THE IMPACT ON INJURED WORKERS OF CHANGES TO NSW WORKERS' COMPENSATION: JUNE 2012 LEGISLATIVE AMENDMENTS

REPORT NO. 1 FOR UNIONS NSW

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EXECUTIVE SUMMARY

In June 2012 the New South Wales workers' compensation legislation was drastically amended on the basis that the scheme was in crisis. The reported year end (2011) actuarial deficit had been $4.1 billion. Yet less than 12 months after the changes came into effect, the NSW Government reduced scheme revenues by granting employers a 7.5 per cent reduction in compensation premiums (effective 30 June 2013). Some four months later, on the 30 October 2013, the Government officially declared that the workers' compensation scheme was no longer in deficit. Employers then received a further premium reduction of 5 per cent, scheduled to come into effect 1 January 2014.

This dramatic turnaround of a 'crisis' level deficit raises important questions about the validity of the actuarial assumptions underpinning the deficit calculation. More importantly, it raises questions about the Government's response, both in terms of its analysis of the data presented by the actuaries and its choices regarding the appropriate actions required to address the financial shortfall. Despite the plethora of strategies available for improving the scheme's arrangements and financial position, the NSW Government's response focused almost exclusively on legislating changes to the medical and financial compensation available to sufferers of work-related injury or illness, and to the procedures through which this compensation is accessed. Consequently, the rapid recovery of the scheme's financial position has been achieved through a dramatic reduction in the compensation provided to and allocated for injured workers.

This research therefore presents a timely and independent examination of the 2012 legislative changes and, in particular, their impact on injured workers during the first year of operation. Given the new arrangements have only been in effect for one year, a full analysis of the impact of the changes on injured workers is not yet feasible. The multi-layered research approach therefore sought to:

- → review the context within which the 2012 legislative changes occurred;
- → obtain and examine preliminary evidence as to how the changes are impacting injured workers in NSW; and
- → establish benchmarks and an ongoing methodology for evidence collection that will enable monitoring of the continuing impact of the 2012 changes.

Together this will inform an understanding of the initial impact on NSW workers and the impact over time as the 2012 amendments filter through to all injured workers.

Initial evidence confirms a significant impact of the 2012 changes on injured workers. The key findings are summarised below with a ✓ denoting positive impacts for workers, a ✗ denoting adverse impacts on workers and a **?** means that it is too premature to judge the impact of the changes:

Weekly benefits		
1	Increase in the statutory weekly payment rate.	✓
2	Change the way earnings prior to injury are calculated to include overtime and shift work. This benefits those who work overtime and shifts, however the calculations can be convoluted, leaving scope for workers to be short-changed.	✓
3	Increase in the percentage wage limits paid after 26 weeks (but only if the injured worker meets work or incapacity for work requirements).	✓
4	Insufficient safeguards surrounding the procedures for work capacity decisions providing opportunities for insurers to unilaterally and unfairly reduce weekly benefits. The result is the potential to erode or eliminate the benefits of 1, 2 and 3 above.	✗
5	Prohibition of payment for legal advice on work capacity decisions, effectively denying injured workers legal support regarding their weekly payment entitlement.	✗
6	Termination of weekly payments when workers reach retirement age (presently 65 years of age) regardless of when injury occurred.	✗
Medical		
7	Entitlements to medical treatment cease 12 months after weekly entitlements are terminated. This leaves workers bearing high costs of necessary, post-injury follow-up treatments, surgeries, prostheses and other aids.	✗
8	New pre-approval requirements can delay necessary treatments, which can cause deterioration in injury and / or treatment withheld until the entitlement period ends.	✗
Journey claims		
9	Compensation for personal injury received by a worker on any journey arising out of, or in the course of employment is no longer claimable unless there is a real and substantial connection between the employment and the accident or incident.	✗
Other claims		
10	Claims for heart attacks and strokes, as well as nervous shock payments to seriously injured workers and their families, are now excluded.	✗
11	Claims for lump sum payments have been restricted, including lump sum claims for injuries that preceded the legislative changes (this could change depending on the outcome of *Goudappel v ADCO*).	✗
WorkCover Independent Review Officer (WIRO)		
12	There is now potential for workers to have this additional port of call for help with resolving problems with their workers' compensation claims.	?
13	WIRO has the potential to improve the quality and clarity of written communication from insurers to injured workers on the basis of WIRO judgments of work capacity decisions.	?
14	The WIRO now possesses unique powers to regulate, monitor and enforce standards of legal practitioners.These benefits are tempered by the prohibition of payments to legal practitioners advising on work capacity decisions as above in 5.	?
15	WIRO can conduct independent research and advise the Minister on findings arising from research or services provided to injured workers.	✓

Return to work		
16	Increased and expanded obligations of injured workers to return to work. These measures are only counteracted on the employer side by augmented powers for WorkCover inspectors to issue employer improvement notices to employers not complying with their workplace injury management and provision of suitable duties responsibilities (but there is an absence of evidence of increased inspections), and a return to work pilot program.	✗
Perceived bullying		
17	The legislated changes enhance the potential for insurers to bully and harass workers by delaying approval for medical treatments and/or pressuring workers to attend any number of medical assessments at short notice and at various locations. The changes do not address pre-existing problems with bullying and harassment, such as persistent verbal threats from insurers and non-responsiveness from WorkCover. The only positive change for workers is the strengthened responsibility for insurers to provide written notice before changing entitlements.	✗
Conflicts of interest		
18	The WorkCover Authority of NSW is both the nominal insurer, with commercial incentives to minimise insurance claim payments, and a public institution, with a responsibility to regulate work health and safety through prevention and rehabilitation, as well as workers' compensation, including the monitoring and enforcement of the regulations binding both themselves and the contracted insurers.	✗
19	Contracted insurers and licensed self-insurers have an inherent conflict of interest as their responsibilities to compensate injured workers and assist them to recover and return to work are overshadowed by their mandate to maximise profits. This conflict has come to the fore with the new system of work capacity decisions.	✗
20	Independent medical examiners and rehabilitation providers have a direct relationship with the insurers that pay them. They have incentives to assist insurers to minimise expenditures for services and payments to injured workers. They do not, however, have incentives to minimise expenditures for their own services, nor do they have incentives to assist the worker to recover. These conflicts of interest have been exacerbated by the legislated changes.	✗
21	Legal practitioners have had incentives to encourage multiple claims and to protract legal claims. These issues have been substantially minimised by the legislated changes.	✓
Transparency and public accountability		
22	The inability to review the specific incentives built into the contracts with Scheme Agents prevents examination of the performance management system and the potential incentives that may exist. Furthermore, there has been a significant reduction in publicly available information from WorkCover NSW regarding compensated injury and illness. This has diminished opportunities for public discussion, independent assessment and accountability of operators of the scheme. Between 1998 and 2010, WorkCover NSW publicly released detailed information about compensated injury and illness claims via annual Statistical Bulletins. These bulletins are no longer produced.	✗

As a result of the 2012 legislative changes, vulnerable individuals who were already suffering the effects of work injury or illness are now experiencing increased trauma, distress, depression, financial hardship and unnecessarily prolonged and exacerbated pain when their treatments are delayed. The resulting impact on a victim's partner, children and other loved ones is also unconscionable.

This study has found that the costs of injuries are increasingly shifting from the workers' compensation scheme to the workers and their families. Consequently, the risks associated with working are felt more acutely by workers. The financial burden of workplace injuries also transfers to federal tax-payer funded safety nets such as Medicare and Centrelink benefits.

Workplace injuries and illnesses are a consequence of work health and safety failures by employers. Nonetheless, the continuing premium reductions are likely to reduce funds available to regulators to monitor and enforce safe work practices, while also eroding employer incentives for improvement in injury prevention.

Overall, the approach taken to amending the scheme appears to be undermining its ability to meet its fundamental purpose –to provide appropriate support to workers who suffer injury and illness at work. Together these findings highlight the need for robust public discussion of workers' compensation arrangements in NSW. This requires NSW constituents to be better informed about the state's workers' compensation scheme; its structures, mechanisms, benefits, limitations and trends. The withholding of comprehensive work injury and illness data from the NSW public since 2010 inhibits such debate. Ultimately, public engagement in the conversation is not possible unless the NSW Government increases transparency around the structures, accountability and performance of all parties to this process: insurers, scheme agents, employers and claimants. Focusing only on claimants is demonstrating to be morally unacceptable and economically counterproductive.

This report establishes benchmarks and an ongoing methodology for collecting evidence of how workers have been impacted by the 2012 changes to the workers' compensation legislation. Three levels of data are identified for future reporting:

1. Broad quantitative data on scheme collections and expenditure, return to work, welfare and Medicare expenditure – published by WorkCover, Safe Work Australia, Hansard and ABS.
2. Specific quantitative data from injured workers on their claims management experience and their understanding of their rights, stigma in gaining employment post-injury, motivation for returning to work and the social and financial impact of being injured – it is recommended that this data be collected through online surveys of injured workers repeated annually.
3. Case studies of individuals – follow-up the benchmark case studies to monitor developments and examine new cases.

The broad quantitative benchmark data reveals that scheme expenditure and expenditure on payments and services to injured workers have not increased in NSW over the last decade. Yet, all expenditures paid directly and indirectly through services to workers have decreased since the 2012

changes took place, with the exception of payments to rehabilitation providers. Enquiries from injured workers to the Injured Workers' Support Network highlight an increasing pattern of grievances with insurers and with reduced payments. Meanwhile, WorkCover significantly reduced the enforcement of worker's compensation and work health and safety regulations in the years leading up to the changes. This multi-layered methodological approach will provide an understanding of how workers continue to be impacted as the 2012 amendments filter through to all injured workers, until the study concludes in 2015.

GLOSSARY

AIGroup	Australian Industry Group
AMWU	Australian Manufacturing Workers' Union
ARPA	Australian Rehabilitation Providers Association
AWE	Average weekly earnings
AWU	Australian Workers Union
CAS	WorkCover Claims Assistance Service
CE	Current earnings
CFMEU	Construction Forestry Mining and Energy Union
CTP insurance	Compulsory third party insurance
GP	General Practitioners (medical doctors)
ILARS	Independent Legal Assistance and Review Service
IME	Independent medical examination
IWSN	Injured Workers' Support Network
KPI	Key performance indicators
NPB	Non-pecuniary benefits
NSW	New South Wales
NSWNMA	NSW Nurses & Midwives Association
PwC	PricewaterhouseCoopers
RTW	Return to work
WC	Workers' compensation
WCA	Work capacity assessment
WCC	Workers' Compensation Commission
WCD	Work capacity decision
WHS	Work health and safety
WIRO	WorkCover Independent Review Officer
WorkCover or WorkCover NSW	WorkCover Authority of NSW
WPI	Whole of person impairment
1987 Act	*Workers' Compensation Act 1987 (NSW)*
1998 Act	*Workplace Injury Management and Workers Compensation Act 1998 (NSW)*
WHS Act	*Work Health and Safety Act 2011 (Cth)*

Private insurers, insurers or scheme agents	Allianz	Allianz Australia Workers' Compensation (NSW) Limited
	CGU	CGU Workers' Compensation (NSW) Limited
	CTX	Cambridge Integrated Services Australia Pty Ltd (trading as Xchanging from 1 October 2010)
	EML	Employers Mutual Workers' Compensation (NSW) Limited
	GBS	Gallagher Bassett Services Pty Ltd
	GIO	GIO General Limited
	QBE	QBE Workers' Compensation (NSW) Limited

TABLES AND FIGURES

INTRODUCTION

In June 2012 the Workers' Compensation Legislation Amendment Act 2012 (NSW) significantly and controversially revised access to compensation for journey claims, restricted the thresholds for entitlements and strengthened return to work obligations for injured workers. The stated intention of the policy change was to stimulate employer focus on prevention, return employees to work more quickly, reduce insurance premiums and improve the financial viability of the system (Joint Select Committee on the NSW Workers Compensation Scheme, 2012). However, trade unions, lawyers, doctors and occupational therapists have criticised the changes to the system because of potential loss of entitlements and hardships suffered by injured workers (Patty, 2012).

Prior to this legislative change, scholars understood that there were inadequacies in the reach of workers' compensation (for instance Quinlan, 2004; Purse, 2011). A string of government inquiries (cf. Industry Commission Australia, 1994; Grellman, 1997; Productivity Commission, 2004; Joint Select Committee on the NSW Workers Compensation Scheme, 2012) and multiple rounds of legislative changes since the 1990s have signalled the discontent of state and federal policy makers with the NSW Workers' Compensation Scheme. This report demonstrates that the 2012 legislative changes fall short of addressing the long-standing problems identified by the Industry Commission Australia (1994); Grellman (1997); and the Productivity Commission (2004). The NSW 2012 legislation has restricted workers' access to compensation, without directly addressing the prevention of workplace injuries and illnesses or supporting timely and durable return to work for injured workers. The impact of these changes is poorly understood. This research project is the first time an independent research organisation has evaluated the impact of the changes. A NSW Legislative Council inquiry into the impact of the changes is due to commence in August 2014, and this research-based evaluation will contribute to this enquiry.

The aims of this study are to:

1. Review the impact of changes to Workers Compensation legislation in NSW on injured workers; and
2. Establish benchmarks and a methodology for ongoing collection of data to monitor the impact of the legislation to December 2015.

This project is envisaged as phase one of a potential two stage, long-term monitoring exercise to be completed at the end of 2015. The second phase will be undertaken using benchmarks and a research framework developed in this preliminary report. This report presents the findings from phase one: an exploratory and benchmarking exercise. Therefore, this report explores the immediate impacts of the change in policy, describes the range of data available, sets benchmarks to compare against in subsequent years, and presents an analysis of trends in the first year of operation of the new system.

This report is structured as follows:

Chapter 1. ***Background*** – a brief history of workers' compensation in NSW to provide an understanding of how the 2012 changes to legislation arose.

Chapter 2. ***Methodology***

Chapter 3. ***Weekly payments*** – an exploration of how injured workers have been and will be impacted by the changes to weekly entitlements, including the introduction of work capacity decisions and the WorkCover Independent Review Officer.

Chapter 4. ***Medical entitlements*** – an understanding of how injured workers will be impacted by the cessation of compensation for medical treatments and the new pre-approval requirements.

Chapter 5. ***Journey claims*** – ways in which injured workers are impacted by the restrictions to journey claims.

Chapter 6. ***Other claims*** – an exploration of the ways injured workers are impacted by the changes to claims for heart attacks, strokes, nervous shock payments for seriously injured workers and their families, and lump sum payments.

Chapter 7. ***Return to work*** – an understanding of how the legislative changes impact injured workers' return to work and prevention of injury programmes.

Chapter 8. ***Scheme governance*** –descriptions of governance and regulation of the workers' compensation system, including the inherent conflicts of interest, information and power asymmetries and the monitoring and enforcement of regulations.

Chapter 9. ***Benchmarks*** – establishes and describes the three layers of benchmarks for data which will continue to be available throughout the study period to provide ongoing evidence of the impacts of the changes on workers.

Chapter 10. ***Conclusions***

1. BACKGROUND

1.1 LEGISLATIVE HISTORY

The workers' compensation system in NSW remained relatively unchanged for almost six decades, following the introduction in 1926 of the first comprehensive, no-fault, compulsory workers' compensation for all NSW workers. In stark contrast, the last three decades have been a tumultuous time for the workers' compensation scheme. Employer premiums and the financial position of the scheme have fluctuated, prompting government to routinely amend or overturn legislation. The various changes to the scheme's legislative framework are summarised in the following timeline.

1910	*Workmen's Compensation Act 1910 (NSW)*	- The first no-fault workers' compensation scheme in NSW was introduced for workers in 'dangerous' occupations.
1926	*Workers Compensation Act* 1926 *(NSW)*	- Established no-fault comprehensive compulsory workers' compensation for all workers in NSW. - Workers' Compensation Commission introduced.
Early 1980s	Unpalatably expensive premium rates for employers.	- Premiums rose from 2.65% of payroll in 1976/77 to an estimated 4.3% in 1985. - Benefits payable doubled in five years, matters were slow to be resolved and worker rehabilitation was inadequate. - Established the State Compensation Board (which preceded the WorkCover Authority).
1987	*Workers' Compensation Act 1987 (NSW)* (the '1987 Act')	- Introduced the publicly underwritten, no-fault, NSW Workers' Compensation Scheme. - Abolished common law remedies for workplace injuries or death caused by employer negligence. - Replaced the judicial system with an administrative system of conciliation and arbitration. - As a result the target premium rate of 3.2% was achieved and the scheme was in surplus for several years.
1989	*Workers Compensation (Compensation Court Amendment) Act 1989 (NSW)*	- Reinstated common law remedies with significant restrictions, including a minimum threshold for economic and non-economic losses and a maximum limit on remedies payable. - Returned 'the workers' compensation system in NSW to a judicial structure.
Early 1990s	Scheme in surplus and amendments made to improve accessibility to benefits for injured workers.	- In 1990 the average premium rate reduced to 2.6% – below the 3.2% target that had been achieved in 1988/89 and a $1.1 billion surplus was announced in May 1990. - Increased benefits and expanded the range of benefits available, widened access to common law and encouraged the use of rehabilitation services. - Premiums as low as 1.8% in 1994/95.
1995-1996	Scheme in deficit and various amendments made to restrict and reduce benefits for injured workers.	- 1995 amendments increased the strength of connection between benefits payable for an injury and the employment, requiring that the work be a 'substantial contributing factor' to the injury. - 1996 amendments restricted access to benefits in a range of ways.

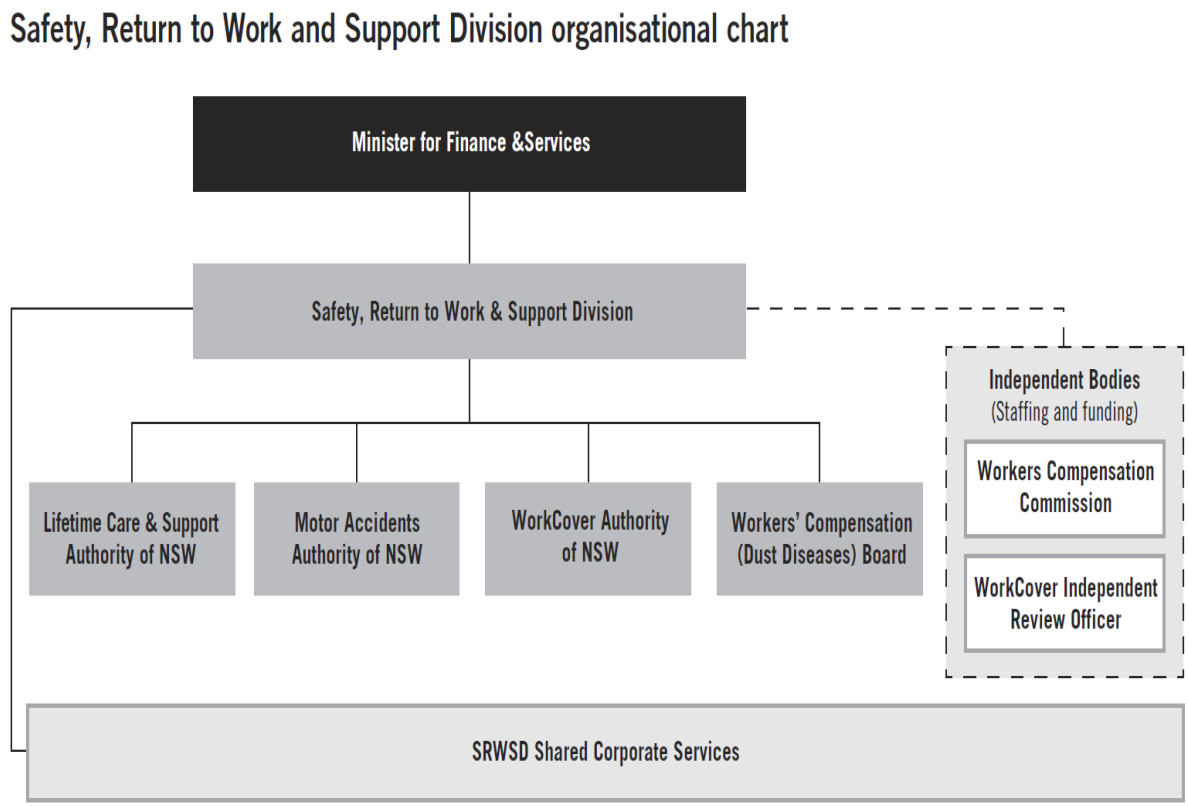
1997	Grellman Report	- Grellman report found that there was a lack of stakeholder ownership and accountability in the scheme; insurers had poor incentives to implement best practice, despite being over-managed by government; WorkCover had inherent conflicts of interest; the legislation was overly complex and disjointed; and premiums were unfairly collected, while benefits were unfairly distributed. - Grellman recommended no less than a complete overhaul of the workers' compensation system – this did not come to pass.
1998	*Workplace Injury Management and Workers Compensation Act 1998 (NSW)* (the '1998 Act')	- Designed to prioritise rehabilitation and timely return to work in the workers' compensation system, as well as minimise the time taken to resolve disputes. - Introduction of an Advisory Council, Industry Reference Groups, the Workers Compensation Premiums Rating Bureau and alteration of the role of the WorkCover Authority of New South Wales. - Nevertheless, by 1999 the scheme was estimated to have a deficit of $1.64 billion, which had risen to $2.18 billion in December 2000 with premiums averaging 2.89 per cent.
2000	*Workers Compensation Legislation Amendment Act 2000*	- The Workers' Compensation Commission (WCC) was (re)established, claims and dispute procedures were altered and common law access to remedies was restricted. - Premiums steadily declined by close to 40 per cent between 2002 and 2009.
2010	*Workers Compensation Regulation 2010*	- The regulations and various additional guidelines are called up under the 1987 Act, have not been legally contested, and therefore have the same legal enforceability as the Act.
2012	*Workers Compensation Legislation Amendment Bill 2012 (NSW)* and the *Safety, Return to Work and Support Board Bill 2012 (NSW)*	- Established the Safety, Return to Work and Support Board, which oversees the functions of various authorities, including the WorkCover Authority of NSW , the Motor Accidents Authority of NSW and the Lifetime Care and Support Authority of NSW. This Board replaces the former Compensation Authorities Staff Division with a single governing board. - The Workers Compensation Legislation Amendment Bill 2012 amended the 1987 Act and the 1998 Act in various ways, which impact directly on the workers and are examined in detail in this report.
Sources: Grellman (1997); Lozusic (1999); Purse (2011); Roth and Blayden (2012)		

The NSW workers' compensation scheme is now regulated by two complementary pieces of legislation, the 1987 Act and the 1998 Act. These Acts are also to be read in conjunction with the *Workers Compensation Regulation 2010* and various guidelines, which have the same legal enforceability as the Act because they are called up under the Act.

1.2 ADMINISTRATIVE HISTORY

The NSW workers' compensation scheme is administered by the WorkCover Authority of NSW (WorkCover). WorkCover sits in the Finance and Services portfolio, as described in Figure 1 below.

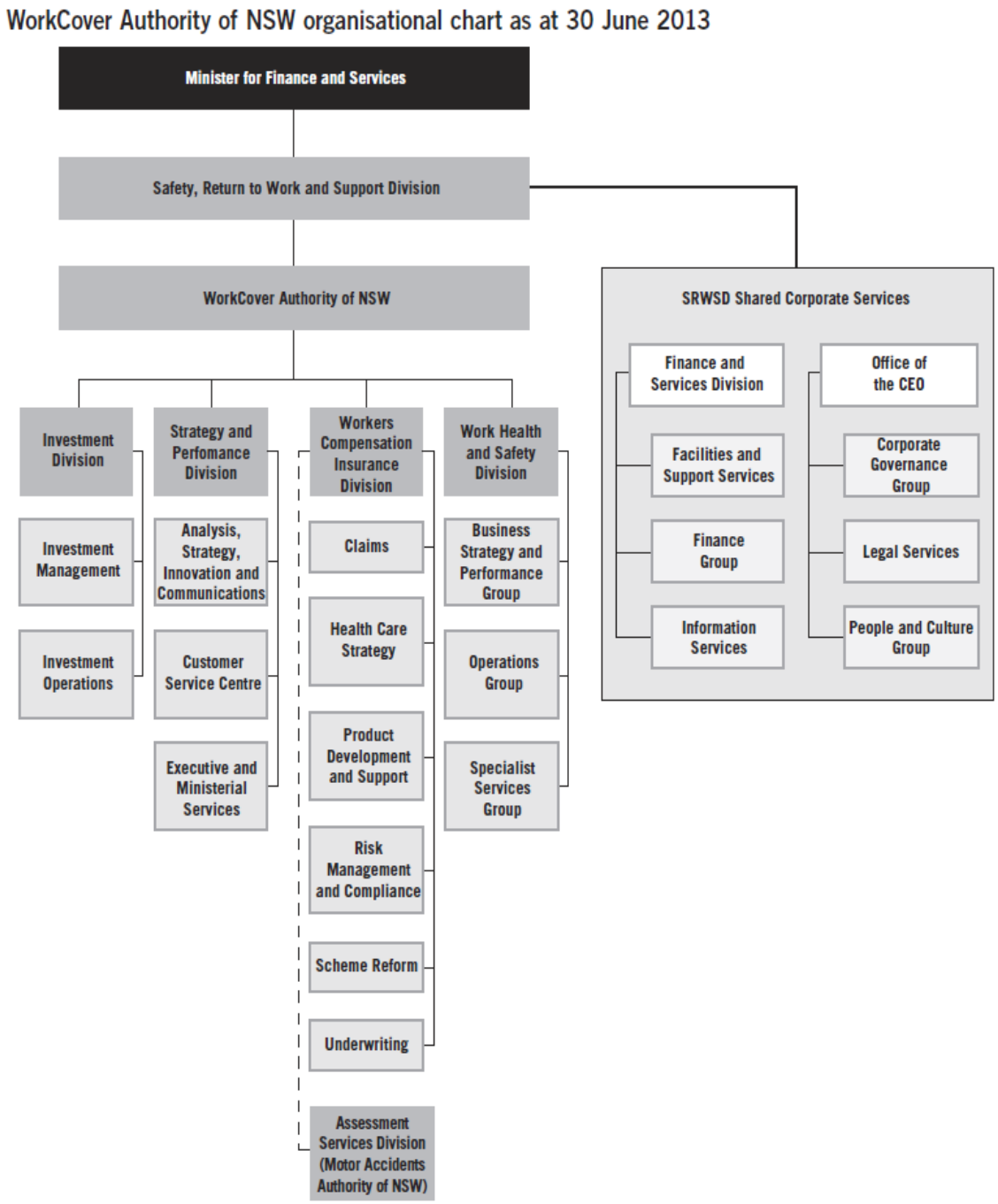
FIGURE 1: SRWSD ORGANISATIONAL STRUCTURE



Source: *WorkCover NSW Annual Report*, 2013: 5

WorkCover was the first Government agency to integrate injury prevention, rehabilitation and compensation into a single body with a unified mission (WorkCover NSW, 2003a: 2; WorkCover NSW, 2013a). This structure signifies an acknowledgement of the interconnectedness of occupational injury prevention, injury rehabilitation and workers' compensation. WorkCover's current organisational structure is depicted in Figure 2.

FIGURE 2: WORKCOVER NSW ORGANISATIONAL STRUCTURE



Source: *WorkCover NSW Annual Report*, 2013: 6

The WorkCover scheme's expenses are funded by insurance premiums levied on those employers who pay more than $7,500 in wages in a financial year, or have an apprentice or trainee on staff (Roth and Blayden, 2012: 2; Garling, 2013: 2). Each employer's premium is calculated on the basis of

industry premium rates, the wages paid to employees and (for all but small employers) insurance claims history.[1]

Until December 2004, WorkCover's role was primarily one of oversight and regulation; monitoring workers' compensation and injury management schemes, licensing insurance companies to provide workers' compensation insurance and manage their own insurance fund, and assisting insurers to meet statutory requirements (WorkCover NSW, 2004a). Comprehensive changes exacted from 1 January 2005 also meant that WorkCover became the Nominal Insurer replacing the six insurance companies previously licensed to provide workers' compensation services, and merging and assuming control of the six compensation funds. In doing so, WorkCover became both the insurer and regulator of workers' compensation insurance services, in much the same way as it is both advisor and regulator of businesses in regard to injury prevention and work health and safety (WHS).

One year later, on 1 January 2006, WorkCover appointed seven private insurance companies under fixed term, performance based contracts to act as Scheme Agents for the provision of insurance policy and claims management services (WorkCover NSW, 2006a). Information on the performance requirements of the Scheme Agent is limited, although a narrow range of self-reported performance data is summarised and provided semi-annually on the WorkCover website. WorkCover retained control of the compensation fund and remains the Scheme's nominal insurer; however insurance premiums, claims and benefits are now managed by a range of service providers. These include: the NSW government's self-insurance scheme (SICorp), the seven contract scheme agents, 59 licensed self-insurers including government departments and seven specialised license holders in specific industries (Roth and Blayden, 2012: 2; WorkCover NSW, 2013a: 116). WorkCover therefore remains both insurer and regulator in the NSW workers' compensation scheme, although the government's intention to separate the regulatory and insurance functions has been noted (Garling, 2013a).

1.3 COMPENSATION CLAIMS HISTORY

The fundamental purpose of a workers' compensation scheme is to provide appropriate medical treatment and compensation to persons injured at work. Over 130,000 employment related injuries occur in NSW each year with approximately 70 per cent of those being minor injuries requiring less than five days rehabilitation. Typically the workers' compensation claims for these minor injuries involve medical treatment only (Garling, 2013: 4). In contrast, over 40,000 NSW workers every year suffer more serious injuries and illnesses in the course of their employment (see Table 1).

[1] The exclusion of claims history for small employer premium calculation may explain why NSW is one of only two jurisdictions in which the rate of compensation claims made by small employers is higher than the claim rates for any other firm size (see Safe Work Australia 2011).

TABLE 1: REPORTED ANNUAL CASES OF EMPLOYMENT INJURY AND DISEASE IN NSW

	Workplace injury claims	Occupational disease	Commuting injuries	Other claims	**Total major case claims (> 5 days)**	Minor cases (0-5 days)	**All Work Injuries & Diseases**
1992	38,163	9,792	2,036	1,086	**51,077**	na	na
1993	35,925	11,941	1,999	985	**50,850**	na	na
1994	39,307	16,110	2,113	1,059	**58,589**	na	na
1995	42,505	16,811	2,326	1,198	**62,840**	na	na
1996	42,648	16,211	2,426	1,184	**62,469**	na	na
1997	44,654	11,394	2,912	1,149	**60,109**	na	na
1998	43,982	10,176	3,368	1,078	**58,604**	na	na
1999	41,739	9,567	3,376	810	**55,492**	na	na
2000	39,531	9,169	3,683	841	**53,224**	na	na
2001	39,995	9,258	3,700	844	**53,797**	na	na
2002	40,204	9,878	3,701	891	**54,674**	na	na
2003	37,422	9,157	3,527	894	**51,000**	na	na
2004	37,330	9,604	3,621	996	**51,551**	na	na
2005	36,150	9,697	3,612	290	**49,749**	na	na
2006	31,613	8,626	3,488	286	**44,013**	97,227	**141,240**
2007	29,326	8,201	3,452	252	**41,231**	98,972	**140,203**
2008	30,077	8,628	3,325	247	**42,277**	100,265	**142,542**
2009	30,133	8,985	3,512	228	**42,858**	90,330	**133,188**
2010	28,056	10,055	na	na	na	na	**128,923**
2011	28,179	8,981	na	na	na	na	**126,077**
2012	27,696	10,747	na	na	na	na	**129,706**

Sources: *WorkCover NSW Statistical Bulletins 1998-2010* and *WorkCover Annual Reports 2010-13*

The severity of injuries and illnesses is a key driver of the cost of both medical treatment and financial compensation. To this end, Table 2, below, summarises the serious injury cases according to severity, revealing decreasing trends over time. Nevertheless, the failure to significantly improve the prevention of major work-related injuries, particularly those causing long term and permanent incapacity, places an ever-growing financial burden on the scheme.

TABLE 2: SEVERITY OF MAJOR INJURY AND DISEASE CASES

	Employment Fatalities	Permanent disabilities	Long term temporary incapacity (> 6 months)	Medium term temporary incapacity (5 days – 6mths)	**Total major injury or disease**	Incidence rate (Claims per 1,000 employees)	% change
1992	177	9,734	2,796	38,370	**51,077**	25.0	
1993	156	12,285	2,711	35,698	**50,850**	24.9	-0.4%
1994	185	17,598	3,301	37,505	**58,589**	28.3	13.7%
1995	177	20,051	4,398	38,214	**62,840**	28.6	1.1%
1996	181	19,046	5,453	37,789	**62,469**	27.4	-4.2%
1997	173	15,605	5,733	38,598	**60,109**	26.1	-4.7%
1998	181	13,968	6,536	37,919	**58,604**	25.2	-3.4%
1999	163	14,321	6,149	34,859	**55,492**	23.1	-8.3%
2000	181	15,241	5,276	32,526	**53,224**	21.3	-7.8%
2001	139	16,616	4,684	32,358	**53,797**	20.3	-4.7%
2002	177	16,705	4,316	33,476	**54,674**	20.3	0.0%
2003	136	13,263	4,127	33,474	**51,000**	18.5	-8.9%
2004	132	14,251	3,475	33,693	**51,551**	18.3	-1.1%
2005	125	13,877	3,313	32,434	**49,749**	17.6	-3.8%
2006	146	10,986	3,550	29,331	**44,013**	15.3	-13.1%
2007	137	9,062	3,643	28,389	**41,231**	13.9	-9.2%
2008	124	8,760	3,862	29,531	**42,277**	14.0	0.7%
2009	139	8,789	3,986	29,944	**42,858**	14.2	1.4%
2010	113	na	na	na	na	13.4	-5.6%
2011	117	na	na	na	na	12.9	-3.7%
2012	122	na	na	na	na	13.2	2.3%

Sources: *WorkCover NSW Statistical Bulletins 1998-2010, WorkCover Annual Reports 2010-2013*

1.4 SHIFTING THE COST BURDEN

National research demonstrates that Australian employers are bearing decreasing proportions of the costs associated with injuries and illnesses sustained as a result of people working in their business (Quinlan and Mayhew, 1999: 500). Studies of the economic cost of employment injury and illness reveal significant shifts in both the distribution and size of this cost burden since 2001 (rising from a total estimated $34.3 billion in 2001 to $60.6 billion by 2009). Most notably, the proportion of this cost borne by injured workers and their families has increased from 43.7 per cent (or $15 billion) in 2001 to 73.9 per cent (or $44.8 billion) by 2009. In contrast, the economic burden on employers (either directly or cross-subsidised through workers' compensation schemes) has decreased from 24.8 per cent to 16.0 per cent over the same period[2]. The remaining economic cost of employment injury is borne by the community, primarily through publicly funded services such as Medicare and social security systems (Safe Work Australia, 2004; O'Neill, 2012: 6).

Such cost shifting is visible at both state and national levels. For example, a 1993 WorkCover NSW survey of 8,800 employees found 50.6 per cent of workers who had been injured at work did not claim workers' compensation. Instead they relied on at least one of the following: 'Medicare (43 per cent), regular sick leave entitlements (39.6 per cent), personal private health insurance (15.6 per cent), and government social security benefits (7.4 per cent)' (Quinlan and Mayhew, 1999: 494). More recent research, such as the ABS *Work Related Injuries Survey*[3] conducted in 2009-10, revealed only 30 per cent of workers who suffered a workplace injury during the previous 12 months had received workers' compensation. The implications of this cost shifting for private insurers, such as superannuation funds, manifest as rising claim rates. This is an issue of increasing concern, as outlined in a recent Australian Financial Review article, which reported,

> *Soaring life insurance premiums are expected to absorb all the rises in the superannuation guarantee for the next six years, prompting some in the retirement savings industry to re-think their insurance strategies. (Patten, 2013)*

Figure 3 demonstrates an apparent reluctance of some injured workers to access workers' compensation; instead relying on leave entitlements, Medicare, social security and other forms of assistance. Unsurprisingly, a majority of injured workers with no work absence received no workers' compensation. Of concern, however, 12 per cent of workers who took more than 5 days off work also received no financial assistance. Furthermore, 31 per cent of injured employees used their own sick leave to take 1 to 5 days off work, while one in five injured workers used their sick leave or annual leave for even longer periods of absence to recuperate from employment injuries or illnesses. Figure 3 also illustrates the alternative sources of financial assistance reported by injured workers. (Note: financial assistance is available from multiple sources, so the total proportions may be greater than 100 per cent).

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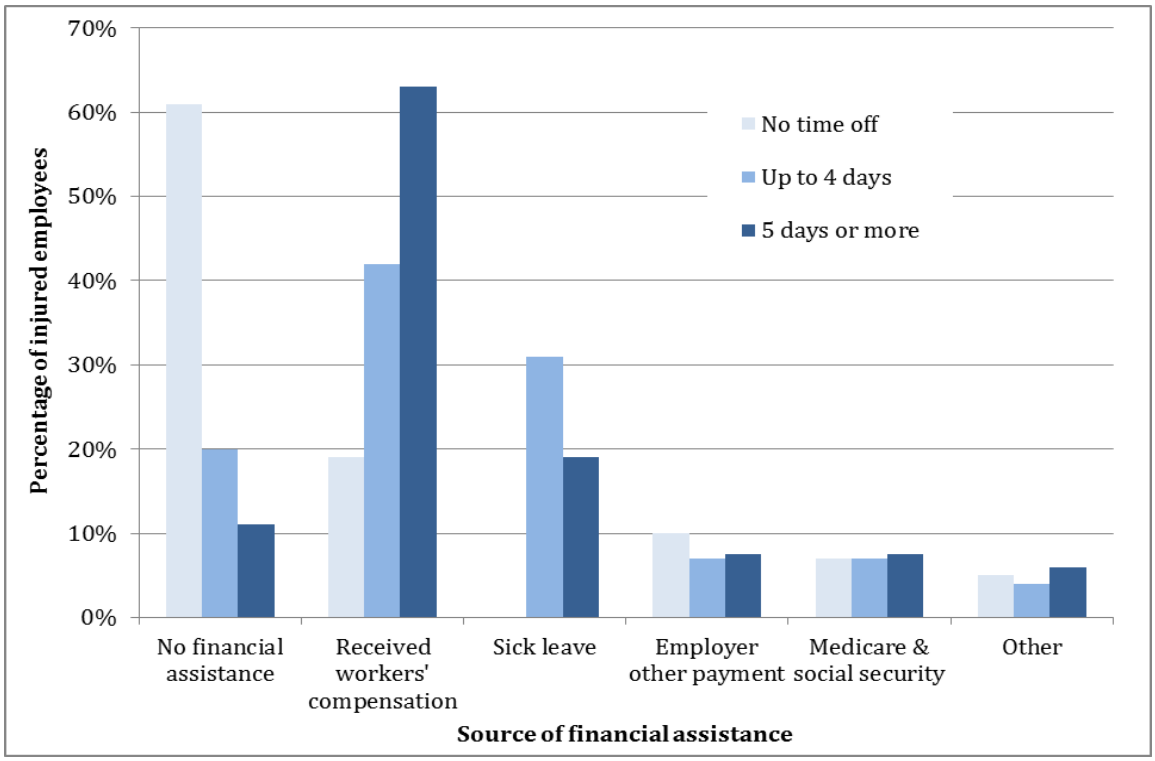
[2] Excluding compensation scheme premiums, the direct costs to employers bear only 5.1 per cent ($3.1b) of the economic costs for work-related injury or illness occurring in their business; up slightly from 2.9 per cent ($1b) in 2001 (Safe Work Australia 2002, 2012).

[3] Similar findings are reported in the ABS 2005-6 study (see Safe Work Australia 2011c. Work-related Injuries in Australia: Who did and didn't receive workers' compensation in 2009-10.)

FIGURE 3: SOURCES OF FINANCIAL ASSISTANCE (ABS SURVEY 2010)



Source: Safe Work Australia 2011, *Work-Related Injuries in Australia: Who did and didn't receive workers' compensation in 2009-10*: 11

Shifting the costs of workplace injuries from workers' compensation schemes onto injured workers, their families and the community has been widely criticised as unacceptable (see for example Industry Commission Australia, 1994; National Commission of Audit, 1996; Productivity Commission, 2004; Purse, 2011). These costs arise because businesses have failed to ensure the WHS of their workers. This problem is exacerbated by the efforts of state governments to compete for business investment by building low-cost, low-benefit workers' compensation schemes.

> *Competition which erodes benefits is invidious. Competition which takes the form of shifting as many costs as possible onto other parties (e.g. to individuals or to the health and social security systems) is also undesirable. As one inquiry participant put it, "ultimately, someone has to pay."* (Industry Commission Australia, 1994: XXXI)

Counter to the notion of employers being held to account for the costs of work-related injury through scheme levies, the Joint Select Committee on the NSW Workers Compensation Scheme asserted that shifting the medical costs of injured workers from the private compensation system to the publicly funded Medicare system was a reasonable proposition:

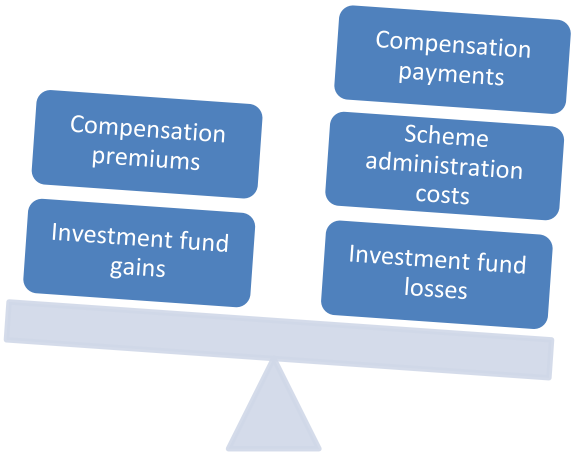
> *The WorkCover scheme should provide a level of reasonable coverage of medical and related treatment, but it is not unreasonable that that coverage be proximate to the date of injury and time off work by the worker. Australia has a comprehensive safety net of medical and hospital coverage for all Australians under Medicare. Injured workers whose workers' compensation medical benefits expire after a time cap are not suddenly*

> *put on the 'scrap heap'. They will enjoy the benefits of the Medicare system like everyone else, including those whose serious accidents were never covered by any accident compensation scheme (e.g. because they were not in a motor accident or they were outside the work place) and those born with serious disabilities.* (Joint Select Committee on the NSW Workers Compensation Scheme, 2012: 70).

Nevertheless, WorkCover's integrated approach to WHS and compensation (cf. WorkCover NSW, 2004a) acknowledges the proven preventative safety effect of workers' compensation premiums (Chelius, 1991: 22; Reber, Wallin and Duhon, 1993: 301-311). This understanding prompted the Industry Commission to conclude that,

> ***Too many of the costs of work-related injury and illness are being borne by affected individuals and taxpayers**, and that redressing some of this imbalance will create the sorts of incentives which will, over the longer term, lead to **fewer (and less serious) workplace injuries/illnesses (and therefore workers' compensation premiums)**.* (Industry Commission Australia, 1994: XXXIV - emphasis in original)

1.5 SCHEME FINANCIAL VIABILITY



The connection between rates of injury and compensation premiums is perhaps most visible when considering the scheme's financial viability. However, these are just two of the many variables involved in calculating the two key measures of financial viability: net assets[4] and funding ratio[5]. Actuarial estimates of future assets and liabilities require predictions about future financial inflows (premium collections and investment gains) and expenditures (compensation payments, scheme administration costs and investment losses) as well as estimations about the present value of the final predictions. These calculations therefore require considered choices about a range of variables such as: economic predictions of employment participation and economic performance; life expectancy; medical advances; and injury rates, as well financial variables including the risk free discount rate; interest rates; inflation rates; Commonwealth bond rates; and the performance of the scheme's investment portfolio.

[4] Net assets is defined, for a hybrid scheme as found in NSW, as 'the assets available to meet the insurer's net claims liability' where claims liability includes the prudential margin, less claims recoveries receivable. (Safe Work Australia 2011b. Comparison of Workers' Compensation Arrangements in Australia and New Zealand.)

[5] The funding ratio is the ratio of assets to liabilities.

The subjectivity inherent in these financial predictions needs to be understood. For instance, observers often mistakenly assume that a rise in outstanding claims liabilities is necessarily the result of increased claims for workers' compensation. However the Auditor General notes that, for 2011/12, the increase in claims liability was not due to increases in claims by injured workers but rather,

> *The key drivers of the increase in the outstanding claims liability are movements in the discount rate, inflation rate and changes to the risk margin.* (NSW Auditor General, 2012: 99)

Table 3 summarises publicly reported key performance data for the NSW scheme for the period 1997 to 2012. In doing so, it highlights the extent to which the scheme's financial position has fluctuated over time, despite persistent legislative and administrative efforts to achieve stability. Some oscillation about a 100 per cent funding ratio is to be expected due to the subjectivity of future cost estimations, however the desired asset to liability ratio for the NSW scheme of between 90 and 110 per cent (NSW Auditor General, 2012: 98) has been met in only four of the past sixteen years.

Of the various trends highlighted by Table 3, one is perhaps particularly noteworthy. Between 2005/6 and 2007/8 the scheme was in surplus with the funding ratio both positive and within the desired band for three consecutive years. At its strongest reported position (i.e. 2006/7), average premium rates were 2.11 per cent and injury claim rates at 13.9 serious injuries per 1,000 workers. Since then, premium rates have progressively decreased by 19.4 per cent while injury rates have oscillated up and down, arriving in 2012 at a level only 5 per cent lower than they had been in 2007.

Notwithstanding the relatively minimal change in injury rates, the cumulative effect of premium reductions from 2005 to 2011 was reported to save employers over $4.5 billion over the period; an amount exceeding the subsequent 2011 estimated scheme deficit (O'Neill, 2012 and WorkCover NSW annual reports 2006 to 2012).

TABLE 3: SCHEME PERFORMANCE 1997 - 2012

Financial year	Net assets ($m)	Funding ratio	Premium rates (% of payroll)^	Serious injury claim rates*	Comment
1996/7	-789	87%	2.7%	26.1	Grellman Report
1997/8	-1,675	77%	2.8%	25.2	1998 Act commenced
1998/9	-1,636	78%	2.8%	23.1	
1999/00	-1,639	80%	2.8%	21.3	Act amended to restrict lump sum
2000/1	-2,756	70%	2.8%	20.3	
2001/2	-2,801	67%	na	20.3	Premium discount scheme introduced
2002/3	-2,982	66%	na	18.5	
2003/4	-2,353	73%	2.59%	18.3	
2004/5	-1,396	80%	2.54%	17.6	WorkCover became nominal insurer
2005/6	+85	**101%**	2.47%	15.3	Performance-based scheme agents began
2006/7	+812	**107%**	2.11%	13.9	
2007/8	+625	**105%**	1.91%	14.0	
2008/9	-1,482	89%	1.82%	14.2	
2009/10	-1,583	89%	1.81%	13.4	
2010/11	-2,363	85%	1.74% #	12.9	Estimated deficit at Dec 2011 was $4.1b
2011/12	-1,497	**91%**	1.70%	13.2	Legislative changes into effect 9/2011

na: Data not reported.
^ Standardised average premium rate, including insured and self-insured sectors.
* Incidence of serious injury claims per 1,000 employees.
# Annual report cites 2010/2011 result as premium rate of 1.68.

Sources: Roth and Blayden 2012: 7; *NSW Auditor-General's Report to Parliament Volume 5*, 2012; *WorkCover NSW Annual Reports and Statistical Bulletins issued 1998 to 2013*; Safe Work Australia *Comparative Performance Monitoring Reports 11-15,* 2009-2013.

The justification for continuing the premium decreases was to ensure NSW's competitiveness relative to other jurisdictions; in particular the neighbouring states of Victoria and Queensland. This desire to use workers' compensation premiums to 'compete' against other jurisdictions for employers is an oddity that has persisted in Australia for more than 25 years. The perception exists in spite of the absence of *any evidence* to support the notion that businesses will relocate to the jurisdiction with the lowest premiums (Purse, 2011: 37-38, emphasis added). Advocates have instead called for 'healthy competition which focuses on cutting service-delivery costs and/or provides better services' citing the potential for 'beneficial competition' to 'greatly improve' WHS outcomes, such as,

> *when insurers actively compete with one another to provide firms with the benefit of their expertise in the use of risk-management techniques to improve workplace safety, claims management, and superior performance in the crucial areas of rehabilitation and return-to-work.* (Industry Commission Australia, 1994: XXXII)

Centring the compensation system on competing with neighbouring states on premium rates belies the motivation to prioritise injury prevention and timely return to work. Furthermore, jurisdictional differences in compensation scheme structures, fund structures,[6] claims excess arrangements and benefit entitlements render such comparisons potentially misleading and invalid. For instance, the lower Queensland premium is enabled by Queensland's very strong net asset and funding ratio position, although the low premium revenues have contributed to a significant decline in the funding ratio from 232 per cent to 130 per cent between 2005/06 and 2011/12 (O'Neill, 2012: 4; Safe Work Australia, 2012).

Similarly, when making comparisons with Victoria's premium rate, one should be mindful of different compensation arrangements applicable to Victorian employers, such as claims excess provisions that typically require employers to pay the first 10 days of lost wages as well as the first $592 of medical expenses (O'Neill, 2012: 4). Differences in serious injury occurrences (Victoria's serious injury rate reportedly between 27 and 42 per cent higher than NSW in the five year period to June 2009) raises questions about the appeal of modelling the NSW scheme on the Victorian workers' compensation system (Joint Select Committee on the NSW Workers Compensation Scheme, 2012: 41).

By June 2011 the NSW scheme was deemed to have an accumulated deficit of more than $2.3 billion, although, as shown in Table 3, the funding ratio remained substantially higher than previous comparable periods of deficit (Joint Select Committee on the NSW Workers Compensation Scheme, 2012: 8). With the global financial crisis impacting heavily on investment returns, an actuarial report provided by PricewaterhouseCoopers (PwC) estimated the December 2011 scheme deficit at $4.1 billion. While the findings were generally supported by the Ernst and Young peer review, others disputed the actuarial assumptions. The Australian Lawyers Alliance and the Law Society of NSW, for example, claimed the deficit had been augmented by $1.5 billion between 2009 and 2012 because PwC altered the actuarial assumptions in 2009 (Joint Select Committee on the NSW Workers Compensation Scheme, 2012: 10). Furthermore, a dissenting statement by Adam Searle, MLC, claimed the decision to apply the Commonwealth bond rate as the discount rate, rather than NSW Treasury rate, inflated the deficit significantly, adding some 7 per cent to the outstanding claims liability (Joint Select Committee on the NSW Workers Compensation Scheme, 2012: 282).

Ultimately however, the viability of the workers' compensation scheme is reliant on sound financial management and so a significant deterioration in the reported financial position was cause for alarm. Consequently, and notwithstanding the subjectivity inherent in actuarial assessments and the typical fluctuations in the scheme's financial assessments, the Government argued that urgent action was needed to reduce the $4.1 billion actuarial deficit (Pearce, 2012b).

[6] Each Australian jurisdiction has either a centrally funded, hybrid or privately funded compensation scheme and each calculates their net asset and liability positions differently. Therefore, caution should be exercised in making cross jurisdictional comparisons of scheme position and performance.

1.6 JUSTIFICATION FOR THE 2012 AMENDMENTS

The amendments that were legislated in 2012 were curiously disconnected from the stated justifications for urgent change. In particular, the deterioration of the scheme's financial position (i.e. to an estimated $4.1 billion deficit at December 2011) was attributed in equal parts to 'external influences impacting investing returns achieved, particularly the "risk free" discount rate used to discount the outstanding claims liability' and a 'deterioration in claims management experience since June 2008' (Roth and Blayden, 2012: 8). Given the impact the global financial crisis was having on equities markets and interest rates at the time, and the explanations regarding actuarial choices in regard to discount rates and other assumptions, the potential for external influences on investment returns was easily recognised and widely accepted.

However, the proposition of a 'deterioration in [the] claims management experience' was more opaque. Both the 2011 actuarial and peer review reports by Ernst and Young had cited issues relating to the governance and oversight of scheme agents' performance (Joint Select Committee on the NSW Workers Compensation Scheme, 2012: 123). This was a position supported by submissions from various employers, employer associations, unions, workers, legal practitioners and other parties to the 2012 Parliamentary Inquiry who had also articulated that the biggest problem with the scheme was the insurance agents (Daley, 2013). Deteriorating claims management therefore appeared to refer to administrative performance issues. This included the efficiency and effectiveness with which agents administer premium collections and deliver compensation services for injured workers, as well as processes for the governance and oversight of scheme agent performance more broadly.

Taking a slightly different approach however, the NSW Business Chamber argued 'there has been deteriorating performance in return to work, which has been one of the key factors contributing to the Scheme's costs', (Joint Select Committee on the NSW Workers Compensation Scheme, 2012: 33). Yet given the trends in employment injury and disease prevention, an increase in average work absence as a proportion of total injures was to be expected. The statistical bulletins provided by WorkCover NSW[7] demonstrate a steady and significant *improvement* over time in the prevention of all severity categories of lost time injuries. By 2009, annual injury data shows 28,462 fewer lost time injury or disease claims lodged than when the bulletins commenced in 1998 (see Table 4). However, the majority of this improvement has been in the prevention of low severity/high frequency (i.e. relatively minor) lost time injuries. Consequently, the average time lost has increased due to the higher proportion of more serious claims. This is also confirmed by benchmarks 3 and 4 in Chapter 9.

[7] WorkCover NSW ceased providing the online publication of detailed injury, illness and claims data in annual Statistical Bulletins in 2010 (i.e. injuries and illnesses sustained in 2009). Therefore, claims data for 2010 onward is unavailable and could not be included in the analysis.

TABLE 4: NUMBER OF LOST TIME INJURY (AND DISEASE) CLAIMS

Year	Fatality	Permanent disability	Temporary incapacity > 6 months	Temporary incapacity < 6 months	Total Lost Time Injury/illness
1998	173	13,968	7,666	70,637	92,452
2009	139	8,789	4,310	50,752	63,990
(2009 vs 1998) improvement in annual injury prevention	23.2%	37.1%	43.8%	28.2%	30.8%
Number and % reduction in	42	5,179	3,356	19,885	**28,462**
injury & disease occurrences	0.15 %	18.2 %	11.79%	69.8 %	100 %
Source: *WorkCover NSW Statistical Bulletins 1998, 2009*					

In contrast, the Joint Select Committee's 2012 report to Parliament identified seven primary factors contributing to the increasing deficit between 2009 and 2012:

1. Work injury damages liability increasing for nine consecutive valuations between June 2007 and December 2011 (this was also highlighted as a particular concern in Roth and Blayden, 2012).[8]
2. Increasing top-up payments for permanent impairment lump sums under the 1987 Act, section 66 (and related pain and suffering lump sum claims under section 67).
3. The increasing cost of medical treatment, with advances in medical treatments being simultaneously more sophisticated and more costly (and medical cost increases exceeding inflation expected to continue).[9]
4. Injured workers remaining on weekly benefits for longer periods, in spite of the number of workers' compensation claims reducing during this period.[10]

[8] This is a selective use of data. Benchmark 1 in this report demonstrates that total scheme expenditure and scheme expenditure direct to claimants did not increase between 2004 and 2012 once adjusted for inflation.

[9] Improvements in medical treatments can also potentially reduce the time required to recover from injury, therefore expenditure in weekly benefits would be reduced, even though medical expenditures have risen. More research is required to understand the relationship between medical costs and weekly benefits.

[10] As outlined above, this is not necessarily poor management but could reflect the changing profile of average injury outcomes. The justification for change could be a selective use of data, which shows that the portion of long-term weekly payment recipients increased, yet fails to mention that the number decreased while the number of shorter term weekly payment recipients decreased by a greater amount. The lack of transparency, with WorkCover no longer releasing Statistical Bulletins, prevents an analysis of this claim.

5. Poor management of claims by scheme agents. Agents' inadequate investigation of new claims and poor management of existing claims were seen as significant factors in the deterioration of the scheme.[11]

6. A substantial increase in the costs of managing the Scheme by the WorkCover Authority.

7. A significant reduction of over 30 per cent in premiums from 2005 to 2011, which substantially reduced scheme revenues thereby eroding the assets available to counterbalance the Scheme's liabilities.

Yet at the conclusion of the Parliamentary Inquiry, the NSW Government proposed legislative amendments that focused almost entirely on injured workers; introducing financial incentives and penalties for returning injured workers to work more quickly; measures to prevent access to compensation for certain types of injuries; and processes to exit some injured workers from the compensation system.[12] The changes failed to also address employer-oriented return to work barriers such as security of employment for injured workers and the adequate provision of suitable work. Similarly, despite the significant financial impact of recent premium reductions, the Government determined that restoring premiums to a higher levels as a means of returning the scheme to surplus was simply untenable (Roth and Blayden, 2012: 8).

Notably, the Government's reforms also failed to address the governance, efficiency and effectiveness of scheme agents and other insurers in administering workers' compensation policies and claims. The decision not to address governance issues is important given the Industry Commission's investigation into worker's compensation concluded that good quality of service from scheme agents in claims administration and service delivery is integral to shaping workplace attitudes and 'facilitating co-operative employee employer relationships which are crucial in achieving good return-to-work rates' (Industry Commission Australia, 1994: XXXII). Furthermore, in failing to require insurers to exercise a legislated duty of care, courts continue to have no basis on which to find insurers negligent in their duties when they fail to exercise a duty of care (Daley, 2013). Similarly, there were no reported increases in WorkCover's activities to enforce the payment of premiums. In the past these enforcement activities, such as wage audits and prosecutions, have returned significant sums to the scheme in unpaid or underpaid premiums and penalties for breeches of WHS legislation (cf. WorkCover NSW, 2001a).

Instead, the Joint Select Committee, and subsequently NSW parliament, chose to address the deteriorating financial position of the scheme by primarily focusing on expenditures to claimants. On

[11] It is likely that a rise in scheme agent remuneration is a factor to be considered here. Scheme agent remuneration increased by 226 per cent between 1997 and 2010 – yet the role of scheme agents was very different in 1997. However, WorkCover no longer releases data on scheme agent remuneration so an analysis of this claim is not possible.

[12] The latter sought to address claims by Allianz Australia that too many injured workers claimed compensation for too long and there were no clear guidelines for exiting them from the system (Joint Select Committee on the NSW Workers Compensation Scheme 2012. New South Wales Workers Compensation Scheme, Parliament of New South Wales).

19 June, two amendment bills were introduced to NSW Parliament and on 22 June the *Workers Compensation Legislation Amendment Bill 2012* and the *Safety, Return to Work and Support Board Bill 2012* were passed in the NSW Parliament.

The key changes are summarised as follows:

→ Provision to reduce weekly benefits according to perceived work capacity.

→ Increases to the statutory upper limits on weekly benefits.

→ Changes to the calculation of average weekly earnings.

→ Criminalising paid legal advice regarding capacity to work decisions.

→ Restrictions on access to compensation for:
- journey injuries;
- heart attacks and strokes;
- nervous shock for seriously injured workers and their families; and
- lump sum claims.

As a result of the legislative amendments in June 2012 the fund took less than a year to return to surplus. The government was able to announce a 7.5 per cent premium reduction for employers from the 30 June 2013 and a further 5 per cent premium reduction for employers effective the 1 January 2014. The remainder of this report examines the impact of the legislative changes on injured workers.

2. METHODOLOGY

The research for this report was conducted in three phases. The first phase involved a desktop review of regulations, available statistical data, case law and relevant literature. For the second phase eleven semi-structured, face-to-face, qualitative interviews were conducted with officials from trade unions, including the Injured Workers' Support Network (IWSN), Construction Forestry Mining and Energy Union (CFMEU), Australian Manufacturing Workers' Union (AMWU) and NSW Nurses & Midwives Association (NSWNMA), as well as the Australian Industry Group (AIGroup) and three legal practitioners. The trade unions included in this study were selected on the basis that they had resources dedicated to workers' compensation and they were willing to participate.

Interviews were requested with appropriate staff from the WorkCover Workers' Compensation Division. After prolonged consideration the Chief Executive Officer of WorkCover, Julie Newman, declined the opportunity to participate in this study to develop benchmarks for assessing the impacts on workers on the grounds that it was too soon to do so.

The second phase of the research also involved attending three IWSN meetings for injured workers. For the third phase, six individual case studies were conducted with workers who had been affected by the workers' compensation changes. The schedule of all interviews conducted in phase 2 and phase 3 can be found attached at Annex A.

An exploration of the different facets of workers' compensation, how they have been altered by the legislation and the impacts on the workers is presented in the following chapters 3 to 8. These chapters draw on information collected from the desktop review of literature and government reports, semi-structured exploratory interviews and IWSN meetings.

3. WEEKLY PAYMENTS

Summary

The most significant impact on injured workers is the introduction of work capacity decisions (WCDs), whereby an insurer can unilaterally decide what an injured workers' capacity to work might be, what job they can do and how much income they can earn. Injured workers' weekly payments are accordingly reduced by the hypothetical income the insurer deems possible. This process effectively negates any possible benefits workers can expect from the introduction of a substantially higher statutory rate of maximum weekly payments.

Injured workers face significant restrictions if they wish to appeal a work capacity decision made by the insurer about their weekly payments. Merit review can only be conducted by the insurer or WorkCover, following that, procedural reviews can be carried out by an independent body, the WIRO. Legal advisors are not permitted to receive payment for assisting injured workers with the WCD reviews.

The new system of step-downs in payments has the effect that weekly compensation entitlements for most workers can be terminated after 130 weeks.

Older workers are disadvantaged by the changes, particularly workers who suffer an injury when they are 64 years of age – their weekly entitlements will cease on their 65th birthday regardless of the circumstances.

> *There is now a completely new process for claims management... the test is now capacity for work, not fitness for work... that's a very significant change and that impact hasn't been seen yet... everyone has work capacity... when you align that to the new entitlement periods, effectively most workers will cease to be entitled to any weekly compensation after 130 weeks. It limits the amount of compensation that will be available to any worker. That's an important change.* (Garling, 2013a)

The 2012 amendments to workers' compensation had wide reaching and multifaceted impacts on weekly benefits for injured workers. These changes and their impacts are summarised in descending order of severity, commencing with the most adverse impacts on workers and ending with potentially positive impacts.

TABLE 5: SUMMARY OF CHANGES TO WEEKLY PAYMENTS

	Summary of change	Impact of change
1. Work Capacity Decisions (WCDs) and **Procedural reviews by independent officer (WIRO)**	The *Workers' Compensation Legislation Amendment Act 2012* (NSW) introduced into S.43-44 of the Workers Compensation Act 1987 the new terms, work capacity decision and work capacity assessment. The insurer now makes the decision about a workers' capacity to work – the work capacity decision (WCD). This may be based on a work capacity assessment (WCA) although the insurer does not need to have regard to a worker's injury(s) or capacity work in making the decision. S.44A(3) states that 'A work capacity assessment is not necessary for the making of a work capacity decision by an insurer'. Weekly entitlements are determined on the basis of the WCD. Previously doctors made the decision about work capacity and workers decided how much they could work and were paid top-up benefits if the wage they earn was less than their weekly entitlement. The 2012 amendments also provided for establishment of the WorkCover Independent Review Officer (WIRO) in the role of overseeing weekly benefit decisions. The ***merits*** of the WCD can only be reviewed by the insurer or by WorkCover. There is no scope for the merits of WCDs to be reviewed by an independent body. A worker cannot refer a WCD to review by WorkCover until they have applied for an internal review by the Insurer. The WIRO can make ***procedural*** reviews of WCDs by insurers. The WIRO's decisions in reviews are limited to a binary decision about whether that WCD stands or the insurer must recommence the process. A worker cannot refer a WCD to review by the WIRO until it has been the subject of an internal review by the insurer and a merit review by WorkCover.	WCDs are having the greatest impact on injured workers. The lack of an independent review mechanism removes all scope for the merits of a decision to be reviewed independently. The decision is entirely a unilateral decision. The Act leaves injured workers' weekly benefits (and by association their access to medical payments 12 months after weekly payments are reduced to $0) at the mercy of their insurer except on procedural grounds.
2. Definition of 'suitable employment' **(S.43A pre change – now S.32A)**	Following the *Workers Compensation Legislation Amendment Act 2012*, the definition of 'suitable employment' continues to mean *employment for which the worker is suited*, as it did before the 2012 legislative changes. However, the insurer now decides what work is suitable for the injured worker and no longer needs to consider whether such employment exists, is available or is geographically accessible to the worker.	Insurers make decisions about the work an injured worker might be doing, the corresponding income they might be earning and therefore how much to deduct from their weekly entitlements. The new provisions on suitable employment give insurers the scope to reduce weekly entitlements to $0 by deciding a worker might be able to do a job, regardless of whether that employment is available or proximate to the workers' place of residence.

	Summary of change	Impact of change
3. Step down of payments	The 2012 amendments increased the ***step-down*** provisions which reduce weekly entitlements as a proportion of pre-injury earnings over time. Thus, before the 2012 amendments, weekly payments declined from 100% of current weekly wage to 95% 26 weeks after injury. After the changes weekly payments now decline from 95% of average weekly earnings (AWE, refer to 1987 Act S.44C-44I)) for 0-13 weeks, to 80% or 95% of AWE for 14 weeks – 2.5 years (the higher percentage applies if working more than 15 hours per week), to 80% for 2.5 years or more from injury. Eligibility for weekly payments also now depends on the assessed degree of whole of person impairment, as do lump sum compensation payments. That is, the amendments introduced grading of degree of injury on a scale of whole of person impairment (WPI) of <10%, 11-20%, 21-30% or >30% for seriously injured workers. These gradings impact on application of the step- downs in weekly entitlements.	Maximum percentages of weekly entitlements payable for longer term injured workers are significantly reduced. Maximum percentages of weekly entitlements payable for injured workers who are assessed as having a lower level of whole of person impairment are also significantly reduced. In practice, insurers are now requiring injured workers to attend multiple medical assessments until the insurer is satisfied with the lowest level of WPI decided by a doctor. (This is not dissimilar to the previous system, except that doctors now decide WPI, which insurers use to assess entitlements. Previously doctors decided the number of hours a worker was capable of working and the insurer was required to 'top-up' the pay to the maximum amount payable if there was a shortfall.)
4. No payment for legal advice regarding WCDs	The 2012 amendments prohibit injured workers from paying for legal advice regarding their work capacity decisions. This covers weekly entitlements, medical and vocational assessments and rehabilitation programmes used to determine the WCD.	The removal of payment for legal advice on weekly benefits entitlements, combined with the lack of independent merits review of WCDs disempowers injured workers to pursue their statutory entitlements.
5. Termination of benefits at 65 years of age (even if injured at 64 years of age)	The weekly benefit automatically discontinues at retirement age (currently 65 years) and not 12 months after retirement age as previously. For injuries received on or after retirement age - there is no change. Benefits terminate 12 months after the first occasion for incapacity resulting from the injury.	The twelve month limit on weekly benefits compensation discourages older workers from working if they are at risk of injury, particularly if they are 64 years of age or above.
6. Calculation of weekly entitlements	The amendments have changed the way weekly income prior to injury, and thus weekly entitlements, are calculated. Prior to the changes, the injured worker's average weekly earnings used to calculate weekly benefits, excluded overtime, shift work, payments for special expenses and penalty rates, but now, overtime and shift penalties are included in the calculation.	The new system can be more complex to calculate; some workers are advantaged and some are disadvantaged, but the impacts are minimal. There is evidence of some employers taking advantage of the complexity of the calculations and understating overtime or extra shifts for workers who do shift work.

	Summary of change	Impact of change
7. Increased statutory rate for injured workers	The 2012 Amendments provided for a substantial increase in the statutory rate of maximum weekly benefit entitlements. Where workers in the past could receive up to the maximum weekly rate of $1,000 (indexed), currently an injured worker can receive a percentage of their pre-injury earnings up to maximum of $1,868.50 (indexed).	The amendments have increased the potential benefits payable for higher income earning workers in the short-term (particularly up to 13 weeks) by raising the maximum pecuniary benefit. Ostensibly this increases benefits for longer-term injured workers, however the insurers' power to make a WCD using the revised definition of 'suitable employment' means that in practice most potential for increasing benefits is reduced by the amount of potential earnings an insurer determines for the worker i.e. hypothetical earnings.

Given the breadth of issues impacting workers' weekly entitlements the subsequent analysis of the impact of changes to weekly benefits will be divided into the following three areas:

3.1 Work capacity decisions (incorporating the new definition of 'suitable employment' and the limitations on the review process).

3.2 Step downs of weekly payments.

3.3 Weekly entitlements after retirement age (benefits terminating at 65 years old).

3.1 WORK CAPACITY DECISIONS (WCDS)

These work capacity decisions are really life changing. (Hayward, 2013)

The critical impacts on workers of the introduction of work capacity assessments (WCAs), work capacity decisions (WCDs) and the WorkCover Independent Review Officer (WIRO) service are summarised in Table 6 below:

TABLE 6: LEGISLATED INTRODUCTION OF WORK CAPACITY DECISIONS, WORK CAPACITY ASSESSMENTS AND THE WIRO SERVICE

	Before 2012 legislated changes	**After 2012 legislated changes**	**Implications of legislative amendments**
Benefits and work capacity decisions	**S.33** Compensation is payable on the basis of total or partial *incapacity* for work. **S.40A:** An injured worker who is partially incapacitated could be required by the employer to undergo an assessment of ability to earn in some suitable employment. In practice this meant the test for eligibility for payments was 'fitness for work', based on a doctor's assessment. **S.43A:** **Suitable employment** refers to employment for which the worker is currently suited, having regard to such matters as the nature of the worker's pre-injury employment, where the worker lives, and the length of time the worker has been seeking suitable employment	Compensation is payable on the basis of *work capacity*. S.32A defines ***current work capacity*** 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. **S.44A:** **Work capacity assessments** must be conducted by an insurer. **S.43:** **The insurer makes a work capacity decision (WCD),** which includes a worker's current work capacity and what constitutes suitable employment, the amount the injured worker is able to earn in suitable employment and other matters. **S.32A:** **Suitable employment** refers to work for which the worker is currently suited, regardless of whether work or employment is available; is of a type or nature generally available in the employment market; the nature of the worker's employment before the injury; and where the worker lives.	The legislation now places an emphasis on the workers' capacity to work in any job, anywhere. Where previously an employer could require the worker to undergo an assessment of fitness for work, now an assessment of current work capacity by an ***insurer*** is compulsory to determine entitlement to weekly benefits. *'What's being appreciated now is, whether or not it was the government's intent, everyone has work capacity. So unless you're in a coma, you have work capacity. There's very few people who don't have work capacity... that then impacts on what compensation benefits you're entitled to.'* (Garling, 2013a) *'Doctors issue a certificate of work capacity, however that is not determinative, that is only one of the issues that the insurer considers in deciding whether you have work capacity or not. Arising from that is what benefits you might be entitled to. So that's a very significant change.'* (Garling, 2013a)

	Before 2012 legislated changes	After 2012 legislated changes	Implications of legislative amendments
Termination of payments through WCDs	**S.52A:** For workers with *partial incapacity*: The entitlement to weekly benefit payments ceases after the first *two years* (104 weeks) if the worker: • Is not suitably employed *and* is not seeking suitable employment – (suitable employment includes appropriate vocational training if the employer does not provide employment); • Is not suitably employed and has previously *unreasonably* rejected suitable employment • The worker has failed to find suitable employment *primarily* because of state of labour market. For workers who had received weekly benefits for more than 12 months – a notice period applied to termination of their benefits (notice period varied according to duration of period on benefits).	**S.38:** (1) A worker's entitlement to weekly benefits ceases after the first two years (at the end of the *2nd entitlement period – which runs 14 to 104 weeks*) unless the worker is entitled to benefits after this date. (2) If the *insurer* has assessed the worker as having no current work capacity, they are entitled to continued weekly benefits. (3) If the insurer has assessed the worker as having current work capacity, they are entitled to continued weekly benefits *only* if: • the worker has applied to the insurer in writing in past 12 months for continued payments after 2nd period; and • the worker is working 15 h.p.w. and earning at least $155 per week (as indexed); and • The insurer has assessed the worker as likely to continue to be incapable of additional employment to increase earnings. (4) For a worker to receive benefits after the 2nd period, the insurer must have conducted work capacity assessment in previous 12 months; AND must conduct one every two years thereafter [unless worker is a 'seriously injured worker' in which case insurer can make work capacity decision without assessment. **S.39:** Workers have *no entitlement* to weekly benefits *after 5 years* – unless worker has 20% permanent impairment.	Pre the 2012 amendments, a worker's entitlement to weekly benefits ceased only in limited circumstances where they had failed to find employment. Under the current legislation, entitlements can cease *unless they meet certain conditions* including working a minimum number of hours weekly. Further, workers are also required to undergo a *work capacity assessment* before entitlements can continue, and must re-establish their work capacity through an assessment every two years thereafter. This means that insurers can unilaterally decide a worker has capacity to work in a hypothetical job, earning a hypothetical income, and their weekly entitlements are then reduced by that hypothetical income. There is a ***five year limit*** to weekly entitlements for workers with partial incapacity unless their impairment is assessed at more than 20%.

	Before 2012 legislated changes	After 2012 legislated changes	Implications of legislative amendments
Legal advice	All injured workers could appoint a legal practitioner to provide advice and act on their behalf.	**S.44(6)** Lawyers are not entitled to be paid for any assistance or legal advice given to workers regarding their WCD.	Lawyers can give workers advice on WCD reviews, but now cannot be paid for doing so. Trade unions can assist workers with WCD review applications. A small number of workers are benefitting from legal or trade union assistance, but most are left completely on their own. *'That's had a significant impact because there's no one to give the injured worker information about their rights and about how they can work their way through the process. So the current view is that the bulk of workers are just accepting the decisions and walking away. (For the 18 per cent of workers who are in unions, some of them are getting advice.)'* (Garling, 2013a).
Sources: **Before** 2012 legislated changes: *Workers Compensation Act 1987 No 70 (NSW)*: historical version 20 January 2012 to 26 June 2012; **After** 2012 legislative changes: *Workers Compensation Act 1987 No 70 (NSW)* - current version 5 July 2013			

The 2012 legislative changes introduced provisions permitting insurers to conduct work capacity assessments (WCAs) to assess a worker's current work capacity (1987 Act, S.44A). The legislation also introduced work capacity decisions (WCDs), conducted by insurers. The WCDs enable insurers to make a 'final and binding' decision about a worker's risk of further substantial injury, current work capacity, hypothetical 'suitable employment' and corresponding hypothetical income, and thus what their weekly benefits should be (1987 Act, S.43(1)). WCDs can be applied to overrule decisions about weekly payments that were made in the Workers' Compensation Commission before the 2012 legislation changes. The crux of this amendment is that insurers can determine weekly payments on the basis of 'suitable employment':

> *Under the new legislation the definition of 'suitable employment', which is relevant to weekly payments after a period of time, is absolutely, completely and utterly oppressive because it says that there are lots of things that you have to have regard to, regardless of whether the work or the employment is available.* (Brennan, 2013)

Importantly, a WCA is unrelated to a WCD. 'A work capacity assessment is not necessary for the making of a work capacity decision by an insurer' (1987 Act, S.44A(3)).

> *A work capacity decision is a discrete decision that may be made at any point in time and can be about any one of the factors described in section 43(1), such as the worker's capacity to earn in suitable employment. This is different to a work capacity assessment which is a review process that may or may not lead to the making of a work capacity decision or another type of decision regarding a claim.* (WorkCover Work Capacity Guidelines 2013, S.5)

WCDs can be made at any point in the life of a claim upon receipt of new information, such as changed capacity to work (WorkCover Work Capacity Guidelines 2013, S.5.1). An insurer can also conduct a WCA at any time. If the worker fails to properly participate in the WCA their weekly payments can be immediately suspended (WorkCover Work Capacity Guidelines 2013, S.4.1). In any event the WCA does not necessarily inform the WCD. This is morally hazardous given that the insurers have a conflict of interest between meeting insured workers' needs and maximising their profits.

The system of work capacity decisions impacts most deeply those injured workers with limited (albeit specialised) skill sets. This is illustrated, for example, by cases of injured construction workers,

> *the new definition of suitable employment is killing them... we've got guys who've been in construction for 40 years, the employer terminates them, they don't know how to use a computer, reading and writing is really difficult, English itself is difficult and the insurer says to them, 'You can be a sales representative.'.. These are not really achievable goals for our workers, but that doesn't matter and just like that, their payments are gone. They're stuck trying to figure out what they're going to do, but they're applying for 15-20 jobs a week, nobody is going to hire them because they're on workers' compensation, they've had an injury. The only way they can even look at getting a job is by hiding that, and if you're asked you have to disclose it.* (Hayward, 2013)

This system conflicts with the recommendation of the (Industry Commission Australia, 1994: XXXV), which was that:

> *Employers be held liable to pay the cost of compensating employees suffering work-related injury or illness (with their liability being discharged upon a 'reasonable' offer of employment being made to formerly injured/ill employees upon completion of any necessary rehabilitation program, or if employees 'unreasonably' refuse to undertake rehabilitation).*

There is a small concession in the amended legislation for seriously injured workers,[13] as they are exempted from WCAs, unless the insurer thinks it is appropriate to conduct a WCA and the worker requests it (1987 Act, S.44A(4)). This could be irrelevant though, because insurers are not restricted from making a WCD for a seriously injured worker. Furthermore, the number of workers who are classified as 'seriously injured' is insignificant. Since the workers' compensation scheme commenced in 1987, there have been 994 workers in NSW who have been assessed as having greater than 30% permanent impairment, and are therefore exempt from having a WCA.[14] There is an additional number of workers for whom an assessment of permanent impairment has not yet been possible because their condition continues to deteriorate and has not yet stabilised, which means these injured workers still sit in a 'grey' area of possibly being 'seriously injured' workers.

The 2012 legislation has also seen the appointment of a WorkCover Independent Review Officer (WIRO) (1998 Act, Part 3). The functions of the WIRO and his delegates are to:

1. deal with complaints about insurers (non-binding power) and encourage insurers and employers to establish complaints resolution processes (this had not been done before);
2. review WCDs and make binding recommendations for the insurer and the Authority (1987 Act, S.44(3));
3. inquire into and report on any aspect of the system, including conducting research, and report to the Minister on relevant matters (1998 Act, S.27); and
4. conduct the Independent Legal Assistance and Review Service (ILARS), [15] which funds injured workers getting matters before the Workers Compensation Commission.

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[13] A '**seriously injured** worker means a worker whose injury has resulted in permanent impairment and:
(a) the degree of permanent impairment has been assessed for the purposes of Division 4 to be more than 30%, or
(b) the degree of permanent impairment has not been assessed because an approved medical specialist has declined to make an assessment until satisfied that the impairment is permanent and the degree of permanent impairment is fully ascertainable, or
(c) the insurer is satisfied that the degree of permanent impairment is likely to be more than 30%.' (1987 Act, S.32A)

[14] This figure excludes the seriously injured workers who have been able to make a common law claim and had a lump sum settlement.

[15] The ILARS service commenced on 1st October 2012. In the first 12 months ILARS received 10,000 applications for ILARS grants: approximately 70 per cent of those applications were for lump sum impairment, approximately 15 per cent were for medical disputes and approximately 15 per cent were for liability disputes. The exact figures will be released in a WIRO progress report later this year (Garling, 2013).

The WIRO is an independent body, which has oversight of Work Cover. However, as with all aspects of the workers' compensation scheme, the WIRO is also regulated by WorkCover in terms of funding, staffing and support services (Garling, 2013a).

Given that the WCDs can have life changing outcomes, it is important to understand how workers can resolve disputes about the decisions. Where a WCD is disputed an injured worker must follow a specific procedure in the order prescribed in the 1987 Act, S.43. Failure by the worker (not the insurer) to complete any one of these steps in the sequence defined below, precludes the worker from taking their review to the next level.

1. Lodge a ***Work capacity – application for internal review by insurer*** form with the insurer in a timely manner. The internal review must be conducted by an appropriate person at the insurance company, who was not involved in the making of the first decision. The applicant should be informed of the decision within 30 days of when the application form was lodged (Guidelines for Work Capacity Decision Internal Reviews by Insurers and Merit Reviews by the Authority, 11 October 2013 Chapters 6.5, 7.2 & 7.6).
2. Lodge a ***Work capacity – application for merit review by the Authority*** form with the WorkCover Merit Review Service. The application for review must be lodged with WorkCover within 30 days of receipt of the decision by the insurer, or 30 days from the due date if the insurer failed to reach a decision in that time. WorkCover can decline to review the WCD if it deems it to be frivolous or vexatious. The merit reviewer must advise the worker of their decision as soon as practicable and preferably within 30 days of receipt of the application (Guidelines for Work Capacity Decision Internal Reviews by Insurers and Merit Reviews by the Authority, 11 October 2013 Chapters 9.1, 9.11, 9.12 & 10.14).
3. The worker may make an ***application to the WorkCover Independent Review Officer*** (WIRO) for a review of the insurer's *procedures* (not the merits of the case) in making the work capacity decision, within 30 days after receipt of the merit review decision from the Authority. (Guidelines for Work Capacity Decision Internal Reviews by Insurers and Merit Reviews by the Authority, 11 October 2013 Chapter 10.15.4). Note that any breaches of procedure by the insurer or WorkCover during the review process (such as delays in making decisions) cannot be included in the WIRO review.

Importantly, to this point in the WCD review process, lawyers are not entitled to be paid for any advice or assistance given to workers (1987 Act S.44(6)). Assistance from a legal practitioner for insurers is only prohibited in the *Workers Compensation Regulation 2010* (S.8 Part 1, Clause 9), 'A legal practitioner is not entitled to be paid or recover any amount for a legal service provided to an insurer in connection with an internal or other review under Section 44 of the 1987 Act in relation to a work capacity decision of the insurer.' Payment for legal advice for insurers is not prohibited in either Act and since insurers have legal practitioners on staff the enforcement of this clause in the 2010 Regulation is improbable. Therefore, the potential for lawyers to give advice to injured workers about their weekly payments has been largely removed from the scheme, even though 'the cost of the lawyers in the process is relatively minimal' (Garling, 2013a).

> *It's a three tiered internal system, ending up with WIRO, that no worker without legal assistance could ever work their way through. It's just grossly unfair.* (Brennan, 2013)

4. The worker can seek a judicial review in the Supreme Court. The WIRO has no formal process for referring workers to the Supreme Court as this has not yet been tested. It is also unknown as yet if workers seeking to appeal the decision in the Supreme Court would receive funding for legal representation through the Independent Legal Assistance and Review Service (ILARS), or if they would need to fund the case themselves. WCD reviews are prohibited in the Act from being referred to the Workers Compensation Commission.

The complexity of the new system is rendered more problematic due to the scarcity of information available for injured workers and lack of access to people who can help them navigate the system. Very few injured workers are able to navigate their way through the new workers' compensation system without legal assistance.

> *It's the ultimate farce, [government says], 'We're going to give you all these rights of review, that basically aren't enforceable anywhere and nobody can help you with them.* (Simic, 2013)

> *There's got to be someone that can intervene to explain the rights and processes to workers.* (Grumley, 2013)

At this stage legal assistance with WCDs is being provided for a select few workers who are either members of a union that has staff with the expertise and time to assist them with reviews or who have a lawyer who is willing to provide this service for them for free. The industrial officer at CFMEU, Sherri Hayward, explained:

> *Our role has been to assist workers in putting in their reviews and that makes up the large majority of work that I'm doing... We've had some success with the internal reviews – I've had two internal reviews overturn the original decision, I've had four overturn the decision but not give them full payments... then we've had a couple of procedural reviews find the original notice invalid. Which, while not a great solution overall, extends the time that they're receiving their weekly benefits, so extends the length of time that they're receiving their medical benefits. We do internal reviews, merit reviews and then procedural reviews because it's not fair to leave these guys high and dry. They can't get legal assistance. These aren't five minute jobs, they take me 3-4 hours per application to put together... Nobody can do these on their own.* (Hayward, 2013)

Therefore, Sherri Hayward, the Industrial Officer at CFMEU is spending at least 12 hours each week compiling WCD reviews for injured workers. Alan Mansfield, the workers' compensation officer and Dave Henry the WHS officer at AMWU are also spending at least 30 hours each week compiling WCD reviews for injured workers. Taylor & Scott Lawyers has one fulltime lawyer committed to doing WCD reviews and four workers' compensation lawyers are also working on one or two reviews per week (Simic, 2013). Richard Brennan, Partner, from McNally Jones Staff & Co is spending three hours per day working on WCDs (Brennan, 2013). These services are being provided by lawyers free of charge because they feel a sense of duty to the workers who have been caught unaware by the legislative changes.

> *It's helping in the sense that it's providing some real information to these poor workers who have suddenly gotten this piece of paper saying, 'You're gone'... All these workers are still in shock, they can't believe that somebody can just turn up one day and say, 'Bang! Your court order is gone.'* (Simic, 2013)

Frustratingly, all these efforts are amounting to little more than postponing the inevitable – that weekly payments and medical entitlements will be terminated.

> *It's really a delaying process to be honest. We can't stop it... What's coming is coming.* (Henry, 2013)

> *For our guys it's less about the weekly benefits and more about [extending] the medical benefits.* (Hayward, 2013)

Financial assistance for legal services is still available for non-WCD related matters. If the decision pertains to liability, medical payments, work injury management, provision of suitable duties or another matter that is not related to the WCD, the worker can lodge an optional request for a review with the insurer and/or contact WorkCover Claims Assistance Service (CAS). WorkCover CAS can check if the notice the worker received is correct and provide the worker with information about their rights. CAS can contact the insurer directly and ask them to look at the case, and point out if the insurer has misinterpreted the Act, but CAS has no authority to enforce any sections of the Act. Workers (or their legal representatives) can also apply to the WIRO for an ILARS grant to pay for legal representation to take their dispute to the Workers Compensation Commission and commence conciliation conference proceedings.

Where parties fail to reach an outcome in the conciliation conference, the claim will be escalated to an arbitration hearing. The Workers' Compensation Commission is prohibited from making any decisions that are inconsistent with the WCD of the insurer. If a dispute is escalated to the Supreme Court, there can be a judicial review, which is usually limited to 'where there has been an error of law on the face of the record of the proceedings or jurisdictional error. This power does not usually allow for a merits review', although there is 'scope for a judicial review to become a 'full merits review'' (May, 2012: 19).

It has been suggested that the 2012 changes aim to 'all but eliminate' the obligations to support long-term injured workers (known as the 'tail end') to make the scheme attractive for a private insurer to take over completely (that is, to privatise the scheme). This is significant because as the legislation stands injured workers are offered no protection of their entitlements if they have suffered a long-term injury. The only allusion to insurers making appropriate efforts to consider the work capacity of the worker (e.g. by conducting a WCA) before making a WCD is contained in the

WorkCover Work Capacity Guidelines 8 October 2013, section 5.1.[16] This seems to mean that insurers can make any WCD they like. In practice, the merits of the WCD cannot be independently reviewed, with the possible exception of a worker taking the case to the Supreme Court, but this is untested.

Meanwhile, insurers can use WCAs as a way to perpetually harass workers into attending assessments with medical practitioners, vocational assessors and functional assessors. Case evidence has shown these assessments need not be proximate to the worker's home, and that workers may not be given fair notice to attend, although if they fail to attend or to 'co-operate' their payments can be suspended.

Similarly, there is evidence of work capacity assessments being used in South Australia as a mechanism for pressuring injured workers in the hope they will choose to leave the scheme. An official 2011 review of the South Australian workers' compensation scheme amendments made in 2009 concluded that 'work capacity reviews were being used as a claims management 'pressure point' in order to get injured workers off the scheme by other means' (Purse, 2013: 214). The use of WCDs and WCAs to pressure workers to leave the workers' compensation system has prompted observers to comment on the unfairness of the system.

> *I think the whole thing is dishonest. What they've done is set up very convoluted legislation to give the appearance that there is some sort of rationale or fairness in it. Every way I look at it, it's basically designed to cut off workers from their weekly compensation. It's all a bit of a charade. It would have been far more honest for the government just to say, 'Look, we just want to get rid of the tail and we're going to cut you off.' In one way it would be kinder than sending workers five pages telling them, 'You can't do this, you're going to be cut off, but you've got all these rights to get reviewed.'* (Simic, 2013)

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[16] When making a work capacity decision the insurer's approach should:

- ensure that all reasonable opportunities to establish capacity for work have been provided to the worker
- ensure that the insurer meets their responsibility of establishing and supporting an injury management plan tailored to the worker's injury as set out in Chapter 3 of the 1998 Act
- evaluate all available and relevant material and relevant considerations
- have regard to the particular facts and circumstances of the worker
- follow a robust and transparent decision-making process with clear, concise and understandable information provided to the worker giving reasons for decisions
- seek any additional information that is required to ensure the worker's current capacity for work is fully understood
- provide opportunity for the worker to contribute additional information, especially if the decision may result in reduction or discontinuation of the worker's weekly payments
- ensure decision makers have the appropriate expertise, ability, and support to make the decision they are making.

Any work capacity decision should be logical, rational and reasonable. It should be a decision that is more likely than not to be correct. In many cases the insurer will already have all the information they need to make a work capacity decision without the need to refer the worker for additional evaluations by third party service providers.

Example
A form worker who performed heavy lifting duties came from a non-English speaking background. The man was injured at the workplace and unable to continue working in his profession. In spite of the fact that he was only trained to be a form worker and had poor command of the English language, he managed to find alternative employment in a full-time job, doing lighter duties. When his workers' compensation case was settled in the Commission the court awarded him around $300 per week to cover his ongoing incapacity to work in a higher paid job. He has recently received a WCD stating that his entitlements will cease. 'And he's upset, he's angry. There's nothing irrational about his reaction.'
Source: Simic (2013)

The WIRO process of reviewing WCDs is still in its infancy, however some interesting anomalies have arisen. These are described in Table 7 below:

TABLE 7: ANOMALIES ARISING IN WIRO REVIEW OF WCDS

When the ***insurer denies liability***, but the denial of liability notice from the insurer (1998 Act, S.74) contains the word 'capacity' WIRO is treating these as WCDs. This treatment contradicts the 1987 Act S.43(2), which states that 'a decision to dispute liability for weekly payments of compensation' is not a work capacity decision.	The worker is ***disadvantaged*** because a denial of liability notice qualifies the worker for ILARS funding to hear the case in the Commission. When denial of liability for weekly payments becomes a WCD matter workers lose the right to have the merits of the case looked at by an independent authority. Furthermore, workers who receive a denial of liability notice for weekly benefits are not receiving benefits until the decision is overturned (if that happens).
WIRO review of a ***WCD*** is treated as being ***derived from a WCA***. This contradicts the 1987 Act S.44A(3), but it is possible to apply the Act this way because the WCD is expressed as being a decision arising from the WCA in Schedule 6, Division 2 (19(1)) of the 1987 Act and Schedule 8, Clause 22(1), 22(2) and 23 of the Workers Compensation Regulation 2010. These clauses pertain to transitional arrangements only, but the WIRO decisions are exploiting themto the full extent to hold insurers accountable through procedural reviews.	Workers ***benefit*** from this treatment of WCDs because insurers are held accountable for making WCDs on the basis of a range of assessments. Once all workers who were injured prior to 1 Oct 2012 have been transitioned, then insurers will have more power to make WCDs on the basis of whatever information they choose.
Sources: Garling (2013a); Hayward (2013); Simic (2013).	

A further note is that the WCAs and WCDs were only newly introduced when this report was being researched. For insurers to carry out WCAs and WCDs workers are required to attend various functional, vocational and medical assessments. Future reports, which are carried out once the WCAs and WCDs are better established, should investigate in more detail the processes involved in each of these assessments and how they are applied by insurers.

3.2 STEP DOWNS OF WEEKLY PAYMENTS

TABLE 8: CALCULATION OF WEEKLY PAYMENTS BEFORE AND AFTER LEGISLATIVE CHANGE

<table>
<tr><th></th><th>Before 2012 legislative amendments to Workers Compensation Act 1987 (NSW).</th><th>After 2012 Legislative amendments to Workers Compensation Act 1987 (NSW)</th></tr>
<tr><td>0-13 weeks</td><td>100% weekly wage
(maximum $1000.00 pw)</td><td>95% weekly wage (maximum $1868.50pw)
Subtract:
• Non-pecuniary benefits (NPB); and
• Potential earnings; and
• Current earnings (CE) (if work capacity exists)</td></tr>
<tr><td>14-26 weeks</td><td>100% weekly wage
(maximum $1868.50pw)</td><td rowspan="2">Total incapacity
• 80% of weekly wage; but
• 95%, if working 15+ hours pw,
(less NPB, CE and potential earnings)
Partial work capacity
- 80% weekly wages IF working <15hrs pw
- 95% weekly wage IF working 15+hrs pw
Subtract NPB, CE and potential earnings in both cases.
Maximum weekly benefit remains $1868.50</td></tr>
<tr><td>26 weeks - 2.5 years</td><td rowspan="3">Permanent impairment (26+ weeks):
90% weekly wage (max $1868.50pw)
Partial incapacity (26-52 weeks only):
80% weekly wage (max $1868.50pw)
Less actual earnings</td></tr>
<tr><td>2.5 years - 5 years</td><td>Total incapacity - 80% of weekly wage
(Subtract NPB & CE)
Partial work capacity
- 80% of weekly wages IF working 15+hrs pw, earning $168+ and unable to undertake additional employment (subtract NPB and CE); else $0
Maximum weekly benefit remains $1868.50</td></tr>
<tr><td>5years +</td><td>No work capacity - 80% of weekly wage
(Subtract NPB & CE)
Partial work capacity
- 80% of weekly wages IF working 15+hrs pw, earning $168+ and unable to undertake additional employment AND worker has 21+% permanent whole person impairment (WPI)
(subtract NPB and CE).
Maximum weekly benefit remains $1868.50</td></tr>
<tr><td>Average weekly wage</td><td>See next page</td><td>See next page</td></tr>
</table>

	Before 2012 legislative amendments to Workers Compensation Act 1987 (NSW).	After 2012 Legislative amendments to Workers Compensation Act 1987 (NSW)
Average weekly wage calculation	Current weekly benefit rate is: - For workers paid under an award, industrial or enterprise agreement: 100% of the rate of remuneration for one week of work (*excluding* overtime, shift work, payments for special expenses and penalty rates), or - For workers not employed under an award or agreement: 80% of average weekly earnings (*including* regular overtime and allowances). - For casual employees: their average weekly earnings are averaged out over the period of their employment. If a casual employee works more than one job they are entitled to be paid the average weekly rate of all those jobs. If a worker has partially returned to work, the workers' current weekly earnings are deducted from their entitlements.	Weekly benefit: - (Pre-injury average weekly earnings *including* any overtime or shift penalties x 95% or 80%) - Less: non-pecuniary benefits (NPB) eg. use of motor vehicle provided by employer - Less: where a worker is assessed to have work capacity, the amount of current earnings (CE); calculated as the workers' current weekly earnings, or the amount the worker is able to earn in suitable employment, whichever is greater. Note: after one year, overtime and shift allowance are excluded from pre-injury average weekly earnings.
Source: **Before** 2012 changes: *Workers Compensation Act 1987 No 70 (NSW)*: historical version 20 January 2012 to 26 June 2012; **After** 2012 change: *Workers Compensation Act 1987 No 70 (NSW)* - current version 5 July 2013.		

In the decade preceding the 2012 legislated changes, various recommendations had been made for changing weekly benefits for injured workers in NSW.

TABLE 9: RECOMMENDED CHANGES TO WEEKLY BENEFITS

Recommended change	Whether the recommendation was met.	
Cease payments for less seriously injured workers after five years, for workers with intermediate levels of injury cease payments after nine years and leave payments indefinitely for the most seriously injured workers.	Weekly benefits cease after five years for injured workers with less than 31% WPI. The number of injured workers with greater than 30% is insignificant. Most workers with 21-30% WPI are also ineligible for weekly payments unless they are working at least 15 hours per week.	✗
'Payment of employer superannuation contributions should continue while a worker is in receipt of weekly benefits.' (Industry Commission Australia, 1994: XLIV).	This change has not been included in the 2012 legislation and superannuation ceases when a worker is in receipt of workers' compensation benefits.	✗
Increase the statutory rate.	The statutory rate has been increased	✓
Sources: Industry Commission Australia (1994); Grellman (1997); Lozusic (1999); Joint Select Committee on the NSW Workers Compensation Scheme (2012); Roth and Blayden (2012).		

The only way in which the 2012 changes follow these recommendations has been to increase the statutory rate from $439.50 per week after workers have been injured more than 26 weeks, to $1,868.50 per week. The changes in statutory rates and a transitional statutory rate of $920.90 are described below in Table 10.

TABLE 10: STATUTORY RATE FOR MAXIMUM WEEKLY BENEFITS PAYABLE

	Before 2012 legislated changes	**After 2012 legislated changes**	**Implications of 2012 amendments**
For first period of partial or total incapacity	First 26 weeks: Maximum = $1,868.50 (indexed) (S.34) (to 31 March 2013)	Maximum = $1,868.50 (indexed) (S.34) (to 31 March 2013)	No change.
After 26 weeks	Maximum =$439.50 per week + additional amounts per week for dependent spouse and children up to $1,000 maximum. (indexed)(S.37(1)(a)(i)) (to 31 March 2013)	Maximum = $1,868.50 (indexed) (S.34) (to 31 March 2013)	Maximum possible rate of weekly pay is substantially higher.
Transitional rate for workers injured prior to 1 October 2012 and receiving payments under the new system	N/A	$920.90 (1 October 2012 to 31 March 2013) (Note that most workers receive 80% of this rate.)	Workers on transitional rate are substantially disadvantaged by comparison with those who become entitled to weekly benefits after 1 October 2012.
Source: **Before** 2012 changes: *Workers Compensation Act 1987 No 70 (NSW)*: historical version 20 January 2012 to 26 June 2012; **After** 2012 change: *Workers Compensation Act 1987 No 70 (NSW)* - current version 5 July 2013; *WorkCover Workers Compensation Benefits Guide*, October 2012.			

This increase in the long term statutory rate potentially improves weekly income support for seriously injured workers (>30 per cent WPI) from $432 per week to $736 per week, effective from the 17 September 2012 (Pearce, 2012a). Insurers have not necessarily been passing on this increase in weekly support, with one seriously injured worker's carer campaigning WorkCover and the insurer for 12 months until this increase in benefits was passed on, and the back-payments were also paid (Grumley, 2013). Moreover this potential boost to weekly payments impacts such a small number of injured workers that the impacts are negligible.

> *To get to 20 per cent permanent impairment that's a very very high level that many seriously injured workers don't reach – e.g. someone who has lost their eye.* (Simic, 2013)

It is also possible that weekly benefits for injured workers could decrease as a result of the changes, because weekly entitlements prior to the changes included provisions for dependants. Prior to the

changes there were a number of injured workers with dependents who were receiving compensation payments up to the maximum of $1,000 per week. WorkCover staff were informed in their training that seriously injured workers could not be disadvantaged by this change, meaning that if a worker was receiving $1,000 per week their benefits could not be reduced. However there is no regulation of this in the legislation, with the closest approximation being:

> *For the purposes of the application under this clause of the weekly payments amendments to a seriously injured worker, the worker's pre-injury average weekly earnings are deemed to be equal to the transitional amount.* (1987 Act, Schedule 6, 19H S.10(2))

An additional problem is that the new system of calculating weekly benefits is,

> *A lot harder for workers to understand, so it's a lot easier for employers to take advantage of that... In the beginning the worker needs to have more input into what their pre-injury earnings were, not the appeal system... it's confusing, it's stressful and it makes things worse than they need to be.* (Hayward, 2013)

The new system of step-downs in payments coupled with new assessments of WPI is being used to terminate payments for long-term injured workers who are unable to work the required 15 hours per week. This matter has begun to have dire consequences for injured workers, as demonstrated in NSW parliament by Paul Lynch, MP for Liverpool. Mr Lynch presented three cases of long-term injured workers who sustained injuries while working in construction. The first injured worker, Mr Goran Josipovic is an experienced bricklayer and gyprocker who sustained 25 per cent whole of person impairment when scaffolding fell on top of him. He is unable to walk unaided, has no qualifications, other than as a bricklayer and gyprocker, and has been unable to find alternative employment. Mr Josipovic's lawyer is quoted, 'I know of no employer that would be prepared to employ an injured worker such as Mr Josipovic. In fact, employing him would present a risk to any employer.' Mr Josipovic has been denied ongoing weekly entitlements on the basis that he is required to work 15 hours or more per week (Legislative Assembly Hansard 20 June, 2013: 21857).

The second injured worker, Mr Joseph Archibald, was granted ongoing weekly payments (and medical entitlements) in the Workers Compensation Commission, as a result of knee injuries sustained while working as a scaffolder. His payments have also been terminated because he is not working 15 hours or more per week because, 'His capacity to work cannot be realised in the real world and it is fanciful and offensive to assert to the contrary.' Mr Archibald's incapacity to work is exacerbated by the insurer indefinitely delaying has required knee surgery (Legislative Assembly Hansard, 15 August 2013: 22314-22315). The third injured worker, Mr Clifford Franciscus, also sustained an injury while working in construction. He was granted ongoing entitlements in the Commission, but has had these entitlements removed as a result of the 2012 amendments to the legislation. Mr Franciscus has continued to seek employment, but has been unsuccessful. Without his workers' compensation payments, 'Mr Franciscus will struggle to feed his family and keep a roof over his head. He will struggle to survive. That is the direct result of the recent legislation. It is the legislation that has terminated the payments' (Legislative Assembly Hansard, 15 August 2013: 22314-22315).

Adam Grumley from the Injured Workers' Support Network is receiving increasing numbers of calls from injured workers asking for financial assistance, such as food vouchers or assistance with paying their utility bills as the weekly payments are reduced.

Example
Garry Naulty, a father-of-two from Blacktown in Sydney, injured his back when working as a storeman for Coles on the 17 August, 2009. Mr Naulty suffered a prolapsed disc at work and was initially awarded $10,000 in compensation and ongoing top-up payments. The top-up payments ensured he maintained his pre-injury income as he continued working for Coles on light duties for another year. Mr Naulty was then unemployed for 12 months before finding employment as a delivery driver, earning $600 per week, less than he was earning before the injury. Under the previous legislation, Mr Naulty was entitled to $300 per week top-up payments to augment his income from delivery driving. Since the 4 June 2013 Mr Naulty has only received $97 per week in top-up payments. In an article by Barclay Crawford for the Sunday Telegraph, Mr Naulty stated that his family's life has been turned ``upside down''. He described the reduction in payments as a ``nasty kick in the guts'' for him and partner Belinda and two daughters. ``We're just an average Aussie family trying to make a go of it,'' he said. ``Does Mr O'Farrell actually know how expensive it is?''
Source: Barclay Crawford, *Sunday Telegraph* 17 March 2013: 18

3.3 WEEKLY ENTITLEMENTS AFTER RETIREMENT AGE[17]

This change to the legislation is inequitable for older workers. It means that one worker can be injured one day before their 65th birthday and receive only one day of weekly payments and 12 months plus one day of medical entitlements, which would cease on their 66th birthday. If that same worker is injured one day later, on their 65th birthday, they are entitled to 12 months weekly payments plus a total of two years of medical entitlements, which would cease on their 67th birthday.

[17] Retirement age means the age at which the person, subject to qualifying requirements, would be eligible to receive an age pension under the Social Security Act 1991 (Cth): s 52(1) Workers Compensation Act 1987 (NSW)

TABLE 11: LEGISLATIVE CHANGES TO WEEKLY PAYMENTS AFTER REACHING RETIREMENT AGE

Before 2012 legislated changes	After 2012 legislated changes	Implications of 2012 amendments to S.52
S.52 (2) (a) For injuries received before retirement age - weekly benefits entitlements may continue up to 12 months after retirement age. (b) For injuries received on or after retirement age - weekly benefit entitlements may continue up to 12 months after period of incapacity first commences resulting from injury.	**S.52 (2)** (a) For injuries received before retirement age - weekly benefit entitlements may continue until retirement age (currently 65 years). (b) For injuries received on or after retirement age - weekly benefit entitlement may continue up to 12 months after period of incapacity first commences resulting from injury.	For injuries received before retirement age - the weekly benefit automatically discontinues at retirement age (currently 65 years). For injuries received on or after retirement age - there is no change. Benefits discontinue 12 months after the incapacitating circumstance.
Source: Before 2012 legislated changes: *Workers Compensation Act 1987 No 70 (NSW):* historical version 20 January 2012 to 26 June 2012; After 2012 legislative change: *Workers Compensation Act 1987 No 70 (NSW)* - current version 5 July 2013.		

Example
John Clarke, a grandfather from Narrabeen in Sydney injured his right knee when a set of stairs collapsed underneath him while he was working full-time in logistics on the 3 March, 2013. Mr Clarke has claimed workers' compensation for the physiotherapy and surgery he received in the months following the injury. However, Mr Clarke turned 65 years old on 21 April, 2013, so was ineligible to receive workers' compensation for wages for the 10 days needed for knee surgery in June 2013 and was forced to use his sick leave. Mr Clarke continues to work, but will require knee replacement surgery in three to five years time: he will be unable to claim compensation for this because it will occur more than 12 months after the date of injury.
Source: Andrew Priestly, *Manly Daily* 29 August, 2013: 8

4. MEDICAL ENTITLEMENTS

Summary

A major change in the legislation is that compensation for medical treatments are terminated 12 months after the termination of the weekly entitlement period, or after the injury occurred if there was no weekly compensation entitlement. For workers who were injured prior to 1 October 2012, this change will take effect from the 31 December 2013. Therefore the impacts of this change have not yet been felt by most workers. Early indications are that workers requiring medication or medical equipment, such as opioids, hearing aids or prosthetic limbs, will struggle financially to purchase this equipment. Workers who require ongoing treatments, such as physiotherapy, to keep themselves fit for work will need to fund these treatments themselves or risk becoming unfit for work. Workers who require operations, such as knee reconstructions, are experiencing difficulties in having these operations approved by the insurer before their entitlement period ceases.

The second change to workers' compensation legislation is the requirement for workers' to obtain pre-approval for medical treatments before attending appointments or surgery. This requirement enables insurers to undermine medical recommendations and common sense as they can delay approval and therefore compensation for treatments indefinitely.

This section on medical expenses will examine the impacts of the two significant changes as follows:

4.1 Termination of medical entitlements

4.2 Treatments to be pre-approved by the insurer

TABLE 12: WORKERS' ENTITLEMENTS FOR PAYMENT OF MEDICAL AND RELATED EXPENSES.

Before 2012 legislated changes	After 2012 legislated changes	Implications of 2012 amendments to workers' entitlements to payments of medical and related expenses.
S.60 (1) The employer is liable to pay costs of treatment, services and related travel costs that are reasonably necessary. **S.60 AA** The employer is liable to pay the costs of domestic assistance subject to a range of conditions. **Maximum amounts an employer is liable** in relation to injured worker: S.61 for medical or related treatment of injured worker is $50,000 (or as amended); S.62 for hospital treatment is $50,000 (or as amended); S.63 for ambulance service is $10,0000 (or as amended); S.63 A for workplace rehabilitation are as fixed by the Authority.	**S.60 (1)** The employer is liable to pay costs of treatment, services and travel costs that are reasonably necessary. **S.60 (3)** The employer is not liable to pay the costs of treatment, services or related travel costs *unless the insurer has given prior approval*. However, the worker's employer is liable to pay for treatment provided within the first 48 hours of the injury happening, without insurer's approval. **S.60 AA** no change **S.59 A** (1) Compensation is not payable to an injured worker for treatment, services and assistance more than 12 months after claim for compensation in respect of the injury was first made, unless weekly payments have been paid or payable to worker. (2) If worker has been entitled to or paid weekly payments, compensation for treatment, services or assistance must terminate at 12 months after the worker ceased to be entitled to weekly payments if not ceased before. (3)If worker again becomes entitled to weekly payments they are also entitled to compensation for treatment, service or assistance during the period in which weekly payments apply. **Maximum amounts an employer is liable** in relation to injured worker: S.61-63 A no change.	Some provisions have not changed, including the *basic liability* of employers to pay costs of treatment, services and travel and domestic assistance, and the *maximum amounts* for which an employer is liable for each category of costs. The maximum amounts have always been and continue to be extended without resistance when workers require further treatment or services. The key changes are: 1. **An employer's liability for costs is now contingent on the insurer giving prior approval** for any costs (after the first 48 hours of injury happening) **S.60 (3).** If workers do not want to be out-of-pocket they must gain approval within a 2 day window of suffering an injury. [According to Dave Henry (AMWU), the intention of this amendment was to stop workers from being able to proceed with treatment they needed, then recover the costs later through the WCC]. 2. The ***insertion of the 12 month limit on cost payments*** – **S.59A** terminates employer liability to pay costs 12 months after first claim made, or 12 months after entitlement to weekly benefits ceases. Furthermore, if an injury is re-inflamed or exacerbated after the 12 month period has expired, or a new injury occurs, the worker is only entitled to medical payments while receiving weekly payments. The 12 month period for medical entitlements cannot be restarted NB. Section 59A came into effect on 31 December 2012, so all medical benefits for workers will be terminated on 31 December 2013 unless they remain entitled to weekly benefits. Therefore the impact of this amendment has not yet been felt by injured workers.
Source: Before 2012 legislated changes: *Workers Compensation Act 1987 No 70 (NSW):* historical version 20 January 2012 to 26 June 2012; After 2012 legislative change: *Workers Compensation Act 1987 No 70 (NSW)* - current version 5 July 2013.		

4.1 TERMINATION OF MEDICAL SUPPORT AFTER 12 MONTHS

The 2012 legislation amendment mandates the termination of medical entitlements 12 months after an injured worker is no longer entitled to weekly entitlements, or 12 months after the injury date if a worker did not receive weekly benefits. Long-term injured workers who are transitioning to the new workers' compensation system have been informed that their medical entitlements will terminate at the 31 of December, 2013. Workers who were injured before they turned 65 years old have their medical entitlements terminated when they reach 66 years of age – for some this is before the 31 December 2013. This change to the scheme conflicts with the recommendations of the Industry Commission:

> *The Commission's view is that all medical and related expenses (such as the costs of necessary rehabilitation programs) incurred by those suffering a work related injury or illness should be met under workers' compensation arrangements. If this is not the case, the extent of transfers to Medicare should be estimated and mechanisms explored to pass the costs back.* (Industry Commission Australia, 1994: XXXVII)

By opting to terminate medial entitlements after 12 months the cost of medical treatments, services, medications and aids will be borne by the Medicare system and the workers themselves. This change to the legislation was made in the absence of any evidence that medical treatments for injured workers cease 12 months after weekly entitlements cease. There is, however, ample evidence to the contrary – that medical expenses continue for many years after a workplace injury is suffered. In a British Columbia (Canada) study of claims to the Workers' Compensation Board (WCB), 2 million claims made by 800,000 claimants over 11 years were matched to the British Columbia Linked Health Database to understand the requirements for workers' compensation claimants to visit general practitioners (GPs). This study found that workers' compensation claimants were more likely to be frequent users of GPs. More importantly for this research, this study found that once an injured worker had made a workers' compensation claim they permanently increased their requirements for GP services (Hertzman, McGrail and Hirtle, 1999: 589) This finding was consistent for those who had suffered a first time injury or multiple injuries – that they were more likely to require medical services of a GP in subsequent years than people who had not suffered workplace injuries.

Hertzman *et al.* (1999) also drew on data from the Workers' Compensation Board and British Columbia Linked Health Database for 117,147 workers who lodged claims for workplace injuries in 1991 in British Columbia, Canada. This data demonstrates that medical payments (for physicians, clinics and hospitals and alternative providers) per injured worker continue well beyond the first 12 months after the date of injury. A summary of this data is provided below:

TABLE 13: MEDICAL CLAIMS AFTER WORKER IS INJURED

	Average number of medical claims per injured worker	Amount of medical claims per injured worker
1991 (year of workers' compensation claim for injury)	3.2	$147.55
1992	7.4	$592.25
1993	8.6	$531.52
1994	7.7	$443.61
1995	7.6	$707.84
1996	6.9	$702.63
Source: Hertzman, McGrail and Hirtle (1999: 592)		

Hertzman *et al.* (1999: 594) also demonstrate that the workers injured in the base year, 1991, were approximately twice as likely to require hospital services in each of the five years after the injury was claimed than their non-injured counterparts, who were matched by age and sex. Similarly injured workers' expenditure on physician services remained at least three times higher in each of the five years after injury claim than their non-injured counterparts.

These findings from Hertzman *et al.* (1999) highlight the inappropriateness of ceasing medical payments for workers' compensation claimants from 12 months after the injury date, or after entitlement to payments cease (whichever is the latter). Requirements for medical treatment for workplace injuries continue well beyond the arbitrary time limit imposed by the 2012 workers' compensation amendments.

An additional problem for injured workers is that the 2012 legislation applies retrospectively. Even where workers have been granted ongoing medical entitlements in a Workers Compensation Commission decision, this legislation renders those decisions null and void. For instance, many workers have suffered industrial deafness and been granted periodic replacement of hearing aids for the remainder of their lives. The 2012 legislation change to medical entitlements terminates those entitlements. This is confusing and upsetting for workers who have a written commitment from the insurer, or from the Workers Compensation Commission, stating that particular medical expenses will be compensated.

> *I had a 67 year old guy ring me, crying, because he can't afford to buy a new hearing aid.* (Hayward, 2013)

There are three particular areas where the withdrawal of medical entitlements will be problematic:

- → On-going physiotherapy treatments;
- → On-going opioid medication for pain relief; and
- → Requirement for new or replacement equipment such as hearing aids (Garling, 2013a).

There is no mechanism for appealing the termination of medical entitlements – under the new system the decision to terminate is final.

With medical entitlements ceasing after 12 months workers are forced to use their own funds or private health insurance, if they have it. In response, private health insurers have begun to refuse payment on medical treatment for work-related injuries, despite the workers' compensation scheme failing to cover the worker's claim (Dawson, 2013).

Example
Bill is a 70 year old retired aircraft engineer who worked for 40 years. He suffers from tinnitus, an incurable and constant high-pitched ringing sound in his ears, as a consequence of his work in the aviation industry. Previously Bill was entitled to receive replacement hearing aids under a workplace injury claim settled in 1997. The settlement included compensation for replacement hearing aids every four years and hearing aid maintenance. However, in the 16 years since the injury claim was settled Bill has only replaced his hearing aid once, in 2008. Nonetheless, he is required to pay $6,000 for his second replacement hearing aid under the new workers' compensation legislation. Bill views his settlement in the Workers Compensation Commission as a contract and was shocked when the contract was terminated by the government legislation.
Source: Hypothetical example based on a similar article in *The Port Stephens Examiner* 18 July 2013.

4.2 MEDICAL TREATMENTS TO BE PRE-APPROVED BY THE INSURER

The 2012 amendments require that prior approval be granted by the insurer for all medical treatments unless the medical treatment occurs within 48 hours of the injury or is exempted under the WorkCover Guidelines (1987 Act Section 60[2]). The insurers always had the power to delay treatment, which in turn would delay a workers' recovery, which would often exacerbate the injury and reduce the chances of a durable return to work outcome (cf. Henry, 2013; Hayward, 2013; and case studies 1, 2 and 3 in Chapter 9). This change to the legislation strengthens that power held by the insurers. When combined with the 12 month limit on payment of compensation for medical and related expenses (1987 Act, S.59A), there is tremendous power for insurers to avoid paying medical expenses at all by delaying pre-approval until the 12 months has expired. Workers requiring new hearing aids every few years have been notified these will stop being provided for under workers' compensation. Many have attempted to have their hearing aid updated before their entitlements end on the 31 December 2013, but the insurers are ignoring their requests because after the 31 December they will no longer be liable. Similarly for major operations, such as knee reconstructions or spinal blocks, insurers are usually delaying approval until it will be too late.

Some workers are getting caught out by this change to the legislation. For instance, a worker who has suffered a musculoskeletal injury, which has come on gradually as they use their back, knee, shoulder or wrist repetitively over time, will often visit their local physician independently for an initial assessment. They may be advised at this initial appointment that their injury is a workplace injury and will require further treatment. The worker will then declare the injury to their employer

and seek workers' compensation for treatments. Insurers are denying compensation for the initial consultation or ongoing treatments on the grounds that the worker did not seek pre-approval (Simic, 2013).

This new legislation is also impacting adversely on injured workers who require ongoing treatment to maintain a level of fitness they need to keep working. For instance, there are nurses with back injuries who are unable to gain preapproval from the insurer for treatments, such as physiotherapy, they require to keep working or to return to work sooner. The Workers' Compensation Commission has intervened in some instances and made orders for the insurer to pay for medical treatments (Dawson, 2013; Gersbach, 2013).

Insurers have long had the strategy of delaying approval for treatments, and particularly for major operations, in the hope that injured workers would give up. Prior to the legislation changes workers could choose between waiting 6-9 months to have the case heard in the WCC, while their condition deteriorated, or they could complete the operation or treatment themselves, then seek to recover the costs later through the WCC. The legislation change brings into question whether the WCC can still decide that insurers must reimburse a worker for a treatment or operation that was not pre-approved. The WCC made a decision recently that medical expenses in this scenario could be reimbursed, however, WorkCover is appealing that decision (see *Barsoum v S. O. And H. Boyagi t/as All Sales Plastics, matter no. 10052/12* based on the WorkCover Guidelines S.3.2.1.1). Therefore workers must await the outcome of that case to better understand their chances of attaining compensation for treatments or operations when insurers delay approval (Brennan, 2013).

Legal tip
There is potential for workers to circumvent the legislated requirement for pre-approval by applying the 1998 Act (S.41A), which states that the Chapter 3: Workplace Injury Management requirements 'apply even when there is a dispute as to liability'. These requirements include seeking 'to achieve optimum results in terms of the timely, safe and durable return to work for workers (1998 Act S.41) and establishing and maintaining an injury management program (1998 Act S.43), which includes 'the treatment, rehabilitation and retraining of an injured worker (1998 Act S.42). Until recently the AMWU had only been using this section of the 1998 Act to pressure insurers to provide an injury management plan (WorkCover never enforced this requirement). The AMWU has now successfully applied this chapter of the 1998 Act to the case of an injured worker where the insurer was denying liability for rehabilitation services, but reversed their decision on the basis of this chapter of the legislation.
Source: Henry, 2013.

5. JOURNEY CLAIMS

Summary
Workers injured while journeying to or from work are no longer eligible to receive workers' compensation. This change in legislation shifts the costs of journey claims from the workers' compensation scheme to other sources of funding, including Medicare, Centrelink benefits and possibly the third party insurance scheme. The cost of journey claims to the NSW workers' compensation scheme were negligible (2.6 per cent of claims within the scheme) and journey claims did not impact on employer premiums. Therefore the impact of eliminating journey claims from the scheme unless there is a real and substantial connection between the journey and the work will have a minimal impact on the scheme or employers. By contrast, workers who are injured while journeying to or from work suffer a significant impact as the benefits from the workers' compensation scheme surpass benefits available from the other sources.

TABLE 14: JOURNEY CLAIMS PROVISIONS

Before 2012 legislative amendment	Before 2012 legislative amendment	Implications of 2012 amendments
S.10 Journey Claims (1) States that a personal injury received by a worker on any journey to which the section applies, arising out of or in the course of employment, is compensable. (1A, B & D) exclude personal injuries according to attribution. (2) Excludes personal injuries received during or after interruptions or deviations in certain circumstances. (3) Lists the journeys to which the section applies – essentially to and from the worker's place of abode and place of employment.	**S.10 Journey Claims** The original S.10 provisions remain intact. The only change is the insertion of S.3A which limits the effect of S.3, and states: **(S.3A)** A journey referred to in subsection (3) to or from the worker's place of abode is a journey to which this section applies only if there is a real and substantial connection between the employment and the accident or incident out of which the personal injury arose.	• **S.3A** introduces the limiting requirement that there must be a 'real and substantial connection between the employment and the accident or incident…' for a journey claim under S.10(3) to succeed. • S.3A therefore applies to all journey claims to and from the worker's place of abode that are referred to in S.10(3). • The meaning of 'real and substantial connection' will be crucial. • South Australian law -*Workers Rehabilitation and Compensation Act* 1986 S.30(5)- may provide some guidance: Case law interpreting its provision that *'there is a real and substantial connection between the employment and the accident out of which the injury arises'.*
Source: **Before** 2012 legislated changes: *Workers Compensation Act 1987 No 70 (NSW):* historical version 20 January 2012 to 26 June 2012; **After** 2012 legislative change: *Workers Compensation Act 1987 No 70 (NSW)* - current version 5 July 2013.		

Access to claim compensation for injuries incurred during the journey to or from work has been restricted by the 2012 legislative changes on the basis that employers have limited capacity to

manage the risks of the journey (Industry Commission Australia, 1994: XXIX; Joint Select Committee on the NSW Workers Compensation Scheme, 2012: 52). Another justification for the change was that other Australian jurisdictions do not provide broad coverage for journey claims (Joint Select Committee on the NSW Workers Compensation Scheme, 2012: 52).

The restriction of compensation for injuries incurred while journeying to or from work constitutes a cost shift from the workers' compensation scheme to other sources of funding, such as third party insurance, Centrelink or Medicare. These other sources of funding are less likely to provide the same level of ongoing care as the workers' compensation system (Melbourne School of Population Health, 2011: 32-33).

This change was supported by employer and insurance groups even though journey claims only constituted 2.6 per cent of claims within the scheme, did not impact on premiums and half of the journey claims expenses in the scheme were recovered from compulsory third party (CTP) motor accidents insurers (Joint Select Committee on the NSW Workers Compensation Scheme, 2012: 53-54). The change makes little difference to the overall cost of the scheme. Thus, one submission to the Joint Select Committee noted:

> *The PWC report identifies that of the $4 billion alleged deficit only $70 million is made up of journey claims … Approximately $35 million is recovered against third party insurers [under the Motor Accidents Compensation Scheme].* (Australian Lawyers Alliance, 2012: 12)

The removal of journey claims disregards the fact that workers make the journey to work solely so they can do their work, otherwise they would not make that journey.

> *Work-related motor vehicle accidents are a leading cause of work injury, and account for approximately 31 percent of Australian work fatalities.* (Melbourne School of Population Health, 2011: 32)

This is a particular impost on workers who must travel long distances for work, such as miners or forestry workers. While NSW CTP insurance provides compensation for drivers who are not at fault, 'at fault' drivers risk being substantially penalised for making a journey they only make for the purpose of doing their job. In other jurisdictions without access to journey claims, there is broader protection under third party compulsory insurance to protect against the risk of being 'at fault' (Joint Select Committee on the NSW Workers Compensation Scheme, 2012: 55-56). Similarly, pedestrian or bicycle accidents are not covered by NSW CTP insurance, so removing the possibility for compensation under workers' compensation journey claims exposes workers walking or riding to work to risks they would not be exposed to if they did not do that work (Joint Select Committee on the NSW Workers Compensation Scheme, 2012: 56).

One legal practitioner stated that the journey claims amendment makes little difference to workers, as it was already very difficult to make a journey claim (Dawson, 2013). Nonetheless, workers have been unable to make claims that would have been accepted before the legislation changes. For instance, two nurses, in separate incidents, have tripped and fallen in the car parks of the work premises while walking from their parked cars to the hospital and both have had their workers' compensation claims declined (Gersbach, 2013).

Richard Brennan, Partner from McNally Jones Staff & Co. has found that at least 95 per cent of journey claims incidences are no longer liable for workers' compensation (Brennan, 2013). He has only had success in pursuing three journey claims. In two instances the journey had ended and the worker was at the workplace, yet the insurer had denied liability on the grounds that it was a journey claim. In the third instance the worker was required to travel directly between two employment locations while working for the same employer. Two of these cases were resolved before a court hearing was required and the third was resolved in the Workers Compensation Commission (Brennan, 2013).

Ivan Simic, Partner, from Taylor & Scott Lawyers has also found that most journey claim cases are now declined, including where a worker was told by his boss to drive from one work site to another and suffered an injury in transit (Simic, 2013).

Sherri Hayward, Industrial Officer with CFMEU revealed that from the CFMEU's perspective the change to journey claims is not having an impact on workers yet because these claims are so rare (Hayward, 2013). Two workers who have wanted to make journey claims since June 2012 were able to demonstrate a meaningful connection between the work and the accident, and thus successful in their applications for workers' compensation. A third worker had a car accident on the way to work, but as a CFMEU member he successfully made a claim for weekly benefits through the CFMEU journey claim insurance. Journey claim insurance is available through the CFMEU (underwritten by CoverForce) and the AWU (underwritten by Willis), but it is generally unusual for unions to offer this service. Overall the cost of journey claims for the NSW workers' compensation scheme is insignificant because there are so few claims made (albeit they are generally expensive claims). Nonetheless the termination of journey claims was an emotive issue, which motivated workers to get involved in the campaign to restore workers' compensation rights after the June 2012 changes.

6. OTHER CLAIMS

Summary

Workers' compensation claims for heart attacks and strokes have been effectively eliminated. The amended legislation requires that the employment gave rise to a significantly higher risk of the worker suffering heart attack or stroke. This legislation is untested in court as yet, but it is likely that other factors, such as genetic predisposition or lifestyle will preclude the worker (or their dependants) from receiving compensation. Nervous shock suffered by a seriously injured worker or their family is no longer compensable through NSW workers' compensation.

Claims for lump sum payments have also been restricted, claims for pain and suffering, for injuries causing less than 10 per cent WPI and multiple claims are now excluded. This includes claims for injuries that preceded the legislative changes (this could change depending on the outcome of Goudappel v ADCO).

The remaining types of workers' compensation claims that have been impacted by the 2012 legislative changes are considered in this chapter:

6.1 Claims for heart attacks, strokes and nervous shock

6.2 Lump sum payments

6.1 CLAIMS FOR HEART ATTACKS, STROKES AND NERVOUS SHOCK

TABLE 15: ENTITLEMENT TO COMPENSATION FOR HEART ATTACKS, STROKES AND NERVOUS SHOCK

Before 2012 Legislated Changes	After 2012 Legislated Changes	Implications of 2012 amendments
S.151P No damages are to be awarded for psychological or psychiatric injury except in favour of (a) the injured worker or (b) a parent, spouse, brother, sister or child or the person who, as a consequence of the injury or death of their relative, has suffered a demonstrable psychological or psychiatric illness and not merely a normal emotional or cultural grief reaction.	**S.151AD** (1) No damages for pure mental harm may be awarded against an employer in respect of the death of or injury to a worker if the pure mental harm arises wholly or partly from mental or nervous shock in connection with the death of or injury to the worker unless the pure mental harm is a work injury (that is, an injury to the worker or to another worker). **S.9B** No compensation is payable for injury that consists of, is caused by, results in or is associated with heart attack or stroke unless *the nature of the employment gave rise to a significantly greater risk* of the work suffering the injury than had the work not been employed in employment of that nature.	**S.151AD means that:** 1. A worker cannot make a claim for damages for nervous shock when the nervous shock is not actually a work injury, Thus nervous shock suffered as *a reaction to* a work injury is *not* covered. 2. Relatives of an injured or deceased worker cannot make a claim for compensation for nervous shock because their injuries are not work injuries. **The insertion of S.9B means that**: the Act now excludes compensation for heart attack or stroke or any injury associated with these conditions - unless a worker can show the work itself gave rise to a significantly greater risk of such an injury.
Source: **Before** 2012 legislated changes: *Workers Compensation Act 1987 No 70 (NSW)*: historical version 20 January 2012 to 26 June 2012; **After** 2012 legislative change: *Workers Compensation Act 1987 No 70 (NSW)* - current version 5 July 2013; *Workers Compensation Legislation Amendment Act 2012 No 53 (NSW).*		

The changes to workers' compensation legislation in 2012 have resulted in injured workers and their families no longer being able to make claims for compensation if workers suffer heart attacks, strokes, traumatic accidents or death at the workplace.

> *The bottom line is that the legislation has effectively excluded all those sorts of cases… That just seems to me to be an injustice.* (Brennan, 2013)

For heart attack claims, this means:

> *You'll find that many cardiologists will say, 'Being involved in that very heavy lifting process was a substantial contributing cause of the heart attack on the day.' But under the new law that's not going to be enough, because if that person has some sort of small, if you like, genetic defect or some other contributing cause of the heart attack, which usually does happen, it's a complicated thing medically, they will be excluded from making a claim. Unless I can show that particular lifting incident was virtually the sole and exclusive medical reason for the heart attack occurring, there's no compensation there, which I think is very unfair because maybe that wouldn't have happened if it weren't for the fact they were lifting that 100kg beam.* (Simic, 2013)

For nervous shock claims this means that:

> *With the nervous shock legislation, basically we can't make those claims anymore for members of the family who have suffered injury as a result of the death of a loved one on site.* (Simic, 2013)

6.2 LUMP SUM PAYMENTS

TABLE 16: COMPENSATION FOR NON-ECONOMIC LOSS AND LUMP SUM BENEFITS

Before 2012 legislated changes	After 2012 legislated changes	Implications of 2012 amendments
S.66(1) entitles a worker to compensation for an injury that results in permanent impairment. **S.66(2)** provides for the calculation of the amount of compensation for every degree of permanent impairment from less than 10% to greater than 75%. **S.65A(3)** excludes entitlement to compensation in respect of permanent impairment that results from a primary *psychologica*l injury unless the degree of permanent impairment is *at least 15%* and it is a primary psychological injury not a secondary one. S.67 provides for compensation for *pain and suffering* up to $50,000 where caused by permanent impairment over 10%.	**S.66(1)** entitles a worker to compensation for an injury that results in greater than 10% permanent impairment. **S.66(2)** provides for the calculation of the amount of compensation for every degree of permanent impairment from 10% to greater than 75% **S.66(1A)** only one claim can be made for permanent impairment compensation resulting from an injury. **S.65A(3)** the same exclusion applies as previously to permanent impairment related to primary psychological injury.	**Key changes include**: No compensation is now available where worker suffers ***less than 10%*** permanent impairment. Workers are not entitled to compensation for ***pain and suffering*** caused by permanent impairment. Injured workers cannot now make more than ***one claim*** for a lump sum payment in relation to a particular injury.
Source: **Before** 2012 legislated changes: *Workers Compensation Act 1987 No 70 (NSW)*: historical version 20 January 2012 to 26 June 2012; **After** 2012 legislative change: *Workers Compensation Act 1987 No 70 (NSW)* - current version 5 July 2013.		

The permanent impairment benefits payable remain unchanged. The maximum payment for whole of person impairment has been $231,000 since 1 January 2007 and for pain and suffering has been $50,000 since 1 January 2002 (1987 Act S.66). The difference is that fewer injured workers are eligible for these lump sum benefits.

> *The 10 per cent limitation limits most people from making claims.* (Hayward, 2013)

For instance, injured workers who have suffered industrial deafness are now highly unlikely to be able to apply for lump sum payments. To reach a 10 per cent WPI assessment, they must have suffered at least 25 per cent binaural hearing loss – which is extremely unusual (Hayward, 2013). Psychological claims are also extremely unlikely to be granted lump sum payments (Hayward, 2013).

The restriction to one claim only has also impacted many workers who have suffered a deterioration in their condition (Hayward, 2013). An additional impact on workers is that the Workers' Compensation Commission has a back log in hearing claims for at least six months. This delay compounds stress for the workers who suffer from the ambiguity of not knowing what will happen (Hayward, 2013). This problem is exacerbated as workers (and their legal representatives) await the outcome of *Goudappel v ADCO* in the High Court.

Goudappel v ADCO
Goudappel v ADCO has arisen because the 2012 amendments removed the option to apply for lump sum payments (up to $50,000) for pain and suffering and lump sum claims for permanent impairment of 10 per cent or less, arising as a result of a workplace injury. The 2012 legislation was written to apply retrospectively to injuries that occurred before the 19 June 2012. Goudappel v ADCO was taken from the arbitrator level of the Workers Compensation Commission, to the Presidential level. The President ruled in favour of ADCO, that the legislation could be applied retrospectively. That decision was appealed to the Court of Appeals, which ruled in favour of the injured worker, Goudappel, that the legislation could not be applied retrospectively. On the 11 October, 2013, the High Court granted leave to WorkCover to appeal the Court of Appeal decision to the High Court. In the meantime, the WIRO is granting ILARS applications for funding lump sum claims for impairment of 10 per cent or less and lump sum claims for pain and suffering if the injury was sustained before the 19 June 2012. This case will be heard in the High Court some time in 2014. If the High Court finds in favour of Goudappel, then there is a chance the government could change the legislation again to remove the ambiguity that presently exists and override the precedent set by Goudappel.
Sources: Brennan (2013); Simic (2013)

7. RETURN TO WORK

Summary

The inquiries and discussions which lead to the 2012 amendments to the workers' compensation legislation emphasised timely return to work. Prioritising the timely and durable return to work outcomes of injured workers is underpinned by ample evidence that injured workers remain healthier and recover faster if they can return to a suitable working environment as quickly as possible (where safe to do so).

However, the changes made in 2012 place significant obligations on workers without imposing reciprocal obligations on employers to provide suitable employment opportunities. For example, the legislation now requires injured workers to seek suitable employment with any employer according to their deemed work capacity, rather than (where possible) working steadily toward the rehabilitation required to return to their pre-injury work and employer. If the insurer determines the injured worker to be non-compliant with this requirement then entitlements can be suspended or terminated.

Given the differences between employee perceptions of fitness for (pre-injury) work and insurer perceptions of work capacity, as described in Chapter 3, the legislated changes present a potential career risk to workers whose injuries require considerable recovery time.

There are two changes designed to encourage employers to facilitate an injured worker's return to duty: tweaking premiums for small businesses and introducing a WorkCover return to work pilot program to compel employers to provide suitable duties. There is no evidence of these changes having an impact on return to work outcomes.

Evidence across multiple disciplines, including disability groups, employer groups, unions, insurers and clinical experience, demonstrates that injured workers benefit from being at work than being unemployed (Waddell and Burton, 2006: viii). In particular, returning to work has been shown to improve workers' physical and mental health and well-being, particularly if they can be re-employed within a six-month period (Industry Commission Australia, 1994: XLV; Waddell and Burton, 2006: ix; Rueda, Chambers, Wilson, Mustard, Rourke, Bayoumi, Raboud and Lavis, 2012: 541 & 554). The health benefits range from promoting healthy recovery and rehabilitation, reducing the risk of poverty and improving well-being and quality of life (Waddell and Burton, 2006: viii). The manner in which the employer and insurer manage return to work programmes can have a profound impact on the injured worker:

> *Psychosocial factors (personal and occupational) exert a powerful effect on musculoskeletal symptoms and their consequences. They can act as obstacles to work retention and return to work; control of such obstacles can have a beneficial influence on outcomes such as pain, disability and sick leave.* (Waddell and Burton, 2006: 25)

Psychosocial factors often come down to the post-injury relationship between the worker and their employer. In particular, superior return to work outcomes are observed where a worker feels valued and/or the employer perceives the employee to be genuinely attempting to get back to work

(Gebert, 2013). Research has also demonstrated the important role of transitional work arrangements (temporary modified, or suitable work) and communication between employers and health care providers in facilitating early and sustained return to work (Waddell and Burton, 2006: 26). In particular, effective communication between the insurer and the employer is critical because employers need an adequate knowledge and understanding of employment injuries if they are to effectively support injured workers' timely and durable return to work (Gebert, 2013; Goodsell, 2013).

Timely and durable return to work is not only critical for the injured worker but also for the workers' compensation scheme:

> *There's clear evidence that getting back to safe work in most cases is really important for the long-term recovery of a person from any workplace injury, both financially, psychologically and medically. Secondly, it minimises the cost of the claim to the scheme and to the employer.* (Goodsell, 2013)

Best practice workers' compensation arrangements therefore incorporate early intervention, and involve employers and employees maintaining a constructive relationship, while working together on a workplace-based rehabilitation plan (Industry Commission Australia, 1994: XXXI; Goodsell, 2013).

Summarising the government's return to work objectives, WorkCover reported,

> *Employers are obliged to facilitate injured workers return to work by finding suitable work where it is reasonably practical. Similarly a worker who is fit for work is required to make reasonable attempts to return to suitable employment when it is safe to do so.* (WorkCover NSW, 2013a: 14)

The following sections examine the extent to which legislated return to work obligations on injured workers and their employers promote the collaborative interventions that facilitate timely and sustained return to work. These sections include:

7.1 Obligations on injured workers

7.2 Obligations on employers

7.3 Barriers to return to work

7.1 OBLIGATIONS ON INJURED WORKERS

While the 1998 Act prioritised rehabilitation and timely return to work, the 2012 changes focused more directly on timely return to work (see Table 17).

TABLE 17: RETURN TO WORK PROVISIONS

Before 2012 legislative amendment	After 2012 legislative amendment	Implications of 2012 amendment
S.48 Injured worker's obligation to return to work An injured worker must make all reasonable efforts to return to work with his or her pre-injury employer (that is, the employer liable to pay compensation to the worker) as soon as possible, having regard to the nature of the injury.	**S.48 Return to work obligations of worker** S.48(1) A worker who has current work capacity must, in cooperation with the employer or insurer, make reasonable efforts to return to work, in suitable employment or pre-injury employment, at the worker's place of employment or at another place of employment.	**S.48 (1)** - Imposes more conditions in relation to workers' *obligations* to 'return to work'. - Expands workers' obligations by broadening the search for work from making reasonable efforts to return to work *with the pre-injury employer* to work in suitable employment at the worker's place of employment *or at another place of employment*. (i.e. with *any* employer) - Introduces a requirement *to cooperate* with the employer or insurer when making efforts to return to work. NB the insurer determines whether a worker has been *cooperative* – see S.48A(1) - Applies to a worker who has *current work capacity* – which may delay the workers' obligations under S.48 until a WCA has been conducted.
	S.48(2) includes three circumstances in which a worker is *to be treated as* making a reasonable effort to return to work in suitable employment or pre-injury employment. These include when waiting for: a required rehabilitation process to commence, or for an employer to respond to a request for work, or that work to actually commence.	- S.48 (2) provides for three circumstances in which a worker is exempted from the requirement actively to seek work - when the delay in is due to the employer or the rehabilitation service.
	S.48A Failure to comply with return to work obligations of worker: This section provides for the insurer to suspend and ultimately terminate compensation in the form of weekly payments, as well as cease and determine their entitlement to weekly benefits, if a worker fails to comply with an obligation imposed under S.48.	**S.48A** is newly inserted. Notably: - an insurer must comply with notice requirements when suspending weekly payments – suspension operates *at least* 14 days after notice is given; - up to 28 days suspension is permitted; - if the worker fails to comply for the entire 28 day suspension period, the insurer may terminate weekly benefits by giving written notice.
Source: **Before** 2012 legislated changes: *Workers Compensation Act 1987 No 70 (NSW):* historical version 20 January 2012 to 26 June 2012; **After** 2012 legislative change: *Workers Compensation Act 1987 No 70 (NSW)* - current version 5 July 2013; and Section 48 *Workplace Injury Management and Workers' Compensation Act 1998* as amended.		

As discussed in Chapters 1 and 3, critical changes in the 2012 legislation emphasised reducing the cost of the scheme by terminating weekly and medical entitlements for workers who did not meet their insurer's return to work expectations. The justification for reducing entitlements was couched in a framework of readying injured workers for a timely return to work by,

> *capping weekly payment duration to within a certain timeframe and thereafter ceasing payment of weekly benefits [which] would give workers a fixed timeframe during which they know they need to work toward a certain level of work readiness.* (Pearce, 2012b: 26)

The Joint Select Committee on the NSW Workers Compensation Scheme (2012: 59-61) cited a range of advocates of 'stepping-down' injured workers' weekly payments after 13 weeks, rather than 26 weeks post-injury. The strategy sought to encourage injured workers to return to work faster, however none of the advocates provided evidence of a connection between reducing financial benefits and return to work rates. Instead, they only offered opinions that reducing benefits will improve return to work rates. The Australian Lawyers Alliance countered these arguments,

> *The suggestion that ceasing payments will 'assist injured workers to move forward from their workplace injury to focus on their future employment prospects' is as offensive as it is misconceived. It is prefaced on the unsubstantiated assumption that injured workers do not want to return to work.* (Joint Select Committee on the NSW Workers Compensation Scheme, 2012: 75)

Indeed, a 2007 PriceWaterhouse Coopers report commissioned by the South Australian government found that 'most workers return to work as soon as their injuries have healed regardless of any issues of economic incentive articulated through the benefit system' (Purse, 2011: 56). There was scant evidence of correlation between reduced weekly payments and return to work rates. Instead there was evidence that injured workers are mostly likely to return to work because they have recovered from their injury, not because their compensation payments were reduced or terminated. Injured workers also echo this sentiment:

> *We don't want to be on compo or Centrelink... We want to be back at work.* (Injured worker, IWSN meeting 14-10-13)

Annual surveys conducted for the Heads of Workers' Compensation Authorities in Australia and New Zealand in 2011 and 2012 provided further evidence, asking injured workers, 'What is the main reason you returned to work?' and 'Is there any other reason you returned to work?' The responses (listed in Table 18) identified the primary reason why people returned to work was because they had recovered from their injury. Although the research demonstrated that economic issues can be a motivation for returning to work (17 to 18 per cent said it was their main reason for returning to work), it did not provide convincing evidence that reducing or terminating payments will encourage people to return to work, particularly where they do not feel it is safe to do so.

TABLE 18: REASONS FOR RETURNING TO WORK

	2010/11 Main reason returned to work (2,462 respondents)	2010/11 Other reasons for returning to work (2,574 respondents)	2011/12 Main reason returned to work (2,537 respondents)	2011/12 Other reasons for returning to work (2,537 respondents)
Recovered from injury	37%	43%	36%	42%
I wanted to return to work	18%	34%	19%	38%
Economic need/ Needed the money	17%	29%	18%	29%
Offered alternative duties	7%	11%	6%	9%
Was told by doctor/doctor's advice	6%	9%	8%	12%
Bored at home	4%	10%	3%	9%
Pressured from employer	4%	6%	3%	5%
Wanted to keep job	2%	4%	2%	4%
Benefits stopped/too low	1%	2%	1%	2%
Supportive employer	1%	1%	0%	1%
Offered part-time work	0%	1%	0%	1%
Part of RTW plan	0%	0%	0%	1%
Self-employed/run own business/ farm	0%	1%	0%	0%
Didn't like being on workers' compensation	0%	0%	0%	0%

Source: *Return to Work Monitor*, Campbell Research prepared for Heads of Workers Compensation Authorities, 2011: 27 and 2012: 28.

Terminating payments in isolation from rehabilitation efforts is argued to, at best, simply shift injured workers onto the social security system (Australian Rehabilitation Providers Association - NSW, 2012: 5). The NSW Workers' Compensation Scheme Issues Paper, which prompted changes to the legislation in 2012, also asserted that 'workers need to be supported by appropriate rehabilitation to make them as work ready as possible' (Roth and Blayden, 2012: 10; see also Pearce, 2012b: 25).

These claims are supported by Australian Rehabilitation Providers Association's (ARPA) extensive literature review of national and international rehabilitation and return to work material. Inadequate rehabilitation was identified as one of two important barriers to return to work. The research found,

> *Any change in benefits alone – without subsequent workplace rehabilitation services to ensure that nonmedical barriers to return to work are mitigated – will not impact positively on return to work outcomes... an injured worker's motivation to cooperate in*

> *return to work is not necessarily financial. Negative influences for return to work include poor workplace relationships, lack of respect for the employer, the worker's beliefs regarding their injury, the overzealous involvement of partners and advice from medical providers that sanction incapacity or dependence on treatment. These are known as bio-psycho-social factors. An injured worker who suffers from one of the above will be no more likely to return to work even if their benefits are reduced.* (Australian Rehabilitation Providers Association - NSW, 2012: 4)

Yet, Table 19 illustrates serious problems with the rehabilitation system for workers' compensation in NSW. Rehabilitation costs significantly more per worker and there are significantly less injured workers participating in rehabilitation in NSW than other jurisdictions across Australia. In 2011/12 only 29 per cent of injured workers in NSW participated in rehabilitation, compared to the national average of 45 per cent. Importantly, NSW workers also had significantly less involvement in building their return to work plan, were given less assistance with the return to work program and were less likely to have someone at their workplace assisting them with their return to work program than all other Australian and New Zealand jurisdictions.

Past injury data also suggests the earlier an injured worker is referred to a rehabilitation service provider, the better the return to work outcome.

> *'Cases referred within the first 12 months post-injury achieved a much higher return to work rate, and had a significantly shorter period of rehabilitation at a significantly lower cost, than those referred after 12 months'* (Australian Rehabilitation Providers Association - NSW, 2012: 3).

Yet, more seriously injured workers in NSW are more likely to be delayed in visiting a rehabilitation provider than in other jurisdictions. Recent data suggests injured workers in NSW took 31 months on average to be referred to a workplace rehabilitation provider and it took more than two years for 55 per cent of injured workers to be referred to a rehabilitation provider. The impact of delaying referral to a rehabilitation provider is demonstrated in Table 20:

TABLE 19: REHABILITATION PARTICIPATION AND COSTS

Participation in rehabilitation (600 injured workers respondents in each year)										
	Participation in rehabilitation	**Mean rehabilitation costs per injured worker**	**Working with same employer worker had before injury**	**Return to same sort of duties as was doing before injury**	**Injured worker had a return to work plan written for them**	**Injured worker was involved in developing return to work plan**	**Return to work plan was helpful for the worker**	**Injured worker was given assistance to complete the return to work programme**	**Injured worker was assisted by someone at work with their return to work programme**	**Given suitable duties when first returned to work**
	% of NSW injured worker respondents	**$**	**% of NSW injured worker respondents**	**% of NSW injured worker respondents**	**% of NSW injured worker respondents**	**% of NSW injured worker respondents**	**% of NSW injured worker respondents**	**% of NSW injured worker respondents**	**% of NSW injured worker respondents**	**% of NSW injured worker respondents**
2011/12	29%[a]	$2,804[b]	85%	74%	61%	77%[c]	74%	53%[d]	25%[e]	85%
2010/11	31%	$2,503	84%	72%	59%	76%	76%	58%	34%	86%
2009/10	36%	$2,845	89%	72%	61%	73%	73%	54%[f]	35%	85%
2008/09	33%	$2,407	84%	79%	56%	73%	76%	58%	29%	86%
2007/08	29%	$2,177	85%	76%	56%	75%	76%	59%	34%	80%
2006/07	24%	$2,011	86%	79%	53%	72%	76%	62%	20%	83%

[a] This is significantly below the national average of 45%

[b] This is significantly above the national average of $1,548

[c] This was the lowest percentage of workers who were involved in writing their return to work plan in the Australian and New Zealand jurisdictions - others were between 80% and 87%

[d] This was the lowest percentage of workers who were given assistance with their return to work plan in Australian and New Zealand jurisdictions - others were between 57% and 86%

[e] This was significantly lower than the national average of 31%

[f] This was significantly lower than the national average of 60%

Source: *Return to Work Monitor 2006/07 to 2011/12*, Campbell Research prepared for Heads of Workers Compensation Authorities

TABLE 20: REFERRALS TO REHABILITATION WHERE WORKER IS ASSISTED TO RETURN TO WORK

Worker is assisted to return to work with the ***same*** employer	
Delay to referral	**Return to work rate**
Less than 6 months	80%
Between 6 months and 18 months	76%
Between 18 months and 3 years	76%
More than 3 years	60%
Total number of referrals: 8,747; Average delay to referral: 25.77 weeks	
Worker is assisted to return to work with a ***new*** employer	
Delay to referral	**Return to work rate**
Less than 6 months	50%
Between 6 months and 18 months	35%
Between 18 months and 3 years	24%
More than 3 years	19%
Total number of referrals: 7,857; Average delay to referral: 149.49 weeks	
Source: *Joint Select Committee on the NSW Workers Compensation Scheme* (2012: 121)	

Notably, Table 20 provides evidence that workers are roughly twice as likely to return to work if they remain with the same employer, than if they move to a new employer. By extension, workers who remain with their pre-injury employer are more likely to be referred to rehabilitation services, rehabilitate and return to work, not necessarily in that order:

> *The model of getting better first and then returning to work has been demonstrably unsuccessful. To improve return to work outcomes and rein in costs, the current paradigm must change from return to work to stay at work. It is important to keep injured workers engaged within the work context. To facilitate this, injured workers and their employers must be enabled to drive the process and engage with a workplace rehabilitation provider early in the life cycle of the claim.* (Australian Rehabilitation Providers Association - NSW, 2012: 3)

Therefore, as part of an effective rehabilitation programme, workers need access to appropriate duties which are progressively adapted to match the workers' level of recovery. This ensures 'their

effective rehabilitation and reintegration into the workplace' (Industry Commission Australia, 1994: XLV; see also Waddell and Burton, 2006: 25).

However, this recommendation comes in the absence of legislation to ensure, or at least encourage, employers to hold a position open for the injured worker and to manage their successful return to the workplace as they recover from injury. In this regard, the NSW Bar Association raised the concern that, 'in the absence of a requirement for employers to provide suitable employment for a worker returning from injury, work capacity testing does not achieve its stated goals' (Joint Select Committee on the NSW Workers Compensation Scheme, 2012: 75).

7.2 OBLIGATIONS ON EMPLOYERS

Disappointingly, the 2012 amendments emphasised workers' obligations to return to work without imposing reciprocal obligations on employers to provide suitable employment opportunities. There were, however, two minimal changes designed to encourage employers to facilitate return to work.

The first change was the introduction of an Employer Safety Incentive and Return to Work Incentive for small and medium employers paying less than $30,000 premiums per year (Insurance Premium Order 2013-14 under the 1987 Act, Sections 12 and 13). Both incentives entitle the employer to a 10 per cent discount on workers' compensation premiums if they can get injured workers back to work within 13 weeks from the date of injury.[18] These incentives do nothing more than reduce premiums if injured workers return to work within 13 weeks; they do not address issues with workplace safety, rehabilitation or suitable duties for workers per se. These are critical omissions. Furthermore, critics cite a lack of checks and balances to verify that businesses are complying with the required minimum standards:

> *It really is a PR exercise for the government to be able to walk out there and say, 'We're looking after small business.* (Henry, 2013)

The second change was WorkCover's introduction of a 'Return to Work Engagement with Workplaces' pilot program. The six-week program, announced in October 2012, aimed to improve return to work outcomes in NSW by enforcing the obligation of employers to provide suitable employment for workers with work capacity (WorkCover NSW, 2012b). The pilot had targeted three areas:

- large and medium-size businesses with the potential for significant reductions in claim frequency and cost;
- medium-size businesses with injured workers not at work (premium affected by claims experience); and
- small businesses with injured workers not at work (not premium affected).

[18] For reasons unknown the Employer Safety Incentive entitles employers to a 10 per cent premium discount if the injured worker returns to work within 4 weeks, or a 10 per cent discount if the injured worker returns to work between 4 weeks and 13 weeks from the date of injury. Thus there is no difference between the two incentives.

WorkCover's 2013 Annual Report revealed the pilot had 'focused on the impact of WorkCover's engagement with employers on the delivery of improved return to work options for injured workers' (WorkCover NSW, 2013a: 19). However, to date no results have been made available. WorkCover's 2013 Annual Report, released in October 2013 – one year after the program was announced, claimed 'WorkCover is currently considering the findings and results of the pilot program' (WorkCover NSW, 2013a: 19). Industrial officers at AMWU and CFMEU report seeing no evidence of the program being applied in manufacturing, construction, mining or forestry industries (Henry, 2013; Hayward, 2013).

The analysis in Section 7.1 above demonstrates that the legislative framework needs to encourage employers to facilitate their injured workers returning to work by keeping them engaged with the workplace and performing appropriate duties. Despite this, employers' obligations to provide suitable employment remain unchanged in the amended Act. Further, changes aimed at encouraging employers to facilitate timely return to work are unlikely to motivate them to engage in the necessary communication and cooperation required to assist injured workers back to work.

7.3 BARRIERS TO RETURN TO WORK

Section 49 of the 1998 Act states that the employer 'must at the request of the worker provide suitable employment for the worker'. This does not apply, however, if 'it is not reasonably practicable to provide employment' or if the worker left that place of employment, or the employer terminated the workers' employment. Consequently, suitable duties provisions are undermined by the potential for employers to dismiss an injured worker after 26 weeks from the date of injury has lapsed (1998 Act, S 248). [19]

From the workers' perspective, gaining new employment post-injury can be extremely difficult if their employment has been terminated:

> *It's very hard to get re-employed [with a new employer] – I would have applied for maybe 3-400 jobs... Any sort of workers' comp claimant is viewed with suspicion.* (Grumley, 2013)

> *I've seen so many people get terminated since the laws came through, because at the end of the day, if you're not working it doesn't matter to the insurer... so the detriment is all to the individual... If you're certified for 20 hours per week it's not the insurer's fault your employer doesn't have suitable duties... I've seen this a lot more since the changes came through – employer's saying, 'Suitable duties? Oh, I don't have any.' Because, well, why should they keep you on? The insurer's not going to pick up the payment anyway.* (Hayward, 2013)

[19] Employers are likely to be impacted by a premium increase if they medically retire an injured worker once 26 weeks have lapsed. However, the 2012 legislative changes have reduced the premium impact on employers, because injured workers receive reduced weekly benefits after 26 weeks.

The public health sector has proven particularly reluctant to provide light duties or suitable duties for workers who are trying to return to work. Reported below are examples of the types of obstacles clinical nurses and aged care workers are reporting to experience when they seek suitable duties during recovery from a work injury:

Example
Clinical nurses' work is highly physical and if they are injured and required to take time off they lose physical strength in their whole body. These workers require a graduated return to work program, which conditions their bodies to bring them back up to full strength and original duties. However, workers are being inhibited in their desire to return to work. Return to work programs or light duties are not available for workers who are awaiting surgery, so their overall suitability for work can deteriorate while they await their surgery. Some employers are proving unwilling to have people return to work unless they can perform all their pre-injury duties. The employer's reasons for not providing nurses with suitable duties include: - 'the nurse can't assist with cardiac arrest treatment because of his/her injury so he/she can't be allowed back at work' - 'we aren't willing to give him/her administrative duties' - 'the psychiatric nurse can't restrain patients (several staff are required to assist when a patient needs to be restrained) so he/she can't come back to work' - 'he/she can't bend over long enough to administer eye drops or enemas, but can perform all other required duties, however the worker cannot return until all duties can be performed safely'
Source: Dawson (2013); Gersbach (2013)

> *[In practice] there is no incentive for the employer to offer suitable duties. WorkCover is supposed to have greater powers to be out there and enforce it, but they're not using them.* (Hayward, 2013)

Alternatively, legislation requiring employers to retain a suitable position for injured workers for 12 months from date of injury, may be more of an injury prevention incentive to small employers than premium variations (Industry Commission Australia, 1994: XLVI). Furthermore, clearly articulating guidelines regarding the meaning of reasonably practicable (within this context[20]) may be beneficial.

When injured workers engage a lawyer to assist them with their bid to return to work, the lawyer can bring applications to the Workers Compensation Commission as a workplace injury management dispute. Section 49 of the 1998 Act states that employers must provide suitable employment for an injured worker who wants to return to work, 'so far as is reasonably practicable'. Where it is reasonably practical for the employer to provide suitable employment for an injured worker, often these cases are successful in the Commission (Brennan, 2013).

[20] For example, Safe Work Australia has provided a detailed guide for the WHS context, titled: "How to Determine What is Reasonably Practicable to Meet a Health and Safety Duty".

Another reported barrier to timely and durable return to work is the pre-approval system for medical treatments. Delays in medical treatment are preventing workers in the health sector from returning to work sooner. In practice, 'there's roadblocks all the way in trying to return to work' (Grumley, 2013).

A further return to work barrier is the perception that workers' compensation schemes encourage rehabilitation providers to prioritise the needs of the insurer over the best interests of the worker (South Australian Parliamentary Committee on Occupational Safety, Rehabilitation and Compensation in Purse, 2013: 214).

> *The nature of [the] claims management relationship has an inherent potential not just to compromise the independence of rehabilitation professionals but also the legitimacy of rehabilitation itself. Rehabilitation providers who raise complaints concerning the treatment of injured workers or who question the professional basis of rehabilitation decisions by claims managers may find that referrals soon dry up. Other providers find this behaviour intimidating and subsequently become reluctant to challenge claims managers, with the result that the rehabilitation industry, or a large section of it, loses much of its professional independence over rehabilitation matters.*
>
> *This professional subordination is most graphically illustrated where rehabilitation providers are used by insurers both to provide injured workers with rehabilitation services and claims managers with work capacity assessment reports designed to terminate the weekly payments of these very same workers. Put slightly differently, the legislative intent underpinning occupational rehabilitation is discredited, trust by workers seriously eroded and the standing of the industry – despite the genuine commitment of most rehabilitation professionals – brought into disrepute. Instead of helping workers, rehabilitation becomes a tool to remove them from the system.* (Purse, 2013: 214-215)

Thus, there is a sense among injured workers that rehabilitation providers appointed by the insurer are not independent and are siding with the insurer to pressure unfit workers back to work, rather than rehabilitating workers. Independent rehabilitation providers can be selected by the worker, and these independent rehabilitation providers can play a more conciliatory role, helping insurers and workers achieve the rehabilitation and return to work objectives (Grumley, 2013).

8. SCHEME GOVERNANCE

Summary

The NSW Parliamentary Inquiry into the workers' compensation scheme identified various problems with claims management practices and with scheme governance more broadly. Many can be traced to three somewhat interrelated factors: the conflicts of interest and moral hazards inherent in the workers' compensation system; power and information asymmetries between scheme participants (and other stake-holders); and issues relating to regulatory enforcement. The 2012 changes have done little to address the resulting consequences these present for injured workers.

There are systemic conflicts of interest in the NSW workers' compensation system. The capacity of insurers and WorkCover to bully injured workers is substantial and the 2012 amendments did not address this issue. As a result workers feel more powerless to defend against bullying as they are unable to engage legal support and feel at the mercy of the case managers who make the WCDs. The powerlessness of injured workers is exacerbated by significant differences in both power and knowledge between insurers (including scheme agents) and injured workers.

Communication from insurers to injured workers remains unclear and inaccessible, however the WIRO has power to make recommendations about improving the quality of written communication regarding the WCD. Nonetheless, there remains tremendous scope for insurers and WorkCover to bully and harass injured workers. Since the 2012 changes, workers feel more powerless to defend against bullying as they are unable to engage legal support and feel at the mercy of the case managers who make the WCDs.

As noted in Chapter 1, WorkCover NSW engages with two types of insurers in the NSW workers' compensation scheme. Seven scheme agents hold commercial contracts (scheme agent deeds) with WorkCover (the nominal insurer) to provide workers' compensation insurance services. Also, WorkCover NSW has licenced 59 self-insurers and seven specialised license holders in specific industries to provide workers' compensation insurance to their employees.

Unlike Government, which has a fundamental public interest responsibility, insurance firms and self-insured businesses are corporate entities. Their primary responsibility is to their shareholders; their core motivation is to optimise profits by maximising revenues (premiums and contract fees) and/or minimising expenses (e.g. payments to injured workers, service providers, administration etc). Insurance firms will not be motivated to optimise rehabilitation or return to work outcomes, nor to provide workers with information about their eligibility or entitlements, if these activities conflict with their profit seeking objectives. Purse (2011) explains,

> *Insurers are not neutral participants in the workers' compensation arena. On the contrary, they are 'active players' that seek to further their own financial interests even if that entails shifting costs onto employers and workers, through premium setting practices or efforts to reduce worker entitlements.* (Purse, 2011: 41)

The following sections discuss implications of these arrangements for scheme administration and reported impact on injured workers. The sections in this chapter include:

8.1 Conflicts of interest

8.2 Power and information asymmetries

8.3 Enforcement

8.1 CONFLICTS OF INTEREST

The contracting of policy and claims management services to insurers presents a potential conflict of interest - in that profit maximising firms are not only *motivated* to minimise expenditure, for example, but in many cases have the *means* and *opportunity* to do so. Effective formulation, monitoring and enforcement of contractual terms therefore play a critical role in providing the incentives needed to align the Scheme Agents' goals to those of WorkCover and its various stakeholders, thereby controlling the way insurers behave when participating in the compensation system.

The Scheme Agent Deeds provide insight into the contracted obligations and current incentive structures. The Deeds reveal that scheme agents are paid 'service fees', which is effectively a retainer. Scheme agents then receive bonuses for achieving certain mandatory and optional performance targets. Fees are payable into the three fee pools that can vary according to changes such as the number of policies in force, the earned premiums, the policies in force, the number of payment transactions, the level or quantity of services for injured workers (e.g. medical services) or the numbers and size of employers (Scheme Agent Deed 2010-2014: 84). Insurers also administer the reimbursement of payments to third party service providers, such as medical practitioners and rehabilitation providers (Scheme Agent Deed 2010-2014: 87). The three types of fees payable as specified in the Scheme Agent Deeds are as follows:

1. **Service fees**, payable for:
   (i) Scheme services, including collection of premiums, conduct of claim services and third party service provider management. These are payable as the portions of claims, premiums and liabilities under management of the total number of claims in the scheme (market share).
   (ii) Project services.
   (iii) Disengagement services (never used as contracts have never been disengaged).
2. **Mandatory KPI fees**, payable for providing services (as above) and reviews in a timely fashion. Under the contracts, insurers are obliged to meet the various target key performance indicators (KPIs) by achieving a score greater than 0 per cent in respect of each KPI. The nominal insurer may introduce, remove or change KPIs at their discretion.
3. **Optional incentive fees**, a percentage paid on the basis of the number of claims processed and the longevity of the claims (Daley, 2013). Under the contracts, insurers are not obliged to meet the incentive fee targets, but will not receive the incentive fees if targets are not met. The targets to be attained are return to work targets and 'financial outcome measure' targets (Scheme Agent Deed 2010-2014: 135).

While the scheme agent deed (template) is publicly available, access to details of the specific performance indicators and targets contained in Schedule 5 has been withheld from the public amid claims the information is 'commercial in confidence' (Hansard, Peter Primrose MLC questions to parliament June 2013). This lack of transparency prevents examination of the quality or intent of contracted expectations and incentives regarding the delivery of policy services and claims management. For example, say a KPI relates simply to 'cases closed', this may be achieved where a worker has recovered and returned to work, or where an insurer denies liability and the injured worker, for one reason or other, fails to appeal the decision.

It has been suggested that releasing the KPIs publicly may expose anomalies that skew the incentive system toward minimising costs rather than compensating injured workers and supporting them in returning to work, thus encouraging insurers to act in ways that contravene the legislation (Henry, 2013). Scheme agents are also restricted from making any statements to the media or the public regarding the scheme (Scheme Agent Deed 2010-2014: 81). Furthermore, the deeds provide absolute discretion for WorkCover to terminate the contract with 120 days notice (Scheme Agent Deed 2010-2014: 97). This option has never been exercised and no insurer has been prosecuted for failure to comply with the legislation (Henry, 2013).

> *It's just totally perverse. It's really not centred on minimising costs for the scheme. It's about maximising profits that can be generated from the contract with WorkCover.* (Henry, 2013)

Although unconfirmed, it is likely that service fee payments to insurers are activity-based with payments made for activities, such as sending a worker for an independent medical examination (IME), conducting a WCA, or even the worker seeking a review. Given that 'self- insurers can be over-zealous because it's their money' (Garling, 2013a), the KPIs need to be worded carefully in the contracts so as to avoid motivating dysfunctional consequences; such as workers being sent to countless IMEs or subjected to unlimited WCAs, each of which can be stressful and difficult for the worker, but each providing the insurer (and medical assessor) with additional income from WorkCover.

Workers who perceive they have been needlessly subjected to these types of activities report compounding stress and anxiety and a desire to give up on the workers' compensation system. If they do, the insurer is financially rewarded for 'closing the case' (Henry, 2013). Thus, the KPIs can provide an incentive for insurers to deny liability, which exacerbates the number of disputes and is counter-productive in getting injured workers back to work (Garling, 2013a). Critics suggest,

> *The problem for the insurers in a scheme like NSW is that it's not their risk. They're just agents. So they don't have their best claims managers on the job. They can be slack, about all sorts of things. If the incentives aren't right, it can be just statutory money for them. It just rolls in.* (Goodsell, 2013)

Importantly, many of the relationships between insurers and other parties in the workers' compensation scheme – government bodies, service providers, employers and workers – may be characterised as morally hazardous. A moral hazard is defined as, 'any situation in which one person makes the decision about how much risk to take, while someone else bears the cost if things go

badly' (Krugman 2009: 63 in Purse, 2011: 41). In this case, injured workers bear the risk of insurers' expenditure decisions (e.g. approvals of treatment and financial support).

> *What they've done is written in moral hazards into the contract, so it actually undermines the purpose of the legislation... For WorkCover it's about reducing costs.* (Henry, 2013)

Examples of conflicts of interest include,

- → WorkCover is both the nominal insurer, with commercial incentives to minimise insurance claim payments, and a regulator, with the responsibility to monitor insurers and enforce contracts. This becomes a conflict of interest when, for instance, WorkCover needs to ensure that insurers are providing injured workers with their entitlements
- → Contracted insurers and licensed self-insurers have an inherent conflict of interest as their responsibilities to compensate injured workers and assist them to recover and return to work are overshadowed by their mandate to maximise profits. This conflict has risen to the fore with the new system of work capacity decisions.
- → Independent medical examiners (doctors) and rehabilitation providers are paid by the insurers. They have incentives to assist insurers to minimise expenditures for services and payments to injured workers. They do not, however, have incentives to minimise expenditures for their own services, nor do they have incentives to assist the worker to recover. These conflicts of interest have been exacerbated by the legislated changes.
- → Legal practitioners have had incentives to encourage multiple claims and to protract legal claims. These issues have been substantially minimised by the legislated changes

8.2 POWER AND INFORMATION ASSYMETRY

Literature reviews and interviews with injured workers and their advocates suggest governance issues are further complicated by problems of power inequities and information asymmetry. For example, insurance companies have a financial incentive not to provide workers with clear and detailed information about eligibility and entitlements to compensation and benefits. These information asymmetries give insurers an unfair advantage (Purse, 2011: 43), thus necessitating their effective regulation. However, the wide range of problematic behaviours elicited by insurers suggests they hold a privileged position in the scheme and monitoring and regulatory enforcement is inadequate.

> *This privileged position reflects the 'information is power' maxim and often feeds into the broader power imbalance, whereby claims managers have the ability to challenge injured workers' continuing entitlement to compensation without proper grounds for doing so. There are, as indicated earlier, legitimate grounds on which workers' entitlements can be challenged. However, the fact that weekly payments can be discontinued for the duration of a dispute creates incentives for claims managers to strategically "manufacture" disputes in order to exert leverage designed to limit or terminate workers' claims.* (Purse, 2013: 215)

COMMUNICATIONS

The ability to engage in unfair behaviour relies, in part, on a worker's lack of knowledge about their rights, entitlements and appropriate procedures. WorkCover's Work Capacity Guidelines 2013, S.2, requires that insurers communicate with injured workers and that those communications are 'transparent', 'effective' and use 'plain language'. Furthermore, 'the insurer must use a sound decision-making model that includes appropriate controls and review processes aligned with the *General Insurance Code of Practice* [which is a commercial code of practice not tailored for personal injury insurance] incorporating a quality assurance and continuous improvement framework.'

> *They don't. I don't think I've ever seen a letter at any time from an insurer that makes sense. Unfortunately it's always been that way... they're always not going to make sense because it's a strategy that insurers employ. The less a person knows about the system, the easier it is for you to pull the wool over their eyes.* (Hayward, 2013)

> *If you are left totally uneducated then you're not about to raise [the issue], 'I didn't get my payment', because you don't know... There's a total and utter absence of awareness.* (Henry, 2013)

> *Workers have no idea what their rights are and they can't find out where to learn what their rights are, except through very limited sources... Insurers are not going to explain to an individual what his [or her] rights are – that would be contrary to the whole concept. For the insurer to say, 'I've just made a decision that takes away your weekly benefits, but if you want to challenge that decision and overturn it, this is what you've got to do.' – I think that's an interesting concept. I don't think there are too many insurance clerks doing that.* (Garling, 2013a)

Historically, only around half the samples of NSW workers' compensation claimants surveyed in Table 21 have found the insurer, or the information provided by the insurer, to be helpful:

TABLE 21: EASE OF CLAIM, ACCURACY AND HELPFULNESS OF INSURER COMMUNICATIONS

Communication with insurers (600 injured worker respondents in each year)			
	% Injured workers who found it easy to get information about making a claim when first injured	**% Injured workers who received accurate information from insurer**	**% Injured workers who found the insurer helpful**
2011/12	79%	57%	52%
2010/11	80%	57%	52%
2009/10	81%	58%	54%
2008/09	80%	na	na
2007/08	82%	na	na
2006/07	81%	na	na
na: information not available			
Source: *Return to Work Monitor* 2006/07 to 2011/12, Campbell Research prepared for Heads of Workers Compensation Authorities			

The introduction of the WIRO service and the review of WCDs by the WIRO has opened the door to the possibility for insurers to be held accountable for the quality of communication with injured workers. The WIRO decisions have criticised the quality of written communication from insurers. Lack of clarity about the date of commencement of the WCA, or the date of termination of weekly benefits can amount to failure to give proper notice, which is an offence in the legislation (see for example the WIRO decisions 1,2,3,4,5,6 & 17). In two instances WIRO has recommended that WorkCover investigate a potential breach of section 54 of the 1987 Act, which requires notice be given before termination or reduction of weekly payments (WIRO decisions 2 & 15). There is no evidence of WorkCover following through on these binding recommendations from the WIRO (Garling, 2013a; Simic, 2013).

The WIRO decisions have also pointed to ample examples of vague and careless written communication from insurers, such as:

- → reference to the careful consideration of documentation held by the insurer, without identifying the documentation that was considered (refer to WIRO decision 6);
- → inadequate explanations of entitlements (refer to WIRO decision 7);
- → notification of cessation of wages, rather than cessation of workers' compensation entitlements (refer to WIRO decision 8);
- → 'elliptical' and 'eccentric' sentences, which fail to give notice of cessation of benefits (refer to WIRO decision 9); and
- → insurers stating that the WCD will have no impact on other entitlements, which was deemed 'confusing, confounding and unacceptable' (refer to WIRO decision 11 p8).

The WIRO decisions have highlighted that insurer's WCDs can read 'in part like a Biblical begattery with several recurring phrases' (WIRO decision 15: 8), 'slippery syntax' (WIRO decision 14: 7), 'garbled reasoning' (WIRO decision 15: 14) and 'grammatically challenged' sentences (refer to WIRO decision 12), rendering them misleading and at times blatantly contradictory (such as the 'parataxic anomaly' found in WIRO decision 15: 2).

The requirement for decision makers to clearly explain the line of reasoning in coming to a decision is reinforced by a recent High Court decision, *Minister for Immigration and Citizenship v Li* [2013] HCA 18. This case found that decision makers need to clearly demonstrate the reasoning behind their determination (WIRO decision 15: 7). The lack of clarity in communication from insurers is not helped by the Guidelines from WorkCover, 'which are themselves so inferential, allusive and opaque as to render a complete understanding all but impossible' (WIRO decision 10: 3).

These decisions by the WIRO have prompted insurers to improve the quality of the notices provided to injured workers. This is not necessarily beneficial for injured workers because as long as the WIRO finds problems, such as notices being invalid, there is an avenue through which workers can have their weekly payments extended for at least three more months (and by extension the termination of their medical expenses can be postponed for an additional 12 months). The seven scheme agents are responding quickly to the WIRO decisions and fixing the problems with written communication. The self-insurers are slower to respond because they have less workers' compensation cases, however eventually they will also resolve all the problems found by the WIRO (Hayward, 2013).

Once all the notices are valid, workers will have no mechanism for external review of the decision through the WIRO procedural reviews. This situation arises because the WIRO procedural review is the only avenue for appeal of the WCD.

The WIRO has also identified problems with the legislation preferencing verbal communication over written notification. The WIRO's WCD review decisions 1,2,5,6,7,8,9,12 & 15 questioned the appropriateness of communicating verbally with workers who may not speak English as a first language, or who may have limited education. Verbal communication also prevents the WIRO from overseeing the accuracy, quality and fairness of the communication.

Preferencing verbal over written communication has wide-reaching consequences. For instance, when English is a second language or workers suffer from industrial deafness, telephone calls are not helpful (Hayward, 2013). Furthermore, insurers can tell workers over the phone that they will not be accepting liability for a medical consultation or treatment. Most workers are unaware that 'they need to push through', instead they just 'walk away'. Usually insurers are responsible for paying for the medical appointment, which is why they decline liability over the phone rather than putting it in writing. It is difficult for workers to know they have a right to keep pressuring the insurer to pay for the consultation (Grumley, 2013). Verbal communication where workers are being harassed, bullied or abused can easily go unchecked. Accountability is limited to an injured worker including incidences of bullying or harassment in the procedural review of the WCD for the WIRO. The WIRO can then publicly condemn the insurer in the WCD decision and the review to parliament.

PERCEIVED BULLYING

In September 2010 the NSW Department of Premier and Cabinet engaged PricewaterhouseCoopers (PwC) to conduct a review of alleged bullying and harassment at WorkCover NSW. PwC made a number of recommendations for improving management and behaviour at WorkCover. Nonetheless problems are reported to have persisted and a Parliamentary Inquiry into bullying at WorkCover is presently underway. There have been at least 90 submissions to this inquiry, 49 of which are publicly available. The submissions suggest the culture of bullying within WorkCover is endemic and the impact is not limited to employees, but extends to the injured workers using the WorkCover service.

> *Bullying is **very** bad, and it is happening more and more.* (Hayward, 2013)

The interview findings from this study support this claim, with respondents reporting to have experienced various forms of bullying by insurers. Some examples include:

- → Injured workers attend a medical assessment where the treating doctor concludes that they require surgery or major treatment. Insurers are informed of the need for surgery or treatment to expedite recovery and return to work. However, the insurer delays granting pre-approval, verbally threatening to deny liability for the medical treatment, causing the worker unnecessary stress and worry as they wait to find out whether they can get their treatment. Meanwhile the original injury continues to deteriorate (Henry, 2013).
- → An injured worker was informed verbally that the insurer was going to make an adverse WCD and instructed to start his own business by taking out a mortgage against his home. The insurer said that if he was earning an income (through his business) then he would continue to

receive weekly entitlements. He did exactly what the insurer told him to do, then they cut off his payments anyway. The worker lost his house (Hayward, 2013).

The case manager from the insurer was continually ringing up a member, threatening him, saying, If you don't do what I say your benefits will be withdrawn.' So there was this ongoing threatening behaviour going on. I tried to contact the insurer on behalf of the member, but the minute I said, 'Non-compliant with the guideline', the insurer shut me down. He said, 'I'm not authorised to talk about this case' and hung up on me... I've never had an insurer hang up on me before. (Henry, 2013)

Insurers were never great, absolutely they were never great, but the level of arrogance that has been built into the system by this government is absolutely incredible. (Henry, 2013)

The research interviews uncovered numerous examples of cases in which injured workers reported insurers to have attempted to undercut entitlements, bullied the worker or taken advantage of their poor knowledge about procedures or entitlements. Key examples are summarised in Table 22 below:

TABLE 22: PROBLEMS INJURED WORKERS EXPERIENCE WITH THE INSURER

Reported actions taken by insurers
'Doctor shopping' – sending the injured worker to multiple doctors to investigate the same condition, until the insurer receives the report with a minimal impairment assessment.
Insisting the insurer or employer accompany the injured worker to medical appointments, using intimidation and bullying to influence the outcome of the medical report.
Making an injured worker who nominated their own doctor wait the full 21 days (maximum allowed time to approve a medical appointment) before approving that visit – then only approving it once the appointment is taking place –causing the worker unnecessary stress.
Refusing to pay transportation costs for an injured workers' to visit doctors while requiring them to travel (with their injury) several hundred kilometres to visit specified medical practitioners and inferring that nonattendance will be deemed as failing to comply and payments could be suspended.
Verbally instructing an injured worker to attend a doctor's appointment at short notice (as little as 2 or 3 hours) and threatening termination of payments for non-attendance.
Instructing workers to attend medical assessment and saying not to bring anything (eg previous reports, x-rays, MRI results etc) to the appointment. When the medical practitioner cannot complete the assessment without that information the insurer suspends workers' payments for failure to comply with obligations.
Threatening to suspend a worker's payments on non-compliance grounds if they attempt to take an audio recording of a medical appointment or bring along a witness.
Telling the injured worker they were at fault so should not be claiming workers' compensation.
Notifying verbally, but not in writing, that they will not accept legitimate medical claims - when they are

legislated to pay. (Note: The legislation now requires provisional approval for 'reasonable medical expenses', which is significantly compounding the problems experienced with this insurer strategy. In particular, workers who require surgery are having the approval for payment delayed until their 12 months of medical expenses expires (Dawson, 2013; Alan Mansfield, AMWU, IWSN meeting 19/9/13 & injured workers at IWSN meeting 25/9/13).
Providing written notification that is inaccessible and difficult to understand, particularly for workers from non-English speaking backgrounds. (Note: The WIRO review process has improved the accuracy of notices – particularly for scheme agents (the process will be slower with self-insurers). The WIRO has made recommendations that the language is simpler and clearer, but these recommendations are not binding, nor are they enforced by WorkCover).
Failing to provide adequate information about eligibility, rights, entitlements and procedures for claims and appeals. (Note: the complexity of the system is very difficult for injured workers to understand e.g. It is not clear that you can choose your own doctor or rehabilitation provider).
When work capacity assessments are in process the worker is precluded from participating in a job placement programme for injured workers.
Insurer appointed medical practitioners and rehabilitation providers are seen to be 'siding with the insurer', contributing to the adversarial nature of the system, rather than being concerned with the health and rehabilitation of the worker. (Note: The WCAs and WCDs were designed to limit the adverse impacts of multiple medical assessments, but this is not working as intended because insurers are still requiring multiple practitioner assessments until they get the report they are seeking. For example, the injured worker in case study 4 of this report was told verbally by the insurer that they were commencing WCA and that the outcome would require the worker to go to Centrelink – indicating that the WCD was a *fait accomplis*, regardless of evidence.)
Private investigators hired to do surveillance of the injured worker and their families – to check the condition of the injured worker and take pictures of them during their time off work are notoriously inaccurate – taking photos of the wrong person, producing pictures of neighbours or other strangers who are fully capable.
Telling workers that they need to use their income protection insurance policy and are not eligible for workers' compensation. (Note: This can be beneficial for the worker because income protection insurance benefit rates are usually higher, but insurers telling workers to use their own insurance goes against the principal of the workers' compensation system and medical costs are not covered.)
Telling a 65 year old worker to repay payments they paid him in error after he turned 65 years old.
Refusing to accept to pay for an IME nominated by a worker.
Sources: Injured Workers' Support Network meetings, interviews with trade union officials, injured workers and legal professionals.

8.3 ENFORCEMENT

WorkCover NSW is the regulatory body with statutory authority to monitor and enforce both WHS and workers' compensation in NSW. The regulation of WHS incorporates monitoring and enforcement of the *Work Health and Safety Act 2011 (NSW)* and supporting regulations and guidelines to ensure safe practices at all workplaces. This area focuses on the safe practices of employers. The second area is the monitoring and enforcement of Workers' Compensation Acts, regulations and guidelines. This area centres on practices of insurance agents, workers, employers, medical practitioners and legal advisors.

WorkCover has more than 300 'field active inspectors' with jurisdiction to monitor all potential breaches of WHS and workers' compensation matters in NSW. Where serious offences occur (failure to comply with duty, causing serious injury or death), WorkCover has the authority to prosecute the employer (*Work Health and Safety Act 2011 (NSW) S.230)*. Historically, enforcement of WHS standards has been inadequate across most Australian jurisdictions:

> *Although fines and penalties have an important role in deterring unsafe work practices, prosecution of occupational health and safety breaches is not being pursued with enough vigour. Fines and penalties are inconsistent between jurisdictions, and too low in some to be a credible deterrent. Even where maximum fines are high, courts rarely impose large penalties. Even in cases of gross negligence or wilful misconduct leading to death or serious injury, severe penalties (including gaol sentences) are often not applied.* (Industry Commission Australia, 1994: XLI)

The effective management of WHS is a critical factor in reducing the frequency and severity of work-related injuries (O'Neill, 2012: 5). Monitoring and enforcement of WHS in the workplace is therefore important for ensuring compliance from employers. Yet, the enforcement of WHS in NSW is often criticised for being under-resourced and comparatively weak.

> *The productivity commission also reports that the Victorian Work Health and Safety regulator directs a greater proportion of its budget to enforcement activities (43% vs 12%) and has half as many worksites per inspectors (1,086 vs 2,296) while the NSW regulator directs a greater proportion to education and WHS programs (41% vs 57%). NSW also has by far the largest workforce and the largest number of workplaces.* (O'Neill, 2012: 4)

However, if WHS standards are inadequately enforced there is likely to be a deceptively benign delay before injuries start to occur. WHS failures can be seen to accumulate with growing levels of severity before injuries or illnesses start to occur (O'Neill, 2012: 7). Thus, both the educative/advisory and inspectorate/enforcer roles of WorkCover are critical for the regulation of WHS standards (Industry Commission Australia, 1994: XLI).

> *Instead, 'what we're seeing is an ever-shrinking role of the regulator... In fact the role of the regulator's been changed dramatically, whereby the inspectors are being told, 'Your role is as advisors, to assist employers'. They're told, 'Your client is the*

employer'... So despite the fact the legislation is in place to protect working people, the employer is now the client.' (Henry, 2013)

Benchmark 7 in Chapter 9 demonstrates that there was a decline in the number of penalty notices issued in 2011/12. The NSW Auditor General's report to parliament for 2012 recommended that the reasons for this decline should be investigated to understand if they were attributable to the 11 per cent reduction in the number of investigators or a decline in WHS failures (NSW Auditor General, 2012: 96).

The second area where WorkCover has jurisdiction to monitor and enforce standards is in workers' compensation. WorkCover is the only prosecuting authority in workers' compensation. As such, WorkCover is both the nominal insurer and the regulator of insurers, with an inherent conflict of interest. The WIRO is a complementary body, which has authority to review any matters that fall under the 1987 Act or the 1998 Act and make non-binding recommendations to the Minister arising from that review (notwithstanding the binding decisions the WIRO can make to accept or decline a WCD).

In practice though, 'WorkCover never intervenes; they're a regulator that doesn't regulate' (Hayward, 2013). It is evident that the formal mechanisms for WorkCover to enforce the regulations and legislation through the contracts and licences are not utilised. WorkCover has never terminated a contract with a scheme agent (Henry, 2013). Similarly, the NSW government is not going to terminate a self-insurer's licence. 'The government's policy is to expand the number of self-insurers rather than reduce them, so I don't see that happening' (Garling, 2013a). WorkCover has only once revoked a license with a self-insurer – Wesfarmers' license was revoked in 1985, but their license has since been reinstated (Henry, 2013).

Alternative avenues for enforcement of the regulations and legislation include:

- → Injured workers contacting the WIRO who can confer with the insurer, inform them of their obligations and make non-binding recommendations.
- → The WIRO can report insurer breaches to the Minister through the WIRO annual reports. An important threat for insurers is that the Minister can restructure the incentive fees and KPIs in the contracts to change their behaviour.
- → Injured workers threatening to report a breach to the local newspaper.
- → Union officials can step in to represent injured workers, with all communication passing through the union official, who has the expertise to assert the worker's rights.

Example
A current matter involves an insurer sending a letter of request to a worker to attend an IME, however the letter of request was not compliant. Meanwhile the insurance company's case worker was harassing and bullying the injured worker; threatening to withdraw benefits if they did not do what the case worker told them to do. The WIRO has power to investigate this because it is a breach of legislation (which includes regulations and guidelines) by the insurer. The first thing the WIRO does is communicate directly with the insurer. The WIRO can make a non-binding recommendation to the insurer (or worker) for specified action to be taken (1998 Act, S.47A). The WIRO has not yet needed to exercise this power to make a formal complaint or recommendation because communication with insurers has achieved the solutions required. 'Going to formal inquiries and investigations and making non-binding recommendations as per, say the Ombudsman's office is unwieldy, slow and not effective' (Garling, 2013a). Instead the WIRO has an agreed protocol with the insurers, which involves sending the insurer a 'preliminary inquiry email', and the nominated contact at the insurer responds within 48 hours. The objective is to get the problem solved quickly and the WIRO has had 'remarkable success' in resolving most issues quickly. Unresolved matters can be escalated by commencing a formal complaint, then by naming the insurer on the WIRO website or in parliament. However, the WIRO prefers to speak directly to senior management at the insurance companies If the case is not resolved through direct negotiation then the WIRO can grant ILARS funding for lawyers to pursue the case further if it is not a WCD related matter. The WIRO has no power to enforce directly, such as through imposing a fine, they can only fund legal action or threaten to contact WorkCover and the Minister.
Source: Henry (2013); Garling (2013a)

LEGAL PRACTITIONERS

The WIRO possesses unique powers to regulate, monitor and enforce standards of legal practitioners. In administering the ILARS system, the WIRO oversees approximately 700 lawyers who are contracted to provide workers' compensation services. The WIRO possesses the power to remove legal practitioners from the list of possible ILARS applicants if they perform poorly. Between January and June 2013 three lawyers have been issued with warnings that they could be audited and/or removed from the ILARS list. The first lawyer to receive this warning worked for a large workers' compensation firm. The second lawyer worked for a regional firm and the WIRO is conducting an audit of the firm's practices. The WIRO is mindful in this case of the needs of the injured worker and the scarcity of lawyers working in the workers' compensation area in regional locations. The third lawyer worked for a suburban firm. In this case the WIRO's view was that the lawyer's performance was not acceptable, but a satisfactory explanation was given and the lawyer remained on the ILARS list, but can be audited or removed at any time. All lawyers and their practices can be closely monitored by the WIRO, including the length of time they take to process claims.

> *This is the first time in the history of workers' compensation that we can actually say with some certainty how many lawyers are doing the work and what the cost is. We can be precise on all of those things. Historically the information may have been there but it*

was never actually aggregated within the WorkCover scheme, so there were guestimates about what money lawyers were being paid, whereas we can tell you to the cent… This is extremely significant and it's beneficial for the worker because if we consider that one or more or the lawyers acting for the worker are not performing adequately we can assist them to perform better. Whereas in the past there was no measurement. We can actually provide, we hope, by the end of the year, some pretty good statistics on performance [including statistics on the efficiency of lawyers, where delays are also flagged and lawyers are contacted to account for delays, for instance in delivering medico-legal reports]… This is fairly unusual worldwide. (Garling, 2013a)

MEDICAL PRACTITIONERS

The medical system is not very good at handling workers' comp. (Goodsell, 2013)

Medical practitioners is a real problem… If you just look at one part of it: If a lawyer for an injured worker seeks a medico-legal report from a reporting specialist, there is a regulation that fixes the fees they can charge for those reports… While there is a regulation that sets that out, there are a significant number of doctors who will not charge the regulated fee, they charge above it. That means historically the lawyers had to fund the gap or the injured worker had to fund the gap because the insurers weren't allowed to pay more than the regulated fee. This is particularly the case with psychiatrist practices, where they were charging outrageous amounts. A particular case was brought to our attention because the patient was unable to attend the appointment because they had some psychiatric issues; I think they were, in fact, in hospital. Because they didn't notify the doctor within 48 hours the doctor charged a 'no-show' fee. While the order provides a 'no-show' fee of $50, the doctor charged a 'no-show' fee of $900. Now that's in breach of the legislation.

It's in breach of the intent of the legislation and when I raised that with the particular practice, they effectively asked me, 'What was I going to do about it?' Because there's no provision for enforcement in the Act and when I suggested to them that one provision for enforcement might be the medical board for misconduct, they disagreed, laughed at me and said that wasn't going to happen. However the next day they withdrew their services, so they weren't doing workers' comp anymore. Fine by me. But you do get that attitude, we get that attitude in a number of practice areas and WorkCover don't do anything about it. They can, there are ways of dealing with it, in other words a lot of these medical practitioners are also receiving work from the Commission and from the Motor Accidents Authority and the Dust Diseases Board and so on. So WorkCover, which has control of all those groups, could implement a different approval system for them, but they won't.

They won't touch the doctors… This is an issue. I'm not worrying about that one doctor, particularly. I'm more worried that there are a range of doctors not complying and what are [WorkCover] going to do about it? That's in the reporting area. In the treating area there doesn't seem to be a great deal of interest at WorkCover in monitoring the performance of doctors. Which surprises me, in the sense that, about a third of

> *payments out of the WorkCover authority fund are to the medical practitioners. So of $2.2 billion per year that is paid out for compensation and associated costs, about $650 million goes to the medical professional… WorkCover has been struggling with this issue for years.* (Garling, 2013a)

This issue with the medical profession is widespread throughout the English speaking world because it is not monitored. Similarly there is little regulation and many problems with the rehabilitation providers, which are poorly understood (Garling, 2013a).

EMPLOYERS

The amendments to the legislation have introduced power for WorkCover to issue improvement notices to employers if they are not complying with their workplace injury management and provision of suitable duties responsibilities under Chapter 3 of the 1998 Act *(1998 Act, S.59A-59E).*

Where penalty points can be imposed on an employer or insurer for non-compliance – one penalty point is worth $110 fine and there is a maximum fine of 50 penalty points ($5,500). If penalty points are imposed then the matter must be prosecuted by WorkCover. WorkCover is the only body authorised to prosecute under the workers' compensation legislation (Henry, 2013). While WorkCover has never prosecuted a scheme agent, they sometimes prosecute employers for breeches of work health and safety or workers' compensation legislation.

> *Employers aren't being investigated at all. You ask WorkCover to investigate and they say, 'We don't think there's a reason to.' Even individual workers who've rung WorkCover for advice on issues have found that their phonecalls aren't being returned and when they are the inspector just says to them, 'There's nothing we can do.'* (Hayward, 2013)

WORKERS

WorkCover has authority to investigate all potential breaches of workers' compensation regulations and enforce compliance. The only evidence of this taking place is WorkCover monitoring of fraud and prosecuting parties involved in injured workers claiming benefits fraudulently (WorkCover NSW, 2013b). Details of cases successfully prosecuted by WorkCover NSW are often reported on the WorkCover's website (see www.workcover.nsw.gov.au/aboutus/newsroom/).

There is a widespread perception of worker fraud of the workers' compensation system in Australia, which belies all evidence. A study in 2000 of the state and federal government workers' compensation enquiries found no evidence of worker fraud being rife. Similarly, a 2003 federal Parliamentary Inquiry determined that worker fraud was minimal. Nevertheless, the perception of pervasive worker fraud persists and as a result injured workers suffer from the stigma of being malingerers (Purse, 2011: 47).

> *On the employer's side there's still a stigma about workers' comp... anything you can't see and anything where it seems to go on longer than you think it should for employers there's a sense of, 'this person's having a lend of me... That's a problem for the system'* (Goodsell, 2013)

9. BENCHMARKS

It is recommended that three complimentary levels of data be used for benchmarking the impact of the 2012 workers' compensation legislation changes on workers.

Level One Broad quantitative data – benchmarks the distribution of expenditures in the scheme, numbers of injured workers and longevity of claims, return to work, enquiries to the Injured Workers' Support Network, enforcement measures by WorkCover and cost-shifting to Medicare and Centrelink benefits.

Level Two Qualitative survey – The framework for this survey is provided in this report. It is recommended that this survey be conducted annually to monitor the ongoing impacts of the scheme on workers and their families.

Level Three Case studies of injured workers – these case studies can be followed up at later dates, or new case studies can be added in subsequent reports to track the progress of the changes to the scheme.

9.1 BROAD QUANTITATIVE DATA

Between 1998 and 2010, WorkCover NSW publicly released detailed information about compensated injury and illness claims via annual Statistical Bulletins. Available on WorkCover's website, these aimed to discharge accountability to stakeholders by providing 'a unique guide to the operation of the WorkCover Scheme' and to ensure transparency regarding information on 'general trends in work health and safety'. The 'Forward' section in each of the first nine Statistical Bulletins (issued 1999 to 2005) stated,

> *The aim of the Workers' Compensation Statistical Bulletin is to provide an overview of the major claims in New South Wales. Statistical information presented in this bulletin enables industry and individual workplaces to better understand the nature and extent of a problem in their area and identify the issues for priority action.* (WorkCover NSW, 2003b: 3)

From 2004/05 to 2007/08, the stated objectives of the Statistical Bulletins remained to 'increase[e] community awareness of work-related injury and disease' and although there was a greater focus on claims cost, 'WorkCover provide[d] information about the causes and effects of workers' compensation claims to assist individuals and organisations in their endeavour to prevent workplace injury and disease, and to minimise the social and economic cost of claims through injury management practices' (e.g. WorkCover, 2007b: 3).

Signalling a change in approach, the forward to the 2009 report (issued 2010) omitted references to community accountability and took a more direct focus on businesses, stating,

> *WorkCover publishes this bulletin covering New South Wales workers' compensation claim statistics to inform **its own planning** and to provide **industry** with information about the causes and effects of workers' compensation claims to prevent future workplace injury and disease.* (WorkCover, 2009b: 3 (emphasis added)).

WorkCover has not issued Statistical Bulletins since 2010 despite the website stating, 'it is vital to understand the nature and the extent of WHS issues in industry and workplaces', which is made possible by 'providing data and information to analyse these issues' (WorkCover NSW, 2013c). Unfortunately, without the Statistical Bulletins, future analyses of WorkCover data are limited by the range and detail presented in WorkCover NSW Annual Reports. In an effort to identify current and useful data for benchmarking, WorkCover and non-WorkCover data sources, including Safe Work Australia, Medicare and ABS have been examined.

This section includes the following eight benchmarks:

1. Scheme expenditure
2. Numbers of injured workers, claims and accepted claims
3. Longevity of claims
4. Serious incidence rates and long-term injury claims
5. Return to work
6. Enquiries to Injured Workers' Support Network
7. Enforcement by WorkCover
8. Uptake of Centrelink payment
9. Medicare services

BENCHMARK 1: SCHEME EXPENDITURE

TABLE 23: SCHEME EXPENDITURE – SAFE WORK

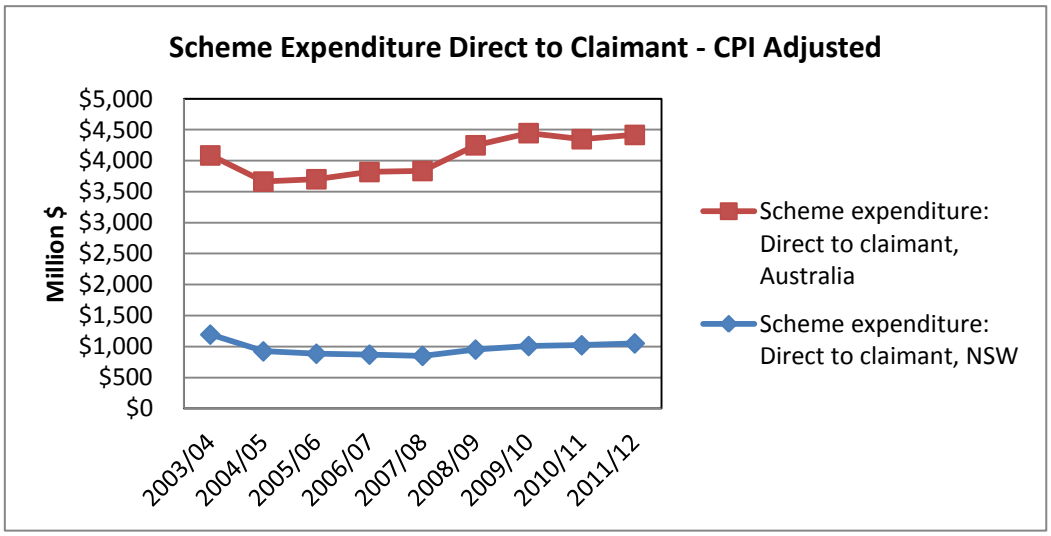
Scheme Expenditure: NSW and Australia Comparison ($ million)						
	Direct to claimant, NSW	Direct to claimant, Australia	Services to claimant, NSW	Services to claimant, Australia	Total scheme expenditure NSW	Total scheme expenditure Australia
2003/04	$1,194.5	$2,892.4	$648.8	$1,312.4	$2,400.9	$5,611.1
2004/05	$948.0	$2,810.3	$522.7	$1,218.6	$2,205.6	$5,653.1
2005/06	$944.4	$3,002.6	$505.0	$1,274.4	$2,043.5	$5,808.7
2006/07	$944.2	$3,198.0	$508.1	$1,325.3	$2,042.5	$6,030.4
2007/08	$964.7	$3,381.7	$535.6	$1,418.8	$2,039.3	$6,300.5
2008/09	$1,094.3	$3,786.2	$606.3	$1,581.4	$2,193.9	$6,936.1
2009/10	$1,194.7	$4,063.8	$636.6	$1,633.4	$2,333.0	$7,302.0
2010/11	$1,257.3	$4,089.2	$632.0	$1,706.6	$2,417.6	$7,448.2
2011/12	$1,310.9	$4,191.3	$689.1	$1,822.7	$2,629.0	$7,838.3
Source: Safe Work Australia *Comparative Performance Monitoring Reports* 11-15, 2009-2013						

Data availability: The Safe Work Australian Comparative Monitoring Reports are released each year in October or November. The reports are available on the Safe Work Australia website. Care needs to be taken to revise data for earlier years, as well as updating the latest year, because there can be a lag effect with some data.

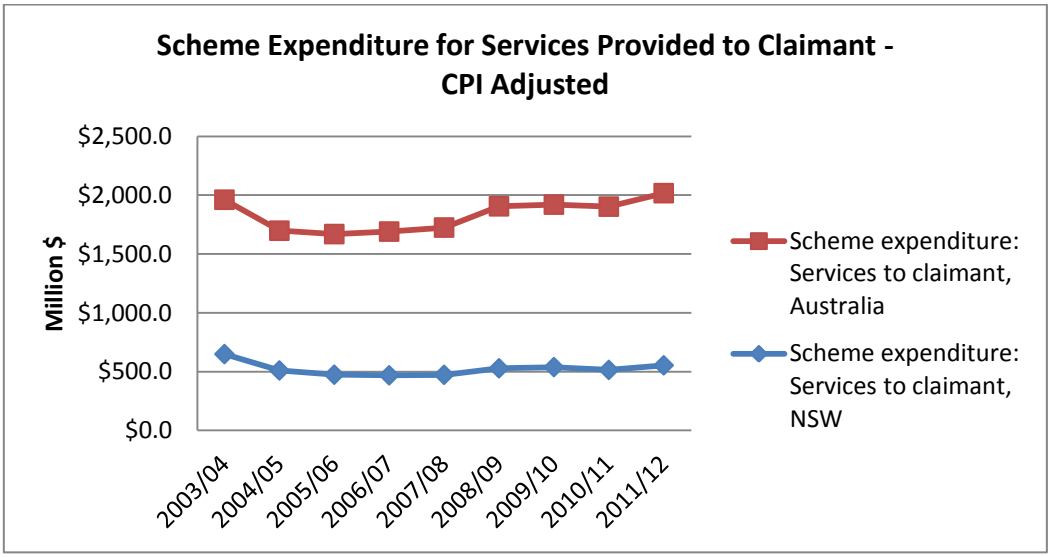
The most interesting finding in this benchmark of the scheme expenditures is that all three measures of scheme expenditures (payments direct to claimants, services to claimants and total expenditure) in NSW did *not* increase between 2003/04 and 2011/12. The comparison with Australia-wide scheme expenditures, which did increase each year, vividly demonstrates the uniqueness of NSW expenditures for claimants remaining flat over this period. Notably, the increase in expenditures in jurisdictions other than NSW is understated because Australia-wide expenditures include the stable NSW expenditures. The third measure, total scheme expenditure, highlights that total scheme expenditures have also not increased in NSW over this period. In fact, when these figures are adjusted for inflation the NSW expenditures are seen to have decreased between 2003/04 and 2011/12. These comparisons are illustrated in the following Figure 4:

FIGURE 4: SCHEME EXPENDITURE INFLATION ADJUSTED – SAFE WORK

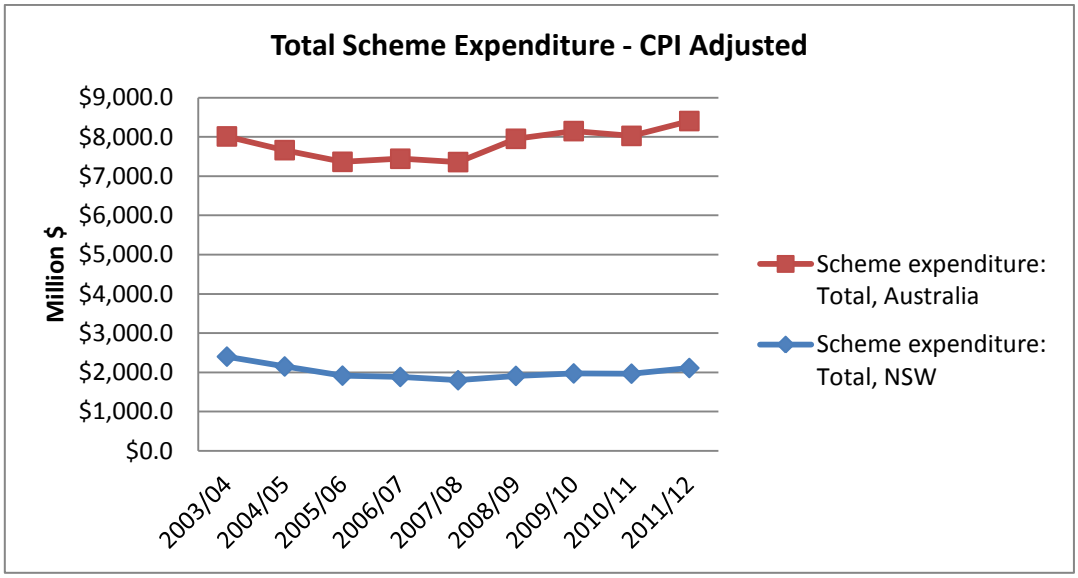
(4a)



(4b)



(4c)



Sources: ABS *6401.0 Consumer Price Index,* Australia Table 1 Percentage Change From Previous Period, All groups, Sydney, June quarters; and Safe Work Australia *Comparative Performance Monitoring Reports* 11-15, 2009-2013

An alternate measure of scheme expenditure has been collected through question time in parliament:

TABLE 24: SCHEME EXPENDITURE - HANSARD

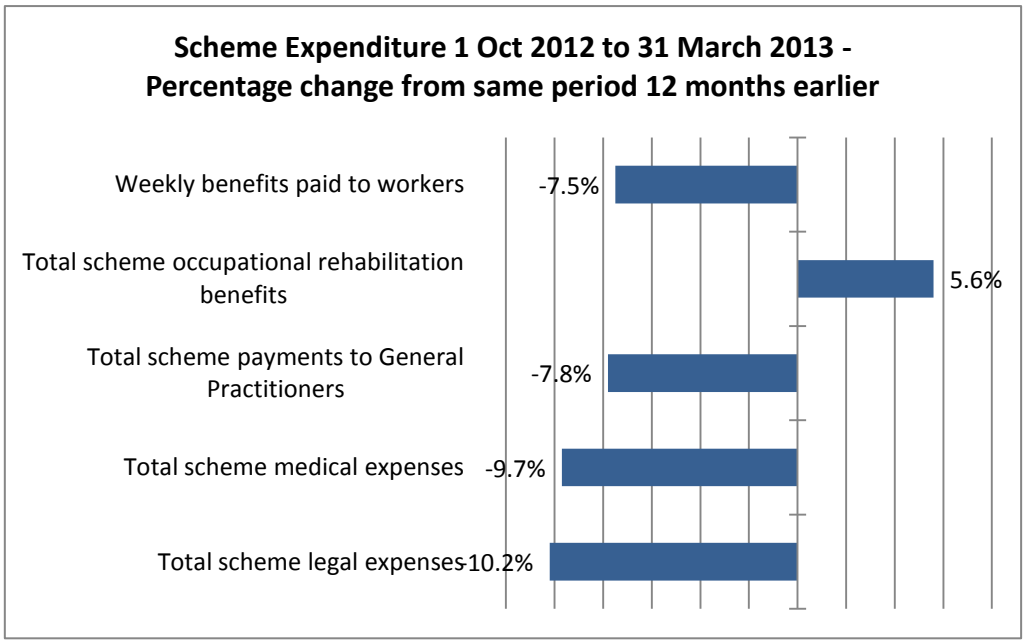
Scheme expenditure 1 Oct 2012 to 31 March 2013 - Aggregated per month				
Weekly benefits paid to workers	**Total scheme medical expenses**	**Total scheme legal expenses**	**Total scheme occupational rehabilitation benefits**	**Total scheme payments to general practitioners**
$million/month	$million/month	$million/month	$million/month	$million/month
$61.50	$37.12	$7.42	$8.58	$6.25
Source: Hansard, Peter Primrose MLC questions to parliament June 2013				

Data availability: Peter Primrose MLC has committed to ask these same questions in parliament twice per year. The questions will be asked toward the end of each biannual session in June and November.

Table 24 provides benchmark data which can be compared to subsequent data, gathered every 6 months during question time in parliament. All these scheme expenditures for injured workers have been reduced since the same period 12 months earlier, except payments to rehabilitation providers.

Figure 5 offers an insight into the extent to which payments have been increased or decreased:

FIGURE 5: SCHEME EXPENDITURE - HANSARD



Then by combining the two data sources the following can be deduced:

TABLE 25: SCHEME EXPENDITURE - COMBINED

Scheme Expenditure ($ million)							
	Total scheme expenditure	**Total paid directly to claimants** [21]	**Total paid to workers as weekly payments**	**Total scheme medical expenses**	**Total scheme legal expenses**	**Total occupational rehabilitation expenditure**	**Total paid to general practitioners**
1 April 2012 to 30 Sept 2012	$1,314.5	$655.5	$414.0	-	-	-	-
1 Oct 2012 to 31 March 2013	-	-	$369.0	$222.70	$44.50	$51.50	$37.50
Source: Safe Work Australia *Comparative Performance Monitoring Reports 15, 2013* and Hansard, Peter Primrose MLC questions to parliament June 2013							

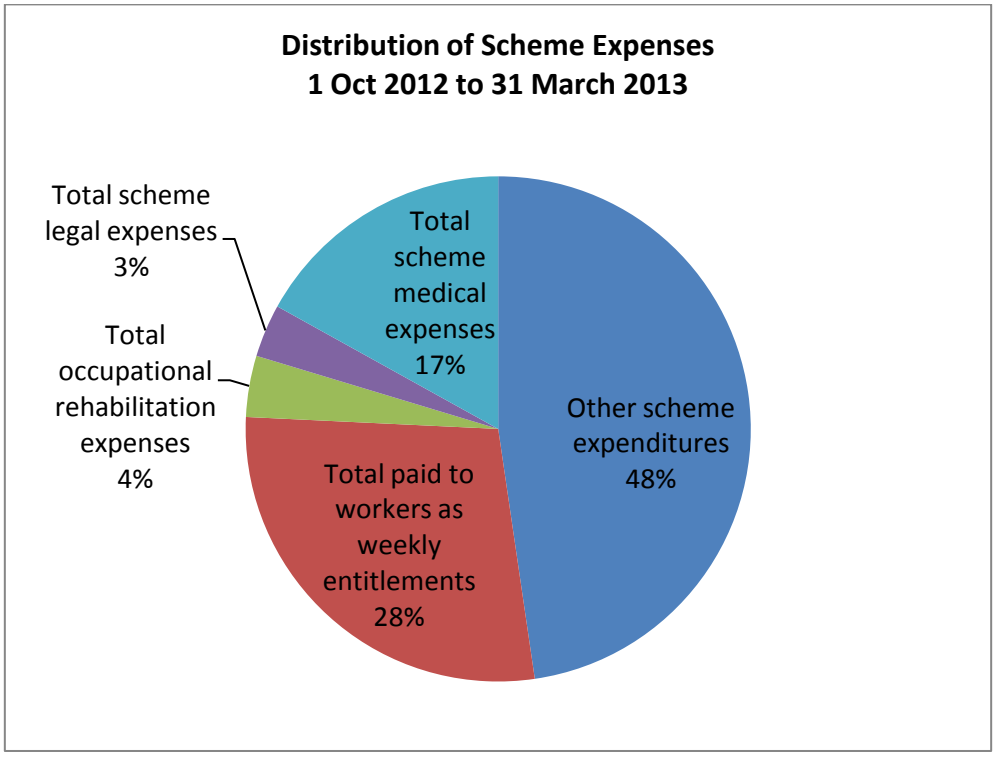
Data availability: Peter Primrose MLC has committed to ask these same questions in parliament twice per year. The questions will be asked toward the end of each biannual session. The Safe Work Australian Comparative Monitoring Reports are released each year in October or November.

[21] This includes weekly payments and lump sum entitlements.

Note that the total paid into the scheme by employers each year is $2.5 billion for 2011/12, 2012/13 and projected for 2013/14 (Hansard, 2013). The WorkCover Annual Report for 2013 states that premiums collected in policy renewal year 2011 were $2.7 billion (WorkCover NSW, 2013a: 116). This is equivalent to $1,250 billion for each 6 month period described in the table above, which is less than the scheme expenditure.

This combined benchmark data in Table 25 offers insight into the distribution of expenses in the workers' compensation scheme. This data is presented again in Figure 6 demonstrating that almost half the scheme expenses are not paid directly to injured workers, or to professionals who support injured workers:

FIGURE 6: SCHEME EXPENDITURE – COMBINED



Given the lack of transparency and inadequacy of data available from WorkCover, there is some ambiguity around the items included in 'other scheme expenditures'. Data available from Hansard papers and Safe Work Australia Comparative Monitoring reports do not provide an understanding of what portion goes to administration of the scheme at WorkCover, regulation of WHS at WorkCover, scheme agents, self-insurers and any other expenses that must be absorbed by WorkCover. It is known, however, that in 2010/11 the seven scheme agents received a total remuneration of $318 million (Joint Select Committee on the NSW Workers Compensation Scheme, 2012: 27).

BENCHMARK 2: NUMBERS OF INJURED WORKERS, CLAIMS AND ACCEPTED CLAIMS

TABLE 26: NUMBERS OF INJURED WORKERS, CLAIMS AND ACCEPTED CLAIMS

Injured workers in NSW 2009/10		
	Number of workers	**%**
Persons who worked at some time in the last 12 months	3,834,300	
Persons who worked at some time in the last 12 months and experienced a work-related injury or illness in that period	213,200	6% of all person who worked
Number of claimants for workers' compensation who received some form of compensation	129,482	61% of all persons who were injured
Number of claims initially accepted – no need to fight for compensation	112,211	87% of all persons who made a claim
Source: 6324.0 Work-Related Injuries from *Multi-Purpose Household Survey* (MPHS)		

Data availability: This data is only available for 2009-10 from the ABS website. ABS expects to release the next data from MPHS for 2012-13 in November 2014.

In the first instance, this table illustrates the portion of injured workers who received compensation in 2009/10. Of the 6 per cent of workers who suffered a workplace injury, only 61 per cent received compensation. This data does not distinguish between injured workers who chose not to claim workers' compensation and those who tried to claim but were unsuccessful. In any case, only 61 per cent of all injured workers receiving compensation is a low rate.

In the second instance, Table 26 reveals that only 87 per cent of injured workers initially had their claim accepted, leaving 13 per cent of injured workers to fight for recognition of their right to compensation. This is a stressful process for these workers. No data is available to reveal how many workers made a claim for compensation that was unsuccessful.

An alternate data source offers insight into how many claims were initially accepted, and how many claimants successfully fought for compensation:

TABLE 27: ALL CLAIMS ACCEPTED OR DELAYED

All Injuries and Illnesses - Claims Accepted or Delayed			
	Total number of claims	**Total number of claims accepted initially**	**Percentage of claims accepted initially**
2007/08	137,051	127,476	93%
2008/09	132,001	122,868	93%
2009/10	129,482	112,211	87%
2010/11	131,672	125,515	95%
2011/12	128,943	122,101	95%
Source: Safe Work Australia, various reports, 2008-2013			

Data availability: The Safe Work Australian Comparative Monitoring Reports are released each year in October or November. The reports are available on the Safe Work Australia website. Care needs to be taken to revise data for earlier years, as well as updating the latest year because there can be a lag effect with some of the data.

From Table 27 it can be seen that between 5 and 7 per cent of claims have initially been declined (13 per cent in 2010), but ultimately the injured worker has received compensation. These figures do not account for injured workers who attempted to claim workers' compensation but were unsuccessful. These figures are similar for all claims excluding journey claims:

TABLE 28: ALL CLAIMS EXCLUDING JOURNEY CLAIMS – ACCEPTED OR DELAYED

All Injuries and Illnesses Except Journey Claims - Accepted or Delayed			
	Total number of claims	**Total number of claims accepted initially**	**Percentage of claims accepted initially**
2007/08	127,278	118,386	93%
2008/09	122,238	113,764	93%
2009/10	120,000	114,175	95%
2010/11	121,342	115,490	95%
2011/12	118,713	112,199	95%
Source: Safe Work Australia, various reports, 2008-2013			

Data availability: The Safe Work Australian Comparative Monitoring Reports are released each year in October or November. The reports are available on the Safe Work Australia website. Care needs to be taken to revise data for earlier years, as well as updating the latest year, because there can be a lag effect with some data.

TABLE 29: JOURNEY CLAIMS ACCEPTED OR DELAYED

Journey Claims - Accepted or Delayed			
	Total number of claims	**Total number of claims accepted initially**	**Percentage of claims accepted initially**
2007/08	9,773	9,090	93%
2008/09	9,763	9,104	93%
2009/10	9,482	9,169	97%
2010/11	10,330	10,025	97%
2011/12	10,230	9,902	97%
Source: Safe Work Australia, various reports, 2008-2013			

Data availability: The Safe Work Australian Comparative Monitoring Reports are released each year in October or November. The reports are available on the Safe Work Australia website. Care needs to be taken to revise data for earlier years, as well as updating the latest year because there can be a lag effect with some of the data.

Surprisingly, journey claims were more likely to be accepted initially by the insurer. This journey claims data demonstrates that there are around 10,000 claims per year and most were not resisted by insurers. It is expected that the claims for journey related compensation will dramatically diminish from 2012/13 with the legislated changes.

Not surprisingly, claims for heart disease, such as heart attacks were unlikely to be initially accepted by the insurer. The data only includes specific types of heart disease: heart attack, angina, myocardial infarction or coronary exclusion. Data for stroke claims are not available. This data indicates how few claims are made for heart disease and that the majority of those claims are resisted by insurers.

TABLE 30: CLAIMS FOR HEART DISEASE ACCEPTED OR DELAYED

Heart Claims (Heart Attack, Angina, Myocardial Infarction or Coronary Exclusion) – Accepted or Delayed			
	Total number of claims	**Total number of claims accepted initially**	**Percentage of claims accepted initially**
2007/08	44	16	36%
2008/09	44	17	39%
2009/10	33	14	42%
2010/11	30	11	37%
2011/12	38	9	24%
Source: Safe Work Australia, various reports, 2008-2013			

Data availability: The Safe Work Australian Comparative Monitoring Reports are released each year in October or November. The reports are available on the Safe Work Australia website. Care needs to be taken to revise data for earlier years, as well as updating the latest year, because there can be a lag effect with some data.

A final indication of the types of claims made by injured workers and the likelihood of insurers opposing those claims is a measure of claims for compensation resulting from exposure to trauma. This is the closest measure to nervous shock claims for family members of workers who have suffered traumatic injuries that is available in the data. This measure is not the same, instead it reflects workers who were present at the site when the fatal or traumatic accident occurred.

Nervous shock claims for family members are no longer claimable under the 2012 legislated changes. These claims for exposure to trauma do however remain claimable. This measure is included as a benchmark to give an indication of the number of claims that are successful and the portion that are resisted by insurers.

TABLE 31: CLAIMS FOR EXPOSURE TO TRAUMA ACCEPTED OR DELAYED

Exposure to Trauma (Witness to Accident Fatal or Other) - Accepted or Delayed			
	Total number of claims	**Total number of claims accepted initially**	**Percentage of claims accepted initially**
2007/08	119	96	81%
2008/09	141	116	82%
2009/10	322	272	84%
2010/11	274	254	93%
2011/12	218	183	84%
Source: Safe Work Australia, various reports, 2008-2013			

Data availability: The Safe Work Australian Comparative Monitoring Reports are released each year in October or November. The reports are available on the Safe Work Australia website. Care needs to be taken to revise data for earlier years, as well as updating the latest year, because there can be a lag effect with some data.

An alternate source of data, the Hansard papers, suggests that the portions of accepted claims are substantially lower than the preceding tables suggest. This can be seen in the following Table 32:

TABLE 32: TOTAL CLAIMS, NEW CLAIMS AND ACCEPTED CLAIMS - HANSARD

New claims compared to accepted and open claims				
	New claims accepted	**Claims open at the end of the period**		**Total new claims**
1 Oct 2012 - 31 March 2013	32,935	68,043		
1 Oct 2011 - 30 Sept 2012	80,433	71,589	**1 Jul 2011 - 30 Jun 2012**	128,943
Source: Hansard, Peter Primrose MLC questions to parliament June 2013				

By these estimations only 62 per cent of claims made in 2011/12 were accepted. This leaves 38 per cent of claimants fighting for their compensation.

BENCHMARK 3: LONGEVITY OF CLAIMS

The following Table 33 indicates the longevity of all workers' compensation claims since 2007/08:

TABLE 33: LONGEVITY OF CLAIMS FOR ALL INJURIES AND ILLNESSES

All Injuries and Illnesses - Length of Payments			
	Less than 12 weeks	**12 weeks or more**	**Percentage of claims that carry on for 12 weeks or more**
2007/08	125,710	11,341	9%
2008/09	120,636	11,365	9%
2009/10	118,349	11,133	9%
2010/11	120,199	11,473	10%
2011/12	119,499	9,444	8%
Source: Safe Work Australia *Comparative Performance Monitoring Reports* 10-15, 2008-2013			

Data availability: The Safe Work Australian Comparative Monitoring Reports are released each year in October or November. The reports are available on the Safe Work Australia website. Care needs to be taken to revise data for earlier years, as well as updating the latest year because there can be a lag effect with some of the data.

Table 33 demonstrates the absence of an upward trend in long-term claims for payments. In 2011/12 only 8 to 10 per cent of all workers' compensation recipients received payments beyond 12 weeks. Furthermore, the number of long-term claimants decreased in the 2011/12 financial year – before the new legislation was introduced to discourage long-term claimants. This data does not provide justification for the 2012 legislation changes to workers' compensation to reduce the numbers of long terms claimants of workers' compensation.

BENCHMARK 4: SERIOUS INCIDENCE RATES AND LONG-TERM INJURY CLAIMS

TABLE 34: SERIOUS INCIDENCE RATES AND LONG-TERM CLAIMS

Serious Incidence Rates and Long-Term Claims for NSW					
	Incidence rate of serious[1] compensated injury and musculoskeletal claims	**Incidence rates of serious1 injury and disease claims**	**Frequency rates of serious1 injury and disease claims**	**Incidence rates of long term (12 weeks or more compensation) injury and disease claims**	**Frequency rates of long term (12 weeks or more compensation) injury and disease claims**
	Claims per 1,000 employees	Claims per 1,000 employees	Claims per million hours worked	Claims per 1,000 employees	Claims per million hours worked
2006/07	-	15.3	9	3.6	2.4
2007/08	13.1	15.4	9	3.7	2.5
2008/09	12.6	15.1	8.9	3.7	2.4
2009/10	12	14.6	8.7	3.8	2.3
2010/11	11.9	14.4	8.5	3.6	2.2
2011/12	11.5[2]	13.5[3]	8[4]	3[5]	1.8[5]

[1] Includes accepted workers' compensation claims for temporary incapacity involving one or more weeks compensation plus all claims for fatality and permanent incapacity.
[2] Each year this is worse than the national average e.g. the national average in 2011/12 is 10.7.
[3] Each year this is worse than the national average e.g. the national average in 2011/12 is 12.2.
[4] Each year this is worse than the national average e.g. the national average in 2011/12 is 7.2.
[5] These are similar to the national averages for each year.

Source: *Safe Work Australia Comparative Performance Monitoring Reports 11-15, 2009-2013*

Data availability: The Safe Work Australian Comparative Monitoring Reports are released each year in October or November. The reports are available on the Safe Work Australia website. Care needs to be taken to revise data for earlier years, as well as updating the latest year because there can be a lag effect with some of the data.

This benchmark of serious and long-term injuries illustrates that the incidence rate of serious injuries and illnesses was already decreasing each year in NSW before the legislation to discourage workers' compensation claims was enacted. Table 34 also demonstrates that although the incidence rates of serious injuries or illnesses in NSW exceed the national averages, the long-term claims for compensation (12 weeks or more) are commensurate with the national averages. This suggests that while NSW workers have been more likely to suffer a serious injury or illness, they have been less likely to claim compensation for 12 weeks or more than their colleagues in other Australian jurisdictions. This raises questions about the validity of introducing the legislation in 2012 to discourage long-term claims for compensation.

BENCHMARK 5: RETURN TO WORK

TABLE 35: RETURN TO WORK

Return to Work (600 injured workers respondents in each year except 2012/13 with 826 respondents)					
	Returned to work at any time since workplace injury or illness	**Currently working in paid job**	**3 Month stable return to work rate***	**If still at work: Days back at work since returning from injury**	**If not at work: Days back at work before stopping work again**
	% of NSW injured worker respondents	% of NSW injured worker respondents	% of NSW injured worker respondents	Average number of days	Average number of days
2006/07	86%	78%	-	155	63
2007/08	86%	76%	-	149	86
2008/09	83%	72%	-	144	87
2009/10	85%	74%	-	134	71
2010/11	86%	78%	-	144	65
2011/12	85%	76%	-	158	86
2012/13	88%	80%	64%*	-	-

* Given that the average no of days back at work before needing to stop work again is 86 days, a 3 month 'stable return to work' is not going to capture a large portion of workers who are unable to work after trying to return to work for 3 months.

Sources: *Return to Work Monitor* 2006/07 to 2011/12, Campbell Research prepared for Heads of Workers Compensation Authorities and *Return to Work Survey* August 2013, The Social Research Centre prepared for SafeWork Australia.

Data availability: The Return to Work Survey and 2006/07 to 2011/12 Return to Work Monitor reports are available on the Safe Work Australia website. The new format of the Return to Work Survey, which commenced from 2012/13 has significantly less data available in it. The next 2013/14 Return to Work Survey should be available on the Safe Work Australia website in August or September 2014.

There was minimal variation in the rates of returning to work at anytime post injury, and being employed when the survey was conducted between 2006/07 and 2012/13. Similarly, the average number of days the injured worker has remained back at work and number of days they were able to return to work before stopping work again was consistent across the six year period. The new measure of 'stable return to work' that has been adopted for the revised survey format since 2012/13 is concerning. Given that the average number of days workers return to work before being unable to work again was close to 3 months in three of the six years measured (86 days in 2011/12, 87 days in 2008/09 and 86 days in 2007/08), a three month return to work is unlikely to be a reliable predictor of the worker stably returning to work.

BENCHMARK 6: ENQUIRIES TO INJURED WORKERS' SUPPORT NETWORK

TABLE 36: ENQUIRIES TO INJURED WORKERS' SUPPORT NETWORK

Injured Workers' Support Network data from incoming phone call enquiries					
	Problems with Insurer	Problems with Work Capacity Assessment	Employer refusal to find suitable duties for employee who wants to return to work	Employee terminated after 6 months from initial date of claim	Problems with benefits being reduced
Apr-13	50%	20%	13%	33%	10%
May-13	65%	33%	19%	30%	12%
Jun-13	52%	43%	26%	17%	26%
Jul-13	67%	53%	7%	20%	27%
Aug-13	85%	65%	30%	20%	55%
Sep-13	84%	68%	18%	16%	58%
Oct-13	82%	68%	14%	18%	50%

Source: Injured Workers Support Network

Data availability: This is a collation of data from the incoming phone call enquiries received by the Injured Worker Support Network Co-ordinator. It is expected that this data will continue to be collected and will become increasingly valuable as the enquiries to IWSN increase.

The data collected by the Injured Workers' Support Network highlights the extent to which injured workers are increasingly experiencing problems with their insurers as the 2012 legislated changes take hold. Unsurprisingly, workers are also calling more frequently about problems with their work capacity assessments, as more WCAs and WCDs are implemented. Similarly, workers are experiencing increasing problems with having their benefits reduced. It is predicted that enquiries to the IWSN about reduced benefits and problems with WCAs or WCDs will amplify as the 2012 legislated changes continue to take effect.

No pattern is emerging from the data on workers experiencing difficulties with being able to return to work performing suitable duties or workers being terminated. A pattern would not be expected here because these matters have not been impacted by the change in legislation. It is noteworthy, however, that around one in every five workers who call the IWSN are experiencing these kinds of problems.

BENCHMARK 7: ENFORCEMENT BY WORKCOVER

This benchmark of enforcement activities by WorkCover indicates a reduction in workplace visits with a ratio of active field inspectors below the national average.

TABLE 37: ENFORCEMENT BY WORKCOVER

Enforcement activity by WorkCover					
	Number of workplace proactive visits	**Number of workshops, presentations, seminars or forums**	**Number of reactive workplace visits**	**Other reactive interventions**	**Number of field active inspectors per 10 000 employees**
2006/07	na	na	na	na	1.1
2007/08	na	na	na	na	1
2008/09	na	na	na	na	1.1
2009/10	8,915	631	15,661	19,138	1
2010/11	9,735	3,015	16,370	23,263	1
2011/12	6,577[1]	1,065[1]	13,652[1]	26,244	1[2]

[1] National average decreased by approximately the same number as NSW decreased by - net effect is that other states did not reduce these activities although NSW did.

[2] National average is 1.1 for each of these years

na – data not available

Source: *Safe Work Australia Comparative Performance Monitoring Reports 11-15, 2009-2013*

Data availability: The Safe Work Australian Comparative Monitoring Reports are released each year in October or November. The reports are available on the Safe Work Australia website. Care needs to be taken to revise data for earlier years, as well as updating the latest year because there can be a lag effect with some of the data.

The reduction in notices issued and prosecutions of employers by WorkCover is illustrated in the following Table 38:

TABLE 38: ISSUING OF NOTICES AND PROSECUTIONS BY WORKCOVER

Issuing of notices and prosecutions by WorkCover						
	Number of infringement notices issued	**Number of improvement notices issued**	**Number of prohibition notices issued**	**Number of legal proceedings resulting in a conviction, order or agreement (number of defendants in a successful WHS prosecution)**	**Total amount of fines awarded by the courts ($'000)**	**Worker fatalities**
2006/07	726	13,243	1,127	300	$11,086	137
2007/08	620	13,109	994	182	$8,600	124
2008/09	686	10,832	767	96	$4,602	139
2009/10	688	12,161	856	76	$5,614	113
2010/11	588	11,326	834	89	$6,039	117
2011/12	357*	8,859	601	84	$7,922	122
* National average decreased by the same number as NSW decreased by - net effect is that other states did not reduce these activities, although NSW did.						
Source: *Safe Work Australia Comparative Performance Monitoring Reports 11-15, 2009-2013*						

Data availability: The Safe Work Australian Comparative Monitoring Reports are released each year in October or November. The reports are available on the Safe Work Australia website. Care needs to be taken to revise data for earlier years, as well as updating the latest year, because there can be a lag effect with some data.

The scaling back of enforcement since 2006/07 is particularly noticeable. Unfortunately data is not available to compare this with the ratios of inspectors and inspector workplace visits since 2006/07, as the data in Table 37 only dates back to 2009/10.

The last column in Table 38, worker fatalities, is drawn from Table 2 in Chapter 1 of this report. Worker fatalities are included to demonstrate that the number of infringement notices issued has decreased dramatically over this period, yet the number of fatalities at work has remained relatively unchanged. Thus, the monitoring and enforcement of WHS has been reduced, even though the incidence of serious WHS failures, resulting in death, has not improved.

BENCHMARK 8: UPTAKE OF CENTRELINK BENEFITS

TABLE 39: CENTRELINK BENEFITS

Number of Recipients of Centrelink Benefits			
	Newstart	**Sickness Allowance**	**Disability Support Pension**
Sep-11	163,805	1,826	267,798
Mar-12	173,395	1,917	268,709
Sep-12	172,949	1,965	267,828
Mar-13	203,633	2,218	267,611
Source: DEEWR electorate data and FaHCSIA electorate data, Department of Human Services 2011-2013			

Data availability: The Commonwealth Department of Human Resources releases the numbers of recipients of these benefits in January and June each year. Data is available by electorate only, so the summation of the NSW electorates needs to be extracted from their tables. Newstart and Sickness Allowance are provided in the DEEWR electorate data. Disability Support Pension is provided in the FaHCSIA electorate data. Data is released for a single point in time in March, June, September and December each year. The delay on this data is approximately 6 months.

Injured workers who are still employed and unable to work, but are forced to transfer from workers' compensation to Centrelink benefits, are most likely to receive Sickness Allowance. Sickness Allowance is paid to workers with a current employment contract, or who are self-employed, suffering a temporary injury and are expecting to return to work. If the recipient's injury or illness deteriorates such that they are permanently incapacitated, or they no longer have a job to return to, they will be transferred to Disability Support Pension or Newstart Allowance depending on assessed capacity for work.

This data does not indicate how many workers have transferred from workers' compensation to Centrelink benefits. Data that demonstrates the cost-shifting from workers' compensation to welfare is not available. This data does, however, provide a benchmark of the total numbers of recipient of these three benefits, which can be compared to numbers of beneficiaries in later years.

BENCHMARK 9: MEDICARE SERVICES

TABLE 40: MEDICARE SERVICES

Medicare services NSW compared with whole of Australia				
People of working age (20-64 years old)	**Number of services NSW**	**Number of services Aust**	**Services per capita* NSW**	**Services per capita* Aust**
1984-85	26,918,896	67,225,338	8.46	7.36
1985-86	29,164,570	64,319,225	9.05	6.92
1986-87	31,251,406	76,885,574	9.54	8.14
1987-88	32,586,372	80,607,411	9.78	8.37
1988-89	33,733,517	85,462,319	9.98	8.69
1989-90	33,529,777	85,625,729	9.80	8.55
1990-91	33,828,585	87,241,939	9.74	8.57
1991-92	35,777,860	93,108,310	10.16	9.00
1992-93	38,848,883	102,243,483	10.95	9.77
1993-94	40,233,541	106,975,297	11.23	10.11
1994-95	42,071,296	112,706,525	11.60	10.51
1995-96	43,345,127	117,313,219	11.81	10.80
1996-97	43,444,326	118,711,556	11.69	10.78
1997-98	43,960,555	120,254,986	11.70	10.80
1998-99	44,520,605	122,795,206	11.71	10.90
1999-2000	45,342,425	124,892,684	11.78	10.95
2000-01	45,679,093	127,868,194	11.72	11.07
2001-02	47,094,684	131,569,170	11.96	11.23
2002-03	46,915,302	131,336,502	11.82	11.06
2003-04	47,404,353	133,272,091	11.87	11.08
2004-05	49,362,303	138,301,919	12.26	11.33
2005-06	50,795,584	144,208,337	12.51	11.64
2006-07	53,244,848	150,327,922	12.94	11.91
2007-08	57,034,771	161,566,292	13.63	12.53
2008-09	59,751,454	169,095,770	14.05	12.83
2009-10	61,740,300	176,047,412	14.35	13.15
2010-11	63,315,696	181,117,327	14.58	13.35
2011-12	64,864,419	185,707,125	14.83	13.51

Sources: Department of Health and Ageing (DOHA), *Medicare Statistics*, June Quarter 2012 and Australian Bureau of Statistics 3101.0 *Australian Demographic Statistics*

Data availability: This data is released annually on the ABS website. Medicare data is available in ABS 4125.0 and population data is available in ABS 3101.0.

This data will not indicate how many injured workers have been forced onto Medicare services even though they are receiving treatment for a workplace injury. Nonetheless, this benchmark data gives a broad indication of the scale of Medicare services used in NSW and the upward trend in use. Injured workers will only start to have their medical entitlements terminated from 31 December 2013 (unless they were terminated earlier because they had reached retirement age 12 months prior). Therefore monitoring the use of Medicare services in NSW and comparing the rate of increase against Australia-wide uses of Medicare will give some indication of the extent to which workers' compensation medical expenses are being cost-shifted to tax-payers via Medicare.

9.2 SURVEY DATA

It is recommended that a web-based survey of contacts on the Unions NSW database and other union contact databases be conducted in the next phase of this research project. Participants should be contacted by email and only injured workers eligible to respond. The survey should be conducted at 12 month intervals to monitor the change in experiences, with the first survey being conducted as soon as possible. The following variables should be included in the survey:

→ Claims management experience
- Health impacts since the claim was made – broken into time intervals and tracking whether original injury has improved or deteriorated and whether additional injuries have been incurred (including psychological injuries).
- Stress level since the claim was made – ask them to report their stress level (scale of 1-10) before injury, at time of injury, 6 months post injury and time since then.
- Any depression, anxiety, suicidal thoughts or similar (frequency scale of 1-5)?

→ Knowledge of the system
- Level of understanding of the system prior to injury (scale of 1-10)
- Level of understanding of the system now (scale of 1-10)
- How they learned about the system e.g. internet, IWSN, union, employer, insurer, friend, lawyer, family, other
- Did the worker complete the WCD review themselves?
- Did the worker receive professional help with WCD review? If so, from whom?

→ Financial impact
- How was injured worker impacted financially?
- How has family been impacted financially?
- What have they had to forgo?

→ Stigma
- Have they been able to retain their job with same company?
- Have they been able to get a job with new company?
- How many jobs have they applied for?
- Have they been asked if they had previous WC claim when applying for jobs?
- Why do they not have a job (if applicable)?

→ When weekly payments decreased what did that motivate them to do?

9.3 CASE STUDIES OF WORKERS IMPACTED BY THE 2012 LEGISLATIVE CHANGES

CASE STUDY 1

John was first injured on 13 March, 2009. He was a construction worker who was on site performing his duties when he walked across uneven ground, twisted his ankle and fell down. He was diagnosed as having broken both his ankles and told there should be no complications, 'no major problems, we'll just keep you on light duties and it should be ok'. So he returned straight to work and 'hobbled around on site for 9 or 10 weeks without a brace on the ankle and it just got worse and worse with the result that they eventually had to give me time off and put me into hydrotherapy and put me in a moon boot for 2 months. Then the specialist gave me the clearance to go back to work. I went back to work on pre-injury duties and I just couldn't stay on my feet because my ankles were that swollen and that painful, so I hobbled around for a couple of weeks and I just couldn't do it so I resigned.'

John resigned in September 2009, then six months later the insurance company agreed to fund surgery for the ankle. He was told the surgery might result in a short-term loss of sensation in his big toe. However, since the operation he has lost all sensation in his toes and foot and he continues to suffer pains up his legs and in his ankle. The diagnosis was that he had nerve damage, most likely because he had continued to walk around at work for the weeks following the injury.

John has visited many specialists and has been told by each of them that he is unable to work or be active on his ankles and feet. As a result he has been unable to continue working in construction, he has been forced to sell his cattle on his farm, to stop operating a bed and breakfast business at home and his marriage broke down. He has been trying to get back to work. In January 2012 he organised a work trial but this was unsuccessful because the limited duties he was capable of were not provided, instead he was required to do more duties for more time each week than had been cleared by medical practitioners. He stopped the work trial after 6 months because he was in too much pain. John continues to require crutches to walk as he cannot bear weight on the bottom of his injured foot. Without the crutches John loses his balance and has had a couple of nasty falls.

While not working John has received weekly benefits from his insurer and medical expenses have also been covered. However, John has not been reimbursed for transportation costs to attend medical appointments organised by the insurer, even though this is a requirement of the workers' compensation scheme. John turns 65 years old in October 2013 and has been informed in writing by his insurer that his weekly benefits will cease on his 65th birthday. He has no idea how he will pay his living expenses after this date, he does not know what his options are for receiving a living allowance and has put his house up for sale because he does not know how he will meet the mortgage payments. John also had no idea that his medical entitlements will cease on his 66th birthday. He is in contact with his legal advisor, who tells him that once the High Court Decision of *Goudappel v ADCO Constructions Pty Ltd [2013]* has been decided there may be an opportunity to apply for a lump sum payment (including for pain and suffering) because his condition has continued to deteriorate.

> *All I want is to be able to get back on my feet and to do the things that I used to do without any problems.*

Source: Case study conducted with injured worker (the name of the worker has been changed to protect their anonymity).

CASE STUDY 2

Linda is a solicitor who was admitted to the bar in 1998. She worked for a small company for more than 8 years as the principal solicitor. Linda was also a company director from March 2008 until she was unfit to work in June 2012 due to her bullying injury. Linda was a committed and hard working employee, who enjoyed close friendships with colleagues in her office. She was considered an expert in her field, with the courts consulting her for advice and the company enjoying a good reputation for the work she produced.

The office environment was unhealthy, with much gossip, criticism, racial discrimination and inappropriate taunts of the staff by the company management. Linda sought to stay out of the fray, avoided the toxic people and focused on her work. Linda was not involved when an employee suffered from racial vilification and was awarded workers' compensation when declared unfit to work in 2009. At that time Linda and other employees were told that if they made similar workers' compensation claims the manager would ensure they would never be employed again.

In late 2009 Linda became the office target, 'mobbed' by all managers and most employees, who undermined her and her work and attacked her verbally. Linda said that by 2012, 'I was basically suicidal, having massive panic attacks, but somehow I held it together and got all my work done... Every day was hell.' The only fault the managers and colleagues could find in Linda or her work was the vague accusation that she was 'threatening other people's work.' In June 2012 the manager told her she would need to do all her work outside office hours because nobody in the office could stand to have her in while they were there. When Linda had a complete break down and did not return to work for one week she was immediately removed as company director, her vehicle benefits were confiscated and she was accused of 'abandoning her job, breaching fiduciary duties and being too honest.' After Linda was unable to work the mob style bullying turned to another employee who subsequently resigned and has been unable to work.

Linda applied for workers' compensation in June 2012 and her entitlements commenced under the old system. Linda suffered a complete nervous breakdown as a result of workplace bullying. Nevertheless in the first three months of her claim the insurer took the full three months allowable to decide whether to accept liability. In that time the workers' compensation investigator interrogated her for five and a half hours, and the insurer sent her to four separate independent medical examinations (IMEs) with psychiatrists. Meanwhile Linda was paying for her own appointments with a psychologist. During the IME assessments she felt demeaned, threatened, intimidated and antagonised by the IMEs. She explained, 'It's so hard to go to these IMEs when basically they're trying to get rid of you.'

There were also difficulties in establishing Linda's weekly benefit rate because her employer refused to provide any employees or the insurer with payslips. Once the rate was established the insurer overpaid Linda approximately $5,000 and then informed her they would garner her weekly statutory entitlement of $446 by $200 per week, leaving her $246 per week. At the end of the financial year the insurer was unable to provide Linda with a correct payment summary. She unsuccessfully pursued the insurer for an accurate payment summary for more than 70 hours over one month. Linda has since discovered that it is common for insurers to overpay workers, recover the payments, but not update the payment summaries (meaning the insurer is potentially able to retain the overpayment for themselves). This matter is being pursued by David Shoebridge MLC.

Furthermore, weekly payments have come sporadically from the insurer and when payments are regular they tend to be random amounts with unexplained tax deductions. Linda has, however, been positively impacted by the 2012 changes as she was transitioned to the new system at the end of September and her entitlements increased to more than $750 per week. Linda has been adversely impacted by the 2012 legislative changes in so much as she will never be eligible to make a lump sum claim for pain and suffering, even though her injury is psychological, i.e. pain and suffering. Between June 2012 and October 2013 she had lost more than $100,000 in income and assets, which she has no hope of recovering.

Source: Case study conducted with injured worker (the name of the worker has been changed to protect their anonymity).

CASE STUDY 3

Barry is a transport worker who suffered a musculoskeletal injury to his neck while at work in May 2009. Initially he was thought to have strained his neck, but medical investigations uncovered impinged nerves in the neck. It took three years for the insurance company (a self insurer) to accept liability for the injury to the neck. During these years the neck injury was exacerbated and when eventually the insurer approved the operation that Barry required in 2012, the injury was more difficult to repair and recovery was prolonged. The injury required spinal surgery and Barry will never recover the full use of his spine.

While waiting for his operation Barry continued to work at his place of employment as much as he could. His employer provided him with suitable duties for about 30 per cent of the time during those three years. Barry worked for a large employer with a range of potential duties available and he was eager to do any work with this employer that would accommodate his injury, but his employer would not allow him to work in a different department. When his employer was not providing suitable duties Barry was actively seeking employment, lodging employment applications and attending interviews. As his job seeking diaries show, he applied for 120 jobs across many different industries, hoping to move into an occupation that would accommodate his neck injury. However, most potential employers asked him if he had ever lodged a workers' compensation claim and he felt they discarded his applications on the basis that he had claimed workers' compensation.

Barry's relationship with his wife and family also suffered during these years as he continued to bear neck pain, which was difficult to live with. The financial impact of receiving only the statutory rate has also been a significant impost on Barry and his wife and children. Barry has suffered secondary psychological injuries, including anxiety, depression and suicidal thoughts, as a result of the treatment he has received from his insurer/employer. Barry describes this as:

> *It's like, well you injured yourself, we can really destroy you, we can stuff your mind up, we can make you untrusting, doubt yourself, bring your self-esteem right down, basically rubbish you to the point where you think the only way to fix it is to kill yourself.*

One strategy used by Barry's employer (and self-insurer) was to only provide employment options that are demeaning, unsatisfying, non-meaningful, such that 'you start to doubt yourself'. Another strategy was for the insurer to indefinitely delay approval for any medical treatments, so that Barry felt he needed to fight for each medical procedure. Barry has also been subjected to surveillance strategies, having an investigator with a camera follow him and his family, taking photos of them as they do activities both in public and on their private property. As a result of these activities Barry suffers from paranoia.

> *They've taken so much away from you; they've taken your privacy from you. It's a kick in the guts.*

Barry's view is that:

> *If they wear you down and tear you down, you'll walk away. And if you walk away, they've won.*

Barry has self-funded several thousand dollars worth of medical procedures, including radiology, physiotherapy, specialist appointments and travel expenses to medical appointments because he did not want to receive the insults from the insurer for making these claims. He has also had private health insurance throughout this period, but has not claimed any work injury expenses on his private health insurance as he says this would be fraudulent.

In early 2013 Barry's insurer conducted a Work Capacity Assessment and simultaneously concluded with a Work Capacity Decision that he was not eligible to receive any workers' compensation payments. Barry's wife is working so he is unable to access Centrelink payments. On just one income Barry's family struggles to pay the mortgage and fund their children's education. Barry will eagerly accept a job with half the salary of his pre-injury occupation if one becomes available. He feels

diminished by not contributing 'a significant portion' to the family finances, let alone not being able to meet his responsibilities, such as, service his car, take rubbish out or hang pictures at home.

> *It makes you feel less of a person, especially when you had the capacity to do it before.*

He worries that,

> *Employment wise, no one wants to give you a go... Your self esteem just gets chiselled away and you start to question yourself, you really go, "Do I have the capacity? Do I have the capabilities?" You start to go, "Maybe I'm not that smart! Maybe I can't really do anything!" You know, the family will just disintegrate.*

Source: Case study conducted with injured worker (the name of the worker has been changed to protect their anonymity).

CASE STUDY 4

Frank is a diesel mechanic who worked for a government council servicing vehicles. On the 8th September 1994 Frank was doing a job that was too heavy and too repetitive for him to do alone. He asked his boss if he could have a qualified mechanic to assist him with the task, but was told he had to work with a young boy who was on work experience. The boy was unable to assist, so Frank did the task on his own and felt immediate impact in his back. Since then he has suffered severe pains in his thoracic and lower back for 19 years as six discs were impacted by the injury. Over the 19 years, muscle spasms in the back have developed into severe neck problems, with five discs in his neck impinged.

Since the injury Frank has had numerous operations and countless medical treatments. At times he has needed to fight the insurer (the employer was self-insured) to pay for the medical treatments in court. When treatments were suspended while he campaigned for compensation, his injury deteriorated. Frank continues to suffer chronic pain:

> *Nothing gets rid of the pain. It's there all the time. I don't sleep very well. I take painkillers and anti-inflammatories every day. I take sleeping tablets at night just to get a little sleep. I generally get between 1.5 and 2.5 hours sleep a night. Then I'm awake again, just in pain... During the day I'm just exhausted and I put it down to lack of sleep and dealing with constant pain… It's been a long hard road, everything's been difficult. Life's been difficult. My relationship's suffered... we're separated at the moment. It's been hard because we've been together 22 years… Every facet of my life has been altered by pain… Not a week goes by when I don't see somebody for some sort of help.*

As a result of the injury Frank has been unable to have children, his relationship has suffered and his father also suffers stress and anxiety from watching Frank in pain. Franks describes his experience with workers' compensation as unwelcomed and harrowing:

> *I don't remember the last time I felt happy...When you get treated the way I've been treated you lose a bit of respect for yourself and you feel lesser of a person. Your mates are doing things, like going four wheel driving and I just physically can't do it... I have to get someone over to help me make the bed because I just can't change the sheets on my own… There is a lot of alienation and stigma attached to the [perceived] malingering bludger workers' comp bloke.*

While on workers' compensation, Frank's weekly entitlements and medical payments have fluctuated. At times the insurer has accepted liability and other times they have denied liability. Frank presently pays for his own weekly remedial massages and hydrotherapy to manage the pain, while the insurer is paying for chiropractor visits.

For the first six months after the injury the employer provided limited suitable duties, most of which were inappropriate. For instance, he was required to lift heavy objects or lean over a planning desk. Then for 18 months the employer consistently told Frank to come back later for suitable duties. At the end of that period Frank was medically retired by his employer.

Frank wanted to be able to work, so he paid $6,000 of his own savings to requalify as a vehicle inspector and establish his own business. The work was very sporadic and he was unable to support himself. The business made a loss and after 2.5 years he changed to a different location and attempted to run a more successful business. He found the work was aggravating his injury and exacerbating the pain. During this time he sold his assets to support himself. Ultimately the business was unsuccessful, so he closed the shop at a loss of $38,000.

Frank would have preferred to find a job as an employee; he applied for more than 40 different jobs, but was unable to secure employment with his movement restrictions. 'I was always constantly looking for work but unable to get it.' Eventually he found another job in 1999 that would suit his capabilities. For the employer to accept Frank in this role he had to work as a sub-contractor, paying for his own insurance as the employer was unwilling to take the workers' compensation risk. This job was suitable for Frank because he had a lot of flexibility to rest when his injury flared up and attend regular medical treatments as required. After 10.5 years of working as a sub-contractor Frank stopped working because the pain he was suffering was too much. During this period he saved his income very carefully so he would be able to support himself in the future, as he expected his back injury would continue to deteriorate.

Frank described his experience with his insurer during this time as follows:

> *It's turned me into a bit of a bitter person, what's happened just because of the way it's happened. I would have liked to have thought that they were there to help me but they help you a little bit but then they actually try and aggravate you and make things worse by denying liability or sending you to this doctor and then sending you to that doctor. I don't understand why they have to keep getting another report when it's plain as day on x-rays and MRI and bone scans that there is a problem. They don't deny there's a problem; they say it's to 'further their interest in my medical condition'. They sent me to a workplace rehabilitation service and she was trying to get me to get a job for 38 hours a week when I had a medical certificate stating no more than 20 hours a week – because they were trying to get me off their books.*

Frank's insurer is completing a work capacity assessment, but he has already been told that when the decision is made he will need to go to Centrelink for any income support. He has been assessed as having 23 per cent whole of person impairment, including 2 per cent for degenerative changes which are the result of the injury. Therefore Frank expects that the insurer will terminate his payments because he is not working 15 or more hours per week. When the payments stop Frank will live on savings and the assets he was able to acquire, through very frugal living and careful saving when he was working. He expects that in the end he will have to sell his house.

> *The way I see it is: I've done everything in my power to help myself. They've done everything in their power to make life difficult.*

Source: Case study conducted with injured worker (the name of the worker has been changed to protect their anonymity).

CASE STUDY 5

Jenny was injured in a car accident while travelling to work in January 2006. The car accident occurred when Jenny's car aqua-planed off the road during wet weather and hit a tree. No other vehicles or people were involved and Jenny was not found to be at fault. The car accident left Jenny with injuries to her foot, knee, leg, shoulder, neck and lower back.

Jenny was employed by a state government organisation, which was self-insured for workers' compensation. The employer/insurer immediately accepted liability, commenced weekly payments, medical entitlements and a return to work programme for Jenny.

Jenny tried very hard to meet all the requirements of the return to work programme, but struggled to get to work or meet the employer's requirements because she had suffered so many injuries. She felt very much unsupported in her efforts to return to work:

> *It was just a bullying, hostile return to work situation. There was no real assistance or help in that sense. If anything it was just all hostile and bullying. Obviously with my injuries and everything I just wasn't coping without that support.*

On 10 May 2006 the employer/insurer pressured Jenny to accept a redundancy package, this was less than six months after her injury had occurred. In the process of the redundancy she was compelled to sign a Deed of Release stating that she relinquished any further rights to raise the matter of her employment, redundancy or workers' compensation. Meanwhile the insurer declined ongoing liability for the accident, terminated her entitlements and Jenny had no option but to claim Sickness Allowance through Centrelink. Jenny complied with a comprehensive Centrelink Rehabilitation Service (CRS) programme, which incorporated hydrotherapy, physiotherapy and attempts to return to work. She had previously qualified as a make-up artist and managed to gain employment in a beauty therapy salon. However it quickly became apparent that she was incapacitated for work, as she did not have the mobility required to do the job. Instead she was aggravating her injuries.

> *It was like a no-win situation. Everything I tried I failed at. I was trying to be proactive about it and organised [the employment] myself but it didn't work out.*

Ultimately, the employer at the beauty therapy salon and the rehabilitation staff at CRS found that her injuries were aggravated by trying to do too much. They recommended that she progress from Sickness Allowance to Disability Support Pension payments.

In the meantime, Jenny's employer had incorrectly used some of her annual leave entitlements when she should have been paid workers' compensation during the short period when the employer/insurer was accepting liability between January and May 2006. The Deed of Release did not prohibit Jenny from taking this matter to the small claims tribunal and she was able to recover the lost wages through the tribunal.

This success in the tribunal then voided the Deed of Release and opened the door for Jenny to take her workers' compensation claim to the Workers' Compensation Commission. At the end of 2007 she was granted workers' compensation payments on the basis of Section 40 – Weekly payment during partial incapacity (1987 Act). However the result in the WCC was only a small portion of what Jenny should have been granted because her lawyer had 'been incompetent' and failed to present all her injuries to the WCC. Instead the lawyer only presented physiotherapy reports for her knee and neck injuries. Jenny was too 'mentally frazzled' to cope with the situation, so the result was that she received only partial compensation for her injuries. The WCC found, on the basis of her knee and neck injuries, that she could work 18 hours per week. She was granted top-up payments to make up the difference between what she could earn in 18 hours per week and what she had earned prior to injury.

Notwithstanding that with the injuries to her lower back, foot, leg and shoulder, which were not considered in the WCC, Jenny is incapable of working at all. The Commission ruling ordered the insurer to pay all weekly entitlements to Jenny dating back to when they had ceased payments in May 2006. The ruling also ordered the insurer to reimburse Centrelink for the CRS treatment and rehabilitation expenses, amounting to $8,000.

In 2009 Jenny completed a short course by correspondence because she was, 'trying to get back into the swing of things.' She is currently completing an additional qualification at TAFE, with the same objective of getting herself back to work. Centrelink is paying for this training because Jenny continues to receive the Disability Support Pension, which entitles her to training assistance from Centrelink.

The stress of the accident, living with injuries and pain and not being able to work has led Jenny to suffer from adrenal fatigue and a hormone imbalance. The symptoms of these problems are muscle weakness, fatigue, low blood pressure and difficulty in concentrating. She struggles with day to day activities. She is unable to meet with friends because she is never certain if she will be able to cope with a social interaction. Prior to the accident Jenny was 'very bubbly, very outgoing and very social'. The accident has changed her life, she is now extremely isolated. Nonetheless Jenny still dreams of being physically capable enough to work again.

> *They're the sort of things you have to deal with. There'd be nothing more that I'd like than to be able to get out and go to work and be amongst people and get that confidence you get within yourself when you're working. I was always a go-getter. I'd always aim for the top. Even when I was working... I was the top person within that 60 person [team] for five months in a row... I was always driving to be better. I'd worked my way up to the top of where I could go. I just can't do that now and that's very frustrating because that's just the type of person I am. I like to put 110% into what I'm doing. It boosts your own ego up in a sense when you get results and when you've done extra well in what you're doing. I just can't do that now. I can't even put words together in a sentence sometimes and I find that really frustrating – due to the fatigue and the pain.*

Jenny is still receiving her weekly entitlements, but has received a WCD notification that her weekly entitlements will cease on 26 December 2013. The WCD states that she has capacity to work full-time as a receptionist. This contradicts the WCC finding that Jenny could only work up to 18 hours per week, and that finding was only on the basis of two of her six injuries (the knee and neck injuries). Jenny has submitted a request to the insurer for an internal review of the WCD, which is currently underway. She finds the review process extremely stressful:

> *They kind of leave you hanging in limbo. Just dealing with this review is so stressful. You can't focus on anything else. It's a horrible way to live. I shouldn't even be going through this because [the payments] were court awarded and it should have just stayed in place, when I was trying to get back out there to get some sort of work capacity, I'm still trying.*

Jenny is claiming assistance with her medical treatments through Medicare and she pays for the $15 gap with her own money. She is technically entitled to be compensated for all medical treatments by her insurer, but fears fighting this battle would be too much stress to cope with. The insurer recently sent her a letter stating that she was only entitled to $136 for all future medical expenses. This letter misinterprets the ruling from the WCC, which had stated that the insurer was required to reimburse $8,000 medical and rehabilitation expenses previously paid by CRS. The notification from the insurer instead redefines the WCC ruling as an order for the insurer to pay up to $8,000 for future medical expenses. This is misleading, as Jenny is entitled to medical entitlements until 12 months after her weekly entitlements cease.

When her weekly payments are terminated, Jenny will only receive Disability Support Pension. She will struggle to pay her small mortgage payments of $250 per week and cover other expenses for herself

and her son. If she can no longer afford her mortgage and loses her house she will not be able to afford to pay rent, because a rental property for her and her son will cost $350. When weekly payments are terminated Jenny will also no longer be able to afford to pay for her medication, which costs $70-80 per month. Without medication her hormonal conditions will deteriorate and she is likely to need to have a hysterectomy. This is extremely upsetting for her as she is only 38 years old and does not want to eliminate the option of having more children in the future.

> *To be just on Centrelink I won't have enough to survive. There's just no way. I'll be able to cover the roof over my head and immediate bills and none of the other ones and forget about food and petrol. I honestly don't know, I'm trying not to think about it because with my hormones being out I'm trying not to put extra pressure on myself. But it's not good. It'll be friends and family who are going to try and step in and help. For someone who was so independent, I mean I've worked and supported myself ever since I was 14 – that gets you down, the fact that you've got to rely on other people's generosity to cover your basic needs. I only just get by now with the amount that I get – I'm just coping. There's no luxuries. There's nothing flash, it's just covering my expenses and you go without. There's no holidays, that sort of thing that I used to do before [the accident]. And to have that little bit taken away from you and be put on the poverty line? I can't even get my head around it. It's so inhumane and wrong.*
>
> *They're thinking that it's going to get people back out to work. They're sadly mistaken because some people just can't work. They're only going to be putting them out on the street.*
>
> *I'd love to be back out there and not have to deal with this, not have to be trying to ring around and find out what I can do. It's so stressful. I'd rather just get up and go to work and have a quality of life, be happy, not have to deal with this, have more money financially. Even the [weekly payment] is nowhere near what I was earning before.*

Source: Case study conducted with injured worker (the name of the worker has been changed to protect their anonymity).

CASE STUDY 6

Sally is a teacher who first suffered an injury to her right knee when she fell down while at work in 2000. She had no problems with receiving workers' compensation for time off work and an operation on her knee. Shortly after this first injury she returned to work as a teacher. Then in December 2007 she fell again while at work and suffered a broken shoulder and reinjured her right knee. She received workers' compensation while recuperating at home for four days. Then the insurance company, GIO, telephoned her at home, once. With her injured knee and broken shoulder she was not mobile enough to reach the telephone before the call was collected by the answering machine. The case manager left no message, instead she posted a letter stating that Sally's workers' compensation benefits would be terminated because she was not contactable. The letter arrived on Christmas Eve.

Sally called her union, the Teachers Federation, and they assisted her to have the workers' compensation reinstated. Sally returned to work for the first and second school terms in 2008, until her knee injury flared up and she required a knee operation. The operation was covered by workers' compensation and shortly after Sally returned to work. She continued working until April 2009, although she did struggle with her knee injury.

In April 2009 she was forced to stay at home because, 'I couldn't continue, I couldn't walk up stairs, I couldn't walk more than 100 metres, my knee was agony.' Sally had engaged one of best knee surgeons in Australia and he recommended that rather than attempting a third, and highly risky, knee operation in the short-term, Sally should attend the gymnasium to maintain reasonable use of her knee. The specialist also advised that Sally was unfit for work as her knee would never regain adequate mobility.

Meanwhile the insurer required Sally to attend six physiotherapy sessions, which were unsuccessful because the knee injury she had was non-responsive to physiotherapy. The advice of the specialist (to exercise her knee in the gym) has been effective for Sally, but the treatments provided by the insurer were counter-productive because they did not account for the extent of damage to the knee. The insurer has also compensated Sally for home assistance twice when a cleaner attended her home. These were the only two ways in which Sally received rehabilitation from the insurer.

From April 2009 Sally remained unfit for work, but voluntarily opted to suspend her workers' compensation payments, instead using her accumulated sick leave, annual leave and long service leave for income. Nonetheless, the insurer, GIO, appointed a rehabilitation service provider, 'Regain'. Staff from both GIO and Regain would call Sally every day, up to three times per day telling her to go back to work. Sally explained, 'The [rehabilitation provider] woman just badgered me. She would say, 'You are fit to go back to work.'' At one point the rehabilitation provider telephoned Sally from her doctor's surgery and demanded that Sally attend a conference immediately at the surgery. Another time the owner of Regain called Sally and told her, 'You need to learn the law' when they were trying to push her to do things that were outside the boundaries of the law.

> *GIO and the rehab people kept on ringing me up, demanding I do this, demanding I do that... I got threatened by the case manager, who said to me, 'You will do what I say or you will not get your knee replaced.'*

Sally complied with the insurer's requirements for assessments to be completed even though she was still self-funding her own living expenses using accumulated leave. Sally was told by her insurer to attend a functional assessment. She felt untrusting of the medical professionals appointed by the insurer and asked to appoint an independent assessor. This request was declined by the insurer and WorkCover, even though the legislation included provision for Sally to meet with a medical professional of her own choice.

Sally's case manager has changed nine times, which has compounded the problems with her case. In one instance the case manager posted her a file complete with full medical reports and receipts for treatments for a different injured worker. The other workers' file was accompanied with a letter demanding that Sally justify those claims for compensation.

In May 2010 Sally became eligible for retirement under the teachers' pension scheme, which provides a pension for teachers from 55 years of age. She continued to hope that her knee would recover adequately for her to work as a casual teacher, as is common practice amongst teachers who are eligible for retirement at 55 years of age. At this juncture Sally remained unfit for any work, so she claimed the statutory rate of workers' compensation to supplement her pension income. Her weekly benefits commenced in June 2010.

Sally has continued to fund all her own medical and rehabilitation expenses. Sally never claims compensation for any of her medication or gymnasium expenses for two reasons. Firstly because she is fearful the insurer will inadvertently divulge her personal details to someone else, for instance by accidentally posting out the wrong file, as another's file had been sent to her. Secondly she 'didn't want any arguments with them. I wanted them to leave me alone.'

In October 2013 Sally's insurer commenced a work capacity assessment, however they did not inform her of this. The rehabilitation provider asked her in November to 'come in for a chat to go over the

files', however closer investigation revealed that the insurer was conducting a functional assessment. When Sally's WCD is completed she expects that her weekly payments will be terminated. Without weekly payments, Sally will be unable to afford to pay for her gymnasium membership, so she will not be able to maintain reasonable use of her knee. Her specialist has predicted that without these regular maintenance exercises she will require a full knee replacement sooner rather than later.

In the process of being involved with workers' compensation, Sally has developed a heightened fear of doctors and workers' compensation related appointments:

> *I'm scared... I instantly think, anything to do with doctors is going to be really bad... These people I'm seeing next week [insurer appointed functional and vocational assessors], I'm terrified of seeing them... I've got two weeks of nightmares... Quite frequently I'll cry in the assessment because I find them terrifying. I'm dealing with people who I know are only there to make sure that my life gets worse.*

Sally has also developed daily anxiety around hearing from the insurer:

> *I try to look on the bright side, maybe I can wake up in the morning and not fear the telephone ringing... GIO were dreadful to me. Sometimes they were ringing up three times a day and harassing me... They instantly assume you're rorting the system.*
>
> *With this kind of pain, some days are ok, but on other days it is so painful. It makes you really depressed, I don't think that I've ever cried as much in my life as I have in the last four or five years.*
>
> *They have no idea of the psychological damage they cause to people.*
>
> *It's an adversarial system that sets up this, 'We're going to get you any way we can' kind of thing.*

Source: Case study conducted with injured worker (the name of the worker has been changed to protect their anonymity).

10. CONCLUSIONS

Analysis of preliminary data raises serious concerns about moral hazards, conflicts of interest, performance incentives and a lack of public accountability and transparency inherent in the NSW workers' compensation scheme. In many cases these issues have been exacerbated by the 2012 changes. Furthermore, a number of legislated amendments present an illusion of increased support for injured workers but this masks a very different reality. For example:

Weekly benefits: The significant increase to weekly payment statutory limits offers a theoretical improvement in the financial support available to injured workers. However, the 2012 changes allow insurers to reduce these payments by the value of wages for a hypothetical job that the insurance case worker assesses the worker as having the *capacity* to perform, regardless of whether such a position is available, where such a position might be located, or whether the medical practitioner deems the worker fit for that duty. This brings into question the extent to which the increased benefits lauded in media releases in September 2012 by the Minister for Finance and Services (Pearce, 2012a) are, in reality, accessible to the workers who need them. Furthermore, evidence suggests procedural hurdles, a lack of access to crucial information and perceptions of bullying are compounding the problems experienced by injured workers who are trying to recover and return to work. Consequently, individuals whose work injury has left them with chronic and debilitating conditions struggle to receive appropriate weekly payments after 130 weeks.

Medical treatment: The changes promised that 'seriously ill workers will have more money from today and access to medical treatment for life' (Pearce, 2012a). In reality, the definition of 'seriously injured' used in this context is extremely limiting. The meaning is radically different to 'serious injury' as applied, for example, to reporting on injury rates. For almost all injured workers, the changes introduced a 12 month time limit that ties medical payments to the cessation of weekly benefits. Accordingly, workers who succeed in returning to work are losing access, after only 12 months, to the critical medical care and equipment they require to address long term medical consequences of work injury or illness. These have included access to surgery, remedial and follow-up treatment, ongoing pain relief medication, and routine replacement of equipment and prosthetics, such as hearing aids.

Return to work: The benefits of timely return to work were clearly recognised in the parliamentary inquiry preceding the legislative amendments. However, while the revised Acts place significant demands on workers, they fail to strengthen corresponding requirements on employers. In particular, provisions for suitable work post-injury and protection against termination of workers with long-term work-related impairment or incapacity are inadequate. Evidence reveals terminated workers suffer stigma and discrimination from potential employers, leaving them demoralised and in some cases traumatised, not to mention financially penalized. The financial burden of weekly benefit reductions and loss of access to medical treatment is unlikely to assist workers to return to work.

There is no doubt that the recovery of the financial position of the NSW Workers' Compensation Scheme has been achieved by dramatically reducing compensation for injured workers. To that end, the justification remains unclear for the NSW Government's decision to ignore the majority of drivers attributed to the financial deficit (as identified in actuarial reports and the parliamentary inquiry) and instead legislate narrowly to limit the access of injured workers to support. Upon

returning the scheme to surplus, the Government also failed to review the impact of the changes on injured workers before granting successive benefits to employers.

A further risk for the scheme is the possibility for the government to introduce legislation allowing them to draw a dividend from the WorkCover scheme. The Victorian government can and does pay annual dividends out of its WorkCover scheme, with $471.5 million being transferred to other Victorian state government departments during the four years from 2012 to 2015 (Keen, 2013). The capacity to extract funds from the state WorkCover scheme reinforces the notion for employers that workers' compensation premiums are a form of taxation, rather than an insurance scheme to protect injured workers (Henry, 2013). At this stage the NSW WorkCover scheme does not allow funds to be transferred out of WorkCover.

An effective workers' compensation scheme is a finely balanced system designed to protect workers from injury and disease. It needs to achieve a careful mix of support and enforcement for both employers and employees. This ensures employers not only understand but meet their WHS obligations and, in the event of injury, workers with legitimate claims are appropriately supported and compensated for costs resulting from the translation of workplace risk to injury or disease, while exploitative claims are discouraged.

Sound governance is required to maintain this balance and ensure the continued financial viability of such a scheme. This pertains to mechanisms including the policies, procedures and accountabilities relating to WorkCover, scheme agents, self-insurers, employers and employees. As evidence of the potential for further improvement, two stakeholders in this study suggested introducing different streams for processing different types of workers' compensation claims would be advantageous. For instance, a minor injury, which will be healed in a short period of time, needs to be handled differently to a major trauma incident or a serious back injury (Garling, 2013a; Goodsell, 2013).

Overall, the findings outlined in this report suggest recent legislative changes have led to intended and unintended outcomes that, on balance, have eroded rather than strengthened the ability of the NSW Workers Compensation scheme to effectively and fairly identify and compensate injured workers.

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ANNEX A: SCHEDULE OF INTERVIEWS

Name	Affiliation	Title	Date
Mark Goodsell	AIGroup	Director, NSW	16/9/13
Ramon Gebert	AIGroup	Senior Advisor, Safety and Workers' Compensation Services	16/9/13
Kim Garling[22]	WIRO	Kim Garling, WIRO	17/9/13 15/10/13
Adam Grumley	IWSN	Adam Grumley, IWSN Co-ordinator	19/9/13
Sherri Hayward	CFMEU	Sherri Hayward, Industrial Officer, CFMEU	26/9/13
Velma Gersbach	NSWNMA	Velma Gersbach, Workers' Compensation Officer, NSWNMA	26/9/13
Neale Dawson	NewLaw	Neale Dawson, Principal Solicitor, NewLaw	26/9/13
Dave Henry	AMWU	Dave Henry, WHS Officer, AMWU	4/10/13
Richard Brennan	McNally Jones Staff & Co.	Richard Brennan, Partner, McNally Jones Staff & Co.	16/10/13
Ivan Simic	Taylor & Scott Lawyers	Ivan Simic, Partner, Taylor & Scott Lawyers	24/10/13
Injured worker	Case study 1	John, injured worker	1/10/13
Injured worker	Case study 2	Barry, injured worker	2/10/13
Injured worker	Case study 3	Frank, injured worker	3/10/13
Injured worker	Case study 4	Linda, injured worker	4/10/13
Injured worker	(not used as worker was not impacted by the changes)		15/10/13
Injured worker	Case study 5	Betsy, injured worker	6/11/13
Injured worker	Case study 6	Sally, injured worker	7/11/13

[22] Listed in the report as (Garling, 2013a) so as to distinguish from the (Garling, 2013) report cited in the reference list.