Comments on the *Work Injury Compensation Act 2019*

August 2019

Introduction

The *Work Injury Compensation Bill*, No. 21 of 2019 ("WICA 2019"), will enact changes to *Work Injury Compensation Act* ("the Act") in several areas, including

- insurers (rather than MOM) will process claims;
- hospitals have legal right to claim directly from employers;
- insurers' position in employers' insolvency; and
- calculation of Average Monthly Earnings (AME) in certain disputed cases.

These amendments update the statutory framework of the Work Injury Compensation regime in line with a more realistic conceptualisation of the insurers' role. Nonetheless, room for improvement remains. Furthermore, some of these amendments raise new questions which require clarification.

1 Default position: Insurers process claims *Cl 36, Part 4 Division 2 esp cl 44*

1.1 WICA 2019 appears to set out, as the default position, that insurers will "process" claims for compensation under the Act, unless MOM decides to do so. While certain grounds for MOM so deciding are set out, these are clearly non-exhaustive, and are inherently discretionary rather than prescriptive. The new role of insurers therefore raises questions in two main areas: the scope of their purview; and the possibility for conflicts of interests.

1.2 Firstly: Are there more substantive criteria or practical guidelines as to what cases, or what stage of the cases, will be under MOM's direct purview? WICA 2019's Part 4 Division 2 ("Processing by employer's insurer") appears premised on the assumption that the injured worker's employer has duly reported the injury to MOM and notified the insurer. That is, it is undisputed that it is a work injury. Where such a fundamental issue is disputed, will MOM take direct responsibility for its determination? What about other, ancillary issues?

1.3 Even if the injury is undisputedly a work injury, issues which affect the claim may remain outstanding for resolution or settlement. Processing of claims is seldom a straightforward mechanical application of formulae.

1.4 This illuminates the second, more troubling aspect of the insurers' expanded role: conflict between their business interest in keeping claim amounts low, on one hand, and their new statutory duty to process claims, on the other. What safeguards will MOM implement to ensure that insurers (being pre-eminently interested parties) will process each claim in accordance with the worker's full rights and entitlements? Will MOM have adequate oversight of cases; for example, by conducting spotchecks on claims processed by insurers, to ensure that workers are not being shortchanged?

1.5 Low-wage manual labourers, who rely most on WICA, are the ones who are most vulnerable and least able to push for their own interests, especially if their understanding of the law is only general, not detailed. For example, a worker who has been persistently underpaid for several

months prior to his injury may have his compensation calculated according to documentation of his short-paid (actual) salary, rather than what he was legally entitled to. Insurers have no incentive to ensure workers are fully apprised of their rights.

1.6 MOM should proactively take responsibility for protecting such workers, and monitor the processing by insurers. Relying on complaints or objections to detect sharp practice by insurers puts too much of a burden on vulnerable workers.

2 Hospitals' right against employers *Cl 16(3)*

2.1 Many migrant workers have treatment (or diagnostic scans or therapy) delayed because of their employers' refusal to pay for it, or tardiness in paying outstanding bills. Hospitals do suspend treatment or services to workers when outstanding bills have not been settled. Delays adversely affect proper diagnosis and timely treatment.

2.2 WICA 2019 creates a legal right for hospitals to recover payment from employers directly. This is a step forward. But how far this legal innovation will benefit injured workers depends on how it is applied in practice. Will hospitals be expected and encouraged to take action against employers for unpaid bills, rather than suspending treatment? Otherwise, this right is simply another option for the hospitals; the workers do not benefit.

2.3 Looking ahead, HOME urges progress towards minimising the employer's role and prerogatives in the provision of and payment for medical treatment: point 6 below, "Medical Treatment: Going forward".

3 Insurers' position in employers' insolvency *Cl 28; cf cl 18(2)*

3.1 Like the current Act, WICA 2019 transfers the employer's contractual rights against the insurer to the worker, when the employer becomes insolvent. However, for many migrant workers, a right to claim reimbursement for medical expenses is practically meaningless and useless, when there are costly ongoing treatments and scans needed. They simply cannot pay upfront.

3.2 WICA 2019 further provides that upon the employer's insolvency, the insurer assumes "the same liabilities in relation to the employee as if the insurer were the employer," subject to the limitation of their liability under the policy.

3.3 The plain meaning of this subsection is that the insurer takes over the employer's duties (under WICA) to the worker. In particular, the insurer should assume the responsibility to pay for the medical treatment. As set out in cl 16, this responsibility is not merely to reimburse the worker, but in substance to pay the medical institution directly.

3.4 Certain ambiguities remain, arising from cl 18(2), which provides that compensation payable (including under cl 28) should be paid by the insurer to the worker (or their estate or representative).

3.5 It should therefore be clarified: Upon the employers' insolvency, would insurers have the same nature of obligation as the employers' in relation to ongoing medical treatment? That is, are they obliged to pay the medical institutions directly (as opposed to merely reimbursing workers)? Will they be required to give the hospitals the necessary guarantees as to payment (subject their limitation of liability) for upcoming treatment?

4 Calculation of AME in certain disputed cases *First Schedule para 6(6)*

4.1 Where there is inadequate evidence of the worker's earnings (ie including overtime), MOM is now empowered to calculate AME based on a multiplier of the worker's basic salary, in order to expedite the claim. This multiplier is yet to be specified.

4.2 We understand from MOM[1] that the uplift from this multiplier should cover 75% of workers in terms of accounting for overtime. However, much depends on the basis of comparison: does that refer to 75% of claimants for permanent incapacity under the Act; or 75% of all WICA cases; or 75% of all employees in Singapore entitled to overtime pay?

4.3 Low-wage manual labourers, who are the most dependent on WICA, may work very long hours. For migrant workers in particular, overtime pay is crucial to paying off their recruitment debts. It is precisely those workers who work the longest hours, and may therefore not be covered by that multiplier, who are most vulnerable to accidents and injury.

4.4 Under the *Employment Act*, employers are obliged to adequately and truthfully document working time records and payslips, and furnish these documents to the workers.[2] If they fail to do so, workers should not bear the cost.

4.5 Rather, if there is dispute about the correct overtime payment, adverse inference should be drawn against the employer who failed to keep or furnish proper records. Recent amendments to the *Employment Claims Act* already mandate such inferences in salary claims.[3] This is long-overdue acknowledgement that workers should not be penalised for the employer's default.

5 Who may issue Accepted Medical Report *Cll 2, 15, 16*

5.1 Under the Act, medical institutions and professionals play two main roles: firstly, as providers of treatment and certifiers of temporary incapacity (viz, medical leave or light duties); secondly, as makers of “accepted medical reports”. In practice, these reports are determinative evidence of the injured worker’s permanent (or, in WICA 2019, “current”) incapacity for the purposes of computing or assessing their compensation.

5.2 Between workers and employers, in the Act’s scheme vis à vis medical institutions and professionals, there is a notable asymmetry. As regards treatment undergone by the worker, the employer’s obligation to pay directly for it is limited to such “approved” institutions as are prescribed by regulations. However, any “health professional” (registered medical practitioner or dentist) may produce an accepted medical report.

5.3 It is now well known that there are medical professionals who prioritise the interests of the employer, who is paying for their services, over their patient’s:[4] to the point of “callous disregard” for the injured worker.[5]

5.4 Professional disciplinary mechanisms extend procedural safeguards for those accused of misconduct. But such proceedings, being protracted and litigious, are ill-suited to protecting

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[1] Ministry of Manpower, Briefing on Proposed Amendments to the Work Injury Compensation Act, 16 January 2019.

[2] *Employment Act 2009* s 96; *Employment (Employment Records, Key Employment Terms and Pay Slips) Regulations 2016* Third Schedule.

[3] *Employment Claims Act 2016* s 21, Fourth Schedule.

[4] Calvin Yang, ‘Firms pressure doctors to minimise medical leave for injured workers despite risk of penalties’, 17 February 2019, *The Straits Times*; Salma Khalik, ‘Docs reminded to give injured workers the rest they need’, 19 October 2018, *The Straits Times*; Kenneth Cheng, ‘Suspended surgeon at Raffles Hospital showed ‘indifference’ to patient’s welfare’, 27 July 2016, *Today*; Rei Kurohi, ‘Court dismisses appeal of doctor who did not give foreign worker sick leave after surgery’, 23 April 2019, *The Straits Times*.

[5] Quoted from the judgment of the Court in *Yip Man Hing Kevin v Singapore Medical Council* [2019] SGHC 102, at [94].

injured workers. As a separate regime with a different purpose from professional discipline, the Act should prioritise protection of injured workers.

5.5 As such, there should be stricter criteria to define who may issue an accepted medical report. Just as regulations will prescribe approved medical institutions, so too should regulations prescribe criteria, or at least disqualifying criteria, for accepted medical reports.

5.6 One important disqualifying criterion should be that if there have been disciplinary proceedings instituted against a health professional, which have passed the preliminary stages (for example, where the Complaints Committee of the Medical Council has ordered an inquiry by the Disciplinary Tribunal), then no assessment from that health professional should be an accepted medical report.

6 Medical Treatment: Workers' right of choice *Cl 37*

6.1 MOM policy in administering the Act requires workers to continue treatment at, and thereafter be assessed for permanent (or current) incapacity by, the same institution throughout their case (notwithstanding onward referral for specialist attention from general practice clinics). Many migrant workers especially in hazardous industries like construction and marine, who do not have the means to pay for acute medical care out of pocket, are treated by private institutions appointed by their employers.

6.2 Furthermore, cl 37 (s 13 of the current Act) requires workers to submit for medical examinations, as and when required by their employer, by a health professional arranged by the employer. MOM has interpreted the current Act as giving employers the right to decide which institution would do the assessment of permanent incapacity.

6.3 As earlier described, doctors have sometimes acted against their patients' interests: particularly when beholden to the patient's employer. An injured worker's health cannot be left to be protected by the glacial mechanisms of professional discipline.

6.4 Workers should have the freedom to receive treatment and assessment at the medical institution of their choice. Unless there is a significant difference in cost, giving the choice to employers is a paternalistic anachronism. This should not be conflated with refusing treatment or deliberately disregarding medical instructions. WICA 2019 is an opportunity to clarify this principle.

7 Medical Treatment: Going forward

7.1 WICA 2019's innovations in respect of the legal framework for medical treatment of workplace injuries are a welcome starting point. But there remains much scope for a more humane, just and updated approach to ensuring workers have access medical treatment.

7.2 A much needed development is direct billing between medical institutions and insurers. The statutory scheme is that treatment that is deemed "clinically indicated" by the former must be paid for by the latter, subject to the policy's parameters. In this scheme, there should be no scope for the employer to (in effect) gatekeep the worker's access to treatment.

7.3 HOME suggests that provision of direct billing facilities, at least with the leading restructured hospitals, could be part of the performance standards for designated insurers.