the amendments.
- **Providing more support for injured workers to navigate the system, and reducing red tape and complexity for health service providers.** Unintentionally, the reforms have been accompanied by significant confusion and limited pathways for injured workers to access information, such as the availability of review processes. There have also been new administrative burdens placed on health professionals, which can detract from the need to meet the health needs of injured workers, both of which would be well served by better education and information on the new rules.
- **Improving the efficiency of the review process.** The existing 3-tiered dispute resolution process appears to be reasonable in principle and works well in many cases. However, there are several examples of when the separation and sequencing of the process (WIRO) and the merit (WorkCover) review creates a regulatory burden for insurers, employers and injured workers:
 - Delays in decisions are likely to occur as a result of the sequencing of the review process, with both employers, insurers and workers venting frustration when an outcome is overturned late in the process. In some cases, this is because of unintentional errors in process (such as complying with an inaccurate guideline),

leaving injured workers and employers uncertain about the outcome and entitlement. It is also observed that the difference in interpretation of the Act between WIRO and WorkCover has resulted in a high rejection rate at the process review.

- The process of review is made more complex because of dual role⁶ of WorkCover/Nominal insurer as a regulator and insurer, and because the role and function of the WIRO is not clearly defined. In practice, the role of the WIRO has extended to fill the gap created by the challenge for WorkCover in issuing advice. It has also created a role for the WIRO (in as much as legislation allows it) to keep WorkCover accountable for implementation of the legislation. While WIRO appears to be delivering value in this role, it is not clear that the administrative burden is minimised by having multiple review bodies: the Workers Compensation Commission (WCC), WorkCover, and the WIRO.
- It is also questionable whether the Independent Legal Assistance Review Service (ILARS) is an appropriate or efficient way of funding legal advice when there is a disagreement regarding entitlements. The ILARS mechanism contains no incentives to ensure that the only genuine complaints seek legal redress, and it is not clear whether the vehicle for legal funding should be nested within the WIRO.

These challenges warrant further government review, backed by a proper analysis of the costs and benefits, to determine whether the current approach best meets the objectives and guiding principles of the Act.

Improving fairness and equity whilst maintaining financial stability

- **Providing adequate and reasonable support for badly injured workers.** The threshold set in the legislation for defining seriously injured workers is somewhat arbitrary and needs to be considered with reference to the total number of people involved, and to specific examples where injured workers will be close to the thresholds and the impact of this restriction on them. It is observed that for injured workers with a WPI of 21-30 per cent, workers compensation benefits now available in NSW are generally less generous than in other jurisdictions. Any revision to the treatment of substantial injuries could be done in the context of the National Injury Insurance Scheme, under which jurisdictions are working towards a set of minimum benchmarks for work-related injuries, which will cover eligibility and lifetime benefits.
- **Providing appropriate medical benefits for injured workers that need ongoing support to return to work where financial sustainability remains viable.** This would require review of the reasonableness of time-limiting benefits for injuries that do not meet the threshold of a severe injury to avoid the creation of disincentives to return to work to delay the end of medical benefits. This could be done by making allowance for ‘deferred’

⁶ This ‘dual role’ refers to the tension between the role of WorkCover as an insurer and its role as a regulator. Some submissions to the review noted concerns around the structure of the workers compensation insurance division where WorkCover operates a Nominal Insurer as well as regulates self and specialised insurers. It is understood that these issues are currently being examined and addressed by WorkCover to segregate functions and correct delegation.

surgery/treatment in certain specific cases⁷ at the end of the medical entitlement period, some level of ongoing assistance towards hearing aids and prosthesis as well as modifying the AMA guidelines for certain well defined injuries (such as amputations, partial blindness).

- **Addressing unintended anomalies that have arisen to improve the equity and application of the amendments.** This includes refinements to section 52 to remove the differential treatment regarding access to benefits for workers approaching retirement age and the exemption of seriously injured works from work capacity assessments.
- **Improving the fairness of dispute resolution procedures.** The new process for dispute resolution has limited the opportunities for injured workers to achieve an independent review of their concerns.
 - the scope for arbitration has been restricted
 - the merit review process is believed to lack full independence because of the dual role of WorkCover and the lack of legal representation for workers with respect to work capacity decisions, creating the perception of being ‘pro insurer/employer’

It is a finding of this review that the operation of the WIRO and ILARS needs to be considered by Government at an appropriate time in the future with a view to ensuring equity and streamlining processes across all phases of the dispute, and minimising the adversarial culture around workers compensation which can inhibit the focus on return to work. This may involve a comparison of the new arrangements with the prior use of the WCC, and alternative arbitration mechanisms.

- **Continuing with stakeholder consultation and engagement,** and recognising it as important to ongoing review and refinement of the workers compensation system. This could be used to improve guidance material on the application of the amendments, and to redress unintended or unwanted outcomes that have resulted from implementation to date.
- **Improving the focus on prevention and early intervention.** An important observation from this review is that self-insurers and specialist insurers appear to be more incentivised to invest more in prevention and early intervention than agents under the Nominal Insurer Scheme as their private underwriting models set up stronger incentives to reduce the number and cost of claims. These insurers are believed to have experienced a greater reduction in more serious psychological injury claims by better identifying cases early on that require a different and specific approach to case management.

⁷ Under the current arrangements weekly benefits and entitlement to benefits for second surgery can be available, which lessens the impact of the cap for selected cases.

6 Summary of future review areas

	Early priorities	Medium term outcomes
Address barriers to return to work	<ul style="list-style-type: none"> Review return to work criteria to ensure that they do not impose unreasonable requirements on injured workers. Ensure that reasonable retraining (and possible relocation) costs are recognised. Review barriers to commutations. Improve dialogue between medical providers and employers around suitable duties. 	<ul style="list-style-type: none"> Review anomalies that enable injured workers to be 'better off' without returning to work, including with respect to weekly and medical benefits. Review the reimbursement model to efficiently re-engage the medical community in the workers compensation system. Develop clear mechanisms for encouraging rehabilitation and early intervention.
Minimise the regulatory burden of implementing reform	<ul style="list-style-type: none"> Prioritise the development of clear guidelines on return to work and other aspects of the reforms. Improve communications material and the distribution of information, on the 2012 reforms and the support available to all stakeholder groups under the new arrangements. Review the role of the WIRO to improve the efficiency of the end-to-end review process, and the fairness of dispute resolution procedures 	<ul style="list-style-type: none"> Develop a simpler mechanism for calculating average weekly benefits that is suitable for employees fluctuating.
Improve fairness and equity whilst maintaining financial sustainability	<ul style="list-style-type: none"> Review and where appropriate remove restrictions on weekly and medical benefits that can improve worker outcomes without substantially increasing claim costs. Engage effectively with stakeholders to develop well-targeted strategies for providing additional support for injured workers with a WPI of 21-30 per cent. Engage with stakeholders to develop workable alternatives to medical expense pre-approvals to avoid unnecessary treatment delays. Build skills and capacity of case managers to make appropriate work capacity assessments. Review and potentially remove ILARS and its nesting within the WIRO to ensure the independence and fairness of the end-to-end review process. Address unintended anomalies in legislative drafting, including with respect to workers approaching retirement age, and clarify the exemption of seriously injured workers from work capacity assessments. Review of appropriateness of recess claims for benefits under workers compensation. 	<ul style="list-style-type: none"> Develop better consultation mechanisms to re-engage stakeholders in the implementation of (large scale) reform on a regular basis. Enhance incentives for insurers and employers to focus on early intervention.

Source: The CIE

1 Background

Changes made by the Workers Compensation Legislation Amendment Act 2012 were made in the context of concerns about the deteriorating financial position of the Nominal Insurer Scheme ('Scheme') and capacity to fund future liabilities without substantively increasing premiums. The amendments reinforced the encouragement of injured workers back to work, and refined benefits to promote the financial sustainability of workers compensation in New South Wales.

In June 2012, the Government introduced comprehensive changes to the way workers compensation is delivered in New South Wales (NSW). The 2012 legislative changes, which came into effect through the *Workers Compensation Legislation Amendment Act 2012*, included a requirement to conduct a statutory review of the 2012 amendments.

The Act specifies that the review is to be tabled within 12 months after the end of the period of 2 years or if there is actuarial advice that the Scheme is projected to return to surplus before the end of the period of 2 years.

This early statutory review has been triggered based on actuarial advice. The Centre for International Economics (CIE) has been commissioned by the Office of Finance and Services to undertake the review.

Terms of reference for this review

The *Workers Compensation Legislation Amendment Act 2012* included a requirement in clause 27(1) of Part 19H to Schedule 6 of the *Workers Compensation Act 1987*, setting out the terms of reference for this review:

The Minister is to conduct a review of the amendments made by the 2012 amending Act to determine whether the policy objectives of those amendments remain valid and whether the terms of the Workers Compensation Acts remain appropriate for securing those objectives.

That is, the terms of reference sets out to look at the appropriateness of objectives, as well as the effectiveness and efficiency of the amendments with respect to achieving those objectives.

The seven principles set out in the Issues Paper (summarised in box 1.1) were referred to in the Minister's second reading speech and form part of the basis for the terms of reference for the review.

These objectives or principles of the legislative amendments form an important basis for the CIE's evaluation framework. These form the target outcomes of the legislative amendments and our assessment of the effectiveness and efficiency of the legislative amendments are therefore based around the attainment of these objectives.

It is not within the scope of this statutory review to re-examine whether the changes should have been made.

1.1 Seven principles underpinning 2012 legislative amendments

The NSW Workers Compensation Scheme Issues paper identifies that the best workers compensation schemes:

- enhance NSW workplace safety by preventing and reducing incidents and fatalities
- contribute to economic and jobs growth, including for small businesses, by ensuring that premiums are comparable with other states and there are optimal insurance arrangements
- promote recovery and the health benefits of returning to work
- guarantee quality long-term medical and financial support for seriously injured workers
- support less seriously injured workers to recover and regain their financial independence
- reduce high regulatory burden and make it simple for injured workers, employers and service providers to navigate the system
- strongly discourage payments, treatments and services that do not contribute to recovery and return to work.

Review process

This review has involved:

- a literature review
- stakeholder consultation and the receipt of submissions, and
- detailed analysis of data on workers compensation schemes operating in NSW.

This review was completed within eight weeks. Within this time, contact was made with over 150 stakeholders. A series of meetings with key stakeholders (36 separate groups) and workshops (six) were held to explore the issues with stakeholders directly.

Stakeholders and the general public were able to make written submissions to the review. Over 400 written submissions were received from stakeholders that were approached directly and from those who made a submission via the Have Your Say website, and were considered as part of this review.

Submissions published by the Law and Justice Committee with respect to the concurrent Review of the Exercise of the Functions of the WorkCover Authority being undertaken by the NSW Legislative Council Standing Committee on Law and Justice have also been considered as part of this statutory review of the 2012 workers compensation amendments.⁸

The compressed time frame has imposed natural limits on the this review, which has focused on the impact of the 2012 reforms with respect to the seven reform principles, to highlight areas of consistency or inconsistency and identify areas wherein further improvements to workers compensation arrangements, in light of these principles, may be beneficial.

Structure of this report

This report is structured in the following way:

- **chapter 1** provides an overview of the reforms and the context within which they were developed
- **chapter 2** analyses whether the reform objectives remain appropriate for securing those objectives
- **chapters 3 to 5** analyse the impact of the amendments on the claims experience the outcomes for injured workers, employers, and other key stakeholder groups, with:
 - chapter 3 identifying the impacts that are well aligned to the reforms
 - chapter 4 identifying where the link to objectives is much weaker
 - chapter 5 highlighting unintended impacts and outcomes that are not well aligned to the overarching spirit of the reforms, and
- **chapter 6** provides key findings of the statutory review.

Overview of the 2012 reforms

Reforms to the workers compensation scheme focused on:

- assisting injured workers to return to work
- improving financial support for seriously injured workers, and
- returning the scheme to financial sustainability.

This has been done by:

- changing access to benefits, such as through:
 - restricting access to remove certain types of claims
 - tightening eligibility for access to benefits to ensure benefits were directed to areas where they were needed most
- time-limiting benefits based on:
 - the assessment of Whole Person Impairment (WPI) and work capacity

⁸ More information about the concurrent review is available on the NSW Parliamentary website.

- the participation in work in terms of minimum weekly hours and pre injury average weekly earnings (PIAWE)
- modifying settings for benefit levels within different time-based intervals, either to
 - change the profile of benefits over the life of a claim, such as increasing benefits in earlier years while limiting benefits in later years for most workers
 - increase payments for injured workers still receiving payments over 26 weeks who could be expected to be the claimants with more significant impairment or more complex injuries
- promoting behaviours that are associated with rehabilitation, including by promoting the role of work in recovery
- enhancing powers of the regulator and Scheme agents with the objective of enhancing the effectiveness and efficiency of Scheme administration, and
- promoting cost-effectiveness and efficiency, including by limiting the role of legal practitioners in certain contexts to discourage extended, costly, adversarial dispute management processes.

As shown in chart 1.2, most elements of the reforms focused on tightening or restricting access to benefits, and time-limiting weekly and medical benefit payments.

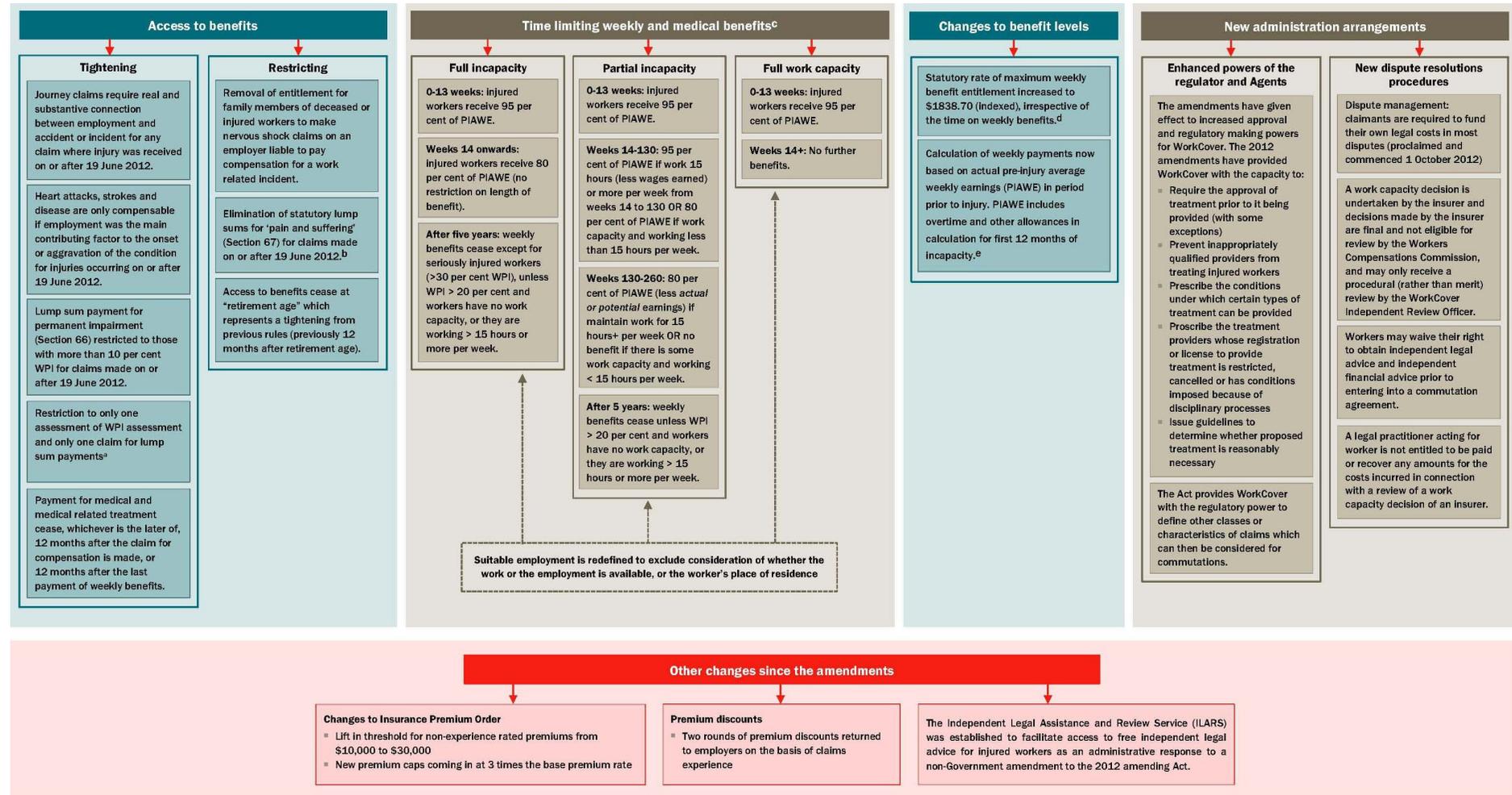
The introduction of work capacity assessments

The amendments established a requirement for injured workers receiving weekly benefits to undertake work capacity assessments at specified points throughout the life of their claim and at least one every two years.

- A work capacity decision is to be made by the insurer after 130 weeks (but can be made sooner), taking into account medical evidence, vocational retraining and other material specified in WorkCover guidelines. Assessments for this decision start after weekly benefits reach 78 weeks, and a notification must be provided to injured workers by 117 weeks. Assessments also continue after 130 weeks and continue for the life of a claim.
- A work capacity decision takes into account medical evidence, suitable employment, vocational retraining, and other material specified in WorkCover guidelines.
- If workers seek a review of their work capacity decision, the amendments require that an internal review be undertaken by the insurer, followed if necessary by a merit review by WorkCover, and if required, a procedural review of the insurer or agents' decision by WorkCover's Independent Review Officer (WIRO). 'Seriously injured' workers as defined by the legislation (WPI assessment greater than 30 per cent) are exempt from work capacity assessments.

The requirement for an injured worker to make reasonable efforts to return to suitable employment was retained in the 2012 amendments. However, 'suitable employment' no longer involves consideration of whether suitable employment exists, is available or is geographically accessible to the worker, and focuses on capacity rather than incapacity. It now requires consideration of an injured worker's abilities including age, skills and work experience.

1.2 Summary of the 2012 Workers Compensation Amendments



Notes: ^aThe legal case of ADCO Constructions Pty Ltd v Goudappel [2013] NSWCA 94, the High Court found that the 2012 reforms to permanent impairment lump sum entitlements are applicable to pre-June 2012 claimants overturning a Court of Appeal finding although it is not yet clear what the effect of the High Court decision is in terms of how it applies to different cohorts or workers.; ^b The overturning of the legal case of ADCO Constructions Pty Ltd v Goudappel [2013] NSWCA 94 by the High Court in 2014 implies that all general claims made prior to June 2012 will no longer receive statutory lump sums for 'pain and suffering'. ^cPrior to the amendments, up to 26 weeks 100 per cent of weekly wage was payable, and after 26 weeks, 90 per cent of weekly wage (less actual earnings) if permanently impaired and 80 per cent of weekly wage (less actual earnings) if partially incapacitated; ^d Previously, the maximum weekly benefit payment after 26 weeks was \$432.50 per week (in April 2012, prior to the amendment) plus additional amounts per week for dependent spouse and children up to a maximum of \$1838.70 (in April 2012); ^ePreviously, it was based on the award rate (excluding overtime, shift work, payments for special expenses and penalty rates) OR for workers not employed under an award or agreement, 80 per cent of average weekly earnings at the time of injury (including regular overtime and allowances).

Source: PWC, 2013, Markey et al, 2013, and NSW Government, 2012

Implementation of the amendments since 2012

The 2012 changes to the NSW workers compensation scheme have been progressively implemented (see table 1.3).

- Some of the changes became effective from mid-June 2012, including changes to journey claims, lump sum payments and nervous shock, heart attack and stroke and disease injuries.
- Changes for newly incurred claims did not become effective until 1 October 2012.
- Claims made prior to October 2012 are eligible for a transitional rate of maximum weekly benefit from January 2013. This rate is 80 per cent of the ‘transitional amount’ of \$920 (indexed), which reflects the deemed amount of the pre-injury average weekly earnings of an injured worker for the purpose of determining weekly benefit entitlements. The transitional rate may be higher or lower than the benefits received prior to the amendments.⁹
- the amendments introduced a time limit for access to medical benefits of 12 months following the cessation of weekly benefits or 12 months after a compensation claim is made, whichever is later. This change became effective on 1 January 2013, meaning that claimants may be impacted by these changes from 1 January 2014 at the earliest.

Hence, the impacts of the reforms are still unfolding, and on some issues, it is too early to make a full assessment of the impact on the workers compensation system.

Still, it is important to acknowledge that the 2012 reforms represent large-scale reform and are part of a defining period in the evolution of the workers compensation system in NSW (see appendix A).

1.3 Implementation arrangements

Transitional arrangements
Transition of journey claims, lump sum payments and nervous shock, heart attack and stroke and disease injuries
<ul style="list-style-type: none"> ■ Commenced 19 June 2012
Transition of weekly benefit claims
<ul style="list-style-type: none"> ■ Commencement from 1 January 2013 for existing claims ■ Commencement from 17 September 2012 for existing seriously injured claimants ■ Commencement from 1 October 2012 for newly incurred claims
Medical benefits
The 12-month medical benefit period commences from 1 January 2013 for medical benefit claims.

⁹ It may be higher than the rate received post 2012 claimants’ rate for weekly benefits, particularly if the injured worker was on a low income or part time, however it could be lower than received by post 2012 claimants particularly where pre-injury earnings were close to the full time, average wage across NSW.

Transitional arrangements
Transitional statutory rate of maximum weekly benefits payable to workers
<ul style="list-style-type: none"> The maximum weekly benefit payable for workers injured prior to 1 October 2012 and receiving payments under the new system is \$920.90 per week
Requirement for notice of changes
Workers must be provided with three months' notice of any changes in benefits.
Exemptions
Police officers, coal miners, workers who make dust disease claims, paramedics and firefighters are exempt from changes

Source: PwC, 2013, Markey et al, 2013, and NSW Government, 2012.

Workers compensation in NSW today

NSW has a publicly underwritten scheme operated by the WorkCover Authority on behalf of the Nominal Insurer. It has different requirements to a privately underwritten insurance scheme, such as those operated by licenced self-insurers, groups of self-insurers or specialised insurers in NSW. The main differences between the publicly underwritten and self-insurance schemes are that employers that participate in privately underwritten schemes operate their own insurance premiums and claims management process, and self-insurers have stricter prudential settings (do not run a Scheme deficit). However, both the Nominal Insurer and self-insurers must comply with the same legislative requirements around workers entitlements in the event of a workplace injury claim.

The WorkCover Authority outsources claims handling to seven Scheme agents.¹⁰ On behalf of WorkCover, Scheme agents issue workers compensation insurance policies, determine and collect insurance premiums, manage workers compensation claims, provide support for injured workers (including rehabilitation), pay compensation benefits to injured workers, and manage any third party service providers such as medical or rehabilitation services. Around three quarters of employees in New South Wales work for an employer that pays a premium towards the Nominal Insurer Scheme.

Around one quarter of employees in NSW work for an employer that has cover through one of several self-insurance options, wherein the self-insurer has a licence by WorkCover to provide its own insurance. There are 41 self-insurers, including a range of shire and city councils, and 19 group self-insurers, for example, Coles Group, Woolworths and the NSW Self Insurance Corporation.

The largest self-insurer in NSW in terms of employees covered is the NSW Self Insurance Corporation, which manages workers compensation through the Treasury Managed Fund (TMF), for all general government sector agencies and a number of state-owned

¹⁰ Nominal Insurer Scheme agents include Allianz Australia Workers' Compensation (NSW) Limited, Xchanging Integrated Services Australia Pty Ltd, CGU Workers Compensation (NSW) Limited, Employers Mutual NSW Limited, Gallagher Bassett Services Pty Ltd, GIO General Limited and QBE Workers Compensation (NSW) Limited.

corporations that elected to join the scheme. The NSW Self Insurance Corporation covers around 18 per cent of the state's employees.

There are also six specialised insurers, which have a licence to provide insurance to employers within a defined industry, including Catholic Church Insurances, Coal Mines Insurance Pty Ltd, Guild Insurance Limited, Hospitality Employers Mutual Limited, Racing NSW and StateCover Mutual Limited. Specialised insurers are required to hold an authority from Australian Prudential Regulation Authority (APRA) to provide workers compensation insurance policies in Australia, and strict rules apply in relation to capital adequacy (in order to fund future liabilities), ownership and control, and risk management.

Self-insurers and specialised insurers are subject to rules, which intend to ensure that other employers in the State will not be required to meet the cost of claims if these entities are not able to meet their workers compensation liabilities. For instance, they must either lodge a deposit with WorkCover or provide a bank guarantee to secure total outstanding claims and are required to maintain a sufficient premium pool in order to sustain a prudential margin above estimated outstanding claims liability to give a high probability of sufficiency. For example, for self-insurers the required prudential margin is 30 per cent. Self-insurers and specialised insurers are subjected to stricter prudential management settings than the Nominal Insurer.

Unlike under the Nominal Insurer Scheme wherein employers pay a premium reflecting industry performance and the broader performance of the Scheme, employers covered by a self-insurance option pay a premium that more directly reflects their success in scheme management and claims outcomes. There is hence a stronger price signal for effective claims management under a self-insurance arrangement.

Table 1.4 compares the structure of workers compensation in NSW with other jurisdictions. The NSW WorkCover Scheme is a managed fund scheme, with the Workers Compensation Nominal Insurer underwriting the risk.¹¹

Several other states provide centrally funded insurance operations similar to WorkCover NSW such as the WorkCover Authorities of Victoria, Queensland and South Australia. Distinct to NSW, Western Australia operates a privately underwritten workers' compensation scheme wherein private insurance agencies are approved to provide workers' compensation insurance to WA employers.¹² As shown in table, the proportion of employees in NSW that are covered by self-insurance arrangements is relatively high compared to other states.

¹¹ WorkCover Authority of NSW, 2013. *Annual Report 2012-13*.

¹² WorkCover Authority of NSW, 2013. *Annual Report 2012-13*.

1.4 Structure of workers compensation in NSW and other key jurisdictions

	Units	NSW	VIC	QLD	WA	SA
Employees covered, 2010-11	m	3.17	2.64	1.97	1.09	0.71
Employees covered by self-insurance	per cent	24	6.1	9.0	9.3	n.a.
Fund type		Managed fund	Central fund	Central fund	Private insurer	Central fund

Note: Schemes that are centrally funded have their work health and safety and workers' compensation functions, staffing and operational budgets funded by premiums. For privately underwritten schemes, the non-workers compensation functions are funded directly from government appropriation. WA operates a privately underwritten scheme, which means that private insurance agencies are approved to provide workers' compensation insurance to WA employers. The NSW scheme is classified by Safe Work Australia as a 'managed fund', combining some of the features of centrally funded schemes and privately underwritten schemes.

Source: Safe Work Australia, 2013.

Comparisons with other jurisdictions

The terms of reference for the review refers to ensuring premiums are comparable with other states. This is important for promoting a productive and competitive business environment in NSW.

It is acknowledged that greater comparability across jurisdictions should also be achieved through the NIIS, where jurisdictions are agreeing minimum benchmarks for catastrophic workplace injuries that will lead to greater harmonisation of the types of injuries associated with workers compensation.

Prior to the reforms, the NSW workers compensation system was more generous than other jurisdictions in relation to several benefit entitlements. This was particularly the case in relation to the duration of medical expenses (no time or dollar cap on benefits for reasonable medical treatment, whereas other states already had a time or expenditure cap), journey claims (excluded in some jurisdictions), and in relation to the number of claims and threshold of claims for WPI lump sums.

The NSW 2012 reforms 'borrowed' from the design of workers compensation systems in other jurisdictions. This has particularly been the case for Victoria (which has a 12 month restriction on medical benefits, uses work capacity assessments, and has a restriction on the number of WPI assessments for lump sum claims), and South Australian (in terms of journey claims). However, not all elements of systems borrowed were imported into the 2012 reforms and the NSW system remains different to the larger Schemes in other jurisdictions. For instance:

- under Queensland legislation, insurers can discharge their liability to make weekly payments of compensation through a lump sum payment if the impairment is stable and stationary or through a redemption payment if the condition is not stable and stationary for the purpose of assessing permanent impairment after two years from the claim date. The application of these provisions effectively to 'exit' injured workers from the workers compensation system results in higher uptake up of common law provisions.

- Victoria requires employers to provide injured workers with suitable employment for a period of 52 weeks if the worker has incapacity for work and/or pre-injury or equivalent when they have returned to full capacity
- The South Australian legislation around journey claims is similar to the current NSW legislation, however contains much greater detail. The provision that gives coverage of journeys if ‘the journey is undertaken in the course of carrying out duties of employment’ has been important to the case law in South Australia. There is not similar detail in the NSW legislation, although the ‘real and substantial connection’ provision could have a similar effect.¹³

One of the notable areas of difference across jurisdictions is the way that major injuries are provisioned for that are not, in terms of the NSW definition, extensive enough to qualify for the benefits available for ‘serious’ injuries (table 1.5).

Caution must be used in any inter-jurisdictional comparison, as no two workers compensation systems are alike. For instance, while work capacity testing applies in Victoria and South Australia, direct comparisons are difficult given the importance of the surrounding context to the use of work capacity testing such as access to review mechanisms, and the legislated powers of insurers which vary.

However, in some respects injured workers in NSW with WPI of 21-30 per cent post injury may have their medical entitlements terminated earlier than other jurisdictions. Following the amendments, benefits from the workers compensation system for a substantively injured worker in NSW could be terminated as early as 3.5 years after injury, which is 12 months after a work capacity decision (due by 130 weeks), or earlier if the work capacity assessment is undertaken earlier. If an individual has work capacity, weekly benefits will cease at 5 years, and medical entitlements would cease at 6 years.

A high-level comparison of the contrasts and similarities in entitlements across different schemes is provided in appendix B.

1.5 Comparison of entitlements for an injured worker with a WPI of 21-30 per cent

Benefit entitlement	
Uses work capacity assessment to establish benefit entitlement?	
New South Wales	▪ Yes
Victoria	▪ Yes
Queensland	▪ No
South Australia	▪ Yes
Western Australia	▪ No
What is the cut-off timing for weekly benefits?	
New South Wales	▪ Subject to continuing incapacity, until retirement age

¹³ The Development and Environment Professionals’ Association, Undated. ‘Analysis of journey claims in South Australia’.

Benefit entitlement	
Victoria	▪ Subject to continuing incapacity, until retirement age
Queensland	▪ Maximum duration of five years or reaching capped amount (higher use of lump sum payments and common law)
South Australia	▪ Subject to continuing incapacity, until retirement age
Western Australia	▪ No cut-off timing but capped amount
What is the maximum amount of compensation per week after final stepdown?	
New South Wales	▪ 80 per cent of PIAWE
Victoria	▪ 80 per cent of PIAWE
Queensland	▪ Greater of 75 per cent of normal weekly earnings or 70 per cent of Queensland ordinary time earnings
South Australia	▪ 80 per cent of average weekly earnings
Western Australia	▪ 85 per cent of average weekly earnings
What is the cut off timing for medical entitlements?	
New South Wales	▪ 12 months after date of claim or cessation of weekly benefits
Victoria	▪ 12 months after date of claim or cessation of weekly benefits
Queensland	▪ Maximum five years (higher use of lump sum payments and common law)
South Australia	▪ No cap or specific limit
Western Australia	▪ Reasonable expenses covered up to a capped amount

Note: Other states use WPI assessment or similar Degree of Permanent Impairment to determine access to entitlements, with a partial exception of Western Australia, which still has elements of a Table of Maims approach to determining compensation.

Source: The CIE, based on Safe Work Australia, 2013 and NSW WorkCover, 2014, and various sources.

Concerns about financial sustainability prior to 2012

The NSW Government stated in its Issues paper that it was ‘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’. Prior to the 2012 amendments, there was a systemic, ongoing deterioration in the claims experience and resulting deterioration in the financial sustainability of the Nominal Insurer Scheme.

WorkCover acts on behalf of the Nominal Insurer and at the time, the Nominal Insurer was estimated to be in deficit by over \$4 billion. The Scheme was also not meeting its target funding ratio (the ratio of assets to liabilities) which had deteriorated over this period by 7 per cent to 78 per cent.

The Scheme actuary projected that an increase of 28 per cent in premium rates would have been required if no changes were made to the Scheme.¹⁴

¹⁴ NSW Government, 2012. ‘NSW Workers Compensation Scheme: Issues Paper’.

Actuarial analysis of deteriorating financial sustainability

The latest actuarial valuation by PwC before the implementation of the 2012 reforms was published in March 2012. It reported the outstanding claims liability for the NSW Workers Compensation Nominal Insurer as at 31 December 2011, which was estimated to be in deficit by over \$4 billion, representing a deterioration of \$1.7 billion in the six months to December 2011 (see table 1.6). Positive changes to investments and other assets were more than offset by increases in liabilities, of which the gross outstanding claims liability is the most significant component.

The funding ratio (the ratio of assets to liabilities) deteriorated further over this period by 7 per cent to 78 per cent. This was well below targets established by WorkCover of maintaining a range of 90 per cent to 110 per cent, and average funding ratio over the period 2010-2015 of greater than 95 per cent.¹⁵

The deterioration in the *outstanding claims liability* over the six months was attributed:

- in a significant way (**around 60 per cent**) to the reduction in the risk free discount rates over the six months, reflecting a deterioration in the market indicators of potential risk-free rates of return on assets such as government bond rates which are used in setting discount rates
- to a lesser extent, the claims handling experience was deteriorating – with a deterioration of around **15 per cent** attributed to:
 - the higher than expected claims experience for the six month period and change in actuarial assumptions on which the valuation was calculated
 - increase in claims handling expense allowance
- to the unwinding of the discount of the previously held outstanding claims liability (**over 15 per cent**). This refers to an accounting adjustment to account for the change in liabilities from the previous valuation estimates of liabilities less actual payments in the period, and adjustments to inflation expectations.

1.6 Headline indicators of Scheme financial position

	30 December 2011	30 June 2011	Six month change
	\$m	\$m	\$m
Investments	13 004	12 129	+875
Claims recoveries	484	470	+15
Other assets	1 231	720	+511
Total assets	14 719	13 319	+1 400
Gross outstanding claims^a	16 588	14 737	+1 851
Unearned premium provision	1 066	377	+689
Unexpired risk provision	259	41	+219
Other liabilities ^b	888	527	+361

¹⁵ PwC, 2011. WorkCover NSW: Paper 2 Solvency Management: Discussion Paper..

	30 December 2011	30 June 2011	Six month change
	\$m	\$m	\$m
Total liabilities	18 802	15 682	+3 119
Surplus/ (Deficit)	-4083	-2363	-1 719
Funding ratio	78 per cent	85 per cent	-7 per cent

^a Includes claims handling expenses and a 12 per cent risk margin. ^b Comprised of trade and other borrowings.

Source: PwC, 2012. WorkCover NSW Actuarial valuation of outstanding claims liability for the NSW Workers Compensation Nominal Insurer at 31 December 2011, 12 March 2012.

Over half of the change in the outstanding claims liability between 30 June 2011 and 30 December 2011 was attributed to changes in assumptions around risk free discount rates, and only around one eighth due to deteriorating claims experience. As will later be discussed, however, the deterioration in the claims experience from 2008 until the implementation of the 2012 reforms was systemic/structural and was the key rationale for the reforms.

2 *Appropriateness of the intent of the 2012 reforms*

This review requires that the appropriateness of the objectives of the amendments be considered, which are defined by the seven stated principles for workers compensation that were set out at the time of the amendments.

A review of the seven principles of the Act finds that some principles lack specificity and some are unmet. Principles that are deemed most appropriate relate to ensuring the financial sustainability of the workers compensation system, promoting recovery and return to work, guaranteeing long-term support for the seriously injured, reducing the regulatory burden, and discouraging payments that do not contribute to recovery and return to work.

The policy objectives are valid but the Workers Compensation Act is not appropriate for securing all of those objectives

Individually, the seven principles are good, appropriate aspirations for society.

However, it is doubtful that all these objectives can be delivered solely, or well, through workers compensation legislation, which can be limited in the extent to which it can drive the behaviours sought. The analysis contained in this report highlights this with respect to the *Workers Compensation Legislation Amendment Act 2012*, which shows some principles were largely unmet.

It is a finding of this review that:

- **some of the principles have not been well served because of the way that the balance between competing objectives has been settled** —it is valid (and normal) to have public policy objectives that are competing, and the challenge is to obtain an appropriate balance. In this case of the amendments, the balance has been in favour of addressing the deterioration in financial sustainability of the Nominal Insurer and ensuring the competitiveness of premiums, which in practical terms means that the support available for less seriously injured workers to recover and regain independence is necessarily less
- **some principles cannot be adequately targeted, and have been almost untouched by the amendments** — for instance, experience ratings are the primary mechanism for attaining prevention objectives in the Act by addressing the moral hazard issue that can otherwise exist if there is no penalty for an injury occurring. However, experience ratings are partial in their application and more likely to impact claims management

outcomes rather than prevention. There is also a risk that linking premiums to prevention (or reduction in incidents) could lead to under-reporting of claims¹⁶

- the CIE believes that the objectives listed below are most appropriate for the *Workers Compensation Legislation Amendment Act 2012*:
 - **ensuring optimal insurance arrangements**, which includes ensuring the financial sustainability of premiums and benefits
 - **promoting recovery and the health benefits of returning to work**, which includes the element of promoting financial independence for less seriously injured workers, which is not deemed to be distinct from the benefits of return to work and the broader financial sustainability intent
 - **guaranteeing long-term medical and financial support for seriously injured workers**
 - **reducing the high regulatory burden and make it simple for injured workers, employers and service providers to navigate the system, and**
 - **discouraging payments, treatments and services that do not contribute to recovery and return to work.**

Principles considered as appropriate for workers compensation legislation

The merits of each of the seven principles are discussed in more detail in appendix C.

Ensuring optimal insurance arrangements

A key element of optimal insurance arrangements is that the workers compensation system is able to provide enough funding for the benefits that it distributes. This means that it is essential that both the level of premiums, and the distribution of benefits, is sustainable.

This points to the importance of financial sustainability as an appropriate principle for the workers compensation system more broadly. If the workers compensation system is not financially sustainable, neither premiums nor benefits can be set at an optimal level.

Therefore the CIE considers that optimal insurance arrangements implies financial sustainability, premium affordability and competitiveness, adequate funding of liabilities, a cost-effective set of benefits directed to desired health and social outcomes and well-designed dispute resolution mechanisms. Some of these factors are covered specifically in the other guiding principles and so are discussed elsewhere. Financial sustainability is more directly implied in principle 2 in particular and it remains appropriate that financial sustainability be a core principle for workers compensation arrangements in NSW.

Prior to the reforms, the Scheme was not meeting reasonable prudential objectives, with the funding ratio (of assets to liabilities) of 78 per cent in 31 December 2011, well short of the target level of 90 to 110 per cent.

¹⁶ It is acknowledged that WorkCover has other initiatives in place to achieve prevention outcomes that are not the subject of the amendments, and this finding is specific to the amendments, not the prevention activities of WorkCover more broadly.

In the absence of improvements to investment performance, the Scheme would not have returned to a surplus by June 2013. Moreover, this improvement and external factors such as discount rate assumptions would not on their own have been sufficient to support financial recovery.

Around 50 per cent of the deterioration in the Scheme from a surplus in 2008 of \$1.1 billion to a deficit of \$4.1 billion in 2011 was due to the sustained increase in liabilities from changes in claims experience since 2008, while the remaining change was largely due to revisions made to discount rates and risk margins. The change in the underwriting results of the scheme was for the most part due to the value of claims incurred¹⁷, which increased by close to 40 per cent between the first half of 2008 and the second half of 2011.¹⁸

This was driven by an increase in the liabilities associated with weekly benefit claims, medical expenditure, and Workplace Injury Damages, which together accounted for around 80 per cent of total outstanding liabilities in December 2011 and 95 per cent of the deterioration in outstanding claims liabilities since 2008.¹⁹ Increases to ‘top up’ payments for Permanent Impairment (Section 66 and Section 67) and increased utilisation of Pain and Suffering (Section 67) payments were also emerging as drivers of the deterioration in the outstanding claims liability.²⁰

Promoting recovery and the health benefits of return to work

Promoting recovery and the health benefits of return to work is supported by research and medical bodies as being consistent with health outcomes. Where absence from work is not medically required, health outcomes are generally more favourable where rehabilitation includes return to work.

A major review in 2007 titled *Work and Common Health Problems* showed that long-term disability and work loss may lead to worse mortality such as from heart disease, lung cancer and suicide, and health outcomes, such as poor physical health, high blood pressure and chest infections, long-term illness, poorer mental health and wellbeing and higher rates of medical attendance and hospital admission.²¹ Studies also show that return to work is an important aspect of rehabilitation, with benefits ranging from general health and wellbeing improvements (such as self-esteem, self-reported health, physical health and self-satisfaction) to lessening of psychiatric distress.

¹⁷ PwC, 2012. *Actuarial valuation of outstanding claims liability for the NSW Workers Compensation Nominal Insurer as at 31 December 2011*, 12 March 2012, p.264.

¹⁸ PwC, 2010. *Actuarial valuation of outstanding claims liability for the NSW Workers Compensation Nominal Insurer as at 31 December 2009*, 9 July 2010, p.10.

¹⁹ NSW Government, 2012. ‘NSW Workers Compensation Scheme: Issues Paper’.

²⁰ Ernst and Young, 2012. *External peer review of outstanding claims liability of the Nominal Insurer as at 31 December 2011*. Prepared for WorkCover Authority of New South Wales, 22 March 2012.

²¹ The Royal Australasian College of Physicians, Australasian Faculty of Occupational and Environmental Medicine Policy on preventing work disability, Sydney 2010.

However, the positivity of the return to work experience is critical, as it translates into actual health outcomes — a positive return to work experience has positive health benefits, and a negative experience can produce the opposite.

Research also shows a strong relationship between positive employer engagement (making contact with injured employees, providing support etc.) and return to work in terms of health outcomes.²²

In terms of the 2012 amendments, it is appropriate that the Act seeks to require that:

- employers support injured workers to recover at work through the provision of suitable duties wherever possible, and
- to the greatest extent possible, injured workers are not financially penalised by being less able to work at their pre-injury rate.

Of course, putting these principles into practice is difficult. For instance:

- it is a judgement as to the point at which an employers' responsibility ends, and the responsibility of other security nets, such as the Newstart allowance for unemployment, the Disability Support Pension or Medicare, begins
- there are factors that influence a worker's employment situation that are outside of the role of supporting recovery from an injury (such as market conditions and the location of an employee with respect to employment)
- in practice, reductions in work capabilities as a result of a workplace injury can reduce the chance of (re)employment, with the existing or an alternative employer, and
- it can be difficult to attribute changes in work capabilities to a workplace injury, as opposed to age related degeneration or other factors, which further complicate the scope of responsibility of the employer as opposed to other forms of social safety net.

These issues are particularly pronounced in a small businesses and/or rural/regional environment, where it may be more difficult to accommodate an injured worker requiring alternate or restricted duties. Hence, while the objective is appropriate, more work is needed to achieve this aim.

Guaranteeing quality long-term medical and financial support for seriously injured workers

Of all the principles that of guaranteeing quality long-term medical and financial support for seriously injured workers was most widely supported by stakeholders. The principle also reflects the need to provide a 'guarantee' that the system will be financially capable of supporting seriously injured workers and provide adequate security with respect to the level and stability of the support provided. The challenge for the system is to identify and distinguish *who* is seriously injured, and the contention surrounding implementing this principle in practice is in establishing what constitutes a serious workplace injury.

²² Safe Work Australia, 2014, *The National Return to Work Survey: The role of the employer and workplace Australia and New Zealand: 2013*, Canberra.

Reducing the regulatory burden

Reducing regulatory burden is an appropriate and core objective for government:

- excessive regulation imposes unnecessary costs on stakeholders, particularly in relation to workers compensation when injured workers and employers will often be ‘new’ to the system in the event of an injury
- excessive administrative requirements or other significant barriers facing an injured worker, employer, insurer, or service provider can impose unnecessary delays and change incentives for participation in the workers compensation system, and in work. For injured workers, an excessive regulatory burden can be particularly counterproductive, and exacerbate physical or mental disability, and
- a lower regulatory burden for workers compensation is linked to improved health outcomes for injured workers, with better relationships between injured worker, health care providers, and the ‘system’ at large linked to earlier recovery outcomes.²³

Regulatory ‘burden’ (where requirements are more onerous than required to meet objectives) can occur through improper drafting or during implementation, or when inadequate information and support is provided to enable stakeholders to navigate the system. Best practice in the implementation of reform is achieved when navigation of the system is transparent, simple and predictable.

While an important objective for the *Workers Compensation Legislation Amendment Act 2012*, analysis in this report shows that this objective is not one well met.

Discouraging payments, treatments/services that do not contribute to recovery and return to work

The principle of introducing greater discipline around which payments promote or discourage recovery and return to work is found to be appropriate, although the challenge is in defining what types of treatments and services remain reasonable.²⁴ Some of the key challenges include the following.

- **Medical practitioners often find it difficult to ‘exit’ patients from the workers compensation system** as medical practitioners strive for higher patient outcomes, without having to bear the choice of relative benefits and costs of pursuing further treatment.
- **It can be difficult to distinguish between necessary and discretionary ‘maintenance’ treatment, in terms of an ability to work.** Moreover, the treatment regime is likely to be linked to the broader bio-psycho-social health status of an injured worker, not just the elements which relate to work readiness.

²³ Kilgour, E., Kosny, A., McKenzie, D. and Collie, A. 2014. ‘Interactions between injured workers and insurers in workers’ compensation systems: A systematic review of qualitative research literature’, *Journal of Occupational Rehabilitation*: 2014.

²⁴ It is recognised that the return-to-work principle is not always applicable to some people who are catastrophically injured, where treatments and services are more appropriately about maintaining quality of life. It should also be recognised that there is diversity in this group of people, and there are people with catastrophic injuries who can and do engage very actively in work and rewarding careers.

- **Pre-existing and degenerative conditions can be difficult to separate from work-injury-related health needs.** This is particularly problematic given the ageing of the workforce in NSW.

The ‘reasonableness’ of payments in terms of enabling return to work also depend on the extent to which support is available from other sources, and the attribution of the injury to the workplace. As described by the Joint Select Committee on the NSW Workers Compensation Scheme (2012)²⁵:

The WorkCover scheme should provide a level of reasonable coverage of medical and related treatment, but it is not unreasonable that coverage be proximate to the date of injury and time off work by the worker. Australia has a comprehensive safety net of medical and hospital coverage for all Australians under Medicare.

²⁵ Markey, R., Holley, S., O’Neill, S., and Thornthwaite, L. 2013. The impact on injured workers of changes to NSW Workers’ Compensation: June 2012 legislative amendments: Report No. 1 for Unions NSW. Macquarie University, Centre for Workforce Futures, December 2013.

3 *Several early outcomes appear well aligned with intent*

Despite its early stage of evolution, there are already early indications that some elements of the 2012 amendments have done what they were supposed to do.

While some of the changes are not entirely attributable to the amendments, they will have had an impact on:

- *addressing the deficit of the Nominal Insurer Scheme, in line with the objective of ensuring optimal insurance arrangements*
- *putting downward pressure on premiums*
- *promoting return to work*
- *increasing some measures of financial support to the most seriously injured workers; and*
- *discouraging payments that do not achieve recovery and return to work.*

These impacts culminate in the significant fall in the number of claims and overall claims expenditure, and an apparent fall in the propensity to claim.

However, the early timing of this review limits the availability of empirical evidence to assess whether these outcomes are sustainable.

For instance, the fall in claims is more extensive than the change in entitlements would suggest. Other than the amendments, the use of Scheme agent incentives by WorkCover to close claims may have impacted claims experience, although this would not account for the size of the fall, which signals uncertainty around eligibility.

It is likely that claiming behaviour will change over time as more is understood about the application of the large scale reforms embedded in the 2012 amendments, as part of the process of challenging of thresholds and increasing awareness of eligibility.

This limits the capacity of this review to assess the longevity of financial impacts, except to point to the risk that claims, and claims expenditure, could at least partly rebound.

Early signs that reforms have been successful in terms of intent

There are early signs that the amendments have begun to achieve what they were designed to do, with:

- early signs of improvement in the structural deficit of the Scheme
- a reduction in premiums to levels more comparable with other states and territories
- changes to claims experience, including increased rates of injured workers exiting the Scheme earlier, which is in line with the intent to promote return to work, and

- increases in weekly payments for seriously injured, particularly benefits received after 26 weeks on workers compensation weekly payments under the post-reform arrangements compared to prior to the reforms, consistent with 'guaranteeing' support for seriously injured workers.

Fall in the number of claims and total claims expenditure

The amendments were designed to change access to benefits for an injured worker, depending on the nature of the injury and the duration for which benefits were available. They also altered the level of benefits, which in some cases were higher, and some lower.

This reflected a shift in focus towards encouraging return to work and greater rationalisation of compensation according to level of impairment and duration in the system.

The impact of this shift can be observed from a significant fall in the number of claims across all categories of entitlements, while the average payment for all claims (except for commutations) has increased substantively. Those that remain on benefits generally receive more. Table 3.1 provides an overview of the change in claims number, average payment size and the net impact on expenditure, comparing quarterly claims data for March 2012 and March 2014.

The largest contributors to the fall in quarterly payments were medical claims, weekly benefits and journey claims (in that order).

3.1 Quarterly change in claims, comparison of March 2012 and March 2014, Nominal Insurer Scheme

Type of claim impacted	Change in payments made	Change in average payment size	Net impact on quarterly expenditure	
	No.	\$	\$m	%
Weekly benefits	-14 309	+1 422	-26.6	-14
Journey claims	-5 230	+2 769	-22.5	-54
Medical claims	-19 363	+257	-16.0	-14
Section 66	-1 351	+2 284	-14.0	-41
Commutations	-30	-35 182	-5.1	-91
Section 67	-394	+664	-4.6	-36
Heart attack claims	-19	+897	-0.4	-30

Note: Includes both ongoing and new claims for the quarter.

Source: CIE using NSW WorkCover data.

Overall, the number of claims reported (new claims) since June 2012 has also fallen by around 24 per cent (non-deafness claims):²⁶

- around one third of the fall in new claims reported is due to the exclusion of most journey claims²⁷

²⁶ Letter from Michael Playford to CIE, 10 June 2014.

- It should also be noted that a reasonable proportion of these have some entitlement from the CTP scheme, including at-fault drivers²⁸
- the cause of the remaining two thirds is less clear and may be due to changes in behaviour/culture, impacting the propensity to claim.

Approximately 10 per cent of the 25 per cent reduction in the number of active claims is due to lower numbers of claims reported *since* June 2012 (new claims).

Of the remaining 15 per cent, attributed to existing claims, around 50 per cent occurred before the work capacity decisions would appear in the data. There has been insufficient time lapse since the amendments for the one-year medical cap or the 5-year weekly cap to have had a practical impact.

It appears, therefore, that there has been considerable self-selection by claimants out of the program, due to the reforms. Other than the amendments, the use of Scheme agent incentives by WorkCover to close claims may have also impacted the claims experience.

The average payment size has increased across all but one entitlement type (table 3.1). In the case of weekly benefits, this is likely to reflect amendments to align benefits more closely to pre-injury potential income levels and increase maximum weekly benefit thresholds.

In the case of other entitlement groups such as lump sum payments (section 66) and medical claims, the amendments did not change the structure/level of payments, but still average payments have increased. One possible explanation is that the amendments introduced greater restrictions around access to benefits, which may have changed the cohort of claimants towards individuals with more significant injuries (which typically receive higher payments).

Changes in the number of claims payable has produced a significant reduction in claims expenditure for the Nominal Insurer Scheme, with the largest overall impact attributed to weekly benefit claims, journey claims, medical benefits and section 66 benefits (in that order). While the fall in medical benefit payments have been in line with recent trends, weekly benefits have been more directly affected since the amendments:

- The work capacity assessment has, to date, been significant in altering access to weekly benefit entitlements and will therefore impact future medical payments, which are linked to the end date of weekly payments.

²⁷ It is possible that some of the fall in journey claims reflects changes in employer behaviour as, prior to the reforms, employers were able to code motor vehicle claims as journey claims to reduce premiums, as journey claims are excluded from experience premium calculations.

²⁸ All people who are injured in a motor vehicle accident in NSW, including at-fault drivers, are likely to be eligible for some entitlements under the CTP Scheme and, depending on how seriously injured they are, they may also have entitlements under the NSW Lifetime Care and Support Scheme. Prior to the 2012 reforms, workers compensation insurers could recover costs of claims related to motor vehicle accidents from the CTP insurer and this arrangement is still in place. However, CTP entitlements would not apply for slips, trips, falls or railway journey related injuries.

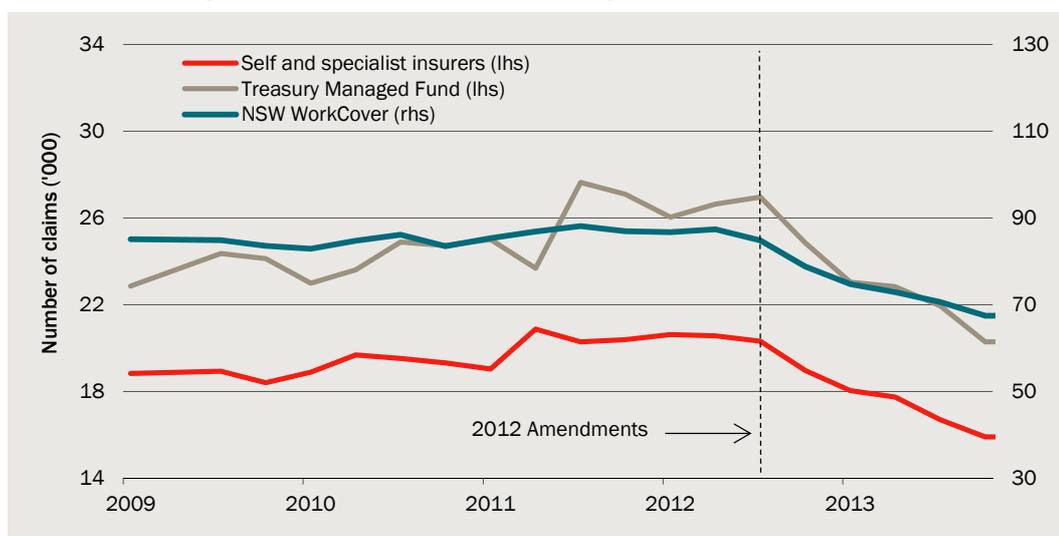
- The amendments, and perhaps the discourse around the legislative changes, have also been significant in altering the propensity to claim, which indicates substantial uncertainty surrounding the sustainability of the trends in claimant behaviour.

A similar experience in the fall in claims volume, and overall expenditure, has been replicated for self-insurers and specialised insurers. As shown in chart 3.2, the number of claims (on a quarterly basis) to self and specialist insurer and the TMF decreased following the reforms.

The decrease in claims was relatively uniform across the different insurance schemes, with claims decreasing by between 4 per cent to 5 per cent per quarter since the introduction of the reforms:

- active compensation claims under the Nominal Insurer Scheme fell by 23 per cent in the 18 months to December 2013, with payments down by 14 per cent in that period
- the number of active compensation claims with self and specialised insurance schemes has fallen by 23 per cent over the 18 months to December 2013, with the level of payments declining by 22 per cent, and
- the number of active claims with the TMF schemes has fallen by 24 per cent over the 18 months to December 2013, with the level of payments declining by 33 per cent.

3.2 Self and specialist insurers total claims experience



Data source: NSW WorkCover.

Appendix D provides a more detailed overview of the amendments and their impacts on claims data to date.

Signs of improvement in the underlying financial position of the Scheme

Ensuring the financial sustainability of the Nominal Insurer Scheme, and the workers compensation system more broadly, is consistent with the principles of ensuring optimal insurance arrangements and putting downward pressure on premiums.

The \$4.1 billion deficit of the Nominal Insurer Scheme in December 2011 has swung to a \$1.4 billion surplus in December 2013. As shown in table 3.3, around two thirds (\$3.95 billion) of the \$5.9 billion improvement in the budget position was due to changes in gross outstanding claims. This translates to a significant improvement in the funding ratio, with assets likely to be sufficient to pay for future liabilities.

However, for a number of reasons there is uncertainty around whether the funding position will be sustained including, but not limited to:

- future (unexpected) changes in claiming patterns, which will affect the sustainability of the weekly and medical benefits claims experience
- the extent to which Work Injury Damages may continue to escalate
- the weekly benefit level, which has been higher than expected with many of the transitioned claims being assessed as having little or no work capacity
- the stability of WPI assessments in relation to slippage as WPI outcomes cluster around thresholds over time
- the future impact of Work Capacity Decisions on the number of continuing weekly active claims, and
- the potential for expenditure on disputes to escalate.

This makes it too early to determine whether the improvement in the financial position of the Scheme is sustainable.

3.3 Change in budget position of the Nominal Insurer Scheme since June 2012

Balance sheet as at:	June-2012 (Pre-reform)	Dec-2013	Difference
	\$m	\$m	\$m
Investments	12 784	14 742	1 958
Claims recovered	461	421	-40
Other assets	1 297	1 870	573
Total assets	14 543	17 034	2 491
Gross outstanding claims	17 560	13 608	-3 952
Unearned premium provision	398	1 054	656
Unexpired risk provision	100	2	-97
Other liabilities	1 031	925	-105
Additional agent remuneration payable	0	83	83
Total liabilities	19 090	15 673	-3 417
Surplus/ (Deficit)	-4 547	1 361	+5 909
Funding ratio	76 per cent	109 per cent	+33 per cent

Note: The valuation is based on the successful challenge by Mr. Goudappel to the retrospectively of reform changes to Section 66 (permanent impairment) and Section 67 (pain and suffering). The impact of a successful appeal in the High Court of Australia (which was in fact successful) was estimated to improve the outstanding claims liability of around \$355 million.

Source: WorkCover NSW.

Impact of changes in investment returns

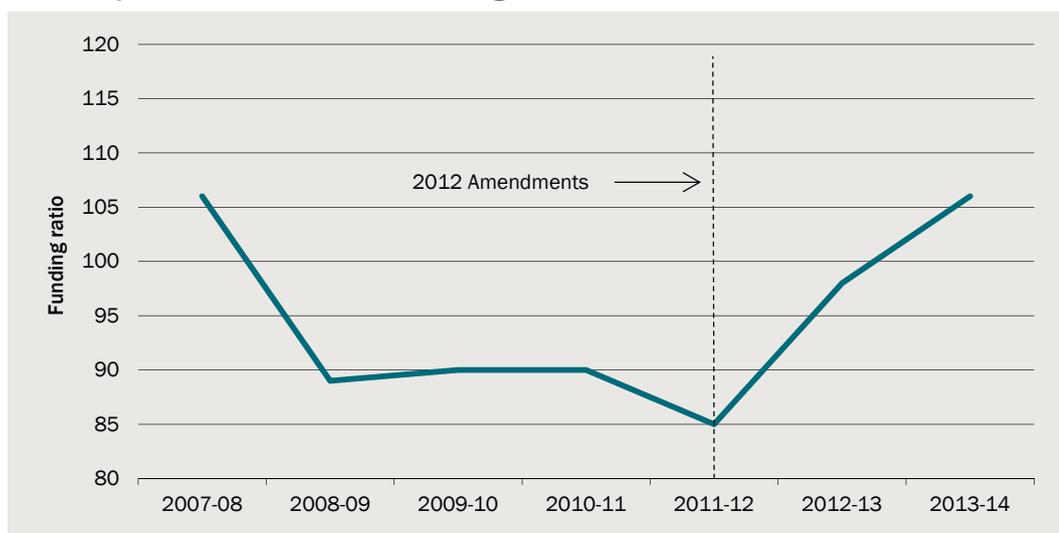
Around **one third** of the improvement in the budget position was due to an increase in the value of investments (\$1.96 billion).

Investment returns have been volatile over the past 5 years, reflecting the sharp fall and subsequent rebound in domestic and international share markets. More recently, domestic interest rate cuts and quantitative easing in both the United States and Japan have driven down long-term government bond rates. The reduction in risk-free rates of return has led investors to demand riskier financial assets which have helped to further support share prices and investment returns of NSW WorkCover.

WorkCover's investment portfolio with NSW Treasury Corp, which is made up of a number of assets including cash, domestic and international shares, and property, has also benefited from the sharp rise in global share markets.²⁹

Without the improvement in investment returns the Scheme would have remained in deficit. Moreover, investment returns remain volatile.

3.4 Impact of amendments on funding ratio



Data source: NSW WorkCover.

Impact of changes in incentives for Scheme agents

Some of the reduction in gross outstanding claims was assisted by revisions to Scheme agent remuneration arrangements.³⁰

In the fourth quarter of 2011, WorkCover provided *additional* tail remuneration measures, consisting of a bonus per identified claim, which stops receiving weekly

²⁹ Examining the investment component of the Nominal Insurer Scheme's balance sheet is beyond the scope of PwC's role as independent auditor. It is therefore difficult to fully explain the change in the value of investment assets over recent years.

³⁰ PwC, 2014. *WorkCover NSW Full Report: Actuarial valuation of outstanding claims liability for the NSW Workers Compensation Nominal Insurer as at 31 December 2013*, p83.

compensation prior to December 2012 and remains off weekly compensation for at least 12 months, to increase the incentive for Scheme agents to close tail weekly claims (claims more than 2 years post injury).

In addition, WorkCover revised the Scheme Agent remuneration arrangements for 2013 and 2014, including by introducing a fee for each complex claim Work Capacity Assessment Decision not overturned, a fee to limit unnecessary reactivation activity during transition of claims to the new regime and a fee for managing Seriously Injured Workers.³¹

These changes have better incentivised Scheme agents over the transition period and are not directly attributable to the amendments. Since June 2012, the number of weekly claimants for older accident years has continued to be significantly lower than expected, and incentives have had an indirect impact on the number of claimants receiving medical benefits (as a majority of tail weekly claimants also receive ongoing medical benefits).

- WorkCover and Scheme agents suggest the revised remuneration arrangements have contributed to this experience.
- However, in a letter to CIE (10 June 2014), the Scheme actuary expressed his own view that ‘self-selection by claimants would have been a more important driver’ (impacting the propensity to claim) than Scheme agent incentivisation.

Thus, we expect that the legislative changes were a more significant, but not the sole driver of the change in claims experience.

Premiums have become more comparable with other jurisdictions

Due to the initial responsiveness in the claims experience to the reforms, there has been a significant reduction in average premiums. Due to the amendments, the average premium is now broadly in line with the Australian average. Premium reductions were provided initially to a relatively small number of large firms, followed broader reductions particularly to those employers that improved their claims experience.

However, some employers report that the reforms did not impact (lower) their premiums.

Chart 3.5 shows the narrowing gap between NSW premiums and Australian average premiums due to the reforms. However, premiums remain higher in NSW than other state-based centrally funded schemes, with the exception of South Australia.³²

A further 5 per cent reduction in average premiums was announced for NSW employers participating in the Nominal Insurer Scheme, to 1.4 per cent in 2014-15, following announcements of premium reductions in both the Queensland and Victorian WorkCover Schemes. Despite the additional reductions, average premiums will still be

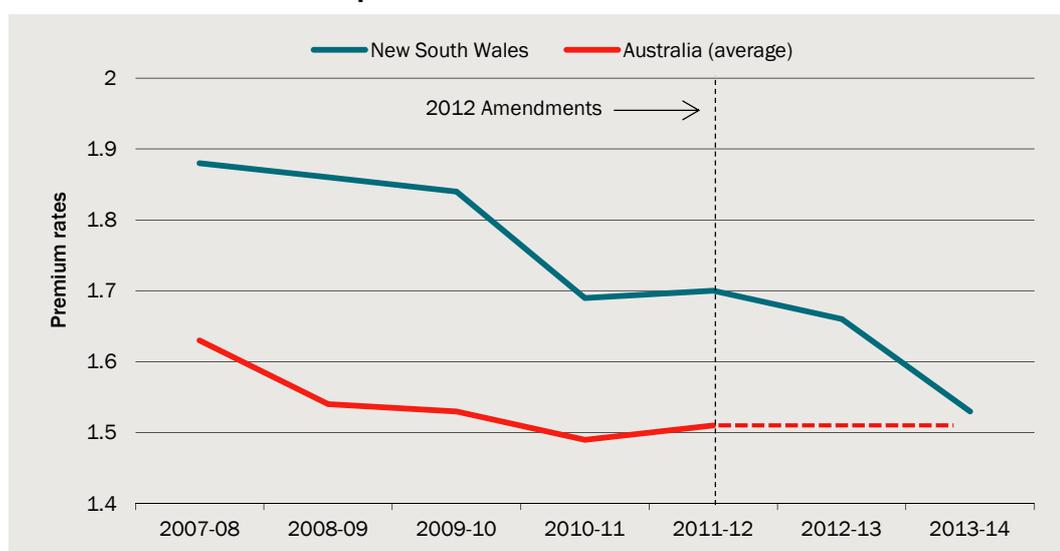
³¹ PwC, 2014, *WorkCover NSW Full Report: Actuarial valuation of outstanding claims liability for the NSW Workers Compensation Nominal Insurer as at 31 December 2013*, p48.

³² Finitive Consulting, 2013, ‘Premium Ratings and Scheme Insights’, d’finitive [workers compensation], June 2013, see www.finitive.com.au.

lower in the Victorian (1.27 per cent) and Queensland (1.20 per cent) WorkCover schemes in 2014-15.³³

While not attributable to the reforms, small business impacts have been mixed due to the raising of the threshold for small businesses to receive an experience setting, from \$10 000 to \$30 000 in premiums paid each year. This has resulted in a greater number of small firms not receiving a direct price signal to improve their claims management experience.

3.5 Premium rates and impact of amendments



Note: The Australian average reflects the average of all States and Territories (standardised to provide a comparable basis). In the past two years, the premium experience has been mixed, with small adjustments in Victoria (downward), Queensland (upwards) and WA (upwards), and SA (no change), with more significant changes to premiums for the Comcare scheme (upwards), Tasmania and ACT (upwards). See Finity Consulting, *Premium Ratings and Scheme Insights*, June 2013.

Data source: NSW WorkCover. Safe Work Australia, 2013 (latest data available is for 2011-12).

Improved incentives to return to work and many workers have exited the system

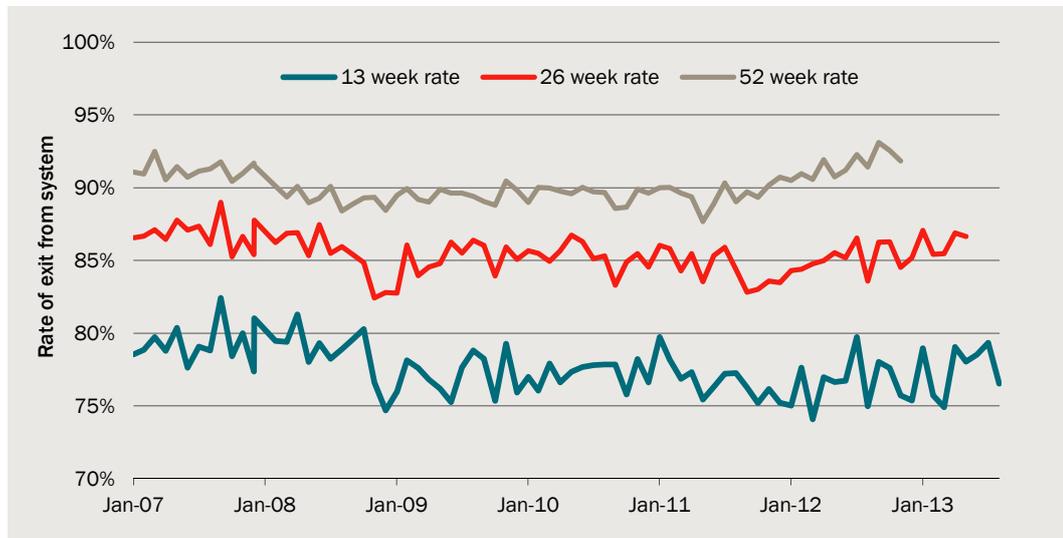
The amendments introduced strong financial incentives to encourage less seriously injured workers to recover and return to work.

The significant reduction in claims in association with the legislative reforms reflects the fact that there is a higher rate at which claimants are exiting the system. There is a range of reasons why claimants may exit the system, including self-selection out of the system, (perceptions of) no longer being eligible to remain on benefits, retirement, or migration, hence exiting the workers compensation system may or may not involve return to work.

The Scheme actuary reports return to work rates, but these refer to the rate at which benefits cease for a range of reasons provided above. The experience of 'return to work' rates, reflecting the *rate at which injured workers are exited from the system* at different time intervals, is shown in chart 3.6.

³³ OHS Alert, 2014. 'Victorian premiums cut as Qld miners' rates plunge', 19 June 2014. <http://www.ohsalert.com.au/topics.php?stream=235QLD>

3.6 Rate of exit from system at different intervals



Data source: NSW WorkCover

The data on 'return to work' rates at 26 weeks and 52 weeks suggests 'positive post-reform experience'.³⁴ The proportion of injured workers exiting the system within a year has been steadily increasing since the start of 2012 and currently stands at around 92 per cent, compared to less than 90 per cent prior to the reforms.

The data does not allow us to conclude that increases to the rate of injured workers exiting the system have resulted in better return to work outcomes. In addition, return to work surveys capture all injured workers including those off work for a minor period of time, with periodic variation in 'return to work rates' possibly reflecting changes to the severity of claims or the employment market rather than outcomes for individuals with more significant barriers to return to work.

Anecdotally, however, several submissions from individuals working across the workers compensation system (in regulatory or insurance roles) suggest return to work rates have improved. One coordinator of the WorkCover Authority submitted to the CIE that:

The change in wages policy has had a positive impact on people returning to work. More people are returning quicker.

It is also likely that the employment market was an important contributor to any return to work experience, with the number of unemployed persons and the unemployment rate decreasing across NSW in the post-reform period from a peak in January 2010.³⁵

Increasing payments for the seriously injured

Increasing payments for those that are seriously injured is consistent with the principle of guaranteeing quality long-term medical and financial support for seriously injured workers.

³⁴ PwC, 2014, Letter from Michael Playford to Gary Jeffery.

³⁵ Montoya, D. 2013. *NSW Regional Labour Force Trends: Statistical Indicators 3/2013*.

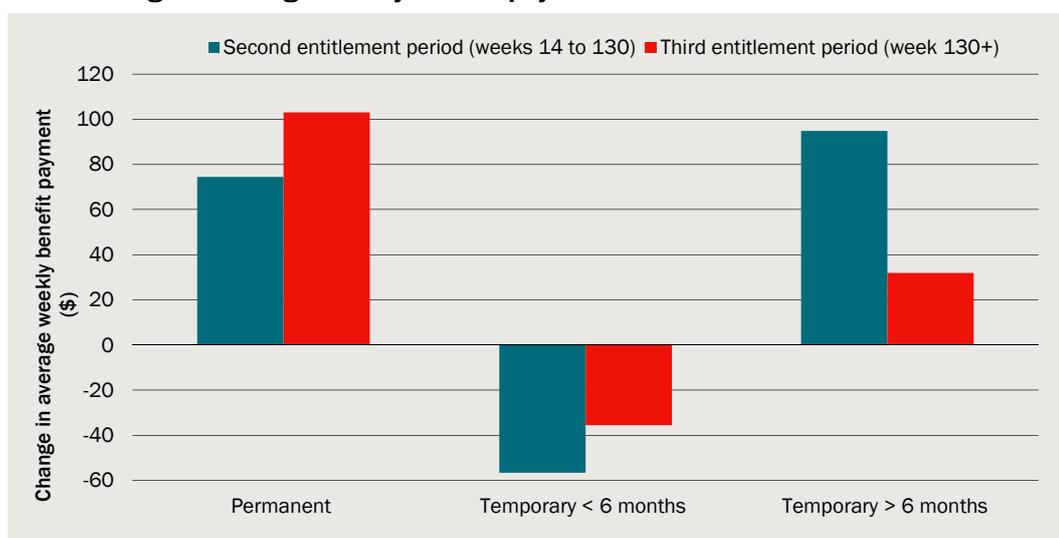
The ‘seriously injured’ (as defined by the legislation) are now able to receive a higher share of their pre-injury average weekly earnings by raising the maximum benefit thresholds, particularly in terms of their weekly benefits after 26 weeks. This has been consistent with the intent of the legislation, to guarantee financial and medical support for the seriously injured.

Chart 3.7 shows the change in average weekly benefits from the March quarter of 2013 to the March quarter of 2014 in terms of moving from old to new benefit levels. It shows the impact on injured workers that are ‘permanently incapacitated’ and ‘temporarily incapacitated’ with ‘time lost’ (days off work) of less than 6 months, and 6 months or more, respectively.

Injured workers with permanent impairment and temporary impairment that have had a substantive period of absence from work (in excess of 6 months) are, on average, receiving higher average weekly benefits provided they remain in the Scheme.

- For the second entitlement period (weeks 14 to 130), the increase in payments is most significant for those *temporarily impaired with ‘time lost’ of over 6 months*.
- For the third entitlement period (from week 130 onward), the increase in payments is most significant for those defined as *permanently impaired*.

3.7 Change in average weekly benefit payments from WorkCover scheme



Note: Permanent incapacity represents permanent total incapacity and permanent partial incapacity. Temporary disability is split into the time lost from work, in days, as either less than 6 months or greater than 6 months. The data utilised is quarterly, which has been divided by 13 to estimate weekly payments.

Data source: NSW WorkCover.

In both periods, average weekly benefit payments for those with temporary incapacity of less than 6 months has fallen in both the second and third entitlement periods.³⁶

³⁶ This has a range of possible explanations including the number of claimants exiting the system (duration on benefits), the number of injured workers that are not working 15 hours or more each week that would be receiving a lower percentage of PIawe (80 per cent), and the potential use of work capacity assessments at earlier than mandatory time periods.

It is acknowledged that there may be differences in the severity of injuries between the cohorts of individuals under the pre and post-reform systems, as well as differences in the average duration of the cohort on benefits, which would contribute to these differences.

Removal of payments for pain and suffering

The removal of payments for pain and suffering is consistent with the principle of discouraging payments that do not contribute to recovery and return to work.

While workers suffer psychologically as a result of their injuries, section 67 payments for pain and suffering are unlikely to contribute directly to recovery and return to work.

Little evidence has come to bear that has been contrary to this, although the removal of section 67 is unpopular with advocates of workers, and a large number of submissions were received from injured workers on the perceived unfairness of pain and suffering not being directly acknowledged, when pain and suffering has clearly been experienced.

To the extent that the amendments sought to remove payments that did not encourage return to work, the exclusion of section 67 payments has been consistent with the objectives of reform.

However, their removal may well have reduced the 'buffer' available for injured workers to fund any adjustment costs that might otherwise enable them to retrain or relocate to return to work.

4 *Weaker signs of impact in other key target areas*

Caveats around the early timing of this review aside, there is little or no early evidence that the reforms have achieved some of the objectives of the workers compensation system.

This is particularly the case with respect to injury prevention, reducing the regulatory burden, and supporting less seriously injured workers (mainly those with a WPI of 21-30 per cent) to recover and regain their financial independence.

Various issues have also been raised around the fairness of reforms, which have the potential to detract from the spirit of the objectives.

In many cases, these factors culminate in (unaddressed) barriers to return to work, limiting the extent to which the amendments can be said to meet the policy objectives.

The key ‘problem areas’ relating to the amendments arise with respect to:

- the inadequate targeting of some key objectives (discussed in this chapter), and
- unintended and/or undesirable outcomes that have arisen as a result of implementation to date (discussed in the following chapter).

Barriers to return to work

Changes to suitable employment provisions, in theory, provide better alignment between payments and recovery, and return to work, which are clearly in line with the objectives of the Act.

However, where return to work is possible in terms of work capacity, in some cases it is very difficult to achieve employment outcomes because of the lack of support provided to deal with the practical return-to-work barriers.

This makes addressing barriers to work a practical consideration in order to meet the more direct objectives of promoting recovery and return to work.

It is recognised that not all barriers to work are driven by the legislation. Often barriers to work are cultural, reflecting the nature of the relationship between employers and employees, the nature of the injury (particularly where cognitive injuries are involved), and the personal circumstances of an individual worker and/or an individual incident.

Similarly, the solutions to barriers to work are multifaceted: some require legislative change, changes to dispute resolution procedures, changes to practice around implementation (case management in particular) or changes to workplace culture.

Barriers imposed by location and retraining requirements

Recovery and return to work for less seriously injured workers is intended to be promoted, *irrespective of the location and requirement to change industries.*

Under the amendments, no regard can be given as to whether the particular job exists or the worker's geographical location.³⁷ Slater & Gordon Lawyers state that the way this change has been effected gives rise to the potential for work capacity assessments being used as a tool to cease or limit a worker's benefits without a fair opportunity for the worker to respond. The reforms have resulted in an increase in workers 'exiting the system' either through returning to work, or because they cease to be eligible for entitlement, or because of self-removal from system without a corresponding return to work. The Australian Association of Surgeons report that:

It is a forward move that capacity (rather than incapacity) is now assessed by the treating medical specialist. However, there does appear to be an unrealistic expectation of job placement in some cases. Rehabilitation providers supply extensive reports, suggesting suitable transfer of skills, but in practice this is often unrealistic.

This is likely to have a higher impact on injured workers from rural and regional locations. The NSW Bar Association, for instance, report that due to the suitable employment provisions an injured worker living in Moree recently received a work capacity assessment saying he could work as call centre supervisor (which are more likely to be located in city centres).

Several options were put forward by stakeholders to better achieve return to work outcomes. These include, but are not limited to:

- specifying that alternative employment is reasonably accessible to the worker
- meeting the costs of transitioning to a new employment or location
- meeting retraining costs to enable workers to shift into more suitable post-injury employment.

Several submissions have highlighted the fact that costs associated with relocation and retraining are even more of a barrier to return to work as a result of other changes to payments since the reforms, largely because lump sum compensation is no longer payable, which may have previously been used to start a new career or business.

This is particularly the case for injured workers that fall below the 11 per cent WPI threshold required to access lump sum compensation, even though their injury may render them permanently unfit for work or the type of work performed previously. For instance, the Australian Association of Surgeons' submission reports that many of the spinal injuries to labourers only register in the 5 per cent to 8 per cent WPI range, but have permanent impacts on work capacity in their previous occupation.

³⁷ New South Wales Bar Association submission.

Aside from the WPI threshold issue, the reforms have limited the likelihood of commutations by reducing the number of claimants in receipt of ongoing weekly compensation, which is key criterion for eligibility to receive a commutation payment.³⁸

Barriers to providing suitable duties

Submissions have pointed to several barriers to providing suitable duties that have been created or perpetuated by the 2012 amendments. These include, but are not limited to:

- the role of the General Practitioner as a gatekeeper and the confidentiality requirements associated with medical information, which limits discussion around suitable duties
- the insufficiency of reimbursement mechanisms for doctors to take the time to engage the employer with respect to appropriate return to work duties and to prevent delay
- the bureaucratic nature of the WorkCover Return to Work guidelines, which are said inhibit injured workers from being accommodated at work,
- the formality of the administrative/compliance documentation required, which acts as a barrier to early return to work, and
- employer reluctance to provide suitable duties.³⁹

Notwithstanding attempts by employers, in many cases it is also unrealistic for employers to be able to provide suitable duties.

Commonly cited examples are injured workers from the building sector and across manual trades, as well as manufacturing.

Anecdotes from injured workers of the impact of lack of retraining provisions where the employer cannot provide suitable employment are provided in box 4.1.

³⁸ A commutation is an agreement between the injured worker, employer and scheme agent or insurer to pay all of the injured worker's entitlements to weekly benefits, medical, hospital and rehabilitation expenses as a lump sum.

³⁹ To counter any reluctance to provide suitable duties, the reforms introduced employer improvement notices, which can impose penalties on employers if they fail to comply with return to work obligations. These notices are intended to be used to support dialogue around how employers can support recovery through return to work. WorkCover is also piloting program focused on Early Return to Work Engagement with Workplaces Program to adopt a more consultative approach to employer engagement around suitable duties.

4.1 Impacts of lack of retraining opportunities and suitable work opportunities

“I was terminated and have not been able to get any employment. I am not skilled for anything else, I was assessed at 21 per cent permanent impairment. As of the *(date removed for confidentiality)*, I am having my benefit cut from the insurance company because the insurance company deem I can work even though I have no training for the jobs they say are available to me. My work capacity decision did not take into account my work skills or my education level or the fact that I have not had any retraining offered which was suitable to what I needed.”

“Can’t do usual duties. Got the sack. And after applying for over 400 positions. Two retraining attempts where it was found the duties were unsuitable, managed one successfully but can’t find a job again.”

“The retraining I was offered was for employment which pays minimal wages (business administration) and uses none of my pre-existing skills.”

“I have applied for over 200 jobs since January. I am not qualified for most of the jobs that my work capacity assessment is based on and the insurance company will not retrain me.”

“I have been assessed by Work Cover with 25 per cent whole person impairment. I received weekly payments for approximately 1 year at which time my employment ended due to unsuitable light duties.”

“My level of impairment for now is 12 per cent for back and 5 per cent for neck, I was terminated from my employers in May 2013 and in this time have managed a little work but cannot find or get permanent employment since this time and just average about \$200 a week in wages.”

Barriers to return to volunteer work

There is anecdotal evidence that injured workers are reluctant to undertake (or declare) volunteer work, due to fear of being determined as having a capacity to work and putting at risk weekly benefits received.

This is an undesirable outcome in many respects, given the demand for volunteer workers, and the importance of volunteer work to improving the positive social engagement and sense of purpose of injured workers, which are both positively associated with return to paid work.

Potential for delays in rehabilitation

Unnecessary or avoidable delays in rehabilitation are a barrier to return to work that, in some respects, are alleged to have been adversely impacted by the amendments.

For instance:

- the reforms did not introduce any direct mechanism to provide additional requirements for insurers or employers to invest in the rehabilitation of the injured worker — this is likely to be particularly noticeable where there is no financial penalty

for employers associated with the length of a claim (such as for employers that are not experience rated)⁴⁰

- rehabilitation costs are also rarely included in weekly payments, and
- changes to the legislation that extend the powers of WorkCover such as to require all treatment be approved prior to it being provided and to provide for rules to be applied (via WorkCover Guidelines) in determining whether it is reasonably necessary for a treatment or service to be given or provided have the potential to introduce delays to treatment.
- Some submissions have also highlighted that Scheme agents may have less clear guidelines or incentives around investment in rehabilitation services that have caused delays in receiving approvals for injured workers to access rehabilitation services, and therefore delayed the process of returning to work.⁴¹

Challenges for workers suffering from a deteriorating injury

The amendments introduced a range of restrictions to discourage payments, treatments and services that do not contribute to recovery and return to work, and to promote recovery rather than ‘reward’ non-recovery.⁴²

However, the application of the changes poses genuine challenges to workers with deteriorating injuries, injuries that cannot be appropriately treated within legislated timeframes, or medical conditions that arise in the course of the injury or treatment that were not foreseeable at the time the claim was made.

This creates scope for a lack of alignment between the objectives sought and the outcomes achieved.

For instance:

- Certain injuries may not require surgery within a 12-month period after the injury was first sustained but may later become apparent.
 - In those circumstances, the strict capping of medical expenses to a 12 month period may prevent an injured worker from receiving cover for medical treatment for a work-related injury because the extent of the injury was not apparent within the initial 12 month period,⁴³ although this would depend on the workers entitlement to benefits for further surgery

⁴⁰ For instance, self-insurers report that they have always had significant, direct incentives to promote return to work outcomes and effective rehabilitation, through the impact on expenditure. For non-experience rated employers under Nominal Insurer Scheme (the majority of employers under the Scheme), the incentives for rehabilitation are much weaker, and the reforms have not addressed this divergence.

⁴¹ Workers Health Centre submission.

⁴² This includes, for instance, permitting only one WPI assessment, one lump sum claim for permanent impairment, and restricting medical expenses to a 12 month ‘window’.

⁴³ Australian Medical Association (NSW) Limited, submission

- The injured worker would need to carefully consider whether the injury is stable, and the timing of their lump sum payment, which can be difficult.
- The legislation does not allow for ‘maintenance’ expenses. Stakeholders see the restrictions as unfair for workers that have returned to work but require medical treatment to remain in employment or maintain a level of involvement in the workplace.
 - For instance, the withdrawal of benefits is seen as unfair in relation to ongoing physiotherapy treatments, ongoing medication for pain relief, repeat surgery consequent on injury (such as knee replacement) and the requirement for replacement equipment such as prostheses, spinal cord stimulators or hearing aids.
 - The NSW Bar Association reports that it is a common situation that the provision of successful ongoing medical treatment keeps an individual at work and earning a pre-injury level of wages.

Several examples of anecdotes from injured workers of the impact of the amendments on compensation for deterioration are provided in box 4.2.

4.2 Impact of restricted compensation for deterioration

“I had surgery on the elbow using a method that released tension on the tendon further down the arm. I made a WPI claim and was awarded more money for the scar than the injury. This method of surgery was unsuccessful and after 18mths further surgery was performed and then noted an hole tear on the elbow, so the tendon was cut and reattached in another location. I was not allowed to claim WPI for this now as the Compensation laws deny that and also further treatment. I am now left in the position of no compensation or treatment for an injury that was caused by poor management practices and procedures.”

“My WPI was rated at 11% before my injury had stabilised. I was 9 years into my claim before they conducted their first proper investigation. I waited 2 years for them to approve the surgery. With the new laws and the ruling in the high court, it would seem that I can't have another WPI done which would actually be a true reflection of my WPI as my injury is now identified and almost stable.”

“My case was or is before this date (*date removed for confidentiality reasons*) I had injury I had 3 months rehab got better then huge flare up at home (*date removed for confidentiality reasons*), this is why claim refused. Treating doctor and Neurosurgeon both agree that it was initial injury flare up. Insurance Company say no.

5 *Early signs of unintended impacts of reforms*

There are early signs that unintended outcomes have resulted from implementation that highlight areas of potential inequity, or outcomes that detract from the spirit of the objectives.

There are early signs that this may be the case with respect to:

- *the inability of the amendments to reduce the regulatory burden or improve the ease of navigation through the system*
- *insufficient support provided to significantly injured workers that do not meet the legislative definition of ‘seriously injured’, and*
- *inappropriate work capacity assessments and decisions as a result of inadequate review processes and/or skill gaps among case managers, which are unintentionally detrimental to the recovery and rehabilitation of some injured workers.*

In some cases, the possible detraction from the objectives of the amendments may be due to issues with implementation and the early stage of what has been ‘large scale’ reform.

Despite the infancy of the reforms, there are several areas where unintended impacts have arisen, which are arguably counter to the spirit of the objectives of reform, referred to by stakeholders as areas that have ‘fallen through the cracks’. These areas include:

- the ‘inadequate’ support provided for substantial injuries that do not meet the high (WPI) definition of seriously injured
- the negative impact of the medical benefit ‘window’ on health outcomes
- the impact of reforms to injured workers with work capacity but permanent conditions with lifetime medical expenses
- the unintentional impact to the ‘culture’ of workers compensation through increased legislated powers to insurers without enough independent review (aside from with respect to process-related disputes)
- the negative impact of the reforms on abilities to navigate the system, particularly for the injured worker, but also for medical practitioners, and
- the impost of the workers compensation system on lower income workers, including part time and casual workers, and individuals with a pre-existing disability.

Impacts on injured workers that fall short of the WPI threshold for serious injury

Considerable stakeholder feedback was received on the perceived inequity of benefits that are now available for workers that sustain a major workplace injury, but are not eligible for the benefits associated with a serious injury.

Which injuries are 'serious'?

There is considerable contention around the definition of a seriously injured worker. The legislation defines a seriously injured worker as having greater than 30 per cent WPI, which impacts those that are intended to be exempt from worker capacity assessments and the 12 month window applying to medical assessments.⁴⁴

Injuries that fall **below** the 31 per cent threshold (which we define as substantive impairments) include substantial loss of use of a leg, loss of sight in one eye, and substantial loss of use of one hand, or total loss of movement in wrist.⁴⁵ Those on the cusp of 31 per cent but below may include individuals with spinal cord damage and chronic pain, which constitutes a serious debilitating injury that can prevent a worker from maintaining employment. These are frequently regarded by stakeholders, particularly in the context of the ability of a worker to return to work, as serious injuries.

The definition of a seriously injured worker has consequences for weekly payments and medical payments (which are linked to the weekly payment).

Workers with *less than* 31 per cent WPI may have substantive impairment, but still be subjected to a work capacity assessment. Many stakeholders believe this leaves these workers vulnerable to the insurer and rendered to eventual removal from the system. Whether this occurs in practice or not, the threat of being removed from the system particularly in relation to the impact on medical payments has been seen to be at odds with the principle of guaranteeing support to the seriously injured.⁴⁶

While the amount of support provided to workers at different WPI thresholds is ultimately a policy decision, there is anecdotal evidence that insufficient support is available to workers with a substantive impairment (below a WPI of 31 per cent) to enable them to recover and return to work.

Box 5.1 provides several anecdotes from workers with substantive impairments to highlight their experiences as a result of the reforms.

The Scheme actuary has previously stated that if the medical cap for the band relating to 20 to 30 per cent WPI was removed, the impact on the outstanding claims liability would

⁴⁴ There is some uncertainty regarding the exemption of seriously injured workers from a work capacity assessment. This relates to an inconsistency between section 38(5) and section 38(1) of the amendments, which are potentially contradictory, with section 38(1) indicating that all injured workers are subjected to a work capacity decision.

⁴⁵ Australian Society of Orthopaedic Surgeons submission, 2012.

⁴⁶ It is noted that workers that sustain these types of injuries would still be eligible for other forms of social safety net once the period of workers compensation entitlement expires.

be between a \$183 million and \$290 million increase, and the impact on future annual claims would be an \$18 million to \$62 million increase.⁴⁷

5.1 Stakeholder views on provisions for seriously injured workers

“My whole person impairment was 25 per cent on the *(date removed for confidentiality reasons)* that I now feel has increased. [Insurer] had given approval for a right shoulder operation with all ongoing costs for the *(date removed for confidentiality reasons)* and also approved a second operation with ongoing costs for my left shoulder on *(date removed for confidentiality reasons)* now I am informed that the rehab for both shoulders has been stopped as of *(date removed for confidentiality reasons)* but the second operation is ok to go ahead. This is putting a huge burden on my family and marriage all because somebody decided to change the rules therefore breaking the agreement I made at the time of my injury to continue working and being looked after for the rest of my life.”

“My level of impairment is 28 per cent. I have been advised not to have any more surgery as I suffer from complex regional pain syndrome and my pain levels would only increase. I am totally depressed stressed and no money as my payments were terminated in *(date removed for confidentiality reasons)* I have appealed to merit review still no answer nearly 6 months now.”

“I have been classified as a Seriously Injured Worker. Since then, all physio, exercise, physiology, massage has been stopped. Treatment for a shoulder injury which occurred as a result of the damage to the nerves in my right leg has been declined and surgery for repairs to the initial surgery has also been declined. I do not know what to do to limit the decline in my condition.”

More information on the impact of amendments on workers with substantive impairment, and the alignment of these impacts with the seven reform objectives is provided at appendix E.

Injured workers with work capacity but permanent conditions with lifetime medical expenses

The amendments aim to introduce greater discipline in the system with respect to treatment costs, and the 12 month window⁴⁸ attempts to achieve this by setting a definitive time period for the payment of medical expenses.

This creates a challenge for injured workers that need to fund medical expenses beyond the entitlement period, particularly if/when alternative forms of funding are unavailable

⁴⁷ Parliament of NSW, 2014, Transcript from hearing 3 of the inquiry into review of the exercise of the functions of the WorkCover Authority, 12 May 2014.

⁴⁸ Reasonably necessary medical treatment expenses expire 12 months after weekly benefits cease or 12 months from the date of the claim where no weekly payments are received or, in some cases where second surgery benefits are granted, a further 13 weeks after surgery.

or insufficient. The most commonly cited areas of concern relate to workplace injuries associated with:

- hearing impairment, and
- amputated limbs requiring prostheses.

The drawbacks associated with the medical window depend largely on the adequacy of funding under alternative schemes. In the case of hearing aids for instance, this is restricted to children and young adults, older persons, and those with complex needs who are funded under the Commonwealth Hearing Services Program.

The problem may also be exacerbated by increases in the thresholds for accessing other forms of compensation such as lump sum payments for permanent injury. For example, for hearing loss, the reforms introduced a higher threshold of 20.5 per cent for binaural hearing loss (which is equivalent to a WPI of around 11 per cent) meaning that anyone below the threshold is no longer entitled to lump sum compensation.

Prostheses, like hearing aids require regular maintenance, and replacement to continue being efficient to the worker, including regular visits to a prosthetist which are important to the proper functioning of the prosthesis. In the case of prosthetic limbs, the consequences of not having access to appropriate treatment may be deterioration of other body parts such as harm from unnecessary strain on muscles due to poor performance of a prosthetic limb that needs replacing.

It would be an unintentional outcome of the amendments if workers were disincentivised to return to work for the purpose of extending the time in which medical benefits were payable.

However, this would appear to be the case for these types of injuries in particular.

The way that the reforms influence entitlements for hearing impairment related to work injury in NSW compared to other jurisdictions is provided in appendix E. This shows that the impact of the reforms with respect to hearing impairment has been to make compensation and payments for services in NSW more restrictive than most other jurisdictions.

The Scheme actuary estimated that if the medical cap were not to apply to any claims relating to hearing aids, prosthetics and home and vehicle modifications:

- the cost of new claims would be about \$20 million per annum *more*, and
- there would be a once-off increase to the outstanding claims liability of \$100 million to \$140 million (around 1 per cent of the current size of scheme expenditure).⁴⁹

Encouragement of inappropriate treatment approaches

The '12 month rule' has the potential to disadvantage patients that may benefit from conservative treatment of certain conditions including spinal, shoulder and some other

⁴⁹ Transcript from the inquiry into review of the exercise of the functions of the WorkCover Authority, 12 May 2014.

known regions, when a 'wait and see' approach is more suitable.⁵⁰ This is particularly relevant for conditions where the natural history of the resolution of the underlying medical condition may take longer than 12 months.

However, the amendments could potentially incentivise the bringing forward of treatment, particularly when alternative sources of funding outside of workers compensation are unavailable to the injured worker. According to some medical practitioners, this problem can be exacerbated by the eligibility of funding a further 13 weeks after surgery. Hence, the amendments may not assist in the conservative management and treatment of medical conditions.⁵¹

The complexity is also not helped by uncertainty among some medical specialists as to whether a second and/or subsequent injury to the same part of the body is actually a re-injury of the initial incident or a 'new' injury, which impacts on the funding accessible via the workers compensation system for treatment.

Pre-approvals processes may lead to delays

The current requirement for approval of each consultation (beyond 48 hours after injury) may lead to potentially costly delays in terms of treatment outcomes, and is referred to by stakeholders as overly burdensome. This is particularly for conditions requiring surgery and/or ongoing or varied management following an initial report or claim.⁵² The same issue has been observed with respect to established treatment packages, such as physiotherapy after surgery, which currently require individual approval of each treatment.

While there is a requirement for approval of treatment to be made by claims managers within 21 days, several stakeholders have commended that this period is 'too long', and moreover, it is often the case that approval times are even longer as claims managers can defer decisions on the basis that independent medico legal examination is required.⁵³

This is particularly detrimental where early treatment is required to maximise recovery/function and/or minimise treatment costs.

Whilst being the subject of a large number of submissions from the medical community and from injured workers, early intervention is widely acknowledged as being consistent with best practice medical care. For instance, a Norwegian study showed that there were reduced odds of returning to work when the injured workers had to wait longer for surgery.⁵⁴ A Canadian study compared the differences in expedited status and surgical

⁵⁰ Australian Society of Orthopaedic Surgeons (ASOS), submission

⁵¹ ASOS, submission

⁵² Australian Society of Orthopaedic Surgeons and Australian Medical Association NSW, submissions

⁵³ Australian Society of Surgeons, submission.

⁵⁴ Rossvoll, I., Benum, P., Bredland, T., Solstad, K., Arntzen, E. and Jorgensen, S. 1993, 'Incapacity for Work in Elective Orthopaedic Surgery: A Study of Occurrence and the

setting under the workers' compensation system to analyse the effect of wait time to surgery on return to work rates. This study showed that a shorter wait time and thereby a reduced total disability duration increased the worker's likelihood of successfully returning to work.⁵⁵

Impacts of changes to individuals with pre-existing disability

The CIE met with employers that hire physically disabled workers to understand how the reforms have impacted a person with a pre-existing disability prior to injury. Some specific questions as to the appropriateness of the reforms with respect to this very specific group of the population were raised. Although raised in the context of physical disability, some of the concerns may apply to injured worker with a pre-existing psychological impairment:

- the question was raised of how an individual with a pre-existing physical disability would afford the transportation, commonly meaning taxi fares, to attend medical appointments particularly those that have been established by the insurer:
 - Typically this group of individuals does not have a savings buffer for these expenses, as they are frequently earning an income below the poverty line
- concerns were raised about the difficulty in complying with the complexity of the system, particularly in seeking multiple medical assessments and medical approvals, and questions were raised as to the appropriateness of the level of burden on someone with a physical disability:
 - questions were raised about the appropriateness of seeking multiple medical assessments, in order to save the insurer some money on treatment, when this may impose substantive costs on the individual in terms of their capacity to return to work
 - stakeholders pointed out that individuals with physical disability take significantly longer to move between locations
- concerns were raised with respect to the high risk nature of travel for individuals with a physical disability to participate in work, and the impact of restrictions on journey claims to these individuals particularly given they are typically low income earners (which is likely to preclude them from taking out other forms of life insurance).

Increasing power of insurers without commensurate capacity building

Insurers have been awarded greater power as a result of the amendments, but have not necessarily been provided with the incentives or support required to ensure that these new powers are implemented appropriately.

Probability of Returning to Work After Treatment', *Journal of Epidemiology and Community Health*, 1993.

⁵⁵ Koehoorn, M. McLaeod, C. and Hogg-Johnson, S. 2011. 'Do Private Clinics or Expedited Fees Reduce Disability Duration for Injured Workers Following Knee Surgery?', *Healthcare Policy*: 2011.

Several submissions to this review referred to ‘case mismanagement’ and poor decision-making, which has not been prevented or managed by the dispute resolution processes available.

The nature of many of the criticisms are highlighted in box 5.2.

While the extent of the problem is difficult to ascertain (and is beyond the scope of this review), there are several elements of the amendments that do not address these concerns. For instance:

- there are limited opportunities for an independent review of a work capacity assessment, and itself can cause substantial delay⁵⁶
- the restrictions placed around legal representation in the merit review process do not exist in any other jurisdiction, where injured workers are typically afforded legal representation
- insurers often form relationships with medico-legal houses to undertake medical assessments, which can, and apparently do, produce assessments that are at odds with the medical assessments pursued by the injured worker, yet insurers are empowered to use their own assessment, and
- the additional powers given to the insurer, such as to request further medical opinions and decline other medical advice, can result in unwanted delays.

The *unintentional* impact of the reforms has been to create a significant divergence between injured workers and insurer perceptions on the spirit of the amendments, such as to promote the recovery in order to return to work.

5.2 Stakeholder anecdotes on implementation of reforms by insurers

“Since the 2012 legislative changes, the insurance company managing my case is becoming increasingly difficult to deal with and at times dishonest, with interventions by WorkCover Authority require to resolve the issues. Yet the insurer is never financially penalised for their behaviour.”

“My treatment by [Insurer] has been appalling: medical certificates are ignored, phone calls (to Newcastle) are not returned, complaints to WorkCover are responded to by sending me a Section 74 notice.”

“I was assessed by one doctor as having 13 per cent level of whole person impairment but the Work Cover Doctor determined that the impairment was 4 per cent.”

“Insurer sent me to who I believe was unprofessional doctor of their choosing and who subsequently produced his biased report to favour the insurance company who paid him to write it. My treating doctor and specialist agree I should have a fusion to offer some chance of a positive prognosis. Insurance company closed my case based on their shonky doctor’s report.”

⁵⁶ Although there is the opportunity for review of WPI decisions at the Workers Compensation Commission, there is a requirement to fund own legal expenses if legal aid is not obtained.

Unfairness around dispute resolution procedures

The 2012 amendments introduced new processes for dispute resolution, which are set out in appendix E.

Many stakeholders to the review have highlighted concerns around with new dispute resolution process in terms of fairness and independence, which in many cases are seen to unintentionally disadvantage injured workers.

These concerns relate primarily to the following:

- injured workers are unlikely to be able to put together the documents and gather and present lay and expert evidence necessary to support their claims for a merit review
- the merit review process will therefore favour the insurers and WorkCover who are primarily concerned with reducing employer and fund liability,
- the merit review process cannot be considered a truly independent review pathway for workers or one that makes the system simpler for them to manage,⁵⁷
- the scope for arbitration has been restricted, despite the importance of arbitration in conciliation and perceptions of fairness, and
- the limiting of legal presentation for injured workers to ILARS.⁵⁸

Most of these concerns have led some injured workers to feel that they are not fairly judged in terms of their work capacity decision, leading to perceptions that the work capacity decision process can be used to terminate a worker's benefits rather than to achieve a sustainable and realistic return to work objective.

A potential power imbalance between insurers and injured workers may be particularly problematic in the context of any shortcomings in capacity and capabilities in compensation insurers, which some stakeholders have stated exist as a result of high turnover and inexperienced staff. The impact of capability issues will be greater where the insurer has greater power to make decisions.

Adverse impact on return to work outcomes

The WIRO provides direct engagement with insurers to contribute to their awareness about problems with the implementation of their new powers in terms of the appropriate process.

However, this is no guarantee that injured workers will receive an equitable outcome.

A commonly cited example is the misuse of section 74 notice, which pertains to a denial of liability, which are also (inappropriately) being used for work capacity decisions. This treatment contradicts the 1987 Act which states that 'a decision to dispute liability for weekly payments of compensation' is not a work capacity decision. It also disadvantages the worker because when denial of liability for weekly payments becomes a Work

⁵⁷ Law Society of NSW, submission.

⁵⁸ There are also limitations with the funding model for process reviews via ILARS, which does not discourage inappropriate dispute claims.

Capacity Decision matter, workers lose their right to have the merits of the case looked at by an independent authority.

Hundreds of submissions to this review were received from injured workers highlighting the perceived bias in the system, which is also a source of further anxiety for injured workers. As previously acknowledged in chapter 2, the recovery of the worker (and by extension return to work outcomes) is negatively impacted by adversarial interaction with insurers and other systemic failures such as delays of payments or processes, denials of claims and limited professionalism. That is, the perception of systemic bias negatively impacts return to work outcomes.

Navigating the system is difficult for the worker and costly for service providers

The legislation has restricted access to legal representation in many ways. An important impact of the reforms has been to significantly reduce the role of lawyers, particularly in terms of work capacity assessments and, in relation to other decisions, by requiring that individuals bear their own costs of representation unless they can seek legal aid. One senior public servant indicated that lawyers previously played a role in filtering out which claims were nonsensical and provide advice, most of which was free, whereas now lawyers are largely removed from the system. Some stakeholders also claim that, to date, WorkCover Authority has not adequately communicated the reforms and their impact on workers' options such as to receive assistance from the WIRO.

One stakeholder also expressed the view that the lack of information about the pathways and processes of the workers compensation system, as well as the role of lawyers having been significantly reduced, may be a cause of workers having exited the system.

This review has highlighted many reasons for exits from the workers compensation system, some of which are related to the amendments, and some not.⁵⁹ However, it is acknowledged that the difficulties associated with complexity of the system would further dissuade some injured workers from participating in the system. It is also acknowledged that this complexity has not materially improved (and may have worsened) since the amendments, partly given the early life cycle of such large scale reforms.

One injured worker submitted to the CIE:

No one appears to understand the claims system, or able to explain the process to the worker. Nor the agents for the employer/insurer. The agents/case managers are not readily available to assist (once a returned phone call 5 weeks later).

Worker's Comp Assistant only repeat what is in legislation. They cannot advise as they do not know individual cases. There is an extremely high level of frustration and stress to process expenses claims.

There are also examples of where the legislation has been poorly understood. For instance, in relation to journey claims there remains scope for a journey claim to be made, however, these

⁵⁹ This includes, for instance, return to work, retirement, migration, and movement onto other insurance (private health or CTP) and social safety net systems.

may not have been made as a result of interpretation particularly by insurers that journey claims have been removed from the system.

In addition, some service providers believe that the amendments failed to meet their objectives of reducing the high regulatory burden imposed to service providers operating in the workers compensation system.⁶⁰ The reforms have not reduced regulatory burden for service providers and additional red tape, such as the AMA (NSW) submitting that they have received hundreds of calls requiring assistance with the many levels of bureaucracy and requirements in relation to the conduct of Scheme agents in administrating the Scheme.⁶¹

⁶⁰ Australian Medical Association NSW, submission

⁶¹ Ibid.

6 Key findings

By and large, the 2012 amendments sought to:

- *contribute to economic and jobs growth by ensuring premiums were comparable with other states and that there were optimal insurance arrangements*
- *promote recovery and the health benefits of return to work*
- *guarantee quality long term support for seriously injured workers, and support less seriously injured workers recover and regain financial independence, and*
- *discourage payments, treatments and services that did not contribute to recovery and return to work.*

This was achieved by:

- *reducing benefit payments overall, whilst trying to maintain fairness in the distribution of benefits to injured workers*
- *incentivising employers to focus on return to work, and incentivising injured workers to recover at work where appropriate, and*
- *distribute benefits in a way that removed disincentives to work as a result of workplace injury.*

The amendments have helped to optimise insurance arrangements by reducing liabilities under the Nominal Scheme to a more sustainable level, and there are early signs that total claims, and the type of claims, have fallen and changed to be more in line with the principles sought.

However, it is too soon to tell whether the change in the financial position of the Nominal Insurer Scheme is sustainable, and whether changes in claiming behaviour will continue to be experienced across the workers compensation system.

Moreover, the process of implementing the substantial nature of the changes has posed challenges.

Some gaps in coverage are evident, as are inconsistencies in the application of the amendments. Some unintended barriers to return to work may also have been created.

It is also not clear that the balance struck between the health needs of injured workers and the need for cost containment are well aligned with the guiding principles of the Act.

Early signs of financial viability, albeit only partly linked to new incentives and the distribution of benefits

As a package of measures designed to support optimal insurance arrangements (which given the deficit issues prior to the amendments, included supporting the financial sustainability of the Nominal Scheme), the amendments contributed to an almost immediate reduction in benefits payable and reduction in forecast Scheme liabilities.

There have been three rounds of premium reductions for employers under the Nominal Insurer Scheme since the amendments, creating more competition between the Nominal Insurer Scheme and Specialist Insurers (and to a lesser extent self-insurers and SICorp), delivering cost savings for government and business.

Drivers of the reduced financial cost to government and employers

The improved financial position of the Nominal Insurer Scheme in particular is the result of:

- improved investment returns by the Nominal Insurer Scheme, accounting for 33 per cent of the improved financial position of the Scheme since the amendments; and
- a reduction in workers compensation liabilities, accounting for 66 per cent of the improved financial position of the Scheme.

In addition, there are also lower liabilities payable by self-insurers and employees covered by the TMF.

Changes in investment returns, while positive, are not the core function of the Scheme or the TMF, and are likely to fluctuate over time in response to changes in economic conditions. They are not the subject of the objectives of the Act or the seven principles of the 2012 amendments, and are therefore not the focus of this review.

From a purely financial perspective, the focus of this review is on the impact of the amendments on the total and average cost of claims, considering the efficient cost of claims, and the distribution of costs across stakeholders, particularly injured workers.

There are several key drivers of the reduction in the financial cost of workers compensation liabilities as a result of the amendments.

- **Enhanced incentives to return to work, which have improved return to work rates**, including for workers that are not able (or yet able) to return to full work capacity. Official 'return to work' rates for injured workers at 26 weeks and 52 weeks have increased since the amendments (noting that 'return to work' rates refer to the rate at which a worker is exited from the system for a range of possible reasons) and are currently at relatively high levels compared to previous years. However, there is consistent anecdotal evidence that this is inflated by increases in work capacity rather than actual employment outcomes as a result of the conditions of work capacity assessments.
- **Exiting claims from the workers compensation system.** A significant driver of reduced liabilities has been the effectiveness of the amendments in exiting long-term claims from the workers compensation system. The number of active claims with a

weekly benefit payment has fallen by close to 35 per cent since June 2014, and the number of active compensation claims receiving a medical related payment has fallen by 27 per cent, due largely to Scheme exits. In some cases, this is ‘cost reducing’ where benefits paid were unnecessarily delaying return to work. In other cases, cost impacts cannot be determined if workers are transitioned from workers compensation onto Commonwealth funded social support systems.

- **Improvements in technical efficiency.** Technical efficiency is the effectiveness with which a given set of inputs is used to produce an output, which has been enhanced in terms of legal costs by the reduction in legal input in the management of claims. The increase in legal costs seen prior to the amendments, particularly for insurers/scheme agents, appears to have been arrested by changes around dispute resolution, and legal costs for claimants has been in decline since June 2012 (See appendix D). Legal costs are now required to be paid by each party, irrespective of the result of the legal matter, and legal representation in no fault compensation matters has been restricted to disputes before the Workers Compensation Commission and Work Injury Damages (common law) claims, and is not permitted in relation to work capacity assessments/decisions.

The impact of the 2012 amendments on reducing administrative costs and red tape is inconclusive, and possibly too early to determine, although most stakeholders contended that red tape has increased due to the administrative costs of implementing new systems, new reporting requirements, and the three-stage dispute resolution process which arguably has a higher rejection (and therefore repeat) rate as implementation challenges continue to be resolved.

Reduction in financial liabilities is in part due to restricted benefits to injured workers

All workers compensation schemes face the ongoing challenge of balancing:

- the desire to return workers to the maximum medical recovery achievable and the highest quality of life, and
- meeting statutory obligations at the lowest cost possible.

This challenge is reflected in the seven principles upon which the amendments are based, where health and wellbeing outcomes are sought alongside cost containment and competitiveness considerations. Indeed the principles are sufficiently at odds such that they are unlikely to ever be achievable in unison, and/or in equal measure.

Achieving the ‘right’ level of compensation is a value judgement, which in the case of the 2012 amendments has been one where more benefits are payable to fewer injured workers, and the workers compensation system now arguably takes a less generous and less inclusive approach to benefit payments.

Analysis of the data available since the amendments were implemented shows that a large proportion of injured workers remaining in the workers compensation scheme are unlikely to be materially penalised. For instance, the proportion of active compensation

claims that include a weekly benefit payment, which implies time lost, has fallen from 49 per cent prior to the amendments to 44 per cent in March 2014.

However, this is certainly not the case for long-term claims in particular, which have been directly curtailed by the amendments, strongly influencing workers to return back to work or transitioning them onto other forms of social security or insurance systems.

Still, even in its altered state, the benefits available to workers injured at work, in most cases remain more generous than those available to workers injured outside of the workplace.

Large scale, system wide change

The 2012 amendments represent a major shift in the incentive system underpinning the workers compensation system in NSW, designed to penalise or reward behaviours that support financial sustainability. Whether the impacts were direct or indirect, the 2012 reforms affected all key parties in the NSW workplace injury management system:

- **injured workers** (unless 'seriously injured') typically face financial penalties for not returning to work where some work capacity exists, and the financial penalties grow in line with the period of work absence, unless injuries are classed as 'severe'
- **employers**, albeit indirectly or as a result of concurrent reforms, were incentivised to improve safety and claims management or face financial penalties (excluding smaller employers), and are required to focus on the provision of 'suitable duties' for injured workers in order for work capacity assessments to be effective, and
- **insurers and agents** gained greater powers to force work capacity into the mainstay of the way that workers compensation benefits are distributed.
- **regulators** were given new powers and responsibilities, with WorkCover inspectors able to issue legally binding improvement notices to employers not meeting management and return to work obligations with penalties payable. Changes in complaints and dispute resolution processes were also introduced through the merit review function of WorkCover and the new role and powers set out for the WIRO

Various exceptions were made, but in the main, the 2012 reforms will be considered alongside large-scale reforms in 2001 and 2006 as representing a substantial change in the intention, function and operation of workers compensation in NSW.

Some behavioural changes are already evident

Analysis of claims data since the amendments shows early signs of behavioural change in workers compensation claims:

- **Reduction in minor injury claims.** Prior to the amendments the proportion of active compensation claims that were the result of a temporary injury that resulted in less than 6 months off work was growing quickly. Between 2009 and 2012, this segment of the total number of compensation claims increased by 5 percentage points to 49 per cent. Since the amendments, this proportion has stabilised.

- **Substantial increase in rate in which benefits cease.** The proportions of claimants that exit from the system within one or two years, as recorded in WorkCover's official 'return to work' rate data have increased since the amendments and are currently at higher levels compared to previous years. These changes are likely to partly reflect the amendments and the introduction of a number of incentives for Scheme agents to close compensation claims that had been open for more than two years.

Gaps in coverage and inconsistencies in application are apparent

There are several areas where injured workers are said to have 'fallen through the cracks' with early outcomes that are not within the spirit of the amendments. The most commonly cited examples include:

- workers that sustain a workplace injury which requires ongoing support to enable their return to work (such as the provision of hearing aids and prosthetics) but will either not qualify for support, or are disincentivised from returning to work to delay the end to medical benefits
- workers that sustain a substantial workplace injury but do not meet the WPI threshold for a seriously injured worker may not be receiving the support required to genuinely contribute to their return to work and/or recovery
- older workers that are disadvantaged in terms of the duration of access to benefits due to a drafting anomaly in the legislation around benefits for retiring workers, and
- omission of restrictions in benefits to recess claims when journey claims have been altered to ensure a link between the injury and employment.

Unintended disincentives to work

Despite the strong intent of the amendments to promote return to work and recovery at work, this is not uniformly achieved.

- **Workers with serious injuries can be disincentivised to return to work by the new benefits regime.** Workers with a WPI of greater than 30 per cent receive no encouragement to return to work, and are not supported by the workers compensation system to entice employers to find suitable duties. Several stakeholders commented that some seriously injured workers would like to return to work, particularly when mental capacity is not impaired.
- **Workers with a disability.** Workers with a pre-existing disability face additional challenges in terms of their participation in the workforce. Accessing work is often a more difficult process, with the additional time required to prepare to get ready for work. This can make it more difficult to meet the hourly requirements for work when return to work is achieved. The greatest disincentive to work raised by disability groups as part of this review is the 2012 changes to journey claims. People with a disability can have a higher propensity to falls and thereby being injured to-and-from work. Hence, the new limits to journey claims have a disproportionate impact on workers with a disability.

- **Potentially higher payments on the transitional rate than return-to-work salary.** Given the way that PIAWE is calculated, it is possible for injured workers to receive higher weekly benefits on the transitional rate than they would if they returned to work. This directly disincentives return to work.
- **Volunteer work.** There is anecdotal evidence that injured workers face barriers to volunteer work for fear of reducing entitlements, even when volunteer work is positively associated with social engagement and a propensity to return to paid work.

Achieving balance between the health needs of injured workers and minimising costs

Many stakeholders refer to the ‘pendulum’ of trade-offs between benefits paid and cost containment having ‘swung too far’ in favour of cost containment as a result of amendments.

While to a certain extent the ‘right’ amount of funding for benefits is an unresolvable question, there are several respects in which the amendments have created a disconnect between health outcomes for injured workers and the objectives of the amendments.

Caps and medical approval of medical expenses

While 12 months may be a sufficiently long duration to ensure the provision of appropriate medical care for injured workers, this is not always the case. Stakeholders have raised several concerns about the approval requirements and time-limiting of medical expenses which result in:

- **Delays in treatment.** Some of the reasons for delays in medical treatments highlighted by stakeholders include:
 - the lack of clinical skills of many case managers resulting in their referral for medical advice from medico-legal firms, which can result in conflicting medical opinions with those of treating doctors and lead to delays
 - the approval process for medical expenses beyond 48 hours after injury, and
 - a lack of understanding on the part of doctors, who are not aware of the intricacies of workers compensation and do not realise that there is a limit to the time that services will be funded, and when various interventions to improve diagnosis and treatment need to be made.
- **Poorer health outcomes.** Access to timely and effective medical treatment at the earliest possible stage is a well-established cornerstone of good medical treatment.

Time will tell

In many respects, it is too early to determine the impact of the amendments on the financial sustainability of workers compensation in NSW, and the effectiveness of individual amendments on behaviours.

For instance:

- it is too early to observe whether additional cycles of medical expenses are generated when injured workers become entitled to them
- it is too early to be certain that the insurance operations of the Nominal Insurer Scheme are able to achieve sustained improvement, given a substantive part of the financial turnaround has reflected favourable outcomes of investment operations.

The impacts of large-scale change take time to be properly implemented and observed, according to some stakeholders as long as four, and preferably five years, with at least another twelve months required from now before any meaningful data-driven observations can be made.

Taking time to improve systems and processes

The success of the amendments in terms of meeting their objectives should improve over time as the processes and infrastructure to support the new system are bedded down.

Hence it is likely that some of the difficulties highlighted in this review may reflect teething issues which may dissipate.

One of the most commonly cited ‘teething’ problems is the discrepancy between the legislation and supporting guidelines, with the former open to interpretation, and the latter unable to yet provide consistent guidance on how to interpret and implement the changes in a manner compliant with the legislation. Commonly cited examples include guidelines on making work capacity decisions and estimating weekly benefits payable to injured workers.

This is likely to reflect shortcomings in the planning phase prior to the amendments, as well as challenges in developing robust and defensible guidance material to ensure a consistent approach to implementation across NSW.

Scope for further review and refinement

It is a finding of this review that several themes warrant further consideration by government to enable the amendments to best achieve the intentions of the Act.

Addressing barriers to return to work

- **Providing better tools and supports to enable return to work outcomes. This may include:**
 - amending return to work criteria around geographic and career transfers to impose only ‘reasonable’ requirements on injured workers. This is likely to require some recognition of the costs of relocation and retraining.
 - removing barriers to commutations where they provide a workable and mutually agreed outcome for employers and injured workers. The existing restrictions to commutations reflect a reluctance to expose the Nominal Insurer Scheme to funding risk, but for self-insurers and specialised insurers these risks are

internalised, and if both parties should seek to enter into a voluntary and mutually agreeable commutation arrangement it seems reasonable that they should not be prevented from doing so (as is currently happening under existing workers compensation legislation), so long as workers are protected (receive proper legal advice) and are not coerced into suboptimal agreements

- redressing anomalies that result in injured workers being ‘better off’ without returning to work
- **Engaging health professionals to better achieve return to work. This may include:**
 - improving communication between employers and medical professionals to support work capacity and the provision of suitable duties
 - providing more education of medical professionals on the nature of the amendments to offset a ‘natural’ reluctance of practitioners to recommend return-to-work prior to an improvement to pre-injury health status
 - reviewing the reimbursement model for medical services to efficiently re-engage the medical community in the workers compensation system
 - developing clear mechanisms for encouraging rehabilitation and early intervention.
- **Providing more support and focusing on small business.** There continues to be a large divergence between the preparedness of large and small businesses in the event of a workplace injury. This includes with respect to the policies and processes in place to deal with an injury that reflects an understanding of the requirements of employers, as well as an ability to provide suitable duties. This is particularly the case now that the experience rating threshold for premiums has been lifted, removing the price incentives on smaller employers to reduce injuries and claims, and reduce the size and duration of claims. This could include greater information provision and assistance with allowing for commutations.
- **Improving the efficiency and consistency of work capacity assessments.** Whether as a result of the early days of reform, the remuneration model, or other factors, there is variability in the effectiveness of claims managers to make work capacity assessments, and insufficient tools available to improve the quality of work capacity decisions. This may require capacity building for claims managers to respond to the disconnect between the new powers of insurers and the skills of case managers to fulfil them.

Minimising the regulatory burden associated with implementing reform

- **Minimising complexity and reducing the administrative burden of calculating weekly benefits.** The PIAWE approach is complex and often difficult to calculate, and yet it is still able to generate ‘winners’ and ‘losers’ compared to a more simple averaging calculation that was used previously and is still used by those exempt from the amendments.
- **Providing more support for injured workers to navigate the system, and reducing red tape and complexity for health service providers.** Unintentionally, the reforms have been accompanied by significant confusion and limited pathways for injured workers to access information, such as the availability of review processes. There have also been new administrative burdens placed on health professionals, which can

detract from the need to meet the health needs of injured workers, both of which would be well served by better education and information on the new rules.

- **Improving the efficiency of the review process.** The existing 3-tiered dispute resolution process appears to be reasonable in principle and works well in many cases. However, there are several examples of when the separation and sequencing of the process (WIRO) and the merit (WorkCover) review creates a regulatory burden for insurers, employers and injured workers:
 - Delays in decisions are likely to occur as a result of the sequencing of the review process, with both employers, insurers and workers venting frustration when an outcome is overturned late in the process. In some cases, this is because of unintentional errors in process (such as complying with an inaccurate guideline), leaving injured workers and employers uncertain about the outcome and entitlement. It is also observed that the difference in interpretation of the Act between WIRO and WorkCover has resulted in a high rejection rate at the process review.
 - The process of review is made more complex because of dual role⁶² of WorkCover/Nominal insurer as a regulator and insurer, and because the role and function of the WIRO is not clearly defined. In practice, the role of the WIRO has extended to fill the gap created by the challenge for WorkCover in issuing advice. It has also created a role for the WIRO (in as much as legislation allows it) to keep WorkCover accountable for implementation of the legislation. While WIRO appears to be delivering value in this role, it is not clear that the administrative burden is minimised by having multiple review bodies: the Workers Compensation Commission (WCC), WorkCover, and the WIRO.
 - It is also questionable whether the Independent Legal Assistance Review Service (ILARS) is an appropriate or efficient way of funding legal advice when there is a disagreement regarding entitlements. The ILARS mechanism contains no incentives to ensure that the only genuine complaints seek legal redress, and it is not clear whether the vehicle for legal funding should be nested within the WIRO.

These challenges warrant further government review, backed by a proper analysis of the costs and benefits, to determine whether the current approach best meets the objectives and guiding principles of the Act.

Improving fairness and equity whilst maintaining financial stability

- **Providing adequate and reasonable support for badly injured workers.** The threshold set in the legislation for defining seriously injured workers is somewhat arbitrary and needs to be considered with reference to the total number of people involved, and to specific examples where injured workers will be close to the thresholds and the impact of this restriction on them. It is observed that for injured

⁶² This 'dual role' refers to the tension between the role of WorkCover as an insurer and its role as a regulator. Some submissions to the review noted concerns around the structure of the workers compensation insurance division where WorkCover operates a Nominal Insurer as well as regulates self and specialised insurers. It is understood that these issues are currently being examined and addressed by WorkCover to segregate functions and correct delegation.

workers with a WPI of 21-30 per cent, workers compensation benefits now available in NSW are generally less generous than in other jurisdictions. Any revision to the treatment of substantial injuries could be done in the context of the National Injury Insurance Scheme, under which jurisdictions are working towards a set of minimum benchmarks for work-related injuries, which will cover eligibility and lifetime benefits.

- **Providing appropriate medical benefits for injured workers that need ongoing support to return to work where financial sustainability remains viable.** This would require review of the reasonableness of time-limiting benefits for injuries that do not meet the threshold of a severe injury to avoid the creation of disincentives to return to work to delay the end of medical benefits. This could be done by making allowance for 'deferred' surgery/treatment in certain specific cases⁶³ at the end of the medical entitlement period, some level of ongoing assistance towards hearing aids and prosthesis as well as modifying the AMA guidelines for certain well defined injuries (such as amputations, partial blindness).
- **Addressing unintended anomalies that have arisen to improve the equity and application of the amendments.** This includes refinements to section 52 to remove the differential treatment regarding access to benefits for workers approaching retirement age and the exemption of seriously injured works from work capacity assessments.
- **Improving the fairness of dispute resolution procedures.** The new process for dispute resolution has limited the opportunities for injured workers to achieve an independent review of their concerns.
 - the scope for arbitration has been restricted
 - the merit review process is believed to lack full independence because of the dual role of WorkCover and the lack of legal representation for workers with respect to work capacity decisions, creating the perception of being 'pro insurer/employer'

It is a finding of this review that the operation of the WIRO and ILARS needs to be considered by Government at an appropriate time in the future with a view to ensuring equity and streamlining processes across all phases of the dispute, and minimising the adversarial culture around workers compensation which can inhibit the focus on return to work. This may involve a comparison of the new arrangements with the prior use of the WCC, and alternative arbitration mechanisms.

- **Continuing with stakeholder consultation and engagement,** and recognising it as important to ongoing review and refinement of the workers compensation system. This could be used to improve guidance material on the application of the amendments, and to redress unintended or unwanted outcomes that have resulted from implementation to date.
- **Improving the focus on prevention and early intervention.** An important observation from this review is that self-insurers and specialist insurers appear to be more incentivised to invest more in prevention and early intervention than agents under the Nominal Insurer Scheme as their private underwriting models set up stronger incentives to reduce the number and cost of claims. These insurers are

⁶³ Under the current arrangements weekly benefits and entitlement to benefits for second surgery can be available, which lessens the impact of the cap for selected cases

believed to have experienced a greater reduction in more serious psychological injury claims by better identifying cases early on that require a different and specific approach to case management.

A Evolution of workers compensation in NSW

Evolution of workers compensation in NSW

The 2012 amendments were enacted when the Scheme was under considerable financial pressure. It is useful to understand the historical dimension to periods of financial instability, as workers compensation arrangements have changed over time in response to cycles in financial performance, among other things.

The first no fault workers compensation scheme was established in 1910. Premiums were generally 'high' and reform was minimal. Prior to 1987, private insurers withdrew from the NSW workers compensation market following heavy losses (PwC, 2011) and premiums were relatively high (4.3 per cent of payroll in 1985-86).

Since 1987 there have been periods of reform, largely in response to fluctuations in premiums and financial performance. For instance:

- periods of increasing deficits have typically followed changes to benefit levels (such as in the mid-to-late 1990s), when increases to premiums led to reforms to reduce costs
- when there has been an emerging surplus, there have typically been reductions in premium rates and reforms that increase the scope or level of benefits paid to injured workers, such as in 1991-1992 when premiums were reduced and the Government increased both the weekly benefits for workers who were incapacitated for longer than 26 weeks, as well as lump sum payments for permanent impairment.⁶⁴

There have also been swings in other aspects of the workers compensation system over time that have influenced the approach taken to the setting of premiums and the distribution of benefits under the Scheme. These include:

- **changes in access to common law provisions** which allow for claimants to pursue employers for damages where there is negligence. The original Scheme was designed to provide no-fault compensation, abolishing access to common law and commutations. This was later repealed in 1989, and access to common law (referred to as Workplace Injury Damages from 2001⁶⁵) has been retained for economic losses resulting from permanent WPI, where the work injury is the result of the negligence of the employer.

⁶⁴ Roth, L. and Blayden, L. 2012. *Workers compensation: an update. May 2012.* NSW Parliamentary Research Service e-brief.

⁶⁵ NSW workers compensation arrangements allow injured workers to sue for modified common law damages in certain circumstances. These are referred to as work injury damages claims. A work injury damages settlement cancels all further entitlements to statutory workers compensation benefits including weekly payments, medical, hospital and rehabilitation expenses (NSW WorkCover, 2014, 'Work Injury Damages', <http://www.workcover.nsw.gov.au/injuriesclaims/benefitsentitlements/Pages/Commonlawdamages.aspx>).

Until 2012, workers were eligible for non-economic damages for ‘pain and suffering’ (section 67)⁶⁶

- **changes in the focus on worker rehabilitation**, which has broadly increased over the period. The *Workplace Injury Management and Workers Compensation Act 1998* focused on proactive injury management and some benefits became dependent on the worker ‘taking reasonable steps to obtain suitable employment’, and the 2012 amendments attempted to reinforce this by reducing support that does not promote worker rehabilitation and health outcomes
- **changes in review mechanisms and processes**, where over time there have been attempts to move away from judicial, adversarial systems of review towards administrative, expedited systems of review, particularly via 2000 and 2001 reforms
- **greater use of market incentives** targeted at employers and insurers to reduce injury and actively participate in injury management and early return to work programs
- **expansion in the role of WorkCover** – which expanded from being the regulator to both the regulator and Nominal Insurer, replacing the six insurance companies to become the Nominal Insurer in 2005 and in 2006, establishing performance based contracts for seven private insurance companies to provide insurance policy and claims management, and
- **various use of deficit reduction techniques**, such as Commutations of weekly benefits, incentives for insurers to manage ‘tail claims’, and changes to thresholds for entitlements.

Chart 1.4 provides an overview of key reforms and features of the NSW workers compensation scheme from pre-1987 to present.

⁶⁶ According to the recent Court of Appeal decision of *Goudappel v ADCO Constructions Pty Ltd* (2013) NSWCA 94, 29 April 2013, a worker still has a right to recover lump sum entitlements as long as a general claim for compensation has been made prior to 19 June 2012.

A.1 Evolution of workers compensation in New South Wales

Key reforms during period	<p>The first no fault workers compensation scheme was established in 1910.</p> <p>A new scheme was established by the Workers Compensation Act 1926 (NSW). It remained relatively unchanged for several decades. It did not focus on the rehabilitation of injured workers.</p> <p>The current scheme began in 1987 following the withdrawal of private insurers from the compensation market in NSW, after several insurers became insolvent.</p>	<p>The 1987 Act introduced the publicly underwritten, no-fault NSW Workers' Compensation Scheme, tying premiums to OH&S performance. It had controversial elements, namely the move to an administrative system of dispute resolution and restricted access to the common law. Benefits were considerably lower in early years of the Scheme than pre-1987 but these were later increased.</p> <p>The WorkCover Authority was established in 1989, replacing the State Compensation Board.</p>	<p>Cost-cutting measures were introduced in 1996 and 1997 to address high claims volumes and contain costs.</p> <p>The 1998 and 1999 reforms sought to reduce scheme deficit, increase industry consultative processes and promote return to work. Further reforms introduced in 2000 and 2001 were significant but administrative in nature. The 'Table of Mains' approach is replaced by assessment of percentage impairment, and the Workers Compensation Commission is established to administer and expedite disputes (replacing an adversarial, court-based approach).</p>	<p>Changes were mostly operational. In 2005, WorkCover became both the Nominal Insurer and the regulator, replacing 6 insurance companies previously licensed to provide workers' compensation services, and assuming control of the funds.</p> <p>In 2007, WorkCover appointed 7 private insurance companies under fixed term, performance based contracts to act as Scheme agents for the provision of insurance policy and claims management services.</p>	<p>Wide-ranging, comprehensive reforms were introduced in 2012 via the <i>Workers Compensation legislation Amendment Bill 2012</i>, such as to increase funding for 'seriously injured' workers and strongly incentive return to work. The reforms introduced a 'Work capacity decision assessment' and aim to improve deteriorating Scheme performance.</p> <p>The <i>Safety, Return to Work and Support Board Bill 2012</i> establishes the Safety, Return to Work and Support Board.</p>
Key outcomes and statistics	<p>Pre-1986 Premiums were high relative to today. These increased substantially from 2.65 per cent of payroll in 1976-77 to 4.3 per cent in 1985-86.</p>	<p>The fund had a surplus of \$1.1 billion and target premium rate dropped to 1.8 per cent. Weekly benefits and lump sum payments for workers incapacitated for longer than 26 weeks increases.</p>	<p>By 2003, the Scheme is in \$2.98 billion deficit and funding ratio of 67 per cent</p> <p>Premium of 2.8 per cent of payroll through late 1990s</p>	<p>From 2002-2009, the average premium rate declines by 40 per cent from 2.59 per cent to 1.88 per cent. This remains higher than Qld, WA and Victoria.</p> <p>The financial standing of the scheme continued to improve from 2004-2009</p> <p>Now in a surplus of \$0.62 billion. The funding ratio improves from 66 per cent to 105 per cent by 2008.</p>	<p>The deficit increases to \$4.1 billion by end of 2011, due to external factors, increases in claims and per claim costs. This provides the rationale for reform.</p> <p>In June 2013, net assets improved to +\$0.31 billion, and a funding ratio increases to 102 per cent</p>
	<p>1926-1985 Period of minimal reform</p>	<p>1986-early 1990s Return to financial performance</p>	<p>1995-2002 Deterioration in performance</p>	<p>2003-2008 Improving performance</p>	<p>2009-2014 Deterioration, leading to reforms</p>

Source: The CIE, based on Roth and Blayden, 2012, PwC, 2012, Markey et al, 2013

B High level comparison of benefit regimes

B.1 Overview of similarities and differences in entitlement regimes

Entitlement type	Comparison with other key jurisdictions
Work capacity assessments and weekly payments	<ul style="list-style-type: none"> ■ Weekly benefit entitlements under the NSW scheme are very similar to those from the Victorian scheme, including the requirement of the injured worker to undergo work capacity tests and in terms of the 'step-down' provisions. The entitlements are more restrictive than all the other schemes. ■ The step-down provisions in NSW are more rapid than in South Australia, and Queensland. ■ Queensland and Western Australia still distinguish between award and non-award, whereas NSW has removed this distinction. ■ Only Victoria and South Australia (other than NSW) have legislation around work capacity testing (not Queensland or Western Australia).
Benefit duration restrictions beyond 5 years and cessation at 'retirement age'	<ul style="list-style-type: none"> ■ The South Australian scheme weekly payment duration is until retirement age, similar to the post-reform NSW scheme. ■ The post-reform NSW scheme remains less restrictive than the Queensland scheme which has a maximum duration of five years or a cap of \$273 055 (indexed). ■ In Western Australia, there is no duration cap but instead there is a cap of \$190 700 on total benefits payable, which is likely to impact the duration of claims. ■ There is no cap on the duration of weekly payments under the Victorian scheme.
Journey claims	<ul style="list-style-type: none"> ■ The NSW scheme remains more generous than that of Victoria and Western Australia, where journey claims are excluded. ■ The reforms have brought journey claims in to line with South Australia, which requires a real and substantial connection between the employment and the accident or incident. ■ Compared to the Queensland scheme, which covers journey claims, the current NSW scheme is still less generous.
Medical claims	<ul style="list-style-type: none"> ■ The NSW scheme introduced restrictions to medical payments in line with the Victorian scheme. ■ The NSW scheme is structured quite differently to the Queensland and Western Australian schemes: <ul style="list-style-type: none"> – the Queensland scheme has a cap on the duration of medical coverage of 5 years. Payment can be refused for medical expenses if the worker's condition is unlikely to benefit – the Western Australian scheme has a cap of \$57 319 on reasonable expenses plus an additional \$50 000 on the order of an arbitrator and \$250 000 in certain cases.

Entitlement type	Comparison with other key jurisdictions
Approvals processes and powers of WorkCover in relation to medical treatment/expenses	<ul style="list-style-type: none"> ■ The schemes in Victoria, South Australia and Queensland are all comparable to the current NSW scheme which provides a stronger regulatory framework than the pre-reform NSW scheme: <ul style="list-style-type: none"> – in Victoria, there is control over treatment provision, especially with limiting treatment with poor evidence base. The scheme can also respond to over servicing and poor billing practices – in Queensland, WorkCover can impose conditions on provision of medical treatment – in South Australia, WorkCover can disallow medical expenses if it considers them unreasonable and the provider may seek a review of a decision to disallow. ■ There is no specific provision under the Western Australian scheme, similar to the pre-reform NSW scheme, thus the current NSW scheme is relatively broader.
Pain and suffering	<ul style="list-style-type: none"> ■ Prior to the reforms, it was likely that the NSW scheme was more generous in terms of compensation for 'pain and suffering', compared with other states. ■ The current NSW scheme is more in line with the other jurisdictions although for greater analysis, further details around the amount of compensation need to be explored. ■ In Victoria and South Australia, 'pain and suffering' is implicitly incorporated in the non-economic loss part of the compensation amount, hence it is not a separate category. In Queensland and Western Australia, it has not been specified although common law for pain and suffering is available.
Number of assessments for lump sum benefits	<ul style="list-style-type: none"> ■ Before the reforms, in this regard, the NSW scheme was more generous than schemes in all other jurisdictions. <ul style="list-style-type: none"> – Only one claim can be made in Victoria. – In Western Australia, a table of disabilities applies where only one claim can be made for each injury but another claim can be made for a subsequent injury to the same body part. This makes it difficult to compare to New South Wales – In both Queensland and South Australia, although there are no limits to the number of claims, a reduction (in payment) is made for subsequent claims from the same injury. ■ The current NSW scheme is more in line with the Victorian scheme where only one claim can be lodged. However, the maximum lump sum payable is greater in Victoria (\$527 610) than New South Wales (\$220 000 as at October 2013, with an additional 5 per cent for spinal injury).
Thresholds for lump sums	<ul style="list-style-type: none"> ■ The Victorian scheme is the most similar to the current NSW scheme in that the threshold to receive a lump sum payment for permanent impairment is 10 per cent WPI for physical impairment (compared to >10 per cent in NSW), however it also has a 30 per cent WPI threshold for psychiatric impairment (compared to >15 per cent in NSW). The CIE understands the threshold in Queensland is established by the Degree of Permanent Impairment and is set at 5 per cent. ■ The Western Australian scheme it is difficult to compare as it provides lump sum payments for specific injuries to body parts instead of the WPI assessment.
Access to heart attack and stroke claims	<ul style="list-style-type: none"> ■ The reforms brought New South Wales more into line with Victoria. Victoria restricts all stroke and heart attack claims from the workers compensation system. ■ However, the pre-reform arrangements were more consistent with Queensland, South Australia and Western Australia, which do not generally restrict the coverage of heart attack and stroke claims.
Damages for nervous shock	<ul style="list-style-type: none"> ■ In Victoria, South Australia and Queensland, under the general civil law, relatives or dependants of the injured worker may make nervous shock claims however if successful, the employers will have to bear the costs as the scheme does not indemnify employers for such claims. ■ In Western Australia, relatives or dependants may also make nervous shock claims under the general civil law.

Source: The CIE using various sources.

C Appropriateness of the intent of the 2012 reforms

Each of the seven principles referred to in the Minister's second reading speech to support the 2012 amendments are considered below, to assess the relevance and appropriateness of the reforms/outcomes sought from the *Workers Compensation Legislation Amendment Act 2012*.

Enhancing workplace safety by preventing and reducing incidents and fatalities

- **Workplace safety remains paramount to meeting the responsibilities of government, employers, and other stakeholders. The social and economic benefits of improving workplace safety are significant, reflecting the high cost of poor performance. Poor performance in relation to workplace health and safety interacts significantly with the workers compensation system through the costs borne by the injured worker and paid out via compensation mechanisms.**
- **However, while the principle of enhancing workplace safety is good for society, it is not an entirely appropriate objective for workers compensation due to the weak relationship between the workers compensation system (pricing) and the prevention of injury and fatality.**

There is a societal need to address the incidence of injury and disease claims

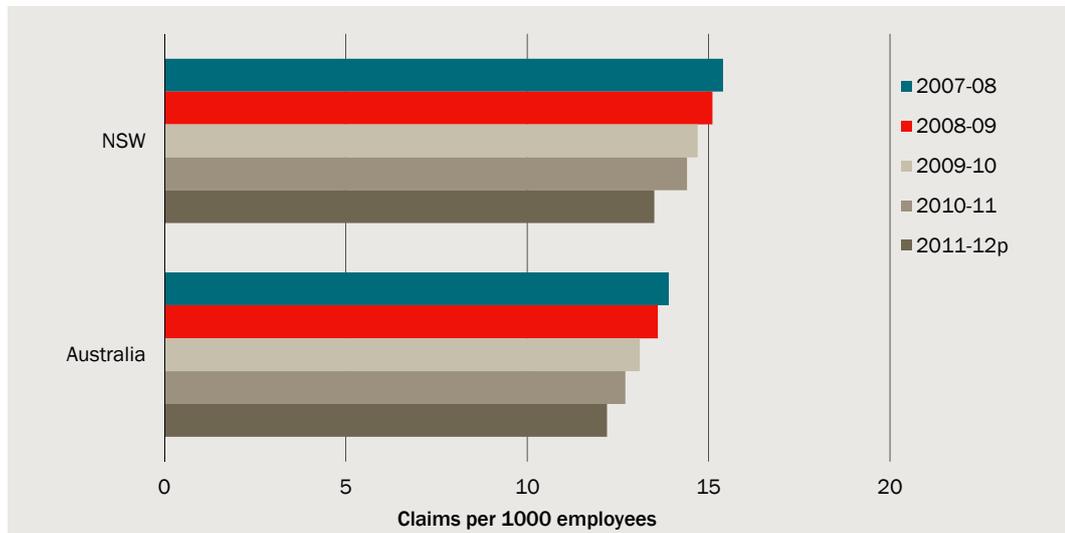
While the incidence of serious workplace claims has fallen over time in NSW, the prevention of injury and disease in the workplace remains an important societal objective. Despite recent falls, the incidence of serious injury and disease claims remains higher in NSW than the Australian average (chart C.1).

While fatalities are lower in NSW than the Australian average, they have remained relatively consistent in NSW in recent years, despite significant falls for Australia as a whole (chart C.2).

Fatalities, injury and disease in the workplace imposes substantial costs on individuals and their families. Charts C.3 shows total and average claim costs for fatality and injury across the Nominal Insurer scheme is significant, and has been increasing in recent years.

There are also costs not reflected in actual claim costs in terms of loss of quality of life and stress of injuries and fatalities to injured workers and their families, and loss in productivity to employers and the economy.

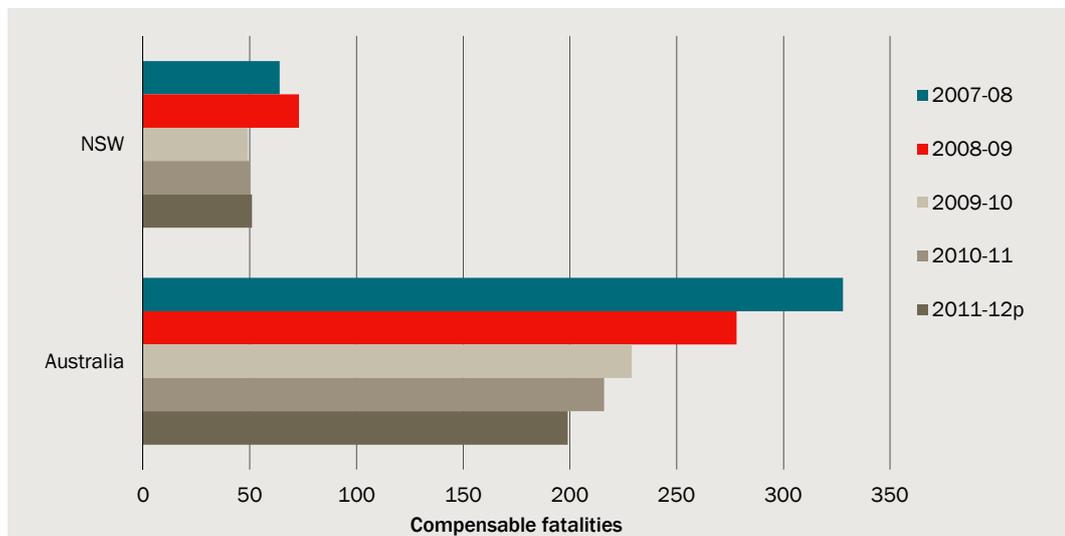
C.1 Incidence of serious injury and disease claims across jurisdictions



Note: This includes all accepted workers' compensation claims involving temporary incapacity of one or more week's compensation plus all claims for fatality and permanent incapacity. Note also that 2011-12 data uses provisional numbers. Estimates for 2011-12 may be revised upwards.

Data source: Comparative Performance Monitoring Report 2011-12, Safe Work Australia, 2013.

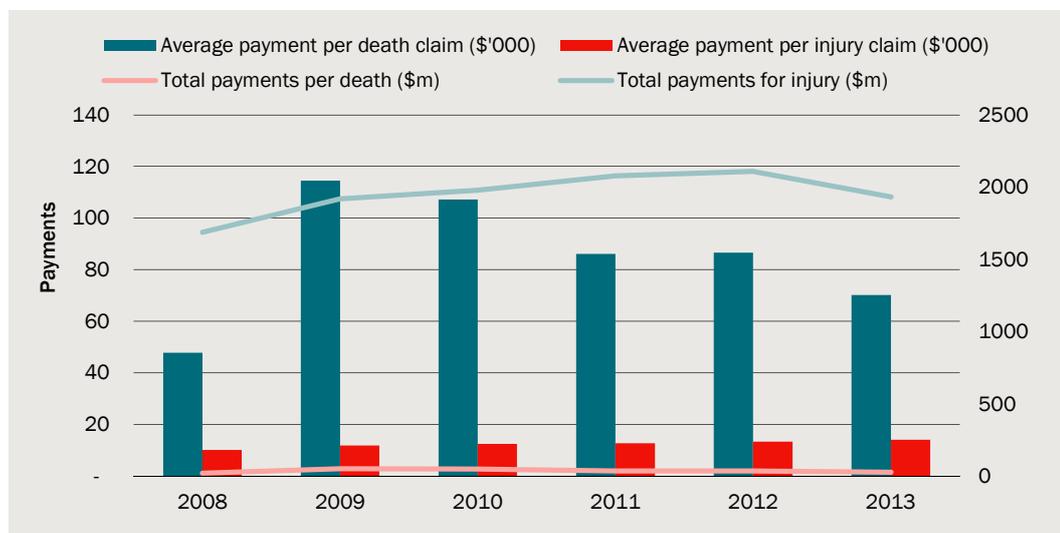
C.2 Comparison of number of compensable fatalities across jurisdictions



Note: Incidence rates for 2011-12 are provisional numbers only. Workers' compensation data are known to understate the true number of fatalities from work-related causes, particularly for conditions that have separate compensation mechanisms such as asbestosis and mesothelioma, and motor vehicle, work-related deaths. Estimates for 2011-12 are provisional and expected to rise as more claims lodged in 2011-12 are accepted.

Data source: Comparative Performance Monitoring Report 2011-12, Safe Work Australia, 2013.

C.3 Total and average payments for death and injury



Data source: NSW WorkCover.

In reality, workers compensation premiums are not a strong prevention tool

The workplace health and safety culture is established by a range of policy settings, in particular work health and safety laws.

However, the major mechanism available to workers compensation systems in relation to the attainment of prevention objectives is experience ratings, which establish different premiums based on claims experience or bonuses/penalties for improvement in relation to claims management (although it is acknowledged that WorkCover undertakes various activities to target prevention that are not directly linked to the amendments). Experience ratings are more likely to impact claims management outcomes rather than prevent workplace injuries.⁶⁷ There is also a danger that linking premiums to prevention (or reduction in incidents) may lead to the adverse under-reporting of claims.

This is particularly the case for smaller sized businesses for whom it would be more cost-effective to handle less-serious claims on their own to keep premiums low. Studies presented at the Symposium on Prevention Incentives further reflect this belief and demonstrate that the linkage between experience rated premiums and the prevention of injuries may not necessarily be strong.⁶⁸

⁶⁷ See Mustard, C., Smith, P., Tompa, E., Petch, J., McLeod, C. and Koehoorn, M, 2012, 'Comparison of worker's compensation experience rating programs in the long-term care sectors in Ontario and British Columbia' in *Symposium on Prevention Incentives*, 2012. This study found very limited evidence that experience rating influences the prevalence of work-related injuries or even duration (or severity) of injuries.

⁶⁸ Clayton found that the general acceptance that experience-rated workers' compensation insurance premiums are a means through which the workers' compensation pricing system can bring about safer workplaces is largely false or misleading. See Clayton, A. 2012. 'Economic incentives in the prevention and compensation of work injury and illness'. *Policy and Practice in Health and Safety*, Issue 1. Pp 27-43.

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

- Premiums represent a relatively small share of total costs, at around 1.7 per cent of payroll prior to the reforms, and with wages representing roughly one third of average business costs.
 - Premiums are an important cost to business that should, and can, be minimised through cost-effective claims management.
 - Premiums should be controllable and should reflect the productivity and competitiveness of a business more broadly.
- Prior to the reforms, premiums were higher in NSW than all other jurisdictions with the exception of South Australia, despite the reduction in premiums of over 35 per cent in the decade leading to the reforms.
 - According to the Scheme actuary, the reforms avoided a 28 per cent increase in premiums to approximately 2.2 per cent of payroll, which would have increased the gap between NSW and other jurisdictions.
 - The reforms have brought premiums down and more in to line with other states, although they are arguably still 'high' given the lower-than-average risk profile of industries in NSW.

State owned injury insurers remain accountable for the financial viability of their Schemes, and there is an overarching requirement for governments to keep premiums at a politically acceptable level or 'affordable'.⁶⁹

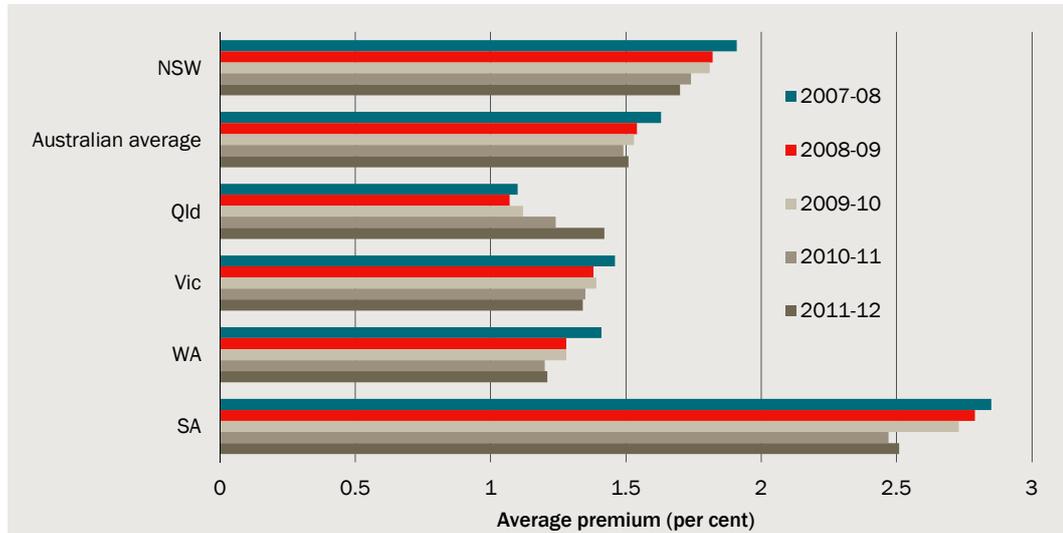
If an increase in the premium is to be avoided, alternative options to achieving solvency objectives are limited, including to:

- achieve better rates of return on investments (difficult in practice without altering risk levels or introducing new management costs)
- reduce workplace incidents and improve claims management performance (difficult to achieve dramatic changes particularly within a short period of time), or
- lower or restructure entitlements to improve the cost-effectiveness of claims with respect to health outcomes and return to work.

Prior to the reforms, premiums were higher in NSW than the Australian average that was not explained by the risk profile of industries in NSW, which have a lower concentration of industries with the highest incidence of claims (C.4 and C.5).

⁶⁹ Most self-insurers, with the exception of SICorp, are required to maintain a funding ratio of around 150 per cent whereas the target of state owned injury schemes is typically to be fully funded (with some flexibility to account for seasonal variation).

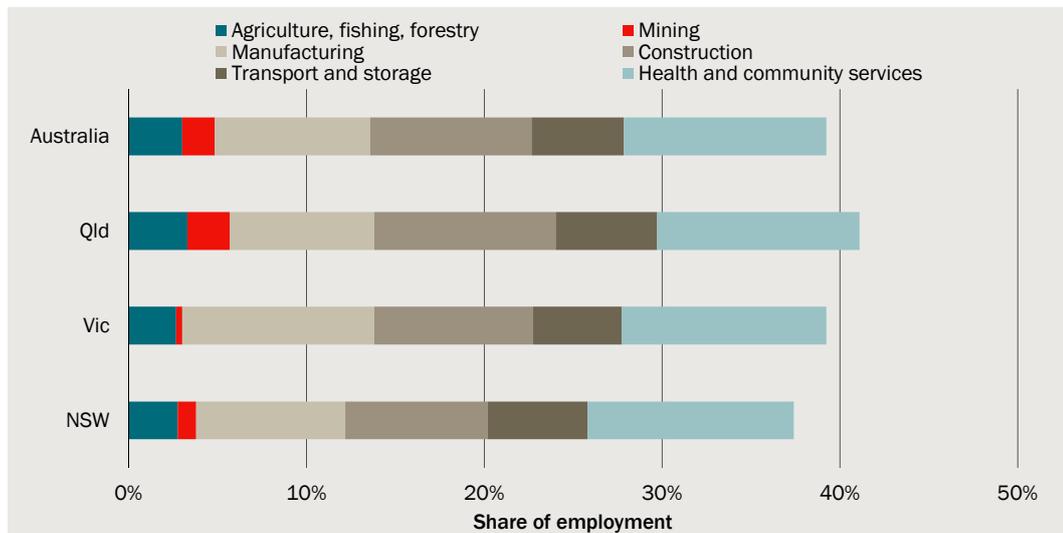
C.4 Standardised premiums between 2007-08 and 2011-12⁷⁰



Note: The data includes self-insurers and specialised insurers.

Data source: Comparative Performance Monitoring Report 2011-12, Safe Work Australia, 2013.

C.5 Share of full time and part time employment by industry, for selected industries with high incidence rates



Data source: ABS employment data, 2014.

Over the decade leading to the reforms, NSW premiums declined by over 35 per cent (chart C.6), but remained more expensive than the Australian average and other jurisdictions, other than South Australia.

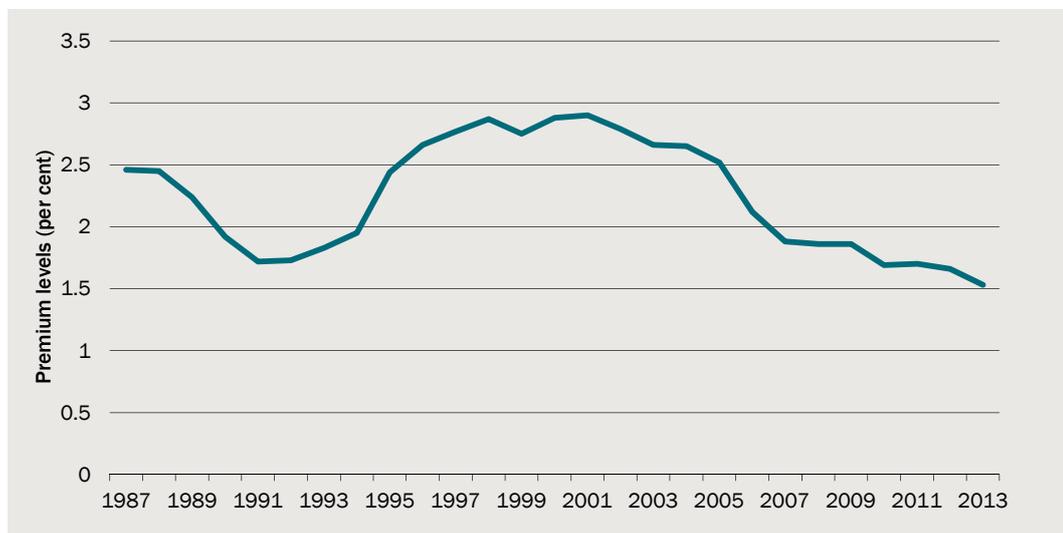
To address the financial position of the Nominal Insurer without the reforms, the Scheme actuary stated that premiums would have needed to increase by up to 28 per cent, implying

⁷⁰ Schemes vary significantly, and some (but not all) of these differences are taken account by Safe Work Australia including: excluding the provision for coverage of journey claims; incorporating self-insurers; incorporating superannuation as a part of remuneration; and standardising non-compensable excesses imposed by each scheme.

that premiums would have needed to increase from an average of 1.7 per cent to 2.2 per cent of wages.

Since the reforms, premiums collected on behalf of the Nominal Insurer have roughly come into line with the middle of all jurisdictions, although remaining higher than other state-based centrally funded schemes with the exception of South Australia. Premiums have reduced from 1.7 per cent of wages in 2011 (pre-reforms) to 1.66 per cent in 2012 and 1.53 per cent in 2013. A further fall in average premiums was announced for the Nominal Insurer Scheme, with premiums to fall to 1.4 per cent in 2014-15, reflecting the downwards movement in premiums for 2014-15 in both the Queensland WorkCover scheme (to 1.20 per cent) and Victorian WorkCover scheme (to 1.27 per cent).

C.6 Premiums collected on behalf of the Nominal Insurer, per cent of wages



Data source: PwC, 2012.

Premiums are a reasonably small, but still manageable component of costs

Premiums represent a reasonably small proportion of costs, on average, at approximately 1.7 per cent of wages (prior to the reforms), and are only one input cost to businesses. Utilising The Enormous Regional Model (known as TERM), labour costs as a share of the Gross Value of Production in NSW represent approximately one third of business costs in NSW (33.7 per cent).

This implies that a 0.5 per cent increase in wage related expenses as a result of increasing premiums from 1.7 per cent to 2.2 per cent of wages would have imposed, on average, an increase in business costs of 0.17 per cent of the gross value of production where businesses do not change their cost structure.

While a 0.17 per cent increase in costs does not appear large, it is important to recognise the spread of the premiums. In the NSW Government Issues Paper, which made the case for the reforms, a range of businesses was identified as having premiums in excess of the average premium level. The range of premiums cited was between 2.6 per cent and 7.05 per

cent prior to the reforms. A 28 per cent increase applied to these higher rates of premiums implies a significantly larger impact.

Moreover, it appears that not all employers had received a reduction in their premiums in line with the fall in average premiums over the decade leading up to the reforms. The Australian Federation of Employers and Industries stated prior to the reforms:⁷¹

A reduction in the average premium rate overall does not translate to a cost reduction for experience rated employers or employers in those industries with higher than average WorkCover Industry Classification rates. Our experience rated members report premium increases, not reductions, over the past three years...

Premiums need to be considered in context of productivity in order to support the overall employment market

Establishing a commitment to keeping premiums in line with other states provides a measure of certainty to businesses and establishes confidence about future costs. Government charges or red tape, when considered in isolation, may each seem reasonable but add up and influence the cost of doing business. Premiums, like wages, impact the cost of hiring and thus, premium settings must be considered in the context of labour productivity. For instance, from the early 2000s, labour productivity in NSW slowed from the levels achieved in the 1990s and in most years prior to the reforms was sitting below the 30-year average.⁷²

Reducing the deficit of the Nominal Insurer Scheme

The terms of reference for this review identifies the importance of reducing the deficit of the Scheme, and the efficiency of the Scheme. This is relevant for the consideration of principle 2 in relation to 'optimal insurance arrangements'. An Issues Paper released by the NSW Government prior to the reforms stated that it was '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'. Ensuring financial sustainability is a necessary but not sufficient condition to the effective operation of the scheme. When finances are sound, then benefit distribution can be stronger.

Arguably, the most significant of driver of the reforms was the Scheme's poor financial performance. There has been a rapid recovery of the Scheme since the reforms to a surplus of \$1 361.3 million in 2013.⁷³ While stakeholders are divided on the merits of the pace with which the Scheme was returned to a surplus, there was a valid, substantive and structural problem in the Scheme financials prior to the amendments.

⁷¹ Submission to Joint Select Committee on the NSW Workers Compensation Scheme, 2012.

⁷² NSW Long-term fiscal pressures report: NSW Intergenerational Report, Budget Paper No. 6.

⁷³ PricewaterhouseCoopers, 2014, *WorkCover NSW Full Report: Actuarial valuation of outstanding claims liability for the NSW Workers Compensation Nominal Insurer as at 31 December 2013*.

Booth⁷⁴ commented that ‘a deficit of that size’ could be the result of poor investment strategies leading to capital losses in the fund (particularly in the very difficult investment climate of recent years), generous benefits, inadequate pricing, poor claims management practices, and impairment or inefficient operation of legal processes.⁷⁵

That said, some submissions deny that the Scheme was in financial crisis, and that the positive turnaround in investment earnings could have been predicted. Hence, without changes to benefit funding, the Scheme could have returned to positive territory without dramatic premium increases.

While it is true that the improvement in investment returns contributed to the improved financial performance of the Scheme, it remains appropriate that financial sustainability is a core principle for workers compensation arrangements in NSW. Moreover, it is believed to be appropriate that the 2012 reforms sought to reduce the deficit and improve the efficiency of the Scheme.

- Prior to the reforms, the Scheme was not meeting reasonable prudential objectives. In its 2008-09 Corporate Plan, WorkCover outlines a target range for the funding ratio to remain between 90 per cent and 110 per cent, and in the 2010-2015 Corporate Plan establishes a target for the average funding ratio over a five-year rolling period of greater than 95 per cent⁷⁶. The funding ratio (of assets to liabilities) was 78 per cent in 31 December 2011
- In the absence of improvements to investment performance, the Scheme would not have returned to a surplus by December 2013. Despite the change in investment returns and external factors such as the discount rate assumptions following the reforms (see chart C.7), these factors alone would have been insufficient to support financial recovery.

In the six months leading to the reforms (to December 2011), the Scheme deteriorated by \$1 719 million to a deficit of \$4 083 million. Most of the deterioration in the six months prior to the reforms was due to revisions to the market outlook.⁷⁷

However, the external peer review of this actuarial evaluation stated that the assumptions, including changes to the risk free discount rates underpinning the deterioration in the budget position, were not unreasonable. Ernst and Young independently reviewed the actuarial statement by PwC and stated that it was likely the deteriorating trend would continue and Scheme liabilities would further increase ‘unless an intervention of circuit breaker is applied (i.e. legislative changes)’ despite WorkCover’s best efforts to implement remediation actions.⁷⁸

⁷⁴ Booth, D. 2012. *Government intervention in insurance markets*. Geoff Masel Lecture 2012.

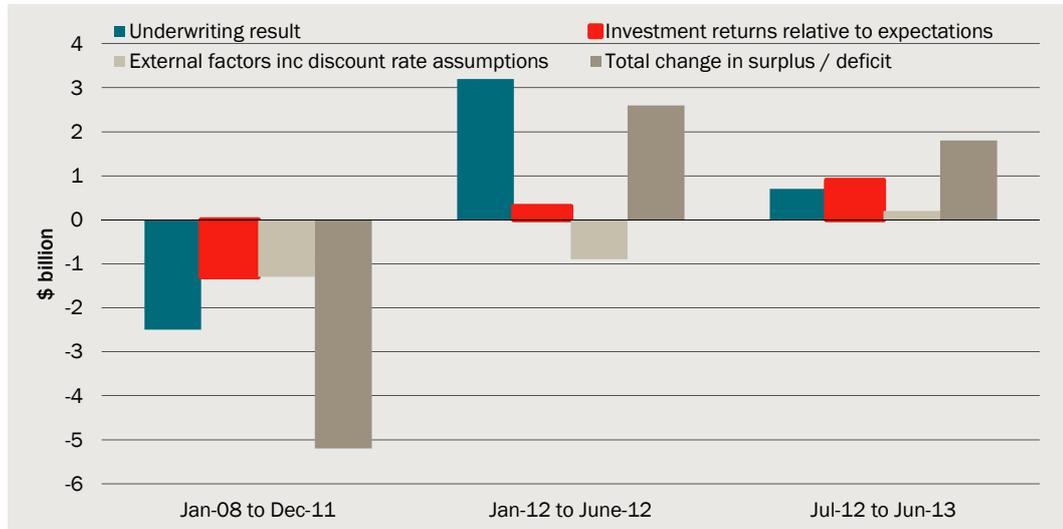
⁷⁵ Booth, D. 2012. *Government intervention in insurance markets*. Geoff Masel Lecture 2012, Australian Insurance Law Association.

⁷⁶ PwC, 2011. *WorkCover NSW: Paper 2 Solvency Management: Discussion Paper*.

⁷⁷ Changes to risk-free discount rates were made in accordance with accounting standards. For instance, accounting standard AASB 1023 states that outstanding claims liability shall be discounted using risk-free discount rates that are based on current observable, objective rates that relate to the nature, structure and term of the future obligations a (PwC, 2014).

⁷⁸ Ernst and Young, 2012, identify risks due to Workplace Injury Damages, Section 66 and Section 67, weekly payments and possibly medical payments.

C.7 Contribution to changes in surplus/deficit

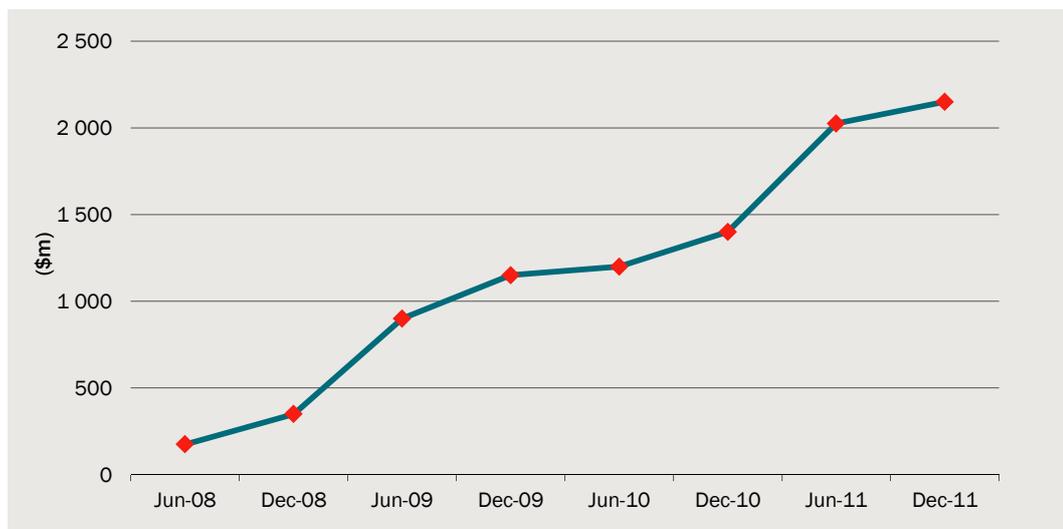


Data source: PwC, letter to Gary Jeffery of NSW WorkCover, 2014.

Moreover, the deterioration in the Scheme from a surplus in 2008 of \$1.1 billion to a large deficit of \$4.1 billion in 2011 was predominantly caused by the sustained increase in liabilities from changes in claims experience since 2008 (chart C.8).

This was caused by an increase in the number of weekly benefit claims remaining on benefits, an increase in medical expenditure, and a significant increase in the number of Workplace Injury Damage claims, which accounted for 80 per cent of outstanding liabilities in December 2011 and 95 per cent of the deterioration in outstanding claims liabilities since 2008. It was also caused by increases to 'top up' payments for Permanent Impairment (Section 66) and the utilisation of Pain and Suffering (Section 67) payments.

C.8 Increase in Scheme liabilities from changes in claims experience/actuarial assumptions



Note: Changes in economic assumptions and investment earnings, which are outside the control of WorkCover, are excluded.

Data source: External peer review of outstanding claims liabilities of the Nominal Insurer as at 31 December 2011.

Promoting recovery and the health benefits of returning to work

- **Promoting recovery and the health benefits of return to work is supported by research and medical bodies as being consistent with health outcomes. Where absence from work is not medically required, health outcomes are generally more favourable where rehabilitation includes return to work.**

In 2010, the Australasian Faculty of Occupational and Environmental Medicine Policy at the Royal Australasian College of Physicians (the Faculty) released a position statement: *Helping people return to work: using evidence for better outcomes*. The Faculty puts forward that the workers compensation system is not benefiting injured workers and systems and legislation pertaining workplace disability require substantial overhaul to facilitate a partnership approach between employer and employee as a fundamental component of return to work management.

The case is illustrated by the fact that compensable injuries have worse outcomes than similar, non-work related injuries. The difference is that, implicitly, the workers compensation system may introduce disincentives for the individuals to recover and return to work and ultimately do a disservice to injured workers.

A major review in 2007 titled *Work and Common Health Problems* showed that long-term disability and work loss may lead to worse mortality such as from heart disease, lung cancer and suicide, and health outcomes, such as poor physical health, high blood pressure and chest infections, long-term illness, poorer mental health and wellbeing and higher rates of medical attendance and hospital admission.⁷⁹ Studies also show that return to work is an important aspect of rehabilitation, with benefits ranging from general health and wellbeing improvements (such as self-esteem, self-reported health, physical health and self-satisfaction) to lessening of psychiatric distress.⁸⁰

Box C.9 highlights some of the recommendations of the Faculty that should be embedded in the system including, for example, finding ways for the patient to return to work.

This is supported by other studies⁸¹ which report that return to work rates are impacted by the injured worker's recovery/rehabilitation.

⁷⁹ The Royal Australasian College of Physicians, Australasian Faculty of Occupational and Environmental Medicine Policy on preventing work disability, Sydney 2010.

⁸⁰ Ibid.

⁸¹ Kilgour, E., Kosny, A., McKenzie, D. and Collie, A. 2014. 'Interactions between injured workers and insurers in workers' compensation systems: A systematic review of qualitative research literature', *Journal of Occupational Rehabilitation*. 2014.

C.9 Key recommendations of the Australasian Faculty of Occupational and Environmental Medicine Policy with respect to realising the health benefits of work for injured workers

Recommendations for policy and legislation

- Early coordinated care with the employee's wellbeing the prime focus, should be embedded within the policy decisions and processes to improve medical care, reduce delays and improve return to work outcomes
- The use of evidence-based medicine and evidence-based policy making should become standard practice and form the basis of return to work approaches
- Policy makers should take the lead in ensuring employees have access to evidence-based information and evidence-based medical care

Recommendations for other stakeholder groups (medical, employer and general community), with implications for the policy environment

- Find ways for the patient to remain at work during the recovery period
- Develop systems support for improved practitioner-workplace communication
- Promulgate the concept that management of a work injury requires management of the injury and management of the work
- Ensure prompt referrals to appropriate specialists, including specialist care in management of medical and occupational rehabilitation, and avoid delays

Source: The Royal Australasian College of Physicians, Australasian Faculty of Occupational and Environmental Medicine Policy on preventing work disability, Sydney 2010.

Hence, it is appropriate that the workers' compensation system considers impacts on return to work. In addition, the positivity of the return to work experience impacts actual health outcomes: a positive return to work experience has positive health benefits, and a negative experience can produce the opposite.

What do return to work indicators show?

Australian durable return to work rates increased from 72 per cent in 2008-09 to 77 per cent in 2012-13, and the return to work rate in NSW was higher than the Australian average in 2012-13. However, the return to work measure simply reflects the response to the question 'are you currently working in a paid job?'

The return to work survey does not show:

- the nature or success of re-employment, in particular whether suitable duties were identified with the workplace at the time of the injury, where the injury was obtained
- the potential levels of under-employment or under-participation relative to the condition
- the sustainability of the return to work program, or
- what is occurring with the remaining 20 per cent of injured workers: were they being appropriately managed in order to promote health and productivity outcomes?

Research has shown that employers have a significant role in promoting return to work outcomes. In recognition of this, Safe Work Australia in 2014 published a more encompassing return to work survey. It reflects surveys taken in 2013 or the post-reform context. The statistics indicated that:

- 38 per cent of workers that had lodged a claim indicated that no one from their work contacted them about their injury (and these workers had significantly lower return to work rates than those that were contacted)
- 75 per cent of workers thought their employers did what they could to support them, with injured workers that felt supported having a higher rate of return to work
- 75 per cent of employers made an effort to find suitable employment, as perceived by the injured worker and these employees had considerably higher rates of success in return to work
- 68 per cent helped with their recovery from injury, with those that perceived they were helped to recover having 50 per cent higher rates of return to work, and
- 81 per cent treated the worker fairly during and after the claims process.

Most striking in the survey is the consistency between return to work outcomes (in terms of return at the time of the survey and return for three months) and the perceived level of employee engagement. While legislation is *only one way* that a return to work culture is promoted, it is one factor that establishes incentives across parties and the recent Safe Work Australia research suggests a strong relationship between employer engagement and return to work as a principle to strive towards.

Supporting less seriously injured workers to recover and regain financial independence

The balance of medical opinion concurs that where absence from work is not medically necessary in the course of management of an injury, then it is best for workers to return to work.

As well as being consistent with the return to work agenda, the principle of supporting less seriously injured workers to recover and regain financial independence also assists the financial sustainability of the Scheme.

Hence, it is appropriate that:

- employers support injured workers to recover at work through the provision of suitable duties where appropriate, and
- to the greatest extent possible, injured workers should not bear the financial cost of being less able to work at their pre-injury rate.

Of course, putting these principles into practice is difficult. For instance:

- it is a policy judgement as to the point at which an employers' responsibility to a 'less seriously' injured worker ends, and the responsibility of other security nets, such as the Newstart allowance for unemployment, the Disability Support Pension or Medicare, begins

- there are factors that influence a worker's employment situation that are outside of the role of supporting recovery from an injury (such as market conditions and the location of an employee with respect to employment),
- reductions in work capabilities as a result of a workplace injury, as opposed to age related degeneration or some other factor, can reduce the chance of (re)employment, with the existing or an alternative employer, and
- it can be difficult to attribute changes in work capabilities associated with a workplace injury, as opposed to age related degeneration or some other factor, which further complicates the scope of responsibility of the employer as opposed to other forms of social safety net.

These issues can be particularly pronounced for injured workers that work for a small businesses and/or work in rural locations, where it may be more to accommodate an injured worker requiring alternate or restricted duties.

Hence, the principle is appropriate, but it is difficult to achieve the balance between fairness and efficiency to ensure injured workers are supported to return to work.

Guaranteeing quality long-term medical and financial support for seriously injured workers

- **Of all the principles, the principle of guaranteeing quality long-term medical and financial support for seriously injured workers was most widely supported across different stakeholder groups.**

The principle reflects the duty of care to individuals that are seriously injured during employment and due to their work-related injuries cannot recover and have ongoing medical and financial support needs. The principle also reflects the need to provide a 'guarantee' that the system will be financially capable of supporting seriously injured workers and provide adequate security with respect to the level and stability of the support provided to these seriously injured workers.

The principle implies that that the system will identify and distinguish who is seriously injured and who is not seriously injured. The contention of implementing this principle in practice is in establishing what constitutes a serious injury.

Reducing the regulatory burden and making it simple for injured workers, employers and service providers to navigate the system

Reducing regulatory burden is an appropriate objective for governments, as excessive regulation can impose additional costs on existing businesses, individuals and community organisations, particularly given that most may be relatively 'new' to the system in the event of an injury.

Regulatory 'burden' (where requirements are more onerous than required to meet objectives) can occur through improper drafting or during implementation.

As acknowledged by the Office of Best Practice Regulation, Governments must have due regard with respect to the type and magnitude of the problem they are trying to solve, the range of policy/regulatory and non-regulatory options available, the potential net benefit to the community of each option, and limit the creation of additional problems through implementation.

Regulatory burden can also occur when inadequate information and support is provided to stakeholders to enable them to navigate the system, which can help reduce the regulatory burden.

Best practice in the implementation of reform is achieved when the interface between the regulators/administrators and stakeholders in terms of navigation of the system is transparent, simple and predictable.

In the case of workers compensation, reduced regulatory burden can also be linked to improved health outcomes. Studies noted earlier by Kilgour, Kosny, McKenzie and Collie⁸² identify a correlation between the nature of the interaction of the injured worker and the health care provider with the 'system' at large. That is, better relationships equate to earlier recovery outcomes.

The converse is also true. Excessive or undue burden on injured workers, employers or service providers such as through imposing unnecessary delays, excessive administrative requirements or other significant barriers can change incentives for participation in the workers compensation system, and in work. For injured workers, an excessive regulatory burden can be particularly counterproductive, and can exacerbate physical or mental disability.

Discouraging payments, treatments and services that do not contribute to recovery and return to work

Another principle closely related to promoting the recovery and health benefits of return to work is to introduce greater discipline around which payments promote or discourage recovery and return to work.

While this can be challenging to achieve, the principle itself is appropriate.

Some of the key challenges to achieving this principle as they relate to the 2012 amendments include the following.

- **Medical practitioners often find it difficult to 'exit' patients from the workers compensation system.** The phenomenon of 'over-servicing' patients occurs because the medical practitioner may continue to strive for higher patient outcomes, without having to bear the choice of relative benefits and costs of pursuing further treatment.

⁸² Kilgour, E., Kosny, A., McKenzie, D. and Collie, A. 2014. 'Interactions between injured workers and insurers in workers' compensation systems: A systematic review of qualitative research literature', *Journal of Occupational Rehabilitation*. 2014.

- **It can be difficult to distinguish between necessary and discretionary ‘maintenance’ treatment, in terms of an ability to work.** Moreover, the treatment regime is likely to be linked to the broader bio-psycho-social health status of an injured worker, not just the elements which relate to work readiness.
- **Pre-existing and degenerative conditions can be difficult to separate from work injury related health needs.** This is particularly problematic given population ageing.

This means that this objective should be qualified by considering what are ‘reasonable’ payments, treatments and services to contribute to recovery and return to work.

A relevant consideration is the extent to which support is available from other sources, and an assessment of which source of support is most appropriate given the circumstances involved and their attribution to the workplace. As described by the Joint Select Committee on the NSW Workers Compensation Scheme⁸³:

The WorkCover scheme should provide a level of reasonable coverage of medical and related treatment, but it is not unreasonable that coverage be proximate to the date of injury and time off work by the worker. Australia has a comprehensive safety net of medical and hospital coverage for all Australians under Medicare.

It appears again in the detail of whether ‘reasonable’ care is provided so as to avoid a negative impact on return to work outcomes, creating distortive treatment patterns or being seen as widely unfair for specific types of injuries which may have permanent ongoing maintenance requirements.

Reasonable principles for society but a difficult task for the amendments to balance them all

Individually, the seven principles are good aspirations for society. However, not all principles can necessarily be delivered solely or well through workers compensation legislation. For instance:

- Workers compensation legislation provides limited financial incentives to prevent and reduce incidents and fatalities.
- There have been clear trade-offs between objectives, one of the most apparent being in addressing the deterioration in the financial sustainability of the Nominal Insurer and ensuring premiums are comparable with other states, while supporting less seriously injured workers to recover and regain independence. This is because the amount of assistance to support less seriously injured workers to recover and regain their financial independence will be necessarily be less if premiums are to be comparable with other states and the financial standing of the Scheme is to be addressed.

Barriers to return to work can be relational and process driven, and much can be achieved in terms of return to work and recovery objectives without any reference to the amendments or the broader legislative framework.

⁸³ Markey, R., Holley, S., O’Neill, S., and Thornthwaite, L. 2013. *The impact on injured workers of changes to NSW Workers’ Compensation: June 2012 legislative amendments: Report No. 1 for Unions NSW*. Macquarie University, Centre for Workforce Futures, December 2013.

D Impact of amendments on claims experience

Key amendments relating to weekly payments of compensation

The 2012 legislative changes introduced a number of changes to weekly payments of compensation.

- Prior to the changes, compensation was payable based on total or partial incapacity for work.⁸⁴ Compensation is now payable on the basis of work capacity, rather than incapacity.
 - Under Section 32A of the 2012 Act work capacity is defined in relation to a worker, as a present inability arising from an injury such that the worker is not able to return to his or her pre-injury employment but is able to return to work in suitable employment.
- Benefits have been more closely aligned to pre-injury potential income levels, as well as ‘work capacity’, which does not consider the actual availability of suitable employment or the location of the employment, but is required to consider an injured worker’s abilities including age, education, skills and work experience.
- Workers that are able to remain on benefits are likely to receive greater support than prior to the reforms due to the increase in the maximum weekly benefit payments.
- The point of decision making on eligibility to payments has been shifted away from the general practitioner towards the insurer.

Changes to weekly benefit claims

As shown in chart D.1, these key changes to weekly benefit provisions have resulted in:

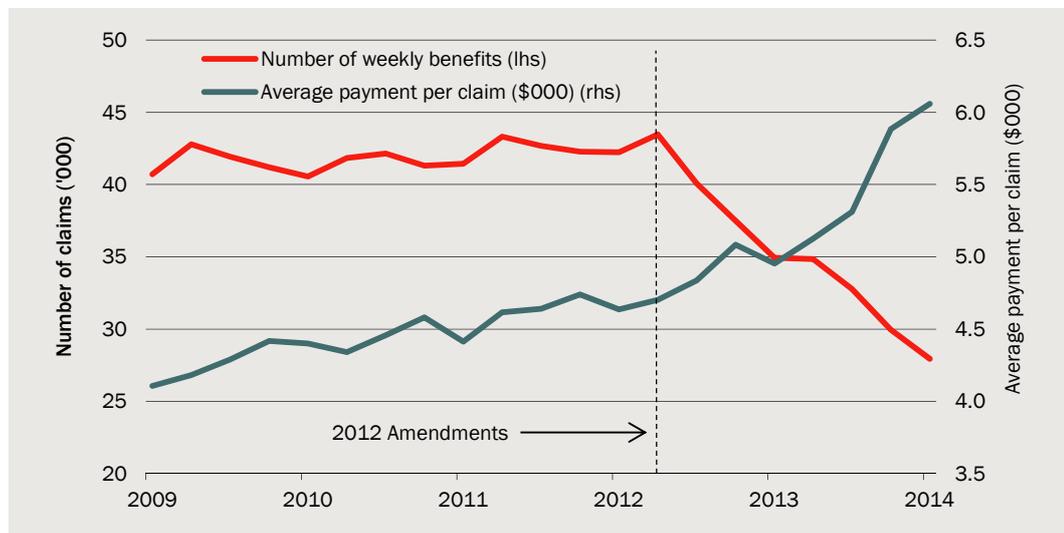
- a significant fall in the number of weekly benefit claims (incorporating both ongoing and new claims), in the order of 14 000 less claims per quarter or almost 35 per cent. The fall in weekly benefit claims is due in part to the fall in new claims and a fall in ongoing claims:
 - the fall in new claims is partly attributed to the exclusion of most journey claims (with a significant share of these claimants in receipt of weekly benefits) but is also unexplained by the change in amendments themselves and more likely attributable to behavior change
 - for existing claims (active prior to June 2012), a significant fall in weekly benefit claims occurred prior to work capacity decisions having come in to effect (around early to mid-2013) suggesting that other factors have also been influential

⁸⁴ Markey, R., Holley, S., O’Neill, S., and Thornthwaite, L. 2013. *The impact on injured workers of changes to NSW Workers’ Compensation: June 2012 legislative amendments: Report No. 1 for Unions NSW*. Macquarie University, Centre for Workforce Futures, December 2013.

- such other factors again include the change in behavior (altering propensity to claim) as well as remuneration incentives provided to Scheme agents to close tail end claims
- a significant increase in the average quarterly weekly payment in the order of 30 per cent, resulting in part from better alignment of weekly payments with average pre-injury earnings. It may also reflect the change in claims composition (severity) and average payment levels.

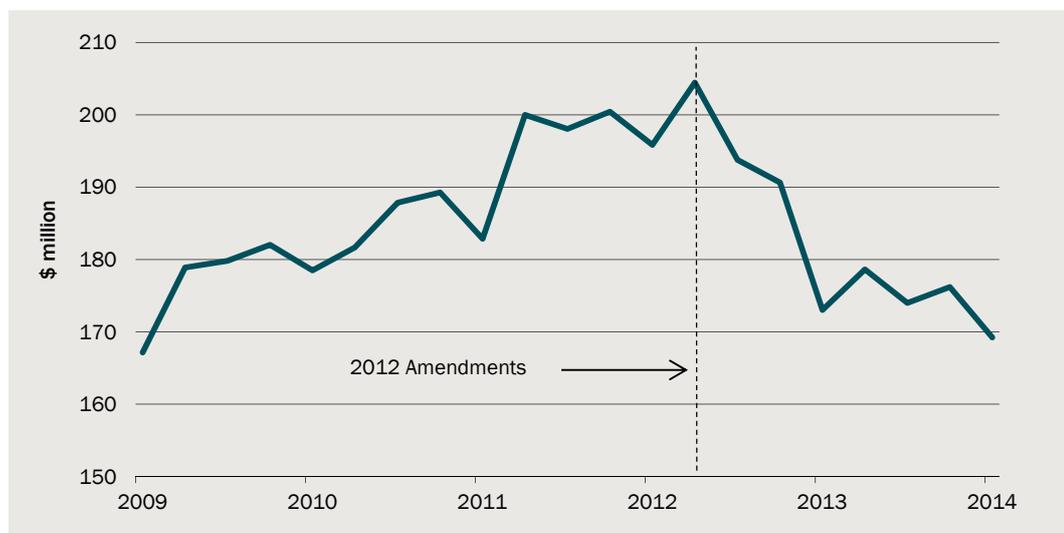
As shown in chart D.2, the net impact of these changes has been a reduction in weekly payments by over \$26 million per quarter (comparing March 2012 with March 2014).

D.1 Recent changes in the number of weekly benefits, quarterly data



Data source: NSW WorkCover.

D.2 Weekly benefits: total (\$m), quarterly data



Data source: NSW WorkCover.

Impacts to individuals with ‘no current work capacity’

Access to weekly entitlements has been significantly tightened for those that have total incapacity. Individuals that were deemed totally incapacitated prior to the 2012 reforms can now be subjected to a work capacity assessment.

- For those without work capacity, the direction of the impact of the amendments to the level of payments after 26 weeks was most significantly impacted by how many dependents the injured worker had (spouse/children). The impact of the amendments on weekly payments also reflects the income level prior to their injury (which is a key determinant of benefits for post-amendment claims) and whether they were on an award wage or a private enterprise agreement.
 - Without the amendments, the maximum weekly benefit payment would have been \$1948.80 for the first 26 weeks (as at April 2014) and, after 26 weeks, \$458.40 per week if the injured worker did not have a dependent spouse or children (as at April 2014). Additional amounts were applicable for dependents.⁸⁵
 - Now, the maximum weekly benefit entitlement of \$1948.80 (as at April 2014) holds after 26 weeks irrespective of the number of dependents.
- The reforms remove the distinction between award and non-award wages.
 - Prior to the reforms, until 26 weeks, workers on an award could receive 100 per cent of their pre-injury average weekly earnings (PIAWE) and workers on a private enterprise agreement could receive 80 per cent of their PIAWE.
 - Since the reforms, individuals with no work capacity (totally incapacitated) may receive up to 95 per cent of their PIAWE until 13 weeks and up to 80 per cent from week 14.

The change in how benefits are calculated may affect a worker either positively or negatively, depending on the wage level of the worker (see box D.4). However, the Scheme actuary stated in a letter to the CIE (10 June 2014) that:

For claims which continued past the old 26 week step down, their weekly benefits in most cases would have actually been materially enhanced. It is only once claims reached the 78-130 week that work capacity assessments and decisions have been introduced.

A few injured workers did acknowledge in their submissions to CIE that their benefits had increased under the reforms. One injured worker stated:

I am finally getting more money, that has been the only benefit.

Impost on lower income workers, including part time and casual workers

In certain circumstances, the step-down provisions can make injured workers that received low wages prior to the injury worse off, while injured workers on average full time wages are made better off. This includes low income, part time and casual workers particularly those that incur a substantive impairment and have no work capacity, who

⁸⁵ A transitional amount of \$920 in October 2012 (indexed to \$960.50 as at April 2014) is used as the deemed amount of pre-injury average weekly earnings of an injured worker for the purpose of determining the weekly payments of compensation payable to existing recipients of weekly payments after they become subject to the weekly payments amendments.

are made worse off under the reforms by receiving only 80 per cent of their wages from week 14 onwards. Some anecdotes of the impact of amendments to injured workers receiving low wages at the time of injury are provided in box D.3.

While some low income workers would be worse off as a result of the reforms, this would not always be the case, and it is too soon to tell whether the reforms impact on workers in different income brackets, in different ways.⁸⁶

D.3 Anecdotes of the impact of reforms from low income and part time injured workers

“I have been terribly anxious and upset. Because of the changes, I received 95 per cent of LAST YEARS pay. Last year I only worked part time (3 days). This meant a loss of \$220 one week when I’d only had one day off. I’m single parent with a mortgage and struggle to make ends meet. Losing \$440 in a fortnight brought me to tears many times.”

“The new law does not take into account there are part time workers I have to work 15 hours to get make up pay of 1 hour as my regular hours are 16 hours. A full time worker only has to work 15 hours to get make up pay to their full time hours.”

“The changes have affected me as I have had my pay cut by \$100 a week as from the end of (date removed for confidentiality reasons). My wage is not huge as I only work permanent/part time and 22 hours per week, 4 and half hours a day 5 days a week. As I was unable to work every day before my operation as I was in too much pain, the 15 weeks started before I even had my operation. I will have to return to work 4 days a week before my pay can return to normal. I feel that this should be addressed so that they can scale the hours to fit the job.

Limit to benefit duration beyond 5 years

The legislative reforms introduced significantly tighter restrictions to the duration that claimants can remain on benefits, and are subject to the level of permanent impairment and ‘work capacity’. Under section 39 of the amendments, benefits cease after 5 years but this does not apply to an injured worker whose injury results in permanent impairment if the degree of permanent impairment resulting from the injury is more than 20 per cent. Section 39(2) states that ‘for workers with more than 20 per cent permanent impairment, entitlement to compensation may continue after 260 weeks but entitlement after 260 weeks is still subject to section 38’ which refers to requirements for work capacity assessments.

Prior to the amendments, around 5.5 per cent of claims (by number) were related to claimants that had a WPI of less than 20 per cent that had been receiving weekly benefits for more than 5 years.

⁸⁶ Pre 2012 workers received up to 100 per cent of PIAWE (calculated differently since the amendments) from weeks 1-26. It is likely that most workers are now worse off from weeks 14-26. After week 26, the statutory rate applied, yet since the statutory rate was not referable to PIAWE, its effect in comparison with the post 2012 reforms is difficult to determine. For example, a worker who had a low income but a dependent spouse and children is likely to have been better off under the pre-2012 reforms post week 26, but many single workers were worse off post week 26 prior to the reforms than they are now.

D.4 Impact of change in payment structures for incapacitated workers

According to the Australian Bureau of Statistics, in February 2012, the average full time, ordinary time earnings of workers in NSW was over \$1300⁸⁷. For the 'average' full time worker, the impact of the reforms is likely to have been positive.

- Prior to the reforms, after 26 weeks of receiving weekly benefits, the average full time worker may have only received \$458.40 per week (as at October 2012) if they did not have dependents, and would receive an additional \$120.80 per week for a dependent spouse and a similar amount for each dependent child).
- Since the reforms, an injured worker with no work capacity might receive around \$1050 per week, assuming they receive 80 per cent of the average full time earnings. A worker without work capacity earning in *excess* of the average full time wage is also better off, earning up to \$1948.80 per week (rate applicable as at April 2014).

For lower income workers, the largest impact of the reforms would be to payments following 26 weeks, when they would need to earn over \$570 per week (or higher if they have dependents) to be better off from the change in maximum payment thresholds. Injured workers on an award rate may be worse off from weeks 14 to 26 as they received 100 per cent of their pre-injury earnings prior to the reforms and would now receive up to 80 per cent of their PIAWE.

Impacts to individuals with 'current work capacity'

Previously, an injured worker that was partially incapacitated may have been required to undergo an assessment of the ability to earn in some suitable employment. However, in the past, the definition of 'suitable employment' covered employment for which the worker is currently suited, having regard to the nature of the worker's pre-injury employment, where the worker lives, and the length of time the worker had been seeking suitable employment (see box D.5).

- **Prior to the 2012 reforms, the requirements for injured workers to access weekly benefits were minimal and financial incentives to return to work were weak.**

Many partially incapacitated workers could receive close to their total pre-injury earnings after adding their weekly compensation to their current earnings. This was particularly the case prior to '26 weeks' (i.e. when the injured worker had received 26 weeks of weekly payments). Now, the maximum pre-injury average weekly earnings is 95 per cent⁸⁸, and this reduces to 80 per cent at week 14 if the worker is not involved in paid employment for 15 or more hours. After 2.5 years (after week 130) a worker is required

⁸⁷ ABS Catalogue 1367.0, State and territory statistical indicators, 'Average weekly earnings', 2012.

⁸⁸ Note that the definition of pre-injury average weekly earnings (PIAWE) has expanded to include overtime and shift allowances up to 52 weeks of benefit entitlements.

to be working 15 hours or more per week, and in receipt of at least \$168 per week, if they have work capacity or benefits cease.

Submissions by injured workers on the impact of changes to suitable employment provisions are provided in box D.6.

D.5 Definition of suitable employment under Section 32A

Suitable employment, in relation to a worker, means employment in work for which the worker is currently suited:

- a) Having regard to:
 - i. the nature of the worker's incapacity and the details provided in medical information including, but not limited to, any certificate of capacity supplied by the worker (under section 44B), and
 - ii. the worker's age, education, skills and work experience, and
 - iii. any plan or document prepared as part of the return to work planning process, including an injury management plan under Chapter 3 of the 1998 Act, and
 - iv. any occupational rehabilitation services that are being, or have been, provided to or for the worker, and
 - v. such other matters as the WorkCover Guidelines may specify, and
- b) regardless of:
 - i. whether the work or the employment is available, and
 - ii. whether the work or the employment is of a type or nature that is generally available in the employment market, and
 - iii. the worker's place of residence.

D.6 Stakeholder submissions on impact of changes to suitable employment provisions

We live in rural NSW – it has been impossible to find work. It seems no one is willing to take a risk on employing me because of my age & my permanent wrist injury.

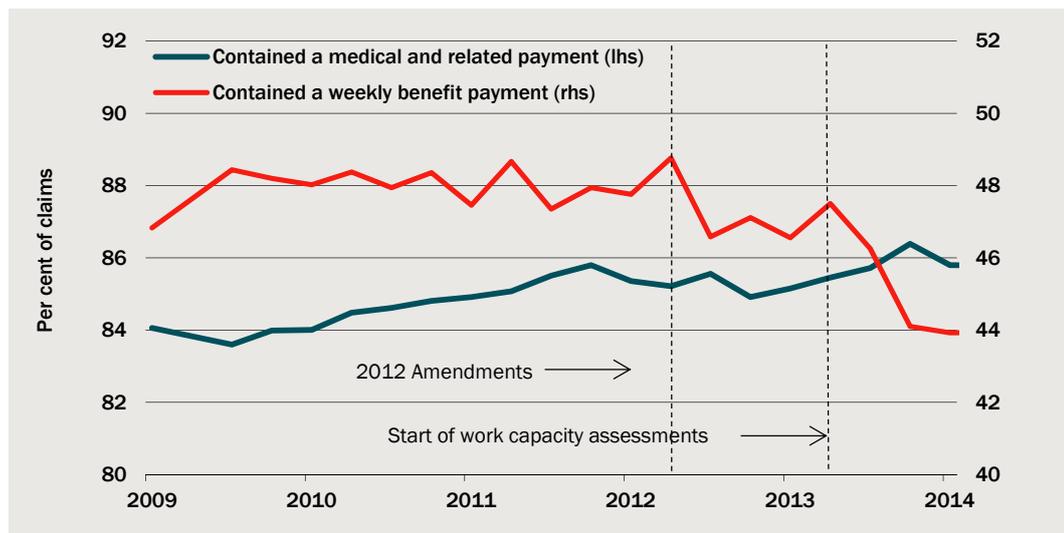
I have been assessed as having an earning capacity of \$980 per week, however there just is not the employment opportunities around the south coast of NSW.

Work capacity decisions

Following the introduction of work capacity decisions, the proportion of active claims with a weekly benefit payment fell from an average level of 47 per cent to 44 per cent in the March quarter of 2014 (see chart D.7). The fall in the proportion of claims with a

weekly benefit correlates to the period where work capacity decisions started to become effective, around mid-June 2013. Work capacity assessments started to be undertaken by Scheme agents in early 2013, however there was a further 3 month lag between a work capacity decision being made and a claim ceasing to receive weekly benefits.

D.7 Proportion of claims with a weekly benefit payment



Data source: NSW WorkCover.

Under section 38(4), the 2012 reforms require an insurer to undertake a work capacity assessment of the worker prior to 130 weeks of the entitlement period, and at least once every 2 years thereafter.

- However, the 'insurer can conduct a work capacity assessment of a worker at any time.'
- The CIE has heard reports of work capacity assessments being undertaken significantly earlier than the period (78-130 weeks) intended by the reforms.

Importantly, section 43 of the Act states that a work capacity decision is undertaken by the insurer and decisions made by the insurer are final and not subject to appeal or review, except a review under section 44 or review by the Supreme Court.

The immediate intent of work capacity decisions appears to have been to significantly increase the powers of the insurer to make a relatively final determination on the rate of weekly benefit entitlement, and for the insurer to have considerably greater scope to reduce or restrict benefits. In contrast, previously the assessment of ability to earn (and eligibility for workers' compensation payments) was based on a general practitioner's assessment of 'fitness to work'. Note, however, there is scope for a worker's diminished ability to compete in the labour market to be recognised through various forms of lump sum payments including commutations.

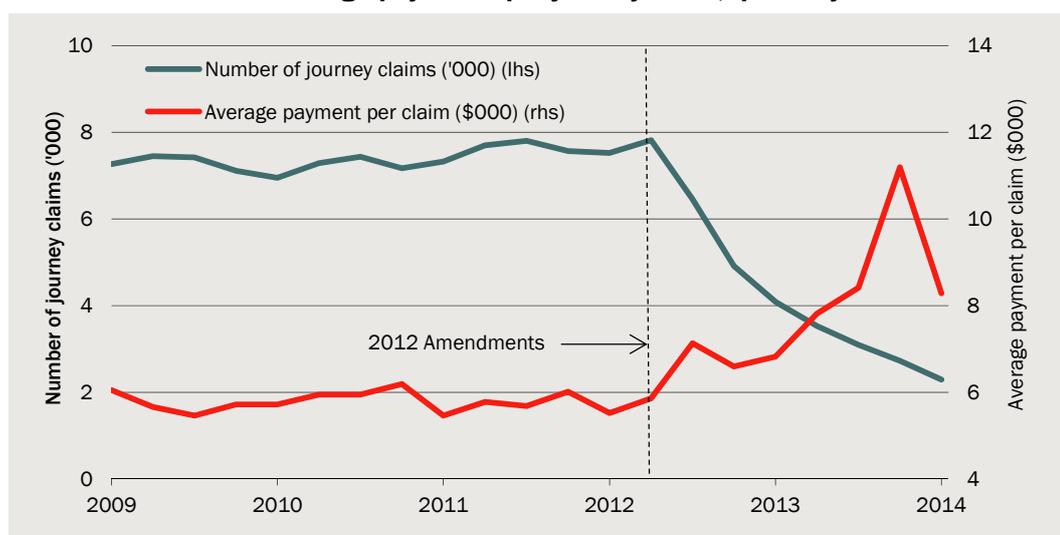
Impacts of amendments relating to journey claims

The third most significant fall in claims expenditure is attributed to journey claims, with the reforms introducing more restrictive guidelines for accepted journey claims. Previously, journeys between a worker's home and work were always covered. The reforms specify that a real and substantive connection between employment and the accident or incident out of which the personal injury arose is required.

Chart D.8 shows that:

- prior to the amendments, the number of journey claims with WorkCover NSW was close to 7 500 per quarter and accounted for more than 8 per cent of claims:
 - close to 45 per cent of these claimants received a weekly benefit payment
- since the amendments, the number of journey claims each quarter has reduced by around 70 per cent, to around 2 300 per quarter for the March quarter of 2014
- the tightening of the conditions under which a journey claim is allowed with WorkCover NSW has resulted in an increase in the average payment per claim.

D.8 Number of and average payments per journey claim, quarterly data

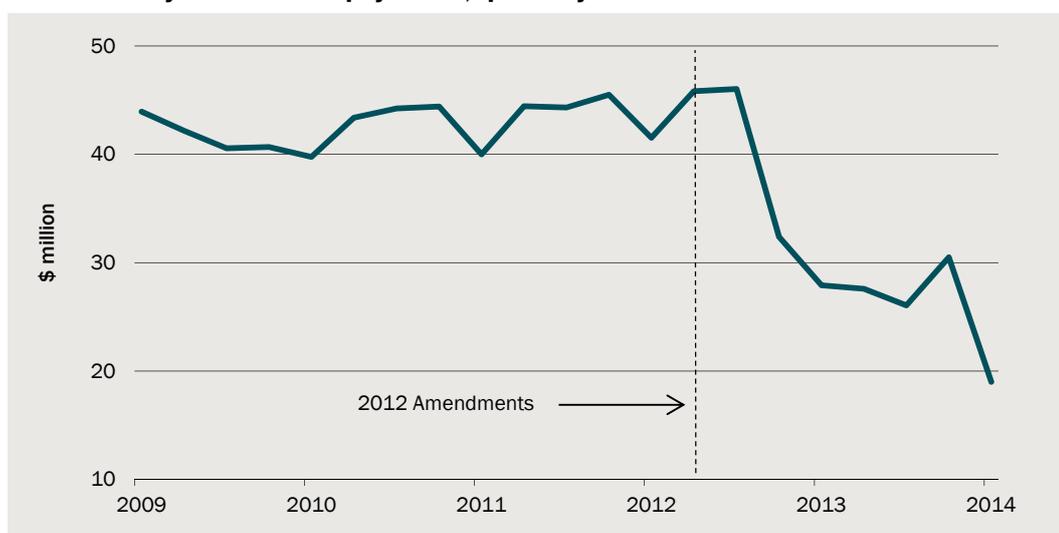


Data source: NSW WorkCover.

As shown in chart D.9, total payments associated with journey claims have fallen by 70 per cent. The CIE has been advised in consultation with stakeholders that some insurers are restricting access to journey claims, beyond the extent of the law. Hence, the sustainability of the magnitude of the fall in journey claims is uncertain given the absence of case law to provide clarity around what constitutes a real and substantive connection.

In addition, the Scheme actuary suspects that prior to the amendments some employers had been lodging a motor vehicle claim as a journey claim to avoid an increase in their premium, as journey claims are excluded from experience premium calculations, and this may have led to an artificially high level of 'journey claims' pre-amendments.

D.9 Journey claims: total payments, quarterly data



Data source: NSW WorkCover.

Amendments relating to medical and related expenses

The third most significant driver of the fall in claims expenditure has been medical and related claims. Through Schedule 4 of the 2012 Act, the amendment tightened access to medical expenses. The amendments restrict payment duration, limit the employer's liability to pay for the cost of any treatment or service or travel related expenses without former approval, limit the employer's liability to pay for travel expenses, and increase regulatory capabilities of the WorkCover Authority to approve or deny various treatment options.

However, according to the Scheme actuary, the one year cap on medical is not expected to have had an practical impact to scheme expenditure prior to 2014. Hence, any change to medical expenditure due to the amendments are more likely to be the result of increased powers to the WorkCover Authority (and Scheme agents) to determine which medical expenses are accepted and possibly the fall in new claims.

Restriction to the duration of medical expenses

Prior to the reforms, there was no time or dollar cap on benefits for reasonable medical and related treatment. Since the reforms, medical expenses are payable for one year after the cessation of weekly benefits, or one year after a claim is made if no weekly benefits are received. These amendments cover all injured workers, except where the level of WPI is over 30 per cent.

- This means that all types of conditions may be affected by the changes to the duration of medical expenses, including conditions where impairment is permanent and expenses associated with this are ongoing.

- The change in medical expense provisions may impose a significant burden on injured workers that also became ineligible for lump sum compensation due to the reforms (injured workers with less than 11 per cent Whole Person Impairment).

Box D.10 provides several accounts from stakeholders as to how the amendments to medical entitlements have impacted current or future access to the reimbursement of medical expenses.

D.10 Impact of termination of medical payments: stakeholder submissions

I have severe hearing loss and have been informed under new legislation that my ongoing medical expenses will no longer be covered. If I wish to stay employed I will have to fund these ongoing expenses myself. This is hardly fair when the initial injury was sustained at work and the hearing loss is ongoing.

The current 30 per cent threshold is totally unrealistic based on the current WPI system and does not provide ongoing protection for severely injured workers, who like myself will have a life time of medical care needs. The current WPI test is extremely strict and harsh. I have been informed that my injury will likely rate me in the low 20 per cent area. This rating will leave me at the mercy of the WorkCover insurance company and their goodwill to keep me in the WorkCover system. Even though I have a lifelong injury that will likely require future surgery and certainly ongoing medical care to address the physical limitations and chronic pain, I will inevitably at some point in the future be terminated out of the current WorkCover system mainly due to my injury not being rated above 30 per cent.

My neurosurgeon advised me of the need for further surgery at a later date. There will be the early onset of degeneration and possible arthritis. My medical costs have been removed since 2013 and told any future medical issues with my injury/surgery will not be financially and/ or covered.

Approvals processes

The reforms increased the regulatory capabilities of NSW WorkCover with respect to service providers. Before the reforms, workers were entitled to all 'reasonably necessary medical treatment', which was subjective and could be disputed. There was no provision for WorkCover to prevent the recovery of costs for treatment by service providers who do not comply with service standards. With the reforms:

- only 'reasonably necessary medical treatment' is approved and there is a requirement for treatment to be approved prior to it being provided (with some exceptions such as 48 hours after an injury occurred)
- WorkCover Guidelines may establish rules around treatment or services to be given or provided, limiting the kinds of treatment and service and the amount an employer is liable to pay under this section for any particular treatment or service, and establishing standard treatment plans for the treatment of particular injuries or classes of injuries.

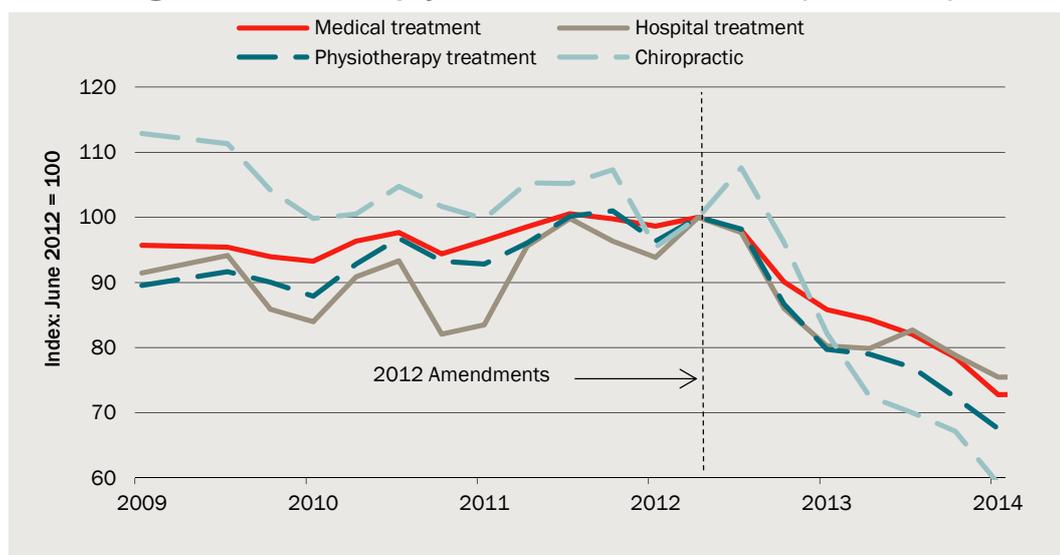
Impact of amendments related to medical claims

The number of medical related claims fell from close to 75 000 per quarter to 55 000 per quarter following the amendments, or by approximately 26 per cent. This reflected a particularly sharp fall in payments for treatments by chiropractors and physiotherapists (see chart D.11). The tightening of conditions under which medical benefits can be claimed with WorkCover NSW has led to an increase in the average payment per claim, which could suggest an increase in the average severity of injuries for which medical expenses are compensated.

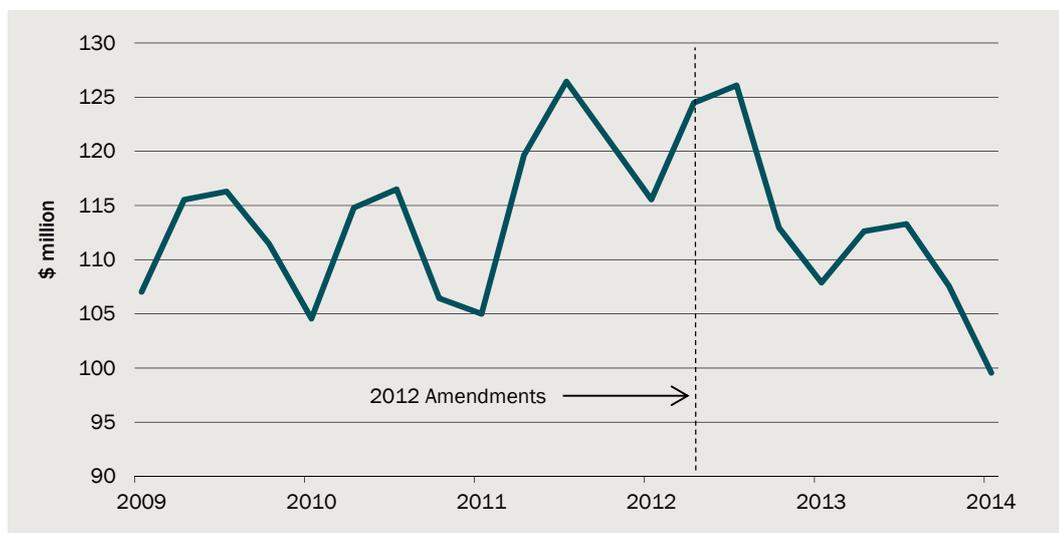
The number of compensation claims in 2011 that received medical payments more than 12 months after the claim commenced or following the final weekly benefit represented 9 per cent of all active claims. Hence, the amendments to medical payments are expected to further reduce medical claims expenditure over the coming year(s).

Overall, medical payments have fallen since the amendments by at least \$16 million per quarter if we compare the March quarter of 2012 with the March quarter of 2014 (see chart D.12), or 22 per cent of the total fall in compensation payments.

D.11 Change in the number of payments for medical treatment (as an index)



Data source: NSW WorkCover.

D.12 Medical claims payments: total (\$m), quarterly data

Data source: NSW WorkCover.

Amendments relating to lump sum compensation (s66 and s67)

Prior to the reforms, lump sum entitlements could have acted as a disincentive for injured workers to return to work and, as a result, may have contributed to the average claim duration for weekly benefit claims. The NSW scheme previously offered two statutory lump sum benefits:

- section 66: for permanent impairment based on assessed level of impairment with a maximum cap of \$231 000
- section 67: for pain and suffering, which allowed workers to make a claim for non-economic loss if their level of permanent impairment reached 10 per cent of the whole person, with a maximum payment of \$50 000.

The reforms abolished section 67 payments for pain and suffering. Section 66 payments for permanent impairment are still available, but the threshold to access these benefits for general physical injury has been increased.

Impact of removal of section 67 payments

Immediately after the amendments, the number of section 67 claims fell from around 1200 claims per quarter to 600 claims per quarter (see chart D.13). Following the Court of Appeal Decision of the *Goudappel versus ADCO Construction Pty Ltd* case on 19 April 2012⁸⁹, the number of active section 67 claims increased but were close to 30 per cent below the level seen prior to the amendments.

⁸⁹ The Court of Appeal found that the amendments to Division 4 of Part 3 of the Workers Compensation Act 1987 introduced by the 2012 amendments do not apply to claims for compensation pursuant to section 66 which are made before 19 June 2012, whether or not the claims specifically sought compensation under section 66 or 67 of the 1987 Act. (Kircher, T.

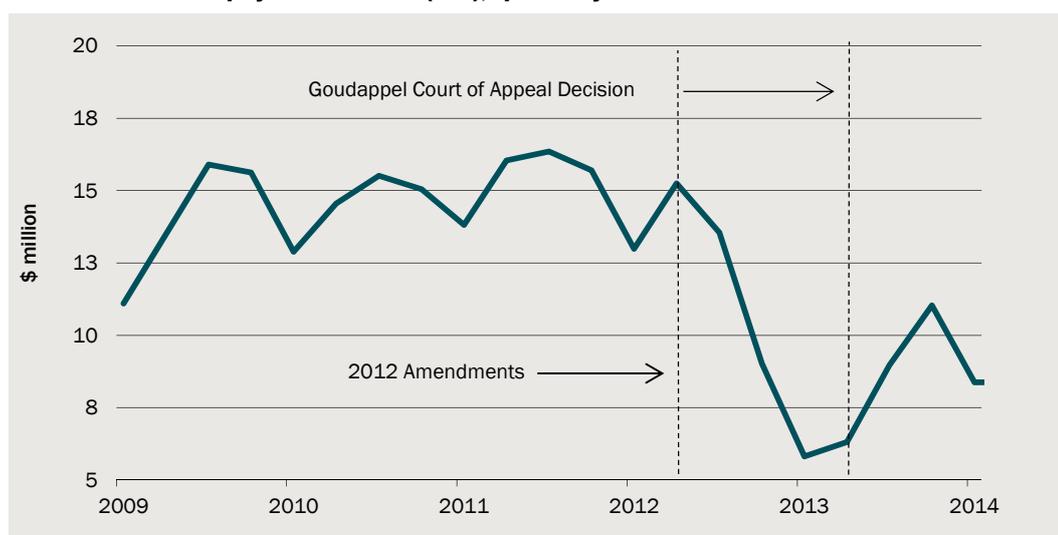
The recent successful appeal in the High Court of Australia is likely to cause claims to fall sharply in future months. Overall, quarterly section 67 payments fell by around 36 per cent between the March quarter of 2012 and the March quarter of 2014.

Restriction to one Whole Person Impairment assessment

In addition, the reforms intended to reduce the cost and incentives associated with creep in impairment, and the assessed level of impairment, by instating a restriction to only one assessment of Whole Person Impairment for lump sum payments, commutation or Work Injury Damage claims (as per Section 322A of the 2012 Act).

Previously, multiple assessments for permanent impairment were available and workers could make claims based on the deterioration of their injury. As a result, over time, workers could reach the threshold of 15 per cent Whole Person Impairment, allowing them to make a common law claim. Lump sum entitlements acted as a disincentive to injured workers to return to work and contributed to the duration of claims.

D.13 Section 67 payments: total (\$m), quarterly data



Data source: NSW WorkCover.

Access to lump sum payments based on Whole Person Impairment

Although the NSW WorkCover Permanent Impairment Guidelines and the American Medical Association's Guides to the Evaluation of Permanent Impairment (5th edition) also applied prior to the reforms, the current scheme is more restrictive. Under the previous legislation, thresholds for accessing statutory permanent impairment lump sums were:

- 1 per cent WPI for general physical impairment
- 15 per cent WPI for psychiatric and psychological impairment

and Poulos, M. 2013. 'Goudappel decision re-opens door for workers – *Goudappel v ADCO Constructions Pty Ltd* (2013)' <http://casenotes.curwoods.info/?p=2155>

- 6 per cent binaural hearing loss.

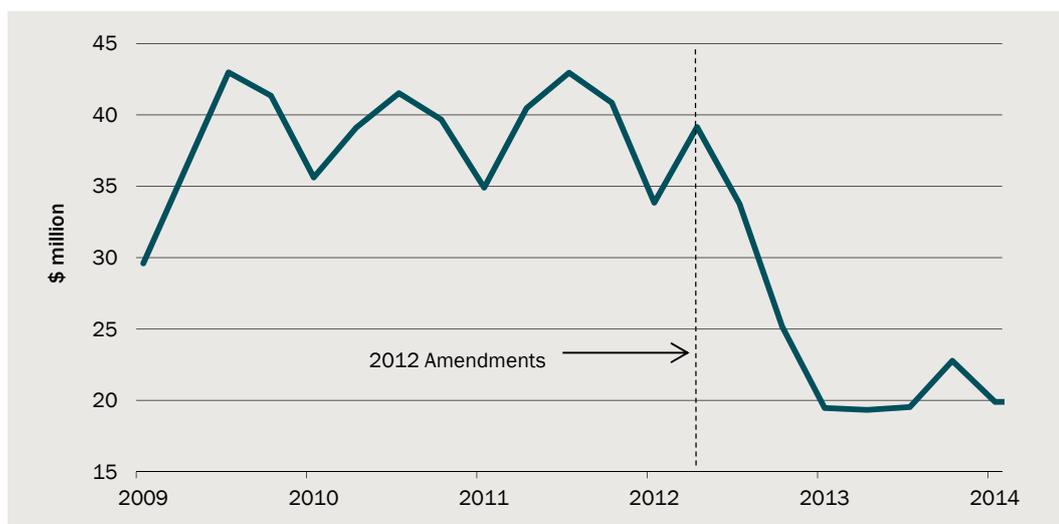
After the reforms, these thresholds were increased to 11 per cent WPI (including for hearing, which translates to 20.5 binaural hearing loss), and were maintained at 15 per cent for psychological injury. This has significantly restricted the pool of claimants eligible for lump sum compensation. Claims for section 66 benefits by claimants with less than 11 per cent WPI accounted for 3.4 per cent of claims in 2011 (pre-reform).

Impact of changes to s66 payments

The number of section 66 claims with WorkCover NSW was over 3 000 per quarter prior to the introduction of the amendments. The amendments have been associated with an increase in the average payment per claim from around \$13 000 to \$16 000, which is likely to be associated with increasing average claim severity.

Overall, total payments associated with section 66 claims declined after the 2012 amendments (see chart D.14), decreasing sharply from around \$38 million per quarter to approximately \$20 million per quarter.

D.14 Section 66 payments: total (\$m), quarterly data



Data source: NSW WorkCover.

Other restrictions to eligibility introduced by reforms

In addition, the reforms introduced a range of other restrictions to the eligibility of heart attack and stroke claims, damages for nervous shock, disease injuries and psychological injuries. Although small, there had been some observed increase in the number of claims emerging from heart attack and stroke, disease and nervous shock claims, resulting in amendments to reduce exposure to future liabilities. Part of the rationale for this was that employers argue that they are not able to influence a variety of risk factors associated with such claims.

The reforms made it more difficult for injured workers to receive compensation for strokes or heart attack. Previously, the scheme still received claims from workers who had had heart attacks even where employment was not a substantial contributing factor despite the fact that these were intended to be excluded. The amendments state that no compensation is payable unless employment was the main contributing factor to the injury, or aggravation of the injury.

Since the amendments, the number of heart attack claims has fallen by around 50 per cent or by approximately 20 claims per quarter. There has not been a noticeable impact on the average payment per heart attack claim, but the impact of restrictions to the nature of heart attack claims has led to a small reduction in claims expenditure.

The 2012 reforms tightened the definition of a disease injury to require the main contributing factor to the contraction, aggravation, exacerbation or deterioration of the disease to be the employment. Dust disease claims are exempt from the 2012 reforms. The extent of non-dust disease injuries is relatively small, however the amendments are expected to reduce exposure to future liabilities for disease claims.

The reforms also require that a purely psychological (stress) claims meet the condition that employment is the primary cause of the condition. The proportion of psychological claims as a share of WorkCover Scheme claims is very small (less than one per cent). The situation is different for the NSW Public Sector (managed via the Self Insurance Corporation), representing around 10 per cent of claims, and potentially other self-insurers. Data suggests that stress-related injuries are the most expensive claims type, and represent a growing liability whereas other types of injuries are reducing in incidence. Employers are pleased with the changes as they cannot control all factors in and beyond the workplace that may influence mental health.

The 2012 reforms excluded nervous shock claims suffered by a relative or dependent of the affected workers, unless the nervous shock itself is a work injury. Data was not available separately for nervous shock claims.

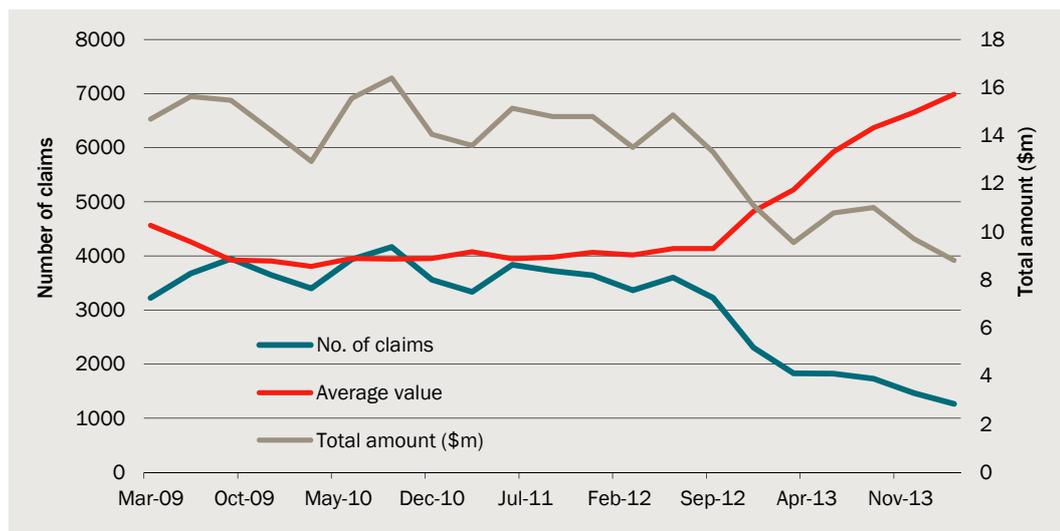
Changes to capacity to seek a review and legal representation

A range of amendments were introduced to restrict the ability of the Scheme to become entrenched with legal disputes. These are summarised in appendix F. Most notably, the amendments prevent the access of an injured workers to legal representation during a work capacity review, and significantly restrict the scope of these reviews. They also eliminate the ability of the Workers Compensation Commission to award legal costs, such that an injured worker must pay their own costs unless they have been granted legal aid through ILARS which was established following the introduction of the amendments.

The intent of the changes was to limit the potential for an escalation in legal costs associated with the introduction of the worker capacity decision assessment. It is often cited that when South Australia introduced work capacity assessments in 2008 they experienced a significant increase in the cost of legal services and Scheme administration.

The impact of the reforms on claimant and insurer legal costs covered by the Scheme can be shown in chart D.15 including the impact of the ILARS scheme, which is covered by WorkCover. The increase in the average payment size is likely to be due to uncertainty surrounding the amendments and the growing share of more severe claims, which are associated with higher legal costs.

D.15 Claimant legal costs covered by the Scheme since amendments



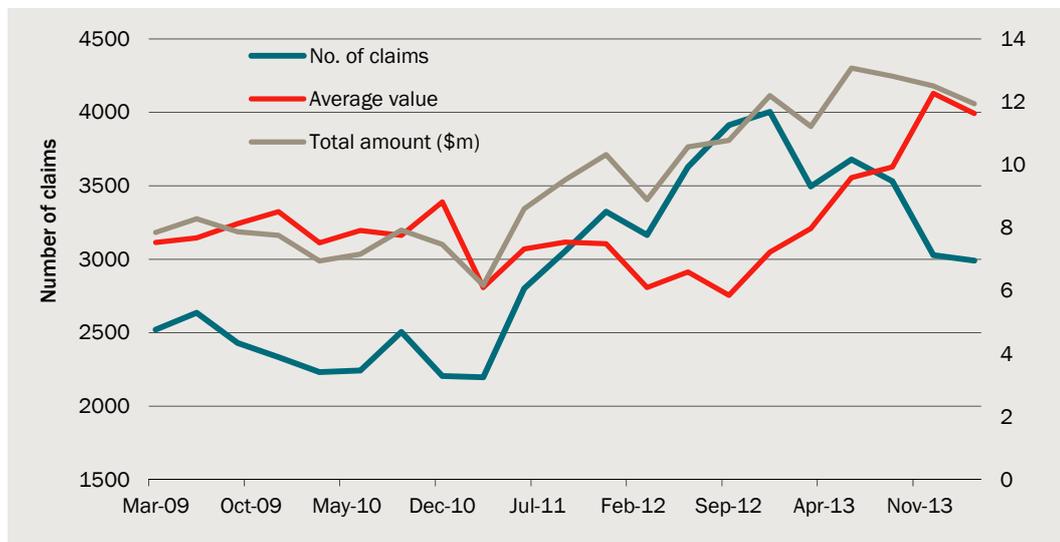
Note: Excludes scheme administration costs.

Data source: NSW WorkCover.

The upwards trend in insurer legal costs, shown in chart D.16 was already occurring prior to the reforms, which is believed to have been due to the reduction in the claim management capacity of Scheme agents, resulting in an increasing reliance on legal providers.⁹⁰ In the post-reform period there appears to be an arrest to this upwards trend, particularly in relation to the number of insurer legal claims.

⁹⁰ PwC, 2014, *WorkCover NSW Full Report: Actuarial valuation of outstanding claims liability for the NSW Workers Compensation Nominal Insurer as at 31 December 2013*.

D.16 Insurer legal costs covered by the Scheme since amendments



Note: Excludes scheme administration costs.

Data source: NSW WorkCover

E Analysis of impacts of reforms to seriously injured workers

E.1 Outcomes for seriously injured workers: changes that may be inconsistent with 7 reform principles

Change to entitlements	Impact of change on worker	Alignment with 7 reform principles
<p>Thresholds for weekly payments beyond 5 years (Whole Person Impairment of 30 per cent or greater, or 20 per cent or greater subject to work capacity assessments)</p> <p>Thresholds for weekly payments also indirectly impact access to medical benefits.</p>	<ul style="list-style-type: none"> ▪ Support for 'seriously injured' (over 30 per cent) are intended to be exempt from a work capacity assessment ▪ Some stakeholders advice there is an inconsistency between 38(5) and section 31(5), and is therefore not guaranteed even if WPI is over 30 per cent ▪ Support for individuals with WPI over 20 per cent and under 31 per cent is subject to a work capacity assessment and not 'guaranteed' ▪ Some injured workers with substantive impairment may not meet new threshold for weekly payments beyond 5 years. 	<ul style="list-style-type: none"> ▪ Increasing the eligibility threshold assists to reduce costs to the Scheme and whole workers compensation system. In theory, establishing a threshold for serious injury is also consistent with reform principles of encouraging workers to return to work and strongly discouraging payments, treatments and services that do not contribute to recovery/return to work. ▪ This can only work in practice if injured workers with substantive impairment have the ongoing care and rehabilitation to do so. In reality, these workers require greater support to return to work than less injured workers. ▪ If this does not occur then regardless of the applied threshold, the outcome is <u>not</u> consistent with the reform principle to guarantee quality long-term medical and financial support for injured workers with substantive impairment (which are serious in nature).
<p>Medical expenses</p> <ul style="list-style-type: none"> ▪ Prior to the reforms, all reasonable and necessary medical treatment would be paid for an indefinite period ▪ After reforms, 'seriously injured' are exempt from 12 month limit for claiming medical and related expenses that applies to other injured workers. ▪ They are still subject to general changes to entitlements (such as requirement for pre-approval, and treatment such as physiotherapy, hydrotherapy, chiropractic treatment or remedial massage therapy must be prescribed by Nominated Treating Practitioner) 	<ul style="list-style-type: none"> ▪ While the amendments have not affected the entitlement of seriously injured workers to indefinite medical treatment, their capacity to receive continuous medical treatment is affected by the new rules, which entitle insurers to review and approve medical treatment on an ongoing basis. 	<ul style="list-style-type: none"> ▪ Entitling seriously injured workers to lifetime medical care is consistent with the reform principle to guarantee quality long-term medical and financial support for seriously injured workers. <ul style="list-style-type: none"> – In practice, some individuals suffer substantive impairment but have different rules that apply which may not be consistent with providing security, particularly in relation to medical care. ▪ Conditions regarding provision of medical treatment, such as the approval mechanisms by insurers, are consistent with the reform principles to strongly discourage payments, treatments and services that do not contribute to recovery. <ul style="list-style-type: none"> – However, in practice there may be inconsistency with recovery outcomes, particularly if administrative delays by insurers in the exercise of their functions caused workers to delay treatment, fund treatment themselves up front, or forgo the best available treatment.

Change to entitlements	Impact of change on worker	Alignment with 7 reform principles
<p>Dispute resolution in relation to threshold assessment</p> <ul style="list-style-type: none"> ▪ Prior to 19 June 2012 if a worker received an adverse decision from the insurer, and wished to take that dispute to the WCC, the insurer was obliged to pay the worker's legal costs, pursuant to a prescribed scale, if the worker was successful. ▪ From 1 April 2013, any worker who makes an application to the WCC must pay his or her own legal costs, regardless of whether the worker wins or loses. Insurers, and their legal representatives, will be funded by the WorkCover Authority but workers, even if they are successful, must pay own legal fees. <ul style="list-style-type: none"> – The Independent Legal Advice Review Service (ILARS) set up by the Government may grant legal aid, where the worker's solicitor is paid at the rate prescribed by the cost regulations in the Act. 	<ul style="list-style-type: none"> ▪ Employer's insurer has more discretion to determine WPI. ▪ Worker has increased interaction with employer's insurer. ▪ A worker can lodge a dispute with the WCC, which uses a panel of medical experts to assess a worker's eligibility for permanent impairment. The WCC can also arbitrate on disputes about weekly payments and liability. <ul style="list-style-type: none"> – But, worker must fund their own legal costs if they wish to dispute insurer's decision at WCC unless they can secure an ILARS grant. ▪ A worker can also make complaint about an insurer's decision about entitlements and payments to the WorkCover Independent Review Officer (WIRO) ▪ WCC/WIRO cannot consider merits of a 'work capacity' decision. 	<ul style="list-style-type: none"> ▪ Placing the decision about WPI being over 30 per cent in the hands of insurers increases capacity for insurers to control scheme costs and reduce regulatory burden. However, unless insurers have highly skilled claims managers who can avoid disputes, this added responsibility can add to costs for insurers and WorkCover. ▪ The amendments appear to have shifted the regulatory burden onto workers who must now fund their own legal costs if they wish to dispute insurer's decisions, unless they can secure ILARS funding. <ul style="list-style-type: none"> – This may result in workers being discouraged to bring disputes, therefore lowering scheme costs and the overall regulatory burden for employers, insurers and the WCC. – However placing the onus on a worker to interact with their employer's insurer and fund their legal costs in any dispute is <u>not</u> consistent with making the system simpler to navigate.
<p>Claim management: restrictions to one claim</p> <ul style="list-style-type: none"> ▪ Post-reforms, restriction of WPI compensation to one claim for statutory lump sum, commutations and work injury damages. <ul style="list-style-type: none"> – This is to enable workers to focus on their recovery, reduce future litigation/disputes and related medical/other expenses. 	<ul style="list-style-type: none"> ▪ Previously, injured workers made many claims for WPI resulting in small assessments. Workers frequently made successive claims for deterioration following on from the work injury. These claims could increase their overall assessment to 15%, the threshold for a work injury damages claim. ▪ An injured worker can now only make one claim for lump sum compensation for a permanent impairment. ▪ Workers cannot claim compensation for deterioration. 	<ul style="list-style-type: none"> ▪ The changes to lump sum claims are consistent with the principle to strongly discourage payments, treatments and services that do not contribute to recovery and return to work. ▪ Stakeholders advise that restrictions on the number of claims can disadvantage workers whose work related injuries require further new treatment (such as surgery) or create other non-pre-existing medical conditions not foreseeable when a claim was made. <ul style="list-style-type: none"> – Where this occurs it would <u>not</u> be consistent with the reform principle to guarantee support for seriously injured workers.
<p>Changes in thresholds for lump sum payments for permanent impairment (section 66), and removal of section 67 payments</p> <ul style="list-style-type: none"> ▪ Thresholds for general physical impairment increased from WPI of 1 per cent to 11 per cent. Includes increase for binaural hearing loss from 6 per cent to 20 per cent. 	<ul style="list-style-type: none"> ▪ Higher standard to meet to receive compensation for non-economic loss. The restriction excludes a large number of injured workers who have substantive impairments. ▪ No pain and suffering associated payments (s67) 	<ul style="list-style-type: none"> ▪ The changes to lump sum payments are consistent with the principle to strongly discourage payments, treatment and services that do not contribute to recovery and return to work.

Note: The changes to commutations, to liberalise availability, have been consistent with the reform principles to guarantee quality long-term medical and financial support to seriously injured workers.

Source: Aegis Consulting Group and the CIE. Consideration given to submissions from NSW Bar Association, NSW Law Society, Australian Lawyers Alliance, Unions NSW, consultations for this review and submissions and evidence to the Standing Committee on Law and Justice, March 2014 and other stakeholder submissions to this review.

F Analysis of change in dispute resolution process and alignment with reform intent

F.1 Change in dispute resolution processes and alignment with the intent of reforms

Nature of dispute	Process/forum for dispute resolution	Legal representation	Alignment with Seven Reform Principles
<p>Work capacity assessment and weekly payments</p> <p>An injured worker wishes to dispute a work capacity assessment by an insurer, leading to a termination of payments due to s43 of the Workers Compensation Act and triggering s59A(2) which brings a worker's medical expenses to an end (after one further year)</p> <p>A decision by an insurer to end weekly compensation is usually based on an assessment that the worker could earn more in employment (the residual earning capacity).</p>	<p>Under the WCA there are 4 stages of review that the worker is entitled to trigger:</p> <p>(a) The worker asks the insurer to "review" its decision. The WCA calls this an "internal review".</p> <p>(b) If dissatisfied with the result of this, the worker can then apply to have the matter considered by the WorkCover Authority "as a merit review of the decision".</p> <p>(c) If dissatisfied with the result of the "merit review" the worker can then apply to have the matter considered by the WorkCover Independent Review Officer (WIRO). This is a procedural review only.</p> <p>(d) If dissatisfied with the decision of the WIRO the worker can, if there is a basis for so doing, seek a "judicial review by the Supreme Court". This is an administrative law remedy.</p>	<p>The worker is not entitled to legal representation during stages (a) – (c).</p> <p>The worker cannot seek ILARS funding for the merit review process.</p> <p>Workers retain a right to appeal to the Supreme Court, seeking an administrative law remedy following the merit review process.</p> <ul style="list-style-type: none"> ■ However, it is unlikely that typical workers can afford the filing fees and costs of bringing such applications. ■ They also cannot risk the possibility of having to pay costs to WorkCover's scheme agent if the Supreme Court dismisses the application. In the nearly two years since 2012 amendments were made, there have been virtually no such appeals. 	<ul style="list-style-type: none"> ■ The merit review process is consistent with the principle to strongly discourage payments, treatments and services that do not contribute to recovery and return to work. <ul style="list-style-type: none"> – This is because the process embeds the right of insurers to determine that a worker has a residual work capacity and that determination is based on a wide range of factors that may bear no relationship to the individual worker's situation. ■ The merit review process operates in a manner that is not consistent with another reform principle concerned with reducing the regulatory burden for workers and in navigating the system. <ul style="list-style-type: none"> – Significant delays are caused by the current approach to review of work capacity assessments. – This is particularly the case where the worker is an immigrant from a non-English speaking background. ■ In addition, there is a perception of lack of independence in the merit review, which is undertaken by WorkCover. This creates an imbalance in access to professional assistance, the system naturally favours the insurer.
<p>Liability</p> <p>An insurer disputes liability for the injury suffered by a worker.</p>	<p>The Workers Compensation Commission (WCC) can arbitrate this dispute and make a decision.</p>	<p>Parties are entitled to legal representation.</p> <p>A worker who makes an application to the WCC must pay his or her own legal costs, regardless of whether the worker wins or loses. However, workers can apply for legal aid from ILARS.</p> <p>Insurers, and their legal representatives, are funded by WorkCover Authority.</p>	<ul style="list-style-type: none"> ■ One of the seven principles aims to reduce the regulatory burden and make the workers compensation system simpler for parties to navigate. <ul style="list-style-type: none"> – Requiring workers to fund their own legal costs for challenge decisions by insurers is <u>not</u> consistent with reducing the regulatory burden for workers or best practice. – ILARS has addressed this issue caused by the reforms to some extent.

Nature of dispute	Process/forum for dispute resolution	Legal representation	Alignment with Seven Reform Principles
<p>Medical assessment</p> <p>An injured worker disputes a medical assessment by an insurer that determines level of impairment.</p>	<p>The medical advisory committee of the WCC can review medical assessments by insurers and recommend a decision.</p>	<p>Parties are entitled to legal assistance to prepare their application but the consideration of medical evidence does not take place in a tribunal setting.</p>	<ul style="list-style-type: none"> ▪ The capacity of workers to seek an independent review of an insurer's medical assessment of their impairment is consistent with the principles which aim to guarantee quality long-term medical and financial support for seriously injured workers and promote the recovery and health benefits of returning to work.
<p>Lump sum payments</p> <p>An injured worker wishes to dispute a decision by an insurer about the lump sum they are entitled to.</p>	<p>A worker can apply to the WCC to have an insurer's decision reviewed. This involves an arbitration process and a decision by the WCC.</p>	<p>The parties are entitled to legal representation.</p> <p>Workers must fund their own costs, but can gain access to ILARS. Insurers' costs are funded by WorkCover.</p>	<ul style="list-style-type: none"> ▪ Enabling workers to have legal representation when challenging the decisions of insurers is consistent with the reform principle to reduce the regulatory burden and make the system simpler for parties.

Source: The CIE

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