A Best Practice Workers Compensation Scheme

Insurance Council of Australia

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Mr Rob Whelan
Chief Executive Officer
Insurance Council of Australia
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Dear Rob

A Best Practice Workers Compensation Scheme

We are very pleased to present our report which examines best practice in workers compensation and proposes a scheme design that would be suitable for Australia either on a national or jurisdictional basis.

We look forward to discussing the report with you and your colleagues, and will be happy to answer any questions relating to our findings.

Yours sincerely

Geoff Atkins

Gae Robinson

Fellows of the Institute of Actuaries of Australia

A Best Practice Workers Compensation Scheme

Part I Executive Summary

Introduction

The Insurance Council of Australia has engaged Finity to propose a best practice workers compensation scheme, competitively underwritten by APRA-authorised insurers, which would be suitable for Australian conditions on either a national or jurisdictional level.

This report draws on a significant body of research as well as our own experience and observations from many years working in the sector.

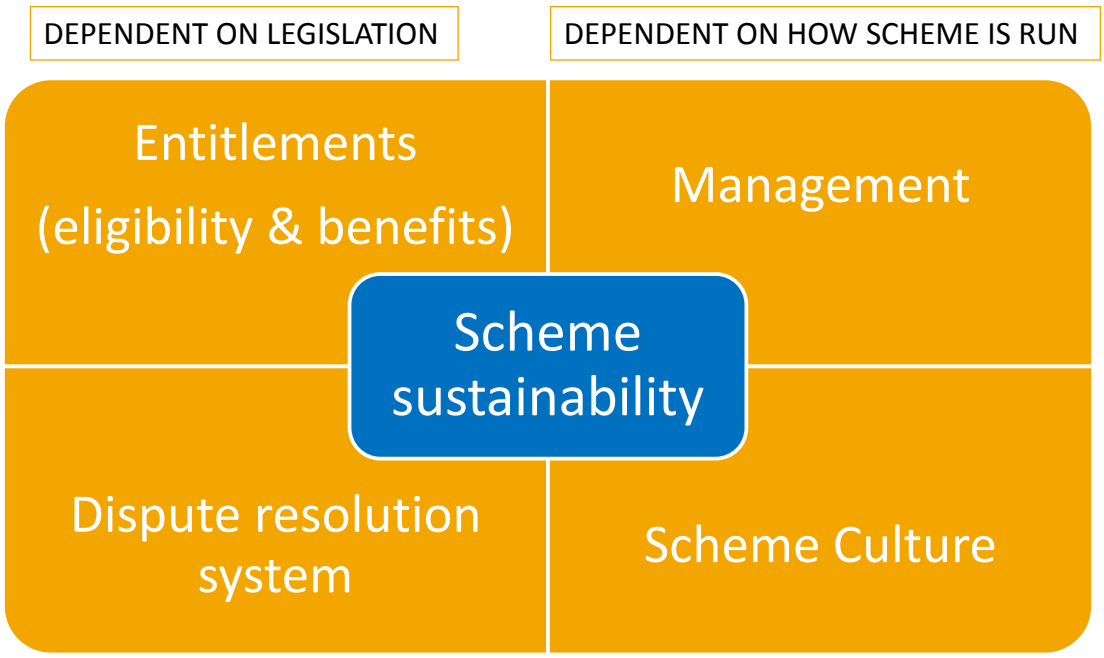
Achieving sustainability

Best practice means sustainability

A best practice scheme will be both financially and socially sustainable.

A sustainable scheme – one that satisfies stakeholder expectations over an extended period – will not give rise to either a financial need or a political imperative to reform the scheme. To achieve a sustainable scheme requires a number of different components, working consistently.

Figure 1 – Drivers of Sustainability



Objectives and principles

Clear objectives for the scheme, stated in legislation and broadly supported, provide the starting point. For example, a simple set of best practice objectives could be:

1. To contribute to the prevention of injuries
2. To support injured workers in returning to work
3. To assist with full recovery
4. To compensate fairly
5. To charge employer premiums that are affordable, reflect risk, and fully fund the liabilities.

Our views about what constitutes best practice are underpinned by the following principles, which overlap with the elements which drive sustainability:

Table 1 – Best Practice Principles

Principle	Comments
Work is good for your health	Recovery will be aided by resuming work.
Establish clear expectations	This will minimise ambiguity and increase accountability of stakeholders.
Focus on the more seriously injured	Compensate the seriously injured adequately. Limit benefits for minor injuries to what is essential.
Strive for efficiency	Maximise the proportion of payments made to claimants.
Appropriate incentives	Incentives should encourage positive outcomes for injured workers and for scheme financials.
Minimise political involvement	Purely political agendas should not drive scheme design or management.

Entitlement and benefits

The law will spell out who is entitled to make a workers compensation claim, in what circumstances and what benefits they may receive. Sections 5 and 6 of the report set out in some detail the best practice proposals, drawing on the many examples and variations observed in Australian schemes and the historical changes that have been made.

Key features of the recommendations are summarised in Table 2 below.

Table 2 – Entitlement and Benefits

Area	Recommendation
Entitlement	
Who is a worker?	A person paying income tax in the PAYE system
What injuries are compensable?	Injuries out of, or in the course of, employment
	Employment a significant contributing factor
Benefits available	
Income replacement	100% replacement for three months, 80% thereafter
	Time limit on benefits
Medical and treatment	Reasonable and necessary costs
	Generally paid for up to a year after income replacement benefits cease
Permanent impairment	Lump sum depending on WPI
	WPI threshold for access
Death	Defined lump sum of moderate quantum
	Additional sum if dependants

The most serious injuries at work deserve lifetime support, which will come from the National Injuries Insurance Scheme recommended by the Productivity Commission and adopted by governments.

Dispute resolution

The workers compensation environment lends itself to an administrative dispute resolution process rather than a judicial one, with decisions being made by a tribunal that is inquisitorial in nature rather than adversarial. Decisions in the first instance can be made by a single expert decision maker, within a framework of objectivity and procedural fairness.

There should be one level of appeal from a decision at first instance. Regarding medical issues, this should involve a Medical Panel. Other issues should be dealt with on appeal by senior members of the tribunal. Access to courts should be available only when there are important or novel issues involved, either referred by the tribunal or in the nature of judicial review.

Managing the scheme

A workers compensation scheme is a complex system with many participants. A sustainable scheme requires a scheme regulator with appropriate governance – Board members with relevant expertise will be an important plank.

The regulator's main scheme management responsibilities are summarised below.

Table 3 – Regulator Responsibilities

Improvements to scheme guidelines
Insurer oversight
Employer compliance
Provider oversight
Interactions with WHS
Performance analysis and benchmarking
Advice to government

The single most important driver of the scheme's success will be the extent to which workers achieve rapid and sustainable **return to work**. Section 7.2 of the report discusses the key factors involved in maximising return to work; insurers and employers, influenced by the regulator, have crucial roles to play.

Premiums

A best practice scheme will see insurers establishing premiums on a fully funded basis[1], with:

- Standard industry rates, determined by the regulator, as the starting point
- Insurers setting their own premium rates, in accordance with 'light touch' regulatory guidelines.

Scheme culture

A sustainable workers compensation scheme will have a positive culture which is the outworking of all other aspects of the scheme's design and management. The types of outcomes observed will be:

- High employer engagement in claim outcomes
- Open and transparent decision-making
- A low appeal rate for decisions
- Staff at the regulator committed to sustainability ahead of compliance.

If an effective scheme culture can be established, and then measured and influenced where necessary, the workers compensation scheme can be sustainable over a very long period.

[1] The HWCA report to Labour Ministers' Council of 1997 *Promoting Excellence: National Consistency in Workers' Compensation* recommended: "Premium rates must be sufficient to ensure a fully funded, financially viable scheme, whilst ensuring minimisation of cross subsidisation." The Productivity Commission in 2004 favoured "premium setting principles which encourage full funding", and recommended premium setting principles (Chapter 10) to be explicitly consistent with this objective.

Part II Detailed Findings

1 Introduction

Finity Consulting has been engaged by the ICA to propose a best practice scheme design for a workers compensation scheme that would be suitable to operate at a national level, or in an individual jurisdiction.

We understand that this report will be used by the ICA in discussions with Federal and State governments about scheme design and the involvement of APRA-authorised insurers in workers compensation. With this in mind this report has been prepared on the assumption that it will be in the public domain.

1.1 Scope

The ICA has asked Finity to propose a design for a best practice national scheme, having regard to the following core principles:

- **Fairness to workers**, by promoting recovery with incentives to encourage return to work
- **Affordability for employers**, with:
  - Appropriate pricing for all employers
  - Appropriate incentives for all stakeholders to improve workplace safety
- **Sustainability** for all, with:
  - A fully funded scheme so that there is no burden on the public purse
  - Appropriate governance that separates regulatory oversight from scheme management.

The ICA has set out its view of the most important design principles for **competitive underwriting of** a statutory compensation scheme. These principles are shown in Appendix A of this report.

In this report we have assumed a competitively underwritten scheme.

1.2 Approach

Our approach to describing a best practice scheme has been mainly top down (i.e. starting from the principles and objectives) rather than bottom up (starting with an analysis of existing schemes). We have used examples that draw upon features of existing Australian schemes. Where relevant we have referred to the literature and findings of other reports and inquiries. Much of the material and suggestions, however, are based on our own experience and our opinions derived from that.

1.3 Structure of this report

This report is laid out as follows:

- Section 2 discusses the principles underlying **best practice**
- Section 3 looks at **catastrophic injuries**, in the context of the proposed NIIS
- In Section 4 we discuss the **management** of all aspects of a workers compensation scheme

- In Section 5 we discuss **entitlement** to compensation – who is entitled to make a workers compensation claim, and under what circumstances?
- Section 6 considers the range of **benefits** which claimants may receive
- **Claims handling** is discussed in Section 7
- In Section 8 we discuss **claim determination and dispute resolution** mechanisms
- Section 9 discusses **pricing** and funding of workers compensation business
- Section 10 deals with **scheme culture**, which is a function of the interaction between scheme design and management and ultimately drives much of participant behaviour
- Section 11 sets out important **reliances and limitations**.

2 What does best practice mean?

Objectives and principles

A best practice scheme is clear about its objectives and is based on a coherent set of guiding principles.

2.1 Clarity of objectives

In order to design an effective scheme, it is necessary to first be clear about the scheme's main objectives. These objectives must be in the legislation and should guide the design and operation of the scheme.

A scheme's objectives will ideally be brief and straightforward[2,3]. A simple set of best practice objectives could be:

1. To encourage prevention of work related injury and disease
2. To support injured workers in returning to work
3. To assist with full recovery
4. To compensate fairly
5. To charge employer premiums that are affordable, reflect risk, and fully fund the liabilities.

2.2 Sustainability

What is a sustainable scheme?

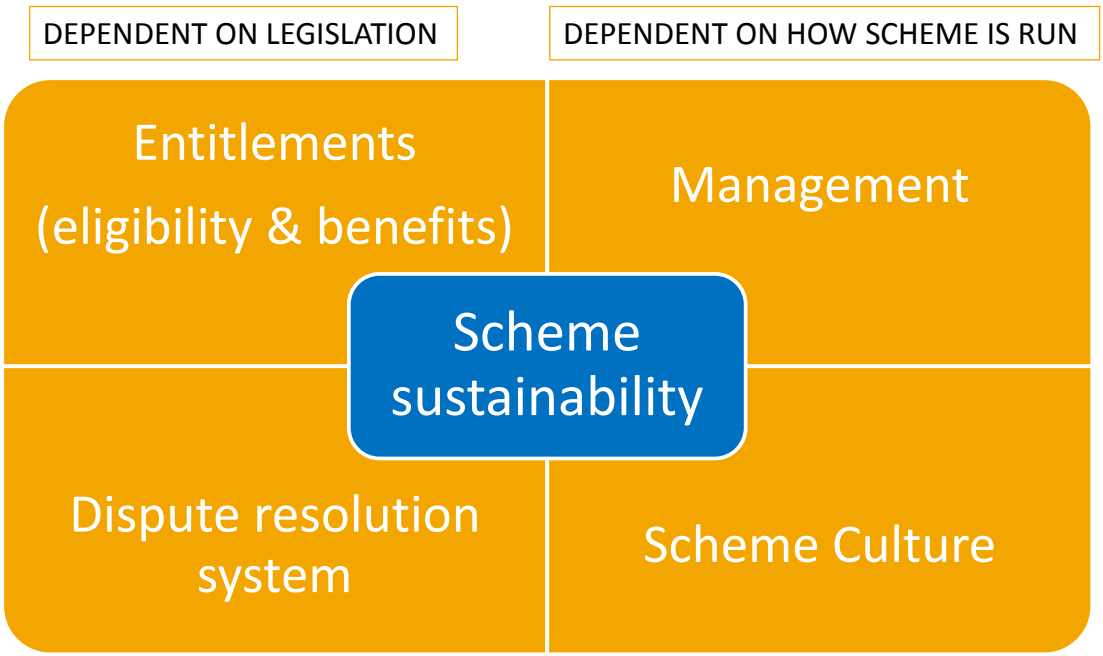
A sustainable scheme satisfies stakeholder expectations over an extended period so there is no financial need or political imperative to reform the scheme.

Sustainability is a function of a scheme's design, as well as its management and culture, which is illustrated in Figure 2.1 below.

[2] South Australia's *Return to Work Bill 2014* is a recent example of clear, straightforward objectives specifically identified in a scheme's governing legislation

[3] *Workers Compensation Legislation Amendment Bill 2012, Second Reading into Parliament Speech,* (19th June 2012), makes reference to best practice objectives.

Figure 2.1 – Drivers of Sustainability



2.2.1 Defining sustainability

Financial sustainability

In a **financially sustainable** scheme, premiums paid by employers fully fund the cost of providing insurance – the cost of claims, scheme expenses and return on capital. Premiums need to be reasonably stable in order to meet the expectations of employers, and need to be regarded as affordable. Insurers will be subject to prudential regulation by APRA which minimises the chance of insurer failure.

Sustainability may be threatened by 'shocks' to the broad economy – such as the sustained drop in interest rates which followed the GFC in 2008 – or by scheme-specific issues, such as increases in claim frequency or benefit payments (average claim size). Sustainability will require identification and management of emerging risks – for example, changing workforce demographics, or new focus areas for claims as awareness levels increase (RSI, mental harm claims etc).

Social sustainability

A scheme will be **socially sustainable** when there is no broad motivation for stakeholders to push for change. The scheme features which will drive social sustainability are:

- **Balance** – there are tensions between the needs of different stakeholders, and these need to be kept in balance. A best practice scheme is not so generous as to be unaffordable, but not so limited as to cause hardship or community concern.
- **Fairness** – all stakeholders, and particularly workers, must consider the scheme as being fair.
- **Consistency** – a scheme with consistency in its design and management will be more sustainable than one where there are inconsistent approaches in different part of the scheme, or where approaches are substantially changed from time to time.
- **Culture** – a culture that says returning to work is good for you, rather than a compensation mentality, supports scheme sustainability. The focus is on capacity rather than incapacity.

Over the last ten years the decisions of governments around Australia have refined benefit levels in line with changing community views regarding a sustainable balance between benefits and costs. Recent changes have been made in order to reduce premiums, while maintaining support for the most seriously injured.

2.2.2 Achieving sustainability

A sustainable scheme can be achieved only when a range of elements work together; see Figure 2.2.

Figure 2.2 – Achieving Sustainability

These elements are discussed in Sections 3 to 10 of this report.

2.3 Guiding principles – this report

Our views about what constitutes best practice are underpinned by the principles set out in Table 2.1, which overlap with the elements which drive sustainability. These principles also align with the principles applied by governments in recent years, which in turn aim to represent community values.

Table 2.1 – Guiding Principles [4]

Principle	Comments
Work is good for your health	Once an injured worker has recovered sufficiently, further recovery will be aided by resuming work.
Establish clear expectations	Clear objectives and rules will minimise ambiguity and increase the accountability of all stakeholders.
Focus on the more seriously injured	The seriously injured have greater needs, and schemes should aim to compensate them adequately. Conversely, benefits for those with minor injuries should be limited to what is essential.
Strive for efficiency	A streamlined scheme, managed efficiently, will benefit all participants, and will maximise the proportion of payments made to claimants.
Appropriate incentives	The scheme design should provide incentives which encourage positive outcomes for injured workers and for the scheme's financials.
Minimise political involvement	Governments are important stakeholders in workers compensation schemes, but purely political agendas should not drive scheme design or management.

[4] Dr Andrew Fronsko defines a similar set of principles in *"Overview of Accident Compensation Schemes in Australia and New Zealand, including features aimed at Optimising Return-to-Health & Return-to-Work Outcomes"* (2008)

3 Catastrophic Injuries and the NIIS

Compensating the catastrophically injured

Scheme design must ensure that workers who are catastrophically injured and permanently incapacitated are appropriately looked after.

One of the difficult balances for scheme design is the aim to care properly (essentially over a lifetime) for those catastrophically injured in a work accident, while having benefits that are not so generous that workers with less serious injuries remain on benefits in the long term. This is often dealt with by defining a 'boundary' between seriously injured and other claimants, and providing long term benefits only for the most serious injuries.[5]

3.1 What is the NIIS?

The National Injury Insurance Scheme (NIIS) offers a consistent approach to providing lifetime care for the **catastrophically injured**. It is intended to ultimately cover all catastrophically injured individuals, independent of the cause of injury (motor accident, work-related, medical misadventure, other) and regardless of fault. Access to the NIIS will be subject to its own definitions, which should then provide a boundary that is soundly managed by the custodians of the NIIS.

The NIIS is a 'sister' scheme to the NDIS. NDIS is a national scheme being progressively launched and covers people with serious disability, mainly from congenital conditions or disease. The NIIS is proposed as a federation of state-based schemes rather than operating as a single independent entity. In each jurisdiction the relevant levies would be paid to the state-based NIIS entity and relevant injuries handled by that entity.

Good progress is being made with implementing the NIIS for motor accidents. Including work injuries in the schemes should not be a difficult task.

3.2 Delivery

Most of Australia's CTP schemes have established a mechanism for providing NIIS-compliant benefits to catastrophically injured motor accident victims, on a no-fault basis. In some states the delivery is via a separate 'long term care' scheme, and in others (only when a monopoly scheme) benefits are delivered within the existing CTP scheme.

In the workers compensation context, provision of the benefits for NIIS participants will be shared between NIIS and the workers compensation scheme:

- Treatment and care benefits will be managed and paid from the NIIS entity
  - The NIIS entity should be the long term care scheme already set up for CTP claims, in order to achieve synergies and maximise the benefits of the specialised workforce
- Income replacement and permanent impairment benefits will be managed and paid by the workers compensation insurer.

[5] The Centre for International Economics, in its review of the 2012 changes to NSW workers compensation, *("Statutory review of the Workers Compensation Legislation Amendment",* June 2014*)*, identifies as a particular concern of stakeholders, the limiting of medicals for seriously injured workers (with WPI 20-30%). There was concern among stakeholders that this could present a barrier to return to work for the seriously injured who may need medical support for a longer period.

3.3 Funding

The workers compensation scheme will fund its share of the NIIS, via either a levy on premiums or diversion of part of the risk premium. With the relatively low incidence of catastrophic injuries from workplace accidents, the required funding will be modest.

3.4 NIIS is best practice

The NIIS arrangement represents best practice because:

- It uses specialist skills in care of the seriously injured by utilising the scale and focus of the NIIS
- It aligns the treatment of those with serious injuries between work and motor accidents (and possibly other accidents in future)
- It optimises sustainability of the workers compensation system by collecting levies to cover the lifetime liability for catastrophic injuries, while keeping the insured scheme to a shorter tail than it would otherwise have.

3.5 Other serious injuries

Only the catastrophically injured will have access to the NIIS. This would include (for example):

- Spinal cord injuries – paraplegia and quadriplegia
- Significant traumatic brain injury
- Multiple amputations.

It is common for workers compensation schemes to define ‘serious injury’ at a lower level of impairment, and to have additional benefits available to those categorised as Serious Injury. The remainder of this report:

- Assumes that all catastrophically injured claimants will have access to lifetime care and support via the NIIS arrangements
- Refers to possible additional (or more generous) benefits which could be made available in the workers compensation context to other seriously injured workers, subject to a suitable threshold for access. This threshold would be a key element of scheme design, but is not discussed further in this report.

4 Managing the Scheme

The regulator and its interactions

The regulator's central role in scheme management plays out in its interactions with all participants in the scheme.

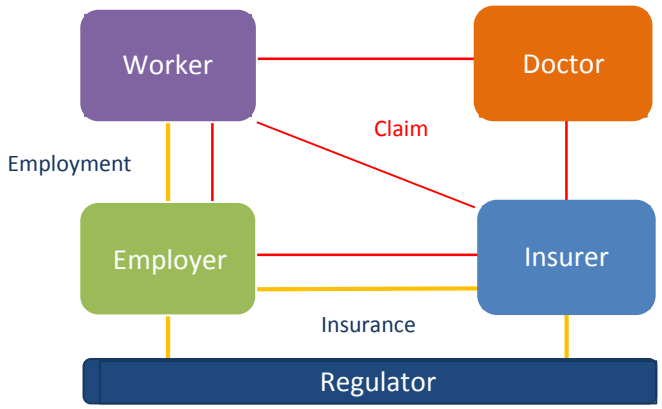
A workers compensation scheme has all the characteristics of a 'system' and needs to be managed as a system. This requires a specialist scheme regulator with independence, expertise and authority.

The scheme regulator has primary responsibility for sustainability of the scheme and needs powers to deal with a wide range of aspects of sustainability.

4.1 Scheme participants

Figure 4.1 shows the relationships between the most important scheme participants; the 'ongoing' relationships are shown as yellow lines, and the claim-specific relationships are indicated in red.

Figure 4.1 – Main Scheme Participants



The **workers** and their behaviour have the most influence on the incidence and cost of workers compensation claims. Activities of the regulator, insurers and employers should all be aimed at having a positive influence on workers' day to day activities via the scheme culture.

Scheme participants beyond those shown in Figure 4.1 include other parts of the health system (specialists, physiotherapists, etc) as well as lawyers and investigators.

This report, in considering only a competitively underwritten scheme, assumes there is no need for a central 'nominal insurer' entity. A guarantee fund (or nominal defendant) would however be required, to pay claims in circumstances where the relevant employer was uninsured. In the unlikely event of insurer insolvency, the guarantee scheme would extend to the workers compensation liabilities of that insurer, funded by a levy on future premiums until the full cost is met.

4.2 The regulator

4.2.1 Legislation and regulations

The scheme regulator operates in the context of the relevant legislation and regulations, and will be well placed to identify and recommend any improvements which can be made to legislation or regulations. For the scheme to be sustainable the scheme regulator must have the mandate, tools and skills to make adjustments to the scheme's workings. As far as possible these adjustments should not depend on amending legislation, because of the difficulty of getting even minor legislative changes passed. Best practice would be to give the regulator the power to make adjustments in one of two ways:

- Clarify legislation through regulatory standards
- Review the efficacy of the legislation every two to three years.

The legislation should be much shorter than the hundreds of pages that typically exist today. The rule making power of the regulator should include both standards (effectively subsidiary legislation) and guidelines (not binding in all situations but driving best practice).

4.2.2 Governance of the regulator

Workers compensation is a compulsory insurance scheme established by legislation. The scheme regulator is most likely to be a public sector agency ultimately subject to control by government, and should not have conflicting roles as both a regulator and an underwriter.

A sustainable and effective workers compensation scheme will be free of political disagreement and purely political influence of the government of the day, and governance of the regulator should be structured accordingly. Having relevant expertise on the Board is critical. A key plank is to have a Board that has a commercial structure, rather than a representative structure where directors are actively involved in the scheme at the time. The representative structure is not appropriate as such directors may either be motivated by vested interests or assumed to be so.

4.2.3 Interaction with WHS

Work Health and Safety (WHS) legislation and regulation is in some ways parallel to workers compensation regulation. Many jurisdictions have considered, and some have implemented, combining the WHS and workers compensation regulators in one entity. At present Western Australia, Queensland and South Australia have separate WHS and workers compensation regulators, while other jurisdictions have a combined regulator (with NSW and Victoria also being the insurer).

The proposed best practice design is for separate WHS and workers compensation regulators, but with a regulatory mandate to co-operate and share information. Separate organisations are proposed to keep focus on the different issues across WHS and workers compensation. The workers compensation scheme should represent a major source of information for WHS authorities, both for planning WHS activities broadly and for targeting specific interventions. In turn, if WHS is improved the results will be better for the workers compensation scheme as well as the workplace.

The workers compensation regulator will establish protocols for working with insurers when WHS targeting is involved, since the insurer has its own commercial relationship with the employer and its own knowledge about claims.

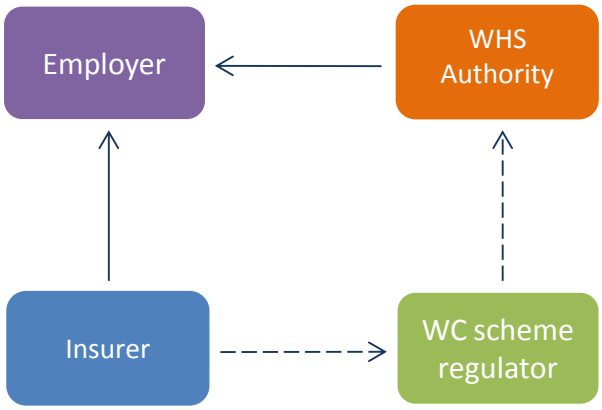
4.3 Oversight of dispute resolution

It is best practice for the scheme regulator to 'own' and manage the dispute resolution process. We discuss dispute resolution in Section 8.6.

4.4 Management of employers

The relationships with the employer are represented in Figure 4.2.

Figure 4.2 – Relationships with Employers



The insurer and the WHS authority will have the day to day interactions with the employer. These include the 'standard' interactions (for the insurer, collection of premiums and management of claims), as well as actions relating to specific circumstances; for example, if the employer has poor accident/claims experience both insurer and WHS authority will have a part to play in addressing that.

When a WHS intervention is needed, the workers compensation regulator should ensure that all relevant information from the insurer is made available to the WHS authority and that the two act in a co-ordinated manner.

The insurer is in a strong position to influence the employer, and the scheme should provide insurers with incentives to influence employers in a constructive way. One of the fundamental strengths of an underwritten insurance scheme is that the insurer has a strong financial incentive to minimise the cost of claims and therefore to work with employers to achieve this. In addition, premiums can be adjusted to reflect an employer's own experience.

4.4.1 Obligations on employers

It is best practice to give medium and large employers a statutory responsibility to assist with (1) managing workers compensation claims and (2) providing opportunities for supported return to work. This would typically apply to employers who have more than 20 employees, and would take the form of an obligation to provide employment – alternative duties, if necessary – for (say) six months after injury.

Best practice will allow, however, for early 'separation' from the employer in situations where continuing in the pre-injury employment does not promote (or may even impede) RTW. Some mental harm claims fall into this category. This approach will promote proper risk assessment of the injury and proper procedures when an injury occurs, and will require suitable compensation such as retraining and a closed period income entitlement.

The statutory obligations would not apply to small employers because they will not typically have the same flexibility; in addition to challenges due to their smaller size, they are unlikely to have a range of different duties available.

Larger employers would typically be required to have nominated return to work co-ordinators, to assist in executing their obligations. The insurer or scheme regulator would normally provide training for return to work co-ordinators.

Incentives for employers to fulfil their obligations will be:

- The premium system – providing both a financial incentive through potential premium reductions and a financial penalty through potential premium increases
- The WHS inspectorate will provide oversight of workplace risk, with both educational and compliance roles.

4.4.2 Employer compliance

Insuring (or self insuring) for workers compensation is compulsory. In relation to oversight of employer compliance:

- Ensuring that all employers are either insured or self insured is the responsibility of the scheme regulator, and can be done in conjunction with the WHS regulator
- Ensuring the accuracy of employers' wage declarations and industry classification should, however, be the primary responsibility of insurers; insurers have the primary relationship with employers, and wages and industry drive the premiums which are collected by insurers. The scheme regulator should have a secondary audit role.

In relation to pricing oversight by the regulator, in Section 9 we suggest a 'light touch' regulatory approach.

4.4.3 Self insurance

Self insurance by employers with a suitable appetite, financial and operational capacity to underwrite their own workers compensation risks should be permitted. The scheme regulator should apply even-handed standards to insurers and self insurers regarding prudential soundness and claim practices.

Employers (and employer corporate groups) wishing to transition to self insurance are required to satisfy a range of financial and other criteria. The current criteria vary by jurisdiction but generally incorporate[6]:

- Minimum **size**
- Sufficient **financial resources** to pay benefits
- Satisfactory **WHS environment** – safety procedures and working conditions
- Capacity to **administer claims** adequately – by own staff or outsourced
- Procedures for **rehabilitation and return to work** for injured employees.

[6] Hurst, M., 2013, *Financial viability of moving to self-insurance,* http://www.finity.com.au/publication/financial-viability-of-moving-to-self-insurance-may-2013/

In our view the current standards for authorisation and regulation of self insurers in Australian jurisdictions are generally more than adequate; the requirements applying in some jurisdictions could be streamlined. It is important that the same regulator be responsible for insurers and self insurers, without the inherent conflict of the regulator also being the insurer (which happens now in some states).

Self insurers would still be required to contribute to the expenses of the workers compensation scheme, via an annual levy.

4.5 Managing the insurers

4.5.1 Selection of insurers

Only insurers with demonstrated capability in delivering workers compensation should be able to operate in the scheme. The selection process would require insurers to demonstrate their competency and experience, and their capacity to meet the scheme's service standards.

4.5.2 Authorising insurers

The scheme regulator should encourage a competitive market among insurers. The scheme regulator is a regulator of product and market conduct; see Table 4.1. APRA should be the prudential regulator of insurers – this means that an insurer must be APRA-authorised, and the scheme regulator need not concern itself with financial security of the insurer.

Table 4.1 – Regulatory Roles: General Insurance and Workers Compensation

Regulatory role	General Insurance	In workers compensation context
Prudential	APRA	APRA
Product	n/a	Scheme regulator
Market conduct	ASIC	Scheme regulator

4.5.3 Oversight of insurers

Best practice will see the conduct and compliance of participating insurers regularly assessed by the scheme regulator. Areas for oversight would include[7,8]:

1. Client service levels – employers and claimants (measured against defined service standards)
2. Compliance with scheme legislation and regulations
3. Fairness in dealings with claimants and employers
4. Benchmarking metrics – pricing, claims performance.

Sanctions against insurers who are not meeting required standards would range from counselling and training at the less serious end, to administrative fines and ultimately suspension of licence for serious performance failure.

[7] The NSW Motor Accidents Authority has a clearly specified guide of insurer obligations ("*Summary Guide of NSW Compulsory Third Party Insurers' Obligations",* 2012)

[8] WorkCover Tasmania's licensing conditions cover solvency, provision of information to stakeholders (WorkCover, policyholders), records management, claims management, injury management and premium setting. They also clearly define instances where insurers must inform the WorkCover Tasmania board in writing.
http://www.workcover.tas.gov.au/insurance/licensed_insurers/license_conditions_for_licensed_insurers

4.6 Managing other scheme providers

Service providers in the workers compensation scheme include:

- Treating doctors and allied health professionals
- Rehabilitation and return to work experts
- Investigators
- Medico-legal experts and assessors
- Lawyers for workers and insurers.

Managing providers – authorising them, and monitoring their performance and effectiveness – can be done only at the macro (whole of scheme) level, and is a responsibility of the scheme regulator. Insurers should be permitted to co-operate in identifying, and intervening with, aberrant service providers. This can make an important contribution to scheme sustainability, as some providers have developed business models that are designed to maximise revenue from workers compensation schemes.

Best practice will involve having a limited number of pre-authorised Independent Medical Assessors, who have specific roles in medical decision-making and dispute resolution processes; see Section 7.

4.6.1 Regulation of fees

As a further control measure, the scheme regulator should have the authority to set maximum fee rates for providers, following consultation with provider group representatives and insurers. There are circumstances in which discretion to pay above the defined maximum may be helpful – for instance, where skilled specialists would otherwise not be willing to participate in the scheme.

4.6.2 Treatment guidelines

Best practice schemes will have treatment guidelines which establish expectations for how some common injuries should be treated, and which provide information on expected recovery times.

4.6.3 Oversight of practice quality

The central statistical data system (see Section 4.8) will have granular information about the services provided in respect of each claim. If concerns are raised about the quality of practice of a service provider (such as over-servicing, or biased reports) the scheme regulator should use this information, along with practice peer reviews, to assess the service provider's practices. The scheme regulator may counsel the provider, initiate a complaint to the relevant professional body, and/or prevent that provider from operating in the workers compensation scheme.

We acknowledge that providing effective oversight of practice quality is challenging for a regulator. It would require close co-operation with insurers, who interact directly with the providers.

4.7 Financial aspects of scheme management

4.7.1 Funding the regulator

It is best practice for the workers compensation scheme regulator's funding to be independent of government budgets. This is achieved by using a levy on premiums, although the levy (shared with self insurers) should fund direct costs of the workers compensation scheme regulation only. Accountability of

the WHS regulator, on the other hand, is best achieved by having direct funding from government or other employer levies.

4.7.2 Scheme efficiency

An overall key performance indicator for the scheme, and a priority for the regulator, should be the efficiency of the scheme. The simplest measure of efficiency is the proportion of the total employer premiums which is paid out as entitlements to and for the direct benefit of injured workers. (For example, medical treatment is for the direct benefit of the worker but a medico-legal assessment is not.)

4.7.3 Latent claims

The scheme will need to deal with potential exposures to latent claims which emerge long after an employee's exposure (asbestos being the most dramatic example to date). This could be achieved by either:

- Defining who will be responsible for such claims in the scheme's rules, e.g. "Insurer/s at the time of exposure is/are responsible for claims", and/***or***
- Allowing the regulator to put funding arrangements in place if and when needed, e.g. where no insurer can be found liable or the exposure is so far in the past that insurer responsibility is impractical.

4.8 Central statistical data

Best practice management of any system or scheme will be evidence-based. To obtain and monitor appropriate evidence requires collecting a considerable amount of data.

4.8.1 Collecting data

With rapid improvements in technology, collecting large volumes of data is more practical than it used to be. In some schemes that have been centrally underwritten but competitively managed, better practice has been achieved by requiring all agents to use a single IT system. In a competitively underwritten scheme, however, there is no case for using a single IT system – each insurer can and should have its own independent system to encourage innovation and (if the insurer wishes) to deal with the whole of its insurance operations.

The scheme regulator should own and operate a central statistical system which records data at a granular level (but does not drive functions or workflow), to which all insurers contribute data. The Personal Injury Register systems operated by the CTP regulators in NSW and Queensland have been successful examples, as have the statistical systems operated in underwritten states such as Western Australia. In order for the central statistical system to operate effectively:

- The data requirements need to be clear, streamlined and consistent over time
- Insurers need to contribute data in a timely fashion.

Insurers and self insurers should use their own IT systems for recording and managing claims. This means that the scheme's operations will not be an impediment to insurers using their systems to be innovative and efficient, and to provide good customer service. For example:

- An insurer may interface with employers online, in a way which supports improved workflow and claims management
- The insurer may integrate workers compensation with other insurance it provides to employers.

4.8.2 Using the data – performance analysis

Collecting detailed data from all insurers will enable a range of performance monitoring and benchmarking at scheme level:

- Exposure – wages, premiums etc
- Claims experience – claim frequencies, amounts, duration etc
- Rates of dispute and dispute outcomes
- Provider performance.

All of the analysis can be used to compare performance across different employers and industries, insurers, and providers. Well designed analysis can be used to focus on areas that are critical to the scheme's overall performance and costs, and can be used to create incentives for improved performance.

Consistent and reliable data analysis is important for identifying and responding to emerging pressure points, and therefore being able to minimise their financial impacts. Failure to do this has been a common theme in schemes which have had sustainability issues in the past. Unfavourable trends, such as increasing claims costs for mature-age workers or for workers with pre-existing disabilities, can be identified and confirmed before they become a major issue.

5 Coverage

The cornerstone of design

The most fundamental element of scheme design is its coverage – who is covered by the scheme, and when are they entitled to claim?

5.1 Who is a worker?

The optimal scheme design is to align workers with the common definitions in employment and tax law. The starting point should be:

> *A person paying income tax in the PAYE system*

The reasons that this is best practice are:

- It matches the expectations of most employers and workers
- It means that premiums collected are more likely to be matched with the exposure to claims
- It is simple and avoids expensive litigation to establish coverage by workers compensation in unusual circumstances
- It minimises the opportunity for employers to avoid paying premiums.

Many small businesses have directors who also work in the business. Coverage should be available to working directors, and income replacement benefits should be calculated based on the wage earnings declared when premiums are paid.

Recent examples

NT WorkSafe moved to a 'results based' test in 2012, which defined as a worker any person performing work for another, unless the person (1) is paid to achieve a stated outcome, (2) needs to supply the equipment or tools required for the work, or (3) would be liable for the cost of rectifying any defect. This test met with difficulties: it was difficult to determine whether the results test applied, and there was confusion around contractors and sub-contractors. The most recent review of the NT scheme in 2014 recommended moving to the simple PAYE definition.

A 2013 review of WA workers compensation recommended the PAYE definition be adopted, and recommended authorising the making of regulations to include or exclude from the definition of worker particular prescribed arrangements.

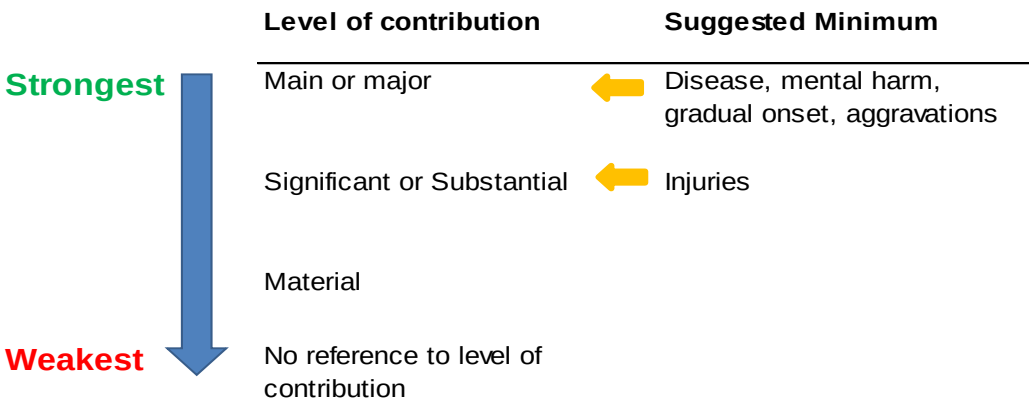
5.2 What is a compensable injury and the necessary link with work?

Most Australian schemes currently adopt similar definitions of injury and work-related disease. Use of the phrase "out of, or in the course of, employment" is the norm, and its application has a large amount of jurisprudence. Adopting this phrase is best practice because its understanding is so well established.

The next question is the degree to which a claimant's employment has been a contributing factor to the illness or injury. Some schemes have adopted a tiered approach, with stricter contribution requirements

for diseases, gradual process injuries and mental harm claims. The words used to specify the extent of contribution fall on a spectrum which is illustrated below. Our suggestions for the adopted minimum levels for different claim types are also shown.

Figure 5.1 – Defining the Contribution of Work



Courts have spent considerable time defining and interpreting these words. A best practice scheme will use a definition that is coherent with the most robust court decisions, in order to limit further litigation on the subject.

Special care is needed with mental harm claims – we discuss the circumstances of these claims, and our suggestions for best practice (including benefit entitlements) in Section 5.5. For such claims, it is established good practice to have a 'carve out' for reasonable management action.

5.3 Should journeys and breaks be covered?

It is sometimes difficult to pinpoint where work or 'the workplace' begins and ends.

Best practice will be to **exclude coverage for journeys to and from work**, for these reasons:

- Journeys to and from the workplace are (by definition) outside both working hours and the workplace environment
- Motor vehicle bodily injury insurance covers injuries sustained on the roads (although in some jurisdictions only if the person was not at fault)
- In other respects, journeys to and from work are simply part of 'daily life'
- Journeys taken **as part of employment** would be covered by the workers compensation arrangements.

Coverage for injuries occurring during a work break sometimes distinguishes between onsite and offsite breaks. Given the complexity in defining and interpreting the numerous boundary issues, the recommended design is to include coverage for injuries during breaks, using the 'contribution of work' to place sensible limits on coverage[9,10].

[9] Peter Hanks QC, in his review, "*Safety, Rehabilitation and Compensation Act Review"* (2013), includes a recommendation (5.7) clarifying journey claims for workers 'on call'

[10] The CIE in its review of the 2012 NSW legislative changes recommends clarity around recess breaks and their implied continued coverage in the NSW scheme. They claim*, "It is arguable that the intent of the amendments to capture only work-related injuries in the workers compensation system would equally apply to unrelated-to-work injuries sustained during work breaks."*

5.4 Subsequent injuries, aggravations and pre-existing conditions

A scheme will also need to deal with situations where:

1. A **subsequent work-related injury** has been sustained following a compensable injury, e.g. an injury to the right hip is sustained due to the worker favouring the right leg after an earlier injury to the left leg.
2. The **initial injury or condition is aggravated** in a workplace incident.

It is best practice for injuries in both of these circumstances to be compensable, using the same eligibility as for the initial claim. If accepted the worker would be entitled to medical and treatment costs, and income replacement where relevant.

The availability (and quantum) of **permanent impairment payments** for subsequent injuries and aggravations is an area for careful scheme design. Assessing the impact of subsequent injuries and aggravations is problematic and can be resource-intensive. Some schemes pay additional 'top up' permanent impairment benefits in these circumstances, and with potentially material additional benefits in play this can be a common cause of contested views and dispute.

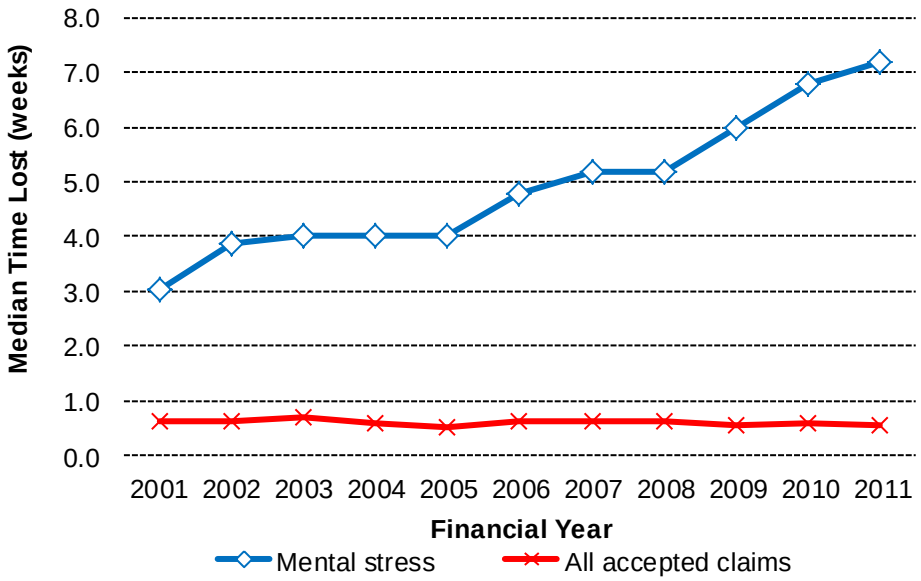
It is best practice to make a 'once and for all' permanent impairment payment for each claim, without further top-up – except where the subsequent injury is compensable.

The benefit design will also need to deal with the impact of pre-existing conditions on compensability, as well as compensation levels for claims where a pre-existing condition has impacted on the claimant's incapacity and recovery. This is an important issue as the take-up of those with disabilities and mature-age persons in employment improves. The legislation will need to limit the extent to which a pre-existing condition contributes to compensability, in order to avoid a disincentive for employers to take on such workers. This will be important in achieving the social objective of greater workforce participation.

5.5 Mental harm claims are different

Mental harm claims are those which originate from a worker's psychological response to a workplace incident or stress. The incidence and cost of mental harm claims have increased, over a range of industries and a number of jurisdictions, over the last ten years or so; for example, see Comcare's experience in Figure 5.2.

Figure 5.2 – Comcare Mental Harm Claims[11]



Mental harm claims need to be thought about and managed differently because (1) immediate return of the worker to the previous workplace can be counterproductive, and (2) it can be more difficult to form an objective assessment of a claim's severity, and of a claimant's recovery.

Some workers compensation claimants, whose initial incapacity relates to a physical injury or illness, later develop psychological issues as a consequence of dealing with their injury and incapacity. In this report we use the term mental harm claims to refer to those where the **primary** injury is psychological, not to claims with psychological 'overlay'.

5.5.1 There is not yet a best practice approach

Compensation schemes in Australia have not yet, in our view, developed a best practice approach to dealing with mental harm claims.

Claims that arise after a single traumatic incident (such as a hold-up or witnessing a fatal accident) may not be complex. Evidence indicates that average times off work for these types of claims are similar to those of injury claims, and that return to the previous workplace and job is often effective. A recent paper on compensation for mental harm claims[12] identified that post-traumatic stress disorder and similar 'event based' mental injuries have a median of three weeks' lost time, compared to a median of nine weeks for other types of mental harm claims. Single incident claims, however, represent a small minority of mental harm claims.

Most mental harm claims develop over an extended timeframe, and often follow a period of difficulties between the worker and others in their workplace. In most cases, prior to commencement of a workers compensation claim, there will have been extensive human resources activity, and often Fair Work or other industrial relations involvement; only the most intractable cases will have become claims. If workers compensation is forced to operate in isolation of other processes, difficulties are likely.

[11] Hurst, M and Shepherd, M. 2014, *Risk Profile of Australian Workers Compensation Schemes,* RMIA National Conference, http://www.finity.com.au/publication/rmia-risk-profile-of-australian-workers-compensation-schemes/
[12] McInerney, A, Gregory, D 2013, *Stress and Mental Injuries – how to compensate?*, Injury Schemes Seminar http://www.finity.com.au/wp/wp-content/uploads/2013/11/R_Compensating-mental-injury_McInerney-and-Gregory_2013.11.11.pdf

5.5.2 Compensability

Determining eligibility for workers compensation in the case of mental harm claims requires a difficult assessment relating to several elements:

- **Nature and extent of harm.** As mentioned, many mental health problems are more difficult to clearly diagnose than some injury claims, and assessing severity is more difficult**.**
- **Causation. T**o what extent was the workplace a contributing factor to the worker's condition? (And were there contributing factors outside the workplace?)
- What is **'reasonable management action**'? A worker's mental illness will not usually be deemed compensable if it is a reaction to management actions which are viewed as reasonable, such as the normal process of performance review and performance management.

Specialist resources will be needed to determine these claims, ideally very quickly after report (e.g. target one week from lodgement) so that treatment can begin immediately.

5.5.3 Benefits Available

We discuss here our suggestions for benefits available for mental harm claims – noting that best practice entitlements for other claims are covered later in Section 6.

Given our view that workers compensation systems are currently not responding to mental harm claims in an optimal way, we propose a different approach for benefits available to, and management of, mental harm claims; the approach and the reasoning behind our proposals are set out below. We note that this approach is untested and could not be regarded as best practice without evidence of success.

1. Income replacement limited to three months maximum, with a one month waiting period from notification of claim
2. Treatment available for 12 months
3. Permanent impairment benefits subject to a high threshold
4. Worker entitled to job placement services (including retraining if approved) at a suitable time within the 12 months
5. No obligation or pressure to return to previous job (unlike physical injuries)
6. No automatic obligation on employer to make work available, or suitable duties
7. Better legal provision to deal with any employment issues (e.g. Fair Work) and workers compensation claims together.

When a mental harm claim arises (except for some single incident claims), the relationship between the worker and the immediate workplace has become a problem. In some circumstances – in particular, cases of bullying and harassment – the worst thing that could be done is to force the employer to have the worker return to the workplace, and to force the worker back to that workplace.

For these reasons, a return to the worker's normal job will often not be the solution. However, it is very important for workers in these circumstances not to go on to feel chronically 'beaten up on' and unemployable. The main goal, therefore, will be to restore the person's self-worth and to help them find other employment. Some **income replacement** during this period will be reasonable and helpful, but

should be time-limited and secondary to the treatment and job placement assistance that can help them recover and find other employment.

Our comments on benefits other than income replacement:

- The **treatment** regimes for mental harm claims will be specific (medical, psychiatric, psychological)
- The **vocational services** required for mental harm claims will be different from those for physical injuries. The skills which will be useful are those of an outplacement service (as opposed to rehabilitation or occupational therapy). Ideally a worker would be able to choose from a number of approved providers, and use a package of services which fits within the scheme's cost parameters.

6 Benefits Paid in Respect of a Claim

Designing the benefits

Most of the work in scheme design sits with defining the benefits that will be paid – benefit types, amounts and duration.

The level of benefits provided, as well as the resulting behavioural impacts, are key determinants of a scheme's costs.

A best practice scheme will have four types of benefits which are paid to, and for the benefit of, the injured worker:

- Income replacement (periodic payment)
- Medical and other treatment
- Permanent impairment
- Death.

We discuss each of these payment types in this section. Broader scheme costs were discussed in Section 4.

The benefits proposed in this section are intended to be consistent with the guiding principles outlined in Section 2.3; these principles derive ultimately from community values and expectations, which governments aim to reflect in scheme design. The proposed benefits also consider the tension between generosity of benefits and affordability which was discussed in Section 2.2.

6.1 Income replacement

A best practice scheme design will have the following features:

- A definition of **pre-injury earnings** that is as easy to determine as possible
- A high level of income replacement initially, with **step-downs** for longer term claims
- **Top-up benefits** to support partial return to work
- **Maximum and minimum amounts** of weekly benefits
- A **work capacity test** for continuing entitlement
- A **time limit** of (say) two to five years
- **Indexation** which replicates increases in average earnings in the community.

We expand on each of these below.

6.1.1 Definition of pre-injury earnings

The first question for income replacement is: what income is being replaced? In principle this is the worker's 'normal earnings'.

For many workers the answer is straightforward – the pre-injury salary. For other employees, including casual workers, normal earnings are harder to define. Suggested best practice would be to use:

Average earnings over the last three months – including regular overtime, but excluding other allowances, bonuses etc.

Special cases which would need further consideration include workers with more than one job, seasonal workers, employees without a three-month history, and working directors.

6.1.2 Income replacement levels

The design of income replacement benefits will normally have two conflicting aims:

- Allow the worker to support their financial commitments and a reasonable pre-injury lifestyle while they are injured, for a period that is reasonable in the circumstances
- Encourage the worker to return to work as soon as they are able to. This is best for the worker (work is good for your health) and also reduces the liability on the compensation scheme.

Replacement ratio

Best practice maximum replacement ratios (% of pre-injury earnings) would be:

- 100% for up to three months after injury
- 80% thereafter. The reduction to 80% allows for the fact that some expenses (e.g. travel) are not incurred when not working, and also encourages return to work.

If superannuation benefits are paid along with benefits (see below), replacement ratios of 90% then 70% would be reasonable.

Top-up benefits

It is normal and appropriate to allow for partial (including gradual) return to work by paying partial benefits during periods when the worker has returned to work but is not working (or earning) at full capacity. Best practice is to calculate top-up benefits as:

Replacement ratio **times** *[pre-injury earnings – actual earnings]*

If this calculation yielded a negative amount, of course no benefits would be paid.

Maximum and minimum amounts

Best practice would see maximum and minimum benefits apply, as follows:

- Maximum weekly benefit = replacement ratio ***times*** 2 times AWE
  - This prevents very highly paid workers from placing a strain on the scheme. The expectation would be that such workers will have taken out their own income replacement insurance, which would cover the earnings not replaced by workers compensation.
- Minimum weekly benefit defined in relation to the minimum wage and social security benefits.
  - This is intended to prevent hardship for low-earning claimants.

6.1.3 Including superannuation

We propose that superannuation contributions at the Superannuation Guarantee (SG) rate, currently 9.5%, be paid along with the income replacement benefits.

This would be a change for all workers compensation schemes, and needs careful thought. It is included in this proposed design because, in our view, it brings workers compensation more into line with current employment practices.

Previously, the administrative problems that would arise if superannuation were to be included were prohibitive. With the introduction of the SuperStream system co-ordinated by the ATO the practical difficulties are now surmountable.

For historical reasons most schemes do not pay superannuation contributions along with income replacement, although the wage base for premiums usually includes superannuation. This approach is out of step with today's workforce, where SG contributions are compulsory and a worker can carry their superannuation account with them as they change jobs.

Paying superannuation will also ensure that any death and disability insurance coverage provided by the superannuation fund continues.

As noted above, the cost of paying superannuation would be factored into decisions about appropriate levels of income replacement. Broadly, if superannuation is paid, then the replacement ratio should be 10% lower.

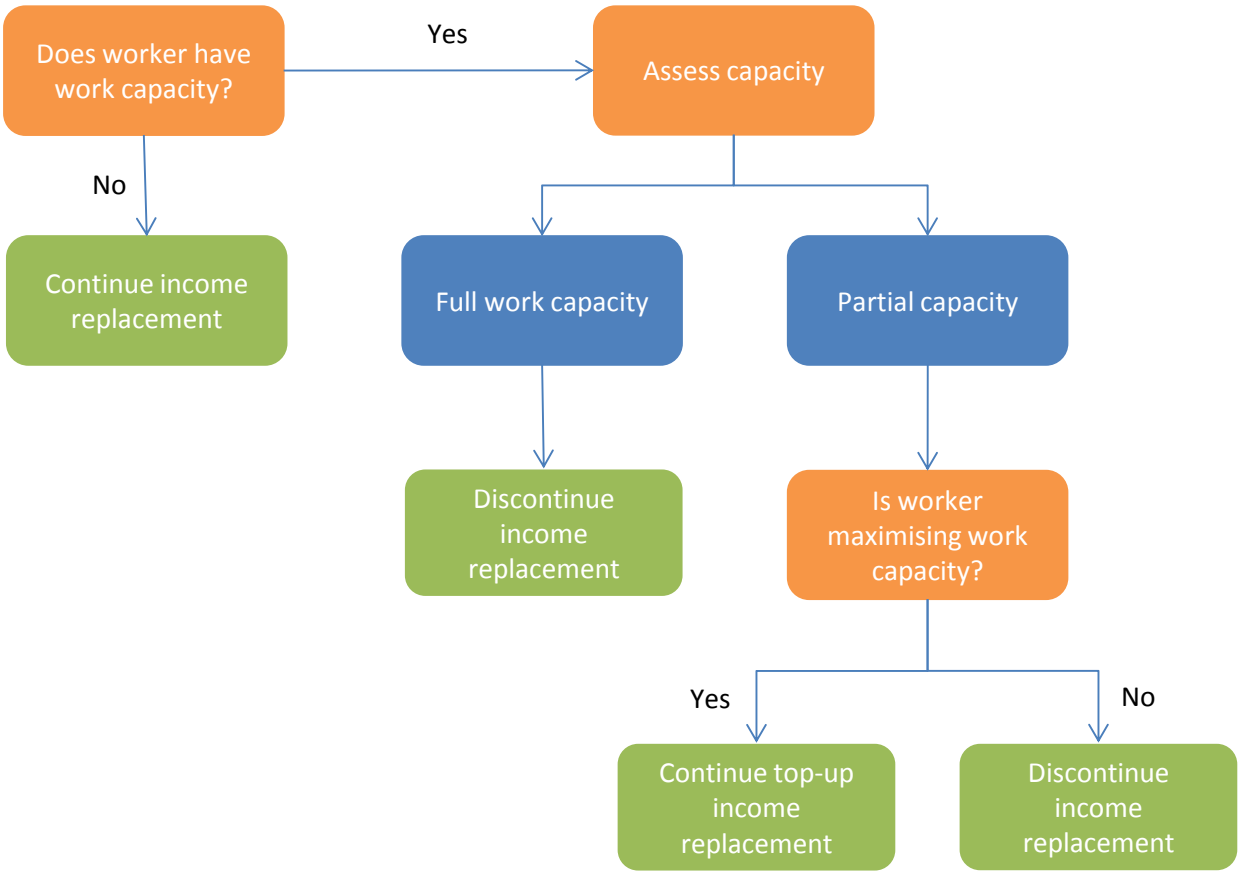
6.1.4 Work capacity test

It is best practice to use a test of work capacity to ensure that workers who are fit to return to work (fully or partially) do so, or – put another way – that workers are working to their full capacity[13]. If not, income replacement would be discontinued. Such a test would be applied at a specified period after the worker's first time off work – say, at two years. It would be applied by answering a series of questions, as shown in the flow chart below.

Several jurisdictions have used work capacity testing with varying degrees of success, which gives indications of the most effective rules and approaches. It appears that the approach currently used in Victoria may be the most effective.

[13] The CIE summarises stakeholder feedback and recommends improving the "efficiency and consistency of work capacity assessments". It acknowledges, *"Whether as a result of the early days of reform, the remuneration model, or other factors, there is variability in the effectiveness of claims managers to make work capacity assessments, and insufficient tools available to improve the quality of work capacity decisions. This may require capacity building for claims managers to respond to the disconnect between the new powers of insurers and the skills of case managers to fulfil them."*
In contrast, the Victorian work capacity test has functioned very effectively over the last decade, limiting the proportion of claimants receiving long-term benefits.

Figure 6.1 – Work Capacity Assessment



As well as terminating the income replacement at a defined duration, a work capacity test also encourages return to work at earlier durations; an injured worker who knows a work capacity test will be applied has less incentive to remain on benefits indefinitely. Therefore, the 'discontinuance' impact of a two-year test will be seen not only at two years but also at earlier durations.

The primary evidence about a worker's capacity would be put together by a doctor. This would normally be done by the worker's treating doctor, but the workers compensation insurer would have the right to challenge a decision and have an Independent Medical Assessor assess the worker's capacity. (Section 8 of this report discusses determinations and dispute resolution.)

The ability for insurer and worker to agree on a closed period payment of up to (say) three months in the future will assist in an effective work capacity assessment process.

6.1.5 Limit on income replacement benefits

Best practice schemes limit the **time period** for income replacement, except for catastrophically injured claimants (who will be in the NIIS); this is consistent with the philosophy that the obligation of the employer to look after its employees is not endless. This approach also achieves a number of objectives:

- It provides additional incentive for return to work (again, likely to be observed **before** the time limit)
- It improves affordability of the workers compensation scheme

- It effectively acknowledges that workers compensation does not cater for the long term unemployed (apart from the seriously injured) – even those who might potentially identify the 'start of the problem' as a work-related injury or illness.

Another option is to limit the **total amount** of income replacement, which provides an incentive for partial return to work.[14]

The time limit on income replacement could be two-tiered – for instance, the limit could be five years for seriously injured claimants and two years for others.

Appendix B.2 summarises the history of time limits applied to income replacement benefits in Australian schemes.

6.1.6 Indexation of entitlement amounts

It is important for sustainability that reasonable provisions for indexation are incorporated into the scheme design.

Scheme parameters – maximum and minimum income replacement, death benefits, permanent impairment benefit amounts and the like – will be indexed annually based on the national Labour Price Index.

Individual income replacement benefits will be indexed annually on the anniversary of the injury date, using the same index. For apprentices, indexation would include the increments in pay rates in the apprenticeship agreement.

6.1.7 Option for employer to pay

Some schemes allow the option for the employer to pay income maintenance and then be reimbursed by the insurer – particularly at early claim durations. This improves efficiency, because most claims are of short duration and for these claims the employer will continue to pay and there will be no need to set up payments from the insurer at all.

Making arrangements of this nature would be up to each insurer and employer.

6.1.8 Ability to agree negotiated settlements

An historical feature of workers compensation schemes, and one still present in some schemes, is the negotiation of settlement of a claim by way of a lump sum, variously called a redemption or a commutation. The prevalence of lump sum settlements has been controversial in some schemes because:

- At the individual claim level, the settlement is seen to save the insurer money
- The availability of settlements can encourage longer claim duration and more disputes
- The interaction with common law elements of the scheme may provide incentives to make common law claims that may not be sustained.

Because of these difficulties most schemes have now moved to placing restrictions on negotiated settlements, some stricter than others.

[14] A dollar limit is used, for example, in Western Australia

Good practice entails a degree of flexibility in resolution of claims while maintaining standards and culture. One fairly flexible approach would be to allow the insurer and claimant to agree on a lump sum settlement in the following circumstances:

- Income replacement has been paid for at least six months
- Reasonable prospects for return to work have been exhausted
- The worker is able to make an informed decision about the consequences of the agreement (there is a key role for the Worker Advocacy service here; see Section 8.3)
- Medical and like costs may be included in the settlement at the option of the parties.

Clear rules are needed regarding offsets, exclusion periods and recovery rights to prevent 'arbitrage' between compensation schemes and government entitlements.

A more restrictive alternative would be:

- The insurer and claimant may agree on a closed period payment of up to 13 weeks' future income replacement to resolve a claim, provided permanent impairment has been resolved prior to or at the same time
- Medical and like costs may not be commuted or redeemed.

6.2 Medical and other treatment

A best practice scheme will provide medical and other treatment that is 'reasonable and necessary', with payments made as costs are incurred. This definition has established jurisprudence. Treatments will include doctor visits, physiotherapy, surgery, other hospital, pharmaceuticals, prostheses, occupational therapy, vocational rehabilitation and associated travel.

The entitlement to treatment should cease 12 months after a worker's entitlement to income replacement ceases (or 12 months from the injury date if there is no income replacement), except for:

- Prostheses – hearing aids, artificial limbs etc
- Deferred surgery. In some cases appropriate surgery can be performed only after a delay from injury. This should normally be identifiable early in the life of a claim, and agreed to early to avoid future disputation.

The time limit means that the scheme's provision of income replacement and treatment costs are linked, and the 12 months acknowledges that there may be some ongoing treatment which supports the worker's return to work.

A best practice scheme would develop **treatment guidelines** which would help in identifying inappropriate treatment or over-servicing.

6.3 Permanent impairment

A best practice scheme will provide a lump sum for permanent impairment, based on a medically defined measure which is as objective and consistently applied as possible. Established best practice is to define

Whole Person Impairment (WPI) using AMA Guides – 5th Edition with Australian modifications, with the assessment being made by an accredited medical practitioner.

Current practice in Australian jurisdictions for determining permanent impairment relies on either AMA 4th or 5th editions, with modified standards generally applying to mental harm injuries, vision loss, hearing loss and pain.[15]

It is best practice to determine and pay any permanent impairment benefit as soon as a claimant's condition is stable, as it is in the worker's interests (financial and psychological) to receive the payment as soon as possible[16]. A determination can usually be made within six months to a year, but in some cases may take up to two to three years.

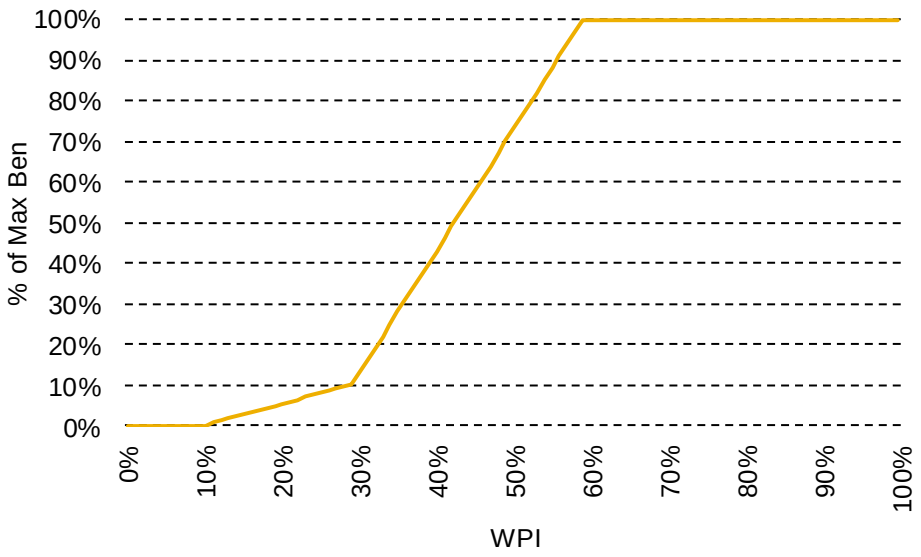
6.3.1 Benefit Amount

It is best practice to define an **impairment threshold** which defines eligibility for permanent impairment compensation; this is typically 5% to 10% WPI. Limiting payment to claimants with relatively serious ongoing impairment means that:

- The scheme's payouts for this benefit type are allocated to those who are in greater need, and the amounts paid to this group can be more generous as a result
- Efficiency is improved by avoiding large numbers of assessments for minor injuries, and many small payments.

Best practice is to have a **maximum** permanent impairment benefit of about $400,000 (this would be indexed), which would cut in at a WPI between 50% and 70%. Benefits for WPI values below this would be defined by a WPI scale (which expresses payments as % of the maximum benefit); Figure 6.2 shows an example.

Figure 6.2 – Permanent Impairment Benefit Scale



[15] *Comparison of workers' compensation arrangements in Australia and New Zealand 2013,* Safe Work Australia
[16] O'Connor, Paul 2009, *Impairment Benefits – finding a better way of working,* 12th Accident Compensation Seminar, Actuaries Institute

Under this scale:

- The payment increases gradually between the WPI threshold of 10% and 30% WPI. This gradual increase reduces the motivation of claimants whose WPI is slightly below 10% to 'manipulate' the WPI assessment in order to reach 10%.
- The benefit increases fairly steeply between WPIs of 30% and 60%, with the maximum benefit paid at 60%.

6.4 Death

Workplace related deaths are infrequent, and it is best practice to award death benefits which would be regarded as reasonably generous.

Benefits on death should include a moderate amount regardless of dependency (say $50,000), which is enough to cover funeral costs and leave a modest amount for the estate.

If there are dependants, a much larger lump sum (determined by formula) would be paid, with a base amount for a dependent spouse and further amounts based on the number and ages of dependent children. A simple example would be $400,000 if there is a dependent spouse, plus $50,000 per dependent child to a maximum of $600,000 overall.

6.5 Flexible retirement

Workers compensation scheme design has not kept pace with changing workforce patterns, in which we are seeing more and more flexible transition to retirement. In recognising this pattern, the scheme design should include:

- Entitlement to claim for a work injury occurring at any age, provided the work pattern is regular
- Coverage of medical and like expenses
- Income replacement available up to the age pension entitlement age, or until the worker's expected retirement age if sooner (subject of course to the same provisions as for any other worker)
- For an injury occurring after the age pension entitlement age, up to three months of income replacement.

This approach integrates workers compensation with other aspects of incomes, particularly superannuation and the age pension. Noting that workers compensation benefits are typically higher than either the age pension or a superannuation drawdown, it is important not to inadvertently create an incentive for people to make a claim just prior to their expected retirement. It is also relevant that if providing workers compensation for older workers becomes too expensive, this could create a further source of discrimination against older workers.

This integrated approach does not leave people stranded. Superannuation has become more or less universal, and would be available to anyone leaving employment. In addition, the age pension safety net applies to everyone (subject to means tests) once the pension age is reached.

6.6 Should benefits depend on employer negligence?

One of the controversial aspects of workers compensation schemes in Australia over the last 30 years has been the role of common law (negligence based) damages, alongside or instead of the statutory entitlements which are paid regardless of fault. By definition, common law benefits can be available only to those who can demonstrate employer negligence in relation to their injury or illness.

The arguments for and against common law have been well travelled since the early 1970s, and views today are driven more by ideology than by considerations of sustainability. A best practice workers compensation scheme will have either:

- No access to common law, alongside a relatively generous permanent impairment benefit scale, or
- A limited common law regime, confined to serious injuries and with a threshold defined using WPI – typically 10-20% would be used.

Both of these models keep the main focus of the workers compensation scheme on compensating all injured workers appropriately and consistently, without the distraction of considering negligence. In addition, restricting access to common law keeps the scheme's legal costs under better control. The details of a restricted common law regime are not covered in this report but are addressed in more detail elsewhere.[17]

Reasons why an unfettered common law regime is not best practice – and works against scheme sustainability – include:

- Having no barrier to common law means many (if not all) claimants will be motivated to consider whether the employer is negligent – causing much energy (and costs in the form of legal fees) to be diverted
- It can lead to inequity of compensation between relatively minor claims which are broadly similar in circumstances, but where one can technically be attributed to employer negligence. An example is trips and falls, where the presence of a minor trip hazard in the workplace can be used to argue employer negligence
- The possibility of a lump sum (common law) benefit is appealing to many claimants, and can create perverse incentives and outcomes:
  - Claimants are motivated to be or appear as 'impaired' as possible to maximise their benefits, which means higher benefit costs and reduced focus on return to work
  - Many claimants do not have the financial skills to properly manage a significant lump sum, and may not use it well, finding themselves with no economic support down the track
- Courts can be unpredictable in their approach, and can set precedents which ultimately lead to higher costs across a whole scheme – for example, allowing common law claims to proceed well beyond the relevant statute of limitations period.

While there are some positive aspects of a common law regime – for example, the prospect of being sued can be a motivation to mitigate workplace risks – in our view these are far outweighed by the negative aspects.

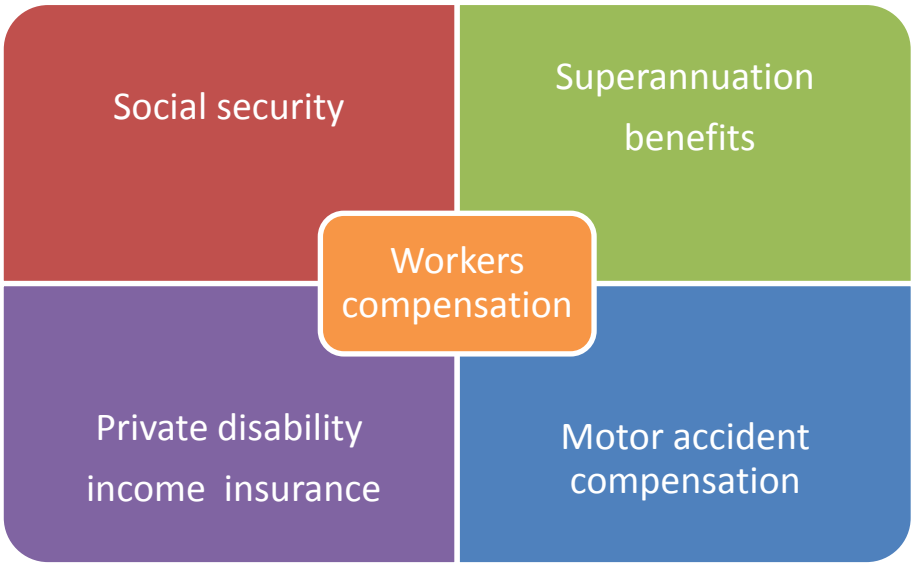
[17] For example, Atkins, G 2014, *Sustainability of Common Law,* Actuaries Magazine http://www.finity.com.au/publication/sustainability-of-common-law-article/

Ideally, employer safety checks and provision of incentives for workplace risk mitigation will be handled fairly and comprehensively by the WHS authority.

6.7 Interaction with other income sources

In some cases, an injured worker who is not able to work at full capacity will be entitled to receive income from other sources alongside workers compensation; these include social security benefits and other income sources shown in Figure 6.3.

Figure 6.3 – Other Income Sources



It is normal for any workers compensation benefits to be paid in first priority, and for any additional entitlements from other sources over and above the workers compensation benefits to function as a top-up.

In relation to workers compensation and social security benefits:

- If it is possible for an injured worker's income replacement (and/or other workers compensation benefits) to be lower than the worker's equivalent social security entitlement, this is an unsatisfactory outcome
- Best practice scheme design will consider the interactions between the scheme and social security entitlements, so that once workers compensation entitlements cease (e.g. time limit on income replacement is reached) workers who are still unable to work will not find themselves in 'limbo' between the two systems.

7 Claims Handling

Handling claims well

"Best-practice claims management is the key to minimising the negative impact of injuries on people, employers and underwriters." – Suncorp 2012 white paper

7.1 Setting and meeting expectations

Injured workers and their advocates need to have reasonable expectations of how the scheme will deal with them – human interactions, benefits, obligations.

Claim decisions need to be made on a consistent basis over time – particularly decisions at the disputed and appealed stages. The more consistent the decisions, the greater will be the consideration of fairness, and the lower the incidence of disputes and appeals.

Behavioural science provides useful input into developing approaches which achieve favourable claims outcomes; see Section 10.6.

7.2 Managing claims – return to work

7.2.1 Focus on return to work

Early and sustainable return to work is in the best interests of employees, employers and scheme[18]:

- It assists with recovery for employees
- It minimises the costs of income replacement (and, as a consequence, other benefits), which ultimately means lower premiums for employers and a more affordable and sustainable scheme.

The primary focus of a best practice scheme is recovery and return to work. Beginning from an emphasis on the health benefits of work, the goals are to:

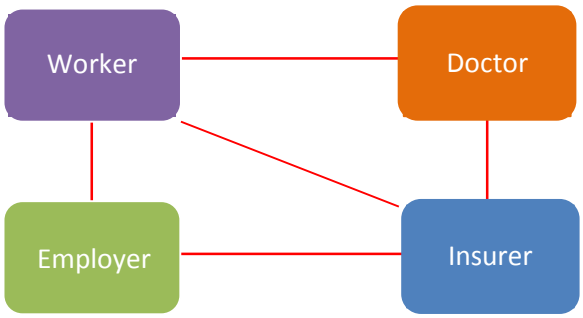
1. If possible, enable the worker to recover from the injury while staying at or returning to work, rather than the old paradigm of 'recover first, then return to work'
2. Identify as soon as possible, and act to minimise, barriers to returning to work
3. Identify as early as possible situations where return to the previous employment is unlikely to succeed, and encourage alternative employment.

7.2.2 Four primary participants

Return to work needs the co-ordinated activity of the four primary participants in the claims process; see below.

[18] *Australian and New Zealand Consensus Statement on the Health Benefits of Work 2014,* Australasian Faculty of Occupational and Environmental Medicine.

Figure 7.1 – Participants in Claims Process



The large majority of claims will be resolved within a matter of weeks without involvement from participants outside this core group. A big challenge for the insurer is to intervene only when necessary, and an effective claim triage process is important for this reason. It is apparent that mental harm claims require immediate triage into a specialist stream.

Provision of specific rehabilitation services needs to be selective; experience has shown that engaging rehabilitation providers as a matter of course has not always been successful. Insurers will need to make specific judgements – in consideration of the specific injuries, and in applying any treatment guidelines – about when additional services will be beneficial.

7.2.3 Legislative enablers

Attempts have been made to use legislation to drive early return to work, for example compulsory preparation of return to work plans. The difficulty with a legislative solution is that it needs to be 'one size fits all' and the effectiveness of the process quickly becomes secondary to compliance. There are, however, two sets of legislative enablers that are part of a best practice scheme:

- For **medium and large employers** – requirement for a return to work co-ordinator, obligation to provide suitable duties, and keep a job open when practical (with penalties for non-compliance)
- For **workers** – requirement to participate in medical recovery and return to work initiatives. It should be clear to the worker that return to work is an **expectation**, even if they are not able to get back to their pre-injury health.

The legislation should enable the scheme regulator to prioritise return to work and give broad powers to make and change guidelines and intervene in other ways.

A different approach to return to work is required for small employers. The scheme regulator should encourage insurers to try different methods, such as the 'mobile case managers' introduced recently in South Australia.

7.2.4 Other enablers

Other mechanisms for encouraging return to work include:

- Encourage claims management which supports claimants' needs other than the medical/physical (social and emotional aspects) and which allows for specific circumstances, such as a worker who does not have easy access to treatment

- Training GPs to provide treatment and advice that supports return to work rather than prolonging an injured worker's perception of being injured or disabled, for example using a 'certificate of capacity' rather than incapacity
- Educating employers so that they understand the benefits of re-integrating injured staff – retaining corporate knowledge and skillsets
- Providing financial incentives for employers who employ workers who have not been able to return to their pre-injury employer (similar to incentives for employers to take on older workers).

7.2.5 To work with current employer or not?

Best practice is to engage the employer in the return to work process. There will be some situations, however, where this is not going to work, such as many mental harm claims (refer to section 5.5) and other situations where the best outcome for the worker is to leave their pre-injury employment.

There needs to be provision for an early decision on whether to focus on return to work with the current employer or not. Job search services should be initiated at an early stage if the latter decision is made.

A great deal depends on the attitude and culture of the employer, and as noted elsewhere culture cannot be legislated. If an insurer identifies an employer with an unhelpful attitude, the insurer should initiate some employer-level intervention, if necessary with the support of the scheme regulator. The insurer has a direct financial incentive to improve the co-operation of an employer and hence improve the employer's claims experience.

8 Determining Claims and Resolving Disputes

8.1 Early claim determination and the employer

Many claims are straightforward to determine. Once sufficient evidence is available from worker and employer (including information via a recorded telephone conversation or online) the insurer should be encouraged to accept the claim, even if on limited terms such as for an interim period or 'subject to' other evidence. Insurers should establish working relationships with larger employers to facilitate this quick response, and they may be willing to give limited claim authority to an employer.

The legislation should permit sufficient flexibility for straightforward claims to be dealt with in the simplest and fastest way possible, while preserving the ability to fully investigate and challenge a claim when warranted.

8.2 Responsibility rests with the insurer

It is the insurer's responsibility to determine claims according to the law and in a fair manner. Most claim decisions are simple, while others can be extremely complex. It is best practice to have service standards for insurers to keep their focus on prompt and fair dealing with employers and workers; Table 8.1 sets out the areas usually covered by these standards.

Table 8.1 – Insurer Service Standards

Requirement	Indicative Examples
Response times	Provide claim form within 1 day of intimation
	Acknowledge claim application within 5 days
Communication	Provide claimant with relevant factual information
	Respond to reasonable requests for information within 3 days
	Advise claimant of rejection of claim (and reasons) within reasonable period
	Ensure communications in plain English and relevant/tailored to claimant
Return to work	Early triage for return-to-work assistance
	Rapid (but not wasteful) communication with worker, employer and doctor about return to work
	Plans for return to work agreed with worker and employer
Timely payment	Pay treatment costs as incurred
	Pay reasonable expenses within 1 month
Record keeping	Maintain file for each claim (may be electronic)
	Keep copies of written correspondence
	Keep records of verbal communications
	Document internal complaint and dispute resolution processes
Conduct	All decisions based on relevant facts and legislation/regulation
	Consult with worker on decisions about their entitlements
	Operate consistently with privacy standards
	Operate in professional and ethical manner

8.3 Education, consistent decisions and information exchange

Nerida Wallace[19] identified that a best practice scheme design can prevent or resolve a very large number of disputes before reaching the formal dispute system:

- 60% by education
- 20% by better informed original decisions
- 8% by information exchange
- 6% by internal review.

The importance of the role of education in best practice is instructive. The approach we suggest, which is not entirely novel but has not been fully developed in Australian schemes, is to have a Worker Advocacy service that is available without charge to workers. The main role of the Advocacy service is to provide education, information and guidance to workers – someone that is informed and 'on the worker's side'. The services would:

- Be independent of, but accountable to, the scheme regulator
- Be funded by the scheme regulator from levies
- Possibly have several competing service providers.

The service would also assist the worker in preparing and presenting material to the insurer and, more importantly, to the tribunal.

8.4 Medical and factual evidence

The most common type of evidence needed to determine a claim is **medical evidence.** There may also be a need for **factual evidence** (e.g. what happened at the time of the injury) and sometimes for **legal evidence,** about how the legislation applies in a particular case.

It is best practice – and, in recent times, increasingly accepted as best practice – to have most decisions about entitlement and benefit eligibility decided by medical assessment, based on objective rules, rather than allowing decisions to routinely be the subject of legal argument and challenge[20]. Medical decision-making means decisions can be made and finalised more quickly and are more objective, which improves certainty for injured workers and reduces scheme costs. In schemes where workers' actions are driven by their legal representatives' advice, workers can be encouraged to 'stay injured' in order to maximise their compensation, and be directed to doctors known to offer favourable opinions. This behaviour hinders rehabilitation and recovery, and pushes more workers towards being off work for a long period and becoming compensation-dependent.

The evidence gathering and decision making process should be built from the principles of an inquisitorial rather than an adversarial justice system.

[19] Wallace, N 2010, *Designing Dispute Resolution Systems – Lessons from Workers Compensation and Magistrates Courts (Australia and New Zealand),* 10th National Mediation Conference

[20] Currently, most Australian jurisdictions (excluding, ACT, NT and Comcare) refer medical disputes to Medical panels, whose decisions are often binding, subject to the presentation of new evidence *("Comparison of worker's compensation arrangements in Australia and New Zealand"*, 2013, Safe Work Australia)

8.4.1 Choice of provider

Most would regard injured workers as having the right to choose their own primary medical provider for management of their injury or illness; this would almost always be their regular general practitioner.

However there will be some 'outlier' doctors who tend to overestimate the worker's incapacity or need for treatment, and thereby encourage the worker to remain off work and to rely on workers compensation. This type of behaviour can greatly prolong the duration of a claim, and increase the overall costs substantially.

We suggest that best practice is to allow employees to choose their own primary provider, but to use approved Independent Medical Assessors for decisions when there is dispute (see Section 8.6 below).

8.5 Investigations

Inevitably, a small proportion of the scheme's claims will be made fraudulently, or some claimants will claim specific benefits or benefit levels to which their actual injury would not entitle them. For example, a claimant with a soft tissue injury may claim (or feign) incapacity to work.

Insurers have a financial incentive to resist fraudulent claims, and are permitted to undertake investigations, at their own cost, within privacy and other conduct standards.

The scheme regulator also has a role in fraud detection and minimisation. This includes provision of tools based on the central statistical system, and support in pursuing alleged fraud of a systemic nature. The scheme regulator will develop, as part of its data responsibilities, access to other information relevant to fraud detection, and can act on a national basis. The regulator should take the lead in prosecuting frauds.

8.6 Dealing with disputes

Once evidence has been gathered and considered, and internal review completed, there will still be some claims where the worker, or less frequently the employer, does not accept the insurer's decision. Disputes will usually relate to one of:

1. Entitlement – is there a valid claim?
2. Level of impairment – and therefore quantum of benefit
3. Termination of benefits.

Where there is dispute, the traditional approach has been to go to court – either to a specialist workers compensation court or tribunal, or to the broad civil justice court system.

With few exceptions, a workers compensation claim is not so complex or unusual that it needs a court hearing to decide it. The law is well established, the types of evidence that may be relevant are clearly defined, and a hearing conducted on an adversarial basis is not necessary.

8.6.1 Resolution system

This environment lends itself to an **administrative resolution process** rather than a judicial one[21], and great progress has been made in Australia with designing administrative tribunals that are inquisitorial in

[21] Cane, P 2009, *Administrative Tribunals and Adjudication*, Hart Publishing, Oxford

nature. Decisions can be made in one place by people with extensive subject matter expertise, within a framework of objectivity and procedural fairness.

Decisions in the first instance can be made by a single expert decision maker:

- It is well established that a large proportion of workers compensation disputes involve medical issues, so a robust system of pre-qualified Independent Medical Assessors is important
- Other factual decisions involving causation, earnings and the like can be made by a single assessor with industry and legal background.

The medical and legal parts of the tribunal should be operated under a single registry system, with active management by an Intake Officer[22] to get all parties and documents in order as quickly as possible. If the Intake Officer is not satisfied that there is adequate objective medical evidence, then an Independent Medical Assessor would be engaged. As soon as information is exchanged, there will be a compulsory mediation.

If the mediation is unsuccessful the case is listed for hearing virtually immediately (within about two weeks) and the arbitrator makes a decision. Wallace argues that a dispute system designed in this way will be quick, effective and inexpensive and will in fact result in fewer disputes.

8.6.2 Appeal

There should be one level of appeal from a decision at first instance. Regarding medical issues, this should involve a Medical Panel. Other issues should be dealt with on appeal by senior members of the tribunal.

8.6.3 Escalation to Court

It is necessary that there be a process of judicial review, as well as early access to courts if there are important or novel issues involved. The scheme regulator has an important role to play in systematic management of court escalation. The tribunal will itself have the authority to channel a case directly to court if that appears to be the most effective course of action.

While administrative processes such as arbitration and medical panels have been broadly successful, the frequency of applications for judicial review has been increasing in recent years, and with many of these applications it is a stretch to consider that the grounds really are points of law. One way to deal with this issue is to have a 'leave to review' process, with the head of the tribunal or the scheme regulator deciding whether leave is given. Judicial reviews that do deal with points of law that are relevant to the scheme should be supported and funded, while those that simply represent dissatisfaction with the result of an individual case should be refused.

8.6.4 Legal costs

Extensive involvement of lawyers representing particular parties has often led to high costs and an adversarial culture in workers compensation schemes. A best practice design means that involvement of legal representatives on individual claims should be needed only in a small minority of cases.

Insurers will generally have access to legal knowledge and skills from within their claims department and should not normally need to engage outside lawyers on disputes.

[22] As described by Wallace

Workers should be able to rely mainly on the Advocacy service outlined above, firstly to prevent a dispute arising in the first place, and secondly through to the tribunal process. If a worker chooses to engage a lawyer at this stage it would be at their own cost.

If there are solicitor-client fees, then there needs to be transparency and disclosure to the regulator (as is currently the case in the NSW CTP scheme).

As noted above, however, some claims are very complex and will require legal skills to reach an appropriate outcome. The Advocacy service will have a limited budget to retain lawyers (with agreement of the tribunal Intake Officer). The scheme regulator will, as an important part of its role, consider cases that need authoritative legal decision, and fund workers' legal costs in these situations.

8.6.5 Measurement and accountability

Each aspect of the dispute resolution system needs to be routinely assessed – volumes, timeframes, costs and resolution rates. Making this assessment does not require examining who wins and who loses.

The scheme regulator, as the ultimate funder of the dispute system and being responsible for the success of the scheme, will make the various players in the dispute system accountable for their performance.

9 Pricing of Workers Compensation

The premium system is an important element of the relationship with employers, and can be used to encourage employers to improve their WHS and workers compensation claim experience.

The pricing approach set out in this section proposes a framework of lightly regulated premium rates which are free from interference by governments and other stakeholders.

9.1 Full funding

The scheme will operate on the principle that insurers should establish premiums on a fully funded basis – which means that premiums (along with investment earnings) are sufficient to cover all claims costs, insurer expenses and scheme expenses. There will be a degree of flexibility in application of the principle in order to encourage innovation and competition.

9.2 Industry rates are the starting point

The basic pricing 'formula' is to apply industry (occupation) based premium rates to employer wages; the rates will depend on industry claim costs and will typically range from less than 0.5% of wages to more than 10% of wages. These rates would include a loading to cover scheme running costs.

Many employers will have workforces spread across a number of occupations, and for these the total premium will be the sum of premiums calculated for individual employee segments.

It is best practice for a scheme regulator to estimate indicative standard premium rates by industry, and to issue these to all participating insurers and the public. These public industry rates establish a benchmark for insurers and employers to assess pricing, and result in a more orderly marketplace.

An important improvement on current approaches is for the regulator to establish regulated industry rates based on experience that **excludes** the largest employers (whose premium will usually be based on their own experience). For example, the data analysed would include only those employers with a base premium of up to (say) $200,000. This will ensure that the industry rates will be more indicative of the experience of employers to which they will be applied.

9.3 Insurer rate setting

It is our view that a best practice premium system gives an insurer the flexibility to establish its own premium rates and contractual arrangements with employers.

The scheme regulator should be informed of each insurer's premium setting approach. This is best achieved by annual submission to the regulator of an insurer's underwriting and pricing guidelines, along with the basis of calculation of its proposed average premium rate. The submission would not be for approval or disapproval by the regulator, but would allow a degree of oversight and the opportunity to query an insurer that is moving markedly out of line with industry trends.

Combining provision of indicative standard rates for small and medium employers with flexibility for insurers assists with an orderly market while encouraging competition.

9.3.1 Restrictions on rates and movements

Employers will expect to be protected against excessive premiums, and will also expect that rates will not vary dramatically from year to year. It is best practice for the scheme regulator to establish rules which limit excessive premiums and excessive volatility.

Limiting an employer's premium to a defined level above the indicative rate deals with potentially excessive premiums; in Western Australia, for example, an insurer requires the approval of the regulator to charge a rate which is more than 75% above the gazetted rate.[23] Experience in WA shows that this approach does not work for large employers with poor claims experience, and suggests that the provision should be limited to small and medium sized employers.

Volatility of premiums from year to year is more difficult to control and best dealt with by insurers through their commercial decision-making. The best mitigant is to have a stable scheme.

9.4 Large vs small employers

The premium system must deal appropriately with all employers; this includes very large companies whose experience will generally be reasonably predictable from year to year, and very small employers which will have a claim very rarely if ever.

It is best practice to allow insurers to 'experience rate' larger employers – that is, to charge premiums which reflect their own experience. This will be seen as a positive by insurers, as the premiums they collect will vary with risk. Large employers with favourable claims experience relative to the industry average will be happy to be experience rated, and those with relatively poor experience may be motivated to improve their experience.

Suncorp identified in its 2012 white paper[24] some of the advantages of experience rating in personal injury schemes: "One of the strengths of privately underwritten personal injury insurance schemes is that they can be more flexible and responsive, meaning they reward policy holders who look after themselves and the people in their care. Risk managers and underwriters will tell you that having a clear and direct link between risk and price is essential if you are serious about changing behaviour to reduce risk and injury."

9.5 Employer excess

It is best practice to oblige employers to pay a modest excess in order to give them a financial stake in claims; this encourages claim prevention and facilitates early return to work where possible. An excess of one week's income replacement is common in Australia and seems to be effective[25].

An insurer would be permitted to offer a 'no excess' policy to small low-risk employers. Insurers would also be permitted to offer larger excesses on a negotiated basis with employers.

An implication of the standard excess is that the central database would not include details of income replacement payments up to one week in duration. If an employer has a no-excess policy, the database will contain a flag to identify the first week of payments. A further implication is that if an insurer issues a

[23] http://www.workcover.wa.gov.au/content/uploads/2014/Documents/Resources/Forms%20and%20publications/Publications/WC-Guide-for-Employers-20.8-web.pdf
[24] Day, A 2012. *What scheme works when people get hurt? Reflections on underwriting options for personal injury insurance"* http://www.suncorpgroup.com.au/sites/default/files/pdf/news/Suncorp%20White%20Paper%20-%20What%20scheme%20works%20when%20people%20get%20hurt%20-%20Nov%202012.pdf
[25] Four schemes have an employer excess of one week or more – NSW, Vic, Qld, SA

policy with a higher excess, it will be necessary for the insurer to report full details of transactions that are within the excess. In practice this will mean that the insurer is likely to need to administer the under-excess claims, which is also good practice in order to ensure that claim decisions and service standards are appropriate and consistent.

10 Scheme Culture

It all adds up to culture

Scheme culture is an intangible but vital outcome that arises over time from the outworkings of the other elements of the scheme's design and operation.

10.1 What does it mean?

Culture can be defined in this context as 'the way we do things around here', or the 'norms of beliefs, values and behaviours shared by participants in the system'. By its very nature, culture is subtle and intangible.

A positive culture will be characterised by a strong up-front focus on safety, and claim prevention. In the claims context, the focus will be on achieving return to work and on fair and efficient claims management.

Table 10.1 describes some examples of positive cultural outcomes, as well as some negatives.

Table 10.1 – Culture: Examples

Positive outcomes	Negative outcomes
Employers and workers demonstrate high regard for safety.	Employers use tactics such as labour hire to shift responsibility to others.
High employer engagement in claim outcomes.	Claimants continuing on income replacement until forced off.
Broad understanding that work is good for your health.	Medical providers focusing on reasons why a person might not be able to return to work.
Open and transparent decision-making.	High dispute rates, and heavy legal involvement in claims processes.
Low appeal rate for decisions.	Reliance on lump sum payments to settle claims.
Engaged staff at regulator.	Providers over-servicing injured claimants.

10.2 You can't legislate for culture

It is not possible to legislate for culture. Regulation, rules, handbooks and the like do not create or change a culture. The best they can achieve is to give some guideposts to the types of behaviour that are desirable, or otherwise, in the interests of scheme objectives.

10.3 How can a scheme culture be influenced?

It starts from the top – the messages given by, and the behaviour of, the leadership[26]. Messages need to be consistent across topics and over time. Clarity of objectives is necessary to achieve this (see Section 2.1).

Those in authority need to establish and maintain widespread support for sustainability and balance.

[26] The Transport Accident Commission (TAC), attempts to define their culture on a prominent place on their website. This is an example of a top-down approach and is likely supported by policies at an individual level.
http://www.tac.vic.gov.au/about-the-tac/working-for-the-tac/our-company-values

The regulator in particular can influence the scheme's culture via the style of its interactions with all scheme participants. Important interactions that set the tone will include:

- Dealing with insurers – being clear about expectations (see more about this below), communicating positively and often, being consistent in decisions and treatment
- Relationships with employers – dealing fairly and reasonably, and not officiously, with all employers including those who have had poor experience.

10.4 Genuine independence of decision makers

Effective operation of the scheme, especially in relation to resolution of disputes, depends on experts (medical and other) doing their jobs in a fair, consistent and even-handed manner. Traditionally there have been worker-friendly doctors and insurer-friendly doctors. Cultures of this kind need to be broken down. A key task of the scheme regulator is to establish and maintain structures and cultures that support both real and perceived independence, and when necessary to intervene with outliers.

10.5 Insurer culture

In the workers compensation context, it needs to be recognised that the employer is the customer of the insurer, while the worker is the claimant. An important challenge for insurers is to establish confidence among workers and other stakeholders that their sole intent is not to minimise the cost of claims. Positive, capable insurer leadership will be necessary to build a culture which contributes to a sustainable scheme. Training and career development for claims staff, e.g. through the PIEF Cert IV program, can be of assistance.

10.6 Input from behavioural science

The workers compensations system is defined in law, but is ultimately about people. Historically, many aspects of workers compensation scheme design have been influenced by legal considerations rather than behavioural factors. The design of both the law and the processes should enable behaviours to be taken into account before legal formalities.

Developments in behavioural finance (such as the 'nudge' theory[27]) have been significant, and the learnings can produce significant benefits for all stakeholders in workers compensation schemes. For example, the NSW Government's Department of Premier and Cabinet has established a Behavioural Insights Unit, which focuses on applying behavioural insights to public policy. A trial in the workers compensation space, applying behavioural insights to claims management, has received positive evaluation in return to work and claim duration.[28]

Wallace's paper on dispute resolution devotes more material to behavioural factors than to either accountability or economic factors.[29]

A best practice scheme will give priority to human behaviours, right down to design of forms, correspondence and telephone scripts.

[27] Nudge theory argues that positive reinforcement and indirect suggestions can influence the motives, incentives and decision making of groups and individuals, at least as effectively as direct instruction, legislation, or enforcement.

[28] *Understanding People, Better Outcomes; Behavioural Insights in NSW* , produced by the Behavioural Insights Unit (undated).
[29] Wallace, N 2010, *Designing Dispute Resolution Systems – Lessons from Workers Compensation and Magistrates Courts (Australia and New Zealand),* 10th National Mediation Conference.

10.7 Can or should culture be measured?

Continually assessing and guiding the scheme culture is an important role of the Board of the scheme regulator. This should involve the following components:

- Being willing always to listen for views of stakeholders outside the regulator itself
- Emphasising the importance of culture inside the regulator
- Undertaking one-off reviews if a potentially significant issue with culture has been identified
- A substantial review of scheme performance and culture (say) every five years.

10.8 Establishing and managing expectations

The behaviour and attitudes of participants in the scheme will become more aligned with scheme objectives the more that their experiences match their expectations.

Establishing reasonable expectations is a challenge, but worth the effort. Often this requires communication of an informal nature. It can be supported in the case of work injuries by using medical guidelines that give reasonable ranges for the recovery times of common injuries.

Consistency of decision making and communication is essential to maintaining expectations.

11 Reliances and Limitations

11.1 Distribution and Use

We understand that this report will be used by the ICA in discussions with Federal and State governments about scheme design and the involvement of APRA-authorised insurers in workers compensation. With this in mind we have prepared the report on the assumption that it will be in the public domain.

Third parties, whether authorised or not to receive this report, should recognise that the furnishing of this report is not a substitute for their own due diligence and should place no reliance on this report or the information contained herein which would result in the creation of any duty or liability by Finity to the third party.

Finity has performed the work assigned and has prepared this report in conformity with its intended utilisation by a person technically competent in the areas addressed and for the stated purposes only. Judgements about the conclusions drawn in this report should be made only after considering the report in its entirety, as the conclusions reached by a review of a section or sections on an isolated basis may be incorrect.

The report should be considered as a whole. Members of Finity staff are available to answer any queries, and the reader should seek that advice before drawing conclusions on any issue in doubt.

While due care has been taken in preparation of the report Finity accepts no responsibility for any action which may be taken based on its contents.

11.2 Limitations: Assumptions

In this report, at the ICA's request, we have assumed a competitively underwritten scheme.

Part III Appendices

A Scheme Design Principles for Competitively Underwritten Insurance

The ICA has outlined what it views as the most important design principles for APRA-authorised insurers for a statutory compensation scheme, in a letter to Finity dated 10 October 2014. We reproduce the ICA's words exactly below, for reference.

Our members who operate as private sector insurers can (and do) underwrite fault based, no fault and hybrid schemes. Irrespective of the scope of a particular scheme, the ICA believes that the most important scheme design principles for private insurers for a statutory compensation scheme are:

- *A long-term commitment by government to private underwriting, due to the significant allocation of capital required, as well as infrastructure costs;*
- *An opportunity to earn a reasonable (but not excessive) return on capital;*
- *Full funding and proper pricing of risk (with affordability supported, if necessary, by a limited form of community rating);*
- *A regulated pricing framework that is free from political interference;*
- *No significant exposure to adverse risk selection;*
- *No retrospective changes that would increase incurred claims costs; and*
- *Effective controls to prevent superimposed inflation, and to inhibit scheme volatility.*

In particular the ICA believes that:

- *Innovation by the private sector in risk rating premiums can improve fairness to employers and is likely to drive changes in employers' risk behaviour as a response to price signals;*
- *Discipline by the private market may also deliver improved effectiveness in controlling claim payments (to be limited to appropriate amounts for those that are entitled); and*
- *Regulatory powers are likely to be more effectively used in relation to the private sector.*

We believe that a competitively underwritten, national workers compensation scheme would serve the national economy. It would drive economies of scale. By supporting operational efficiencies it would drive significant compliance savings for any Australian employer operating beyond the border of a single State or Territory jurisdiction.

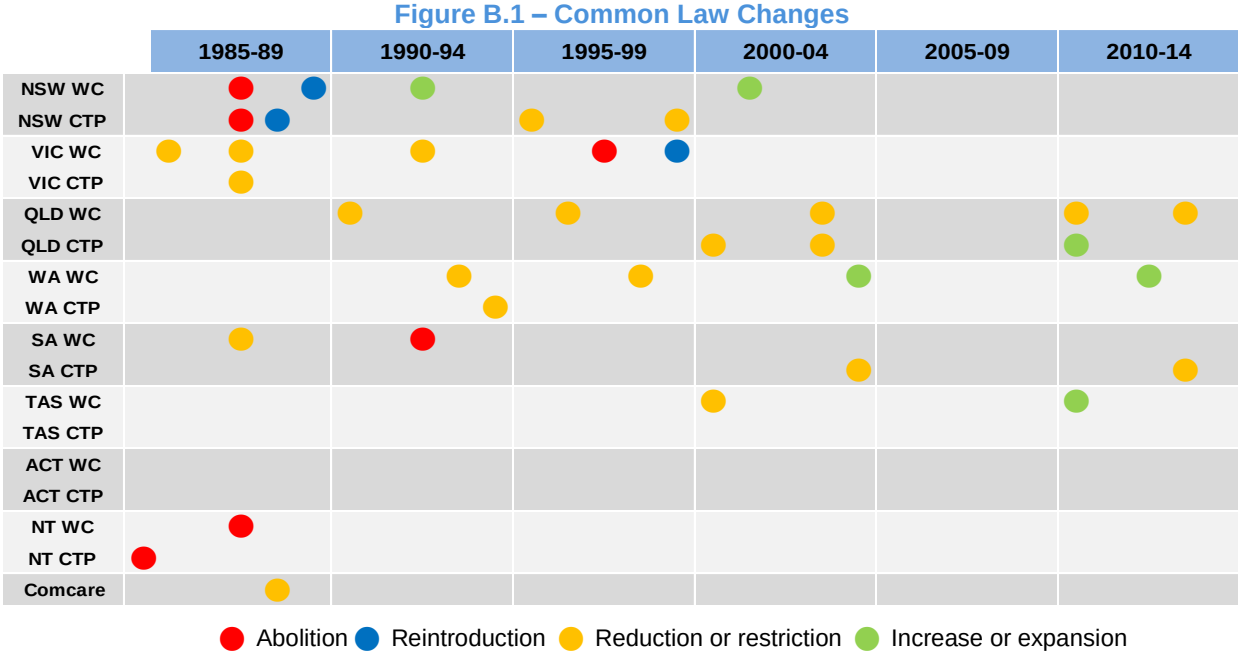
B Scheme Design – Historical Trends

The modern era of change in workers compensation in Australia started in 1985. In this appendix we outline some of the 'megatrends' that have occurred in the 30 years since then, whereby various aspects of scheme design have been initially well regarded and then later recognised as ineffective.

B.1 Common Law

The chart below summarises the changes to common law entitlements for Australian workers compensation and motor accidents schemes over the last 30 years.

Figure B.1 – Common Law Changes



Of the 17 schemes, six do not currently give claimants access to common law; three of the six abolished common law provisions in the 1980s or 1990s.

The last fifteen years have been a period of 'moderate' changes, with no abolitions or re-introductions but a number of schemes restricting or increasing access to common law – and all of this activity took place in only six of the schemes.

South Australia's workers compensation scheme is, however, poised to re-introduce common law access (to seriously injured claimants only) in mid-2015.

B.2 Duration of Weekly Benefits

Table B.1 – Income Replacement Time Limits

Jurisdiction	2005	2012	Current	Work Capacity Tests
NSW	Retirement age	5 yrs	5 yrs	At least every 2 years
Vic	Retirement age	Retirement age	Retirement age	At 130 weeks' compensation
Qld	2 yrs	2 yrs	2 yrs	Not applicable
SA[1]	Retirement age	Retirement age	2 yrs[2]	Not applicable[2]
WA	Retirement age	Retirement age	Retirement age	Not applicable
Tas	9 yrs	9-20 yrs[2]	9-20 yrs[3]	Not applicable
ACT	Retirement age	Retirement age	Retirement age	Not applicable
NT	Retirement age	Retirement age	Retirement age	Not applicable

[1] *Under current legislation, income replacement can continue to retirement age, with a work capacity test at 130 weeks' compensation*

[2] *From 1 Jul 15*

[3] *Depending on WPI*

Source: Safe Work Australia