David Shoebridge MLC
Member of the NSW Legislative Council

The Hon Dominic Perrottet
Minister for Finance and Services
Level 36 Governor Macquarie Tower
1 Farrer Place
SYDNEY NSW 2000

By email to: statutoryreview@finance.nsw.gov.au

3 June 2014

Submission Re Workers Compensation Reform

Thank you for considering the below submission as part of the review of the workers compensation system in NSW.

Introduction

The purpose of a workers compensation scheme must be to protect the economic and social welfare of people injured at work.

Nobody chooses to go to be injured at work. A workplace injury is a misfortune that can happen to any worker at any time. For this reason, workers compensation benefits must be adequate and fair so that those injured at work can:

(a) receive all reasonable and necessary medical treatment
(b) live with economic dignity commensurate with their earning capacity before their injury, and
(c) obtain a fair measure of compensation for the permanent physical and psychological damage they have received.

As a result of the harsh amendments made by the Parliament to NSW workers compensation laws in 2012, this State's workers compensation scheme no longer satisfies any of these tests.

This submission will briefly address the most significant failings in the workers compensation scheme and where appropriate propose remedies. Importantly it also seeks to give a voice to the very many injured workers who have contacted my office and sought the Minister's direct intervention in their claims.

The series of case histories from injured workers themselves demonstrates clearly the devastating impact that the 2012 "reforms" have had on the lives of far too many injured workers.

The Financial Argument for the 2012 reforms

In late 2011 through to mid-2012 the NSW government made a series of announcements to the effect that the NSW Workers Compensation scheme was in severe financial crisis. In March 2012 it released an "Issues Paper" that stated in part:

> The financial sustainability of the Workers Compensation Scheme is deteriorating. An independent valuation of the Scheme's outstanding claim liabilities is undertaken every six

> months (for the periods ending 30 June and 31 December). The most recent valuation is for the period ending 31 December 2011.
>
> …
>
> As at 31 December 2011, the Independent Scheme Actuary calculated the Scheme‟s deficit at $4.083 billion, a deterioration of $1,720 million in six months. Its funding ratio is 78%, a deterioration of 7% in six months.
>
> …
>
> The financial sustainability of the Scheme, at current premium levels, is expected to deteriorate further in future years. This is not good for business or injured workers."

The government claimed that, unless significant "reforms" were made, insurance premiums would have to rise by 28%, costing jobs and reducing the State's competitiveness.

The NSW Business Chamber jumped into the debate and said if premiums increased by 28% that "12,600 jobs were on the line."

With this rationale driving "reform" a Parliamentary Committee was established and, following a remarkably quick (some would say pre-determined) inquiry, it supported the government's reform agenda of slashing benefits and further entrenching the power of the regulator, WorkCover.

In June 2012 the reforms were legislated.

The nature of the 2012 reforms

A brief summary of the 2012 reforms is as follows:

(a) The introduction of workplace capacity testing to reduce and cease weekly benefit entitlements
(b) Denying injured workers legal assistance to challenge workplace capacity assessments
(c) Abolishing the entitlement to compensation for pain and suffering
(d) Abolishing the entitlement to compensation for permanent impairment for injures where the whole person impairment assessment ("wpi") is 10% or less (the great majority of injuries)
(e) Abolishing medical expenses for all but "seriously injured" workers 12 months after they cease receiving weekly benefits (or 12 months from the date of injury if no weekly benefits received)
(f) A marginal increase in weekly benefits for a small class of injured workers (those defined as seriously injured – being those with a wpi of 30% or greater)
(g) Removing workers compensation protection for journey claims
(h) Terminating weekly benefits for all but seriously injured workers after a maximum period of 5 years, and

(i) Applying these changes retrospectively to workers injured before the introduction of the 2012 amendments.

A successful amendment moved by the Greens exempted all emergency services workers from these changes. This was largely a response to a committed industrial campaign from members of the NSW Fire Brigade Employees Union who, in a historic industrial action, surrounded the Parliament with fire engines in protest at the changes.

This submission suggests that the protection afforded emergency services should now be returned to all injured workers in NSW.

The 2012 reforms were not required

In parallel to this statutory review process, the Law and Justice Committee of the NSW Upper House is undertaking its Review of the exercise of the functions of the WorkCover Authority . Evidence that has been presented to the Law and Justice Committee is clearly relevant to this inquiry.

It is essential that the review contact the Committee's secretariat and obtain access to the submissions and exhibits tendered in that inquiry.

Perhaps the key evidence presented to the Law and Justice Committee is that of the WorkCover Authority's scheme actuary, Price Waterhouse Coopers (PWC). That evidence demonstrates that the brutal cuts to workers compensation benefits were not required.

As noted above, the NSW government used a notional $4 billion deficit in the scheme as at December 2011 to make the case for the slashing of workers compensation. However the PWC actuarial report tabled in the parliamentary committee shows that the scheme was not in a chronic deficit situation and was on track to return to surplus without the savage amendments pushed through in 2012.

Links to the reports are available here:

(a) **PWC WorkCover Solvency Report**

(b) Workers Compensation Nominal Insurer Scheme Results 31 Dec 2013

These reports make it clear that the figures which were used to support the scheme cuts in 2012 were the result of a few years of unusually low return on investment following the GFC.

Even if no changes were made to the scheme in 2012 it would have returned to surplus in the coming years. This is due to the fact that long term investment returns have, in the years since 2011, increased closer to their historical norm.

As result, even without the 2012 reforms, the scheme was on track to turn the notional $4 billion deficit of December 2011 into a $2 billion deficit by June 2014, a $0.5 billion deficit in June 2018 and back to surplus by 2021. Figure 2 below shows the PWC solvency projection for the scheme.

Figure 2 – Re-estimated solvency projection

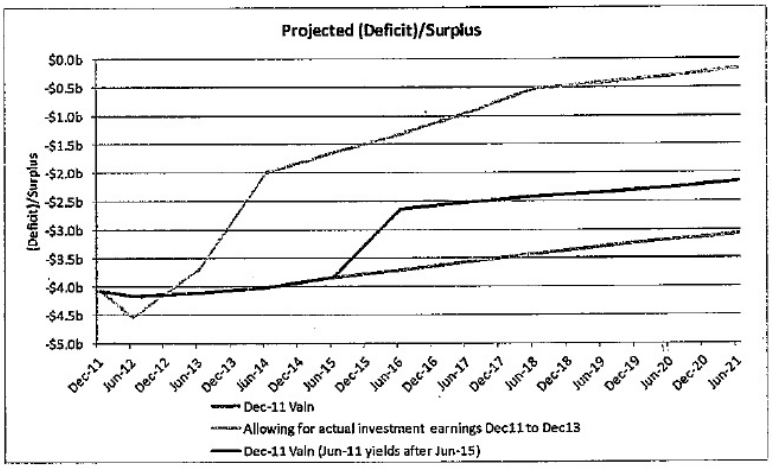

Figure demonstrates that the solvency trajectory is significantly different after allowing for actual investment earnings over the 2 years to 31 December 2013.

The lower discount rates at 30 June 2012 initially produce a further deterioration in the Scheme's funding position.

As at December 2011, the $11 billion that WorkCover had put aside to meet future claims was receiving historically low rates of return due to the ongoing fall out of the Global Financial Crisis and produced this notional $4 billion scheme deficit.

As should easily have been predicted in 2012, investment returns have now bounced back and WorkCover's own actuary is saying it would have been on track to return to surplus without any of the brutal; cuts imposed on injured workers in 2012.

The tragic fact is that the 2012 changes have seen thousands of injured workers lose their benefits and much, if not all of the personal suffering they have endured as a result was unnecessary.

With the increased returns on investments and the savage benefit cuts operating over the last two years, the state's workers compensation scheme has lurched from a notional $4 billion deficit to a current surplus in excess of $1.3 billion.

PWC's best estimate is that the combination of far fewer benefits being paid by the scheme and improvements in the scheme's investments mean that the surplus will reach embarrassingly high level of $5.5 billion by 2019.

The recent decision by the High Court in the case of Goudappel, (which validated a regulation made by the NSW government that retrospectively removed lump sum entitlements for an estimated 16,000 injured workers) has swollen the current surplus by a another $350 million. This further

fattening of the scheme's finances was entirely paid for by injured workers who have lost yet more rights.

With the rationale for the 2012 "reforms" now discredited and an embarrassingly large surplus building in the scheme, it is time to return to injured workers the benefits that were so unfairly, and unnecessarily, taken from them in 2012.

The balance of this submission will consider the very real impact of the 2012 "reforms" on individual injured workers in NSW. My office has been contacted by hundreds of injured workers who have concerns about their treatment under the amended workers compensation system in NSW.

Many of these people have shared their story with my office, asking that I bring their concerns directly to the government's attention. Accordingly I have considered these communications and drawn together the systemic concerns they raise with the scheme. The full text of these communications has been provided to Minister Constance, but for privacy reasons is not included here.

Thank you for your consideration of these important issues, I look forward to your considered response. If you have any further questions, or to discuss, please contact me on 9230 3030.

Kind regards,

David Shoebridge

Issues with the revised scheme

A. The withdrawal of reasonable and necessary medical benefits

Thousands of injured workers have lost their right to payment for reasonable and necessary medical benefits as a result of the 2012 "reforms". There are two principle ways this occurs. They are:

(a) The worker has reached retirement age, and as a consequence of the 2012 amendments, they lose all medical benefits having not been in receipt of weekly benefits for 12 months or more, and

(b) An injured worker has lost their entitlement to weekly benefits as a result of a "work capacity assessment" and as a consequence loses their entitlement to medical expenses 12 months later.

The exact number of workers who have lost their benefits as a result of these changes is not known.

A very conservative estimate of the number of workers who have lost their entitlement to weekly payments as a result of the reforms is approximately 12,000.[1] There are thousands in addition to this who were aged 66 or more at the time of the 2012 "reforms" and were therefore not receiving weekly benefits in 2011. Almost every one of those older injured workers has now lost their right to medical benefits.

In a number of instances the removal of medical benefits (such as the provision of prosthetic limbs, pain medication and ongoing physiotherapy) meant that these workers do not feel they will be able to continue working.

The cost of pain management for continuing conditions is obviously a serious concern for many injured workers, the cost of the medications required is often identified as something which was causing, or likely to cause, severe financial distress.

For older workers who suffer industrial deafness due to exposure to noisy workplaces the loss of medical benefits means they will not receive replacement hearing aids, let alone servicing and batteries for their existing hearing aids. This loss can be severely socially debilitating.

Any money saved by the scheme as a result of the withdrawal of medical benefits is more than outweighed by the distress and suffering caused to injured workers who lose their benefits. This

[1] This is obtained from the 15 April 2014 PWC report to the WorkCover Board that identified the reduction in active weekly payment claims from 40,000 in 2011 to just over 28,000 in 2014. It also accords with the number of "adverse" work capacity assessments issued in the period from 1 January 2013 to April 2014.

submission urges the review to recommend that reasonable and necessary medical benefits be immediately reinstated for all workers injured in NSW.

Some of the comments regarding the removal of coverage for ongoing medical costs were as follows:

> "Please review your decision and cover ongoing medical for those permanently injured - happy to undertake independent medical assessments. I am a Liberal voter, but my god you are losing me and my extended family forever if you do not end this injustice!"[2]
>
> "As a result of the recent changes to Work Cover legislation I will no longer be covered for medical treatment for this disease which has over shadowed my life for so long now. Due to the treatment program I have to date been able to maintain my employment and at least some quality of life, however fear that I will not be able to afford to sustain into the future without financial assistance which to date has come through Worker Compensation Insurance provided through my employer".[3]
>
> "About 2 months ago I receive a letter from my insurer saying under the new act my case would no longer be covered due to it being medical expenses only"[4]
>
> Some of those affected have claims going back to as early as 1989:
>
> "It was reaffirmed to me today that I would have to have the operation by the end of the year to be covered by Worker's Compensation. This is impossible as Dr. Davies is finishing his operations this week and taking a month's holiday. WHAT DO I DO NOW? "[5]
>
> "It is now close to 3 years and my provider has started calling me that my weekly payment will be stopped in March next year".[6]
>
> "My medical expenses will finish in about a year - after wish I will have to try to find out of my small casual wage the money to pay for the drugs - without which I CANNOT WORK!"[7]

[2] Submission 2.

[3] Submission 3.

[4] Submission 11.

[5] Submission 16.

[6] Submission 18.

[7] Submission 19.

"On 15 October payments ceased. I understand medical bills may be paid for further 12 months then that's it. My knee is deteriorating, Professor Ghabriel, the consultant has confirmed that in last 12 months it has declined from 16% to 21% permanent incapacity, and getting worse".[8]

"I have a lifelong occupationally acquired disease complex that will require ongoing long term medical treatment. The new 12 month only cover does not take into account those injured workers who have long term debilitating illnesses acquired through their work."[9]

"I am also becoming increasingly concerned about how we will fund my treatment when my Workers Compensation payments end. I have a workplace acquired chronic disease that is very expensive and is going to take years to treat and I am about to be dropped like a stone. This disease will affect me some way for the rest of my life and very soon we will have to fund my treatment ."[10]

"Seeing as I have been at work now for 12 months my workers comp claim will now be closed on 31.12.13 even though I still am under workers comp, see my doctor monthly and require medications."[11]

"I am so disappointed that no ongoing care is available to me and the treatment I have received to re-open my case through Alliance insurance has been disgraceful."[12]

"I injured my left elbow at work on 6 July 2009. I have had to undergo surgery to my elbow but I still have problems with it. My treating specialist has told me that I will need a total elbow replacement in another 2-3 years' time. I received a letter from the insurer dated 26 September 2013 telling me that I was no longer covered for my medical expenses after 31 December 2013 due to the new legislative changes."[13]

"The medication that I must have and am addicted to cost a fortune every month now either the Federal Government pays or I do (somehow) where the INSURER is / was supposed to

[8] Submission 21.

[9] Submission 27.

[10] Submission 32.

[11] Submission 33.

[12] Submission 42.

[13] Submission 47.

pay. So basically I get approximately $30 a fortnight as opposed to a court ruling that the Insurer pay me a LOW weekly wage until pension age."[14]

"I have only 10 months left before any entitlement for medical help are but lost and taken away after a spinal injury that I have for life, not something a painkiller or an antidepressant will ever fix it."[15]

"I have had to borrow money to pay for surgery to my right foot as nerve damage was occurring and use my accumulated sick leave."[16]

B. Journey claims

The removal of workers compensation coverage for journey claims has caused needless distress and hardship. Travelling to and from work is an essential part of work. For this reason, for almost a century before the 2012 "reforms" any worker who was injured when travelling directly to and from work had been protected by workers compensation.

The removal of workers compensation protection for journey claims is leaving thousands of workers without any protection if they receive an injury getting to and from work. Shift workers, nurses and others who often work long and irregular shifts are particularly at risk from injury as they travel to and from work.

Journey cover costs the scheme very little and there is no rational argument, given the scheme's bloating surplus, for this protection not to be reinstated.

Some of the comments regarding the removal of coverage for journey claims were as follows:

"I have to make sure that it happens inside the school office and not in the playground before I sign on for work. I feel this is unfair as all of the school grounds should be covered including the car park"[17]

"I arrived at the front steps to my work place at the Powerhouse Museum and as a result of the poor repair of the front Museum steps, steps worn, huge gaps that have worn away, I

[14] Submission 56.

[15] Submission 57.

[16] Submission 75

[17] Submission 31.

tripped and fell seven steps, scraped my knee, twisted my ankle, scraped my knee and was dazed and required attention from first aid officers and was sent home.

I was very lucky that I only had to miss three days off of work. However my claim was knocked back because this was considered a journey claim because I did not arrive at my desk and was not performing my work at the time."[18]

"The WorkCover changes in June 2011 meant a legitimate injury on the way home from work has meant that my son has been without income for 18 months"**[19]**

C. Retrospectivity

One of the most unjust elements in the 2012 "reforms" was to impose the changes retrospectively on workers who had been injured prior to 2012. In some cases workers had been injured decades before the 2012 reforms. Many of these workers had received orders from courts and tribunals granting them ongoing entitlements to weekly payments and medical expenses, only to see these court orders become worthless and their benefits lost after a "workplace capacity assessment" from an insurance clerk.

It is not surprising therefore that so many injured workers who have contacted my office were dismayed that their weekly benefits would be discontinued under the new scheme.

The recent decision of Goudappel, referred to above, is only the most recent instance where this retrospectivity has damaged the lives of thousands of injured workers.

Some of the comments regarding the retrospectivity of applying these laws to existing cases were as follows:

"The retrospective changes have been a total breach of faith, as I was told weekly benefits would continue until one year after retirement and I was entitled to them after my settlement. If I had known what changes were coming when I originally got injured, I would have sued for strict negligence and avoided the onslaught of discrimination and harassment that injured workers suffer in this system."[20]

[18] Submission 34.

[19] Submission 71.

[20] Submission 22.

"In August last year I was advised my wages will stop due to not reaching the new capacity laws for work and there for my wages and medical expenses will cease, I have submitted internal review and merit review, the internal review came back in the insurer's way, still have not received response to merit review witch i sent in on 11/11/2013 my wages have stopped as from 06/01/2014 medical expenses will stop in 12 months I still have issues with my left ankle and are on strong pain killers every day!"[21]

"The insurer accepted liability in 1999 and agreed to pay ongoing costs for my medication/doctors. Now my case will be closed and I am unable to hold down a job as I have no qualifications. No adequate rehabilitation was provided. I was told that if I didn't work in any capacity my case would be closed."[22]

"Injured in July 1999…. Under these new laws my "make up" pay will be decreased from 6/3/2014 and I will lose approximately $180.00 per week, as they will only pay 80% of your assumed weekly wage."[23]

"Financially it was a struggle to get by with my COURT AWARDED payment ($379pw after tax) as I am the sole provider for my son, his father is dead so I do not get any child support or help there & both my parents have also passed away so again no help there either. Now with these ridiculous changes my court award means nothing & it has being taken away from me."[24]

D. Denial of ongoing benefits for all but the "seriously injured"

Under the 2012 reforms only "seriously injured" workers are entitled to payment of their reasonable and necessary medical expenses and the provision of weekly benefits beyond 5 years from the date of injury.[25] In fact most injured workers receive far less than 5 years of protection under the "reformed" scheme.

[21] Submission 39.

[22] Submission 40.

[23] Submission 65.

[24] Submission 70.

[25] For most injured workers the maximum period of payment of weekly compensation is 2 years from the date of injury or incapacity. In some cases the date of incapacity can be different to the date of injury (such as where a worker continues with an injury for some time until eventually going off work for surgery or as a result of deterioration in the injury).

A seriously injured worker is defined under the 2012 "reforms" as being a worker with a whole person impairment (wpi) of greater than 30%.

To give some idea of the harshness of this threshold a worker with a leg amputated 4 inches below the knee receives a wpi of 28% and is not considered to be seriously injured by the scheme.

Clearly very many workers who have a wpi of less than 30% are seriously disabled, unable to work and barely surviving now that their payments under the workers compensation scheme have been removed. Severe back injuries routinely receive wpi assessments in the range of 10 to 15%. A crippling psychological injury obtains a wpi assessment of just 15%.

Arbitrary thresholds based on wpi assessments are not a fair or efficient way to determine access to workers compensation benefits. All editions of the AMA Guides (which are used as the basis for wpi assessments) clearly state that an impairment rating is not equal to a disability rating and is not intended to be a measure of disability. Disability has to do with limitations or restrictions in job functions. WPI assessments only deal with the anatomic limitations caused by an injury.

A simple illustration of this is as follows. A person who has trained for decades as a concert pianist suffers a very disabling injury if they seriously and permanently damage a finger. They lose the ability to play piano as a concert pianist and suffer significant economic loss. The same injury suffered by a lawyer would be distressing, but it would not cause a disability that would seriously restrict their capacity to work. Yet under the NSW workers compensation scheme both their injuries would receive the same wpi and both be assessed as the same.

This is not fair and it is not rational.

While ever a worker is suffering economic loss, or in need of medical benefits, as a result of a workplace injury they should be covered by the NSW workers compensation scheme.

Some of the comments regarding the removal of benefits due to the harsh WPI thresholds are as follows:

> "I am permanently disabled after this injury but because the new laws state it has to be deemed at a certain level I am entitled to nothing."[26]

> "Work Cover insurers tell me that after a few months post the surgery they will decrease my payments to less than social security benefits, that i could probably get and as i can't

[26] Submission 59.

perform my usual duties, due to having my shoulder in a sling and no lifting allowed could end up having six months to 12 months of no income."[27]

"15 per cent whole person impairment is my determined damage, however the damage this has caused to my family and my future is a lot more than that."[28]

"I am about to attend an assessment of Whole Person Impairment (WPI). When I attend my WPI appointment there can be no included calculation of pain and suffering. My permanent condition of cervical spondylitis results in CHRONIC DEBILITATING PAIN."[29]

"I don't believe I will reach the safety threshold of 30% , the magic figure that is basically one third of a whole body . I mean how ridiculous, my back injury has caused me so much more grief than you can put a percentage figure on."[30]

E. Work Capacity Assessments

Perhaps the most far reaching, and damaging, aspect of the 2012 "reforms" was the introduction of work capacity assessments. These assessments are undertaken by insurance company clerks and routinely remove an injured worker's entitlement to weekly benefits.

During the work capacity assessment process, injured workers are denied legal representation (it is unlawful for lawyers to be paid to assist them with their claims). This is despite the fact that the process is impossibly complex, involving:

(a) An initial assessment by an insurance company clerk based on medical evidence, labour market evidence and material specific to the injured worker in light of complex guidelines issued by the WorkCover Authority;
(b) If the injured worker does not accept the initial decision they can seek an internal review by completing a request for an internal review;
(c) If the injured worker does not accept the internal review they can seek a merit review by WorkCover;
(d) If the injured worker does not accept the merit review they can seek a further review by the WorkCover Independent review Office (WIRO) in regard to any alleged procedural errors.

[27] Submission 64.

[28] Submission 71.

[29] Submission 63.

[30] Submission 52.

At no stage in this tortuous process is an injured worker given legal assistance. In WorkCover's evidence to the Law and Justice committee they advised that:

> *Injured workers in receipt of weekly payments of compensation prior to 1 October 2012 were transitioned by Scheme agents to the new legislative framework from 1 January 2013. Between 1 January 2013 and 30 June 2013, 7,338 work capacity decisions were made by Scheme agents. Of those decisions:*
>
> - *4,227 were non-adverse (weekly payments remained the same or increased); and*
> - *3,111 were adverse (weekly payments were reduced, or were nil).*
>
> *Between 1 July 2013 and 28 February 2014, Scheme agents made 9,371 work capacity decisions of which:*
>
> - *4,974 were non-adverse; and*
> - *4,397 were adverse.*

They further stated that:

> *Between 1 November 2012 and 30 June 2013, 1,645 adverse work capacity decisions were made by self and specialised insurers.*
>
> *In the period 1 July 2013 to 28 February 2014, self and specialised insurers made 3,257 adverse work capacity decisions.*
>
> *For new claims made on or after 1 October 2012 to 28 February 2014, 30 adverse work capacity decisions were made by self and specialised insurers.*

In all more some 12,440 workers received "adverse" work capacity decisions under this new scheme between 1 January 2013 and 28 February 2014.

Only a tiny minority, in total 2,666 internal reviews or 21% of the initial adverse work capacity decisions, were then challenged by injured workers seeking an internal review by the insurer. Again WorkCover's evidence to the Law and Justice committee demonstrates:

> ***Workers Compensation Nominal Insurer Scheme Agents***
> *In the period 1 December 2012 to 30 June 2013, Scheme agents received 447 applications for internal review of a work capacity decision.*
> *Between 1 July 2013 and 28 February 2014, Scheme agents received 1,332 applications for internal review of a work capacity decision.*
>
> ***Self and Specialised Insurers***

In the period 1 December 2012 to 30 June 2013, self and specialised insurers received 216 applications for internal review of a work capacity decision.
Between 1 July 2013 and 28 February 2014, 671 applications for internal review of a work capacity decision were received by self and specialised insurers.

It is notable that the insurance companies' internal review process routinely dismissed the injured workers' reviews and affirmed the initial adverse decisions by the insurers. As WorkCover's evidence to the Law and Justice committee again illustrated:

Workers Compensation Nominal Insurer Scheme Agents
Of the 1,580 internal review applications determined by Scheme agents:

- *1,084 resulted in no change to the decision;*
- *298 resulted in a more beneficial outcome for the worker;*
- *37 resulted in a less beneficial outcome for the worker; and*
- *161 were declined.*

Self and Specialised Insurers
Of the 673 internal review applications determined by self and specialised insurers:

- *491 resulted in no change to the decision;*
- *143 resulted in a more beneficial outcome for the worker;*
- *11 resulted in a less beneficial outcome for the worker; and*
- *28 were declined.*

Even more disturbing is the obvious inability of WorkCover, the scheme regulator, to effectively undertake the relatively small number of merit reviews it receives.

WorkCover's evidence to the Law and Justice Committee demonstrated not only how few injured workers managed to navigate the system to obtain a merits review, but how slow and generally adverse the reviews by WorkCover were:

9. How many work capacity assessments were subject to WorkCover merit reviews during the periods:
a. 1 July 2012 to 30 June 2013?
b. 1 July 2013 to date?
There were 68 applications for merit review finalised in the period from 1 July 2012 to 30 June 2013.
There were 615 applications for merit review finalised in the period 1 July 2013 to 10 April 2014.

10. What were the outcomes of those merit reviews?

Of the 683 merit reviews completed to 10 April 2014:

- *331 resulted in the same outcome as the insurer's work capacity decision;*
- *192 resulted in a more beneficial outcome for the worker than the insurer's work capacity decision;*
- *13 resulted in a less beneficial outcome for the worker than the insurers work capacity decision;*
- *147 applications were finalised without a merit review being conducted, for reasons including:*
  - *applications for merit review being lodged before an application for internal review had been made;*
  - *decisions were not 'work capacity decisions';*
  - *the insurer had either subsequently determined not to rely on the original work capacity decision that was the subject of the application, or had in fact made a subsequent and different work capacity decision on the same issue;*
  - *the worker withdrew their merit review application;*
  - *applications were lodged outside the 30 day time limit for lodging a merit review application under the Act.*

Of the more than 12,440 adverse work capacity assessments made by insurers, injured workers had merit reviews of those decisions by WorkCover in less than 6% of cases. Of those that were reviewed the great majority were unsuccessful meaning:

(a) The insurer's decision was affirmed
(b) WorkCover made a decision that was more adverse to the injured worker, or
(c) The merit review was rejected on procedural or jurisdictional grounds.

The delays by WorkCover in undertaking merit reviews are both unlawful (in breach of their statutory requirement to undertake he reviews in 30 days) and unconscionable. They are unconscionable because any delay where an injured worker is no longer in receipt of their claimed entitlement will, even if the initial decision is overturned, see the worker lose benefits due to the inability for retrospective payments to be ordered.

WorkCover's own evidence to the Law and Justice Committee was that the average time for a merit review was over 60 days with one as yet unresolved claim taking in excess of 199 days. The authority's specific evidence was as follows:

11. What was the average time for the undertaking of the [merit] reviews?

In total, as at 10 April 2014, 683 merit review applications have been finalised in an average timeframe of 61.9 days.

12. What was the longest time taken (or still being taken) for any [merit] review?
The longest time taken (or still being taken) for any review as at 10 April 2014, is 199 days for a current application, which is yet to be finalised.

The final review process by WIRO is so little used it is close to irrelevant in assessing the scheme's performance. WIRO's 2013 annual report makes clear only a tiny number of adverse work capacity decisions (in fact just 2) were reviewed by that office in 2013.

It is understood that this number has significantly increased since but still represents only an extremely small fraction of the total number of potential applicants.

The lack of reviews by WIRO is not the fault of that office which, within its limited powers and resources, has been actively and competently undertaking its various functions. It is simply the result of a lengthy, complicated and disheartening work capacity process that excludes legal help for injured workers.

The difficulty for WIRO and others in assisting workers with work capacity assessments is that few if any participants in the scheme understand what a "work capacity" issue is and what a "liability" issue is. If an insurer denies a claim based on "liability" then the injured worker can be legally assisted by a lawyer and contest the matter in the Workers Compensation Commission.

If however the insurer makes an adverse decision as part of a work capacity assessment there is no right to legal assistance and no ability to challenge the decision in the workers compensation commission. Instead the appallingly tortured review process described above is the injured workers only remedy.

In discussions held by this office with scheme participants it is apparent that what is a "liability" matter and what is a "work capacity assessment" is often impossible to tell. If a worker is advised in a s74 denial of liability notice that their benefits will cease because they are now fit for work the decision could readily be classed as either a "liability" decision or a "work capacity decision". It is understood that these issues are currently being considered by the Court of Appeal in a reserved decision.

The work capacity review process is impossibly complex, hopelessly inefficient, poorly understood and unfair. It is a "reform" that should never have been made. It should be replaced by a simple two-step review process that involves:

(a) An initial internal review, and
(b) An appeal to a single independent tribunal where the worker can be legally represented.

The effect of this failing system is a widespread loss of confidence in the scheme from injured workers. The following represents just a small sample of the frustration, distress and unfairness that injured workers have reported to my office regarding the work capacity assessment process:

> "I have been bullied, harassed, threatened and victimised throughout this. I became suicidal. I have had medical treatment denied as well. The work capacity process denies procedural fairness, it is an overwhelming process which can only result in the insurers favour. To be denied a paid solicitor is another injustice. To have to pay to take your matter to the Supreme Court against an insurer with deep pockets seeks to discriminate and disadvantage even further."[31]

> "The Insurer has absolutely and totally ignored nine independent medical practitioners and health professionals that have all certified that I have no work capacity for any type of employment. The position taken by the Insurer has been replicated by my employer, the NSW Department of Education & Training which has resulted in the Departments refusal to medically retire me forcing me to live off savings rather than access an invalidity retirement pension through my Superannuation.[32]

> "Are these people EVEN HUMAN BEINGS? THEY HAVE NO REGARD FOR ANYONE, MY QUESTION STILL CONFUSES ME - HOW A CASE MANAGER WITH NO MEDICAL BACKGROUND/DEGREE AND TRAINING CAN HAVE THE POWER TO MAKE A WORK CAPACITY DECISION ON A SINGLE IME REPORT, AND COMPLETELY IGNORE MY OTHER 10+ REPORTS FROM MY TREATING DOC WHO I SEE WEEKLY?"[33]

> From a personal perspective, I am horrified at the low handed way the Liberal government (which up to now I have always voted for) has brought in their RETROSPECTIVE LEGISLATION (Regardless of the spin). … I am currently awaiting the result of a WIRO appeal against the work capacity assessment which was done under the guise of "Looking for a job for you!"[34]

[31] Submission 4

[32] Submission 36

[33] Submission 23.

[34] Submission 19

F. Denial of ongoing benefits for all but the "seriously injured"

Many injured workers reported frustration with the delay between making claims and receiving weekly payments. Financial issues were also caused by the gap between incurring medical expenses and payment of them – often two months later – by insurance companies. Many of those responding complained that mistakes by the insurance company often made this wait even longer.

This delay and frustration has only been aggravated by the 2012 reforms to payment of medical expenses.

Prior to the 2012 reforms injured workers were entitled to reimbursement for all reasonably and necessary medical treatment they needed as a consequence of their workplace injury. This treatment could be either agreed to in advance by the insurer or reimbursed at al alter date once the treatment was undertaken.

As a result of the 2012 reforms, medical expenses are only payable by the scheme if they have been pre-approved by the insurer, no matter how trivial or how obviously necessary and reasonable they may be. This has caused significant hardship where reasonable and necessary treatments have been provided by treating doctors but, as they were not pre-approved, were not paid for by the scheme. In other cases the bureaucracy and paperwork required for pre-approval of medication or treatment has deterred claimants from seeking benefits.

The length of claims was a concern in many cases, with insurance company delays and contesting of claims identified as being among the factors that increased claim length.

> "All I want is to get better and get back to work, I enjoy working not sitting around bludging which is how I feel at this point in time I eat between 8 & 10 panadeine forte a day to suppress the pain, I am not the only genuine injured worker out there we only want repairing" .[35]

> "The insurance company have now accepted liability yet I am still waiting to be reimbursed my costs and all leave entitlements."[36]

> "The first 26 weeks I did not receive the correct pay and after the 26 weeks my salary was cut basically to less than what someone gets on the dole."[37]

[35] Submission 1.

[36] Submission 14.

[37] Submission 24.

"to receive a refund on pharmaceutical expense can take anything from 4-6 weeks , if someone "mislays" your Medical certificate I don't get paid then I have to resend a copy and wait until a payment can be made which could be 4-5 days ."[38]

"My injury has scared me physically, emotionally and financially yet I have nil contact from WorkCover, minimal contact from insurance company who are refusing to pay for my medications for the last 6 months and my injury management coordinator with NSW Ambulance no longer wants to deal with my case."[39]

"Given that I am the sole income earner for a family of 3 and a mortgage owner it is EXTREMELY difficult to cope in fact it is impossible to cope on that money and over the last 14 weeks that have been off injured I have been forced to borrow money from relatives and redraw on my mortgage just to feed my family. As it stands I am currently at a $7000 deficit from an injury that is work related and that I am supposed to be PROTECTED for and I am really only half way through the recovery process."[40]
"I just want to have this surgery that was recommended so I can go back and try to work in some capacity, I had always been a hard worker, working 2 and 3 jobs at one stage. My life now is totally destroyed; I had to leave my place of residence as the money I was receiving for compensation was not even covering my rent."[41]

"I am still waiting for Bi lateral hearing aids to be approved so I no longer have to lip read at work."[42]

"I was diagnosed with CRPS in March 2013 but I have been declined treatment since then and still to this day. I am in constant pain, I am taking so many pain killers, I cannot walk correctly, I cannot put my right foot in to a shoe, I am using a walking stick, and I have not been able to drive for nearly 12 months. I have also been diagnosed with depression and on medication for that."[43]

[38] Submission 28.

[39] Submission 37.

[40] Submission 41.

[41] Submission 55.

[42] Submission 61.

[43] Submission 72.

> "I had my left ankle injured in 2008 and it took them 18 months to finally give me permission to have an MRI"[44]

> "I have been waiting well over 16 months for my workers comp. case to be heard and have lost everything I own along with my dignity, pride and the job I loved more than anything."[45]

G. Adversarial claim treatment by insurers

Poor insurer behaviour is the single most common complaint raised with my office regarding workers compensation. Insurers are repeatedly identified as communicating poorly with claimants and defending claims aggressively – often resulting in substantial delays in treatment.

Far too many injured workers believe (often with reasonable cause) that their dealings with the insurance company has exacerbated their condition, and that the insurer's primary interest was remuneration for handling the claim and not assisting injured workers.

In many cases the failure of insurance companies to provide adequate information also delayed claims and hindered resolution for injured workers.

Lack of support within organisations, combined with adversarial treatment by insurance companies has caused a significant number of injured workers to feel marginalised and unable to advocate on their own behalf. As those who have contacted my office have said:

> "This resulted in surgery being delayed for close to two and a half years. The result of these actions has left me with a permanent impairment of 21% to my cervical spine". [46]

> "I filled out an incident notification form earlier in year and no one from insurance company has contacted me".[47]

> "The insurance company 7 months now refuse to pay my wages, say I perceived everything and have left me in limbo".[48]

[44] Submission 17.

[45] Submission 67.

[46] Submission 4.

[47] Submission 6.

[48] Submission 10.

"The insurer has been wreaking havoc now for the past three years, refusing claims, making inappropriate decisions, ignoring WCC decisions, briefing IME's with information that is blatantly incorrect, factually erroneous, deliberately misleading (e.g. telling doctors I worked long hours based on a payslip, when in fact four weeks of time sheets were paid in a two week pay period - something they knew was actually the case). The insurer even cherry picks the information that goes to IME's and fails to provide those tests, investigations and reports that contradict their position."[49]

"I had terrible dealings with the insurer which exacerbated the condition."[50]

"Please take WorkCover insurance policies out of the hands of private insurance companies and their rehabilitation providers as they are only interested in profits and not people."[51]

"TMF, the insurer. They Treat me like a fraud and constantly query my requests for pain killing medication and are very reluctant approve my occasional treatment for extreme pain (when it becomes unbearable)."[52]

"Insurers know they can drag out cases and financially cripple workers and then buy them off with a pittance as they know the worker is almost financially ruined."[53]

"In December 2013 I went through a detox program (2 weeks only) approved & paid for by the insurance company to get off the opiates I had been taking for over 10 years which I am still struggling to put behind me, the insurance co still have not contacted me to see if I am ok & to see if I need any other help like getting into a pain management program etc. to help me deal with the pain I am still in constantly every day"[54]

"Allianz for 21 months "disputed Liability""[55]

[49] Submission 12.

[50] Submission 13.

[51] Submission 25.

[52] Submission 43.

[53] Submission 48.

[54] Submission 49.

[55] Submission 54.

> "AIG has made it possible to leave me injured all these time and on top of that, as I can prove with lots of documents, instead of taking care of me they inflicted both; more physical and emotional pain on top of the ones from my injuries."[56]

> "Case managers change so frequently people don't seem to know the details of my case or remember what has been said previously. Until I needed surgery all injuries written and spoken to them were accepted and deemed reasonable. As soon as I needed surgery I was given the run around and stalling tactics. I was put under huge stress the night before surgeries."[57]

> "The response I have received from WorkCover and the insurer allocated to my claim has been severely lacking in regards to information."[58]

H. Failure to provide retraining/suitable duties

One of the aspects of the 2012 "reforms" was said to be a greater focus on returning injured workers to work. This does not appear to have been successfully achieved. While there have been some marginal improvements in the overall rate of injured workers returning to work in NSW, the durable return to work rate remains unacceptably low.

While WorkCover often cites high return to work rate figures of 80 to 88% for the NSW scheme this includes every return to work, not matter how short or unsuccessful. A far more useful measure is the "durable return to work rate" developed by Safe Work Australia. This is the proportion of injured workers who have been back at work for 3 months or more on a regular basis since suffering their injury.

Safe work Australia figures show that only 64% of injured workers in the NSW scheme have returned to work for at least 3 consecutive months post injury. While this is a higher rate than in other jurisdictions, it still demonstrates that more than 1/3rd of injured workers are not being returned to durable work post injury.

Many of the injured workers who have contacted my office are extremely keen to get back to work, but have been prevented from doing so by the fact that their employers did not provide suitable duties. This was often perceived as a lack of willingness in employers to make even modest adjustments to accommodate injured workers.

[56] Submission 68.

[57] Submission 69.

[58] Submission 44.

Many other workers have expressed frustration with the failure of the scheme to adequately provide support for them to retrain to be able to find suitable alternative employment. Too often this is due to insurers insisting that injured workers were able to undertake work that they either were physically or psychologically unable to undertake, or for which they knew they did not have the right skills.

I. Abuse of Independent Medical Experts (IMEs)

Medical issues should primarily be assessed by an injured worker's treating medical specialists. Too often the expert opinion of a workers treating doctor (sometimes even treating specialist) is second guessed by an insurance clerk with no formal training and no competence to undertake the task.

In many other cases insurers are seeking the opinion of chosen IMEs (normally considered to have dependably sceptical opinions on the need for treatment and the relationship of an injury to work) without just cause. There are repeated reports of insurers breaching WorkCover guidelines seeking to limit the scope for use of IMEs to contest treating doctors' opinions.

There are a disturbing number of reports of injured workers being sent to multiple IMEs until an insurer obtains an opinion they like.

Other issues repeatedly raised include the fact that IMEs are often not specialists in the conditions being presented. Many injured workers also advised that the IMEs they were assigned were not impartial and would not consider information from treating doctors or specialists.

> "Since the amendments in 2012, I have been sent to the doctor (GP, not a specialist) paid for by the Insurance company. He states that I can work 20 hours a week, despite the fact that my specialist and treating doctor say I am unfit for work".[59]
>
> "The WorkCover doctors I see keep telling me the illness I have is not in the WorkCover book or guidelines they follow. I'm also told pain can't be rated, only fatigue yet they fail to test any cognitive impairments and because I have arthralgia not arthritis my joint pain can't be rated? Yet my joint pain is often crippling.
>
> Many refuse to rate my impairment. Without impairment I cannot apply to be classed as a seriously injured worker."[60]

[59] Submission 22.

[60] Submission 35.

"The insurer has relied on one doctor's report that does not comply with NSW Medical Board Policy Guidelines for Medico-Legal Consultations and Examinations and WorkCover NSW Medical Certificates that do not comply with WorkCover Guidelines for Medical Practitioners, that I have capacity for work. "[61]

"I think I had 4 separate IME consultations and each time condition was diagnosed as getting worse. I was provided with some physiotherapy, however I believe that the insurance company was telling them to only treat me for damaged discs, which is only half the problem. I couldn't understand why they were ignoring my plea to take notice of all the pain. This soon became clear. I at one point the insurance company sent me to an IME who diagnosed that my injuries were caused by the incident at work and that I had 10% whole person impairment. Months later, after I kept asking the insurance company to take all my injuries into consideration, they made another appointment to see the very same IME."[62]

"The insurer is refusing to fund retraining for suitable work, they continually disagree with my treating doctors and keep sending me to 'independent doctors' for second and third opinions. They have now cut off my payments."[63]

"I have two torn discs, two thoracic disks in my spinal cord, been sent to three medical examinations in one year, yet still being stuffed around by EML, I have a friend who is more injured than me and can hardly walk needs a walking stick for balance.

"I didn't ask to be injured, I was injured due to my employer, I have pain 24/7 up to level 8, and I have some idiot at EML trying to tell me that the disc replacement has to be reasonable and necessary. WTF, are they serious?"[64]

"The message I have for the minister is this: When a person is hurt doing their job they do not become the hunted by the insurer or their paid for people (IME. etc) they are still people just like you and have families."[65]

J. Loss of income, esteem and respect for injured workers

[61] Submission 36.

[62] Submission 51.

[63] Submission 62.

[64] Submission 66.

[65] Submission 76.

Even when benefits are paid on time and claims are not vigorously contested by insurers, the impact of pain and injury, loss of wages and the loss of work is debilitating for many people who are injured at work. This scheme even when it works is far from generous and places enormous stressors on even the most robust individuals who are forced to rely on it.

This is reflected in numerous submissions made to my office including the following:

> "I have been trying to live on the compensation payments, which has lowered my standard of living substantially. I am in constant pain & on medication which makes me depressed and lethargic. I have had an anterior inter-body fusion which was supposed to relieve my pain & has left me worse than before, with nerve damage to deal with as well. I have been told by my surgeon that further surgery would almost certainly be required. I am receiving approximately $ 410 per week. As a result of this I withdrew my superannuation, under hardship circumstances, to be able to keep my home"[66].

> "I currently work 17.5 Hours per week because of my injury and subsequent surgery. While the Workers Compensation Claim was accepted and I am still employed by DoCS, I am currently earning about $70,000 per annum less than I was in 2007."[67]

> "My former employer had legal assistance and representation from the very beginning. I had to do nearly everything myself - with no legal training - because I had no money. I haven't had a break from stress for 3 years, or a break full stop. I've had to try and rehabilitate myself. At times I haven't had enough to eat."[68]

Many injured workers also report bullying both by their employer at the time of making a claim and in a number of instances, by the insurer and even WorkCover when they are handling their claim. . In some cases claims of bullying are being summarily dismissed with minimal or no independent investigation.

In other cases where investigation has been undertaken it occurred in a way that exacerbated the problems within the workplace, often forcing the bullied worker to leave. Complaints included:

> "The director (person who ignored the bullying) was asked to investigate my allegations."[69]

[66] Submission 9.

[67] Submission 45.

[68] Submission 50.

[69] Submission 15

> "When my Psychologist suggested I reduce my hours for just a month to help me get through legal issues, my employer then put me off work saying that they can't provide me with suitable duties anymore (minimal key board use and 2kg lifting capacity), although I had been doing them for 3 years now. But because I dropped my hours under 15 they apparently can do this."[70]

> "I cannot risk giving you my contact details because i am scared of more harassment from my employer".[71]

Family relations were often impaired as a result of the claim, with the ongoing stress of dealing with both the injury and the workers compensation system identified as major factors:

> "My ability to be a father is always hampered. The pain means that they will accidentally hurt me just in the process of trying to have my attention or get a hug. I have had to restrict my participation in family time because I am too exhausted or in pain."[72]

> "My work injuries has destroyed my life completely. The main issue with old and current worker compensation it did not take a person like my wife who is caring for me into consideration and she has been put on Centrelink as a carer."[73]

Many workers feel that the workers compensation system is an obstacle to their recovery and their return to work.

> "The system is very broken and needs to be fixed as it makes people sicker, not better."[74]

> "The law needs to be changed as no work place is safe anymore."[75]

> "I have been through hell, and that is just with the insurance company and its torturous interrogator 'doctors'"[76]

[70] Submission 60.

[71] Submission 7.

[72] Submission 12.

[73] Submission 46.

[74] Submission 13.

[75] Submission 26.

[76] Submission 29.

"Since acceptance of the claim, the inappropriate treatment received he changed him from a person who never contemplated suicide to one who has. He's had no time to recover from what has happened. He's just a shell of the man he was"[77]

"We are going backwards in this state and now are the working poor, too scared to take steps to rectify your health because of the WorkCover legislation".[78]

"I started with one disc bulging in my back then went back to work 6 hours a day, 5 days a week and now have three disc bulging in my back".[79]

Conclusion

The 2012 "reforms" were neither necessary nor fair.

For thousands or ordinary workers this has meant that an accident at work has thrown their life into reverse. Mortgages are not being paid and family homes are being sold. Savings are lost. Relationships are breaking down. A system that should be protecting the injured has instead become part of the problem.

Now that the economic argument used to deliver the reforms has been discredited the only ethical response by any government would be to reverse the cuts to benefits that were imposed in 2012. This includes, at a minimum:

(a) Reinstatement of reasonable and necessary medical benefits for all injured workers
(b) The complete removal of the greater than 30% wpi threshold for the ongoing receipt of benefits
(c) Abolishing the "work capacity assessment' process and its replacement with a fairer and simpler process in which workers have a right to be legally represented
(d) A legislative ban on the use of IMEs to contest the opinions of treating medical specialists other than in extremely limited circumstances
(e) The restoration of fair lump sum entitlements, and
(f) Compensation cover for injuries received on journeys to and form a person's place of work.

Whilst not minimising other matters, the systemic dysfunction in how work capacity assessments are undertaken, both by insurers and WorkCover, is the single largest problem facing the scheme. It

[77] Submission 30.

[78] Submission 38.

[79] Submission 53.

must be urgently addressed, and simplified, to prevent needless ongoing distress and inevitable ongoing unfairness.

When speaking with stakeholders across the spectrum, and from any fair review of the submissions to the Law and Justice committee regarding the scheme, it is clear that one of the most significant problems facing the NSW workers compensation scheme is WorkCover itself.

The WorkCover Authority has become an unwieldy and self-referential bureaucracy that is unable to deliver on its legislated functions under s22 of the Workplace Injury Management and Workers Compensation Act 1998 to:

- promote the prompt, efficient and effective management of injuries to persons at work, and
- ensure the efficient operation of workers compensation insurance arrangements.

It was on the advice of WorkCover that the government instituted the bulk of the 2012 “reforms”. Accordingly it is self-evident that advice must be sought outside of WorkCover to fix the system. I hope that this message has been received by both government and those undertaking this review.

I would like to again thank you for your consideration of this important issue. If you have any further questions, or to discuss, please contact me on 9230 3030.

Regards,

David Shoebridge