There are two main statutory schemes of compensation in the Northern Territory: the *Work Health Act 1987* and the *Motor Accidents (Compensation) Act 1979* (MACA). The purpose of this article is to provide an overview of these schemes and the problems they present for plaintiffs/applicants.

Statutory compensation schemes in the Northern Territory

The *Work Health Act*

The Act prohibits "workers" from claiming common law damages from their employers. However note the definition of "worker" includes a requirement for the employer to deduct tax on a P.A.Y.E. basis. Workers whose employers deduct tax on a P.P.S. basis (even in contravention of the tax laws) are excluded from the scheme, but conversely are not prohibited from suing at common law. The impending changes to the treatment of "subbies" by the Tax Office, and Pay As You Go, should make for interesting amendments.

The Act provides a no fault scheme, except where injuries are deliberately self-inflicted. Journey claims (i.e. to and from work) arising from the use of motor vehicles are excluded and placed under the less generous MACA scheme. There is a purported emphasis on rehabilitation and returning to work as early as possible. However given the lack of lighter work such as bench work in a jurisdiction with a small population, large area and minimal manufacturing, in practice this is very problematic.

Some creative attempts to overcome these hurdles have been made, such as the provision of large lump sum rehabilitation payments for the establishment of properly funded and researched businesses which enable an injured worker to restore earning capacity through self employment. Importantly such arrangements let the worker out of the system and escape the stress and uncertainty that goes with it. Unfortunately the dominant view in the Work Health Court seems to be that if such an arrangement is in the nature of a final resolution of the claim, it may well be in breach of the Act and void, which offers insurers little or no protection from further claims and makes them reluctant to enter into such arrangements.

Benefits

For the first 26 weeks of incapacity a worker receives 100% of normal weekly earnings (NWE). Determining NWE accurately can be difficult due to the tortuous definition that runs for about three pages. Very simply, a worker's average earnings over the 6 months (or in some cases 12 months) before injury will be close to NWE. Any residual earning capacity in this first 26 weeks does not affect the worker's entitlement to 100% of NWE.

After the first 26 weeks weekly payments are reduced to 75% of the difference between NWE and earning capacity, capped to a maximum of 150% of average weekly earnings (about $1150). For example a plant operator with NWE of $1,000 and a residual capacity to earn $600 per week as a light courier driver, would be entitled to weekly payments of $300 [($1,000 - $600) x 0.75 = $300]. A totally incapacitated miner with an NWE of $2,000 would receive $1150, not $1500.

NWE is indexed on January 1 of each year by reference to Average Weekly Earnings data provided by the Commonwealth Bureau of Statistics.

Payments should continue until the worker's indexed NWE are restored, or any permanent partial loss of earning capacity is commuted (redeemed). The maximum amount that can be commuted is 156 times Average Weekly Earnings, which is currently about $120,000. The worker must waive any entitlement beyond that amount to obtain a commutation. Commutations must be approved by the Work Health Court which has shown a reluctance to do so where the amount to be waived is significant.

Insurers may cancel or reduce payments by proper notice

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to the worker if the worker ceases to be incapacitated, or unreasonably fails to participate in a rehabilitation program or retraining. The notice provisions must be strictly complied with by the insurer and failure to do so will invalidate the decision to cancel or reduce payments. In limited circumstances the insurer may cease payments without notice e.g. where the worker returns to work or dies.

Medical, rehabilitation and similar expenses

Provided these are reasonably incurred, they must be paid by the insurer. Of course insurers can simply deny the "reasonableness" of an expense, and leave the worker to decide whether to pursue the matter in the Work Health Court. The writer recalls having to argue that a left-handed drafting board for a left-handed worker retraining himself as a draftperson was a reasonable expense.

Permanent Impairment

The maximum entitlement is 208 times average weekly earnings or about $160,000.

Assessment is in accordance with the Fourth Edition of the *American Medical Association's Guides to the Evaluation of Permanent Impairments* (and what a miserable publication that is). Serious lower back injuries such as a crushed L4/L5, prolapsed discs etc, are routinely assessed at 10% to 15% of the whole person. To add insult to injury there is a sliding scale for impairments assessed at less than 15%. An assessment of 13% entitles a worker to only 8% of the maximum; 10% produces an entitlement to 3%; between 5% and 10% gives 2% and less than 5% gives nothing. Doctors who conduct assessments both under WorkCover in South Australia and the Guides have stated that an impairment assessed at 13% under the Guides would be assessed at 25% - 30% under the WorkCover criteria.

Assessment is paid for by the insurer and can be arranged by either party. If either party is dissatisfied with the initial assessment, the Work Health Authority can be asked to convene a panel of three doctors who will conduct a re-assessment. Section 72 provides: "An assessment made by a panel....shall be taken to be the degree of permanent impairment "

In a case currently before the Work Health Court an initial assessment by a worker's treating psychiatrist of 60% (about $100,000) was reduced by a panel to 10% (about $5,000). The insurer provided a video of the worker to the panel, or rather the chair of the panel who is an orthopaedic surgeon, without ever showing it to the worker or his treating psychiatrist. The worker has challenged the panel's decision and the insurer has argued that the Work Health Court has no jurisdiction to hear the worker's case, and that his only avenue is by judicial review in the Supreme Court. A decision is expected within the next 2 weeks.

Death benefits

Where death through work-related injury occurs, funeral expenses to a maximum of about $3,500 and a lump sum of 156 times average weekly earnings (about $120,000) are payable. The lump sum is payable to the spouse and dependents in proportions prescribed by section 62. In addition a weekly amount equal to 10% of average weekly earnings (about $75) is payable for the benefit of each of the deceased's children until they turn 16, or if they continue in full-time education or are handicapped, until they turn 21. If there are more than 10 eligible children, 100% of average weekly earnings is divided by the number of eligible children.

Claims procedures

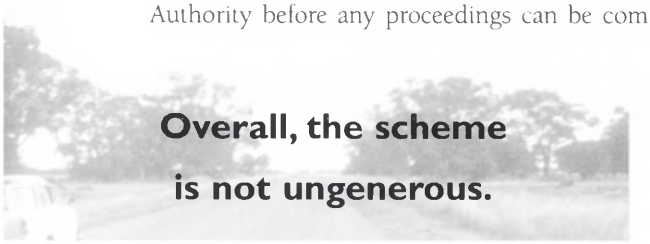
After submitting a claim in the prescribed form accompa- ▶

nied by a doctor's certificate the insurer has 10 working days to either defer, accept or dispute liability for the claim. Failure to make a decision results in the employer being deemed liable for the claim and payment of weekly compensation and medical expenses must be made until the insurer obtains an order from the Work Health Court lifting the deeming provision.

Similarly the insurer must commence paying weeklies and medicals if a decision on liability is deferred. A deferral can only continue for 56 days, after which a decision must be made or the deeming provision operates.

If the insurer disputes liability it must do so by advising the worker in the prescribed form (form 5).

As mentioned earlier, when reducing or cancelling payments made in relation to a claim which has been accepted, the insurer must also use the prescribed form (also a form 5) when advising the worker. Due to recent amendments, if the worker wishes to challenge the insurer's decision, in either case he or she must first seek mediation through the Work Health Authority before any proceedings can be commenced in the Court. While anecdotal evidence suggests a large number of minor disputes are resolved by mediation, which is a welcome change, most large or potentially large claims are not resolved. Furthermore, even if the mediator could facilitate a negotiated resolution it is likely the Work Health Court, with its narrow and restrictive view of such compromises, would view it as "contracting out" of the Act and would not approve it.



If the matter is not resolved at Mediation (at which the worker's lawyer cannot attend), a Mediation Certificate is issued and the worker can commence proceedings. However the recent amendments also require a Judicial Registrar to make an attempt to "settle" or resolve the matter at the first directions hearing. When, predictably, that fails, the worker is able to properly prosecute the claim. The delays and prejudice caused by the amendments have been the subject of submissions to the relevant Ministers by the NT branch of APLA but no response has yet been received.

Case management and conduct of matters at trial is, in the writer's view, unnecessarily lengthy and complex. Over strenuous objection, leave is routinely given to insurers to administer Interrogatories that contain anywhere from 200 - 350 questions, even where the case is a simple review of the insurer's decision to cancel weekly payments. Trials are usually set for 5 or 6 days but routinely take 10 or 11 as insurers seek to try to bolster their cases with hours of virtually pointless video, lengthy cross-examination of the worker (up to 2-3 days), and raising at best marginal and technical defences. Perhaps one objective is to deter other injured workers from pursuing their entitlements knowing they too will be "put through the wringer"? All this in a system supposedly designed to be expedient and non-technical.

The situation is further complicated by the Court's reluctance to allow matters to be settled on a commercial basis. It seems that rather than allow the parties to hand up consent orders about the extent of loss of earning capacity, permanent impairment, arrears, futures and possibly commutation etc, the Court prefers to hear the matter and make a determination. In some situations this seems unfair to both parties. For example the issue may be whether a worker is in fact a "worker" and eligible for compensation. Both parties may have legal advice that their prospects are about 50/50 and wish to settle for half of estimated quantum. But they would not be permitted to record such a compromise in the Court.

Costs

Costs in the Work Health Court are quite generous. They are allowed on virtually the same basis as in the Supreme Court, the only difference being there is no allowance for specific care and conduct on particular items of work performed (this is contrary to APLA NT's understanding of what was intended with the introduction of the recent amendments and is the subject of submissions to relevant Ministers). General care and conduct is allowed which produces an effective rate of between $180 - $250 per hour depending on the skill and efficiency of the practitioner. However unsuccessful workers will not be entitled to costs, and there is nothing equivalent to a suitor's fund. Further, unsuccessful workers can be ordered to pay the insurer's costs, which after a 10 day hearing would usually spell bankruptcy or financial ruin. Legal Aid is usually available to investigate the merits of a claim. If prospects are reasonable the practitioner is expected to "spec" the matter and some funding for disbursements at trial will usually be available from the Contingency Fund.

Conclusion

Overall, the scheme is not ungenerous. It would be improved if workers had an option to sue at common law and benefits were not reduced to 75% after the first 26 weeks. The major procedural problems that need to be addressed are case management and the difficulty of achieving final settlements of claims. As these have been partly caused by a fairly recent review and partly by government policy, they are likely to persist for some time.

The Motor Accidents (Compensation) Scheme (MACA)

The Act abolishes the right of residents of the Northern Territory to claim common law damages for injuries resulting from an "accident". It provides for a no fault scheme of benefits (subject to the contribution of alcohol to the claimant's injuries and provided certain offences were not committed by the claimant). The Act also provides an indemnity to drivers (except where alcohol substantially contributes to the accident or certain offences have been committed). The scheme is administered by the Territory Insurance Office (TIO) and no private insurers are involved except through re-insurance.

"Accident" is broadly defined to be any occurrence arising out of the use of a motor vehicle.

"Resident of the Northern Territory" is essentially anyone

who has lived in the Territory for more than 3 months.

Where injury results to a resident from an accident benefits are payable in accordance with the Act.

Those people who are not residents and are injured as a result of another's negligence may sue at common law but their damages for non-economic loss are capped to 208 times average weekly earnings (about $160,000).

A non-resident may ask the TIO to deem him or her to be a resident if he or she was, at the date of the accident likely to have resided in the Territory for more than 3 months after the accident. Thus a non resident whose injuries did not result from the negligence of another may in these limited circumstances still receive some compensation for their loss.

Compensation for Loss of Earning Capacity

At the risk of oversimplifying it, loss of earning capacity is regarded as the difference between 85% of average weekly earnings (about $750 x .85, or $638 less tax) and the earning capacity (net of tax) of the applicant as deemed by the Board. Payments for total incapacity are therefore capped at about $470 per week net, a particularly meagre amount. As the TIO readily determines applicants to have an earning capacity, actual payments made are very paltry indeed.

Payments to persons under 15 years or who are full-time students are further restricted.

There is no cap on the amount of future weekly payments that can be redeemed.

Medical, Rehabilitation, Attendant Care and Like Expenses

These are payable by the TIO, however what the TIO and the claimant contend are "reasonably incurred" often differs. Regulations prescribe a limit on the amount of attendant care services that can be claimed and the Act purports to give the TIO absolute discretion about such payments.

Permanent Impairment and Death Benefits

These are very similar to benefits payable under the *Work Health Act* mentioned above. Note that where an injured person is likely to permanently remain in hospital the spouse/dependants may apply for the death benefit. Note also that for injuries sustained before 1991 a table of maims applies.

Claims Procedures

A claim in the prescribed form is simply submitted to the TIO. The TIO is prohibited from considering claims more than 3 years old and may decline to consider claims more than 6 months old. A "designated person" is then required to make a decision about the claim. Note that the Act appears only to give the Board of the TIO power to determine benefits under the Act, not a "designated person". This point does not seem to have been litigated.

The designated person can delay making a decision by requesting (from anyone) information reasonably required to enable him or her to make a decision about the eligibility of a person to benefits or the amount of such benefits. The time limit is then extended by the period the information remains outstanding. However if a further 28 days elapse the claimant can request the designated to refer the matter to the Board and the designated person shall do so "as soon as practicable". There is no requirement for the TIO to provide claimants with medical reports about their condition. Most claimants are unable to pay for such reports and there is little if anything a claimant can provide to the Board that has not been provided to the designated person.

The Board then has 60 days to consider the matter and make a decision, although this time limit can be extended if the Board requests a conference with the claimant. It is virtually unheard of for the Board to do anything other than reaffirm the decision of the designated person.

As can be seen it may take in excess of 4 months for a decision to be made by the Board. A claimant who is aggrieved by such a decision then has only 28 days to lodge an appeal (or reference) to the MACA Tribunal. The Tribunal is constituted by a single judge of the Supreme Court and has the power to make its own rules.

Costs and the funding of matters before the Tribunal is very similar to the situation under the *Work Health Act*.

The main problems with MACA are the lack of an option to sue at common law; the inadequate amount paid for loss of earning capacity; lack of a requirement for the TIO to disclose medical reports; and the pointless delay in the Board making a Determination from which an Appeal to the Tribunal can be made.