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The Third Way: Prevention and Compensation of Work Injury in Victoria, Australia

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W.E. UPJOHN INSTITUTE for Employment Research

THE THIRD WAY: PREVENTION AND
COMPENSATION OF WORK INJURY
IN VICTORIA, AUSTRALIA

Upjohn Institute Technical Report No. 00-15

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List of Acronyms

AAT Administrative Appeals Tribunal
ACA Accidental Compensation Act
ACC Accident Compensation Commission
ACT Accident Compensation Tribunal
AHMAC Australian Health Ministers' Advisory Council
AIG American International Group
AIRC Australian Industrial Relations Commission
ALP Australian Labor Party
AMA American Medical Association
APA Australian Physiotherapy Association
ASIC Australian Standard Industry Classification
AWA Australian Workplace Agreements
BPI Best Practice Incentive
CMBS Commonwealth Medical Benefits Schedule
CRCC Commission on Rehabilitation Counselor Certification
CRS Commonwealth Rehabilitation Services
DBS Department of Business Employment
DMB Department of Management and Budget
DRGs Diagnosis-Related Groups
DWG Designated Work Group
EAPs employee assistance plans
E(PS) Act Equipment (Public Safety) Act
FSD Field Services Division
HHI Herfindahl-Hirschman Index
HSD Health and Safety Division
HSO Health and Safety Organisation
HSRs Health and Safety Representatives
HWCA Heads of Workers' Compensation Authorities
IAP Insurer Audit Program
ICA Insurance Council of Australia
ISC Insurance and Superannuation Commission
LIMS Legal Information Management System
MAV Municipal Association of Victoria
MSR Minimum Success Rate
NAL National Acoustic Laboratory
NDS National Data Set
NOHSC National Occupational Health and Safety Commission
OHSa Occupational Health and Safety Authority
OHSC Occupational Health and Safety Commission
OR Occupational Rehabilitation
PIAWE Pre-Injury Average Weekly Earnings
PIN Provisional Improvement Notice

PRU Planning and Review Unit
RIS Regulatory Impact Statement
RPAs Recognised Professional Associations
SATS Site Assessment and Targeting System
SIO State Insurance Office
SSR Sample Success Rate
STCV State Trust Corporation of Victoria
TAA Transportation Accident Act
TAC Transportation Accident Commission
VARC Victorian Accident Rehabilitation Council
VCE Victorian Certification of Education
VCORP Victorian Council of Occupational Rehabilitation Providers
VECCI Victorian Employers Chamber of Commerce
VFMC Victorian Funds Management Corporation
VOHSC Victorian Occupational Health and Safety Commission
VTHC Victorian Trades Hall Council
VWA Victorian WorkCover Authority
WAB WorkCare Appeals Board
WCB Workers' Compensation Board
WCRI Workers' Compensation Research Institute
WISE WorkCover Incentive Scheme for Employers

Acknowledgments

This was a very challenging report for us to prepare. At every stage of the project we found that we were taking a snapshot of a rapidly moving target. Further, in examining the many elements of the WorkCover programme, the team became ever more sensitive to the difficulty of describing all the various aspects of the system from our individual, professional perspectives. Additionally, the VWA has generated some powerful reactions to its policies, both supportive and resistant. A result of this is that the gathering and sifting of information through hundreds of interviews was no simple matter.

This is not to express any disappointment on our part with the project or this report. Instead, it is to highlight our gratitude to those who enabled us to bring this project to what we consider to be a successful conclusion, despite these very considerable complications. We hope that the readers of this report will share our view in this regard, and appreciate the complexities with which we laboured.

We received complete support and cooperation from the management of the VWA, beginning with Chief Executive Officer Andrew Lindberg. Richard Fuller was invaluable to the research team, both in coordinating arrangements and as a source of background and perspective. Special thanks to Brian Cook, who made certain that the data we needed were provided to us, and Derrick Harrison who provided invaluable help in the field. We felt that all of the senior staff members of the VWA were extremely helpful and cooperative, and we thank them collectively. In addition, many other staff persons of the VWA were important to our project, in particular, Helen Chetcuti and Claire Johnson, who assisted us in arranging travel schedules and interviews.

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Of course, any errors of omission or commission rest entirely with the authors.

PSB
HAH
AC
RWM
RWK
TJB

Executive Summary

This study originated because the leadership of the VWA and the responsible Minister wanted an assessment of the performance of the Victorian scheme within a larger perspective. They commissioned the W. E. Upjohn Institute for Employment Research, an endowed, not-for-profit research foundation in the United States, to assemble an appropriate team of workers' compensation experts to conduct such a study. The assignment was to carry out a thorough, independent review of the Victorian system of prevention and compensation for work injuries and to provide a set of informed judgments about the system and its performance.

A group of six workers' compensation scholars (three Americans, two Canadians, and one Australian) conducted over 300 interviews during 13 separate visits to Victoria in 1996 and submitted a report of findings in August 1997. The VWA subsequently asked us to come back and take another look after the amendments of 1996 and 1997, specifically including the merger of the former Health and Safety Organisation into the VWA in July 1996. Four of the original six authors were involved in another 100 interviews and a second report was tabled in July 1998. The present volume contains a combination of the findings of both reviews, with observation dates of either 1996 or 1998.

The methodology of the study is based on a research model developed at the Workers Compensation Research Institute in the United States and adapted by the Upjohn Institute in a series of studies in British Columbia, Canada. It involves a review of published and unpublished documents, extensive interviews with stakeholders and system administrators, vetting the descriptive material to a sub-set of interviewees for factual accuracy, and finally, adding the judgments of the reviewers in the form of "attention points" about the system. The emphasis is on description, not prescription, so the judgments are presented as observations about unique or noteworthy characteristics of the system, or apparent system problems. Policy recommendations are left to local decision makers.

The history of workers' compensation and safety regulation in Victoria is explored in order to place the current system into context. In particular, the transition from the historically private insurance system to public underwriting with the introduction of the WorkCare system in 1985 is described in Chapter 2. WorkCare introduced a uniquely Australian contribution to workers' compensation system design with public underwriting and private service delivery. The

substantial refinement of this framework with the move to the WorkCover system in 1992, and the evolution of WorkCover through 1997 is also documented with a legislative history. Additional legislative review and background are also presented in specific content chapters as needed.

The administrative structure and performance of the VWA as at 1 June 1998 are presented in Chapter 3. As mentioned above, the Victorian system is unusual in the division of responsibility between public and private actors. Like Canadian workers' compensation systems, a public fund bears the underwriting risk and sets the insurance premium levels in Victoria. Like most American workers' compensation systems, private insurers collect the premiums and process the claims of injured workers. The VWA serves as mandatory reinsurer for all claims and regulates all aspects of the scheme, including workplace safety and health (from 1996).

Regulatory aspects of the Victorian system are described in Chapter 4. Using a principal-agent theoretical framework, the ways in which the public authority (VWA) attempts to influence the behavior of authorised insurers and other private actors in the workers' compensation scheme, are described in detail. The VWA simultaneously plays the roles of administrator, insurer, and regulator under WorkCover. This complex assignment is accomplished with a carefully balanced set of incentives and regulations. The licensing of authorised insurers, remuneration and service standards for insurers, and the best practice incentive scheme are reviewed, together with an explanation of the reserving and pricing policies of the VWA. Market structure and performance are considered, followed by an overall assessment of the regulatory program.

The benefits paid to injured workers and their dependents are laid out in Chapter 5. The WorkCover system has altered the benefit structure with the objectives of reducing costs while adequately and fairly compensating injured workers. Another theme of the WorkCover changes, however, has been the attempt to make return to work, rather than compensation, the cornerstone of the system. One unusual feature of workers' compensation benefits in Victoria is the "employer excess." Employers bear the responsibility for the first 10 days of worker lost time, and the first \$426 of medical and like services. This is in sharp contrast to North American jurisdictions where waiting periods, in essence, mean the worker bears initial responsibility.

Since WorkCover began, the number of standard claims has been reduced by over 46 percent. Aggregate weekly benefit payments have been reduced by 26 percent. An attack on

lump sum settlements was launched in reaction to their rapid escalation in the WorkCare years, from \$11.5 million in 1986/87 to over \$220 million in 1991/92. However, after a few years of restraint, lump-sum benefits took off again in 1996/97, reaching \$367 million in 1997/98. By that point, with the accompanying reduction in weekly benefit claims, the total of lump-sum benefit payments actually surpassed weekly benefit payments.

The dispute resolution system of WorkCover is described in Chapter 6. This system aims to reduce litigation costs by promoting informal settlement through a VWA funded Conciliation Service and independent Medical Panels. Disputed claims are required to go through conciliation before they can proceed to court. Medical Panels are empowered to resolve medical disputes authoritatively and decisively. The Conciliation Service is successfully resolving approximately 75 percent of disputes and appears to be an effective gate keeper for court access. Medical Panels in Victoria have had a more checkered history. Early utilisation was dominated by maims cases on their way to court. After revisions to the statute in 1996, which more effectively integrated the Medical Panel system with the Conciliation Service, the timeliness and performance improved significantly.

Unlike in North America, workers' compensation claims do not constitute an "exclusive remedy" against the employer at injury in much of Australia. However, most Australian jurisdictions in which the common law remedy exists have legislatively modified its operation through threshold conditions of access (e.g., minimum level of disability) and capping certain damages. Thus, the 1992 statute introducing the WorkCover system, adopted a 30 percent disability rating or "serious injury" threshold for access to common law remedies in the courts. However, the impact of this threshold was mitigated by the practice of combining physical impairment ratings with a rating for psychiatric impairment. This development and some adverse court decisions were overturned directly in the 1997 amendments, which eliminated access to common law for all injuries or illnesses arising after 12 November 1997.

Occupational rehabilitation in Victoria is discussed in Chapter 7. The primacy of the return-to-work goal is very clear in Victorian arrangements. This reflects the reaction to the apparent excesses of rehabilitation under WorkCare, when as many as 16 percent of all paid claims were entering rehabilitation. Currently, responsibility for rehabilitation is placed with the employer and the insurer. The VWA has only a regulatory role, through approval of occupational rehabilitation providers and enforcement of employer and insurer obligations. Employers with

more than \$1 million payroll are required to develop an occupational rehabilitation program, including a return-to-work coordinator and a requirement to develop a written return-to-work plan within 30 days of an injury. The latter specifically includes consultation with the injured worker. Workers are entitled to reinstatement for a period of 12 months following injury.

The Field Services Division of the VWA has responsibility for health and safety in Victorian workplaces, plus dangerous goods (e.g., hazardous materials) and certain equipment (e.g., boilers) regardless of location. Legislative authority for these functions derives from the Occupational Health and Safety Act of 1985 and related statutes. The Field Services Division was created when the VWA absorbed the formerly independent Health and Safety Organisation at 2 July 1996. The orientation of Victorian health and safety regulation has been evolving from a prescriptive approach to a performance-based approach since 1985.

FSD provides a full range of health and safety services, including inspection, investigation, providing information, advising, registration, licensing, and training. There are some 20 codes of practice promulgated under the act, and a number of operational manuals, which are available on-line as well as in paper format. FSD conducts about 50,000 inspections annually, resulting in 3,600 Improvement Notices, 1,300 Prohibition Notices, 7,000 Written Directions, and about 80 prosecutions. The FSD has been striving to increase the proportion of staff time spent in the field, and to provide the equipment to facilitate that deployment.

The report concludes with a set of attention points, or summary observations about the Victorian system. They are addressed to two sets of issues. First, are those that the authors think are of interest to policymakers and stakeholders outside Victoria, because they may contain lessons for other systems. Second, there are issues that we think should be of concern to Victorians, as unresolved system problems. Some 51 attention points are presented that deal with a range of insurer regulation, compensation, rehabilitation, and prevention issues.

Chapter 1 Introduction

Improving the effectiveness of workers' compensation programmes for work-related disability is an urgent theme in legislative debates across the entire world, both in developed and developing countries. The goal is that workers' compensation benefits should be adequate and equitable, and that they should be delivered in a prompt, efficient manner. Also, national and international competitiveness issues have caused employers to be sensitive to sources of cost variation across jurisdictions, particularly including workers' compensation costs.

In addition, in some states of Australia, the recent past has seen workers' compensation insurance go through a wrenching series of changes from private dominance to public monopoly to the current compromise between private and public insurance. The search for the "holy grail," fair benefits provided at reasonable costs, continues. This volume describes the workers' compensation system of the state of Victoria, Australia. In addition to providing a description of this system, it reports data on system function and the authors' impressions of noteworthy features of the system. We believe this system offers a viable "third way" to accomplish some of the critical functions of a modern workers' compensation system.

There are only three countries in the world that maintain subnational workers' compensation systems for workers injured or made ill by their employment: Australia, Canada, and the United States. Further, there are three relatively distinct models used to organize the insurance responsibilities for making the payments to such workers: private market, exclusive public insurer, and mixed. But the three models do not correspond exactly with the three countries. In fact, all 10 Canadian provinces, 5 American States, and 3 jurisdictions in Australia use the exclusive public insurer approach. Most American jurisdictions, and five states in Australia, use a predominately private market approach. But three Australian states (including Victoria, which is the subject of this report) use a mixed approach, where the public fund bears the underwriting risk, but private agents collect and disburse the money.

Objectives of Workers' Compensation System

The objectives of workers' disability compensation systems are also generally agreed to be three in number. 1) To encourage the prevention of workplace injuries and illnesses; 2) to replace income lost due to workplace injuries and illnesses promptly, adequately, and equitably; and 3) to provide rehabilitation for any permanent impairment that remains after medical recovery. A fundamental principle of workers' compensation is that the products and services produced should bear the costs of workers injured during the production of those products and services.

Prevention is usually encouraged both through direct regulation of the workplace and through indirect financial incentives to employers, generally referred to as "experience rating" of workers' compensation premiums. This device provides that employers with lower numbers of claims and lower costs will pay lower workers' compensation premiums. In all jurisdictions, it is typical to find a public agency that sets and enforces health and safety standards to protect worker health through a direct workplace regulatory approach. It is relatively unusual to find this function performed by the same agency that administers the workers' compensation and rehabilitation system.

There is relatively little variation in the arrangements for compensating temporarily disabled workers. Typically statutes will provide for partial wage replacement (ranging between 60 percent and 95 percent of gross earnings or between 70 percent and 90 percent of take home earnings) in order to maintain an incentive to return to work. Such "temporary" benefits frequently last for a statutorily limited period of time (26, 52, or 104 weeks). There is usually a separate mechanism for compensating "permanent partial" disabilities, those that may impair the individual's functioning but are not sufficient to prevent work entirely. The main approaches include impairment rating, loss of wage-earning capacity, and wage-loss systems.¹

Rehabilitation includes medical treatment, various restorative services, physical therapy, vocational rehabilitation, and other services, depending on the jurisdiction. It may also include permanent alterations to a disabled worker's environment to enable him or her to live independently despite any remaining impairment. Financial compensation is sometimes also paid

¹Barth and Niss. 1999. *Permanent Partial Disability Benefits: Interstate Differences*. Cambridge, MA: Workers Compensation Research Institute. See also, Berkowitz and Burton. 1987. *Permanent Disability Benefits in Workers' Compensation*. Kalamazoo, MI: W.E. Upjohn Institute for Employment Research.

for specific physical injuries (such as the loss of a particular body part, etc.) or for disfigurement or pain and suffering in certain jurisdictions. There is great variety in these arrangements, and sometimes practice depends largely on the legal construction of statutory language. In some Australian jurisdictions, workers are also allowed to sue their employers at common law for negligence in causing their injuries. This is prohibited in North American jurisdictions as part of the “historic compromise” that led to the passage of workers’ compensation legislation in the early twentieth century.

Background and Motivation

This study originated because of the interest of the leadership of the Victorian WorkCover Authority (VWA), especially Andrew Lindberg, CEO. He believed that potential gain could result from a broad, independent assessment of VWA operations, one that would gauge Victoria’s performance against an international standard. In mid 1996, the VWA contracted with the W.E. Upjohn Institute for Employment Research (hereafter Upjohn Institute) to conduct a thorough, independent study of the workers’ disability prevention, compensation, and rehabilitation system in Victoria. The VWA requested that the Upjohn Institute assemble an international team of experts to perform this study, using the basic format established by the Workers (sic) Compensation Research Institute (WCRI) in North America and previously used by the Upjohn Institute in British Columbia, Canada, adapting it as necessary to the Australian environment.

The Authority had the confidence to open itself to scrutiny from the outside, in the expectation that such an independent examination would lead to policy improvements in Victoria. That is our goal as well, along with the hope that this review and analysis might assist policymakers in other jurisdictions. After significant exposure to the Victorian workers’ compensation system, we are convinced that this model does represent a viable “third way,” a distinct blend of private and public elements unknown in workers’ compensation systems outside of Australia.

Our research and analysis team included six workers’ compensation experts: one Australian, two Canadians, and three from the United States. The authors have drawn on their collective experience with comparable studies, including 10 such studies in 7 North American jurisdictions which were authored or coauthored by one or another member of the team.

Additionally, there have been at least a dozen more such studies in the United States, where one or more of the authors served either as a technical reviewer or in some other consultative capacity. Moreover, individual members of the team participated in literally scores of research efforts in the general field of prevention and compensation of disability. The six authors brought a collective total of more than 100 years of experience with workers' compensation, rehabilitation, and prevention issues to this task.

The report summarises the insights the six authors gained over the 1996–1998 period, including 13 separate visits to Victoria. Each author spent at least two weeks on site. The VWA supported our efforts by arranging most of our interviews and by supplying requested documentation and data. In addition, VWA staff helped to focus the efforts of the team through suggesting interview targets and unexplored avenues of which we were not aware. They also respected our independence by resisting the temptation to “look over our shoulders” as we conducted the study. We are deeply indebted to all the informed observers and participants in the Victorian scheme for sharing their observations and confidential judgments with us. We sincerely hope our efforts are worthy of their contributions.

Study Approach

The methodology of this study is derived from a long series of similar studies published in the United States by the WCRI of Cambridge, Massachusetts. Thus far, 30 such studies have been completed by WCRI in U.S. jurisdictions. In addition, the Workers' Compensation Board (WCB) of British Columbia initiated a series of related studies of the British Columbia, Canada workers' compensation system in 1991. Separate studies were completed on the compensation and claims administration system, including vocational rehabilitation and dispute resolution (1991), the occupational safety and health system (1992), the assessment and premium setting system (1992) and the medical and physical rehabilitation system (1993).² Further, some of these

²Hunt, Barth, and Leahy. 1991. *Workers' Compensation System in British Columbia: Administrative Inventory at a Time of Transition*. Richmond, British Columbia: Workers' Compensation Board of British Columbia; Rest and Ashford. 1992. *Occupational Safety and Health in British Columbia: An Administrative Inventory*. Richmond, British Columbia: WCB of British Columbia; H. Allan Hunt. 1992. *Workers' Compensation Board of British Columbia: Assessment Department Administrative Inventory*. Richmond, British Columbia: Workers' Compensation Board of British Columbia; Fulton and Atkinson. 1993. *Medical and Rehabilitation Programs in Workers' Compensation: An Administrative Inventory in British Columbia*. Richmond, British Columbia: Workers' Compensation Board of British Columbia.

studies were repeated after five years in order to provide a “second look” at the progress made in British Columbia.³

The studies were designed to assist public policymakers and other interested participants to better understand their own programs, and to be able to make informed comparisons across jurisdictions. For that reason, the studies of individual systems use a common outline, and to the extent possible, address the same basic issues of workers’ compensation system structure and function. We have adapted this model to accommodate the unique features of the Victorian workers’ compensation system. Thus, this report focuses the model for the first time outside North America.

As such, this report broadens the scope significantly over any single previous study in at least four ways. First, there is a chapter given over to the developments in 1992 that led to the establishment of the current scheme, and then to its many legislative modifications through 1998. The regulatory and insurance arrangements in Victoria are sufficiently unique to warrant special attention, so another chapter is devoted to this subject. In addition, special attention is given in this study to prevention efforts, in part because of the consolidation of the VWA and the Health and Safety Organisation (HSO) in Victoria in 1996. Finally, this report provides a more extensive review of occupational rehabilitation practices than has been customary in North American studies.

The Scope of the Study

The objective of this volume is to describe, with supporting evidence, how the workers’ compensation system in Victoria actually functions, and to do so in a way that maximises the comparability with the previous studies in North America. The intent is to provide an accessible description of the major features of the Victorian system. We also provide some comparative perspective with other jurisdictions, where that is relevant or necessary.

This study addresses nine core issues in the Victorian workers’ compensation system:

- What is the history of the present scheme?

³Hunt, Barth, and Leahy. 1996. *The Workers’ Compensation System of Columbia: Still in Transition*. Richmond, British Columbia: Workers’ Compensation Board of British Columbia; Rest and Ashford. 1997. *Occupational Health and Safety in British Columbia: An Administrative Inventory of the Prevention Activities of the Workers’ Compensation Board*. Richmond, British Columbia: WCB of British Columbia.

- How is the system organised and administered?
- How is the insurance function structured and regulated?
- What benefits are paid to injured workers?
- What dispute resolution procedures are used, and to what effect?
- How are vocational (occupational) rehabilitation services provided?
- How is prevention achieved?
- What are the actual costs of administration, benefits, claims processing, and appeal?
- What aspects of the system deserve further attention?

When this project began, our intent was to provide a snapshot of the Victorian system as of 1 July 1996. We did that in a draft report that we presented to the VWA in December 1996, followed by a revised draft version in February 1997. Subsequently, we asked for and received many helpful comments and suggestions from external reviewers. A presentation was made to the Minister in April 1997, and the final report was submitted in August 1997.⁴

Late in 1997, the VWA proposed that the report be updated to take account of several significant legislative changes that occurred after 1 July 1996. (See Chapter 2.) Following interviews and data gathering that began in May 1998, a second report was prepared that covered these major changes.⁵ This was never intended to be a “stand alone” report; rather, it was meant simply to supplement the earlier, broader study, and it only included four of the original six authors. A final report, subtitled Volume II, was delivered in July 1998, and in August 1998, a presentation of this report was made to the media and stakeholders in Victoria.

This volume represents a blending of the material from the 1997 and 1998 reports. Substantial changes have been made in some portions of the 1997 volume while other modifications are minor. That is because the policy changes that occurred between 1 July 1996 and early 1998 were more extensive in some areas than in others. For instance, the decision was made that the 1998 volume would not update areas relating to regulatory aspects of the scheme

⁴Hunt, Barth, Bogyo, Clayton, Klein, and McGinn. 1997. *Victorian Workers' Compensation System: Review and Analysis*, W.E. Upjohn Institute for Employment Research.

⁵ Hunt, Barth, Clayton, and McGinn. 1998. *Victorian Workers' Compensation System: Review and Analysis*, Volume II, W.E. Upjohn Institute for Employment Research.

or occupational rehabilitation. This reflected the judgment that relatively few changes had occurred in these areas between 1996 and 1997.

Thus, some chapters are virtually unchanged from the 1997 report (Chapters 4 and 7) and pertain to an “observation date” of July 1996. Others originated in the 1998 report (Chapters 3, 5, 6, and 8) and reflect data through July 1998. Chapter 2 represents a combination of the chapter from 1997, which emphasized the precursors to WorkCover, and the chapter from 1998, which describes legislative changes since the enactment of WorkCover. It was also updated to reflect developments through the end of 1998.

Research Approach

We conducted our study using a four-step approach. The elements were 1) an examination of the relevant legislative acts and the policies, regulations, and guidelines developed for their implementation; 2) data gathering and analysis; 3) interviews with individuals knowledgeable about the system and its operation; and 4) reconciliation of the observations we made about the system with the viewpoints of others.

The Act and its Implementation

We began our work with an examination of the Accident Compensation Act 1985 and the Occupational Health and Safety Act 1985 and amendments thereto. Because of the broad mandate of the Field Services Division of the VWA (previously known as the Health and Safety Division), it was also necessary to review the Dangerous Goods Act 1985, the Equipment (Public Safety) Act 1994, and related legislation. We also had access to various policy manuals and training materials including the *VWA Claims Manual*, *OHSA Manual*, *OHSA Operations Manual*, *HSD Branch Manuals*, *HSD Orientation Workbook*, *HSD Regulations*, and *Codes of Practice*. We benefited greatly from the work that has been done by the Boston Consulting Group for the VWA over the past several years. They clearly marked out the trail of what has been accomplished in Victoria.

We also reviewed the Australian Industry Commission studies of Workers' Compensation (1994) and Occupational Health and Safety (1995). The reports of the Australian Heads of Workers' Compensation Authorities (HWCA) provided invaluable context for our predominantly North American team. We reviewed VWA and predecessor Accident

Compensation Commission (ACC) Annual Reports from 1985/86 through 1997/98, as well as other published and unpublished literature on the Victorian workers' compensation programme. Research materials were made available to us by the staff of VWA, as well as by individuals we interviewed during the course of the project. We are deeply indebted to all of these sources.

Data Collection

The VWA provided us with the data we requested covering the system performance from 1985 through 1997/98. These data are designed to provide a clear perspective on the present status of the system, and to enable us to better understand the antecedents of today's system. (See Appendix A-1.) Gathering data that were consistent and comparable for the past decade proved to be difficult. Because of the dramatic changes in system structure, organisation, and performance, many data series were not available on a truly consistent basis. The workers' compensation system in Victoria has been evolving very rapidly.

Interviews

The interviews were designed to probe beyond the statutory language and policy manuals, to learn how the statutes actually are implemented in practice, and how stakeholders experience the system. In 1996, our six-person research team conducted more than 300 interviews with some 260 separate individuals who had substantial experience in and around the Victorian workers' compensation system. In 1998 almost 100 additional interviews were conducted. All the individuals interviewed are listed in Appendix A-2. In all, the persons that we interviewed represent a wide range of interests: from managers and staff of private insurance companies to the VWA regulators they report to; from medical practitioners and physiotherapists to private workers' compensation consultants; from Field Services Division inspectors and information officers to community-based worker advocacy groups; from VWA conciliators to solicitors representing injured workers in common law proceedings; from occupational rehabilitation practitioners to the consulting actuaries for the VWA, as well as virtually the entire top management of the VWA.

Labour stakeholders that we interviewed included representatives of the Australian Workers' Union, the Telecommunications Workers, the Liquor, Hospitality and Miscellaneous Workers, the Australasian Meat Industry Employees Union, the Textile, Clothing and Footwear Union, the Transport Workers Union, the Construction, Forestry and Mining Union, The

National Union of Workers, the Health Services Union, the Australian Education Union, the Independent Education Union, the State Public Services Federation/Community and Public Sector Union, the Finance Sector Union, and the Victorian Trades Hall Council (the peak Federation of trade unions). We also met with representatives of Community Skill Share, the Maroondah Social and Community Health Centre, the Italian Community Assistance Organisation, and members of the Australian Nursing Federation Injured Nurses Support Group.

We did not have the opportunity to survey or interview a large number of individual injured workers. Since injured workers are the major beneficiaries of the workers' compensation system, that could be considered to be a shortcoming. However, our extensive contacts with organised labour and worker advocacy groups served the same purpose, with obvious gains in efficiency for the interviewers. In addition, the VWA now collects feedback from external stakeholder communities, and we were allowed to review this information. Thus, this report relies on the representatives of organised labour, injured-worker advocacy groups, the formal client surveys sponsored by the VWA, and miscellaneous others to represent the views of injured workers in Victoria.

Employer stakeholders interviewed included representatives of the Australian Chamber of Manufactures, the Victorian Employers' Chamber of Commerce and Industry (VECCI), the Metal Trades Industry Association, and the Plastics and Chemicals Industry Association. In addition, we spoke with a number of individual employers, including Coles-Myer, Thiess Contractors, Qantas, Greer Industries, Royal Children's Hospital, Amcor, DuPont, University of Melbourne, Mayne Nickless, Holeproof, Unilever, Shell, ICI, Nippondenso, National Australia Bank, Philip Morris, Kemcor, and Transfield Tunnelling. We also met with the Northern Employers Forum and the Southeast WorkCover User Group in Victoria.

We also talked with administrators of two other state workers' compensation schemes in Australia, three federal agencies, and six other State of Victoria agencies. Of course, none of them are responsible for our conclusions, no matter how much influence they may have had on our opinions.

Reconciliation

Finally, we submitted the descriptions and analysis that resulted from this process to many of the people we interviewed, the people who know the system best. The 1997 Report

(Volume 1) was circulated to about 50 persons for review and commentary in June of 1997. The 1998 Report (Volume II) had a similar, but somewhat smaller, vetting. The cooperation of our interviewees made the study possible in the first instance, as they freely and openly shared their perspectives with us. Their willingness to assist further by checking our interpretations was invaluable, though they bear no responsibility for any errors of fact or interpretation.

Organisation of the Report

The report follows the list of basic questions given above. This introductory chapter concludes with a brief overview of Victoria's industrial environment. Chapter 2 presents the history and development of the current scheme, including a description of the WorkCare programme of 1985 and the transition to WorkCover in 1992.

The third chapter provides an overview of workers' compensation governance and organisation in Victoria; it describes the structure and function of the VWA and other organisations that play a significant role in the current workers' compensation system. The chapter also contains a brief overview of the claims process.

The fourth chapter contains a description and analysis of the unique workers' compensation insurance scheme in Victoria. Our approach to this task employs a principal-agent model, and uses the analyses of industrial organisation economics to explore the structure, conduct, and performance of the scheme. It is based on conditions as of 1 July 1996.

Chapter 5 describes the extensive array of benefits available to workers' compensation claimants in Victoria. Chapter 6 reviews the dispute resolution mechanisms in Victoria, including the Conciliation Service, Medical Panels, and the courts.

The seventh chapter describes the occupational rehabilitation function in Victoria, including the historical antecedents of the current system. This chapter is also based on the system in 1996. Chapter 8 examines the structure and operation of the Field Services Division of the VWA, the unit whose mission is the prevention of workplace injuries and illnesses.

Finally, Chapter 9 presents the study's Attention Points, those areas that might bear additional examination by policymakers, in Victoria and elsewhere. Attention Points were formulated initially after the 1997 Report had been reviewed by interviewees, i.e., those who

were capable of correcting our interpretation of the facts. They were updated in 1998, and again in 1999 as this final version of the study report was prepared.

Victoria's Industrial and Employment Profile

For the benefit of readers outside of Australia, this section gives a very brief description of Victoria's industrial makeup and employment profile. This provides background to understanding some of the policy issues which will follow.

Victoria is the second largest state in Australia in terms of population, with about 4.5 million residents, or 25 percent of the Australian total. Victoria's employed workforce consists of just over 2.1 million persons working in approximately 220,000 enterprises. The unemployment rate during 1997/98 averaged 8.1 percent. Small employers (under \$800,000 payroll) represent about 90 percent of the enterprises but employ only a quarter of the workforce.

Both the enterprises and the employees are heavily concentrated in the urban areas of the state. Greater Melbourne contains about 80 percent of the workforce and 70 percent of the enterprises in Victoria. Regional cities account for about 5 percent of the enterprises and workforce. The remaining workforce is employed in enterprises that are located in the rural areas of the state.

Table 1.1 shows the industrial distribution of employment and enterprises in Victoria. Manufacturing is the largest sector, at 17 percent of employment and 9 percent of enterprises. Retail trade has nearly 15 percent of employment and 17 percent of establishments. The third-largest sector is property and business services, at 10 percent of employment and 13 percent of establishments. Other moderately large sectors include construction, at about 6 percent of employment and 11 percent of establishments, wholesale trade, at about 6 percent of employment and 8 percent of establishments, education, at about 6 percent of both employment and establishments, and health and community service, with 9 percent of employment and 8 percent of establishments.

Approximately 33 percent of all workers in Victoria are unionised. The system of industrial relations is founded on an "Award" from either the Australian Industrial Relations Commission (national) or the Victorian Industrial Relations Commission (state). There have been major changes in the regulatory framework of the industrial relations system in Australia

during the 1990s. Prominent among these have been moves to lessen the role of the award structure in favour of more individualised arrangements. The model for many of these initiatives was the New Zealand Employment Contracts Act 1991. The newly elected Kennett Government was at the forefront of these Australian developments with its enactment of the Employee Relations Act 1992 soon after achieving power. The Federal Government followed suit, although in a somewhat more muted form, when it enacted the Workplace Relations Act 1996.

In 1996, the Victorian Government agreed to refer its industrial relations powers to the Commonwealth with the passage of the Commonwealth Powers (Industrial Relations) Act 1996. Under the Workplace Relations Act, the Australian Industrial Relations Commission (AIRC) is restricted in its ability to make and vary awards to certain specified “allowable award matters” and its power in relation to these allowable matters is limited to making minimum rates awards.

A reflection of the shift from collective to individual labour relations, as represented in the Workplace Relations Act, is the system of Australian Workplace Agreements (AWA). These are individual contracts that individual employees or a group of employees may enter into with an employer but which must be signed individually by employees. The role of trade unions and the AIRC in respect of the negotiation of AWA is expressly restricted. Some collective arrangements remain through the mechanism of certified agreements. Various forms of certified agreements can be made under the Workplace Relations Act, although the favoured type is single-business agreements due to the fact that a multibusiness agreement can only be certified by a full bench of the AIRC, and that body can only so ratify if it is in the public interest to do so.

Note: All uses of “\$” and “dollars” in this report refer to Australian dollars, unless specifically stated otherwise.

Table 1.1 Industrial Distribution of Victoria Workforce and Enterprises, 1995

Industry Sectors	Workforce %	Enterprises %
Agriculture, Forestry	4.7	7.4
Fishing & Mining	0.2	0.2
Manufacturing	17.2	9.2
Utilities	0.8	0.3
Construction	6.6	10.6
Wholesale Trade	6.4	8.4
Retail Trade	14.7	16.8
Hotels, Cafes, Restaurants	4.4	n/a
Transport	4.7	5.0
Communication	2.5	0.1
Finance	3.8	5.3
Property, Business Services	10.0	13.3
Government Administration	3.4	0.3
Education	6.4	5.8
Health & Community Service	8.8	8.0
Recreation	2.0	3.4
Personal & Other Services	3.5	6.0

Source: Australian Bureau of Statistics

Chapter 2 Legislative Foundations of the Victorian WorkCover System

The history of social systems always affect their current structure and performance, sometimes in obvious and sometimes in subtle ways. This is most particularly true of workers' compensation systems, which are the oldest government-organised social insurance systems in many countries around the world, dating from the late 19th and early 20th centuries. Our review of the structure and performance of the workers' compensation system in Victoria would not be complete without an explanation of its historical antecedents.

The current WorkCover system, dating from December 1992, is both an heir to the predecessor WorkCare system and a reaction to it. WorkCare, dating from September 1985, in turn was the product of the perceived inadequacies of the earlier private workers' compensation insurance system. As such, this chapter can be regarded as an exercise in contextualising the historical, political, and environmental background of the present workers' compensation system in Victoria.

Part I of the chapter provides a brief history of workers' compensation in Victoria, culminating with a description of the WorkCare period, from 1985 to December 1992. The latter half of the chapter traces the legislative evolution of the WorkCover system since its origin in 1992. Taken together, these two segments provide an understanding of recent workers' compensation policy trends in Victoria. We expect this material will be particularly valuable to non-Australian readers, for whom this information is much less familiar and less readily available.

Part I – Antecedents of the WorkCover System

Australia is a nation of 18 million people occupying an island continent. In terms of workers' compensation arrangements, it shares with the United States and Canada the distinction of having the major occupational disabilities programme operating at the state level rather than the national level. As a result there are 10 distinct workers' compensation systems in effect—one for each of the six states and two territories plus two federal schemes (one for public

employment at the federal level and the other for the merchant marine engaged in interstate and overseas trade and commerce). This compares with the 12 provincial and territorial systems plus 2 federal schemes in Canada, and the 50 state systems, plus one for the District of Columbia, and four federal schemes in the United States.

While there are substantial similarities between the Australian workers' compensation arrangements and those operative in the United States and Canada, there are also salient differences. For instance, whereas workers' compensation has long constituted the exclusive remedy in North America, until relatively recently all Australian schemes allowed unfettered access to the common law action for negligence for workplace injuries and illness. In the past several years this has changed, with some jurisdictions abrogating the common-law remedy entirely and others subjecting it to threshold entitlement criteria and/or to caps upon settlements and awards.

Similarly, all the Australian schemes operate upon wage loss principles for the calculation of loss of earnings entitlement, although there are significant variants between them in respect to duration of such entitlement and the capacity for it to be capitalised in the form of lump sum redemption payments. However, unlike the United States, scheduled disability principles have not taken hold in respect of payment of wage loss, although such principles do operate in relation to lump sum impairment payments under what is variously called the "Table of Maims" or "Table of Injuries." Many of the similarities and differences between Australia and North America lie in the historical origins of the Australian workers' compensation schemes.

Historical Origins

Like so much of the early legislation of the Australian states, workers' compensation statutes were based very much on the handiwork of the English legislature. The first Australian workers' compensation statute, the South Australian Act of 1900, was essentially a copy of the original English measure . . .; the Workmen's Compensation Act 1897 (Imp). Victoria was the last Australian state to enact workers' compensation legislation, and this measure, the Workers' Compensation Act 1914, again largely replicated the consolidating English Act of 1906 with the addition of the "Table of Maims." This latter feature was derived from the 1908 New Zealand statute and was reputedly the brainchild of the New Zealand judge and jurist Sir John Salmond.

Over time, the various schemes have evolved in separate directions, such that now the Heads of Workers' Compensation Authorities (HWCA), a body comprising the chief executives of the 10 Australian schemes, is involved in a process of trying to achieve greater national consistency.¹ However, until the mid 1980s, workers' compensation in Australia was, overall, characterised by a surprising degree of structural uniformity. Where changes occurred (such as the adoption of the disjunctive "or" in place of the conjunctive "and" in the primary entitlement provision of an injury "arising out of and in the course of employment"; or the extension of coverage to injuries sustained while travelling between a worker's place of residence and place of employment, so-called journey injuries), such changes tended to be picked up relatively quickly by most if not all jurisdictions in a process of legislative "osmosis."

In terms of financing arrangements, the schemes adopted the English system of private insurer underwriting with the ability of enterprises to contract out as self-insurers according to certain criteria. Unlike the English system, the requirement to insure was generally made mandatory, and most jurisdictions, often at the time of enacting their workers' compensation legislation, also created a state-owned insurer which competed in the market with private insurers. The state-owned insurer also tended to have the functional role of an insurer of last resort and thus served a role which in the United States is most often performed by the residual market. In United States terms, the typical Australian scheme was a three-way system of private insurers, a competitive state insurer, and self-insurance option for certain employers. The significant exception was the state of Queensland, which, in 1916, under the radical T.J. Ryan Government, moved to oust private insurers from workers' compensation and established a monopoly state scheme, with no provision for self-insurance.

The Queensland experience was the nearest Australia came to the debates on alternative approaches to workers' compensation that characterised the Progressive era in the United States. There were no organisations in Australia such as the American Association for Labor Legislation, the National Civic Federation, and the National Association of Manufacturers in the United States making a critical evaluation of various reform options.² Nor was there a figure such as Sir William Meredith, the Chief Justice of Ontario, whose investigations and reports to the

¹Heads of Workers' Compensation Authorities, 1996, *Promoting Excellence: National Consistency in Australian Workers' Compensation*: Final and Interim Reports to Labour Ministers' Council, May 1997.

²Robert Asher. 1971. *Workmen's Compensation in the United States, 1880–1935*. University of Minnesota.

Ontario legislature laid the basis for the distinctive workers' compensation arrangements adopted by the Canadian provinces and territories from 1914. The nearest Australian analogue did not occur until 1970, with the trailblazing report on rehabilitation by the then-chairman of the Workers' Compensation Commission of New South Wales, Judge A.T. Conybeare QC.

Stability and Change

Change tended to be somewhat slow and piecemeal. In Victoria, the 1914 legislation operated without amendment until 1922 and then remained unchanged until 1928.³ These changes were often directed to refining and widening the qualifications and restrictions on coverage inherited from the English model; for instance, the income threshold on coverage (apart from manual labour) was progressively diluted and finally removed in 1972. Other restrictions, such as the exclusion of outworkers, survived until the 1985 WorkCare reforms.

More significant changes occurred with the 1937 legislation, which established the Workers' Compensation Board as the body for the determination of contested claims of compensation instead of the general court system, and with the moves in the 1940s, noted above, to include journey injuries and the adoption of the "arising out of or in the course of employment" wording for the primary entitlement provision. This history stamped a particular functional style and approach upon the operations of Australian workers' compensation schemes. As the 1984 Victorian Cooney Report noted:

English workers' compensation legislation and the Australian statutes based upon them reflected [the] perspective of an amelioratory measure—the provision of income support to compensate for wage loss as a result of industrial injury. There was never a hint by the legislature that workers' compensation could encompass any wider role in terms of accident prevention or the vocational and social rehabilitation of injured workers. The enforcement of industrial safety was seen to be the preserve of the inspectorate established to police the provision of the Factories and Shops Act while, apart from some provision for injured war veterans, rehabilitation was not a concept which entered the consciousness of officialdom, being left to private charitable organisations. By contrast, in Canada and in a number of American States influenced by the German model, the

³Orwell De R. Foenander. 1956. *Developments in the Law Governing Workers' Compensation in Victoria*. Melbourne: Law Book Company, p. 1.

provision of rehabilitation services was a prominent feature of workers' compensation administration from the beginning.⁴

During the 1970s, the essentially tranquil nature of workers' compensation in Australia began to change. One of the first markers of this change was the 1970 Conybeare report, mentioned above. Judge Conybeare had long taken an interest in North American developments, and while his report was focused on rehabilitation, it was characterised by an expansionist perspective which, for instance, seriously questioned the role of common law in the workers' compensation system.

On the national political stage, 23 years of conservative rule were brought to an end with the election of the reforming Whitlam government. One of the first acts of this new federal Government was to invite Sir Owen Woodhouse, architect of New Zealand's revolutionary comprehensive national accident compensation system, to investigate the basis upon which a similar scheme could be introduced into Australia. The proposals outlined in the 1974 Woodhouse report would have totally transformed personal injury compensation in Australia and spelt the end of state workers' compensation schemes. However, they fell into the dustbin of history with the fall of the Whitlam government in 1975. Nevertheless, these proposals generated ripples which would contribute to the changes in Australian workers' compensation in the 1980s and beyond.

These changes were most dramatically expressed in the Victorian WorkCare reforms which took effect from September 1985 and which are examined in further detail below. However, the Victorian move to oust private insurers from an underwriting role was followed in South Australia and New South Wales in their WorkCover reforms in 1986 and 1987, respectively. The recent process of change in Australian workers' compensation is reflected in the fact that, over the last two decades, there have been at least 16 official inquiries into the reform of workers' compensation schemes, and that there have been nine new legislative schemes introduced since 1985.

This situation of review and legislative change continues apace, with major scheme reviews occurring in late 1996 in both Queensland and Tasmania and significant legislative amendments enacted in a number of Australian jurisdictions, including Victoria during 1996.

⁴*Report of the Committee of Enquiry into the Victorian Workers' Compensation in Victoria*. 1984. Melbourne: Government Printer, para. 2.5.5.

The drivers of this recent volatility can be better understood by looking at the background to, and evolution of, the 1985 WorkCare changes in Victoria.

The Crisis of Workers' Compensation in Victoria

The changes to workers' compensation arrangements which occurred in Victoria in 1985 represented a fundamental rupture with the general trend of workers' compensation development noted above. The causes for the Victorian changes were primarily financial in nature, although there were contributory factors in terms of the inefficiency of some the system's delivery mechanisms. These financial features can be viewed at a number of levels, involving both short-term and medium-term factors. The medium-term factors involved the volatility of the workers' compensation market between 1974 and 1981, while the short-term factors related to the disappointing experience between 1981 and 1983, following which the Government appointed the Committee of Enquiry into the Victorian Workers' Compensation System (the Cooney Committee) to examine and report upon the problems of the Victorian system.

Medium-Term Factors

In a medium-term perspective, the WorkCare changes were largely a response to the erratic behaviour of the general insurance market, and particularly the workers' compensation segment of that market, which was exhibited from the mid 1970s. This experience appears to have resulted from the conjunction of a number of factors. First, there was the influence of the federal Insurance Act 1973, which regulated the prudential operations of insurers. A number of insurers were faced with problems in regard to financing the solvency requirements laid down under the act within their existing capital structure. The result was a "flight of premium" when companies rejected workers' compensation business in an attempt to meet the solvency margins. Most of these companies managed to secure the requisite prudential buffers and margins after a couple of years, and were ready to buy back a market share in the workers' compensation market through heavy discounting.

In addition, the federal Trade Practices Act 1974 began to change the very restrictive environment in which insurers were operating. This enactment introduced a more competitive commercial environment that required some years of adjustment, and it was certainly a factor in

the premium volatility throughout the middle and late 1970s in all classes of insurance in Australia.

Second was the fallout from the Australian Woodhouse inquiry and report. Had the Whitlam government remained in office and the proposals of the Woodhouse report been implemented, the insurance industry would have faced the prospect of losing all personal injury business. This would have included not only workers' compensation, but compulsory third-party motor vehicle injury insurance and some other areas of liability insurance that involved a personal injury component as well. Given that coverage would have been extended to the self-employed as well, there may also have been a significant loss of private disability insurance business. Faced with the prospect of being ousted from personal injury lines completely and the running out of the claims tail from existing reserves, the industry regarded itself as significantly underfunded. Consequently, premiums were raised in the prospect of meeting the run off involved. The quarantining of the Woodhouse legislation in the Senate Legal and Constitutional Committee and the subsequent fall of the Whitlam government removed this threat and contributed to the vigorous price-cutting war which followed.

Third, according to evidence given by insurance brokers to the Cooney Committee, the mid 1970s coincided with an unusual overcapacity in the international reinsurance market. One of the results was fierce competition for the premium dollar, and this was reflected in heavy discounting in Australia. Thus, these three features combined to produce, from around 1975, a severe price-cutting war in the workers' compensation market, particularly in respect of larger accounts. As interest rates were at historically high levels, part of this fight for market share and premium income also represented the practice of cash flow underwriting to secure funds which could be invested to take advantage of the prevailing high interest rates.

An additional element contributing to this volatility was the role of insurance brokers. Around three-quarters of the market engaged a broker or used the services of an insurance agent in obtaining employers' liability coverage. As a result, brokers had a central role in the placement of insurance coverage. That choice was crucially influenced by the existence and size of commission. When the State Insurance Office (SIO), after receiving a strong influx of business in 1975, decided in 1976 not to pay brokerage fees for the securing of business, it lost half of its workers' compensation portfolio within 18 months. In contrast, generous brokerage fees led to brokers in the period 1977 to 1979, placing a large volume of business with Palmdale

Insurance Company Limited. This insurer went into liquidation in February 1980 and, in Victoria, the payment of claims became the responsibility of the Insurers Guarantee and Compensation Supplementation Fund.

This situation was exacerbated by the entry into the market of some relatively aggressive new underwriters such as C.E. Heath and the American International Group (AIG), which didn't face the claims tail of the established market players. These new entrants were aggressively targeting the larger employer accounts, and the competition in this sector was particularly intense.

The rate cutting peaked in 1978/79 and 1979/80, with an attempt to regain financial rectitude beginning in 1979/80. Thus, surveying the period 1975/76 to 1981/82, premiums increased by only 1 percent while general costs, as measured by the Consumer Price Index, had doubled over this period, and claims costs had increased by some 120 percent.

Immediate Impetus

The immediate impetus which largely led to the demise of private underwriting in Victoria was the dramatic attempt by insurers to suddenly regain much of the ground lost during the period of ferocious rate-cutting. The huge increase in premium rates which occurred in 1981/82 and 1982/83 had the effect of alienating the business community and making that community amenable to other solutions. While Australia-wide the period between 1981 and 1983 showed an average annual rate of growth in workers' compensation premiums of some 49.3 percent, the premium spiral appears to have been even more severe in Victoria. The various employer bodies provided extensive documentation of this dramatic increase to the Cooney Committee.

A membership survey by the Victorian Employers' Federation in November 1982 revealed that a majority of respondents had experienced premium increases in excess of 50 percent in the previous 12 months and some reported increases of 200 percent and 300 percent between 1981 and 1982 despite declining or static claims rates. The Metal Trades Industry Association of Australia reported on the experience of its membership, which showed dramatically escalating premiums, unrelated to claims experience, of up to 500 percent. One company had its premium increased by 184 percent between 1980/81 and 1981/82 even though employment in this company had decreased by almost 17 percent and it had experienced no

claims for many years. The Victorian Small Business Development Corporation reported that premium increases for small business in the previous 2 years had ranged from 80 percent to 400 percent with individual instances of more than 700 percent.

The reason underlying this energetic attempt by the insurance industry to restore its funding levels in this sector can be glimpsed through the actuarial report commissioned by the Workers' Compensation Premiums Advisory Committee in 1983 and prepared by Richard Cumpston, then a partner at E.S. Knight and Company, an actuary active in the general insurance field. This involved an examination of the Form 11 returns by insurers to the federal Insurance Commissioner, detailing the run off patterns for the 50 private insurers engaged in the Victorian market, and an attempt to ascertain what the insurers' outstanding claims reserves should be compared with what reserve provisions they had actually made. The conclusion reached by Richard Cumpston was that while these insurers collectively had made provisions of \$501 million for outstanding claims, the required figure was some \$723 million; that is, as a group, they were underreserved by some 31 percent.

The Problem of Contested Claims

While this roller coaster behaviour of the premium system between 1975 and 1983 shook the business community's confidence in the insurance industry's handling of workers' compensation financing, there were also profound problems with the existing system from the perspective of injured workers and the labour movement. At the forefront of these complaints was the issue of delays in the handling of contested claims.

There was a steady and inexorable increase in the backlog of claims before the Workers' Compensation Board and in the time between lodgment of a claim before the Board and its disposal, notwithstanding the expansion of the Board. By October 1983, there was a backlog in excess of 14,000 cases, and the average time between lodgment of a contested claim before the Board and the claim being brought for hearing was 24 months. A year later, by October 1984, the backlog had further increased to some 17,000 cases.

Apart from the issue of delay, the operation of the system was itself flawed. The chairman of the Cooney Committee, himself a barrister, was moved to describe it, in the foreword to his report, as having "many of the features of a street bazaar."⁵ In particular, only 1.6

⁵Ibid., p. 2.

percent of cases following this average two-year wait were actually heard to judgment, while some 62 percent of cases were being settled at the door of the court.

The Road to WorkCare

Following almost 3 decades in opposition, the Labor Party achieved political office in Victoria in April 1982. By the end of 1982, both the Treasurer, Rob Jolly, and the Minister for Labour and Industry, Bill Landeryou, were the subject of a “deluge of complaints” from employers concerning spiralling workers’ compensation premiums as well as representations from the labour movement about the delays at the WCB. The Government introduced interim legislation in December 1982 and announced that it was considering a thorough review of the system.

The Cooney Committee

In July 1983 the Government announced the appointment of the Committee of Enquiry into the Victorian Workers’ Compensation System, generally known as the Cooney Committee after its chairman, Barney Cooney, a barrister and prominent member of the independent faction of the Australian Labor Party (ALP). The other four members reflected major stakeholder interests. They were Jack Wood, a long-time former lay member of the WCB who was nominated by the Trades Hall Council; J.C. Rademaker, a senior business executive with extensive manufacturing experience as the employer representative; Peter Jackson, deputy general manager of the State Insurance Office known for his knowledge and expertise in workers’ compensation insurance; and Bruce Lilley, then a partner in Coltmans, a legal firm which represented the interests of a number of the major private workers’ compensation insurers.⁶

The Committee received some 117 submissions and followed up with oral evidence from 36 bodies and individuals who either represented key stakeholders in the system or had specialist knowledge and expertise. The stakeholder representation included injured workers,⁷ employer

⁶Ian Baker, then one of Bill Landeryou’s ministerial advisers and later to achieve ministerial office himself in a later Labor government, and a ministry research officer, Alan Clayton, headed the Committee’s secretariat as Executive Officer and Secretary/Research Officer, respectively.

⁷North Richmond Workers’ Compensation Support Group.

and trade bodies,⁸ trade unions,⁹ insurers and brokers,¹⁰ doctors,¹¹ lawyers,¹² rehabilitation providers,¹³ and risk managers.¹⁴

In addition, a number of bodies with particular concerns about the operation of workers' compensation were given representation, with evidence being taken from representatives of the Equal Opportunity Board, the Ethnic Affairs Commission, and the Small Business Development Corporation. Individuals with specialist knowledge and expertise who gave evidence before the Committee included Brendan Hammond, the Registrar of the WCB; Professor Harold Luntz of the University of Melbourne Law School and one of the leading Australian authorities on accident compensation systems; Don Rennie, a New Zealander who previously headed the research department of that country's Accident Compensation Corporation; and Ted Hill, the legendary "king of compo," the leading workers' compensation barrister and coauthor of a book on this area. The Committee also met informally with Judge Harris, who had conducted a review of Victorian workers' compensation seven years previously.

While the clear intention of some within Government was that the Committee would simply "dust off the Harris recommendations and add some refinements,"¹⁵ the Committee in fact undertook a comprehensive investigation of almost all aspects of the Victorian workers'

⁸Metal Trades Industry Association, Victorian Chamber of Manufactures, Victorian Employers Federation and the Housing Industry Association.

⁹Australian Railways Union, Building Workers' Industrial Union of Australia, Federated Liquor Industries Union, and the Victorian Trades Hall Council.

¹⁰C.E. Heath Underwriting and Insurance, National Employers Mutual Insurance Company, and the National Insurance Brokers Association.

¹¹Australian Medical Association.

¹²Victorian Bar Council representing barristers. The Law Institute of Victoria, the professional association for Victorian solicitors, was scheduled to give oral evidence but at the eleventh hour withdrew due to a sharp schism between the plaintiff and defendant wings of that body's workers' compensation section.

¹³Industrial Rehabilitation Service and Vocational Rehabilitation Service.

¹⁴Association of Risk and Insurance Managers of Australia.

¹⁵A ministerial adviser quoted in Mark Considine, *The Politics of Reform: Workers' Compensation from Woodhouse to WorkCare*. Centre for Applied Social Research, Deakin University, 1991 (Deakin Series in Public Policy and Administration, No. 1) at p. 63.

compensation system. This was sometimes a tortuous process,¹⁶ but the Committee completed its report in early June 1984.

While the Cooney Committee report proved to be a very useful source document in terms of detailing the ills of the system, as a vehicle for change it was hampered by the fact that the Committee membership reflected the interests of the existing system and, consequently, on many important issues these members voted to support the interests of the constituency from which they were drawn. The analysis within the report provided a damning indictment of the operation of the current system, and of its failures in both economic and social terms; however, when it came to recommendations and solutions, the Committee largely divided upon interest group lines.

One of the most hard-fought battles within the Committee revolved around how to present (or perhaps disguise) the issue that “[c]ontrol of the workers’ compensation system has through evolution been wrested from the institutional mechanism established to deliver benefits to the injured and given over to—captured by—exogenous parties, namely insurers and the medical and legal professions.”¹⁷ This was finally illustrated in Table 1.16 from the report, which showed how the premium dollar in Victoria was distributed. (see table 2.1)

The Committee divided 3-2 in its decisions on a number of important issues. The recommendation that lump sum redemptions should be removed from the compensation system on the grounds of being destructive of the successful operation of a rehabilitation-oriented compensation system was adopted by this margin. Similarly, the recommendations that there should be a continuance of private underwriting and not a move to a central fund, and limiting lump sums (apart from Table of Maims payments) to highly circumscribed situations, were adopted by this same majority. The recommendation that the common law action be abrogated was taken on a 3-2 split, although the impact of this particular recommendation was essentially negated by the rider to it that the appropriate forum for such action should be the future implementation of a national accident compensation scheme.

¹⁶Ibid., pp. 62-81 for a good account of some of the workings of the Cooney Committee.

¹⁷Report of the Committee, op. cit., p. 2.

The DMB Blueprint

The Cooney report represented a comprehensive review of a system in crisis, but little unanimity in terms of solutions. However, during the period of the Committee's operation, Bill Landeryou had resigned as Minister for Labour and Industry, and, in a reallocation of departmental functions, the administration of workers' compensation was transferred to the Department of Management and Budget (DMB). Consequently, ministerial responsibility rested with the Treasurer. This proved to be a crucial development.

One of the things that marked out the Cooney report from earlier Australian reviews was the strong economic perspective which underlay much of its analysis. It included indicative results of the impact of the recent shock increases in workers' compensation insurance costs upon Victorian business as measured by the University of Melbourne's impact model (ORANI). It was an approach that meshed with the agenda of DMB, which was quick to see the importance of workers' compensation as an economic development issue, particularly in terms of the effect of the financing crisis of workers' compensation insurance upon the trade exposed sectors of the Victorian economy.

The new Department of Management and Budget, under Dr. Peter Sheehan as Director-General, took an interventionist approach to transforming the Victorian economy. As a vehicle for technocratic revolution, it resembled some of the initiatives of Massachusetts Governor Michael Dukakis in the days of the "Massachusetts Miracle." The Department was the major architect of the Government's economic strategy for Victoria, which was released in April 1984. A document entitled *The Next Step Forward* outlined issues concerning the development of the Victorian economy over the next decade. It was followed by a series of economic strategy statements giving a detailed outline of proposed initiatives in individual sectors. It is significant that the outline of the new WorkCare scheme was detailed in one of these economic strategy statements,¹⁸ the fifth publication in this series, following detailed statements on state and regional industry policies, the Government's energy policy, the Portland aluminium smelter, and the tourism strategy.

The workers' compensation statement saw "the current system of workers' compensation [as] unsatisfactory both in respect of its effectiveness and efficiency [and having] considerable

¹⁸*Victoria - Workers' Compensation Reform: Government Statement*. 1984. Economic Strategy for Victoria Statement No. 5. Melbourne: Government Printer (December).

scope to reduce the level of labour costs to Victorian producers, without reducing the level of benefit to employees.”¹⁹ It was perceived as a win-win situation. The Cooney analysis had shown the degree of inefficiency and transaction costs within the old system. A more modern and rational problem-solving approach could address these issues and share the benefits between employers and workers, while the net result would be to advance the economic development of the Victorian economy.

The contours of the new scheme were the result of the work of a high-level taskforce within DMB which took the Cooney analysis and crafted a new framework for the funding and organisation of workers’ compensation in Victoria. While negotiations with the union movement to secure their support for the new scheme produced a number of concessions in respect of the benefit proposals,²⁰ the major difference from the scheme originally conceived by the DMB taskforce lay in the manner in which the new scheme was to be administered.

Initially it had been proposed that the new Accident Compensation Commission would operate as a single fund, on the Queensland Workers’ Compensation Board and New Zealand Accident Compensation Corporation model. The fund would discharge the claims handling, premium collection, and other functions involved in the running of a workers’ compensation system. It was envisaged that, at least for an interim period, some or all of the claims functions would be handled by the SIO, and that premium collection would be undertaken by the State Taxation Office, which was the vehicle for the collection of payroll tax. Again, there were New Zealand analogues for such interim action.

The decision to move to a system of claims administration “agents” resulted from pressure from significant areas of the business community, which was concerned that a government monopoly would become overly bureaucratic and inefficient, and also from the Insurance Employees Union, which was alarmed at the prospect of significant redundancies among its members as a result of the move to a monopoly state fund. This change was made relatively early in the planning process and was incorporated in the Government statement where

¹⁹Ibid., pp. 129-130.

²⁰See Considine, *op. cit.*, pp. 87-88.

it was advanced as a basis to “ensure minimum insurance industry disruption, increased business opportunities and maximum efficiency.”²¹

WorkCare in Operation

WorkCare is a term which has both an extended meaning and a more circumscribed signification. In its extended sense it refers to the triad of agencies, the Accident Compensation Commission (ACC), the Occupational Health and Safety Commission (OHSC), and the Victorian Accident Rehabilitation Council (VARC), as well as the schemes administered by them. The objectives of the ACC, expressed in its legislative charter, included one to “ensure a coordinated approach in the implementation of the accident compensation scheme in liaison with the [Victorian Accident Rehabilitation] Council and the Occupational Health and Safety Commission that emphasizes accident prevention, rehabilitation and operational efficiency.”²²

However, the degree of coordination in practice fell well short of the rhetoric accorded to this goal. It is true that there was cross representation on the Boards of these three agencies and even a WorkCare Co-ordination Committee, comprising the chief executive officers of ACC and VARC and the Chairperson of OHSC, together with a senior representative from the Department of Labour, to provide coordinated executive policy and strategic management decisions. Nevertheless, to the extent that coordination existed, it was in a formal sense rather than one which involved significant functional integration of approach and activities. To a very considerable degree the agencies were separate trains going in a similar direction rather than carriages of a single train.

In its more circumscribed sense, and the one which would be recognised by the Victorian public, the term WorkCare refers to the system of reformed workers’ compensation arrangements which operated from the inauguration of the new system on 1 September 1985 until the beginnings of what is generally called WorkCover, which started 1 December 1992. It is this concept of WorkCare which is addressed in the following sections of this chapter.

²¹*Victoria - Workers’ Compensation Reform*, op. cit., p. 15; also Ch. 9, “The Role of Existing Insurers.”

²²Accident Compensation Act 1985, Section 19(c).

Components of Scheme Operation

Far and away the most fundamental problem that WorkCare experienced was the number and duration of long-term claimants in the system. This was particularly pronounced in the early years of the scheme's operations; at the time of the DMB review in 1987 it was found that around 18 percent of claimants with a standard claim (that is, one involving weekly benefits for more than 5 days) were still in receipt of these benefits after 12 months. While this rate improved over the later years of the scheme (by 30 June 1988, the scheme's actuaries were reporting a fall to around 12.5 percent), the level and duration of long-term claims in Victoria remained comparatively high over the entire WorkCare period.

The duration issue had a dramatic effect on the scheme's funding ratio, which, as can be seen from Table 2.2, had fallen sharply during the first four years of scheme operation to a level in 1988/89 of only 14 percent. This was almost entirely due to lengthening durations and the resulting rise in claim liabilities. Table 2.2 shows that the number of new claims incurred was actually falling through this period. The funding ratio improved following the 1989 reform initiatives to around 48 percent in WorkCare's last year of operation. However, by then the effects of these reforms had been exhausted, and the ACC was reporting that unless further changes were made, the scheme's funding level would remain below 60 percent for the rest of the decade.

Workers' compensation systems are extremely complex entities, in terms of both their own dynamics and their interaction with external systems; as such, assigning rough measures of cause and effect and relative contribution of specific scheme features to particular system outcomes is fraught with difficulty. Such an exercise is likely to overlook important exogenous variables such as the state of the economy and the labour market or demographics, which have profound effects and consequences, for instance, on return to work possibilities. However, a thematic approach to aspects of the WorkCare system in terms of scheme administration, the pricing system, the benefits structure, rehabilitation, and dispute resolution may assist in illuminating some of the problems of system performance.

Administration of the WorkCare Scheme

At the heart of the administrative arrangements of the WorkCare scheme was the system of agency relationships for the discharge of scheme functions. The collection of the levy was undertaken by the Levy Collection Agency, which was an entity within the State Taxation Office. The investment of the collected levy that was surplus to immediate scheme needs was undertaken initially by three fund management agents selected on the basis of tender; all were bodies associated with major banks. The major function of claims administration was the responsibility of nine claims administration agents. These had all been private insurers in the previous system who had successfully tendered for this role.

This element of delegated responsibility for claims functions was, as noted above, a political compromise and a change from the original WorkCare blueprint. This compromise had the effect of creating an arrangement unique in workers' compensation practice. No other state workers' compensation fund in the world operated in this manner. It was an arrangement which was always going to be fraught with tension. Although it was essentially a relationship between principal and agent (see Chapter 4), it suffered from the fact that the agent often had an interest different (indeed sometimes fundamentally opposed) to that of the principal. The most important of these differences were to emerge strongly in relation to the costs of claims which straddled the operation of the previous private insurance system and WorkCover.

The claims administration agents were entities who had recently been engaged in a highly acrimonious fight with the Government over their removal from workers' compensation insurance underwriting and thus had no reason to feel a special commitment to the success of the new system.²³ The difficulty in achieving scheme goals through this arrangement was compounded by the initial basis of claims administration agent remuneration. This mainly consisted of a uniform fee for each claim registered, with an additional rollover fee for any claim which extended into a second year's duration. As the WorkCare fund rather than the agent bore the economic burden of the cost of claims, the profit-maximising strategy for an agent would be to accept every claim and do nothing and hope that the claim would continue into a second year.

²³It should be noted that the Insurance Council of Australia specifically denies this. They assert that the nine agents went to considerable length to work through operational problems, including frequent meetings with the ACC.

In order to simplify the logistics of establishing the scheme during the 12-week (!) implementation phase, employers were generally allocated to the insurer who had provided cover immediately before WorkCare, where that insurer was a claims administration agent under the new scheme. Not only did this arrangement result in disincentives for the claims administration agent to undertake any recovery action against itself (as the former insurer on risk) in respect of liabilities which straddled the two schemes, it also created an opportunity for the transfer of some old system costs onto WorkCare.

The 1987 review of WorkCare conducted by the DMB found evidence of old system claims being passed onto WorkCare and noted the phenomenon of some 1,033 claims with 1 September 1985 (the date of commencement of WorkCare) as the date of injury, notwithstanding that this day was a Sunday and that this figure was without precedent for any other Sunday over the life of the scheme.²⁴ The DMB review also found widespread employer dissatisfaction with the performance of claims administration agents, with employers complaining of delays in reimbursement, poor claims review, irregularity in ordering medical examinations, lack of follow-up action in relation to return to work or referral to the Tribunal, [and failing] to respond to employer's inquiries, complaints, and requests for information.²⁵

These failures had generated a high number of representations to Members of Parliament, Ministers, and the Ombudsman. In particular, the performance of two agents (Accident Compensation Settling Agency and Manufacturers Mutual Insurance), was regarded as sufficiently poor for their contracts to be terminated. C.E. Heath Underwriting and Insurance was also cancelled at that time for other reasons. Yet another agent (Royal Insurance) decided to withdraw from its contract following the announcement of a new system of claims administration agent remuneration which was brought into effect from 1 October 1987.

The new remuneration system, while recognising prompt registration of claims, placed the emphasis upon file closure with a weekly management component which decreased as the number of weeks of compensation on the claim increased. As well, a bonus scheme was introduced from 1 January 1988 which provided a performance bonus to claims administration

²⁴The insurance industry maintains that claims agents were instructed by the ACC to file claims on 1 September if there was any doubt about which Act pertained to the claim.

²⁵WorkCare: Government Statement, 31 July 1987, para. 4.10.

agents with increased return to work rates and more effective claims management. In its 1988/89 annual report, the ACC stated:

The critical administrative issue faced by the Commission remains the need to enhance the performance of claims agents whose principal motivation and objectives need not necessarily be compatible with those of the Commission. The appropriate balance of economic incentives and sanctions, and mixture of regulation and competition has proven to be difficult to find.²⁶

The crafting of a package of remuneration provisions which more appropriately met that balance proved to be a continuing challenge for the ACC over the entire WorkCare period and remains so today for the Victorian WorkCover Authority (see Chapter 4). From the time of the introduction of the October 1987 remuneration arrangements and the January 1988 bonus pool, refinement and enhancement of performance measures have become almost an annual event.

The composition of the claims administration agents was subject to frequent change as well. Following the termination of agents' contracts in 1987, mentioned above, a new agent, FAI Workers' Compensation, was added to the group and the ACC created its own agent, WorkCare Compensation Services, partly to test new computer and administrative systems, but also to assist with handling some of the open claims left after agent termination and withdrawal. Following the termination of Mercantile Mutual's contract in 1989 and the withdrawal by Compensation Business Services in 1990, there remained five claims administration agents. This number rose to six with the admission of QBE Insurance in February 1992.

One of the early problems of the claims administration agent operations, noted in the 1987 DMB report, was the lack of responsiveness to employer concerns. Beginning with the new October 1987 contractual arrangements, the ability of employers to change agents was enhanced and the process of introducing market competition into the agency operations was progressively fostered by the ACC. This process reached its furthest extension under WorkCare with the new agent contracts that took effect from 1 July 1992, which actively promoted competition among agents to gain employer clients. The clear evidence is that agents did become increasingly responsive to employer concerns and began to develop special products and cultivate niche markets. This attentiveness to employer concerns appeared motivated by gaining and

²⁶Accident Compensation Commission, Annual Report 1988/89, p. 23.

maintaining desired market share and position and by offering a wider range of insurance products to targeted employers. However, while the final phase of the WorkCare period saw a much greater level and quality of service from the authorised claims agents to employers than at the beginning of the scheme, there is little evidence that these agents ever saw the injured worker as a client in the same manner that they belatedly came to regard the employer.

Pricing System

The basis of the financing arrangements for the new scheme was the employer levy. Since this amounted to a percentage of employee compensation, the ACC utilised the State Taxation Office as its agent for levy collection since that body was already collecting payroll tax. The levy system operated with levy being paid annually (in arrears) by around 36,000 employers with an estimated liability of \$650 or less and monthly (in arrears) by approximately 90,000 other employers.

Whereas the premium arrangements under the previous privately underwritten system had been based upon occupational classification, the WorkCare levy system utilised an industry rating based on a WorkCare Industry Classification (WIC) code derived from the Australian Standard Industry Classification (ASIC). Under these arrangements all establishments of employers were categorised according to 466 industry types and allocated to one of the seven levy rates, which ranged from 0.57 percent to 3.8 percent of total employee remuneration.

The process of determining industry levy rates was done on the basis that the average rate paid by employers on a statewide basis would not exceed 2.4 percent of employee remuneration over the first five years of the scheme. The result would be that the cost of the new scheme to Victorian employers would be some 48 percent less than the indicative premium rates operative under the old system. The Government costings for the new scheme predicted that it could be fully funded over a period of 10 years at this average premium rate of 2.4 percent of remuneration. These costings were undertaken by Richard Cumpston (then at E.S. Knight and Co.) and David Orford and Bill Szuch of Financial Synergy Pty Ltd and were set out in a three-volume publication, *Costing WorkCare*. The target of 10-year full funding was based on a number of assumptions, including:

- a reduction in the claims rate (i.e., claims per 100 workers) of 15 percent;

- a reduction in the cost per claim (as measured as a proportion of average earnings) by 10 percent;
- a rate of return on funds invested of 14 percent in 1985/86 declining to a long-term level of 9.5 percent by 1990/91 compared with an assumed long-term rate of growth of Victorian average weekly earnings of 7.5 percent; and
- significant savings in the areas of legal, medical, and administrative costs.

While the great majority of employers secured substantial reductions in workers' compensation costs as a result of the new levy system, it was recognised that some employers would pay more under the new system. Accordingly, the Government agreed to a system of interim levies under which employers whose levy rate would have been significantly higher than their fully funded insurance premium under the old system could receive a levy rate which was equivalent to this former premium amount. By mid 1987, around 1,400 employers had been granted interim levies upon this basis at an estimated system cost of around \$6 million annually.

It was intended that the interim levy arrangements would cease on 30 June 1986, when it was anticipated that a bonus and penalty system would be introduced. However, this introduction date was deferred and the interim levy system was progressively extended to 30 June 1987, then 30 August 1987, and finally 30 June 1988, with the introduction of the bonus and penalty system from 1 July 1988. The experience of the scheme in its first two years of operation showed it falling behind the required performance necessary to track the 10-year full funding curve. In these years the average levy rate was 2.2 percent rather than 2.4 percent of remuneration, which equated to an income shortfall from target over this period of more than \$100 million.

A number of factors contributed to this shortfall. First, the data deficiencies of the previous system created great problems in estimating the true industry claims experience, and thus the determination of proper levy rates for particular industries was prone to considerable error. Secondly, following the commencement of the new scheme, a number of industries successfully challenged their designated rates and were reassigned to a lower levy band. Thirdly, the pattern of employment growth was more varied than predicted, and the highest growth proved to occur in low levy rate industries. Fourthly, the underregistration of employers was skewed toward high levy rate industries.

A reallocation of industries and levy rates on the basis of actual claims experience over the first two years of the scheme resulted in an average levy rate of 2.4 percent in 1987/88, but it

fell to 2.3 percent in 1988/89, largely as a result of economic restructuring and industry reclassifications. As a result of the legislative reforms following the Rowe Committee review, the average levy rate was sharply increased to 3.3 percent of remuneration (comprised of an average prescribed industry rate of 3 percent and a 10 percent surcharge) as from 1 October 1989. The band of levy rates was considerably widened from 0.4 percent to 7.0 percent of remuneration (effectively 0.44 percent to 7.7 percent through the operation of the surcharge). As well, the industry classification system was expanded to cover 516 industries.

An attempt to provide a financial incentive for employers to improve their WorkCare claims record was made with the introduction of a bonus and penalties scheme from 1 July 1988. This scheme covered all employers with 1986/87 remuneration of \$450,000 or more and extended to some 7,000 employers with around 29,000 establishments. The scheme was revenue neutral and underwent a series of revisions to increase the rate of contribution to the Bonus Fund from which bonuses were paid (progressively from 25 percent to 50 percent to 75 percent) and to extend its operation to small employers in 1989/90. In the final year of WorkCare's operations, around 85 percent of workplaces earned a bonus and about 13 percent incurred a penalty under this system.

The ACC, in early 1992, began a major review of the total design of the pricing system, considering both Australian and overseas models. Much of this work would bear fruit in the early WorkCover period in the implementation of an experience rating system which has underpinned the financing of this successor scheme.

Dispute Resolution

With the inception of WorkCare, the WCB, the body which determined disputed claims under the previous workers' compensation system, was replaced by the Accident Compensation Tribunal. The Tribunal was structured into three separate divisions. First, a Conciliation Division provided a sifting role. It heard all genuine disputes and was the body which initially considered all other new system disputes and convened Preliminary Conferences to facilitate the settlement of old system claims. Secondly, a Board Division was constituted to run off the backlog of old system matters which had previously been dealt with by the former Workers' Compensation Board. Finally, a Tribunal Division was to resolve disputes about new system cases which had not been resolved at the Conciliation Division.

The overwhelming majority of claims were heard by the Conciliation Division and most related to genuine disputes, a term which referred to the measure in the Accident Compensation Act which provided that claims for weekly payments had to be accepted or disputed within 21 days of the receipt of the claim by the employer. A claim which was not disputed within this period was deemed to be accepted. In the first two years of WorkCare's operations, the percentages of total claims which were disputed in this manner were 5.2 percent (1985/86) and 5.7 percent (1986/87). Following the 1987 review and changes to the claims administration agents remuneration, under which a proportion of such remuneration related to the disputation of claims, the percentage of total claims disputed as to initial entitlement rose to 15.1 percent in 1987/88.

One aspect of this dramatically increased rate of agent disputation was the similarly dramatic level of withdrawal of disputes in relation to initial entitlement. In 1987/88 of the 12,445 disputes lodged by claims agents under Section 109, 5,420 (43.5 percent) were withdrawn by the agent and, in the following year, 6,779 (46.9 percent) of the 14,449 disputes lodged were similarly withdrawn. In large part this phenomenon reflected the difficulty experienced by agents in assembling the necessary information in order to make a determination of liability within the statutory 21-day period. As a result, this period was increased to 28 days under 1989 legislative changes.

The initial institutional structure relating to contested claims resolution underwent a number of changes over the life of the WorkCare scheme. The 1987 legislative amendments restructured the Tribunal into an Accident Compensation Division, a Workers' Compensation Division, and a Contribution Assessment Division. The latter division was created and granted wide powers to resolve issues relating to contributions between the ACC and insurers operating under the previous workers' compensation system. It was composed of one Presidential (i.e., judicial) member. Members of the previous Conciliation Division were metamorphosed into Arbitrators and essentially performed their former duties as members of either the Accident Compensation Division or the Workers' Compensation Division.

More significant was the change brought about by the 1989 legislative reform package, which saw an administrative review body, the WorkCare Appeals Board (WAB), interposed as an independent body between the ACC and the Accident Compensation Tribunal. The WAB commenced operations in March 1990 and was empowered to review any decision (or any

failure to make a decision) by the ACC. The claimant had a period of 60 days following notification of a decision to apply for a review before the WAB. However, if a claimant, in cases involving termination or alteration of benefits, lodged an application for review within 21 days of notice of the decision, then such claimant would continue to receive weekly benefits until the WAB made its decision. This created an understandable incentive to appeal all such cases within the 21-day period of benefit preservation.

The operation of the WAB was governed by a further set of stipulated times in which various material had to be submitted. While neither the ACC nor the employer was granted a right to appear before the WAB, the ACC was required and an employer was able to make a written submission to the WAB within 14 days of an application being lodged. The claimant could also make a statement but had 21 days to do so and had access to both the ACC and employer's statements. As well, a set fee was provided for the cost of case preparation and for medical examinations organised by the claimant or the claimant's representative, including travel costs relating to a claimant's attendance at the WAB. In 1990/91 these costs amounted to some \$6.1 million, of which 57 percent related to case preparation, 42 percent to medical examination costs, and 0.7 percent to claimant attendance costs. With the number of applications to the WAB doubling in the following year, these costs also more than doubled to \$14 million in 1991/92.

The Road to WorkCover

WorkCare—a System under Review

During the seven years of its operation, WorkCare was the subject of ongoing examination and scrutiny. Mention has been made of these reviews in the previous section, as they were often the trigger to elements of scheme modification and change. The Government WorkCare Statement, which was released at the end of July 1987, was the end product of a nine-month review of the scheme by the Department of Management and Budget. While the Statement touched on a range of issues, these were essentially subsidiary to the problems of return-to-work performance. It stated:

The most important deficiency of WorkCare to date has been in the area of return to work. Thus, while the number of standard WorkCare claims has been higher than anticipated and measures are necessary to tighten access

to WorkCare benefits, the major area of concern is the number and duration of long-term claimants in the WorkCare system.²⁷

The Government Statement announced a 10-point reform programme, the major elements of which became part of the Accident Compensation (Amendment) Act 1987, which came into force on 1 December 1987 and was supplemented by the Accident Compensation Regulations promulgated on 4 January 1988. These measures included provisions for a tightening of access to benefits, standardised medical certificates, a widening of the grounds upon which benefits could be suspended or terminated, the appointment of a complaints investigator, capping of common law damages, and increased penalties for fraudulent activities. They were complemented by administrative changes within the ACC such as the establishment of the Employment Monitoring Unit and new procedures on claims monitoring and the new performance-based claims agents contracts.

Following the DMB review, the attention surrounding WorkCare, particularly as a result of the parliamentary debates upon the 1987 legislation, led to the Government establishing, in November 1987, a Joint Select Committee of the Victorian Parliament to further examine the system. The Committee had both a specific and a broad mandate. The former was to investigate the question of contribution to the ACC from pre-WorkCare insurers in relation to injuries whose origins partly lay prior to the establishment of WorkCare. The latter was an open-ended investigation into all aspects of WorkCare.

The Committee, under the chairmanship of Barry Rowe, tabled its first report, into the question of pre-WorkCare insurer contribution, in late March 1988. This report (by a majority) endorsed the Government's view that contribution should exist in respect of all claims which had a part pre-WorkCare origin and not, as the insurers had claimed, that such contribution only applied to injuries of gradual process. The Government then legislated to insert an extensive legislative regime into the act to govern the contribution issue. This legislation was proclaimed on 11 May 1988.

The Final Report of the Rowe Committee was delayed by parliamentary elections in October 1988 and was finally tabled in November 1988. The two-volume report made some 124 recommendations for change. Apart from its recommendations in respect of a changed system of

²⁷WorkCare: Government Statement, 31 July 1987, para 1.6.

contested claims resolution, most of the recommendations contained in the Rowe Report were process- and procedure-oriented, concentrating on matters such as information dissemination (including the production of quarterly reports from the various WorkCare agencies), redesigned claim forms and medical certificates and changes to the operating procedures, policy guidelines, and remuneration arrangements in respect of claims administration agents.

The Government, however, moved to introduce a more extensive package of changes to the WorkCare system with the Accident Compensation (General Amendment) Act 1989 which was assented to at the end of September 1989. This was the second significant reform package following the 1985 legislation. It was a comprehensive set of measures which included

- raising the average levy rate from 2.4 percent to 3.3 percent (including the 10 percent surcharge);
- the reduction of the rate of weekly payments from 80 percent to 60 percent PIAWE for workers on benefits for more than 12 months with a work capacity or level of impairment below 15 percent;
- replacement of the previous minimum-floor arrangements with a compensation supplement for lower-paid workers;
- increasing the period that an employer had to keep a job open for an injured worker from 6 months to 12 months; and
- introduction of the WorkCare Appeals Board as the body responsible for the initial stage of contested claims resolution.

WorkCare—the Internal Repositioning Process

The 1989 legislative reforms provided a breathing space for the WorkCare system, especially in respect of the former downward financial spiral. This can be seen from Table 2.2. The WorkCare fund in 1989/90 reported an operating surplus of some \$373.7 million compared to a deficit of \$12.3 million the year before; this was due mostly to increased revenues as claim payments only declined slightly. Even more strikingly, the unfunded liabilities of the scheme fell by more than 40 percent, from \$4.182 billion to \$2.476 billion, between 1988/89 and 1989/90, and the funding ratio more than doubled, from 14 percent to 30 percent, during this period. This obviously reflected the actuarial impact of the system changes.

These gains continued to consolidate during 1990/91 and 1991/92, with the unfunded liabilities of the scheme being estimated at \$1.819 billion and \$1.862 billion, respectively, and

the funding ratio rising to 46 percent in 1990/91 and 48 percent in 1991/92. However, during these years the Victorian economy had moved firmly into recession and it was becoming clear that this, particularly as it was reflected in labour shedding, was beginning to have a significant impact upon the scheme, both in respect of levy income and difficulties in returning injured workers to the workforce.

The 1991/92 ACC annual report represented a clarion call to action to address these issues. The new managing director, Andrew Lindberg, bluntly declared that:

Once again the WorkCare scheme is at the cross-roads. By year end, the 1989 reform measures had run their course and there is no doubt that further substantial legislative reform is necessary to significantly reduce the financial and social costs of workplace injury in Victoria.²⁸

The ACC managing director stated that the ACC stood “ready to provide every assistance to the Government to implement change during 1992/93.”²⁹ The organisation had already embarked upon a process of analysis and preparation of alternative approaches.

The centrality of the link between claims duration, particularly the number of long-term claimants, and the attainment and maintenance of a fully funded scheme at a levy rate comparable to that of surrounding schemes was brought to the fore through research commissioned by the ACC. This research, conducted by the Boston Consulting Group, estimated that around 70 percent of the cost differential between the Victorian system (with an average levy rate of 3 percent of remuneration) and that across the border in New South Wales (then operating on an average levy rate of 1.8 percent of remuneration) could be accounted for by the different duration experience of the two systems.³⁰

Further, a visit to the United States by the ACC managing director had reinforced the view that, on the basis of Australian and overseas experience, the “compensation cycle” could only be broken by

- a workplace-centred system of rehabilitation and return to work, supported by strong financial incentives and obligations for employers to get injured

²⁸Accident Compensation Commission, Annual Report, 1991/92, p. 6.

²⁹Ibid., p. 7.

³⁰Boston Consulting Group. 1992. *Benchmarking Best Practice: Cost Drivers in Australian Workers' Compensation Systems* (July).

workers quickly and safely back to work, and for employees to rehabilitate, retrain, and find suitable employment;

- a more direct and less litigious approach to reviewing benefits with minimal involvement of lawyers;
- reduced benefits for those claimants capable of work with increased support for the seriously injured;
- restricted access to common law in favour of more efficient forms of compensation; and
- integrated administrative and service delivery systems.³¹

The Move to WorkCover

Given these antecedents, it was highly likely that 1992/93 would see further significant changes to the WorkCare system. When and by whom such change would be implemented would depend upon the election cycle. The Labor Government that had been in power since 1982 was internally divided and weakened by financial management questions, particularly in relation to the sale of the State Bank and the failure of the Pyramid Building Society. As predicted, a Liberal-National Party coalition scored a landslide victory in the October 1992 elections. The new Government moved to completely overhaul the WorkCare system through the introduction of a new WorkCover scheme as one of its first legislative initiatives. While in opposition, the new Government had commissioned the Tasman Institute, a conservative think tank, to provide the blueprint for a new system of workers' compensation arrangements. This report, with accompanying actuarial costings, provided the basis for dramatically overhauling the WorkCare system. This was augmented by input from other sources, and a new set of proposals was rendered into legislative form and introduced into Parliament on 30 October 1992. With a majority in both Houses of Parliament, the new measure, the Accident Compensation (WorkCover) Act 1992, quickly completed its parliamentary stages and received Royal Assent on 19 November 1992. Workers' compensation in Victoria moved from WorkCare to WorkCover on 1 December 1992.

³¹Accident Compensation Commission, Annual Report, 1991/92, p. 7.

Reflections on WorkCare

The WorkCare changes involved a significant break with the past tradition of workers' compensation development. There were no Australian models to hand. Queensland had legislated to establish a state monopoly scheme in 1916, but the Queensland system (even at the time of the introduction of WorkCare) maintained limitations on the duration of weekly payments of compensation which were much more stringent than those in Victoria. Indeed, in a functional sense, the more radical step was not the change from private insurance to a state fund, but the move to operate an extended wage loss system. This broke the general mould—which had existed from the origins of workers' compensation in Australia—of such schemes only providing circumscribed coverage of income loss (usually through prescribed monetary limits), with more income protection for more extended periods being primarily the responsibility of the federal social security system. In addition, the traditional arrangements in workers' compensation schemes for dealing with extended duration claims through lump sum redemptions was proscribed except in very limited situations.

The move to an extended wage loss system placed enormous responsibility upon the institutional mechanisms and processes in charge of injury prevention, rehabilitation, and return to work. As became clearly evident very early in the WorkCare scheme's operation, the issue of extended duration and long-term claims would be the major threat to its continued economic viability. If the system was to operate under its original legislative mandate, it would require a sophisticated and proactive system of claims administration. The breadth of the managerialist vision had to be matched with the strength and depth of the operations administration.

But the operation of the system of claims administration agents was plainly disastrous, at least in the early days of the set fee-per-claim remuneration arrangements. This system, born of political compromise, introduced a unique variant to workers' compensation administration. Questions persist as to whether a different set of remuneration arrangements could have provided the necessary basis for administrative excellence and whether the initially preferred arrangements with respect to a state fund operation would have fared better. The first of these questions is still being played out; the issue of how to align in the optimal manner the actions and behaviour of a third party with scheme goals through economic and other incentives remains a challenge for WorkCover in its present form. The second is somewhat moot. Overseas experience can point to a number of state funds which are a bureaucratic and financial mess. Yet,

it can also illuminate occasional systems of this type which are essentially fully funded and rank among the world's best; British Columbia and Washington are two such examples.

The establishment of an extended wage loss system also brought into sharp focus the issue of the relationship between workers' compensation and the labour market, and in particular the vexed question of the treatment of permanent partial incapacity. Conceptual and legal difficulties had always existed in this regard previously, but their practical (and particularly their financial) effect had been muted by the general limits upon the duration of weekly benefits.

That issue is central to the issue of scheme boundary differentiation; that is, what is the basis upon which workers' compensation schemes delimit their proper area of responsibility and avoid becoming de facto unemployment insurance schemes. In other words, for what period and at what level should workers' compensation support continue for persons whose recovery from injury leaves them with a work capacity, but whose inability to secure employment results primarily from the state of the labour market. This issue had been largely left open in the original WorkCare scheme arrangements, and attempts to provide answers were important components of the 1987 and 1989 amending legislations.

The influence of labour market conditions and their effect upon scheme operations was heightened when the Victorian economy moved into recession. As the economic downturn increasingly affected employment levels in the economy, there was a direct impact on both return-to-work opportunities and scheme financing in a system where income is determined by a levy upon employee remuneration.

The lack of coordinated action between the WorkCare agencies also meant a dissipation of effort and almost certainly a degrading of ultimate results. The potential of using a single fund and its comprehensive database for sophisticated, targeted injury prevention initiatives was never realised. Similarly, the largely arm's-length arrangement between the agencies responsible for claims and rehabilitation/return to work undermined the basis for an integrated problem-solving approach. It also created confusion for employers in having to deal with different agencies over a single workers' compensation claim. Employers and injured workers were passive participants rather than having a controlling involvement in the workers' compensation process. A strong workplace focus was a comparatively late development under WorkCare, but when it came (such as in VARC's Injury Management Program) it yielded superior results and provided indicators for future scheme redesign.

While WorkCare is acknowledged to have been a failure, its problems informed the design of WorkCover and are reflected in many of the features of the present scheme. In particular, the strong focus on the return-to-work goal under WorkCover directly reflects the failure of WorkCare to achieve return to work for so many claimants. Concentration on incentive effects for authorised insurers results from the failure to adequately consider such issues under WorkCare. Dissatisfaction with both the private approach to workers' compensation (pre-1985) and the WorkCare approach (1985–1992) led Victoria to develop the mixed approach that we find today under WorkCover.

Part II – Legislative Evolution of WorkCover

The changes to the WorkCover system fall into three main categories. The first of these relate to the legislative changes representing the unfolding of the Government's WorkCover programme. The second category may be characterised as course correction legislation involving legislative intervention to influence developments that were seen to threaten the intended course of the WorkCover programme, or simply to fine-tune aspects of that programme. The third category may be characterised as consequential amendment legislation as particular provisions of the ACA were modified as a consequence of changes to other systems that impinge upon the operation of the workers' compensation scheme.

This typology does not constitute one of hermetic division; for instance, the Accident Compensation (Amendment) Act 1994, representing the third stage of the WorkCover programme, also contained significant corrective measures. There is, however, one measure that does not fit easily within any of these categories, namely the legislation that brought about the amalgamation of the occupational health and safety and workers' compensation regulatory functions in one agency. In the following analysis it will be discussed under the second category.

The following analysis, organised under these three headings, seeks to contextualise the various changes in respect of the development of, and pressures within, the Victorian scheme and, where apposite, other Australian developments. The major legislative initiatives (encompassed within the first two headings) have often entailed a myriad of changes. It has not always been possible to note every such change in the course of the analysis. However, an appendix to this chapter does provide a checklist of the salient changes wrought by these measures.

Implementation of the WorkCover Programme

Introduction

The incoming coalition Government in the enactment of the Accident Compensation (WorkCover) Act 1992 in November 1992 saw this as the first step in a more comprehensive

programme to overhaul workers' compensation arrangements in Victoria. As the Minister responsible for this portfolio area, Hon. Roger Hallam stated in his second reading speech on 13 November 1992:

“The reforms proposed in this Bill are the first part of a legislative reform process that fulfils the government's commitment to: adequately and fairly compensate injured workers; reduce the costs of workers compensation; make Victorian industry more competitive with other States; and make return to work, rather than compensation, the main objective of the scheme.

In future sessions of Parliament, measures will be introduced to: achieve a more competitive private sector delivery system; reform the pricing system so that employers with safe workplaces are adequately rewarded by a reduction in premiums; further improve the efficiency and effectiveness of workers compensation in Victoria; and privatise the scheme when its stability is assured.”

In later pronouncements by the Government and the Victorian WorkCover Authority, this process was further refined into a four-stage programme. The steps in this process were stated to be:

- Stage One: Overhaul of entitlements, benefits, and administrative structure (December 1992)
- Stage Two: Introduction of authorised insurers to the scheme, reforms to the pricing system, and commencement of occupational rehabilitation programmes (1 July 1993)
- Stage Three: Consolidation of the efficiency and effectiveness of workers' compensation (during 1993/94)
- Stage Four: Privatisation of workers' compensation when the scheme is fully funded and stable (within 3-5 years).

The Accident Compensation (WorkCover) Act 1992 constituted the first of the stages of the WorkCover programme, the Accident Compensation (WorkCover Insurance) Act 1993 addressed the second stage issue and the Accident Compensation (Amendment) Act 1994 can broadly be seen as effecting the third stage. The final stage of the programme was been put on hold, or perhaps even reverse, following the Government's reconsideration of the privatisation issue in the context of national competition policy. This latest area of development lies outside the scope of this report. However, for completeness, the Coalition Government's position on this

issue can be seen in the second reading speech to the Accident Compensation (Amendment) Bill 1998, where the Treasurer, Mr. Alan Stockdale, stated:

“In April 1995 all Australian governments agreed to implement the national competition policy and to adopt the guiding principle that legislation should not restrict competition unless it can be demonstrated that the benefit of the restriction to the community as a whole outweighs the costs, and the objectives of the legislation can only be achieved by restricting competition.

“The Government has reviewed the WorkCover scheme in the light of this principle. It considered whether the privatisation of the scheme would be the best way of giving effect to the national competition policy. The government’s conclusion was that, for social and economic reasons, WorkCover should not be privatised.

“It is the government’s view that the current model, which combines public risk bearing, centralised price setting, a centralised data base, and the regulatory oversight of occupational health and safety and rehabilitation, is the best way to deliver the government’s broader social and economic objectives set out in the legislation. The government believes that the benefits of any restrictions on competition outweigh the costs, and that the objectives of the scheme can be achieved most effectively by leaving the core responsibility for compensation of workplace injury and disease with the Victorian WorkCover Authority.”

Accident Compensation (WorkCover) Act 1992

Introduction

This measure was one of the first initiatives of the Liberal-National Party Coalition Government that came to power in a landslide victory in the October 1992 elections. The Accident Compensation (WorkCover) Bill was introduced into Parliament, and received its second reading, in the Legislative Assembly on 30 October 1992 and in the Legislative Council on 13 November 1992. It was assented to on 19 November 1992 and most of its substantive provisions commenced operation on 1 December 1992. (For a summary of provisions, see Table 2.3.)

It represented the new Government’s response to problems in the WorkCare system. These problems included the actuarial assessment that the scheme had an unfunded liability of \$1.9 billion as of 30 June 1992; an average levy rate upon employers of around 3 percent of

wages; and a return-to-work rate of around 60 percent. The latter compared to a rate of around 85 percent in neighbouring New South Wales. In the Government's view, the most fundamental shortcoming of the WorkCare system was its perpetuation of a "compensation culture." It saw the prime purpose of this legislative initiative, and the ongoing programme that it presaged, as the transformation of the compensation culture to a return-to-work culture. The alteration of the name from WorkCare to WorkCover was a symbol of this change.

Structural Basis of the Workers' Compensation System

This legislation completely transformed the structural and institutional bases of the WorkCare system, abolishing all the former bodies which had administrative authority in that system, and establishing a realigned system of relationships in the new WorkCover system. The Accident Compensation Commission (ACC), the Victorian Accident Rehabilitation Council (VARC), the Accident Compensation Tribunal (ACT), the WorkCare Appeals Board (WAB) and the Victorian Occupational Health and Safety Commission (VOHSC) were abolished. A new Victorian WorkCover Authority (VWA) was created and assumed the functions of both the former ACC and VARC. In the new system, the VWA was to be the body vested with general regulatory management of the entire scheme. With the abolition of the VOHSC, its operational arm, the Occupational Health and Safety Authority (OHSA), was folded into a new Department of Business and Employment. While the Government spoke of the OHSA's responsibilities for workplace risk management as being assumed by the VWA, in practice this change was to take a number of years to achieve.

In the area of contested claims resolution, the responsibilities of the former WAB were assigned to a new Conciliation Service, operating at arm's-length from the VWA with Conciliation Officers nominated by the Minister. As well, a system of Medical Panels was established to resolve disputes over medical issues. The matters formerly determined by the ACT were divided up between the County Court, the Magistrates' Court, and the Administrative Appeals Tribunal according to the nature and dimension of the dispute (see Chapter 6 for a full discussion).

Compensation Entitlement

The necessary employment connection to an injury, in order for such injury to be compensable under the workers' compensation system, has been contentious in most schemes at

one time or another. Across Australia, apart from Tasmania, there had been a move from the dual requirement of an injury “arising out of and in the course of employment” to one of “arising out of or in the course of employment.” The Government chose to tighten the definition of injury so that a worker’s employment had to be a “significant contributing factor” to the injury or its recurrence, aggravation, acceleration, exacerbation, or deterioration, and so provided a stronger employment connection for compensability.

In the 1940s, most of the Australian jurisdictions had widened the element of compensability by deeming injuries while travelling to and from work to be employment related. The Victorian legislation excised this element of coverage, although the compensability of “in the course of employment” transport injuries (for instance, truck and taxi drivers) remained unaffected. The Government argued that travel to and from work were not events over which an employer could exercise control, and that travel expenses were not recognised as an allowable work expense under Commonwealth income taxation legislation. Further, there was compensability for travel injuries under the Transport Accident Act 1986 in most cases.

Return to Work

As mentioned above, the Government saw the change from a compensation culture to a return to work culture as the central driving force behind its legislative initiatives in this area. It estimated that the comparative failure of the WorkCare system to achieve return to work rates relative to those of the New South Wales WorkCover scheme accounted for some 70 percent of the cost differentials between these two schemes.³² Accordingly, the legislation provided a number of initiatives—mostly patterned after the New South Wales legislation—to address the issue of return to work. These included measures directed both to employers and to injured workers.

The existing legislation had a requirement for an employer to hold an injured worker’s position open for a period of 12 months, and to provide suitable employment where the worker was not able to return to his or her pre-injury employment, unless the employer could demonstrate that it was not practicable to do so. The new legislation raised the maximum penalty

³²See Boston Consulting Group, Best Practice Research Program Policy Research Paper No. 1 (July 1992), and No. 2 (September 1992).

for noncompliance with this provision from \$15,000 to \$25,000 and changed the nature of the proviso from being “not practicable” to that of “not possible” to provide suitable employment.

Although VARC in its latter period of existence had begun to move toward workplace-centred rehabilitation activities, the new legislation, following the New South Wales example, placed primary emphasis upon workplace-based rehabilitation. It essentially obliterated the previous provisions governing rehabilitation and inserted a new Part VI, titled “Rehabilitation” into the act. However, this Part consisted only of one section outlining a system of occupational rehabilitation and risk-management programs. Much of the detail of such programs was left to regulations to be promulgated later, but the section set out a framework whereby employers (or at least those of more than a stipulated size) were required to develop an occupational rehabilitation plan for their workplaces.

The maintenance of benefit entitlement by partially incapacitated workers was contingent upon their engagement in “suitable employment” or making every reasonable effort to return to work in “suitable employment.” The definition of “suitable employment” inserted into the act was structured in term of work for which the worker was currently suited (whether or not that work was available). However, this had to take into account the nature of the worker’s incapacity and pre-injury employment together with a number of other factors, including his or her age, education, skills, place of residence, and any rehabilitation or vocational reeducation plan. Rejection of an offer of suitable employment constituted grounds for termination of benefits, as could a refusal to engage in rehabilitation or retraining.

*Benefits*³³

The new legislation provided for a significant restructuring of the benefit structure. This included:

- very substantial changes to the system of income replacement benefits, particularly linking benefit duration to work capacity;
- the reinstitution (with limits) of common law entitlement for pecuniary loss; and
- the institution of a new statutory no-fault payment for pain and suffering as well as some additions to the coverage of the existing “Table of Maims.”

³³A full discussion of benefits is found in Chapter 5.

Loss of Earnings Benefits.

In terms of benefits for loss of earnings, the bill provided for an enhancement of benefits for the more severely injured while quarantining ongoing entitlement for partial incapacity. During the first 26 weeks of incapacity, the benefit level was raised to 95 percent of pre-injury average weekly earnings (PIAWE), subject to a cap of \$603 a week less any notional earnings. After this 26-week period, ongoing benefit levels took on a trifurcated form. For workers adjudged to be seriously injured (the criterion being that of an injury which would rate an impairment assessment of 30 percent or more under the American Medical Association's *Guides to the Evaluation of Permanent Impairment*, second edition), benefits would be paid at 90 percent of PIAWE subject to a ceiling of \$603 a week. The second stream of the new trifurcated structure related to totally incapacitated workers, whose benefits would continue at 70 percent of PIAWE, again with the \$603 a week cap.

The more dramatic change came with the provisions for partial incapacity. For workers in this situation, the benefit level was 60 percent of the difference between the worker's PIAWE and his or her notional earnings, capped at \$362 a week less notional earnings. Notional earnings were defined as the greater of the worker's current earnings or those wages that it is determined that the worker could earn in suitable employment. Unlike seriously injured and totally and permanently incapacitated workers, it was provided that benefits for partially incapacitated workers would cease after two years. The two-year period provided a sharp and clearly demarcated answer to the question which most workers' compensation systems have to face in one shape or another; namely, what is the proper load that the employer-financed work-injury system should bear in respect of labour market failures.

In order to clear some of the existing long-term claims, particularly those of ongoing partial incapacity, the bill provided for what was described as "interim settlements." This was a limited opportunity, for a period of 6 months, for workers who had been in receipt of weekly payments for 12 months or more to enter into a voluntary agreement to accept a lump sum of up to \$10,000. Acceptance of such a payment acted to extinguish any future entitlement, both under the act and at common law, in respect of that particular injury. As a further inducement for

settlement, the bill provided for the payment of a sum of not more than \$200 for legal assistance in respect of securing such an interim settlement.

Common law.

While the initial plans for the WorkCare system involved complete abrogation of the common-law action, the ACA was enacted as a compromise measure to provide common-law damages only for nonpecuniary loss. The 1992 legislation reinstated damages for loss of earning capacity, subject to a threshold and a cap upon damages. The threshold condition involved a determination that the worker's injury would receive an impairment assessment of 30 percent or more under the AMA *Guides*, or that a serious injury certificate has been issued. As well, a court was precluded from awarding damages under either the pecuniary loss or the pain and suffering head of damages where the total damages (before certain reductions) was assessed as being less than \$29,860 for that particular head of damages. The legislation capped the damages payable in respect of pecuniary loss at \$671,960, for pain and suffering at \$184,740, and for a wrongful death action at \$500,000.

The new common-law provisions became applicable to injuries and deaths occurring on or after 1 December 1992. The legislation also mandated a regime for expedited filing and run-off of common-law claims under the previous common-law provisions, backed by a range of sanctions. A court was precluded from hearing such proceedings where the parties had not, within a stipulated period, attended a conference for settlement of the claim. If the matter did not settle at that conference and the damages awarded by a court were not more than 120 percent of the final settlement offer, then the plaintiff was required to pay the VWA's or self-insurer's costs as well.

Table of Maims and statutory pain and suffering payment.

The Table of Maims has been part of the Victorian workers' compensation system since the inception. It had remained almost totally intact until 1985 when it was extended to include impairments of the back, neck, and pelvis. The 1992 legislation provided for further coverage under the Table to include total loss of the power of speech, total loss of the sense of taste and/or smell, total loss of sexual organs, total loss of both breasts or of a single breast, and to allow for the recognition of severe facial disfigurement.

An innovation for the Victorian statute, although already in operation in New South Wales, was the introduction of section 98A, providing a statutory system of compensation for pain and suffering. This was linked to the Table of Maims in that a worker who was entitled to payments under the Table of at least \$10,000 could claim a lump sum pain and suffering payment of up to \$50,000. This payment was for actual pain or distress and anxiety suffered by the worker. It was intended to be scaled in proportion of the worker's condition.

*Dispute Resolution*³⁴

The changes to the dispute resolution framework provided for in the legislation represented a fundamental change in the dynamics of this process. Under the WorkCare system, workers whose benefit entitlements were challenged remained on benefits until the matter was determined at the WAB, provided certain conditions were met. Under WorkCover, this was reversed to provide that decisions to change or terminate benefits take effect after a specified notice period. A worker affected by such a decision could seek review by the Conciliation Service with this review being conducted by a Conciliation Officer.

The role of the Conciliation Officer was set out in the legislation in terms of "having regard to the need to be fair, economical, informal, and quick." Further, and having regard to the objects of the act, the Officer is to "make all reasonable efforts to conciliate in connection with a dispute and to bring the parties to agreement." (section 56(2)) The powers of the Conciliation Officer included those of making recommendations to the parties in dispute, and, in the case of disputes with respect to weekly payments, to issue directions for the payment or continued payment of weekly payments. These directions could be for a period of up to 12 weeks, as well as for a period of up to 10 weeks preceding the time of the direction. Legal representation at Conciliation Conferences was only allowed with the agreement of the Conciliation Officer and the parties to the dispute.

Disputes not resolved at the Conciliation Service could proceed to a more formal process of resolution. Previously this would have been before the ACT, but the legislation abolished this body and a more diffuse process of final resolution was substituted. This involved proceedings either in the County Court, the Magistrates' Court, or the Administrative Appeals Tribunal (AAT). The most general jurisdiction was given to the County Court, with the Magistrates' Court

³⁴ A full discussion of dispute resolution is found in Chapter 6.

largely having a subjurisdiction to the County Court in respect of matters involving sums of less than \$25,000. The major exception to the primary role of the County Court was the jurisdiction given to the AAT in respect to disputes relating to medical and like costs, the costs of rehabilitation services, disputes over contribution payments by insurers under the pre-WorkCare system, disputes over premium matters, and over occupational-rehabilitation and risk-management programmes.

The bill also provided for a system of Medical Panels of selected medical specialists to determine matters referred to them from Conciliation Officers, or the courts and the AAT, in respect of “medical questions”; a term that was broadly defined to include questions of diagnosis, treatment, and capacity for work. The findings of a Medical Panel were made binding upon the parties to a dispute and upon a court or tribunal in proceedings before that judicial body.

Jurisdiction of the Magistrates’ Court

As outlined above, the 1992 WorkCover legislation completely restructured the system of contested claims resolution. Under these changes, the County Court was the body vested with the greatest jurisdictional role, with the Magistrates’ Court essentially having a subjurisdiction to it in respect of matters involving sums of less than \$25,000. The changes were aimed at boosting the role of the Magistrates’ Court and effectively reversing the position of these two courts in terms of jurisdictional importance in the WorkCover system.

This was largely achieved through a redefinition of the existing jurisdictional limit of the Magistrates’ Court. First, it was stipulated that such limit did not include the value of an order made by a magistrate for the payment of weekly payments. Secondly, the 1992 changes imposed a 26-week limit on an order that a magistrate could make for the payment of weekly compensation. The Government contended that their intention was that such a limit should only apply to orders for the payment of weekly payments in arrears and was not to fetter a magistrate in making an order for the payment of ongoing weekly payments. Accordingly, the bill made this intention explicit and extended the limit to 52 weeks.

One of the major reasons for asserting the primacy of the Magistrates’ Court over the County Court for hearing of most matters not resolvable at the Conciliation Service was the lower cost scale operating in the Magistrates’ Court. To reinforce this position, the bill provided

that, in circumstances where proceedings were brought in the County Court and the resultant judgment or decision is one that could have been made in the Magistrates' Court, the costs awarded to the successful party would be those on the applicable Magistrates' Court scale.

Other Measures

The bill made a large number of other changes to the WorkCare scheme. Among these were a range of tougher antifraud measures, aimed at both claimants and service providers, and restricting the ability to issue initial medical certificates to legally qualified medical practitioners. This latter measure removed an earlier (and unintended) extension of this ability to chiropractors and osteopaths. As well, the employer excess in respect of meeting the costs of loss of earnings payments, which was previously set at 5 days, was extended to 10 days. However, this provision would only come into effect on 1 July 1993, when the changes to the premium system (to be dealt with in later legislation) would commence.

Accident Compensation (WorkCover Insurance) Act 1993³⁵

Introduction

As was noted above, when the Government introduced the first installment of the WorkCover programme in late 1992, it outlined further stages of development. The second stage was seen as involving the achievement of a more competitive private sector delivery system and reforms to the pricing system so that employers with safe workplaces were more adequately rewarded in their premium payments. The vehicle for accomplishing this second stage was the Accident Compensation (WorkCover Insurance) Bill 1993, a measure which received its second reading in the Legislative Assembly on 29 April 1993 and in the Legislative Council on 14 May 1993. It was assented to on 1 June 1993. (For a summary of provisions, see Table 2.4.)

As Minister Hallam's second reading speech stated, this measure "provides, generally, for the partial privatisation of WorkCover" and as the initial steps that "will pave the way for the full privatisation of WorkCover once it is stable and fully funded." To this end the legislation changed the legal basis of liability under the scheme from that of a system of fund liability

³⁵The insurance mechanism under WorkCover is described in full in Chapter 4.

(under which the employer premium payment was simply a contribution to the costs of the system) to one of individual employer liability (under which the employer premium payment provided actual indemnity against such liability). This element of employer liability, the Minister observed, was a key ingredient of (what was then perceived as) the successful New South Wales system.

In addition, the liability of the VWA (in its own right and as successor-in-title to the former ACC for injuries from the inception of WorkCare) was formally assigned to the authorised insurers. The practical import of this move was, however, less obvious as such liability (for past injuries, as well as for those incurred in the future) continued to be a collective or pooled responsibility, through the VWA providing a facility of 100 percent reinsurance for it. Nevertheless, effectively the only impediment to future privatisation was removal of this reinsurance mechanism.

Alongside the change in legal liability, there were three other major areas of change undertaken in the bill. The first is closely allied to the change in legal liability; namely, changes required as a result of the reconstituted role for insurers from being mere agents of the VWA to that of bodies with formal legal responsibilities within the scheme.

The second area of change related to the framework for a reformed premium system, based upon experience-rating principles. This new framework was seen as both more equitable in nature, through the effective elimination of cross-subsidies, and as contributing to safer and more return-to-work focused workplaces, through the device of relating premium costs more closely to actual claims costs.

The third major area related to developmental initiatives, such as providing for a form of group self-insurance for municipal bodies, and pump-priming concerns such as measures clarifying the role of the Magistrates' Court, the operation of indexation provisions in the act, and insurance arrangements pertaining to contractors.

New Insurer Arrangements

Under the WorkCare system and the initial WorkCover period, insurers were simply agents of the ACC/VWA providing, in the main, claims-handling and premium-collection services for the system administrator. The new system—which in formal terms at least, was designed to hand legal responsibility for scheme operations to the authorised insurers—required

statutory arrangements governing the licensing of the new WorkCover insurers. Accordingly, the bill contained provisions covering the process by which applications and reapplications to be an authorised insurer were made and determined. As well, a range of matters concerning insurer licences were dealt within the bill. These included issues such as the duration of licences (not less than one year and not more than two years) and the conditions that could be imposed in licences. Some examples are minimum and maximum market share, prohibiting delegation of claims management responsibilities, and the situations in which licences could be cancelled or suspended.

Part four of the bill dealt with the establishment by the VWA of a statutory fund for each authorised insurer. The premiums received by an authorised insurer, and any penalties and like payments in connection with WorkCover insurance, together with any investment income derived therefrom, were required to be paid into the insurer's statutory fund. However, as the VWA provided full reinsurance, such sums were required to be paid from the statutory fund into the WorkCover Authority Fund. Similarly, moneys paid by an authorised insurer, together with that insurer's management fees earned in accordance with the insurer's licence, were authorised to be paid out of the authorised insurer's statutory fund. Such payments were met by a transfer into the relevant statutory fund from the WorkCover Authority Fund.

One of the complications of a system of individual employer liability—a complication not found in one of fund liability—is that compensable claims from workers of uninsured employers cannot be paid unless there is a special fund from which such payments can be met. Accordingly, the bill established the Uninsured Employers and Indemnity Scheme, backed by the Uninsured Employers and Indemnity Fund, to deal with this situation. It also spelt out the sources of income for this Fund, the manner in which claims against it were to be dealt, and the recovery action that could be taken against the uninsured employer.

Changes to the Premium System

In February 1993, the VWA had released a discussion paper outlining the bases for a new premium system for public comment. Although the premium arrangements contained in the bill incorporated some changes in response to the more than 70 written submissions received in this consultation period, the system adopted overwhelmingly reflected the position outlined in the discussion paper. The major thrust of the new system was to remove the significant cross-

subsidies present in the former system. The WorkCare system consciously distorted the differentials between high-risk and low-risk industries, as the structure of the bonus and penalties system institutionalised an element of cross-subsidy between large and small employers.

The aim of the legislation was to produce conditions under which a new premium system, predicated upon the notion of a “true risk” premium, could be implemented; that is, one based primarily on the employer’s claims experience. Of course, the insurance principle dictated a certain insulation of individual employers from this process. The Government anticipated that the new system would have a significant impact upon the premiums paid by employers, particularly large ones.

The bill simply provided the framework for a new system, the essential details of which would be contained in regulations, in particular the annual Premiums Order. This framework gave legislative authority for matters that could be provided for in the Premiums Order and for the general structure governing the process of estimating remuneration, revised estimates, premium assessment, premium payment, and penalties.

In the second reading speech, the Minister also outlined the contours of the proposed arrangements that would be given effect in the Premiums Order. The new system was modelled upon, but went well beyond, that operating in New South Wales in terms of a resort to full experience rating. Whereas, in New South Wales, employers with a premium of \$2,000 or less were charged the industry rate, the new Victorian provisions included the experience of all employers in their premium calculation. However, while aimed at being responsive to the claims experience of employers, the system algorithms were devised to reduce the volatility of premium change on a year-on-year basis.

One of the problems with experience-rated systems is the propensity for gaming behaviour, based on claims coding to cost areas excluded from the operation of the system. In order to address this issue, it was provided that there would be no claims exclusions in the fully operational system, although for a transitional period the exclusions present in the former bonus and penalty system would continue to operate. Another measure to ease the transition to the new system, and particularly the premium impact upon smaller employers (who had enjoyed a greater cross-subsidy under the old system), was that of a remuneration deductible of \$15,000 for all Victorian employers.³⁶

³⁶ See Chapter 4 for more details on some of these provisions.

Municipal Group Self-Insurance

While group self-insurance is an important segment of the workers' compensation environment in the United States, in Australia it has been seen very little. Apart from some tentative initiatives in the 1996 Queensland legislative changes, it has only been sanctioned in a few Australian jurisdictions for the municipal employers. The initiative in the bill thus fell within this restricted Australian tradition, although the Minister in his second reading speech did state that this initiative was a precursor to the wider liberalisation of the existing self-insurance arrangements.

The bill approved the Municipal Association of Victoria (MAV) to establish a local government group self-insurance scheme for the benefit of the MAV and participating local government corporations (a term encompassing municipal councils, water boards, and similar bodies) on terms and conditions determined by the MAV. In line with then-existing provisions for individual self-insurers, the MAV could not apply for such recognition unless its proposed scheme covered at least 1,000 workers in Victoria. In addition, the bill made a range of performance requirements for applications for individual self-insurance (such as resources for claims administration) also applicable to an application by the MAV.

Other Matters

The bill addressed a number of other matters where recent experience had demonstrated that the legislation needed some fine-tuning. One such example concerned the indexation provision in the ACA, under which various amounts provided for in the act were annually adjusted according to a stipulated formula. Such a provision had been in the ACA since its inception; the motivation for its inclusion being the inflationary experience of the 1970s and early 1980s in which the value of workers' (unindexed) compensation payments had been seriously eroded by inflation. What was not foreseen was that, under certain economic conditions, the indexation provision could operate to actually reduce compensation payments. To avoid this eventuality, the provision was amended to include a rider that, where such a reduction would result from the application of the formula, the variation was deemed not to have taken effect.

Among further amending provisions of this nature were those clarifying the relationship between a principal contractor and a subcontractor, where the subcontractor was not a worker,

for workers' compensation purposes. It provided that, while such subcontractors were required to have workers' compensation insurance coverage for their workers, liability for an uninsured subcontractor would be assumed by the principal contractor who would retain recovery rights against the subcontractor in respect of any claims.

Accident Compensation (Amendment) Act 1994

Introduction

The opening words of the second reading speech for the Accident Compensation (Amendment) Bill 1994 were that “[t]his bill constitutes the third stage of the government’s four-stage reform program for workers compensation in Victoria.” This measure was seen as fulfilling the consolidating role mapped out for the third stage, in particular, streamlining existing provisions in areas such as claims management and the VWA’s administrative responsibilities. As well, it looked to making a contribution toward greater national consistency in workers’ compensation in Australia. Additionally, the measure set about addressing particular problems in scheme operations, such as an emerging issue with respect to hearing-loss claims.

The Accident Compensation (Amendment) Bill 1994 received its second reading in the Legislative Assembly on 31 March 1994 and in the Legislative Council on 3 May 1994. It was assented to on 15 June 1994. Its provisions came into effect on varying dates, but significant proportions of these provisions commenced on 15 June 1994 and 1 July 1994. (For a summary of provisions, see Table 2.5.)

Notional Earnings

A continuing area of debate in many workers’ compensation systems, as they grapple with the proper relationship with general labour market conditions, is whether to apply notional or deemed earnings provisions and if so, how. The ability to apply notional earnings was provided for in the WorkCover system. It was not a live issue due to the directions given by the Minister that this measure would be used only in exceptional circumstances. This bill attempted to clarify the role of notional earnings in the system—described by the Government as a “reserve power”—in a manner that reflected this intention.

Essentially, the position taken was that notional earnings would not be applied in circumstances of either employer default or of worker cooperation. The bill provided that notional earnings would not be taken into account in the calculation of a worker's weekly payments for a period not exceeding 104 weeks in total under two sets of circumstances. First, it would not be considered where the employer has failed to provide the worker with suitable employment, and where the worker complied with the requirements relating to returning to work in suitable employment. Secondly, it would not be utilised if the worker was participating in an occupational rehabilitation programme or a return-to-work plan.

Industrial Deafness

While one of the achievements of the WorkCover system claimed by the Government was the significant reduction in the number of reported claims, a striking exception to this was the number of hearing-loss claims. Whereas hearing-loss claims comprised around 15 percent of all claims in 1992/93, a year later such claims represented almost 30 percent of total claims. This increase was, in large part, attributable to the emergence of a number of companies actively involved in the direct canvassing of workers to lodge hearing-loss claims, with two companies being associated with two-thirds of such claims settled. Most of these claims were for relatively minor degrees of hearing loss, at a level generally below that for which hearing aids would be necessary, with little impact upon the worker's life. In a substantial number of cases, the administrative costs associated with processing these claims exceeded the compensation received.

To address these issues, the bill introduced a threshold criterion for compensability for hearing loss of 7 percent loss of binaural hearing. This threshold applied to all claims lodged on and after midnight on 31 March 1994, the date of the second reading of the bill in the Legislative Assembly. The rationale for the 7 percent binaural hearing threshold was that, according to medical opinion, this was the level below which a hearing aid was not required. In terms of fairness, the Government pointed to the 10 percent and 20 percent thresholds operating in the Western Australian and Comcare schemes, respectively.

As well as introducing the threshold, the bill tightened up the structure and process for testing for hearing loss. It provided for the formal adoption of the 1988 National Acoustic Laboratory (NAL) binaural tables as the testing instrument and also for the manner of hearing-

loss assessment. In addition, it stipulated that only persons approved by the Minister, upon the recommendation of the Convenor of the Medical Panels, could be authorised to undertake these assessments. The Government also decided that the costs for below-threshold hearing-loss claims would be exempted from the calculation of employer premiums and made applicable to confirmed premiums for 1993/94.

Conciliation

The bill introduced changes to further strengthen the role of the Conciliation Service. These changes were consistent with the overall thrust of the Government's approach to have matters resolved as quickly, simply, and inexpensively as possible. The Conciliation Service had experienced strains and pressures in the initial stages of its operation. As well as being a new organisation established from scratch, it had to deal with a backlog of cases from its predecessor, the WorkCare Appeals Board, as well as disputes arising from features of the transition from WorkCare to WorkCover. In its first year of operation it conciliated more than 14,000 matters, and the backlog of cases had been reduced from some 7,200 to about 2,000 at the time of this legislation. It was anticipated that by June 1994 the Conciliation Service would be achieving its target of a 28-day turnaround of cases. This resolution period compared with delays of three months and five to six months at the Magistrates' and County Court, respectively.

Having reached this level of stability in terms of throughput, it was adjudged that it was now opportune to further strengthen the role of the Conciliation Service. The Service was resolving three-quarters of the matters referred to it at an average cost of around \$500 per case, compared with a figure of around \$3,000 a case in the Magistrates' Court and \$5,000 in the County Court. Accordingly, the legislation aimed to ensure that matters that were capable of resolution at the Conciliation Service did so rather than unnecessarily proceed through the court system.

The bill provided that contested matters (other than death, maims, and statutory pain and suffering claims) could not be the subject of court proceedings unless they had been referred to conciliation. Court proceedings could not commence until after 28 days had expired from the referral to conciliation, or a Conciliation Officer had issued a certificate declaring that all actions relating to the conciliation of the relevant dispute had been taken, whichever was the earlier date. As well, the bill made it a requirement that applications for conciliation had to be signed by the

applicant personally as a check against litigation being undertaken without the knowledge of the applicant. The Government also undertook to monitor closely the operation of these changes to see if it was found that lawyers had engineered means of bypassing the conciliation process as a means for ensuring the payment of legal costs.

Common Law

One of the features of the initial WorkCover legislation in 1992 was to effect a number of changes to the system of common-law entitlements. One was aimed at limiting the time for bringing proceedings at common law in relation to WorkCare injuries or deaths. Thus, proceedings in respect to injuries or deaths arising prior to 1 September 1992 could not be commenced on or after 1 December 1992, while proceedings in respect of injuries or deaths arising between 1 September 1992 and 30 November 1992 could not be commenced on or after 1 March 1993.

However, these limitation measures were found wanting by the Supreme Court in the case of Jim Isaac Robart v Matchplan Pty Ltd (In Liquidation) (No. 7267 of 1993). To reestablish the position that the Government had intended in 1992, namely the bifurcated regime for common-law entitlements according to section 135B (for pre-1 December 1992 injuries and deaths) and 135A (for injuries and deaths after that date), the bill allowed for the commencement of common-law actions in respect to such injuries or deaths up until, and including, 30 June 1994. The bill also made some technical amendments to sections 135 and 135A regarding post-1 December 1992 injuries and deaths.

In Victoria, there is an extended no-fault (and modified common-law) system for transport injuries which has a number of parallels with the workers' compensation system. In some areas in particular, such as the nature of benefit structures, it has been common practice to maintain substantial parity between these two systems. This bill increased the cap upon damages for nonpecuniary loss under the WorkCover system from \$184,740 to \$298,640 in line with the situation under the Transport Accident Act 1986.

Table of Maims Procedures

The bill brought in new procedures for dealing with Table of Maims (section 98) and the statutory pain and suffering (section 98A) claims. These procedures drew upon the model

adopted in the settlement process for the run-off of WorkCare common-law claims under the 1992 legislation. It now required that claims under both section 98 and 98A be accompanied by medical information supporting the entitlement to compensation, and specifying the extent of the loss, impairment, disfigurement, or pain and suffering. A decision upon liability had to be made, and the claimant notified, within 60 days of the claim being received. If the claimant disputed this decision, the claim was to be referred to a Medical Panel for an opinion as to entitlement to compensation, and the extent of the relevant loss, impairment, disfigurement, or pain and suffering. A final offer in settlement of the claim had to be made within 14 days of receipt of the opinion of the Medical Panel, and such an offer had to be consistent with the opinion of the Medical Panel. If such an offer was not made within this period, a final offer of nothing was deemed to have been made.

Only after these procedures had been completed could a claimant institute court proceedings. Reminiscent of the common-law run-off procedures—where a claimant disputed the final offer in court proceedings, and the amount of the court judgment or order was for less than 120 percent of the final offer—the claimants had to pay their own costs and those of the defendant.

Self-Insurance

Apart from Queensland, which had maintained (until 1996) a complete ban upon self-insurance, Victoria had the most stringent entry requirements for companies wishing to apply for self-insurance status. The 1985 WorkCare changes had imposed a dual threshold requirement of at least 1,000 workers employed in Victoria and net assets of at least \$200 million.

The bill provided for a partial liberalisation by reducing, from 1,000 to 500, the required number of workers that had to be employed in Victoria. As well, following on the recognition of a limited form of group self-insurance for the municipal sector in the 1993 changes, this bill provided that applications for approval as a self-insurer could be made by partnerships or limited partnerships that met the threshold criteria.

An important aspect of the regulatory oversight of self-insurance arrangements relates to the appropriate financial guarantees that a self-insured employer should be required to post, in case the employer becomes financially insolvent. Formerly the Victorian scheme required that a bank guarantee in favour of the VWA be maintained to the level of the actuarially assessed value

of the self-insured employer's outstanding claims liability. However, experience of a failed self-insurer in South Australia indicated that such a provision might be inadequate. The bill increased the amount of security required to be posted to one and one-half times the level of the actuarially assessed outstanding claims liability.

Administrative Responsibilities and Arrangements

The bill made a number of changes to the arrangements under which responsibilities for various functions under the scheme were discharged. The VWA's responsibilities for the determination of payments for the dependents of deceased workers were transferred to the County Court. Also, its responsibilities for the administration of certain funds, including those for minors in respect of death, maims, and statutory pain and suffering benefits were transferred to the State Trust Corporation of Victoria (STCV). The transfer of funds administration to the STCV applied to awards made after 1 July 1994. While the VWA retained administration of funds relating to awards made before that date, the administration of such funds would also transfer to the STCV at a future date.

The bill also rationalised the reporting requirements placed upon the VWA. These had involved providing quarterly reports to government as well as twice-yearly actuarial reports, which included separate independent valuations of the scheme's operations. The Government adjudged that the cost of this reporting regime could not be justified, particularly given the satisfactory nature of WorkCover's performance and its independent, commercially focused board. Accordingly, the bill provided for a new regime under which the VWA would submit a half-yearly operating and financial report to the Minister, in addition to its statutory annual reporting requirements. The half-yearly reports would become publicly available within 14 days of their presentation to the Minister.

Scheme Coverage

The distinction between workers and independent contractors (sometimes expressed in terms of a contract of service as against a contract for services) as a division for scheme coverage has, in all workers' compensation systems, been a difficult one to operationalise. Two such instances were addressed in the bill. First, it stipulated that direct sellers (e.g., Amway and similar distributors) were not workers for the purposes of the scheme. The Government asserted that the arrangement between direct sellers and their suppliers was far removed from the position

of a contract of employment, and their position as independent contractors had been (verbally) recognised by the previous Labor Government.

Secondly, due to older Anglo-Australian jurisprudence as to the status of public servants and other Crown employees, it was customary for workers' compensation legislation to make special provision for the coverage of such persons. With the development of various public corporations and similar administrative bodies, coverage was extended to persons involved with such entities. However, the statutory wording could encompass within its reach local government councillors—persons elected to the governance of municipal bodies in an unpaid (or payment extending only to the reimbursement of expenses) capacity. The bill excluded such councillors from scheme coverage, a position supported by the peak municipal body, the Municipal Association of Victoria.

Harmonisation of Australian Workers Compensation Arrangements

The issue of harmonisation of workers' compensation arrangements is a recurrent issue in the various federal systems in which these schemes operate. Sometimes the issue arises in the political context of trying to assure basic minimum national standards, particularly in the area of entitlements and benefits. This was the impetus behind the National Commission on State Workmen's Compensation Laws in the United States that reported in 1972. In other contexts, the driving issue is that of rationalising arrangements, to allow a more cohesive interface between schemes, or to reduce the capacity for shopping of claims.

Due to a highly public standoff between the Federal Labor Government and the State and Territory Governments (all but one of which was non-Labor in composition), both these issues had come to the fore. The Federal Government was concerned about State and Territory schemes shifting costs to the Federal social security and medical insurance systems. Also, in conjunction with business interests, it was interested in securing a more consistent national framework of workers' compensation arrangements. The State and Territory response was to task the Heads of Workers' Compensation Authorities (HWCA), the body representing the chief executives of the 10 Australian workers' compensation schemes, to develop a programme of national consistency in key elements of workers' compensation operations. The expectation was that the State and Territory Governments would then implement this programme according to an agreed timetable.

Two areas in which early progress was made in this programme were in respect to a national antifraud strategy and in the rationalisation of cross-border entitlements. The Victorian bill contained provisions addressing both these areas. In respect of antifraud activities, it amended the existing secrecy provisions in the act to allow disclosure to other workers' compensation authorities of information relevant to the antifraud activities of those other bodies.

In relation to jurisdictional entitlement to compensation, the HWCA had agreed upon an approach that the Victorian legislation was the first to implement. This approach enshrined the principle that compensation entitlement should be determined by the worker's principal place of employment. In situations where the principal place of employment could not be ascertained (for instance, interstate truck drivers regularly traversing the three eastern seaboard states), entitlement should be determined by the jurisdiction of the employer's principal place of business. The bill also provided some principles to assist the determination of the issue of the worker's principal place of employment. These were that regard be made to worker's work history and the intention of the worker and employer, and that regard not be made to temporary work arrangements in another jurisdiction not exceeding six months' continuous duration.

In order to facilitate the orderly implementation of a national approach to jurisdictional entitlement to compensation, this provision in the bill was not intended to be brought into effect until all State and Territories had legislated in a similar manner. When this was achieved, all jurisdictions would implement their measures on the same date.

Further Incentives to Return to Work

One of the consistent themes of Government pronouncements on WorkCover has been the need to change from a compensation culture to a return-to-work culture. An important feature of encouraging, or perhaps more correctly not discouraging, return to work is the manner in which the system treats income earned in a graduated return to work. If there is a dollar-for-dollar reduction, there is no financial incentive to return to work. Accordingly, the arrangements in this bill provided for forty cents of every dollar of income earned by workers engaging in a part-time return to work to accrue directly to them. It was estimated that under the new arrangements a worker capable of earning \$300 a week would be better off by \$120, while the compensation payment funded by the employer would be reduced by \$180.

Corrective Legislation

Introduction

As has been observed elsewhere in this report, the Victorian Government has shown a strong readiness to intervene to correct trends that threaten the course and intended direction of the WorkCover programme. However, the first measure of this nature did not emerge until three and one-half years into the operation of the WorkCover system, in the form of the Accident Compensation (Amendment) Act 1996. It took action in two areas that were also to feature in subsequent, corrective legislative intervention. The first of these was in respect of what was seen as the inappropriate use of the County Court, rather than the Magistrates' Court, as the forum for the resolution of minor contested disputes. The implication was that this choice may have been influenced by some solicitors attempting to maximise their fees.

The second was in relation to the activities of a small, highly entrepreneurial group of providers in the field of hearing-loss aids and appliances. Indeed, this group of providers was one of the targets of the second piece of corrective legislation, the Accident Compensation (Further Amendment) Act 1996, a measure that entered the statute book less than six months later. The other main change of this nature that was brought about by this statute related to the assessment of impairment in respect of psychological or psychiatric conditions arising as a consequence of, or secondary to, a physical injury.

Finally, the Accident Compensation (Miscellaneous Amendment) Act 1997 constituted the most controversial piece of legislation of the WorkCover programme since the initial 1992 changes with its abrogation of the right of an injured worker to recover damages at common law. However, while the latter two measures raised considerable public debate and controversy, particularly in relation to impairment assessment and common law, they were not solely directed to this end. Indeed, other provisions contained within them represent some of the more innovative pieces of scheme development in the history of the WorkCover programme.

Before turning to these measures, however, it is necessary to consider an earlier statute, the Accident Compensation (Occupational Health and Safety) Act 1996, that effected the merged responsibility of the VWA for the regulation of both workers' compensation and occupational health and safety.

Background

The Accident Compensation (Occupational Health and Safety) Bill received its second reading on 30 May 1996 in the Legislative Assembly and on 20 June 1996 in the Legislative Council. It was assented to on 28 June 1996 and the substantive measures contained in it took effect on 2 July 1996. (For a summary of provisions, see Table 2.6.)

The integration of health and safety and workers' compensation functions within a single body was not unexpected. It took place against a backdrop of debate about the role of occupational health and safety and its relationship to workers' compensation. That there should be greater integration between these two systems was given voice in the federal Industry Commission report on *Work, Health and Safety* as well as by the Victorian Auditor-General.

From the mid 1980s, there had been a growing trend in Australia to linking these responsibilities in a single agency. This began with the Northern Territory Work Health reforms in 1986 and, a decade later, this full integration model operated in New South Wales, the Australian Capital Territory, and in the Comcare scheme for federal public sector employment.

Even before the July 1996 legislation, the VWA had begun to take a strong focus upon injury prevention and occupational health and safety issues. This was manifested in its "Safety, Think it, Talk it, Work it" advertising campaign, in a number of initiatives in selected industries such as the Trucksafe programme, and in a targeted regional injury prevention intervention in the Ballarat area. Within the VWA it was believed that health and safety represented the next frontier, i.e., that considerable synergies might be found through harnessing an insurance system's database. This view was strongly expressed in the Minister's second reading speech where he referred to "the synthesis of the elements of health and safety, workers' compensation and rehabilitation" to provide "a more structured and targeted approach to research, employer best practice and information programs aimed at improving the health, safety and wellbeing of all Victorians."

³⁷A discussion of occupational health and safety is found in Chapter 8.

Legislative Approach

The July 1996 legislation was largely technical in nature. It left the existing statutory framework for the regulation of health and safety in Victoria intact and was concerned with making the necessary changes to the ACA to enable the transfer of functions. The changes to the ACA aimed to ensure that the act provided the requisite legislative authority and power for the VWA to legally take on various tasks being given to it and to be appropriately accountable in its administration of these tasks. To this end the objectives and powers of the VWA needed to be suitably augmented, as well as ensure that the VWA's Ministerial accountability extended to this new role.

In an operational sense, the major change to the ACA related to details concerning the WorkCover Authority Fund. Provision had to be made for the handling of a range of penalties recovered and fees payable under the various health and safety statutes. As well, there needed to be provision to receive any amount certified by the Treasurer, after consultation with the Minister, as a contribution from the Consolidated Fund to the costs and expenses of the administration by the Authority of the particular health and safety statutes. On the other side of the ledger, it was necessary to provide for the payment of moneys from the WorkCover Authority Fund for purposes required by regulation and that land or buildings owned by the VWA could be used in its administration of the health and safety legislation.

The regulatory structure of health and safety was left largely intact. The major contentious issue revolved around the transfer of staff from the Department of State Development to the VWA. The mechanism employed by the July 1996 legislation involved a written designation by the Minister of those persons who were to transfer to the VWA. The basis of transfer was that the transferring staff were to be employed by the VWA on the same basis as it employed its existing staff, and on terms and conditions determined by the Minister to be no less favourable than the existing conditions enjoyed by the transferees. The transferees would retain their superannuation and accrued leave entitlements. However, with the transfer staff ceased to be officers or employees of the public service. The bill also contained a provision precluding the Supreme Court from adjudicating the matter that no entitlement to compensation lay in respect of a person ceasing to be a public servant by virtue of the transfer.

The balance of the July 1996 legislation involved highly specific changes to the Dangerous Goods Act 1985, the Equipment (Public Safety) Act 1994, and the Occupational

Health and Safety Act 1985. The main substantive measure authorised a health and safety inspector to take affidavits for any purpose relating to or incidental to his or her role as an inspector.

Accident Compensation (Amendment) Act 1996

Introduction

The Accident Compensation (Amendment) Bill received its second reading on 16 May 1996 in the Legislative Assembly and on 5 June 1996 in the Legislative Council. It was assented to on 25 June 1996.

The targeted areas were the dispute resolution system, the activities of some allied health service providers, and employer compliance with their obligations under the scheme. A second corrective purpose was to clarify and give full effect to the government's original intentions in respect to the common law changes made in 1992.

The legislation sought to support the return-to-work goals of the scheme by modifying the wording of the provision governing entitlement to weekly compensation. The legislation also extended coverage under workers' compensation to persons engaged in federal government training programmes.

Maims Claims and Dispute Resolution

Claims for lump sum compensation for permanent impairment under the table of maims and payments under the statutory pain and suffering provisions had emerged as a major issue for the workers' compensation regulator in both Victoria and New South Wales. In the latter jurisdiction, a significant increase in the number of these claims constituted a substantial feature of the cost blow-out in that scheme. In Victoria, these claims were a major contributing factor to the backlogs being experienced at the Medical Panels and at the County Court. The Government believed that the growth in these claims was associated with the drying up of common-law work for lawyers and a consequent transfer of the focus of legal activity. The Government was concerned also with the transaction costs (mainly legal costs) associated with these lump sum payments. It estimated this cost to be approximately 60 cents for the delivery of \$1 in compensation benefit.

These concerns coalesced with those about the appropriateness of the court forum being utilised in contested matters generally. In the six-month period from March to August 1995, 59 percent of County Court writs were resolved for amounts that fell within the Magistrates Court jurisdictional limit of \$25,000. This resulted in delays and in higher costs, with an average cost of \$3,500 for a Magistrates' Court case compared to that of \$7,000 for a County Court matter. In 1995, around 1,600 WorkCover matters were lodged in the Magistrates' Court compared to around 2,400 such matters at the Melbourne County Court. However, whereas in this period the Magistrates' Court resolved around 2,300 WorkCover cases, only about 880 such matters were finalised in the County Court. It was hypothesised that the choice of the court was driven by the higher legal fee scale operating in the County Court. The legislation introduced changes to address both the concerns about the transaction costs associated with lump sum compensation and with the choice of legal forum for contested matters.

Lump sum compensation.

The bill contained a range of provisions directed to achieving a quicker and less litigious resolution of lump sum maims and statutory pain and suffering claims. First, it required that a claimant for such compensation must include with their claim a copy of all medical reports upon which he or she intended to rely. The insurer or self-insurer must also provide his or her medical reports at the time of the offer of compensation. Secondly, where a claimant disputed the decision made in respect of his or her claim, it required that the matter go to conciliation. Further, no court proceedings could commence until the Conciliation Officer issued a certificate certifying that all reasonable steps had been taken by the claimant to resolve the dispute. Third, it retained the discretion in Conciliation Officers to refer medical questions to a Medical Panel, but removed the existing compulsory referral of lump sum compensation claims to Medical Panels before they could be taken on to the courts. Fourth, where such a matter was not resolved at conciliation, the insurer or self-insurer was required, within 14 days of a Conciliation Officer's certificate being issued, to make a final offer, with such offer being consistent with any opinion from a Medical Panel. Finally, a new section 104A was inserted that empowered the Minister to issue directions governing the procedures for the resolution of disputes in relation to claims for lump sum compensation, with these directions being binding on all parties and their representatives.

Jurisdictional limits.

The legislation increased the jurisdictional limits of the Magistrates' Court in respect of lump sum compensation from \$25,000 to \$40,000 and, in relation to weekly payments, from 52 to 104 weeks of arrears of payments. It provided that in any proceedings before the County Court whose outcome could have been achieved in the Magistrates' Court, any party-party costs payable to the claimant would be at the relevant scale of costs operating in the Magistrates' Court. Additionally, a new section 50A was inserted which allowed significant cost penalties to be ordered against a legal practitioner, who, without reasonable cause, instituted proceedings in the County Court that should have been brought in the Magistrates' Court. Penalties would also be levied against a practitioner whose actions caused costs to be incurred improperly through a misconduct or a lack of. The County Court could order a range of cost penalties against the practitioner, ranging from repayment to the client of any money paid on account of costs to payment by the legal practitioner of all legal costs in the matter.

Hearing-Loss Services

There had been growing concern about the activities of a small group of firms that had been aggressively marketing their services for hearing-loss testing and the provision of hearing aids and other appliances. These activities had included telephone marketing and the stationing of caravans with test equipment outside factory gates. The concerns about such operators included the prospect of further hearing loss and injury as the result of the supply of substandard and inappropriate hearing aids and appliances and the fitting of such aids by poorly skilled and untrained persons. The bill amended the definition of "medical service" so as to better control the benefits for hearing aids and limit those who could prescribe them. The law also placed limits on the persons who could test for hearing impairment.

Employer Compliance

An obligation of an employer is to provide a worker who is no longer incapacitated for work with employment equivalent to that which he or she undertook prior to their injury or, where the worker has a degree of incapacity, suitable employment consistent with their work capacity. In recognition of the nature of employment conditions (e.g., very small employers), this obligation was qualified by the stipulation that it did not apply where it is impossible for the

employer to do so. However, in the absence of any procedural framework in respect of this employer obligation, there were difficulties for the regulator in securing compliance.

Consequently, the legislation inserted a further provision outlining a process whereby the VWA provided written notice to an employer of its intention to file charges against the employer for failing to comply with its obligations in this area. The employer is given 60 days after the service of the notice to demonstrate to the VWA's satisfaction that it is not possible to comply.

The legislation also strengthened the regulator's enforcement powers in cases of employer noncompliance in other ways. A new section, 250A, provided for directors and officers to be held liable for offences against either the ACA or the WorkCover Insurance legislation that are committed by a corporate entity, where the offence was committed with the consent or connivance of the director or officer, or where the commission of the offence was attributable to any willful neglect of the director or officer. As well, the bill extended the time limits for prosecution of a range of employer offences from one year to three years, bringing them in line with other like provisions in the act.

Common Law

The interplay between legislature and judiciary concerning the purport and effect of the Government's 1992 changes to the system of common-law damages entitlement became a recurrent feature of the history of the WorkCover scheme. The bill contained a number of provisions designed to strengthen the Government's original aims with respect to the common law provisions in the ACA and, specifically, to overturn the interpretation of these provisions given in recent decisions by the Victorian Supreme Court and Court of Appeal.

The bill amended section 135A of the ACA to make it clear that, except as provided in the amended section, a worker must not commence common-law proceedings to which section 135A applies without first obtaining a determination of the degree of his or her impairment from the VWA or an authorised insurer or self-insurer. This was in response to the decision of J. Ashley in Bowles v Coles Myer, [1995] 1 V R 480, to the effect that common-law proceedings could be brought under section 135A without the impairment thresholds being satisfied. The decision in Bowles was approved by the Victorian Court of Appeal in Hanrahan v Davis (unreported, 10 May 1996).

Section 135A was amended to prevent a determination that a serious injury existed under section 93B of the ACA (that is, in respect to ongoing entitlement to weekly payments) from being used to determine impairment for purposes of section 135A, unless the initial decision specifically so stated. This further amendment was to overcome the decision by the Court of Appeal in Hanrahan.

Determining the Limits of Partial Incapacity Payments

As legislation then stood, a worker's entitlement to weekly compensation ceased after the worker had been *incapacitated* for a period of 104 weeks, unless the worker had a serious injury or was totally and permanently incapacitated. This formulation was to act as a disincentive to return to work, particularly on modified or alternative duties, and hence militating against one of the cardinal goals of the scheme. Accordingly, the bill amended this entitlement provision to now provide that such entitlement would cease after the expiration of an aggregate of 104 weeks (whether consecutive or not) in which a *weekly payment has been paid or is payable* to the worker, unless the worker has a serious injury or is totally and permanently incapacitated. This reformulation was seen as removing any perceived disincentive for partially incapacitated workers to return to work on alternative duties during the rehabilitation process.

Coverage of Workers

The bill provided for a mechanism whereby the Governor in Council could, by order, recognise and declare particular government training programmes, and specify a class of payments as deemed remuneration for such programmes. The trainees involved in a recognised programme would be deemed to be workers employed by the persons providing the workplace-based training. While the Governor in Council mechanism would be the applicable mechanism for other programmes, the legislation recognised the Landcare and Environment Action Program and the New Work Opportunities Program, both conducted by the Commonwealth Government, to be declared training programmes. The Commonwealth Government had agreed to finance the insurance cost for trainees in these programmes, at the relevant industry rate, for the duration of the programme.

Access to Certain Funds Without Affecting Benefits

WorkCare had introduced a measure that provided workers' compensation weekly payments offset by specified other payments (e.g., ill-health disability payments under an individual worker's occupational superannuation scheme). This was in order to prevent some workers from receiving benefits that exceeded their pre-injury earnings. In response to criticism, the bill allowed workers to access amounts of these other payments that represented their own contributions, where the accessed amount was used for the purposes of an "approved capital expenditure" according to guidelines issued by the VWA, without affecting their workers' compensation weekly payments. As well, the opportunity was taken to completely redraft section 96, governing the interaction with other benefits, to clarify the effect of the receipt of other particular benefits upon a worker's entitlement to workers' compensation weekly payments, and to provide for a reporting mechanism for such other payments.

Accident Compensation (Further Amendment) Act 1996

Introduction

The Accident Compensation (Further Amendment) Bill received its second reading on 14 November 1996 in the Legislative Assembly and on 4 December 1996 in the Legislative Council. It was assented to on 17 December 1996. (For a summary of provisions, see Table 2.7.)

Apart from measures providing greater flexibility and responsibility to employers in the areas of self-insurance and agency arrangements, this legislation has a strong element of regulatory control over problematic areas. This can be seen in the provisions drafted in response to unscrupulous agent behaviour in respect to hearing-loss claims and in those changes to the assessment of impairment directed to psychological or psychiatric conditions arising as a consequence of, or secondary to, a physical injury. Many of the measures set forth in this legislation broke new ground, such as the proposal for the payment of lump sums by installment, and the provisions in respect of coordinated care programs.

Assessment of Impairment

The act made some significant changes to the system of impairment assessment. Before this legislation, the ACA mandated that the assessment of impairment must be made according to

either the second edition of the *AMA Guides to the Evaluation of Permanent Impairment* or a subsequent prescribed edition of those guides.

The new section provided that assessment of impairment may be undertaken according to regulations prescribing the methods of assessment. If no such regulations are in force, then the assessment will be made according to the second edition of the *AMA Guides*. The Minister may issue operational guidelines for the use of the prescribed methods, or of the *AMA Guides*, and require that the assessment be undertaken by medical practitioners who have successfully completed a training course, approved by the Minister, in the application of the appropriate instrument.

More controversial, under the new section 91, there must be no regard to any psychiatric or psychological injury, impairment, or symptoms arising as a consequence of, or secondary to, a physical injury. Presumably in order to avoid a sudden rush filing of claims, the commencement of this change was made with effect from the day of the second reading speech in the Legislative Assembly, namely 14 November 1996. This restriction was motivated by the increasing number of workers who were able to obtain a “serious injury” classification by adding a psychiatric impairment rating to one for physical impairment to achieve the 30 percent threshold.

The view expressed in the second reading speech was that the action taken in the legislation was necessary “to ensure that the classification of serious injury remains within the bounds originally envisaged by the government.” The Government was careful to point out that the move did not affect situations where there is a direct relationship between the psychiatric condition and the work injury, such as a bank teller traumatised as the result of a bank robbery.

Lump Sum Payments for Maims and Pain and Suffering to be Paid by Installment

Lump sum compensation is seen by some as militating against effective rehabilitation and return-to-work outcomes. As well, some studies have reported cases of the lump sum payment being badly managed or dissipated. These views were also expressed in the second reading speeches in explaining the rationale for setting limits on lump sum payments for benefits under sections 98 and 98A. If a worker dies before all installments due to him or her are made, the worker’s personal representative can apply for payment of the amount of outstanding installments.

Self-Insurance and Self-Management

The legislation contained a series of measures directed toward developing greater employer responsibility and involvement in workplace safety and claims management. These included important changes to the threshold requirements for self-insurance and in the introduction of agency arrangements, whereby employers who are unable or unwilling to take on the financial responsibility entailed with self-insurance can nevertheless undertake a range of tasks formerly conducted by the employer's insurer.

The Victorian workers' compensation system has traditionally taken a more restrictive view to access to self-insurance than most other Australian schemes. From 1946 to 1985 this option was closed except for companies that held existing self-insurance approval. In 1985 this bar was removed, but significant threshold conditions were imposed upon all self-insurers. In particular, a requirement was that companies have at least 1,000 employees in Victoria and net assets of least \$200 million. The employee number requirement was subsequently lowered to 500 employees.

This legislation moved markedly away from this approach. It replaced the minimum employee and net asset requirements with a simple provision that a body corporate shall not make an application for approval as a self-insurer "unless it satisfies the prescribed minimum requirements as to financial strength and viability." The legislation also continued a process of devolving responsibility for scheme approvals from the Minister to the VWA.

In terms of employer self-management, the legislation introduced a new division into the ACA, titled "Agency Arrangements." It provides a framework for employers to enter into arrangements with an authorised insurer which can appoint the employer as its agent in relation to the carrying out of specified functions. Under this proposed framework, the VWA maintains a strong element of regulatory oversight and control with power to veto, vary, or terminate arrangements. The areas in which an employer can act in place of an insurer under an agency arrangement are largely claims-focused and include assessment of initial entitlement, arranging medical examinations, and issuing notices under the act.

Prohibited Conduct Relating to Touting for Claims

This measure was modelled upon similar provisions in the New South Wales Workers' Compensation Act 1987. Its specific targets were a number of organisations that actively and aggressively promoted the lodgment of hearing-loss claims for a fee. The measure makes it an offence for an agent to engage in prohibited conduct in relation to protected claims. Under the legislation, only hearing-loss claims fall into the category of protected claims, but others can be declared by regulation.

The provisions in this division operate to impose penalties upon agents engaging in prohibited conduct and also prevent them from recovering a fee for such activity. Prohibited conduct involves inducing a client or encouraging others to make claims and to use the agent, or to engage in unsolicited contact with a person to encourage him or her to make a claim. The legislation provides for a penalty on an agent who engages in prohibited conduct of \$2,000 for a first offence and \$5,000 for a second and subsequent offence. The VWA can also notify insurers that a specified agent is restricted or prohibited from the recovery of fees. As well, the VWA can prohibit an agent from acting for any person in connection with any claims or in connection with specified types of claims. The penalty for contravention of such a direction is \$20,000.

Coordinated Care Programs

The managed care movement, which has played an important part in U.S. health care arrangements for some time now, has been slow to develop in Australia. The provision in this legislation to insert a new section 99AAA into the ACA dealing with coordinated care programs is one of the first steps in this direction. It was, however, clearly viewed as an experiment with the legislation providing that it would cease to operate on 1 January 1999. Subsequent legislation has extended its operation.

Under this system, a worker may be required to submit a written coordinated care programme outlining the medical, hospital, nursing, personal and household, occupational rehabilitation, and ambulance services required for the worker's injury. Details as to the type, extent, and frequency of such services must be specified. The programme is prepared by a medical practitioner who is chosen by the worker, but if the worker does not so act, a medical practitioner may be appointed to prepare the programme.

The second reading speech indicated when a worker may be required to submit a coordinated care programme:

- the worker has not recovered sufficiently to return to work within the normal recovery period, and current treatment is considered inappropriate or ineffective;
- there has been an inappropriate use of opioid analgesics; or
- there is evidence of “doctor shopping.”

The Accident Compensation (Miscellaneous Amendment) Act 1997

Introduction

The Accident Compensation (Miscellaneous Amendment) Bill received its second reading on 12 November 1997 in the Legislative Assembly and on 9 December 1997 in the Legislative Council. It was assented to on 23 December 1997. (For a summary of provisions, see Table 2.8.)

In terms of public debate, the central and most controversial item in this measure was the abrogation of the right of an injured worker to recover damages at common law. However, this statute also makes some fundamental alterations to a range of other elements of the WorkCover scheme, particularly in the area of statutory benefits. Indeed, the title of the statute, the Accident Compensation (Miscellaneous Amendment) Act, belies the fact that it introduces the most sweeping changes to the system since the 1992 legislation which inaugurated the WorkCover regime.

Common Law

The abolition of the right to recover damages at common law (new section 134A(1)) took effect from 12 November 1997, the date of the second reading of the bill:

“[a] worker who is, or the dependents of a worker who are or may be, entitled to compensation in respect of an injury arising out of or in the course of, or due to the nature of, employment on or after 12 November 1997 shall not, in proceedings commenced in respect of the injury or otherwise, recover any damages of any kind.”

An exception to this exclusion occurs in the case of proceedings under Part III of the Wrongs Act 1958, in the case of the death of a worker, which arises out of a transport accident

and in circumstances where there would be an entitlement to compensation under the ACA. The December 1997 legislation also provided that a dependent of a worker may recover damages under Part III of the Wrongs Act for the death of a worker in circumstances other than a transport accident. In this situation, however, the maximum amount of damages that may be recovered is \$500,000.

Workers injured before 12 November 1997 have up to three years from the date of their injury to initiate proceedings for damages in respect of such injury, with the proviso that no proceedings may be commenced after 31 December 2000. In cases where the cause of action arose before 12 November 1997 but the incapacitating effects of the injury were not known until after that date, the three-year limitation period begins to run from the date of such knowledge.

The abolition of the common law action also extended to actions by injured workers against third parties. However, the VWA can recover from a negligent third party the amount of statutory compensation paid to the worker.

Death Benefits

This legislation also made significant changes in respect of death benefits. These changes apply both to the nature and level of the statutory lump sum payable to the dependent spouse and dependent children of a deceased worker. It introduced an income-support pension for dependent spouses and children, one related to the worker's pre-injury average weekly earnings (PIAWE). The new regime, after 12 November 1997, was significantly different with the statutory lump sum received varying according to the number of dependent children.

Weekly Payments

The system of weekly payments was also significantly changed as a result of this legislation. Prior to 12 November 1997, this system of benefits involved workers receiving 95 percent of their PIAWE for the first 26 weeks of incapacity. After 26 weeks there was a trifurcated level of benefits, depending upon whether the worker was classified as having a "serious injury" or whether the classification was in terms of "total and permanent incapacity" or of "partial incapacity." The post-26-week benefit levels were 90 percent of PIAWE for serious injury cases, 70 percent for workers classified as totally and permanently incapacitated, and 60 percent for those classified as partially incapacitated. Benefits for partial incapacity ceased after 104 weeks.

Under the new legislation, there was a move away from benefit entitlement predicated upon injury status to one based upon work capacity. The relevant distinction is between workers who have a current work capacity and those who do not. The legislation defined the concept of “current work capacity” as meaning “a current inability arising from an injury such that the worker is not able to return to his or her pre-injury employment but is able to return to work in suitable employment.”

For claims lodged on or after 12 November 1997, where entitlement arises after that date, injured workers received a benefit of 95 percent of PIAWE for the first 13 weeks of benefit entitlement (called the first entitlement period) where they have no current work capacity. The legislation lifted the ceiling upon payments to \$850 a week or 125 percent of average weekly earnings. For workers with a current work capacity, payments during the first entitlement period are the difference between 95 percent of the worker’s PIAWE and the worker’s notional earnings, again subject to a ceiling of \$850 a week.

During the second entitlement period (an aggregate period of 104 weeks of benefit entitlement including the first entitlement period), the benefit payable to workers with no current work capacity was 75 percent of PIAWE, subject to the weekly ceiling of \$850. For workers with a current work capacity, the benefit payable is the difference between either 60 percent of the worker’s PIAWE and 60 percent of the worker’s notional earnings or the difference between \$510 and 60 percent of the worker’s notional earnings, whichever was the lesser of these two calculations.

In both the first and second entitlement periods, a worker’s entitlement to benefits was made dependent upon compliance with a series of statutory obligations. These obligations included:

- making reasonable efforts to participate in an occupational rehabilitation service or return to work plan;
- making reasonable efforts to return to work in suitable employment;
- participation in various assessments of work capacity, rehabilitation progress, and the like.

Failure to so comply would lead to cessation and loss of benefits.

After 104 weeks, being the expiry of the second entitlement period, a worker's entitlement to benefits ceased unless the worker was assessed as having no current work capacity and was likely to continue indefinitely to have no current work capacity. Where these conditions were satisfied, weekly benefits continued to be paid at the rate of 75 percent of PIAWE, subject to a ceiling of \$850 a week. Workers receiving these post-104 week benefits were subject to complying with a similar range of obligations as pertained to benefit entitlement in the earlier periods. Failure to comply resulted in cessation and loss of benefits. There was a requirement for ongoing assessment of workers receiving these benefits "as often as may be reasonably necessary," a stricture which equated to at least once every two years.

Benefits for workers with a current work capacity ceased after 104 weeks, but there was provision for continuing benefits in certain cases. The conditions for such continuing payment were that the worker:

- had returned to work for a period of not less than 15 hours a week; and
- was in receipt of current weekly earnings of at least \$100;
- because of his or her injury was (and was likely to continue indefinitely to be) incapable of undertaking further or additional work or employment which would increase their current weekly earnings.

Such workers were entitled to benefits at the rate for workers with a current work capacity during the second entitlement period.

The Government also propounded a "no disadvantage" policy in respect to benefit changes in this legislation. Accordingly, workers whose claims were lodged prior to 12 November 1997, and who were either on or were subsequently determined to have an entitlement to weekly payments, continued to be paid at their existing rate. However, these workers would be classified in accordance with the new classifications and progressively assessed under the new classification requirements. Thus, workers formerly classified as totally and permanently incapacitated were deemed to have no current work capacity, and those formerly assessed as partially incapacitated were deemed to have a current work capacity. Workers classified as seriously injured continued to receive weekly payments based on 90 percent of PIAWE for as long as they continued to meet the 30 percent impairment threshold.

Permanent Impairment Noneconomic Loss Benefits

The legislation made significant changes to compensation for permanent impairment as well. The table of enumerated bodily losses, traditionally referred to in Victoria as the “Table of Maims,” has been part of Victorian workers’ compensation legislation since the original 1914 statute. However, during the last decade it has undergone a considerable transformation. Under the former Workers’ Compensation Act 1958, payment of a benefit under the Table of Maims acted to cut off receipt of weekly benefits. The ACA made such payments additional to any other compensation payable under the act. In WorkCare, compensation under section 98 was characterised as being “in respect of permanent impairment and other nonpecuniary loss.” Following the WorkCover changes in 1992, the section 98 Table reverted to the terminology of “Compensation for Maims” but, at the same time, supplemented this Table with a separate statutory provision for compensation for pain and suffering.

The legislation returned to the language of “compensation for noneconomic loss.” Its most radical change was in moving beyond the enumerated list of impairments to a system of whole person impairment. While injuries incurred prior to 12 November 1997 continued to be assessed in accordance with sections 98 and 98A of the act, new claims (incurred on or after 12 November 1997) fell under either section 98C or section 98E. The primary provision was section 98C. A worker with a compensable injury which resulted in a permanent impairment, as assessed in accordance with the regime outlined in section 91 of the act, was entitled to compensation for noneconomic loss according to the terms of section 98C. This was not automatic since section 98C set certain threshold conditions, screening out claims where the degree of impairment was less than 10 percent in the case of physical impairment, and where the degree of impairment was less than 30 percent in claims for permanent psychiatric impairment.

The 10-percent-whole-person impairment threshold was the same as applied under the Transport Accident Act (the scheme of no-fault and common-law benefits for motor vehicle accidents in Victoria), and under the federal Comcare system (the workers’ compensation system for federal public sector employment). Having overcome the threshold, the compensation payable under section 98C was streamed to a number of bands according to the assessed degree of impairment. The first band encompassed situations where a worker’s degree of impairment was assessed as being between 10 percent and 30 percent. In such cases there was a base payment of \$5,000 and an additional amount of \$2,000 for each percentage of impairment in

excess of 10 percent. The second band (greater than 30 percent and less than 70 percent) had a base sum of \$45,000 and percentage increments of \$3,250, and the third band (greater than 70 percent and less than 80 percent) had a base amount of \$175,000 with percentage increments of \$12,500. For any assessed impairment in excess of 80 percent, there was a single stipulated payment of \$300,000.

Again, in accordance with the Government's "no disadvantage" policy, section 98E provided a safety net, at least in situations where the worker's injury was of a type encompassed in the traditional Table of Maims. Section 98E had appended to it a Table which was largely reflective of the losses detailed in the section 98 Table of Maims. The compensation amounts in the section 98E Table range from \$3,228 for the loss of a toe joint to \$161,390 for eight specified conditions, such as total loss of the sight of both eyes (or of an only eye), quadriplegia, and paraplegia. Where a worker suffered a compensable injury resulting in a total loss under the section 98E Table, and the amount payable under section 98C for this condition would be less than that provided for under section 98E, the worker could claim under section 98E rather than 98C.

The legislation also significantly changed the manner in which payments for noneconomic loss were made. First, it provided that noneconomic loss payments up to \$10,000 were to be paid by way of a lump sum. Payments between \$10,000 and \$30,000 were to be dealt with by an initial lump sum of \$10,000 and monthly installments of \$600 in accordance with a statutory formula. In cases where the noneconomic loss payment was greater than \$30,000, one-third of this sum was to be paid as an initial lump sum (rounded up to the nearest \$100) with the balance in monthly installments.

The reason for not immediately implementing this new system of payment of noneconomic loss benefits lay in Commonwealth/State relations. In particular, the concerns related to the taxation treatment that would be accorded to distributions made on an installment basis, together with the impact that such installment payments would have upon a worker's entitlement to social security payments. In the second reading speech, the Government argued that "an impairment payment remains a capital sum whether paid as a lump sum or by installment. This has been accepted by the Commonwealth in relation to taxation." In addition, the Victorian government "is continuing to press the Commonwealth to treat installments as having no effect on any social security entitlement." Accordingly, "until such time as the

government receives a favourable response to this request, all payments will be made as a single lump sum as currently occurs.”

Impairment Assessment

The legislation also provided further refinements to the system of assessment of impairment. From 1 September 1998, impairment assessment largely would be based on the fourth edition of the *AMA Guides to the Evaluation of Permanent Impairment*. Three exceptions exist. First, in respect of psychiatric impairment, it provided that the relevant instrument would be the *Clinical Guides to the Rating of Psychiatric Impairment* prepared by the Medical Panel (Psychiatry). Second, hearing losses would be assessed according to current National Acoustic Laboratory methods, converted to a whole-person impairment percentage. Third, the chapter of the fourth edition of the *AMA Guides* dealing with pain was excluded. The Government justified this exclusion on the grounds that this chapter provided no workable methodology for ascribing a percentage impairment for chronic pain, and that each individual chapter on a body system included a component for pain.

Premium

The legislation amended the ACA to make clear that “a reference to remuneration includes a reference to superannuation benefits.” This change affected superannuation benefits paid or payable in respect of services rendered by a worker after 1 January 1998. It brought the definition of remuneration into line with that which applies in the Payroll Tax Act 1971. Given the increasing resort to salary packaging which includes a significant employer superannuation contribution, this change is likely to significantly increase premium income.

Dispute Resolution

The legislation made a number of changes to the dispute resolution process, which further strengthens the roles of Conciliation Officers and of Medical Panels. Prior to these changes, court proceedings could only be instigated once a certificate from a Conciliation Officer had been issued stating that all action in respect of conciliation had been taken, or after the expiry of 28 days from the date of lodgment of the referral to conciliation. From 1 February 1998, proceedings could not be brought in the Magistrates’ Court or County Court unless the dispute

had been referred to conciliation, and the Conciliation Officer had issued a certificate stating that all reasonable steps had been taken by the claimant to settle the dispute.

A Conciliation Officer was empowered to request parties to the conciliation to produce specified documents or information regarded as relevant to the dispute. A failure to comply with such a request had the effect that any such document or information could not be tendered in evidence in future proceedings relating to the dispute. The authority of Conciliation Officers to direct payment of the arrears of weekly payments was increased from a period of 10 weeks to 24 weeks. If a Conciliation Officer has given a direction concerning the payment of weekly payments, that officer may also direct the payment of the reasonable cost of medical and like expenses provided during the period of the direction on weekly payments. In situations where the dispute revolved solely around the payment of medical and like expenses, and the Conciliation Officer was satisfied that there was no genuine dispute, that officer could give a general direction for payment of such costs up to \$2,000.

The legislation also greatly strengthened the powers of Medical Panels. Previously the opinion of a Medical Panel on a medical question had binding effect only when the question had been referred to the Medical Panel by a court. Now the opinion of a Medical Panel on a medical question was to be accepted as final and conclusive and binding upon courts and all other decision makers, regardless of the source of the referral, or when the medical question was referred.

The legislation also modified the institutional landscape relating to dispute resolution. First, it amended the provision governing the functions of the VWA to allow that body to “establish and fund a WorkCover Advisory Service.” It was intended that this service would be provided without charge to both workers and employers. Similar bodies operate in a number of North American jurisdictions. Secondly, the legislation removed the jurisdiction of the Administrative Appeals Tribunal to deal with matters concerning the payment of medical and like expenses. This jurisdiction was transferred to the Magistrates’ and County Courts, although the AAT would determine any matter brought before it prior to the date of transfer of jurisdiction.

Consequential Amendment Legislation

Introduction

Workers' compensation schemes provide an interface with an extensive range of other systems, including those concerned with occupational regulation (e.g., medical practitioners and lawyers), industrial relations, vocational training, road injuries compensation, court administration, public sector financial management, and the like. When there is a change in the statutes governing these other areas of activity, there will often be a consequential need to amend particular provisions of the workers' compensation statute. This category constitutes the most common form of amendment to the ACA, although one that is usually technical in nature and minor in impact. Examples of this form of change to the ACA are the Employee Relations Act 1992, the Medical Practice Act 1994, the Financial Management (Consequential Amendment) Act 1994, the Vocational Education and Training (Amendment) Act 1994, the Transport Accident (General Amendment) Act 1994, the Constitution (Court of Appeal) Act 1994, the Equal Opportunity Act 1995, the Vocational Education and Training (Amendment) Act 1995, the Mental Health (Amendment) Act 1995, the Miscellaneous Acts (Omnibus Amendments) Act 1995, the Legal Practice Act 1996, the Education (Amendment) Act 1996, the Chiropractors Registration Act 1996, and the Co-operatives Act 1996.

Employee Relations Act 1992

The move from the WorkCare to the WorkCover system was paralleled in another major change made by the newly elected Liberal Government. The new Government's policy platform called for radical change of the industrial relations framework in the direction of a more flexible and market-driven structure. To this end the Employee Relations Act 1992 was enacted. This measure was assented to on 24 November 1992, just five days after the WorkCover legislation received assent. Central to this was the move away from a system of industrial awards to a new system based upon (individual and collective) employment agreements. The legislation also provided for significant restrictions upon industrial action and, in particular, circumscribed the area of lawful picketing.

The legislation abolished the Industrial Relations Commission of Victoria and created a new body, the Employee Relations Commission of Victoria. Accordingly, among the consequential changes flowing from this measure was a change to section 154(2) of the ACA. This provision related to the composition of the three-member Self-Insurance Review Tribunal (a body which was subsequently abolished in 1994), one of whom was the President of the Industrial Relations Commission of Victoria or the President's nominee. The change simply related to substitution of the term "Employee Relations Commission" for that of "Industrial Relations Commission" in this provision.

Medical Practice Act 1994

The Medical Board of Victoria had historically been a creature of government, and had been criticised as being unresponsive to complaints lodged against medical practitioners. The Medical Practice Act 1994 represented an overhaul of the system. A new Medical Board of Victoria was incorporated and made independent of government for the first time. A result was the need to modify the definition of "medical practitioner" in the ACA to reflect that the Medical Practice Act 1994 is now the governing legislation.

Financial Management (Consequential Amendments) Act 1994

The Financial Management (Consequential Amendments) Act 1994 was a measure in the Government's efforts to implement global appropriations and standardise financial reporting requirements in all legislation. It introduced consequential amendments to a considerable number of statutes, including the ACA, in two main areas. The first related to changes to enable the government to achieve one-line appropriation legislation in the 1994-95 and subsequent budgets, while the second involved the repeal of the annual reporting requirements in existing legislation. With the passage of the Financial Management Act 1994, part seven of which governed annual accounting and reporting requirements for public bodies, individual annual reporting measures in various legislation had become redundant. Accordingly, sections 35, 36, and 38B of the ACA, which dealt with the form of the VWA's financial accounts and records, the VWA's annual reporting requirements, and the auditing of the VWA's accounts by the Auditor General, respectively, were repealed.

Vocational Education and Training (Amendment) Act 1994

The Vocational Education and Training (Amendment) Act 1994 involved a number of changes to the industry training system in Victoria. A result was that the definitions of “remuneration” and “worker” in the ACA required changing.

Transport Accident (General Amendment) Act 1994

Victoria is one of the three Australian jurisdictions that operates a reasonably comprehensive no-fault compensation scheme for transport accidents. The Transport Accident (General Amendment) Act 1994 undertook a range of changes to both the Transport Accident Commission (TAC) and to the transport accident scheme.

The Transport Accident Act 1986 enshrines a statutory duty upon the TAC “to design and promote, so far as possible, a program designed to secure the early and effective medical and vocational rehabilitation of persons injured as a result of transport accidents.” The TAC has long had a significant involvement with medical rehabilitation and has, particularly in recent years, been extending its presence in vocational rehabilitation. This has included involvement in return-to-work initiatives and job placement programmes. These initiatives have brought with them workers’ compensation implications. Accordingly, these 1994 amendments specified that the employer of a worker employed under such a programme is deemed to have a WorkCover insurance policy in respect of such a worker only with the TAC. The requirement in the Accident Compensation (WorkCover Insurance) Act 1993 that all employers maintain a policy with an authorised WorkCover insurer does not apply to these arrangements. Nevertheless, the premium payable in respect of the TAC programmes are to be calculated in accordance with the WorkCover Premiums Order, and payable as if the worker was employed and remunerated by the TAC.

Constitution (Court of Appeal) Act 1994

The Constitution (Court of Appeal) Act 1994 was the first major alteration to the structure of the Supreme Court of Victoria since that court’s establishment in 1852. The legislation divided the Supreme Court into two divisions, namely a Court of Appeal and a Trial Division. These changes necessitated the amendment of a number of other statutes, including the

ACA, to reflect the new structure. Accordingly, in section 52(1) of the ACA, dealing with appeals from the County Court on a question of law, this amending statute substituted the term “Court of Appeal” for “Supreme Court sitting as a Full Court.”

Equal Opportunity Act 1995

Equal opportunity legislation in Victoria is an area of social policy that has enjoyed general bipartisan political support. Both the first legislation, the Equal Opportunity Act 1977, enacted by the Hamer Liberal Government, and its replacement by the 1984 legislation of the Labor Government enjoyed such support. The Equal Opportunity Act 1995 repealed and replaced the 1984 legislation following a comprehensive review of this legislation by the Parliamentary Scrutiny of Acts and Regulations Committee. The new legislation extended the grounds of prohibited discrimination from the then-existing seven categories (sex, marital status, parental status, race, impairment, religious beliefs, and political beliefs) to embrace a further seven attributes on the basis of which discrimination is prohibited. The seven new categories are age, status as a career, lawful sexual activity, pregnancy, physical features, industrial activity, and personal association.

As part of the move to include age discrimination as an area of prohibited activity, the legislation removed provisions in a wide range of legislation that mandated compulsory retirement. One such provision that was repealed was section 29(2)(c) of the ACA that stipulated that the office of a director of the VWA become vacant when such a director attained the age of 72 years.

Vocational Education and Training (Amendment) Act 1995

The central thrust of the Vocational Educational and Training (Amendment) Act 1995 was to allow specified functions of the State Training Board to be delegated to persons or bodies with an interest and expertise in training, appointed by the Governor in Council on the recommendation of the Minister. As well, the legislation operated to allow a partial deregulation of apprenticeships and traineeships. Consequential upon these changes were a few minor technical amendments to the ACA.

Mental Health (Amendment) Act 1995

The Mental Health (Amendment) Act 1995 followed a number of reports on mental health services at both the national level and in Victoria. A consultant's report for the Australian Health Ministers' Advisory Council's (AHMAC) Working Group on Mental Health Policy drafted model clauses for the use of the states and territories in the development of nationally consistent mental health legislation. Also, the act built on recommendations of a local working party, established to review the act in the context of relevant international, national, and state policies. The approach taken continued from the "Framework for Service Delivery" initiative, which was adopted in 1994, providing for the mainstreaming of psychiatric services into the general health system, the identification of new service delivery options, and a greater emphasis on community-based services and involvement by the private sector. These changes also resulted in usage of a different nomenclature that necessitated adoption in other statutes. Accordingly, the legislation amended the definition of "hospital" in the ACA to substitute for the expression "a psychiatric in-patient service" the term "an approved mental health service."

Miscellaneous Acts (Omnibus Amendments) Act 1995

It is often difficult for Ministers and Departments to gain time for the introduction of substantive measures that can effect minor or technical amendments to legislation. One method to overcome this is the device of a miscellaneous acts amendment statute. The Miscellaneous Acts (Omnibus Amendments) Act 1995 was one such vehicle, dealing with minor changes to a range of measures ranging from Civil Aviation (Carriers' Liability) Act 1961 to the Extractive Industries (Lysterfield) Act 1986.

Included were amendments to sections 32 and 33 of the ACA dealing with the WorkCover Authority Fund and the VWA's borrowing powers, respectively. These changes reflected the move to bring the VWA's activities in this area within the purview of the Borrowing and Investment Powers Act 1987. The wording of the VWA's powers to invest the funds in the WorkCover Authority Fund was changed from "in any manner which may be approved by the Treasurer for the purposes of this section" to "in accordance with the powers conferred on it under the Borrowing and Investment Powers Act 1987." As well, this measure substituted the term "Secretary to the Department of Treasury and Finance" to "Director-General

of the Department of Management and Budget” in section 244 of the ACA, dealing with those persons who could lawfully receive certain documents consistent with the secrecy provisions of that section. This alteration simply reflected the change in title of the senior official in the State’s chief finance ministry.

Legal Practice Act 1996

The Legal Practice Act 1996 represented the most wide-ranging reform of the structure and regulation of the legal profession since the 1891 Legal Profession Practice Act established the basic structure for legal practice in Victoria. The 1996 legislation combined a strong deregulatory thrust with elements of greater regulation. Greater control can be seen in the creation of the office of Legal Ombudsman to oversee complaints against lawyers. The moves toward deregulation were more numerous and significant. One was the removal of the *de facto* “compulsory unionism” in the profession by permitting the use of multiple self-regulatory professional associations, called recognised professional associations (RPAs). Another was the prohibition of rules compelling practitioners to acquire chambers or business premises in a specified location or from a specified body.

While the 1891 legislation created a fused profession, in practice the demarcation between barristers and solicitors remained sharp and real. The legislation, at least linguistically, abolished the distinction by referring to all persons admitted to practice by the Supreme Court as “legal practitioners.” Those engaged in legal practice were described as “current practitioners.” It was in recognition of these changes that the legislation made some consequential amendments to the ACA. Thus the term “legal practitioner” was substituted for those of “solicitor” and “barrister” in the ACA.

Education (Amendment) Act 1996

The Education (Amendment) Act 1996 implemented two main changes to the Victorian education system. The first was to widen the range of persons from overseas who could attend Victorian state schools on a fee-paying basis as well as allowing application fees to be charged to overseas students applying to enroll in these Victorian schools. The second change was to allow arrangements between school principals and employers whereby senior secondary school

students could be engaged in workplaces for extended periods in fulfilling the requirements of a course of study within the Victorian Certificate of Education (VCE) curriculum framework. This initiative built upon “work experience” arrangements that had been in operation since 1974. The new measure extended beyond work experience to work placement involving extended, on-the-job learning that is related to a structured training curriculum for year 11 and year 12 students.

One of the issues that needed to be addressed was workers’ compensation coverage of these student workers. Existing provisions in the ACA operated in relation to coverage of pupils on work experience activities. However, these required modification in light of the extension of work placements to include engagements with self-insurers and of employers conducting nonprofit training or skill centres. Thus, self-insurers were made subject to some of the obligations placed upon scheme-insured employers in respect of compensable injuries suffered by these student workers, but they were also shielded from some other obligations such as mandated rehabilitation and return-to-work measures.

Chiropractors Registration Act 1996

The Chiropractors Registration Act 1996, together with its companion Osteopaths Registration Act 1996, represented a further step in moving from traditional models of occupational registration to a more modern model, particularly in the area of medical specialties. This change had earlier been applied to the registration of medical practitioners [see the discussion of the Medical Practice Act 1994, above] and nurses. The Chiropractors and Osteopaths Act 1978 was seen as deficient in a number of ways, including having one board to regulate and inquire into two distinct and competing professions and lacking a statutory definition of unprofessional conduct.

The recognition of chiropractors and osteopaths in separate legislation required some minor consequential terminological adjustment in the ACA. Accordingly in the definition of “medical service,” and in provisions governing medical examinations and the issuing of certificates, the term “registered chiropractor, registered osteopath” was substituted for that of “registered chiropractor and osteopath.”

Co-operatives Act 1996

The cooperative sector, involving the voluntary association of persons to meet common goals through a jointly owned and democratically controlled enterprise, has been an important movement in Australia as well as elsewhere in the world. On 30 June 1996 there were 1,026 cooperative societies on the Victorian register of cooperatives with total assets of between \$160 million and \$170 million. As well as long-established bodies in areas of primary production (e.g., in the dairy industry, egg production, and fishing), these organisations existed to provide services in diverse fields including child care, taxis, community radio, and housing.

The Co-operatives Act 1996 was a consolidating and modernising measure governing the formation, registration and management of cooperatives, replacing the former governing legislation, namely the Co-operation Act 1981 and Part VI of the Housing Act 1983, dealing with rental housing cooperatives. This change required a minor consequential amendment to the provision in the ACA providing deemed coverage under the scheme to secretaries of cooperative societies, remunerated (in addition to the payment of expenses) by more than \$200 per annum. Accordingly the reference to the Co-operation Act 1981 was change to the Co-operatives Act 1996.

Having completed our historical tour of workplace injury legislation in Victoria, we are now prepared to tackle the structure and performance of the system itself. The next chapter describes the organisation of the Victorian WorkCover Authority, the principal administrative agent of the system as it exists today.

Table 2.1 Where the Premium Dollar Goes—Victoria (circa 1983)

Weekly Payments	22%
Redemptions	16%
Common Law	10%
Death	3%
Table of Maims	1%
Hospital and Medical	17%
Administration	15%
Legal	12%
Brokerage	4%
TOTAL	100%

Source: Cooney Report, Table 1-16.

Table 2.2 Performance of the WorkCare Scheme: 1985/86 to 1991/92

	1985/86 ¹	1986/87	1987/88	1988/89	1989/90	1990/91	1991/92
Estimated Incurred Claims ²	81,883	100,116	95,069	91,965	83,745	77,113	70,479
Total Income ³ (\$, millions)	471	747	632	854	1,250	1,407	1,321
New Claim Payments (\$, millions)	65	333	538	715	694	749	910
Operating Surplus/ (deficit) ⁴ (\$, millions)	353	335	(9)	(12)	374	472	193
Net Outstanding Claims Liabilities (\$, millions)	535	2,300	2,720	4,865	3,532	3,347	3,583
Net Assets ⁵ (\$, millions)	369	704	694	682	1,056	1,528	1,721
Unfunded Liabilities (\$, millions)	165	1,596	2,025	4,182	2,476	1,819	1,862
Funding Ratio (%)	69.0	30.6	25.6	14.0	29.9	45.7	48.0

Source: Accident Compensation Commission Annual Reports

¹10 months only; from 1 September 1985

²Figures include actual claims for the period, together with an estimate of the number of incurred but not yet reported claims (IBNRs) estimated at 30 June 1992.

³Income from levy, investments and other sources.

⁴Excluding movement in outstanding claims liability.

⁵Net assets excluding recoveries.

Table 2.3 Accident Compensation (WorkCover) Act 1992 – Summary of Provisions

Area of Change	Changes Effected
Structural Basis of the Workers' Compensation Scheme	<p>Insertion of new objects of the Accident Compensation Act.</p> <p>Establishment of the Victorian WorkCover Authority (VWA), in place of the Accident Compensation Commission.</p> <p>Establishment of the WorkCover Advisory Committee.</p> <p>Establishment of a new Conciliation Service in place of the WorkCare Appeals Board.</p> <p>Establishment of Medical Panels.</p> <p>Abolition of Accident Compensation Tribunal and allocation of its functions to courts and Administrative Appeals Tribunal.</p>
Entitlement Provisions	<p>Addition of the requirement that a worker's employment be a "significant contributing factor" to a compensable injury.</p> <p>Removal of compensability of stress claims in cases of reasonable employer action in areas of change of employee status and discipline.</p> <p>Removal of coverage for injuries sustained in travel to and from work.</p>
Return to Work and Occupational Rehabilitation	<p>Strengthening of employer obligation to hold injured worker's job open and increase in penalties for noncompliance.</p> <p>Replacement of former measures governing rehabilitation with a single framework provision for a system of occupational rehabilitation and risk management programs.</p> <p>Insertion of definition of "suitable employment" for operation of partial incapacity provisions.</p>
Benefits	<p>Significant restructuring of loss of earnings benefits, providing enhancement of benefits for more severely injured while essentially limiting duration of partial incapacity benefits to 104 weeks.</p> <p>Transitional provision of "interim settlements" for ongoing partial incapacity recipients.</p> <p>Change to conditions governing redemption of weekly payments.</p> <p>Reinstatement of common law damages for loss of earning capacity, subject to a 30% impairment threshold and to a cap on damages.</p> <p>Extension of range of conditions covered under the Table of Maims.</p> <p>Introduction of a system of statutory payments for pain and suffering.</p>
Dispute Resolution	<p>Provisions detailing appointment and powers of Conciliation Officers and members of Medical Panels and procedures before these bodies.</p> <p>Provisions detailing jurisdiction of Magistrates' Court, County Court and Administrative Appeals Tribunal and transitional measures.</p>

Area of Change	Changes Effected
Other	<p>Change to effect of superannuation payments on weekly payments.</p> <p>Change to grounds and process for alteration or termination of weekly payments.</p> <p>Power to issue initial medical certificates restricted to medical practitioners.</p> <p>Employer excess extended from 5 to 10 days, with effect from 1 July 1993.</p> <p>Provision for VWA to enter into reciprocal agreements with bodies in other jurisdictions.</p> <p>Tougher antifraud measures.</p> <p>Changes to secrecy provisions.</p>

Table 2.4 Accident Compensation (WorkCover Insurance) Act 1993 – Summary of Provisions

Area of Change	Changes Effectuated
New Insurer Arrangements	<p>Basis of liability under the scheme changed from one of fund liability to that of individual employer liability.</p> <p>Liability of the VWA for compensable injuries transferred to the authorised insurers, retrospective to commencement of WorkCare; however, the VWA to totally reinsure all liabilities, both retrospective and prospective.</p> <p>Establishment of a new statutory fund for each authorised insurer and detailing the basis upon which these funds operate.</p> <p>New framework instituted for the regulation of authorised insurers, including licence duration and conditions.</p> <p>Establishment of the Uninsured Employers and Indemnity Scheme and Fund to deal with compensating workers whose employer is uninsured under the new insurer arrangements.</p>
Premium System	<p>Establishment of the framework for a new experience-rated premium system, giving legislative authority for matters to be provided by regulation in the Premiums Order, including the process of estimating remuneration, revised estimates, premium assessment, premium payment, and penalties.</p> <p>Authorisation of VWA to enter into reciprocal agreements with bodies in other jurisdictions in respect of matters pertaining to the payment of premiums and calculation of remuneration.</p> <p>Detailed provisions dealing with “related employers” for the purpose of premium calculation.</p> <p>Additional provisions dealing with the recovery of premiums or penalties.</p> <p>Provisions requiring the preservation of relevant books and accounts for at least five years.</p> <p>Additional provisions dealing with warrants to enter and search premises.</p> <p>Provisions dealing with evidential matters in relation to proceedings for the recovery of premium or penalty.</p>
Extension of Self-Insurance	<p>Authorisation of the Municipal Association of Victoria to establish a system of group self-insurance for local government bodies and stipulation of the conditions governing this system.</p>
Jurisdiction of Magistrates’ Court	<p>Stipulation that the \$25,000 jurisdictional limit of the Magistrates’ Court did not include the value of an order made by a magistrate for the payment of weekly payments.</p> <p>Extension from 26 weeks to 52 weeks of the period for which a magistrate could make an order for weekly payments.</p>

Area of Change	Changes Effected
Other	<p>Redefinition of nature of rehabilitation services through new definitions of “occupational rehabilitation service” and “personal and household service.”</p> <p>Refinement of the statutory provisions governing the coverage of contractors and subcontractors.</p> <p>Requirement for the financial and claims performance of self-insurers to be included in VWA annual report.</p> <p>Change to indexation provisions to deal with situations of negative inflation.</p> <p>Change to Table of Maims maxima.</p> <p>Requirement to provide a claimant with information concerning medical or hospital services relevant to his or her claim.</p>

Table 2.5 Accident Compensation (Amendment) Act 1994 – Summary of Provisions

Area of Change	Changes Effected
Claims Management	<p>Clarification of the circumstances in which notional earnings provisions would not be applied.</p> <p>Refinement of provisions governing the payment of weekly payments to a worker who ceases to reside in, or is temporarily absent from Australia.</p> <p>Provision for the VWA to issue advisory practice notes.</p>
Hearing-Loss Claims	<p>Introduction of a threshold criterion for compensability for hearing-loss claims of 7% loss of binaural hearing.</p> <p>Tightening of testing processes for hearing-loss claims, both in terms of the testing instrument and of persons authorised to undertake hearing assessments.</p>
Conciliation	<p>Requirement that no claims (other than death, maims, and statutory pain and suffering claims) could not be the subject of court proceedings unless referred to conciliation and until after 28 days from such referral or the issue of a certificate by a Conciliation Officer.</p> <p>Requirement that conciliation applications be signed personally by applicant.</p>
Common Law	<p>Overturning the effect of a Supreme Court decision and reestablishing the time limitations for bringing common law actions set out in the 1992 legislation.</p> <p>Effecting a number of technical changes to the common law provisions.</p> <p>Upward alignment of the cap on damages for nonpecuniary to that existing under the Transport Accidents Act scheme.</p>
Table of Maims and Statutory Pain and Suffering Claims	<p>Introduction of new procedures for dealing with Table of Maims and statutory pain and suffering claims.</p> <p>Cost penalty where amount awarded is less than 120 percent of final offer made to claimant.</p>
Self-Insurance	<p>Reduction from 1,000 to 500 the requisite minimum number of employees for an applicant for self-insurance.</p> <p>Provision for partnerships meeting threshold criteria to apply for self-insurance status.</p> <p>Increase in the level of posted bank guarantee to 150 percent of actuarially assessed outstanding claims liabilities.</p>
Administrative Responsibilities	<p>Transfer of VWA's responsibilities for payments to dependents of deceased workers and for certain funds to the County Court and the State Trust Corporation of Victoria, respectively.</p> <p>Change to the VWA's statutory reporting requirements.</p>
Scheme Coverage	<p>Removal of direct sellers and local government councillors from scheme coverage.</p> <p>Exclusion of travel to and from a place of pick-up from scheme coverage.</p>

Area of Change	Changes Effected
National Harmonisation	Change to secrecy provisions of the ACA to allow disclosure to other workers' compensation agencies of information for antifraud activities. Enactment of a provision determining compensation entitlement where multiple jurisdictions are involved; this provision to be activated at the same time that other jurisdictions make this move.
Other	Increase in the proportion of income earned by workers engaged in part-time return-to-work that is retained by these workers. Refinement of the arrangements for recovery of compensation existing between the VWA and the Transport Accident Commission. Change to the third-party indemnity arrangements.

Table 2.6 Accident Compensation (Occupational Health and Safety) Act 1996 –
Summary of Provisions

Area of Change	Changes Effected
Amendment of the Accident Compensation Act 1985 (ACA)	<p>Amendment of powers of the VWA to undertake dual role of regulation of workers' compensation and Occupational Health & Safety.</p> <p>Amendment of objectives of the VWA in respect of this new role.</p> <p>Ensuring the VWA's Ministerial accountability extends to this new role.</p> <p>Requirement for payment into the WorkCover Authority Fund of various penalties recovered and fees payable under various health and safety statutes, together with contributions from the Consolidated Fund relating to the administration of such statutes by the VWA.</p> <p>Ensuring that money can be paid out of the WorkCover Authority Fund for purposes required by regulation and that land or buildings owned by the VWA can be used in its administration of occupational health and safety legislation as well as the ACA.</p>
Transitional Provisions Relating to the Transfer of Staff	<p>Requirement for written designation by the Minister of those persons administering the occupational health and safety legislation who are to transfer to the VWA.</p> <p>Specification of the terms and conditions under which persons so designated are to transfer to VWA employment.</p> <p>Limitation of the jurisdiction of the Supreme Court to prevent it from adjudicating on the issue that no entitlement to compensation lies in respect of a person ceasing to be an officer or employee of the public service by virtue of the legislation.</p>
Amendment of the Dangerous Goods Act 1985 (DGA)	<p>Substitution of the term "Authority" (i.e., VWA) for "Director-General" and allied changes of this nature to reflect the transfer of responsibility to the VWA.</p> <p>Insertion of a provision that giving authorisation to an inspector to take affidavits for any purpose relating to or incidental to his or her role as an inspector.</p> <p>Insertion of a new section in the DGA relating to the transfer of responsibilities.</p> <p>Emendation of some minor typographical errors.</p> <p>Transitional provisions in respect of the transfer dealing with such matters as documents issued by the Director-General and inspectors.</p>
Amendment of the Equipment (Public Safety) Act 1994	<p>These provisions amending the E(PS)A essentially mirror the changes made to the DGA outlined immediately above.</p>
Amendment of Occupational Health and Safety Act 1985 (OH&SA)	<p>Similarly, the amendments (ss 50-70) made by this statute to the OH&SA are in essentially the same terms as the parts amending the DGA and E(PS)A.</p>

Table 2.7 Accident Compensation (Further Amendment) Act 1996 – Summary of Provisions

Area of Change	Changes Effected
Assessment of Impairment	<p>Insertion of a new section 91 into the ACA governing impairment assessment, providing for the instrument for assessment, manner of assessment, and training for assessors.</p> <p>Provision that, in assessing a degree of impairment under the new section 91 regime, regard must not be had to any psychiatric or psychological injury, impairment, or symptoms arising as a consequence of, or secondary to, a physical injury.</p>
Payment of Lump Sum Maims Payments in Excess of \$5,000	<p>Insertion of a new section 98B into the ACA providing for payment in equal monthly installments, over a five-year period, of maims payments over \$5,000 and statutory pain and suffering payments.</p>
Coordinated Care Programs	<p>Insertion of a new section 99AAA into the ACA, establishing a system of coordinated care programs governing the provision and management of compensable medical and like services to workers.</p>
Agency Arrangements	<p>Insertion of a new division into the ACA enabling arrangements between an authorised insurer and an employer whereby the latter acts as the insurer's agent in relation to specified provisions of the act</p>
Approval of Self-Insurers	<p>Substitution of a requirement of meeting "prescribed minimum requirements as to financial strength and viability" for existing requirements for approval of self-insurers.</p> <p>Substitution of the VWA for the Minister as the entity responsible for self-insurer approvals.</p>
Prohibited Conduct Relating to Touting for Claims	<p>Insertion of a new division into the ACA, prohibiting certain conduct by persons in the facilitation of claims, especially hearing loss claims, by workers and providing for a system to police this prohibition and for sanctions against such prohibited conduct.</p>
Refinement of Existing Provisions	<p>Provisions refining the operation of existing provisions in the ACA, including</p> <ul style="list-style-type: none"> • benefit calculation for serious injury; • determination of the degree of impairment in the case of injuries to the back, neck, or pelvis in section 98; • treatment of superannuation and termination payments in section 96; • procedure for setting the maximum compensable cost level for medical and like services under section 99; • dramatic increase in the statutory penalty for breach of various secrecy provisions in the act.

Area of Change	Changes Effected
Minor Technical Amendments	<p>A considerable number of minor technical amendments, including changes to</p> <ul style="list-style-type: none"> • the definition of “medical question” and “notional earnings”; • the nature of scheme costs to which self-insurers must contribute; • the awarding of costs in the County Court.
Amendment of Other Legislation	<p>Amendment of the Accident Compensation (WorkCover Insurance) Act 1993 in respect to</p> <ul style="list-style-type: none"> • the process for the estimation of rateable remuneration; • allowing premium reductions in cases of insurer/employer agency arrangements. <p>Amendment of the Transport Accident Act 1986</p> <ul style="list-style-type: none"> • adoption of the ACA provisions in regard to psychiatric and psychological conditions in impairment assessment; • determination of the level of fees, costs, etc., in respect of services and provisions in a manner similar to that adopted under the ACA.

Table 2.8 Accident Compensation (Miscellaneous Amendment) Act 1997 – Summary of Provisions

Area of Change	Changes Effected
Abrogation of the Right to Recover Damages at Common Law	General abrogation of the right to recover damages at common law, with effect from 12 November 1997, for injuries occurring in compensable circumstances. An exception for a wrongful death action relating to a transport accident occurring in circumstances compensable under the ACA. A further exception for a wrongful death action in circumstances other than a transport accident, but with damages capped at \$500,000.
Death Benefits	Significant change to the nature and level of the statutory lump sum death benefit payable to a dependent spouse and dependent, with this sum varying according to the number of dependent children. Introduction of a system of income support pensions for dependent spouse/s and children.
Weekly Payments	Restructuring of the system of weekly payments, moving from a system of benefit entitlement (and benefit level) predicated upon injury status to one based upon work capacity, distinguishing workers who have a current work capacity (CWC) and those who do not. Benefits operate in three stages—first 13 weeks, weeks 14 to 104, and post 104 weeks. In the first two stages, different benefits operate according to whether the worker has a CWC or not with a stepdown at 13 weeks. In the post 104 week period, benefits generally cease for workers with a CWC, although there is a stipulated area which is excepted from such benefit extinguishment.
Permanent Impairment Noneconomic Loss Benefits	Significant change in compensation for impairment from the traditional table of enumerated losses to a system of whole person impairment. Threshold levels of 10 permanent impairment operate in the case of physical impairment and 30 percent impairment in claims for permanent psychiatric impairment. For impairments above these thresholds, compensation is streamed to four payment bands depending upon the level of assessed impairment. Subject to a “no disadvantage” policy, to avoid lesser payments under the new system than under the old.
Impairment Assessment	Change to the fourth edition of the <i>AMA Guides</i> for assessment of physical impairment and a locally produced guide for psychiatric impairments to take effect from 1 September 1998. Also changes to the assessment of hearing loss and of pain.
Coverage	Coverage exclusion in respect of “work for the dole” programs.
Premium	Inclusion of superannuation payments after 1 January 1998 in the definition of “remuneration” for premium assessment purposes.

Area of Change	Changes Effected
Dispute Resolution	<p>Further tightening of the conditions precedent to a matter being heard by the court system.</p> <p>Additional powers and authority given to Conciliation Officers.</p> <p>Enhancement of the powers of Medical Panels.</p> <p>Authority given to VWA to establish and fund a WorkCover Advisory Service to provide free assistance to workers and employers.</p> <p>Removal of the jurisdiction of the AAT to deal with disputes over medical and like service payments.</p>
Penalties	<p>Fivefold increase in the maximum penalties for various Occupational Health & Safety offences and for employer noncompliance with occupational rehabilitation measures.</p>

Chapter 3 VWA Structure and Performance

Our practice is to complete the description of a workers' compensation system with an overview of its performance for the past 10 years. However, before beginning that analysis, it is worth commenting on the remarkable degree of change in the Victorian workers' compensation system in the past decade. Even apart from the "sea change" in 1985 to WorkCare and the subsequent one in 1992 to WorkCover, there has been substantive legislation nearly every year that affected the operation of the system. (See Chapter 2.)

Thus, this analysis cannot truly compare apples to apples. It is not possible to hold "other things constant" because the system has been evolving continuously. Still, it is necessary to answer the basic questions about workers' compensation system performance: How many work-related injuries and illnesses are there? What is being done to prevent these injuries and illnesses? How many workers are receiving compensation and in what amounts? How many dollars are being spent, in benefit payments and administrative costs? What is the cost of the system to employers? Is the system financially sound?

Our analysis will also highlight changes since 1991/92, the last full year of the WorkCare system. This will demonstrate the magnitude of the changes that have occurred in Victoria. The system performance data are presented in bar-graph format. This has two virtues; first, it highlights trends in the data, and second, it does not create a false impression of precision in the numbers. Because of the extensive system changes described throughout our report, this is an appropriate level of analysis. However, the numbers underlying our graphical analysis are also presented in Appendix Table A-1.

The chapter begins with a brief account of the structure of the VWA as of 1 June 1998. Then we will turn to the performance analysis—working through trends in the general economic environment, prevention activities, the number of claims, the benefits flowing to claimants, the cost and staffing levels to administer the system, and finally, premium rates and funding status.

VWA Structure

Figure 3.1 shows the organisational structure of the VWA, as of 1 June 1998. It reflects the reorganisation of 17 February 1998. This reorganisation represents the latest step in the implementation of the merger of VWA and the Health and Safety Organisation (HSO), which was legislated in June 1996 and followed a careful evaluation and internal consultative process among the VWA leadership during the latter half of 1997.

As compared with 1996, this structure is flatter and more streamlined, with significant integration of insurance and health and safety support functions. The inspectorate was left intact under the Director of Field Services, though it was slightly reorganised and dropped the former matrix management structure which combined management of field staff with a statewide content focus (Dangerous Goods, Plant Hazards, or Work Environment Hazards). There are four groups (Central, Western, Eastern, and Northern) reporting to the Manager of Field Operations. In addition, there is a Field Support unit, a Licensing unit, a Technology branch (which includes Chemical Technology, Engineering, Ergonomics, and Occupational Hygiene), and Management Systems. The Division also has an Operations Planning group reporting to the Director of Field Services. The Field Services Division had a complement of 292 personnel as of 31 May 1998.

The changes in the Field Services Division since the merger in 1996 have been very significant. For example, the time in the field has increased by 27 percent through 31 March 1998 over the year earlier; the goal is a 30-percent increase by the end of the year (30 June 1998). Additional significant gains in field time are anticipated, as the Division seeks to raise the percentage of available time spent in direct service delivery from 46 percent at 31 March 1998 to 60 percent in the future. Ultimately, the goal is to double the field-time hours with no increase in staff complement.

Operations Management Division is responsible for regulation of insurers and other providers under the scheme. Operations Management had a complement of 135 personnel at 31 May 1998. Reporting to the Director of Operations Management are Managers of Evaluation and Compliance, Litigation and Prosecution, and Service Management. The Manager of Evaluation and Compliance is responsible for compensation investigation and health and safety investigation. The Manager of Litigation and Prosecution deals with compensation and health

and safety prosecutions, the upcoming runoff of common-law cases, plus the remaining runoff of Section 98 and 98A cases, and the new Impairment Benefits. The Manager of Service Management is responsible for provider service management, self-insurance, systems, implementation, and pre-1985 insurer programmes.

The Policy Division had a staff of 69 persons at 31 May 1998. This division handles legislative services, performance monitoring, strategic policy, research and development, and injury management. There are a number of interesting initiatives under way in this division, which essentially serves as the spearhead for change at the VWA. Future changes in the scheme are being reviewed and tested in the Policy Division today.

The Conciliation Service had a complement of 69 persons at 31 May 1998. The personnel who work at the Conciliation Service are employees of the VWA. However, the Conciliation Officers are appointed by the Minister, and the VWA administration does not have the power to hire and fire them. The Conciliation Service appears to be an effective and efficient operation which forestalls more serious (and costly) disputes in upwards of 70 percent of cases referred for conciliation.

The Information Services Division, with 71 employees, and Corporate Services, with 54 employees, serve the needs of the VWA as central service staffs. Information Services has not changed in organisation in recent years, and it is at work developing a new data system that will integrate the claims and field services data to provide workplace profiles. The new Corporate Services Division pulls together areas of Personnel and Industrial Relations, Legal Services, Organisational Development, and Finance that support the operation of the VWA.

Last, but by no means least, is the Public Affairs Division. With a staff complement of 34, the Public Affairs Division represents the public face of the VWA. The Public Affairs Division maintains an active media presence that promotes specific public awareness campaigns through electronic and print media. There is also an aggressive outreach effort that brings the VWA message to individual workplaces, as well as trade shows, industry gatherings, and other opportunities to reach target audiences. The VWA has had a recent, successful campaign to promote rollover protection for older farm tractors, as well as a continuing active safety-promotion campaign, and notable success with a back-care promotion programme, developed in combination with the professional provider organisations in Victoria.

Scheme Performance

We review here the highlights of scheme performance over the last 10 years, largely ignoring the specific changes in legislation, administration, and measurement that affect the numbers. As indicated, we do not have strict comparability within every data series. We use the numbers as broad indicators of direction and will present them in graphical form to emphasize the fact that we are trying to paint a statistical picture, but with a very broad and imprecise brush.

The presentation will begin with a look at some of the economic forces underlying the performance of the workers' compensation system. Then we turn to measures of some of the activities to promote health and safety in Victoria's workplaces. The manager of the workers' compensation scheme, the Victorian WorkCover Authority, absorbed the former Health and Safety Organisation in July 1996. With this change came a transfer of health and safety to a new Minister in the Government as well as some significant changes in leadership. In addition, the HSO had already been subject to considerable reorganisation over the previous decade. These changes aside, we will endeavour to look at those performance measures that are available for the entire period. This will provide us with an overview of the way that the health and safety mission has been pursued in Victoria.

Then we will look at the number of claims of different types, followed by an examination of the aggregate costs of those claims. Again, there have been significant changes in the definitions and in practice with regard to different types of injuries. We report broad trends while avoiding some of the details of measurement. Next we review the cost of administering the system. In this case, Victoria is fortunate to have good data on the administrative costs of processing claims and settling disputes. By virtue of the publicly funded nature of the Victorian system, it is possible to track most administrative costs, including friction costs, through payments to vendors of the various services.

However, Victorian employers have a 10-day "excess," which amounts to a deductible for the first 10 days of disability and the first \$426 of medical and like costs. There are no data available on these private costs. Thus, comparisons with other jurisdictions are difficult. Self-insured employers are another notable gap in the data system, since there are virtually no data available about their performance. But there are only 23 such employers in Victoria, and they constitute only about 8 percent of the overall workers' compensation benefit payments.

Our analysis will finish with a look at the employer's cost of insurance (not including the 10-day employer "excess"), and the funding status of the scheme as a whole. We will find that employers' costs have been very substantially reduced in Victoria in the last several years. Despite this trend, the scheme is fully funded and has been for the past five years. This is an impressive performance, indeed.

Economic Forces

Figure 3.2 shows the trend in employment in Victoria for the last 11 years. Employment has grown by only 10.3 percent over the decade, or 1.0 percent per year. Annual figures and rates of change are reported in Appendix Table A-1. Total employment in Victoria peaked in 1989/90 and is just returning to that level in 1998. The loss of 200,000 jobs in the recession of the early 1990s clearly bolstered the political resolve of those who believed that the WorkCare workers' compensation system in Victoria was "part of the problem."

The unemployment rate in Victoria is shown in Figure 3.3. Again, the rapid increase in unemployment in the early 1990s was a force for social change. The stubborn persistence of unemployment since also has had a fundamental impact on the balance of power between workers and employers in Victoria. This is reflected in Figure 3.4, which indicates that labour market developments served to restrain wage growth. In fact, average weekly wages in Victoria rose by less than the growth in prices in 6 of the past 11 years. The result is a decline in real wages for the decade. Thus, it would be fair to say that economic conditions for workers in Victoria have been difficult since 1990.

Underlying economic conditions affect workers' compensation systems both directly and indirectly. The number of workers obviously affects the number of people exposed to workplace hazards, but labour market conditions can also affect the likelihood of filing a workers' compensation claim, especially for long-term chronic problems like overuse syndrome. There can also be an indirect effect, expressed through the political system, or perhaps even the judicial system.

It is within this context that the WorkCover scheme must be evaluated. Victoria has made a remarkable transition in just six short years, but there is still tremendous controversy about the changes in the workers' compensation and workplace health and safety systems in Victoria. Emotions have been running extraordinarily high in Victoria. On 29 October 1997, organised

labour and the Plaintiff Lawyers' Association turned out an estimated 100,000 demonstrators against the restriction of access to common law for injured workers. A former Coalition Minister who once held the portfolio for health and safety resigned from Parliament partly in protest over the Government's workers' compensation reforms. The Labor Party representative handily won a bye-election, which further fired the hopes of those in opposition. But, the Government prevailed and passed its workers' compensation reform bill in December 1997 (as outlined in Chapter 2). The bitterness that remained over these issues, and the diverse perceptions that can result, were very obvious to us upon our return to Victoria in June 1998. That is one reason why it is important to review the performance numbers.

Prevention Activity

As indicated earlier and described more fully in Chapter 8, there has been virtually nonstop change for the health and safety function in Victoria; the latest being the absorption of the HSO by the VWA in July 1996. Nevertheless, the basic legislative mandate has remained constant since the passage of the Occupational Health and Safety Act in 1985. Victoria has pursued a performance-based approach to occupational health and safety since that legislation. But in practice, the tradition of standards enforcement has died hard in this environment. Many of these problems are recounted in Chapter 8, but here the internal contradictions of the past decade come into sharp focus in a very mixed performance record.

Figure 3.5 shows the number of inspections conducted in each year since 1989/90. The peak in 1993/94 was actually not related to any of the changes in the workers' compensation system, but it represented a special statewide campaign to register all boilers in Victoria. There is little trend apparent in these data before WorkCover was enacted in 1992, and actually a negative trend from 1993/94 through 1996/97. The 30 percent increase in 1997/98 is the result of a major push to get more resources into the field after the merger of VWA and HSO.

Figure 3.6 shows the number of improvement notices issued each year since 1989/90. Improvement notices are written directions requiring a person or organisation to fix a breach of the law. It is obvious that there have been some very dramatic changes here, again reflecting changes in policy and internal turmoil as the HSO went through repeated reorganisations in the early 1990s. Improvement Notices grew rapidly after 1994/95 and were 61 percent higher than the low point in 1997/98.

Prohibition notices are written directions prohibiting an activity that the inspector believes involves or will involve an immediate risk to the health and safety of any person. The activity cannot be restarted again until an inspector certifies that the risk has been removed. As seen in Figure 3.7, the number of such citations declined rapidly from 1991, as HSO tried to effect a change from a prescriptive tradition to a more behavioural- or performance-oriented approach. The number of prohibition notices has bounced back since 1994/95 as more attention was focused on the enforcement effort and more resources have been put into the field. However, in 1997/98, the number of such notices declined by 11 percent.

Figure 3.8 displays the number of prosecutions for health and safety violations (under all three acts, see Chapter 8 for details). Over the past four years, the numbers of prosecutions held in a narrow range of 79 to 86 per year. Employers continue to feel that prosecutions are incompatible with the model of the inspector as a consultant, while labour feels that the number of prosecutions is symbolic of the (inadequate) degree to which employers are held responsible for the safety and health of their workers.

Number of Claims¹

Figure 3.9 shows the number of claimants in receipt of weekly benefits during the last 11 years. It represents the “stock” of claims rather than the flow, since any claimant who receives weekly payments in the given year is included. But it shows how dramatically the population of workers’ compensation claimants in Victoria has been reduced. From 1987/88 to 1997/98 the number of weekly benefit claimants fell from over 88,000 to under 37,000 (a drop of 58 percent). The number of claimants in 1997/98 was below that of 1993/94 by 5 percent, though employment had grown by 7 percent during the same period. This magnitude of gross change is very unusual, and it reflects a number of different influences. We will attempt to disentangle those influences in the remainder of the chapter.

Figure 3.10 shows that the number of “standard claims” has declined by 51 percent during the decade from about 60,000 per year to just over 29,000 in 1997/98. This number

¹A more extensive discussion of claims and benefits is found in Chapter 5.

should be less affected by changes in statute, since “standard claims” exclude both the effects of the increase in the employer “excess” to 10 days and the elimination of journey claims. Further, this reduction is borne out by the similar decline in the number of fatal claims, shown in Figure 3.11. These declined by 59 percent in the past decade.

Figure 3.12 demonstrates that this decline also applies to “medical-only” claims, although the peak occurs much later for these claims. Medical-only claims, which do not involve lost work time, have declined from over 18,000 in 1992/93 to under 9,000 in 1997/98. There has been an even more precipitous decline in hearing-loss claims (Figure 3.13), from about 10,000 in 1993/94 to approximately 1,200 in 1997/98. This followed the raising of the threshold to qualify for hearing-loss benefits in 1994, and subsequent efforts to discourage “rorting” of the system for hearing-loss claims. This is another demonstration of the Government’s determination to resolve what they regard as a policy problem. Hearing-loss claims have also become a “problem area” in other jurisdictions around the world. What is different in Victoria is the aggressive policy response to the problem and the continued follow-through until the problem is resolved.

There has been a more modest decline in the number of claimants in receipt of Table of Maims (permanent partial) payments, from about 11,000 in 1993/94 to 7,024 in 1997/98, as shown in Figure 3.14. However, the average Table of Maims payment has been rising rapidly over the same period, so that total payments for Table of Maims injuries have actually increased. Finally, Figure 3.15 shows the number of common-law settlements over the last 10 years. This series peaks in 1992/93, with the filing of a massive number of claims preceding the implementation of WorkCover on 1 December 1992. The runoff of these claims is virtually complete by 1997/98.

Claim Payments

Figure 3.16 shows the 11-year trend in total claim payments. The rapid growth in total claim payments under WorkCare is apparent. For the five years from 1987/88 through 1992/93, the annual growth rate in total claim payments was in excess of 16 percent. The 37 percent drop from 1992/93 to the following year demonstrates the major change of direction in workers’ compensation in Victoria. In 1997/98, total claim payments in nominal terms were still 14 percent less than at their peak in 1992/93, and growing at 12 percent per year since 1994/95.

Figure 3.17 presents the trend in medical and like payments. This includes treatment by medical doctors, physiotherapists, occupational rehabilitation providers, etc. The figure shows the same basic pattern, although the decline in 1993/94 was not as dramatic (25 percent) and a bounce back in 1995/96 was substantial. The result is that medical and like payments in 1997/98 were about 3.5 percent lower than at their peak in 1992/93 and growing at 12 percent per year since 1994/95.

Figure 3.18 demonstrates that weekly benefit payments have been rising at nearly 12 percent per year since 1994/95. Despite this, they were still 26 percent lower in 1997/98 than in 1991/92. A good deal of this is attributable to the increase in the employers' excess from 5 to 10 days in 1993/94. WorkCover statistics show that the number of standard claims declined by 20 percent between 1992/93 and 1993/94. Weekly benefit payments declined by 40 percent between these two years.

Figure 3.19 shows the changes in the maximum weekly benefit specified by statute. The maximum weekly benefit has increased by 49 percent from \$457 (1987/88) to \$680 (1997/98) over the last 11 years, or 4.1 percent per year. Thus, maximum weekly benefits have expanded slightly faster than average weekly earnings, which increased by 44 percent over the same period. Figure 3.20 shows that the increase in the average weekly benefit in Victoria from 1987/88 to 1997/98 grew by 36 percent, or 3.1 percent per year. The fact that the maximum benefit has risen more rapidly than the actual weekly benefit means that more workers will qualify for the statutory wage-replacement level and the maximum benefit will limit weekly compensation for relatively fewer workers. Figure 3.20 also shows that the average weekly benefit rose more rapidly since 1991/92 than before.

Payments for death claims are shown in figure 3.21. These benefits increased substantially from 1987/88 to 1991/92 before falling back. Death benefits in 1997/98 were 32 percent lower than in 1991/92. For the entire decade, death-claims payments rose by nearly 60 percent, even though the number of fatal claims dropped by 59 percent. Clearly, there was a very significant increase in the average compensation per fatality. This is shown in Table A-1, where the average settlement for death claims rises from \$47,506 in 1987/88 to \$88,884 in 1997/98, or 6.5 percent per year.

Figure 3.22 shows payments in compensation for permanent impairment (Table of Maims) in Victoria. The pattern here is for strong growth throughout the period, with the

exception of 1992/93 to 1993/94, apparently reflecting the initial influence of WorkCover in encouraging earlier filing of claims, before the changeover to WorkCover. This is the only year-to-year decrease evident on the figure, and it is the only pause in the growth of Table of Maims payments since these were first instituted in 1985. From 1987/88 to 1997/98, benefit payments for claims under the Table of Maims rose from \$15.9 million to \$147.5 million, or by 828 percent—a rate of increase of 25 percent per year.

Figure 3.23 reports claim payments made under the provisions of common law. Since workers' compensation in Victoria was not an exclusive remedy as in North America, the worker was entitled to pursue tort relief for workplace injuries. However, both remedies were not available for the same injury, so workers' compensation benefits had to be paid back from any settlement that an injured worker might secure at common law. The "blowout" of these payments up to 1992/93, accounts for some of the determination of the government to get this area under control. At any rate, common-law costs seemed to be under control in the first few years of WorkCover, only to begin to rise sharply again in 1996/97, leading to the Government's decision to attempt to end access to common law completely in the spring of 1997.

Overall, legal costs have been substantially reduced by the WorkCover reforms. The desire to speed resolution and reduce the formality of procedures was one of the cornerstones of the changes to the workers' compensation system. Figure 3.24 shows that legal costs peaked at \$121 million in 1992/93, at just over 10 percent of total benefit payments, and then fell to approximately \$70 million by 1997/98. It remains to be seen how much the repeal of common-law access will affect the level of legal costs, as the runoff of the pending claims will take several more years.

Administration

The cost of administering the workers' compensation scheme is another element in evaluating the system's efficiency and effectiveness. Figure 3.25 reports the total scheme administration costs for the past 11 years under WorkCare and WorkCover. The reported level includes payments to agents and authorised insurers, but it does not include the cost of administration by self-insured employers. The figure shows that costs have been quite constant since 1989/90. Indeed, administrative costs declined under WorkCover but then increased in 1996/97 coincident with the absorption of the occupational health and safety responsibility.

Figure 3.26 shows the variation in the permanent staff level of the VWA and its administrative predecessor, the Accident Compensation Commission (ACC). Table A-1 shows that both ACC staff and WorkCare Compensation Services staff expanded rapidly until 1991, with rapid declines thereafter. The doubling of the staff in 1996/97 represents the merger of the formerly independent HSO with the VWA.

Financial Status

For employers, the “bottom line” on workers’ compensation is “how much does it cost?” This is not unique to Australia. Figure 3.27 displays the average workers’ compensation insurance premium rate for Victorian employers for the last decade. As recounted in Chapter 2, the ACC under WorkCare had attempted to stem the tide of rising insurance rates in the late 1980s, with some success as indicated by the figure. But holding the rate at a relatively high 3.3 percent to retire the unfunded liability was not sufficient to satisfy employers, or voters, and the WorkCover scheme was conceived with employer costs, economic development, and job growth in mind from the start.

Figure 3.27 indicates the success the Government has achieved in lowering workers’ compensation rates for Victorian employers. At the 1997/98 rate of 1.8 percent, the scheme has attained a reduction of 45 percent over the peak rate of 3.3 percent (1988–1991). The increase to 1.9 percent on a slightly elevated wage base (reflecting the inclusion of superannuation in the base effective 1 July 1998) does not substantially change this picture. System administrators are confident they can maintain the 1.9 percent rate for the foreseeable future.

Figure 3.28 shows that premium income has not declined as rapidly as the premium rate. This reflects the fact that assessable payrolls have been growing at more than 5 percent per year throughout the last decade. In addition, there has been the very positive contribution of double-digit investment earnings to funding the Victorian workers’ compensation scheme in the past several years. In 1997/98 the Fund earned a 12.9 percent rate of return on its assets.

The growing health of the fund can also be seen by comparing Figure 3.29, which represents total assets held, with Figure 3.30, which represent gross liabilities. Of course, liabilities represent new claims as well as revaluations by the independent actuaries and legislative changes to the scheme itself. Nevertheless, total assets have mounted steadily during

the period, surpassing \$3.8 billion by 30 June 1998, while liabilities first dropped and then rose to \$3.9 billion.

Figure 3.31 shows the funding ratio for the Victorian workers' compensation scheme. At the beginning of the decade, funding ratios were between 40 percent and 50 percent, meaning that the scheme held less than half as much in assets as its estimated future obligations. However, the financial health of the scheme has rapidly improved under WorkCover and the scheme has been essentially fully funded since 1994/95.

Conclusion

Reflecting upon the past decade of performance by the Victorian workers' compensation scheme, the greatest impression is one of system change. As discussed throughout the study, the changeover from WorkCare to WorkCover was a fundamental system change, sustained and supported by a new and different political philosophy. System architects moved swiftly and boldly toward the objectives stated by Minister Hallam in 1992 (See Chapter 2) within just a few weeks of being elected. They have persisted with the plan since, despite obstacles and objections.

This persistence has clearly been reflected in the performance of the scheme. Many fewer injuries are being recorded, fewer claims are being filed, and costs to employers are down substantially. The accomplishments of the WorkCover scheme are really quite remarkable. However, workers' compensation systems are like balloons; when you squeeze one place, there is a bulge (or blowout) created somewhere else. In the Victorian case, the biggest bulge came in permanent disabilities (Table of Maims, pain and suffering, and common law). However, the Government moved very aggressively in 1996 and again in 1997 to stop this development. Now the challenge is to stabilise the system, consolidate the gains, and make "the Victorian revolution" permanent.

Figure 3.1 Victorian WorkCover Authority Organisation Structure, 1 June 1998

Figure 3.2 Employment in Victoria

Figure 3.3 Unemployment Rate

Figure 3.4 Average Weekly Earnings

Figure 3.5 Number of Inspections

Figure 3.6 Number of Improvement Notices

Figure 3.7 Number of Prohibition Notices

Figure 3.8 Number of Prosecutions

Figure 3.9 Claimants in Receipt of Weekly Benefits During Year

Figure 3.10 Standard Claims Reported

Figure 3.11 Fatality Claims

Figure 3.12 Medical-Only Claims

Figure 3.13 Hearing-Loss Only Claims

Figure 3.14 Claimants in Receipt of
Table of Mains Payments

Figure 3.15 Common-Law Settlements, Total Loss

Figure 3.16 Total Claim Payments

Figure 3.17 Medical and Like Payments

Figure 3.18
Weekly Benefit Payments

Figure 3.19 Statutory Maximum Weekly Benefits

Figure 3.20 Average Weekly Benefits

Figure 3.21 Death Claim Payments

Figure 3.22 Permanent Impairment Payments

Figure 3.23 Common-Law Payments

Figure 3.24 Legal Costs

Figure 3.25 Total Scheme Administration Costs

Figure 3.26 Permanent Commission/WWA Staff

Figure 3.27 Average Premium Rate

Figure 3.28 Premium/Levy Income

Figure 3.29 Fund (total assets)

Figure 3.30 Gross Liabilities

Figure 3.31 Funding Ratio

Chapter 4 Regulatory Aspects of the Victorian WorkCover System

Introduction

The regulatory system plays a very important and interesting role in the Victorian WorkCover scheme. Victoria relies on a combination of private insurers and a state authority to manage the provision of workers' compensation insurance. Most systems in Australia and elsewhere tend to rely more heavily on the private sector to perform insurance functions. Other systems utilise a state agency to provide workers' compensation insurance. Victoria is somewhat unusual in that it delegates some insurance functions to the private sector while others are retained by the Victorian WorkCover Authority. Similar arrangements exist in New South Wales and South Australia.

The underlying premise or philosophy of the WorkCover scheme is important to understand the structure of its regulatory institutions and evaluating their performance. The premise is that the state needs to bear the underwriting risk and closely manage the provision of workers' compensation insurance to ensure that coverage is readily available to all employers at the lowest possible cost while serving the overall social goals of the system. The widely perceived shortcomings of the private system before 1985 are a legacy that helps to explain the perspective that the government needs to take a close hand in guiding the system. At the same time, the problems encountered with the public WorkCare system and the Government's desire to return more autonomy to the private sector have resulted in the mixed public-private system under the current WorkCover system.

Structuring a mixed system that provides the right controls and incentives and delegates decisions to the most appropriate entity is a challenge given the many options available and the complex interactions between Government mandates and private choice. The Government has elected to maintain direct control over those parameters that it believes are essential to scheme objectives and that are not likely to be achieved if left simply to market forces. At the same time, the Government has delegated certain functions to insurers, with regulatory controls and incentives, where it believes that private incentives and private choice can promote efficiency and scheme objectives. Refining the mix of public and private functions and regulatory controls

and incentives is a task that will continue to challenge the VWA as it moves forward into the twenty-first Century.

This mixed approach increases the responsibilities of the state in terms of providing certain insurance services as well as closely overseeing the activities of private insurers. As discussed below, the VWA confronts a significant principal–agent problem in inducing authorised insurers to promote scheme objectives. The VWA must coordinate its functions with those of private insurers to achieve the objectives of the system. In some respects, the VWA and insurers operate as partners in working together to provide workers’ compensation insurance to employers and their workers. In other respects, the VWA acts like a traditional regulator in ensuring that insurers’ actions comply with scheme requirements and serve the goals of the scheme. This gives rise to some unique issues for the VWA that are not present with pure private or pure Government workers’ compensation insurance systems.

This chapter describes the relative roles of the regulatory authority (VWA) and the insurance industry in achieving the goals of the Victorian workers’ compensation scheme, and it assesses their performance as of 1996. Along the way, we will explore the limits of regulation and the role of market forces in such a mixed system.

Relative Roles of Market and Regulatory Mechanisms

Understanding the roles of Government and private decision mechanisms is key to understanding the management of the WorkCover scheme. Public and private entities share the responsibility of providing workers’ compensation insurance in Victoria, but the nature of their responsibilities differs and creates relationships that are somewhat unique.

Figure 4.1 provides a schematic diagram of the delegation of insurance and regulatory responsibilities among the different entities. The VWA administers the WorkCover scheme, bears the risk through reinsurance, and regulates insurers and other providers. Insurers service insurance policies, adjust claims, and assist employers with risk management. Employers are responsible for complying with statutory requirements for workers’ compensation coverage, selecting their insurer, and risk management. Other service providers and intermediaries perform functions similar to their activities in other systems.

This section provides an overview of the relative roles and responsibilities of these different entities in performing workers' compensation functions in Victoria. The basic decisions made by regulators or through public choice mechanisms are identified, as well as those made by "the market" or private choice mechanisms. First, the nature of the principal-agent problem is outlined to provide a frame of reference for the evaluation of the regulatory structure.

Managing the Principal-Agent Relationship

The economic theory of the "principal-agent conflict" is particularly relevant to the structure of the Victorian WorkCover scheme. The problem arises when one entity, the principal, wants to induce another entity, the agent, to take some action that is costly to the agent (Varian 1992). It may be costly or difficult for the principal to directly observe the behaviour of the agent, but the principal may be able to observe the outcome of the actions of the agent. In the standard theoretical treatment, the principal's problem is to design an incentive payment, $s(x)$, which induces the agent to produce the desired output, x . However, in some real-world situations, principals also may face constraints in observing the output produced by the agent. This is more likely to be the case in complex systems like workers' compensation, where the "product" has multiple dimensions which are difficult to measure and involve a considerable time lag between action and result. In this instance, a principal may utilise an array of conduct and output measures, controls, and incentives to influence agent's behaviour.

There are several principal-agent relationships nested in the structure of the WorkCover scheme. Principal-agent relationships exist between 1) workers and employers; 2) employers and insurers; and 3) the VWA and insurers. It is the relationship between the VWA and authorised insurers that is of primary interest here, but it is important to understand that scheme outcomes are not solely controlled by insurers. The VWA uses mechanisms that rely on insurers and employers to promote the objectives of the system and the interests of workers. It is costly for insurers and employers to perform such actions, and it is costly for the VWA to monitor and control insurers' and employers' behaviours.

Agents typically face two types of constraints which influence their actions. One is a participation constraint, which is the potential gain to the agent from engaging in other activities. The principal must ensure that the agent receives at least this level of utility (or profit in the case

of a firm), i.e., the agent's opportunity cost, to enlist the agent's participation. The second constraint involves incentive compatibility. This means that the agent will choose that action which maximises his utility based on the incentive schedule offered by the principal. In the standard theoretical model, the principal cannot control the agent's action directly, but can only influence the agent's actions by the choice of incentive payments.

The solution of the principal-agent problem is relatively simple when the principal is a monopolist with full information. The more interesting case is when the agent's actions are hidden so that incentive payments can only be based on output. Assuming that output is not fully controlled by the agent, then output-based payments to the agent will necessarily have a random component and the optimal incentive scheme will involve some degree of risk sharing between the principal and the agent. If the principal imposes too much risk on the agent, the principal has to raise the average payment to compensate. On the other hand, if the principal assumes too much risk, the agent has little incentive to perform well. The general solution to this problem implies that greater uncertainty and/or greater risk aversion on the part of the agent will force the principal to bear more risk. Moreover, if the principal faces both high-cost and low-cost agents but is unable to accurately distinguish between the two, the principal will choose a payment scheme that effectively yields the low-cost agent a surplus and the high-cost agent just enough to make him indifferent between participating and not participating.

Arguably, the VWA faces a more complex problem in that it must achieve multiple outcomes which are somewhat difficult to measure objectively. At the same time, the VWA can monitor and regulate insurer conduct, which may be precluded in other principal-agent relationships. Hence, the optimal strategy for the VWA is determined by the relative cost and effectiveness of controlling insurer conduct directly versus influencing insurers' output or performance through incentives. The challenge for the VWA is to implement a cost-effective set of conduct and performance measures, regulations, agreements, standards, penalties, and rewards that will induce insurers and employers to maximise scheme objectives. The VWA's primary tools to influence insurer behaviour are 1) the licence agreement, 2) audits, 3) licence actions and penalties, and 4) the Best Practice Incentive (BPI) scheme. With the exception of BPI, these mechanisms appear to be more oriented toward conduct than outcomes. This system needs to be carefully evaluated in light of the interests of the Government and the other stakeholders that affect WorkCover outcomes and the constraints they face.

Role of the Victorian WorkCover Authority

The VWA wears several different hats under the current WorkCover scheme. One is that of a Government administrator responsible for the overall performance of the scheme and ensuring that employers comply with scheme requirements. This role is akin to that played by workers' compensation administrators in Australia and the United States under private systems. The VWA's second hat is that of insurer. Some of the functions performed by insurers in private systems are performed directly by the VWA. The VWA's third hat is that of regulator in the traditional and nontraditional senses of the term. In this role, the VWA oversees insurers' performance of the functions which they have been delegated as well as ensuring that insurers meet the financial standards necessary to perform these functions.

Administrative Role

There are certain generic administrative functions inherent in any workers' compensation scheme that are typically performed by a Government authority, including the VWA. These functions stem from the state's responsibility for the overall management of a Government-mandated social insurance scheme with statutorily prescribed coverage, benefits, and eligibility requirements. For the VWA, these functions include system monitoring and evaluation, recommending legislation, employer compliance, dispute resolution, and public information.

Insurance Role

In addition to administering the WorkCover scheme, the VWA performs some of the functions that might otherwise be performed by private insurers. The insurance functions performed by the VWA include bearing risk through reinsurance, pricing, funding claims, reserve analysis, investment management, and compilation and analysis of claims data. These activities were retained by the VWA when Victoria implemented the WorkCover scheme. The VWA has sought to minimise the principal-agent control problem by undertaking these activities directly, although the reinsurance function gives rise to a related moral hazard problem. Without other controls and incentives, insurers would have no incentive to minimise claim costs, as the VWA reinsures 100 percent of all claims payments. Such arrangements are unusual in private

reinsurance contracts (except for fronting arrangements), which involve some risk sharing between the reinsurer and the ceding company.

Regulatory Role

Other insurance functions have been delegated to insurers. In one sense, VWA functions as a contractor of services performed by insurers acting as vendors. In another sense, VWA is a regulator, controlling insurers' entry into and exit from the market for private workers' compensation services, as well as enforcing requirements and restrictions on insurers. The blend of contractual, regulatory, and incentive mechanisms reflects the VWA's strategy in managing the principal-agent relationship it has with authorised insurers in providing insurance services to employers and workers.

The distinction may be more than semantic in terms of how the VWA exercises control over insurers in various situations. The process for becoming an authorised insurer has many characteristics of a contractual relationship between the insurer and the VWA. In effect, VWA is a selective gatekeeper to the market for private insurance services purchased by employers. Insurers agree, in writing, to a detailed set of requirements to gain admission to this market. The VWA is able to exercise leverage over insurers by denying, revoking, or degrading an insurer's authorisation to serve the market. This is very much like the process for designating servicing carriers for residual markets in the United States except that VWA-authorised insurers go on to compete for accounts, whereas in the United States, employers are assigned to residual market servicing carriers.

In a more traditional regulatory environment, the regulatory authority would not typically enter into such detailed written agreements with regulated entities. The requirements for admission to a market would be set by law and regulation, and regulators would essentially be compelled to admit any entity meeting the requirements. The VWA does act more like a traditional regulator in overseeing certain aspects of insurers' market activities and services to insureds that are governed by competition. However, the VWA's ability to direct insurers' behaviour at this level is more limited.

The dual nature of this regulatory role allows the VWA to exercise considerably more leverage in influencing the behaviour of its agents, i.e., insurers, in fulfilling scheme objectives than other workers' compensation authorities. This is consistent with the philosophy underlying

Victoria's mixed public-private system, with its roots in the previous WorkCare system. The mixed approach places considerable responsibility on the VWA for scheme outcomes, which it seeks to fulfill through extensive market intervention. It also gives rise to some tension and confusion about the relationship between VWA and insurers and the degree of autonomy that insurers have. This dual nature of VWA's regulatory role will need to be reconciled with any efforts by Victoria to enhance insurers' discretion within the WorkCover system.

Insurers' Role

The insurers' role under WorkCover is more substantial than it was under WorkCare but less substantial than it was under the private system previous to WorkCare. Under the current system, insurers perform essentially all of the client service functions that would be performed in a traditional private insurance market environment. These functions include marketing, sales, underwriting, premium collection, loss prevention, claims adjustment and payments, litigation, case management, setting reserves, and data analysis and statistical reporting. These are the actions that the VWA seeks to influence through its system of controls and incentives. Insurers do not perform insurance functions retained by the VWA, which are primarily risk bearing, pricing, and investment of policyholder funds. Insurers receive fees for their services which are set by the VWA.

Insurers compete for accounts in order to increase the amount of service fees they receive. Assuming there are some economies of scale in servicing workers' compensation accounts and that service fees cover the marginal cost of servicing an additional account, insurers can increase their profits by servicing more accounts and increasing their service fee revenues. With the base price determined by the VWA, insurers compete on quality of service, with particular emphasis on risk management services, and other in-kind services to employers.¹ This is the way in which the VWA attempts to harness market forces and private incentives to encourage insurers to provide high quality service and contain costs.

¹By law, insurers are prohibited from making monetary kickbacks to employers to get their business. However, it is common that insurers provide additional in-kind services and equipment to employers, which effectively increase the value of services employers receive in relation to the premiums they pay.

Role of Other Market Participants

The functions performed by other market participants under WorkCover—employers, workers, producers, and vendors—are very much the same as in private workers' compensation systems. Employers are required to carry workers' compensation coverage, which they can purchase through an authorised insurer, or they can receive approval from the VWA to self-insure. Employers must take responsibility for compliance with statutory requirements, employ safety measures to reduce losses, and assist in case management and returning injured employees to work. Producers, i.e., agents and brokers, serve as intermediaries between some employers and insurers and facilitate insurance transactions. Vendors of risk management, claims administration, health care, and rehabilitation services function and compete much as they do in other systems.

Description of Victorian Workers' Compensation Regulatory Scheme²

This section provides a detailed description of the ways in which the activities of insurers are regulated by the state, and how decisions are made by the VWA with respect to workers' compensation services. The contractual as well as the traditional regulatory functions of the VWA are outlined. Emphasis is placed on the most important aspects of the regulatory scheme and other areas where regulators or insurers perceive that changes need to be made. Outlining the regulatory structure is essential to assessing the structure and performance of the market for insurers' services as well as the performance of the overall scheme. The federal solvency regulatory system for Australian insurers, including WorkCover insurers, is also described under Market Structure.

The VWA's regulatory functions are performed by the Scheme Regulation Division which is headed by a director who reports to the chief executive. There are four units within the Regulation Division, each supervised by a senior manager: 1) Health and Rehabilitation; 2) Investigation and Compliance; 3) Insurance; and 4) Transitional Projects. The principal regulatory functions are the responsibility of the Insurance Unit, which has several subunits, each supervised by a manager: 1) Business Systems; 2) Self-Insurers; 3) Licence Management

² This description is current as of 30 June 1996.

and Insurer Review; 4) Provider Services; 5) Regulatory Monitoring and Planning; and 6) Executive Support.

The Regulation Division has the primary interface with the authorised insurers. The Division is responsible for writing the licence document, the reinsurance agreement, supporting manuals, and policy documents that outline what is required of insurers. The Division also implements the BPI scheme and prepares the Authorised Insurer Quarterly Performance Table.

The Licence Management and Insurer Review unit is responsible for monitoring insurers' compliance with the licence agreement, developing the framework for regulation, remuneration, audits, performance visits, information, and technical interpretations of the act. This unit also is involved in helping to design and modify BPI provisions, which are ultimately determined by the Board of the VWA.

Table 4.1 provides summary statistics on the premiums collected and costs incurred by the VWA under the WorkCare and WorkCover schemes over the financial years 1986/87 through 1995/96.³ As can be seen from this table, premiums, claims costs, and operating costs increased considerably over the period 1987 to 1993. Total costs increased from \$412.5 million in 1987 to \$1,223.3 million in 1993. Some of this increase is presumably attributable to growth in the Victorian economy, but it is recognised that costs also increased for various reasons related to the WorkCare scheme (see Chapter 2). This trend was reversed with the implementation of WorkCover. Premiums fell to \$883.4 million in 1996. Claims and operating costs also dropped significantly to \$763.9 million in 1995 but increased to \$897.6 million in 1996. Managing these costs while achieving the objectives of the scheme in serving injured workers is the principal focus of the VWA's regulatory system.

Authorisation of Insurers

The authorisation of insurers to provide workers' compensation services in Victoria is the principal foundation for the VWA's array of regulatory activities. The requirements for authorisation, and the agreements which insurers must sign to become authorised, bind insurers

³Unless indicated otherwise, references to specific years or periods are based on VWA "financial years," which run from July 1 to June 30 of the following year. For example, a reference to 1996 will imply the 1995/96 financial year as defined by the VWA. The last year for which data are shown in this chapter is 1996.

to a detailed set of obligations in performing workers' compensation services. Regulators can restrict or withdraw this authorisation as a way to sanction insurers if they fail to perform their obligations satisfactorily.

The Accident Compensation (WorkCover Insurance) Act of 1993 provides strong and comprehensive authority to the VWA to regulate WorkCover insurers. The act only allows "authorised insurers" to issue or renew a WorkCover insurance policy. The act requires authorised insurers to be separate companies that only write Victorian WorkCover insurance. All authorised insurers are subsidiaries of parent companies, but they must maintain certain firewalls between them and their parents and affiliates. The secrecy provisions of the act are also significant and help to maintain this separation. An authorised insurer is not allowed to share any individual employer or claimant information with its parent or affiliates. Insurers may make payments to their parents for certain services. The VWA does not appear to be in a position to closely evaluate or restrict these payments unless they are clearly excessive or threaten an insurer's financial condition. Presumably, the requirement for separate Victoria workers' compensation insurers is intended to increase the control of the VWA and help to ensure that the insurer is focused principally on the WorkCover scheme.

An insurer incorporated in Victoria must apply for a licence to become an authorised insurer. The VWA develops the form for application and the requirements for any supporting documentation. The act prescribes fairly comprehensive criteria which the Authority may use to consider licence applications, including

- the suitability of the applicant;
- its financial viability;
- the provisions of the memorandum and articles of association of the applicant;
- the applicant's history of claims management;
- the efficiency and effectiveness of the WorkCover scheme; and
- any other matters the Authority considers appropriate.

The VWA may refuse an application if the applicant is authorised to carry on business other than WorkCover or the applicant is not a wholly owned subsidiary licenced by the federal regulator. WorkCover licences are granted for 12 to 24 months and can be renewed. The VWA

can deny renewal applications based on the above criteria, failure to comply with the act and conditions of the licence, and any other reasons deemed appropriate by the Authority.

The VWA has broad authority with respect to additional conditions it may impose on an insurer's licence. The VWA can require or prevent an insurer's undertaking of a specified amount or class of WorkCover insurance. Insurers may not refuse to offer insurance to employers unless mandated or approved by the VWA or the employer is not in compliance with the act. The VWA can require an insurer to earmark certain assets to cover WorkCover obligations. Insurers also may be prohibited from delegating claims management to an intermediary.

The licence and supporting documents developed by the VWA set very detailed conditions and standards for authorised insurers, which gives the VWA considerable ability to control insurers' activities. These documents include a comprehensive checklist of items which the insurer is expected to address in indicating its interest in becoming an authorised insurer. A detailed description of these documents is beyond the scope of this report, but it is helpful to summarise their major components. The conditions of the licence cover such areas as

- corporate requirements and arrangements;
- responsibilities of the insurer;
- audit requirements;
- administration of the statutory fund;
- the insurer's market share;
- the remuneration received by the insurer;
- computer systems;
- security;
- warranties and covenants; and
- suspension, cancellation, and surrender of the licence.

Supporting schedules outline a code of conduct, insurers' quality control and audit program, remuneration, computer systems, licence actions, and additional functions.

Insurers must have paid-up capital of not less than \$2 million, which is equivalent to the federal regulatory requirement. The VWA requires insurers to maintain and supply accounting records which accurately record its transactions and financial position. In practice, the VWA

relies principally on the accounting statements required by the federal regulator. Insurers are not allowed to attain a market share in excess of 49 percent. Detailed service standards pertain to employer service requirements; processing insurance policies; charging premiums and managing receivables; managing claims; managing long-term and severe injury cases; resolution of complaints; and assuming policies from other insurers.

WorkCover licences may be degraded, suspended, or cancelled for any reasons deemed appropriate by the VWA. Insurers incur a financial penalty in direct proportion to the percentage difference between the Minimum Success Rate (MSR) and the Sample Success Rate (SSR), based on an audit of their compliance with the service standards, which is applied to their quarterly service fee. The VWA may impose additional penalties for other breaches of the reinsurance agreement and associated conduct and service standards. Financial penalties are capped at 8.5 percent of an insurer's quarterly service fee.

If an insurer is penalised more than 5 percent of its service fee in any one quarter, its licence will be qualified. Licences also may be cancelled or qualified for harassment of claimants, fraud, incompetency or inefficiency, and breach of confidentiality. There are four tiers of qualification or degradation depending on the length of time penalties exceed 5 percent. These tiers ultimately lead to the cancellation of an insurer's licence if the situation is not corrected.

Authorised insurers are required to enter into a reinsurance arrangement with the VWA in which insurers fully cede all premiums and losses to the Authority. This agreement effectively transfers all underwriting risk to the Authority. The reinsurance agreement is very detailed and covers a number of areas, including employer and worker services, premiums, and claims and case estimates. The VWA also has the right to assign the policies, claims, and obligations of an insurer whose licence is cancelled to other authorised insurers. Policy forms and related notices must be sent directly to the employer and not an intermediary. Employers must pay premiums directly to their insurer and not an intermediary.

Reserving and Pricing

The VWA determines the price or rate charged for workers' compensation insurance. This effectively eliminates direct price competition as a determinant of market performance. The rate to be charged is promulgated by the VWA in a premium order every year (signed by the

Governor-in-Council), as provided in the act. Victoria's pricing formula, detailed in Figure 4.2, has been characterised as the purest experience rating system utilised in Australia. It uses an unweighted three-year average that balances sensitivity to changing experience with stability. The premium calculation starts with the employer's prior rate and then adjusts this rate based on experience.

The experience component is weighted by employer size (payroll) so that small employers' rates are based less on their own experience and more on their industry and class experience. With the exception of a \$50 minimum premium, there are no size or risk-related adjustments such as policy or loss constants, premium discounts, or schedule rating. As an employer becomes smaller, the formula effectively lengthens the time span that occurs before an employer is fully experience-rated. This contributes to the continuity of the formula. Consequently, there are fewer abrupt changes in an employer's rate because of changes in experience or other factors.

As noted in a VWA 1995 working paper, *WorkCover Premium System*, premiums are designed to meet five principles:

- 1) the system must be fully funded, i.e., premiums must cover all expected claims payments;
- 2) premiums must match claims risk and minimise cross subsidies;
- 3) the system must be statistically valid;
- 4) the system must be based on sound insurance principles; and
- 5) the system must promote prevention and return to work.

Premiums must cover the estimated total liability for a particular policy year (as calculated by two independent actuaries) plus the administrative costs of the scheme, including insurer service fees. The total claims liability for a given policy year comprise actual payments made in that year, claims incurred but not reported, and case reserves.

The general premium formula for an employer is based on the prior estimate or rate and recent claims experience of the employer (calculated as an employer experience factor) as follows:

$$\text{premium rate} = (Z) \times \text{employer experience factor} + (1-Z) \times \text{prior rate};$$

where Z is the sizing and experience factor (ranges between 0 and 1) based on the employer's total payroll weighted by industry risk (see Figure 4.2). Because the prior estimate starts with the industry rate for a new employer, the formula effectively increases the degree of experience

rating as the size and the length of experience of an employer increase. The experience factor is based on the ratio of fully developed claim costs of the employer's workplace as a proportion of the workplace remuneration over a three-year period.

The experience factor also is adjusted by individual insurer *F* factors, which are designed to correct insurers' tendencies to underestimate reserves.⁴ This is also intended to prevent insurers and employers from gaming the system by underestimating incurred losses to improve their experience adjustments. In theory, *F* factors are based on insurers' initial estimates of reserves compared with their actual claims payments for a given policy year. The *F* factors also adjust premiums for costs that are not reflected in the basic pricing formula, such as VWA administrative costs and dispute resolution costs.

The Actuarial and Statistical Analysis unit in the Scheme Development Division is responsible for premium calculations as well as other statistical research required for scheme administration and policy analysis. This unit provides the data and reports used by the independent actuarial firms (Tillinghast and Trowbridge) to perform valuations of reserves at the end of the financial year and for semiannual updates. Starting in December 1996, the actuarial unit began utilising its own models and performing its own actuarial valuations of and projections for the scheme and compares its results against the analyses of the actuarial firms. VWA staff cite evidence indicating their analyses and projections to be more accurate than those of the actuarial firms. The VWA actuarial unit also found inconsistencies in the assumptions used by the actuarial firms. The actuarial firms also perform special analyses of the pricing formula and related issues on request of the VWA. The VWA unit employs analysts with a financial and statistical background but does not have any staff actuaries of its own.

Service Standards and Enforcement

Insurers' performance requirements are outlined in the licence and reinsurance agreement, which includes schedules outlining detailed and comprehensive standards of quality of service and a code of conduct. The areas covered by these documents were listed above. Generally, they require insurers to be diligent, responsive, timely, and efficient in carrying out their service functions. Their provisions establish specific minimum service requirements (e.g.,

⁴The VWA indicates that, historically, reserves have been underestimated by 30 percent.

the maximum number of days for processing policies, premium calculation, and claims), as well as general principles that support the objectives of the scheme in serving injured workers.

Arguably, these standards govern both conduct and performance. The ambiguity lies in whether one regards “service” as an outcome or product. For example, there is a general service standard requiring insurers to provide necessary information to employers which includes a specific standard (among others) that insurers respond to employers’ written requests within 10 working days. Is the desired outcome a well-informed employer, the provision of adequate and timely information by insurers, or insurer responses to written requests within 10 working days? The difficulty in measuring the first two results may incline the VWA to set a more specific, objective, and measurable test as reflected in the third result. Regardless of how they are viewed, failure to meet these service standards triggers a regulatory response in terms of financial penalties and licence actions rather than an adjustment of incentive payments.

Enforcement of the standards is an important activity of the VWA. The licence agreement includes a schedule outlining an insurer quality control and audit program. The Insurer Audit Program (IAP) tests audit standards and insurers’ compliance with the service standards. Insurers must submit a self-audit program for approval to the VWA and are required to implement that program. A director of the insurer must personally certify the accuracy and regulatory compliance of its audits.

The Authority also retains the right to perform and does perform its own review of an insurer’s self-audit or conducts more detailed audits of its own. In practice, the VWA has contracted with accounting firms to perform its audits. Financial penalties for identified performance failures are exacted as a percentage of an insurer’s service fee based on the “success rate” of the transactions sampled compared with a minimum success rate. The maximum penalty is 8.5 percent of the service fee for a given quarter.

The VWA is revamping its audit program to respond to recognised deficiencies in the old program. The intent of the new program is to focus on broader measures of performance and decrease the emphasis on penalising minor errors. The new program outlines insurer business functions, their components, and key objectives which are intended to help insurers focus on the most important areas for testing and compliance. Sampling procedures are carefully specified.

Tested claims are required to satisfy all aspects of compliance, but minor failures will not constitute a failure of the test.

Remuneration

The remuneration system, outlined in a supporting schedule for the licence, determines the service fee that an insurer will receive. The authority sets aside a certain amount of funds in a service-fee pool which is allocated to insurers according to their market shares for each quarter. For example, for the 1995/96 financial year, the VWA allocated \$72.3 million in service fees, or \$18.075 million per quarter. Service fees are initially calculated at the beginning of the quarter and recalculated at the end of the quarter to account for transfers in business among insurers. The market share formula credits an insurer \$115 for every policy it writes, plus 5.3 percent of the premiums derived from the policies it writes. This effectively sets an average payment that each insurer receives for servicing a given policy or portfolio of policies which is not based on performance. There also is a levy fee on debts incurred prior to WorkCover that is assessed according to the time when the debt was incurred (3 percent for post 30 June 1993 debts and 25 percent for pre-30 June 1993 debts). In addition, insurers can receive a discretionary costs fee for non-common law related legal costs, medical costs, investigation costs, and other extraordinary costs as determined by the Authority. These additional fees transfer some further risk from insurers to the VWA.

Best Practice Incentive Scheme

The BPI scheme sets performance standards and provides financial rewards to insurers for meeting these standards and/or improving their performance. In the past, the measures have been 1) the cost of claims as a percentage of industry premiums; 2) premiums collected as a percentage of the premiums to be collected; 3) the percentage of reported claims referred to conciliation; and 4) claims duration. Insurers receive points for meeting or exceeding performance benchmarks set by the VWA in monitored areas, and financial rewards are paid according to the number of points an insurer receives. For the 1995/96 financial year, the BPI payment was \$6 million.

As of the date of this review (July 1996), the VWA planned to move to a broader measure of performance for the 1996/97 BPI program. Insurers will be rewarded on a sliding

scale up to 5 percent depending on their relative performance in bringing in actual costs below expected costs. The premium collection measure also will be retained but the other measures will be dropped.

Monitoring and Statistical Reporting

Three units in the Scheme Regulation Division perform statistical analysis used by the VWA for management and public information. The Regulation, Monitoring, and Planning unit is responsible for statistical information and reports, BPI scheme calculations, market share calculations, remuneration fee calculations, and special requests. The Actuarial and Statistical Services unit prepares statistical analyses used for management information and planning, as well as premium and reserve calculations. The Business Analysis unit is responsible for preparing special reports and analyses for senior management and the Board. This unit also has prepared the VWA's annual report for the last two years, but this function may revert to the Scheme Development Division in the future. These three units are the principal users of the VWA database.

The general database used for the various statistical analyses is extracted weekly from the ACCtion system transactions information. Insurers are mandated to use this system according to the licence document. This enables the construction of databases at a unit transaction level which the VWA staff believe is essential for the type of analyses that are performed. The database is divided into 200 tables, which facilitates analysis within a table but requires more effort to join data across tables. Almost all data from ACCtion are captured. Historical data are not available for some elements. Anyone at the VWA can access the data, and data users have sought to agree on some standardisation of definitions (e.g., long-term claims) to ensure more consistent analyses across users.

The Regulation, Monitoring, and Planning unit also is responsible for administering the Legal Information Management System (LIMS), which requires insurers to record and report legal actions. This helps the VWA keep track of legal actions and the impact of litigation on costs. Data quality has been a problem with this system, and VWA reconciles LIMS data with other data to identify anomalies. Poor performance is communicated to regulate compliance.

Communications with Stakeholders

The VWA has a comprehensive communications strategy which is designed to acquire and convey information to all major stakeholders. The stated purposes of this strategy are to create and maintain stakeholder support; to minimise the frequency, severity, and cost of workplace injuries; to increase the rate at which injured employees return to work and improve their maintenance at work; and to encourage quality service by insurers and providers. The Authority conducts a number of programmes using various media to implement this strategy. Among its programmes, as of July 1996, were publication of informational brochures; management of insurers' printing; translation of employers' brochures into different languages; ethnic print and radio advertising; video production; promotion of new initiatives; displays at trade conferences; press releases, media response, and editorials; sponsorships; and stakeholder liaison and networking. Insurers are responsible for printing their own insurance contracts.

While all of these activities are valuable in helping stakeholders and the general public understand WorkCover, stakeholder communication is critical to the VWA regulatory function. The VWA utilises a special insurer advisory committee to discuss regulatory issues and communicate VWA policy. This and other forms of VWA communication with insurers are important and deserve further scrutiny. This is especially true in Victoria's mixed system, where regulators apply a much closer hand in managing insurers' service functions.

Self-Insurance Regulation

Self-insurers are regulated within the Insurance unit of the Scheme Regulation Division. Self-insureds have an advantage under the law, relative to other employers, in that self-insureds can make immediate decisions as to whether a claim is compensable. Self-insureds also avoid the cross-subsidy paid by other large employers who pay more than their share of costs. Self-administration also is an option, although it has been rarely used to date (1996); discussions are under way with two employers who seek self-administered status. Under the act, self-administrators make their own claims decisions but the VWA carries the risk. Self-administrators' premiums are reduced by the amount loaded for administration (i.e., the servicing fee). Self-administration can serve as an interim step to full self-insurance, or as an end in itself.

The VWA characterises its self-insurance requirements as the toughest among the Australian states, except for Queensland. Self-insureds must have \$200 million in net assets, 500 full-time employees, and be a corporate body. There are no group self-insureds. Self-insureds also must demonstrate that they meet a “fit and proper” test, which involves determining that they are financially viable and that they can serve scheme objectives. As of December 1996, the VWA was authorised to approve self-insurance applications, which previously had to be approved by the Minister of Finance. The fit and proper test has four elements: 1) financial viability; 2) claims performance; 3) workplace safety; and 4) the infrastructure for administering claims. With respect to claims performance, the employer must be above average for measures such as cost of claims, duration, and frequency. Workplace safety is evaluated using Health and Safety Division audit results.

Self-insurance authorisation is granted for an initial three-year period, and every four years thereafter. Self-insureds must obtain a bank guarantee for one-half of their liabilities as certified by an approved actuary. Self-insureds must purchase unlimited excess coverage for catastrophes. They also must implement a self-audit program and contribute to the WorkCover fund, except for administrative costs. The self-audit program focuses on claims administration, rehabilitation, and loss prevention. In 1996, the self-insureds began reporting data which the VWA uses to monitor and benchmark their performance. Self-insureds are allowed to use neither captives nor third-party administrators. This is consistent with the intent of using self-insurance to promote greater employer control of their own risk and claims.

There are 23 self-insured employers, accounting for 9 percent of scheme remuneration. At the time of this study, the VWA had nine self-insureds under assessment and was reviewing two new applications. Processing self-insurance applications also involves negotiating the self-insured’s assumption of the tail of its outstanding claims. The self-insured receives any related premiums collected less any benefits already paid.

There are barriers to self-insurance, in addition to regulatory requirements, which help to explain why it is not more predominant. These barriers include employer apathy (which may be encouraged by the decrease in premium costs under WorkCover and the strong experience rating component of the pricing formula), the fact that workers’ compensation is not viewed as a core competency of employers, and the rigorous assessment process.

Investment Management

The Victorian Funds Management Corporation (VFMC) manages the funds accumulated by Victorian Government agencies, the bulk of which are owned by the Transportation Accident Commission and the VWA. For the VWA, these funds cover the Authority's future obligations to claimants as well as any surplus it maintains. Participation in VFMC is voluntary for Government agencies. VFMC currently manages \$7 billion, of which about \$3 billion is owned by the VWA.

The VFMC investment strategy emphasizes growth and income within certain prescribed constraints. The VFMC's inflation-adjusted return is between 4 percent and 5 percent. VFMC management believes that its performance is quite comparable to that of insurers and other conservative portfolio managers. The VFMC would like to match the liability profile of each fund with its asset duration and return. The funds have to be 95 percent invested. Average asset duration is two to three years. The VFMC can invest in derivatives for hedging purposes.

The mix of VWA assets are 35 percent domestic equities; 20 percent foreign equities; 10 percent domestic interest income investments; 10 percent foreign interest income investments; 10 percent inflation-indexed investments; 10 percent real estate; and 5 percent short-term investments. Interest income earned on VWA assets allows the VWA to collect less in premiums than would otherwise be needed to cover its future obligations. Thus, the earnings of the funds are an important influence on the price of insurance.

Market Structure

Some elements of the structure-conduct-performance framework used by industrial organisation economists are employed in this section and the next to analyse the market for private insurance services under WorkCover. Figure 4.3 outlines this framework. The principal-agent problem also is important to understanding the behaviour and performance of insurers. This section focuses on those structural aspects of the market for the services provided by insurers that are critical to the system's performance. The key factors that influence market structure are regulation, insurer cost functions and market strategies, and employers' ability and inclination to shop for insurers' services. To the extent there is a market for certain services performed by insurers, parameters such as the number and size of insurers, entry and exit, and how insurers differentiate their services are important to understanding how this market

functions. This discussion is relevant because changes in the structure of the market would affect scheme performance.

Federal Regulation

In addition to regulation by the VWA, Victoria's workers' compensation insurers also are subject to supervision by the federal regulator, the Insurance and Superannuation Commission (ISC). The exercise of ISC's jurisdiction over WorkCover insurers is somewhat ambiguous, but it could effectively limit the insurers eligible to apply for authorisation to become a WorkCover insurer. The ISC also regulates the holding companies for WorkCover insurers, which could indirectly affect the structure and performance of the market for insurer services under WorkCover.

The ISC focuses primarily on solvency, with an emphasis on "supervision" rather than "regulation." This means that ISC tends to monitor and consult with insurers frequently and persuade them to rectify problems, rather than enforce detailed regulations specifying what insurers can and cannot do. There only have been a handful of insurer failures since the ISC's inception in 1973. Its objective is to limit the cost of insolvencies, not totally eliminate them. The primary responsibilities of the ISC are to establish limited restrictions on insurers; supervise specific aspects of insurers' financial structure and operations; monitor prudence; enforce minimum standards; and maintain close contact and consultation with insurers. The ISC must approve the independent auditors used by insurers.

The ISC system establishes three progressive layers of financial tests: a solvency margin, a capacity margin, and a prudential margin. Regulatory attention and intervention intensifies as an insurer falls below these tiers. The solvency margin is the lowest tier (\$2 million in surplus) and could trigger regulatory takeover of a company, if necessary. The ISC works with a company to try to avoid insolvency, if possible. At the time of this review, the ISC was considering establishing risk-based capital standards as have been implemented in other countries.

Insurers are required to file quarterly and annual financial reports. The ISC sets accounting standards for insurers who are required to report investments at their market value. Financial reports must be certified by independent actuaries and accountants. The ISC does not emphasize comprehensive regulatory exams but does perform targeted exams which focus on

particular areas of concern. Much of the ISC's interaction with insurers is confidential. The ISC communicates regularly with the states on matters of mutual concern. Of course, the states can also revoke an insurer's authorisation for state-controlled business which can create a solvency problem.

Historically, the ISC has exercised limited regulation of insurer market practices and relied on the common law to protect consumer rights. The ISC authority in this area is provided by the Insurance Contracts Act of 1973, which defines the regulatory relationship between insured and insurer and codifies the aspects of common law which govern this area. The act was expanded in 1994 to give more power to ISC to enforce codes of practice. The industry also operates a consumer complaint tribunal which seeks to resolve insured-insurer disputes.

There are 169 authorised insurers in Australia representing 18 groups. There are 25 authorised reinsurers and a handful of captives. The ISC prefers that international insurers establish Australian subsidiaries as opposed to branches. The ISC does not regulate alien insurers but regulates the intermediaries that broker international transactions. There are no restrictions on consumers' purchases of insurance from alien insurers. Domestic groups hold the predominant share of the Australian market.

The ISC does not regulate state-owned and state-controlled insurers. Victorian WorkCover falls into a gray area in that insurers write the business but cede all of it to the VWA. Technically, this requires the ISC to regulate authorised WorkCover insurers in Victoria, but, in practice, the ISC appears to pay little attention to these insurers. Yet, the VWA relies on ISC financial requirements and financial reports to evaluate and monitor authorised WorkCover insurers. The regulatory responsibilities of the ISC and the VWA with respect to Victorian workers' compensation insurers will need to be clarified and coordinated if Victoria delegates more insurance functions and decision making to authorised insurers.

Number and Size of Insurers

There were currently 14 authorised insurers providing WorkCover services (as of 30 June 1996). This number may be somewhat less than the number of insurers that might typically write workers' compensation insurance in a private market system in a state of comparable size to Victoria. However, it should be pointed out that the relevant market in which insurers compete

does not cover the full scope of workers' compensation insurance. Rather, it is the market for the set of services delegated to insurers. This effectively limits the size of the market to competition for the services and service fees allocated to insurers, i.e., only 5 percent to 6 percent of the total premiums collected. Moreover, entry is closely regulated, services are highly prescribed, and potential profits are constrained. For these reasons, we would not expect a large number of insurers to service the WorkCover market. With these considerations, 14 insurers appears to be a reasonable number of companies to serve the market and should provide an adequate number of choices to employers and adequate competition for employers' business.

The market also is relatively concentrated, with a few insurers holding a dominant share of the market. Table 4.2 tracks the concentration of the Victorian workers' compensation insurance market from 1993 to 1996. The top four insurers held 73.6 percent of the market in 1993 and 67.3 percent of the market in 1996. The Herfindahl-Hirschman Index (HHI) was 1,618 for 1993 and 1,374 for 1996.⁵ The 1993 levels of concentration would be considered relatively high by conventional standards, but the decrease in concentration over the last four years is significant and suggests a fairly competitive and dynamic market environment. Concentration increased in 1996 with the merger of CIC and Heath and the exit of AIG, but the resulting increase in the HHI was only 50 points. Moreover, the current levels of concentration are reasonable given the relatively small size of the market for insurer services. Smaller markets would be expected to be more concentrated, all else equal (Klein, Nordman, and Fritz, 1993). It is not uncommon for larger state workers' compensation markets in the United States to have comparable levels of concentration.

Table 4.3 tracks insurer market shares over the four years from 1993 to 1996. Several large insurers have lost market share, and some smaller insurers have gained market share over this period. If this is the result of effective competition by more efficient insurers, it bodes well

⁵ HHI is a commonly used measure of market concentration that measures the relative size distribution of all firms in the market. It is calculated by summing the squared market shares of all firms. This gives disproportionately greater weight to the market shares of the larger insurers, which is consistent with economic theory about the relationship between firm size and market power. The U.S. Department of Justice antitrust guidelines define HHIs between 1,000 and 2,000 as constituting moderate market concentration and HHIs in excess of 2,000 as constituting high market concentration. Note that these benchmarks have been established for national markets that are larger and more difficult to enter than smaller state markets. Most state workers' compensation markets in the United States have HHIs between 1,000 and 2,000 but are viewed as highly competitive.

for the performance of the market. On the other hand, if this trend reflects unfair competition or attempts to secure business with excessive extra services or manipulation of premium classifications, then it should be a matter of concern.

Entry and Exit

The level of entry and exit has been somewhat limited under WorkCover, but given the size of the market and the tight licensing requirements, it appears reasonable. Table 4.4 summarises this activity from a statistical perspective. Nine insurers were initially authorised as servicing agents under WorkCare. In 1987/88, four of these agents dropped out and two more insurers became agents, resulting in a net decrease of two agents. In 1989/90, two more agents dropped out, leaving five authorised agents in the system. Through the end of WorkCare, two new insurers entered the market, one insurer resumed operations, and one insurer dropped out. Exits were prompted either by termination by the VWA or voluntary withdrawal.

The demands upon and incentives for servicing agents under WorkCare encouraged fewer insurers to be in the market than the more promising business opportunities opened under WorkCover. It is apparent that some companies were induced to become authorised insurers because of expectations about growth and profit opportunities resulting from greater privatisation. If these expectations are not realised, there may be some retrenchment and exits by currently authorised insurers. Exits could be even more numerous if insurers are required to establish their own information and transaction systems. Although WorkCover entry requirements and barriers are relatively high, they do not seem excessive considering the orientation of Victoria's mixed system and do not appear to have seriously compromised competition.

However, the issue of entry barriers and market concentration requires continued attention by the VWA. Some insurers may exit if it becomes too costly for them to operate in this market and/or if Victoria does not privatise the market. This could dampen competition and reduce incentives for the remaining authorised insurers to be innovative and improve their quality of service. It also could reduce the VWA's leverage in influencing insurers' conduct. Additionally, if Victoria moves to greater privatisation, entry requirements would have to be reassessed to ensure they are commensurate with the requirements for a system that places more

emphasis on private choice and competition. It would be desirable to have additional, financially strong insurers enter the market if it was privatised.

Insurer Differentiation

Insurer differentiation of their services is the principal mechanism for competition in the Victoria WorkCover market. Historically, there has been a perception that insurer differentiation has been limited but this may be changing. All the insurers interviewed contended that their service strategies are different than those of their competitors and are essential to increasing their market shares. It is difficult to evaluate the validity of this contention without more extensive examination and comparison of insurers' services. Some insurers may be enhancing their services and targeting niche markets in anticipation of greater privatisation. Indeed, many insurers cited efforts to improve their facilities to analyse employers' experience and help them contain costs. Delegation of information system responsibilities to insurers and publication of insurer performance statistics could also encourage insurer service differentiation. Future adjustments in the regulatory scheme will likely have a significant impact on this dimension of market structure.

Market Performance

This section evaluates how well the scheme performs in areas that are affected by regulation and insurers' activities. Because of the unique nature of the Victorian scheme in its reliance on a combination of public and private choice, the framework of this analysis differs somewhat from the conventional market structure-conduct-performance analysis. The primary question is how well the mixed system of public-private provision of workers' compensation insurance has achieved the objectives of the WorkCover scheme. This is a difficult question to answer because of the close integration of VWA administrative and regulatory responsibilities and insurer activities. The performance measures available reflect the impact of all of these institutions, and it is difficult to isolate the effects of regulation and market structure per se. Hence, this performance analysis is somewhat general, and its reflection on insurer efficiency must be qualified.

It helps to have a historical perspective in evaluating insurers' performance under the current WorkCover scheme.⁶ Most observers agreed that the system was in bad shape prior to WorkCare. Pricing was extremely cyclical, and coverage was difficult to purchase and very expensive when the market hardened. Small employers were most vulnerable to this market volatility. Large employers had more leverage to make deals with insurers.⁷ Subsequently, under the WorkCare scheme, the system was plagued by runaway costs, excessive durations, and a growing class of dependent injured workers. As discussed elsewhere, prices have stabilised under WorkCover, costs have decreased, and the availability of coverage is not an issue.⁸

Underwriting and Availability of Coverage

Insurers' underwriting responsibilities are considerably different under Victoria's mixed system than under a private system. In a fully private system where insurers bear the risk, underwriting is key to the insurers' risk management and avoidance of adverse selection. In this environment, an insurer will reject employers who are perceived to be too risky in relation to the insurer's price structure, causing claim costs to exceed the premiums collected and attracting more high-risk employers. However, insurers do not face this problem under WorkCover. For this reason, insurers' underwriting function is confined to proper classification of risk and determination of the correct premium, which they perform on behalf of the VWA. Insurers interviewed, for the most part, confirmed that they are not selective in terms of the types of risks they seek to write.

To a limited extent, some insurers may use underwriting to tailor their business toward employers for whom the standard service fee is perceived to yield a larger profit margin given the level of service that the employers will require and the potential for audit exceptions and penalties on the handling of their claims. This strategy has to be implemented through selective marketing and service perquisites. Some insurers, anticipating privatisation, also may be seeking

⁶See Chapter 2 for a more thorough account of the history of workers' compensation in Victoria.

⁷Tasmania's private workers' compensation market is often cited as an example where cyclical pricing occurs when there is minimal regulation.

⁸At the same time, recent developments in New South Wales indicate that this mixed public/private model is not immune to these problems.

to write employers that they perceive will be more profitable in a private system under which they would bear the risk.

Because insurers have little incentive or ability to reject high-risk insureds, the availability of workers' compensation coverage is not an issue per se in Victoria, in contrast to private systems. Under Section 11 of the WorkCover Act, an authorised insurer may not, without the consent of the VWA, refuse to issue or renew an insurance policy to an employer. This provision does not apply if the employer has not complied with the law or regulations governing WorkCover. Hence, there is no need for a residual market mechanism as in private systems where insurers can refuse to write an employer for a number of reasons. Only the supply of special additional services are subject to insurer discretion and may be less available to small and high-risk employers.

However, other performance issues do arise in this area. Insurers' diminished incentives for accurate underwriting can result in instances of incorrect classification and pricing. Indeed, some insurers take pride in their ability to lower employers' premiums by reclassifying their workforces. This is appropriate if an employer has been misclassified, but there also is the potential for manipulation of classification for competitive purposes. We do not know whether or not this is a serious problem. The audit process is intended to prevent classification and pricing errors, but it is an imperfect substitute for stronger insurer incentives to get it right.

Marketing

VWA officials observe that competition among insurers to attract employers does not appear to have had a significant effect on employers' selection of insurers or insurers' performance. The VWA indicates that turnover of employers is limited to less than 1 percent annually.⁹ Insurers tend to market their services in a traditional "promotional" sense but, historically, do not appear to have focused on their relative performance in terms of outcomes. Employers lack the information to effectively identify the better performers. There are other

⁹This contrasts with a Boston Consulting Group survey of 300 Victorian employers, among which 14 percent had changed insurers within the last year (Boston Consulting Group, 1995).

reasons why employers may rarely move their business, including other insurance coverages they may purchase from an insurer and the relationship they have established with an insurer.

Reserving

It is possible that some insurers would have difficulty in estimating losses and pricing coverage for workers' compensation without the Authority's assistance. VWA staff noted that insurers typically do not have the analytical resources to determine adequate reserves and evaluate their risk. This is significant given the long tail of workers' compensation insurance claims. According to the VWA, insurers consistently underestimate the development of case reserves and incurred-but-not-reported (IBNR) claims. Studies indicate that a significant portion (60 percent) of losses are not paid until five years after the injury year, so it is easy to see how insurers might underestimate reserves.

The VWA acknowledges that some insurers are getting better at analysing their losses and their risks at a technical level, but senior company managers sometimes do not use this analysis to make good business decisions. It also was observed that insurers in Victoria had to climb a big learning curve, and that approximately 50 percent to 60 percent of insurers have made considerable progress but 20 percent are doing a poor job. The *F* factors are intended to adjust for the reserving accuracy of each insurer, but this objective may be obscured if *F* factors are also used to adjust for scheme costs not reflected in the base rate. At the same time, it is fair to point out that the ACCtion system is not designed in such a way as to make it easy for insurers to extract this information and perform this kind of analysis.

Premium Collection

Employer reporting of remuneration and the collection of the proper premium has been an issue in Victoria, as elsewhere. In the 1993/94 financial year, the function of premium collection was transferred from the Government to insurers. VWA audits of selected employers have identified \$15 million in unpaid premiums, plus \$5 million in penalties. The VWA will audit a random sample of employers this year (1996) to estimate the magnitude of under-reporting. The VWA believes that this is a function which should be delegated to insurers. Competition among insurers for accounts and employers' desire to lower their premiums create

disincentives for proper reporting of remuneration. The fact that premiums are fully ceded to the VWA reduces insurers' incentive to collect the full amount due the VWA. However, VWA staff do not perceive this to be a significant problem in relative terms as they indicate that 99 percent of premiums are collected properly.

Premium and Claim Costs

The overall cost of the WorkCover scheme is a principal concern of most stakeholders. Even workers and noninsurance providers have a stake in this, as increasing costs will raise pressure to reduce benefits and medical and rehabilitation services. To the extent that costs can be minimised by effective loss prevention and return to work strategies, more resources are available to pay benefits and provide additional services to injured workers. As noted above, the overall cost of the system is affected by all the institutions involved in regulating and providing WorkCover services. Hence, while it is instructive to examine cost trends, it is problematic to attribute these trends among the different institutions affecting them.

Table 4.5 shows figures for the basic premium rate (premiums divided by leviable remuneration), the published rate, and the ratio of claims payments to premiums for the 1986–1996 period. The decrease in the published rate from 3.3 percent in 1992 to 1.98 percent in 1996 is a remarkable accomplishment. Victoria currently offers the lowest rate among Australian states at 1.8 percent for 1996/97. The ratio of claims payments to premiums on a fiscal year basis is an imperfect performance measure because the premiums are associated with a different set of policies than the claims payments. During the period 1994–1996, the average annual ratio of claims payments to premiums was 81.1 percent. To the extent this fiscal year ratio reveals anything about the policy year experience, it suggests a relatively efficient level of performance—in terms of the relation of benefits received to benefits paid—that is commensurate with the experience in competitive workers' compensation insurance markets.

Several factors have contributed to this improvement. One is system reforms under WorkCover. Another is refinement of the pricing formula and restoration of full funding to increase employers' incentives to reduce losses. A third factor is VWA and insurer efforts to encourage loss prevention and improve case management. Public dissatisfaction with the abuses

under WorkCare and a change in the culture pervading workers' compensation insurance also may have helped to discourage workers "gaming" the system.

The ability of Victoria to sustain this low cost is the subject of considerable discussion. Many observers point to underlying cost drivers that will ultimately force premiums up. It is typical for costs to rebound in systems that have undertaken significant reforms as different interest groups whittle away at the reforms and search for new ways to stretch the system. Victorian officials are aware of this tendency and are seeking to further increase efficiency and forestall erosion of previous reforms.

Profitability

The profitability of WorkCover insurers is particularly difficult to measure and is a source of considerable disagreement. Insurers contend that the service fee is inadequate and that selling WorkCover services is not profitable enough to sustain their long-term operations under the current system. The question then is why insurers stay in the market. One possible explanation is that profits are higher than they are alleged to be, particularly considering that risk is low. Another reason is that some insurers expect to increase their profits by increasing their market share or benefiting from possible privatisation. A third explanation is that there are economies of scope in marketing WorkCover insurance with other coverages supplied by affiliates and that the overall profits from selling a package of insurance coverages makes WorkCover business more viable.

Table 4.6 presents aggregate figures on scheme financial performance. While year-to-year financial results are somewhat volatile, it is apparent that there has been significant improvement during the period up to 1996. The scheme sustained a net loss every year during the 1986–1989 period. Since then, income has exceeded expenditures in all but two years.

While the scheme's financial performance appears to be much improved, what do the data indicate with respect to insurers' financial performance? Table 4.7 presents income figures by insurer for the 1995 report year based on ISC statistical reports. However, these figures do not appear to be very meaningful given the peculiarities of the WorkCover mixed system. Because insurers cede all premiums and losses to the VWA, their income is a product of their expenses from providing insurance services and the revenues they derive from service fees plus any

investment income from assets they hold. There is a wide variation among insurers in terms of expenses and income, which may be partly due to differences in results reported on a calendar-year basis for ISC versus results that would be measured on a policy-year basis. Also, income and expense figures are subject to considerable manipulation from an accounting perspective, particularly with respect to reporting payments to parents and affiliates for the services they render. Hence, it is difficult to evaluate insurers' claims of inadequate profits.

In 1995, Victorian insurers' profits after income taxes ranged from a negative 34.2 percent of premium revenue to a positive 20 percent. Many insurers reported zero or negative profits, and the median profit rate for all insurers was zero. Closer analysis of more consistent financial data will be necessary to develop meaningful profit estimates. Still, it is unlikely that such an analysis will find that insurers are making excessive profits from WorkCover, or one would see much greater interest from other insurers to get into the market.

Products and Quality of Service

There is not true competition among WorkCover insurers in terms of products offered, as the basic WorkCover policy and coverages are prescribed by law and cannot be modified. However, if we adopt a broader concept of product that encompasses the full set of services offered by insurers, then there is some opportunity for service differentiation and the question of service performance becomes relevant. Clearly, insurers can affect scheme performance by offering better and more innovative services that help lower costs and promote other employer and worker interests. However, a principal challenge that is present with any workers' compensation system with private providers is the fact that it relies on first and second parties, employers and insurers, to deliver services to a third party, workers, who do not control the other parties. Also, under the current system, insurers and employers do not reap the full financial benefits from better services (at least without a fairly long time lag), which diminishes their incentives for good performance.

The VWA identifies service delivery as the greatest problem under the current system. Insurers are not perceived as being innovative with respect to identifying problem areas and developing solutions. Of course, insurers do not have their own money at stake, and they are alleged to view problems to be WorkCover's concern. Insurers' efforts to help employers

improve workplace safety is one area of concern. VWA officials believe that insurers do not tend to provide comprehensive loss-prevention services as part of their normal package of services. In their view, insurers' standard approach to risk-management services is not geared toward employment-related coverages that involve human resource considerations.

VWA officials believe that insurers fail to actively analyse their data to identify cost drivers or problem areas and implement or recommend effective cost-containment strategies to employers and public officials. Insurers also are thought to be insufficiently responsive to small employers. The VWA indicated that loss-prevention advice tends to follow the occurrence of an injury. Insurers may negotiate separately with employers to provide more extensive loss-prevention services. As noted above, there are other risk-management providers (sometimes affiliated with insurers) who also provide loss-prevention services in Victoria.

The VWA's view of the extent of loss-prevention services provided by insurers contrasts somewhat with insurers' characterisation of what they do. All of the insurers interviewed indicated that they perceive loss prevention and risk management to be an important part of their services and one of the principal ways they differentiate themselves to employers. At the same time, insurers acknowledge they could do more in this area, and some are seeking to expand these services within the constraints they face. However, lack of innovation by insurers is attributed to inadequate remuneration.

Long-term case management also has been identified as a problem area (see Chapter 7). From the perspective of the VWA, insurers are good at processing claims but not as good at managing cases involving long-term and severe injuries. VWA staff indicate that insurers seek to close claims as quickly as possible by paying lump sum settlements and through other means. There is a concern that there still are an excessive number of long-term claims that could be resolved. Of the approximately 4,500 serious-injury claims (as of 30 June 1996), one senior VWA manager "guesstimated" that only 900 would be completely unable to do any work. Another 900 are probably drug dependent and would need to be detoxified before returning to the labour market. Many remaining long-term claimants have had no recent medical treatment and their current disability statuses are unknown. The VWA intends to investigate these cases for potential long-term return to work, as well as consider some claimants for psychological testing and rehabilitation.

Several factors are identified as contributors to insurers' performance at service delivery. One is the historical legacy of insurer practices with respect to claims management, which remains from prior systems. In this view, the insurance "culture" is not geared toward conserving human capital but, rather, in terms of "doing deals" to get workers to sell their rights to further compensation. It is alleged that insurer personnel receive insufficient training on effective claim-management practices. It also is observed that employers do not seem to discriminate among insurers very well. They do not know what to look for in terms of selecting a good service provider. It should be noted that, historically, the Authority has not published performance statistics for individual insurers that would help employers select insurers.

VWA officials indicate that insurers' service performance has improved since the implementation of WorkCover but that it still falls considerably short with respect to achieving system objectives. At the same time, the authorised insurers tend to be more advanced than other insurers in handling workers' compensation claims. Some of the improvements developed under WorkCover have been extended to other areas of the insurers' business. The question is whether insurers can make the leap to effectively manage the difficult, long-term cases (roughly 20 percent of the total cases).

Table 4.8 summarises service performance statistics by insurer for the first quarter of 1996. The data indicate considerable variation in insurer service performance, particularly for categories such as timeliness, case reserve accuracy, and medical panel delays. At first glance, the performance of some insurers in the areas of timeliness and medical panel delays appears to be quite poor. It is difficult to determine simply by looking at these data the extent to which these statistical differences are attributable to true differences in performances and to what extent they are attributable to differences in insurers' portfolios of risks. However, at first blush, they do give credence to the view that some insurers are considerably better than others in performing their service functions and promoting scheme objectives.

If good controls for differences in portfolios could be employed, it would enable analysts to target poor performers and perhaps work with them to upgrade their performance. Significant differences in service performance raise questions about the efficacy of the current incentives in encouraging all insurers to provide good service. This issue would become more relevant if the

VWA published these performance statistics to allow employers to use this information in comparing carriers.

Solvency

Insurer solvency and solidity is an important issue under WorkCover, although not as significant as in systems where insurers bear underwriting risk. Under WorkCover, the VWA assumes claims obligations, so an insurer's failure would not create problems in meeting these obligations, nor would it create a deficit that would have to be covered by other stakeholders. On the other hand, the failure of a WorkCover insurer would, at the very least, require the VWA to transfer its policies, which would create some disruption and impose some transactions costs. Also, an insurer in financial trouble might lower its quality of service in an effort to reduce costs, which would negatively affect scheme objectives and constituencies.

Table 4.9 presents figures on assets and liabilities by insurer for 1995 as reported by the ISC. Most insurers have net assets close to the \$2 million capital requirement mandated by the ISC and the VWA. Consequently, their ratios of assets to net assets and liabilities to net assets (conventional measures of capital adequacy) tend to be much higher than the ratios that insurers would normally maintain. Presumably, the parent companies of these insurers have decided that it is not efficient to maintain higher levels of capital in Victoria workers' compensation insurers. Given that these insurers do not bear underwriting risk and their parents are in a position to infuse more capital if needed, this does not raise a concern about the financial solidity of these insurers that would be present if the circumstances were different. Of course, if these insurers accept more risk in the future as the result of privatisation measures, it is clear that they would need to be capitalized at a higher level to satisfy safety objectives. They also would need to generate sufficient profits to provide company owners with an adequate rate of return on this additional capital.

Regulatory Program Assessment

This section evaluates the performance of regulatory functions and issues raised with respect to these functions. This analysis is based on interviews of regulators and insurers as well as quantitative or other objective measures of regulatory performance that are available. We cite

comments from the different stakeholders that were interviewed and reflect on those comments. In many of these cases, we were not in a position to validate the comments that we received. However, there are a few instances where data are available to add some perspective on these issues.

While regulators and insurers are proud of their significant accomplishments under WorkCover, both sides perceive the need to significantly improve certain aspects of the regulatory program. Insurers, in particular, indicate considerable dissatisfaction with a number of things that regulators do and have called for substantial reforms. A strong theme in their criticisms is the perception that regulators are too heavy handed and treat insurers in a demeaning manner. Insurers do not believe that the VWA acts as a true partner with an appropriate level of mutual respect and trust with insurers. Comments by some VWA staff about insurers tend to confirm insurers' view of regulatory attitudes, although senior VWA management is seeking to improve the relationship between regulators and the regulated.

Management of the Principal-Agent Relationship

The way in which the VWA manages its principal-agent relationship is key to the performance of the regulatory program. Is the VWA using an optimal mix of conduct and outcome measures, controls, and incentives to induce insurers to maximise scheme objectives? Determining whether the VWA is using the best possible regulatory strategy is beyond the scope of this report, but it is reasonable to make some observations on the cost-effectiveness of some of its regulatory mechanisms. Mechanisms that are difficult and costly to administer and, at best, have only a marginal positive effect on insurer performance should be reconsidered. There may be other measures that could be initiated or strengthened that would accomplish the job at a lower cost and/or with greater benefits.

Specifically, the VWA's relatively heavy reliance on conduct monitoring and control versus outcome-based incentive payments should be assessed. Both regulators and insurers are buried in the minutia of enforcing and complying with numerous detailed conduct-oriented standards rather than focusing on and rewarding overall performance. This system is costly for all parties, gives rise to significant tensions between regulators and insurers, may present conflicting objectives, and may induce insurers to expend an excessive amount of effort on

nominal compliance with an arbitrary set of conduct standards at the expense of service outcomes.

This approach also may be somewhat unusual relative to the ways in which most principal–agent relationships are managed. Moreover, the vision of the insurers’ role under WorkCover may be somewhat different now than when the current regulatory system was implemented. Is the regulatory system still optimally designed given the direction of the WorkCover scheme? This question is nested within the broader question of the delegation of insurance functions between the government and insurers. If insurance functions are reassigned or other changes made to enhance the role of the private sector, how should regulatory policies be modified?

Some aspects of the principal–agent problem faced by Victoria might be obviated by delegating more responsibilities to and increasing reliance on market forces and private choice. This section considers the cost-effectiveness of current regulatory mechanisms as well as more fundamental changes to the regulatory structure that would significantly alter the principal–agent relationship between the VWA and insurers.

Authorisation of Insurers

The authorisation process appears to be fairly rigorous although not necessarily inappropriate given the responsibilities shared between the VWA and insurers, and the conduct-oriented nature of the regulatory system. Interviewed insurers did not complain about the authorisation process, but they may see an advantage to it to the extent that it discourages entry by other insurers. Moreover, the requirements for authorisation do not appear to be so steep as to prevent an adequate number of insurers from serving the market in its current form. The detailed and well-documented standards promote a mutual understanding of what is expected from insurers and a clear basis on which to judge their compliance.

On the other hand, greater reliance on outcome as opposed to conduct standards might be easier to administer and achieve greater success in promoting scheme objectives. This would require the VWA to design a more limited set of performance standards that would focus on insurers’ results rather than how they achieved those results. Performance standards could encompass any outcomes with appropriate weights that the Government determined to be

desirable, including minimising claim, legal and administrative costs, timeliness in processing claims and paying benefits, conformance with the statutory requirements of workers' compensation, and success in returning injured workers to productive employment. The VWA could set minimum performance standards in these areas and a system of rewards and penalties based on insurers' performance relative to the standards. While there are already some elements of this approach in the current regulatory system, the emphasis on outcome-based incentive payments could be significantly enhanced.

Victoria might also revisit its requirement that authorised insurers be separate companies that only provide WorkCover coverage. The rationale for this requirement is still somewhat unclear to an external observer. It is not obvious that requiring separate WorkCover insurers improves performance in serving WorkCover objectives. While this has not necessarily proven to be an excessive entry barrier, removing this requirement could reduce administrative costs for insurers and possibly attract more efficient companies. The VWA could still enforce conduct and performance standards on authorised insurers, regardless of whether WorkCover was their sole business.

If Victoria moves to a more private system, it will have to reexamine its licensing process and determine what is appropriate under a different regulatory scheme. In such an environment, more consideration would need to be given to financial evaluation and monitoring as well as rate and market conduct regulation. Intensive monitoring and regulation of insurers' conduct and performance may be less feasible and necessary if private incentives replace the VWA as the principal regulator of insurers' activities. In addition, it would be preferable to have a larger number of insurers compete in an insurance market where the product includes risk bearing.

Service Standards and Enforcement

The audit program is cited frequently by insurers as a problem area. They express the concern that auditors lack sufficient expertise to understand what they are auditing, and that audits are too focused on identifying minor exceptions to arbitrary performance standards and miss the "big picture" in terms of insurers' overall performance. Consequently, insurers are induced to focus on activities aimed at avoiding audit exceptions rather than overall performance and scheme objectives. Insurers also complain that the audits are aimed at finding and penalising

errors rather than giving insurers an opportunity to cure problems identified and sanctioning the failure to cure identified problems.

However, it should be pointed out that one of the objectives of an audit program is to encourage insurers to comply with service standards before they are audited. If insurers are only penalised after they have had an opportunity to cure problems found by external auditors, insurers' incentives to comply with standards proactively are diminished. The solution may be a combination of better standards and the selective use of retrospective as well as prospective penalties to induce optimal conduct. Some errors may be obvious failures to comply with established standards that insurers should have corrected or avoided on their own, while others may reflect legitimate ambiguities or situations which insurers could not have avoided. Auditors also should be properly trained and not solely junior staff with little or no insurance experience. Insurers could be encouraged to establish more rigorous self-audit programs.

The new audit program may effectively address many of these concerns. Insurers indicate that they believe the new audit program is a substantial improvement over the previous one. At the same time, some insurers expressed surprise and frustration that certain provisions of the new program still contain unfairly punitive aspects that they did not expect. Not all insurers, however, share the view that the new audit program departs from what was discussed.

A more radical idea would be to do away with the audit program altogether. This would not be feasible if the VWA retains a heavy emphasis on enforcing conduct requirements, but it might be reasonable if it shifted its focus to performance standards and incentives. Performance measurements and incentive payments would need to be strengthened to offset decreased emphasis on conduct regulation. The advantages of eliminating the regular audit program would be reducing the costs of conducting and complying with the audits and refocusing insurers' efforts toward achieving the best results in the way most efficient for each insurer. This would not preclude the VWA from performing limited market conduct exams on a random basis or specialised targeted exams in response to employer and worker complaints of poor performance.¹⁰

¹⁰Market conduct examinations, in the traditional sense, would be more limited in scope than the current service audits. Market conduct examinations would assess whether insurers were complying with statutory requirements and the terms of their contracts with insureds.

Pricing and Reserving

Opinions differ on the desirability of the scheme's current pricing formula, which is the primary mechanism that the VWA uses to influence employer behaviour. The VWA believes that the formula has performed relatively well in helping to restore the scheme to full funding, establishing more accurate, risk-based premiums for employers, diminishing cross-subsidies, and enhancing employers' incentives to improve their experience. At the same time, the VWA recognises that the formula is not perfect and that there may be ways to improve it.

One of the significant issues is the cross-subsidies that still exist within the current formula. These cross-subsidies primarily benefit small employers. They stem from 1) the \$15,500 remuneration deductible; 2) the \$7,500 exemption limit, below which employers do not have to pay any premium; 3) the small sizing and experience factor (*Z*) for small employers; and 4) the maximum industry rate of 7 percent. The VWA estimates that the cross-subsidy to small employers from the first three factors amounts to approximately \$20 million at present.¹¹

Among the many options that have been identified for discussion purposes are: placing a floor on the *Z* factor and adjusting the *Z* factor for an employer's industry's performance in broad bands to help small employers; including dispute resolution administrative costs in claim cost measurements; increasing variable excess options available to employers; and refining classifications to the three- or four-digit industry level. The VWA points out that changes to the premium system should not be considered in isolation but evaluated as a set in terms of their impact on employers and scheme objectives.

Among the goals of the options identified above are to make an employer's rate more responsive to its experience and to help small insurers who are not large enough to benefit significantly from individual experience rating. This would increase the interest in industry-wide cost containment and best-practice initiatives. However, while these are laudable objectives, individual employers still could pursue a "free rider" strategy by benefiting from the safety investments of their competitors without making commensurate investments of their own.

¹¹ A 1995 VWA working paper (*WorkCover Premium System*) discusses these and a number of other issues and options.

There also are questions with respect to the simplicity and transparency of the pricing formula. There appear to be different opinions among VWA staff on this issue. The Authority does receive a number of complaints from employers, particularly small ones, that the formula is too complex and difficult to understand. However, one advantage of the formula cited is that there is no formal mechanism for insurers to cut “side deals” with employers, which would further complicate employers’ understanding of the basis of their premium calculation. This presumably focuses employers’ attention and incentives to improve their experience.

Other experts outside the VWA criticise certain aspects of the pricing formula. They note that the prior rate component of the formula dampens large swings in the premium. At the same time, it serves to perpetuate the cross subsidy built into the formula. The prior rate approach differs from the more common method of blending the industry rate with the experience of an employer, as is done in New South Wales. An alternative would be to employ a more traditional experience rating formula which would adjust an employer’s rate more quickly based on its relative experience. While this would diminish the degree of continuity in the current formula, it would reward and penalise employers more promptly according to their experience and enhance their incentives to prevent and contain loss costs.

VWA staff respond that the current formula’s greater reliance on an employer’s previous experience provides a better prediction of the employer’s future experience, based on statistical theory. They also point out that greater reliance on industry experience would provide a greater cross-subsidy to poor performing employers. Credibility theory suggests that placing excessive reliance on a small employers’ prior experience would lead to inaccurate pricing with respect to a small employers’ future experience. Indeed, VWA staff note that when the scheme employed lower sizing constants, it tended to “bleed premium” and, hence, was raised to \$360,000 in 1995/96—an amount the VWA believes to be the right level. In sum, they conclude that recent changes will result in a reasonably balanced price structure, with the exception of the cross-subsidy still provided by the \$15,500 remuneration deductible.

It is reasonable to surmise that the VWA’s *F* factors have contributed to the improvement in reserve estimates over time and have helped to expedite the transition to full funding. However, the *F* factors still receive considerable external criticism from outside experts, as well as insurers. It is alleged that the *F* factors are a catchall that picks up any errors in previous premium calculations, as well as underreserving. This is perceived as inequitable in that it has a

disproportionate impact on large employers who, in effect, pay for the prior miscalculations of the scheme. VWA staff disagree that *F* factors are employed as a catchall for previous errors, noting that the factors only relate to the previous year.

It also is asserted that the \$15,500 statutory deduction has a large impact on *F* factors. If this criticism of the *F* factors is correct, they should not be manipulated simply to maintain the appearance of a low base rate. It should be noted, however, that regardless of the accuracy of this criticism, the *F* factors are intended to adjust premiums for costs that are not reflected in the individual employer pricing formula. It would be more straight forward to incorporate these costs directly into the base rate. At the same time, some type of mechanism like *F* factors is needed to correct the incentives of insurers and employers to underestimate reserves when their own funds are not at risk.

Remuneration

A significant limitation of the current remuneration formula is that it fails to discriminate among the levels of service that insurers are required to provide for their respective portfolios of risk. It also does not discriminate among insurers in terms of their performance or quality of service to employers and claimants. For example, an insurer does not receive a greater amount of fees if it manages a disproportionately higher number of long-term and difficult cases, which require more intensive management. Similarly, the remuneration formula does not reward insurers for doing a better job at loss prevention and case management, resulting in lower claim costs and higher success in returning injured employees to work. Insurers bear the additional cost of these efforts, but the financial benefits accrue to the VWA, injured workers, and employers. The BPI scheme is intended to provide financial payments to insurers for better service, but its performance measures are imprecise and the total amount of the rewards is small. Some complain that insurers with a disproportionate share of employers with short-term and less difficult cases are unfairly advantaged under the current remuneration scheme.

The VWA is aware of these concerns and is considering changes to address them. It has discussed negotiating customised contracts with each insurer, rather than one generic contract with each insurer. This would allow the VWA to recognise the type of portfolio held by an insurer in determining its remuneration. The VWA also has discussed inducing insurers to lower

costs by sharing a portion of the savings with them. This kind of approach may have considerable merit and should receive serious consideration.

Best Practice Incentive Scheme

The total amount of BPI payments that can be made, \$6 million, is relatively small compared with the remuneration provided through the service fee, approximately \$70 million. Consequently, the impact of the program on insurer behaviour is limited. However, the program also may influence behaviour through the signal it provides, which could provide a psychological motivation to some insurers' management. VWA staff expressed the view that the financial impact of the program is more significant than any signaling aspect. This perception may change if insurer-performance statistics are published. Still, as long as the VWA bears the burden of claim costs, it needs to find ways to increase the financial incentives for good performance. This could be accomplished through increasing BPI payments and/or revamping the remuneration scheme.

This area, along with service standards and enforcement, deserves serious reassessment. Could the VWA achieve greater success in promoting scheme objectives at a lower regulatory cost by increasing performance-based incentive payments? This would be another way to enhance insurers' gains and incentives from better performance. Similar to the current system, insurers could receive a minimum service fee for meeting minimum performance standards and additional payments for exceeding these standards. The difference would be that performance payments would comprise a greater portion of insurers' total remuneration. Scheme cost savings could help to fund incentive payments. Economic analysis could be employed to determine the optimal incentive payment system. Such a system would require close attention to refined outcome measures to minimise biases and incentive incompatibility.

The outcomes that could be measured and rewarded could include 1) minimising claims, legal, and administrative costs; 2) paying the benefits required by statute on a timely basis; 3) timely remission of funds to the VWA; 4) returning injured workers to productive employment; and 5) any other outcome that the government seeks that is not encompassed in the first four. These outcomes are subject to objective if not perfect measurement. While any performance measurement and reward system will necessarily be imprecise, the VWA could redirect its

regulatory resources to developing and monitoring cost-effective measures and incentive payments.

To optimise performance, the outcome measures would need to encompass any objective that the Government perceives to be important and that insurers would be inclined to ignore or diminish if not rewarded. Hence, the system would have to establish an appropriate balance between incentives to contain costs and pay benefits so that workers would get no more and no less than what they were entitled to.

Monitoring and Statistical Reporting

The Authority's database gives it a distinct advantage in performing various analyses necessary for proper pricing and analysing cost drivers. The VWA can conduct statistical analyses using unit transaction data for the entire system. Hence, the database provides maximum credibility and flexibility that considerably exceeds what any insurer can perform with its own data. This includes valuation of individual case reserves that can be estimated with a high degree of accuracy. On the whole, it appears that VWA prospective loss cost estimates have proven to be relatively accurate relative to actual experience (aside from the criticisms about the need to manipulate *F* factors). The VWA also has been able to set adequate rates, which has quickly restored it to full funding since the implementation of WorkCover.

The tie between the detailed transaction information extracted from the ACCtion system and the VWA's database significantly contributes to the flexibility, content, accuracy, and timeliness of the VWA analysis. VWA can turn around loss cost estimates and premium calculation within weeks after the end of injury year. This far exceeds the capabilities of workers' compensation authorities in most other states in Australia, or in the United States. However, the VWA believes that the ACCtion system is becoming outdated and needs to be replaced or turned over to insurers to develop their own systems. The high cost of replacing the ACCtion system is obviously a significant motivation to delegate this function back to insurers.

Some insurers also express a preference to use their own systems, which are tailored to their specific needs and other information systems. Understandably, these tend to be larger insurers with stronger information systems departments within their company structure. They do not hide the fact that they perceive requiring insurers to develop their own systems will serve as

an entry barrier that will help to cull the market of marginal players. Other insurers express concerns about the cost and their ability to develop their own systems.

Most insurers, regardless of their views on whether there should be a common system, indicate that the current system is not well suited to their needs to extract information to serve their clients. Indeed, some insurers' disproportionate demands on the ACCtion database have been a source of contention and have compelled the VWA to attempt to restrict excessive use of the database. This further frustrates insurers, who believe they are unfairly criticised for not doing more analysis to help their clients better manage risk and claims. Developing a cost-effective solution to this dilemma which will serve both regulators and insurers is one of the biggest challenges facing Victoria at the present time.

Self-Insurance

As noted above, Victoria's requirements for self-insurance are relatively stringent, and few employers are self-insured. There is considerable interest in easing restrictions on self-insurance and self-administration. Self-insureds generally are thought to demonstrate better claims performance, although this may reflect a selection bias. Other perceived advantages are self-insureds' increased control over claims management, ability to consider other human resource issues involved with claims, and the involvement of various levels of management in cost-containment efforts. The VWA is interested in opening the process to encourage the 250 largest employers to move toward self-insurance. It is envisioned that self-insureds would still need to satisfy stringent but more flexible capital requirements and demonstrate that they have achieved an initial level of performance based on health and safety measurements.

There are several ways to make self-insurance easier. The Boston Consulting Group has recommended liberalising the capital requirement using some form of a point scoring model. Allowing insurers to increase their deductible or level of retention could be another approach to increasing self-insurance. The Boston Consulting Group also has suggested raising the variable excess limit from 10 days to 26 weeks as another way to allow employers to retain more risk. Victoria already has the highest limit in Australia, as the other states typically have five-day limits. The current 10-day variable excess provision could be adjusted to anywhere from 1 month to 1 year, depending on the size of the employer and other considerations. Self-administration

also could be expanded by easing its requirements. The VWA believes that it will be necessary to perform an actuarial analysis of expanding self-administration to establish the correct incentives. Self-administrators will have to demonstrate that they are financially viable and employ a full-time WorkCover administrator.

There are some concerns with respect to increased use of self-insurance, such as employers suppressing claims and adverse selection. The cross-subsidy to small employers would have to be resolved to avoid excessive adverse selection. In the United States, cross-subsidies and other factors have helped to push approximately 30 percent to 40 percent of the workers' compensation insurance market into self-insurance in many jurisdictions. But it is very important that an employer choose self-insurance because of its underlying efficiency, not as a way to avoid the payment of cross-subsidies or administrative cost levies.

The VWA might consider allowing group self-insurance. Self-insurance is not viable for small employers unless they participate in a group plan. The VWA has not favored group self-insurance because risk is shared among group members and, hence, diminishes a participating employer's incentive to reduce risk. However, requirements for group self-insurance can be structured in such a way that participants can still gain some efficiencies without abusing the system to avoid paying their fair share of costs. Group self-insurance can be limited to employers in a common industry or trade association, where members of the group can combine efforts to address similar safety and claims-management problems. A group also can exercise peer pressure on its members to contain costs, particularly if it can charge risk-based premiums and exclude employers that fail to meet the group's standards. Group self-insurance would expand options for small- and medium-sized employers and increase their bargaining power with insurers.

The prohibition against the use of third-party administrators by self-insureds also might be reconsidered. The VWA has noted that one of the barriers to self-insurance is that employers do not view this as one of their core competencies. However, access to a third-party administrator would allow a self-insured employer to outsource claim administration, if that is more efficient, while maintaining a strong incentive to prevent losses and return injured workers to productive employment.

Communications with Insurers

Poor communications with regulators ranks near the top of insurers' concerns with the current regulatory scheme. Insurers loudly complain that regulators do not communicate with them openly and respectfully as equal partners in the WorkCover scheme. Insurers contend that the VWA's communication structure fails to support the close working relationship that it purports to. Many VWA staff appear to have a different perception and do not believe insurers' criticisms are justified. These different perspectives must be reconciled if the VWA is to forge a more constructive and positive relationship with insurers.

This problem might be addressed through facilitated sessions in which both sides can freely express their views; understanding the other person's side is the first step to agreeing on measures that will address the problem. The current advisory committee structure also might be strengthened to increase the VWA's accountability to insurers. The advisory committee could receive periodic reports and briefings and be notified of any significant developments or issues that the VWA was considering. The VWA could establish a policy of formally responding to questions, complaints, and recommendations of the advisory committee and providing support for any response.

Employer Information

The WorkCover regulatory scheme relies on employer choice to induce insurers to control claim costs and provide good service. Competition among insurers to secure employers' business is intended to counteract some of the perverse incentives implicit in the principal-agent relationship between the VWA and insurers. If employer choice is to play this role, employers must have the incentive and the necessary information to purchase services from better performing insurers. It is intended that the experience rating aspect of the pricing formula provide the proper employer incentives. Yet, it has been observed that employer movement among insurers is limited, and insurers that score relatively low on the VWA's performance benchmarks still write a significant amount of business. Some of this may be due to imperfections in performance measurement, but a lack of information on the part of employers with respect to insurers' performance and its impact on their costs also could be a contributing factor.

Providing information to employers is a critical component of the WorkCover regulatory scheme. This information can take two forms. One is general education on how to shop for an insurer and lower workers' compensation costs. This approach focuses on key areas and disseminates high-level information to all employers, as well as more detailed information on request. The other type of information is the publication of performance statistics for individual insurers. The VWA is working on a prototype report for this purpose. The objective is to help employers identify insurers who offer better service, and it could ultimately help to lower employers' premiums by improving their experience.

Insurers are understandably concerned about the accuracy of such a report, but it has the potential to attract employers to insurers with good performance records and increase competition. The key is whether the report helps to better inform employers about insurers' performance, or provides misinformation or is misunderstood by employers and encourages movement to insurers who are not good performers in reality. The development of accurate performance measures and useful explanatory materials will be essential to the success of this effort. The VWA should be prepared to enhance the service performance data available to employers and take other steps to improve employers' information and understanding of the implications of their choices. The VWA's communications strategy includes a number of promising initiatives, particularly the Best Practices Incentive programme, which is targeted at industries with notoriously poor safety records, such as road transport.

There is an issue with respect to the relative roles of the VWA and insurers for informing employers. In theory, the public sector has an interest in disseminating information that promotes public goals, that it can provide most efficiently, and/or that would not be adequately supplied by private entities. Generally, the VWA's information products seem to meet at least one of these criteria. One service that might fall into a gray area is the development of individual employers' claims experience reports for feedback and peer comparisons. Ideally, this is something that insurers would prepare as part of their services and promotion to employers. However, many insurers appear to lack the ability to prepare such reports, and since the VWA is the ultimate risk bearer, it has an interest in encouraging employers to reduce losses. Improvements in insurers' access to employers' claims data and greater competition for employers' business could facilitate shifting this task to insurers.

Other Regulatory Tools

The VWA has employed other administrative and regulatory devices to promote scheme objectives. For example, under the Work Incentive Scheme for Employers (WISE) program, the VWA agrees to pay half the salary of long-term claimants for 6 months to employers who hire them. Thus far the program has had only 172 placements. The VWA is developing a register of interested employers to expand the program. Senior management would like to use WISE to target the 3,000 “direct payees,” claimants whose employers are no longer in business. There is a proposal to pay insurers an incentive of \$1,000 if they are able to return the claimants to work.

Innovative programs like this can be valuable in a mixed system, where private financial incentives may be insufficient to encourage insurers and employers to achieve scheme return-to-work objectives. Such programs may need to be reevaluated in the context of privatisation efforts, which may or may not serve the same objectives.

Concluding Observations

Victoria’s workers’ compensation scheme has come a long way in improving the efficiency and quality of the insurance services provided to employers and workers. At issue, is whether it can achieve further significant improvement, either by refining its current regulatory tools or making more fundamental structural changes. It is possible, but perhaps unlikely, that fine-tuning the VWA’s regulatory tools will make much of a difference. If insurers’ incentives and constraints stay essentially unchanged, one would expect their performances to remain the same. Some insurers may continue to learn how to serve their clients better, but they are unlikely to make considerable investments in innovation and improving service with the limited profits offered under the present system. Conceivably, performance may deteriorate if insurers have been basing business decisions on expectations about the future that will not be realised.

The expected outcomes of more fundamental changes to WorkCover regulation or increasing the role of the private sector are uncertain but may warrant exploration. It is possible that the VWA could achieve equivalent if not better performance, at a lower regulatory cost, by increasing its emphasis on performance- or outcome-based incentive payments rather than strengthening its enforcement of conduct standards. Additionally, there are a number of ways to enable private choice to play a greater role in increasing the efficiency and equity of system outcomes, when the costs and benefits of market decisions can be properly aligned. Of course,

policymakers will need to consider the effect of alternative market and regulatory arrangements on the tradeoffs between cost containment and other scheme objectives. Victoria should explore these options with an open mind and a clear eye in determining the future course of workers' compensation.

Table 4.1 Premiums and Reimbursements (\$, millions), 1986–1996

Fiscal Year	Total Premiums	Total Claims Payments*	Total Operating Costs	Total Costs/ Premiums (%)
1986/87	586.8	332.6	79.9	70.3
1987/88	705.9	537.7	103.7	90.9
1988/89	795.1	715.4	181.5	112.8
1989/90	1170.8	694.4	181.5	74.8
1990/91	1261.3	749.2	185.6	74.1
1991/92	1129.2	909.5	183.6	96.8
1992/93	1127.8	1049.6	173.7	108.5
1993/94	838.6	622.7	165.7	94.0
1994/95	889.2	602.8	161.1	85.9
1995/96	883.4	724.0	173.6	101.6

* Claims expenses minus claims recoveries.

Source: VWA

Table 4.2 Market Concentration, 1993–1996

Fiscal Year	No. of Insurers	CR4*	HHI**
1992/93	8	73.6	1,618
1993/94	17	68.0	1,476
1994/95	16	64.2	1,321
1995/96	14	67.3	1,374
Annual Avg.	13.8	68.3	1,447

* Combined market share of top four insurers.

** Sum of squared market shares of all insurers.

Source: VWA

Table 4.3 Insurer Market Share Trends (% Premiums),
1993–1996

Insurer	1996	1995	1994	1993
AIG	--	0.8	0.6	0.1
AMP	2.4	2.0	1.7	1.1
CATH	0.6	0.7	0.6	0.5
CIC	--	13.5	15.9	19.9
CU	2.0	1.7	1.2	1.0
FAI	8.7	8.1	7.4	7.7
GIO	14.3	15.1	14.4	16.8
GUILD	0.1	0.1	0.1	0.1
HEATH	--	6.0	5.7	3.2
HIH	17.4	--	--	--
MERC	4.9	4.3	4.2	4.4
MMI	23.6	25.0	27.7	26.5
NZI	6.9	6.7	6.3	6.2
QBE	12.0	10.7	10.1	10.5
SUN ROYAL	2.8	1.9	1.4	0.4
VACC	2.2	1.9	1.6	1.1
ZURICH	2.2	1.7	1.1	0.5

Source: VWA

Table 4.4 Market Entries and Exits, 1986–1996

Financial Year	No. of Insurers	No. of Entries	No. of Exits
1986/87	9	0	0
1987/88	7	2	4
1988/89	7	0	0
1989/90	5	0	2
1990/91	5	0	0
1991/92	6	1	0
1992/93	8	2	1
1993/94	17	9	0
1994/95	16	0	0
1995/96	14	0	2

Source: VWA

Table 4.5 Premiums in Relation to Remuneration (\$, millions), 1986–1996

Fiscal Year	Premiums (\$, millions)	Remuneration (\$, millions)	Premiums/Remuneration (%)	Published Rate (%)	Claims Payments/Premiums (%)
1985/86	78.2	20,830.6	2.30	2.20	13.1
1986/87	707.9	27,049.7	2.62	2.40	47.1
1987/88	735.3	30,878.9	2.38	2.40	71.5
1988/89	828.4	34,839.5	2.38	2.40	85.7
1989/90	1,208.2	38,070.3	3.17	3.30	62.9
1990/91	1,298.7	37,941.9	3.42	3.30	66.5
1991/92	1,141.2	37,598.0	3.04	3.30	90.3
1992/93	1,100.0	37,960.1	2.90	3.00	101.8
1993/94	838.6	39,637.2	2.12	2.25	83.8
1994/95	889.3	42,759.0	.08	2.25	77.2
1995/96	883.4	45,026.5	1.96	1.98	82.2

Source: VWA

Table 4.6 Scheme Financial Performance, 1986–1996

Financial Year	As Percentage of Premium Revenue							
	Premium Revenue (\$, millions)	Claims Expense (%)	Underwriting Expenses (%)	Underwriting Result (%)	Investment Revenue (%)	General Admin. Expenses (%)	Profit/Loss before Abnormals (%)	Profit/Loss after Abnormals (%)
1985/86	457.5	14.2	4.7	-35.8	3.0	6.9	-39.7	-39.7
1986/87	586.8	56.7	5.7	-263.2	25.0	7.9	-243.8	-241.0
1987/88	705.9	76.2	3.8	-39.5	-10.6	10.9	-60.8	-60.8
1988/89	795.1	90.0	6.3	-266.0	8.4	16.6	-273.9	-273.9
1989/90	1,170.8	59.3	5.4	149.1	7.0	10.1	145.8	145.8
1990/91	1,261.3	59.4	4.8	50.5	11.5	9.9	52.1	52.1
1991/92	1,129.2	80.5	5.7	-16.5	17.0	10.5	-10.0	-3.8
1992/93	1,127.8	93.1	n.a.	125.6	19.4	15.4	129.6	129.6
1993/94	838.6	74.3	8.4	17.6	11.5	11.4	18.6	13.7
1994/95	889.2	67.8	8.0	-6.1	24.2	10.1	8.4	39.7
1995/96	883.4	82.0	8.7	-32.0	32.4	11.0	-10.3	-1.9
Annual Avg.	901.1	68.5	5.6	-28.8	13.5	11.0	-25.8	-21.8

Table 4.7 Insurer Income, Report Year 1995

Insurer	Premium Revenue (\$, thousands)	As Percentage of Premium Revenues						
		Claims Expense	Underwriting Expenses	Underwriting Result	Investment Revenue	General Admin. Expenses	Profit/Loss before Tax	Profit/Loss after Tax
AIG	3,635	123.6	.9	-7.6	2.1	0.7	-6.1	-6.1
AMP	13,562	113.7	0.0	0.0	0.4	0.4	0.0	0.0
CATH	73,066	57.9	0.6	11.1	0.1	0.0	-0.4	-0.4
CIC	144,336	-8.5	-7.4	7.4	0.1	4.7	2.8	2.8
CU	14,463	30.3	47.7	21.0	11.5	0.0	32.5	20.0
FAI	79,955	156.5	0.0	0.0	0.6	6.9	1.5	1.0
GIO	118,561	79.1	0.0	0.0	0.2	0.0	-0.5	-0.3
GUILD	37,795	67.5	18.7	-1.3	7.2	3.5	2.3	1.7
HIH	36,304	55.5	0.0	0.0	0.3	0.3	0.0	0.0
MERC	13,738	98.3	-3.2	-40.3	-5.7	5.5	-51.5	-34.2
MMI	232,093	51.9	0.0	0.0	-4.4	4.0	-6.7	-5.5
NZI	58,304	162.4	0.0	0.0	8.9	7.8	1.1	0.7
QBE	102,285	132.9	0.0	0.0	0.1	0.0	0.1	0.1
SUN ROYAL	8,787	255.8	9.3	9.3	-0.7	0.0	8.7	9.3
VACC	166,088	74.6	24.9	2.1	-3.9	5.3	-7.1	-4.0
ZURICH	10,131	180.8	0.0	0.0	7.4	7.4	0.0	0.0
Median	48,050	88.7	0.0	0.0	0.2	2.1	0.0	0.0

Source: ISC

Table 4.8 Insurer Service Performance, First Quarter 1996

Insurer	Premium Collection (%)	Claim Duration 104 Weeks (%)	Disputes (%)	Claim Cost Ratio (%)	Timeliness (%)*	Time Loss (%)**	Case Reserve Accuracy (%) 1993/94 Claims	Medical Panel Delays (%)
AIG	99.2	37.5	13.0	52.8	0.0	49.5	72	50.0
AMP	97.1	26.5	18.2	50.9	0.0	47.1	117	36.4
CATH	100.0	37.1	10.6	47.5	50.0	54.2	136	100.0
CU	98.6	26.5	11.4	54.0	33.3	51.0	81	60.0
FAI	99.1	54.3	16.1	60.6	28.0	45.4	68	54.1
GIO	95.4	31.9	16.3	57.2	19.2	52.4	101	91.0
GUILD	95.9	12.5	42.1	31.9	0.0	45.5	660	100.0
HIH	98.4	45.0	18.2	53.4	25.0	51.9	67	61.5
MERC	96.8	35.7	12.7	67.7	8.3	49.7	128	77.4
MMI	99.4	41.6	15.8	48.5	20.0	50.1	139	69.3
NZI	97.6	46.5	14.6	57.7	11.1	50.3	124	81.5
QBE	96.3	35.2	15.9	58.1	17.7	47.9	129	34.8
SUN ROYAL	96.4	31.7	15.4	54.0	0.0	47.0	95	42.9
VACC	97.9	26.7	10.1	60.4	57.1	48.9	77	83.3
ZURICH	97.1	18.1	13.8	62.6	0.0	56.7	98	78.6
Median	97.6	35.2	15.4	54	17.7	49.7	101	69.3

Note: These performance measures are based on definitions used in VWA statistical reports.

* Cases not classified after 104 weeks plus cases classified after 520 days.

** Number of weekly payments in last three months.

Source: VWA Authorised Insurer Performance Table

Table 4.9 Insurer Assets and Liabilities (\$, thousands), 1995

Insurer	Assets	Liabilities	Net Assets	Assets/ Net Assets (%)	Liabilities/ Net Assets (%)
AIG	17,773	16,271	1,502	1183.3	1083.3
AMP	37,531	35,531	2,000	1876.6	1776.6
CATH	175,105	126,106	48,999	357.4	257.4
CU	33,715	31,648	2,067	1631.1	1531.1
FAI	329,614	4,748	324,866	101.5	1.5
GIO	310,100	307,418	2,682	11562.3	11462.3
GUILD	59,883	46,757	13,126	456.2	356.2
HEATH	182,100	180,100	2,000	9105.0	9005.0
MERC	168,633	73,460	95,173	177.2	77.2
MMI	575,965	573,198	2,767	20815.5	20715.5
NZI	244,122	241,340	2,782	8775.1	8675.1
QBE	280,277	278,124	2,153	13018.0	12918.0
SUN ROYAL	41,534	38,706	2,828	1468.7	1368.7
VACC	32,566	30,306	2,260	1441.0	1341.0
ZURICH	35,604	33,604	2,000	1780.2	1680.2
Median	168,633	46,757	2,682	1631.1	1531.1

Source: ISC

Figure 4.1 Victoria Workers' Compensation Insurance Regulatory Scheme

Figure 4.2 Workers' Compensation Premium Calculation

$$[(1-Z) \times R] + (Z \times E) = PR$$

Z = sizing and experience adjustment factor

R = prior rate for the workplace

E = experience factor for the workplace

PR = premium rate

$$\frac{F_t C_t + F_{t-1} C_{t-1} + F_{t-2} C_{t-2}}{W_t + W_{t-1} + W_{t-2}} = E$$

F_t = Insurer's F factor for year t

C_t = claims paid plus case reserves for year t

W_t = remuneration for workplace for year t

E = experience factor for the workplace

$$PR_t \times W_t = \text{Employer Premium}_t$$

Figure 4.3 Structure - Conduct - Performance Framework

Source: Scherer and Ross (1990)

Chapter 5 Benefits

When the Accident Compensation (WorkCover) Act was enacted in 1992, the responsible Minister, Mr. Roger A. Hallam, enunciated a set of goals for it. As expressed by him at the time of the second reading of the bill, four of the seven goals dealt directly with issues relating to benefits:

- Adequately and fairly compensate injured workers;
- Reduce the cost of workers' compensation;
- End the overcompensation of the partially incapacitated and those with minor injuries and the undercompensation of the severely injured;
- Make return to work, rather than compensation, the main objective of the scheme.

At first appearance, some of these goals may appear to be mutually inconsistent. In particular, the goal of reducing system costs may seem to be incompatible with the goal of assuring that injured workers are adequately and fairly compensated. A widely held perception is that jurisdictions with relatively expensive workers' compensation programmes are those that offer generous benefits to their workers. And by parallel, this viewpoint holds that relatively inexpensive jurisdictions must provide only inadequate and unfair benefits.

These perceptions are rejected by some experts who have observed jurisdictions having both relatively high cost to employers combined with low benefits to workers (the worst of all worlds), and some other jurisdictions with relatively low costs to employers and high levels of benefits (the best of all worlds). Though all jurisdictions can be expected to desire to have the best of all worlds, attaining that is no simple task.

In order to accomplish its goals, the WorkCover scheme, by statute and implementation, fixed its sights on those elements that could drive down system costs without doing harm to those workers whose economic security depended upon the scheme. The plan was predicated on the theory that lowering system costs would make some resources available to increase the benefits available to certain workers (those with the most severe injuries), allow the fund to

eliminate its deficit position, and also permit employer costs to be reduced. Essentially, four sets of measures were taken to implement this strategy.

Reducing Claims

In a sequential context, the first step in reducing costs was to reduce the number of claims for compensation. An obvious, though challenging, method to achieve that was through the implementation of occupational health and safety programmes that would result in fewer workplace injuries and illnesses. A variety of policies were implemented to accomplish this, but the most significant step, undertaken in 1996, was the repositioning and restructuring of the state's occupational health and safety agency to align it with WorkCover goals. Another very important measure was the adoption of experience rating in the premium system as a means of encouraging positive prevention practices by employers.

At least three other measures taken supported the goal of reduced claims. One of these was to limit the use of lump sum settlements. A widely held view is that the presence of lump sum settlements can "attract" minor, or nuisance, claims. For example, the availability of such settlements may induce claims from persons whose conditions may not have arisen out of the work environment, or who have not suffered compensable injuries or illnesses at all. Insurers are often tempted to settle these claims with a lump sum payment, rather than incur the costs of defending them, with the possibility also of losing them. The 1992 law curtailed the availability of lump sum settlements on the grounds that they may retard the goal of getting injured workers to eventually return to work. This motivation was also behind the increase in the employer "excess," or deductible, from 5 to 10 days in 1993. However, it also had the effect of reducing the number of claims that the VWA and the authorised insurers had to cope with.

Lump sum payments were still available to persons receiving benefits under sections 98 and 98A. These payments, which in some cases could be quite large, might also induce individuals to seek these benefits, and could encourage their solicitors to pursue them vigorously. This source of lump sum payments may not be so likely to expand claims for weekly compensation as it might be to increase claims for this specific type of benefit. However, for certain conditions such as hearing loss, there may be no claim for weekly benefits, and the potential availability of the maim benefit is the chief source of the claim.

Several steps were taken to discourage claims for hearing loss. A number of measures have been aimed specifically at perceived abuses that emerged under WorkCover involving such claims. As a result of these and a more general concern, the Government ordered steps to crack down on the conduct relating to the touting of claims in the 1996 amendments.¹

Yet another set of measures to reduce the volume of claims shifted the responsibility for injuries sustained in accidents during travel to and from the workplace from the VWA to the Transport Accident Commission (TAC). This change reduced the costs of workers' compensation and made the scheme conform more closely with practices in North America and less like the systems in western Europe. It also implemented the philosophy that employers should not have to pay for things over which they exercise no control.

Reducing the number of claims for workers' compensation is no simple task, at least in an environment where the employment level is stable or growing. Where the goal is to achieve this without undermining the rights and economic security of workers, it is especially ambitious. The WorkCover scheme employed several measures to accomplish this. Insofar as they proved to be successful, they allowed the programme to provide greater attention to the claims that remained, and to aid in the control of system costs.

Reducing Litigation Costs

A second set of measures aimed at reducing costs, without necessarily paring back benefits, was focused on the programme's litigation costs. If the resources spent on litigation could be lowered, the outcome could be lower insurance costs for employers while enabling higher benefits to be paid to workers. Indeed, if this was successful it would also allow the paying down of the unfunded liability. In general, a system's litigation costs can be lowered by reducing both the frequency of controversy and the intensity of dispute, as represented by the stage at which the dispute is ultimately resolved. If the direct costs of disputes (i.e., legal and forensic medical costs) could be cut back from where they had been, it would result in a win-win outcome for both employers and workers. The specific measures taken to reduce litigation costs are described in the following chapter. Suffice it here to note that two measures were seen as essential in limiting these costs. First, the Conciliation Service was to assist in the prompt resolution of issues and disputes in an informal manner. Second, the use of Medical Panels was

¹ Part 7A-Prohibited Conduct Relating to Touting for Claims.

envisioned as a means to promptly settle disputes over medical questions, thereby minimizing the “dueling docs syndrome” that exists in many other jurisdictions.

Health Care Costs

A third set of steps designed to reduce system costs without jeopardising worker-income security entailed improved controls over health care costs without diminishing the quality of services provided. Clearly, the most direct route to such controls is by assuring that fees for medical and like services are not excessive. Worldwide, many jurisdictions have responded to rapidly growing health care costs by adopting fee schedules. Yet a number of jurisdictions have found that unless some controls are also imposed over the utilisation of health care, fee schedules alone may be ineffective in achieving the desired economies.

Though it was judged not to be possible to push down the scale of medical fees in nominal terms, it was possible to minimise or prevent increases at a time when the average level of overall prices was rising. Additionally, the authorised insurers were encouraged to monitor the type and quantity of services provided to prevent inappropriate or superfluous treatment and billing. The development of treatment protocols is also consistent with these measures. Without doubt, a tactic that was employed by the VWA from the outset in order to achieve its goals was to attempt to control the medical and like costs of the programme.

Benefits and Return to Work

A fourth set of measures to achieve cost controls was aimed at return to work. The strategy has been a complex one because of the expressed goal to redistribute benefits away from those who were thought to be overcompensated to those who were believed to be undercompensated. It involved discriminating between those whose conditions warranted more generous benefits and those whose circumstances did not. The matter was not simplified by the multiplicity of compensation benefits, i.e., weekly benefits, maims benefits, and damages at common law. This tricky balance was to be sought while reducing system costs and assuring that benefits were fair.

The centerpiece of the strategy to limit benefit costs, at least in situations where the injury or illness was not severe, was based on the concept of “serious injury.” A “serious injury” was defined as one that would be rated at 30 percent or more according to the *AMA Guides to the*

Evaluation of Permanent Impairment (second edition). No benefit reductions were envisioned for persons judged to be “seriously injured”, because higher benefits for these workers could be forthcoming. The concept was used to affect benefits in several circumstances. First, it was believed that the bulk of injured workers would recover fully and return to employment within 26 weeks from the date of injury. A person eligible for workers’ compensation benefits was to receive 95 percent of the worker’s pre-injury average weekly earnings, a generous rate when measured against standards in most other jurisdictions.

The replacement rate dropped to 70 percent after 26 weeks of incapacity, where the worker remained totally incapacitated but was not found to be “seriously injured.”(The rate could drop below 70 percent if there was partial incapacity and no “serious injury.”) For a “seriously injured” and totally incapacitated worker, the rate dropped to 90 percent after 26 weeks. The point was simply to prevent the very high wage-replacement rate from inducing persons to unreasonably prolong their period of benefits, thereby delaying their return to work. “Serious injury” was the line drawn to separate those whose wage-replacement rates would drop more or less.

Similarly, a worker’s entitlement to benefits was to cease 104 weeks from the time of incapacity if the worker was neither totally and permanently incapacitated nor “seriously injured.” To cope with the very substantial buildup of long-term compensation recipients inherited in 1992, and to prevent any recurrence of the problem, the 104-week threshold was seen as a potential source of significant cost reduction, with no harmful effect for workers who had significant disabilities.

The 104-week limitation could also be seen as a crude alternative to the setting of “notional earnings,” that is, the difficult task of assessing permanent partial disability. Rather than attempt to estimate what the specific earnings impact of a permanent partial disability might be, Victoria chose to limit income maintenance benefits to two years for those capable of work. For those unable to work, benefits for life were available.

Aside from the obvious cost savings that the 104-week limit would provide, it was also seen as a way to counteract a perception that workers’ compensation had encouraged some considerable degree of malingering under WorkCare. To protect those workers with severe medical conditions, the “serious injury” criterion would allow the continuation of long-term benefits.

Another way that the new scheme could target benefits to those with more severe conditions was to utilise the “serious injury” concept as a requirement to access the common law for damages from the employer. Other measures in the law could also screen out benefits for those with less severe injuries. The statute provided that damages for either pecuniary losses or for pain and suffering had to be above certain specified amounts. This eliminated claims that were likely to involve small amounts of money. Upper bounds were also specified for either type of damages.

Changing Tactics

The process of implementing a dramatically new law such as WorkCover is a dynamic one. All the parties involved in the system, including the courts, shape the workings of the law. And as the parties adjust to the evolving law and learn how to use it for their own purposes, it is transformed such that unforeseen strengths and weaknesses become evident. In at least two very significant areas, the “serious injury” concept and the Medical Panels, what developed as the law evolved was quite different than was planned. Changes were made in response to these developments primarily as reflected in the amendments to the laws in 1996 and 1997. However, those changes appear to be fully consistent with the explicit goals of the 1992 statute. They appear to result not from any change in the Government’s basic objectives, but rather, a recognition that certain measures had been less successful than anticipated.

From the Authority’s perspective, the key concept of “serious injury” was undermined from two sources. As will be noted in Chapter 6, a series of decisions by the courts, in particular in Bowles, Hanrahan, Nichols, and indirectly but significantly Petkovski, all served to lower the bar for claimants seeking access to common-law damages. The other attack on “serious injury” emerged as impairment ratings were pushed up to and beyond the 30 percent threshold by adding psychological impairment onto the rating for physical impairment. Placing a quantitative rating on a psychological impairment can be particularly subjective, and it is bound to involve a higher variance than in most cases involving physiological impairments. Certainly, the development of what some call “physical-mental” cases appeared to reduce the screening power that was expected of the “serious injury” criterion. The result of the undermining of the concept of

“serious injury” was that in 1997 the concept was abandoned, and access to common law was ended for injuries occurring after 12 November 1997.

The important role envisioned for the Medical Panel process also was weakened by a combination of circumstances. In particular, the excessive burden placed on the process beginning in 1994 meant that significant delays, costs, and other problems would—and did—result. Curiously, the rating of impairment was not a subject that resulted in a “medical question.” As such, evaluations of impairment made by a Medical Panel were not binding upon both sides of a dispute. Differences over the assessment of a maim might still cause a claimant to seek satisfaction at court, or at least begin the process and then accept a settlement along the way. This reality frequently led to higher payments made by insurers under sections 98 and 98A of the act than would otherwise have been made. In 1997, the law was amended so that a dispute over an impairment rating was to be considered to be a “medical question” and therefore could be settled decisively by a Medical Panel.

Aggregate benefit payments for maims grew substantially after 1993/94 (see Table 5.5). As greater attention was focused on these claims, evident shortcomings in the scheme to compensate for such conditions warranted attention or repair. The schedule of injuries had survived virtually intact from its 1914 origins. With only a few exceptions, no uniform guide or standard existed with which to rate impairments. That is, only impairments to the back, neck, and pelvis were required to be rated according to the *AMA Guides*. However, some persons doing these ratings had little experience with or training in the use of the *Guides*, or in the general rating of impairment.

A consequence of the lack of uniform standards or the inappropriate application of the *Guides* was an inconsistency in ratings, which resulted in dispute and contention. The absence of uniform and consistent standards also hampered the provision of benefits for pain and suffering (section 98A). Another concern held by some was that the *AMA Guides* were already in a fourth edition while Victoria clung to the second edition. Further criticism was aimed at the absence of benefits for certain conditions or losses that simply did not appear in the Table of Maims.

Eligibility for Entitlement

A worker is entitled to compensation under the Accident Compensation Act 1985 if there is an injury arising out of or in the course of employment, and if the worker's employment was a significant contributing factor. A worker's dependents are entitled to compensation if an injury arising out of or in the course of employment was a significant contributing factor resulting in, or materially contributing to, the death of the worker.

The language in this statute parallels that which is found in many other jurisdictions, insofar as "arising out of" and "in the course of employment" are utilised. Some jurisdictions connect these phrases with "and" rather than "or," but the treatment of the terms in practice suggests that this difference is somewhat academic. The requirement that the worker's employment was "a significant contributing factor" is not commonly attached to entitlement language in workers' compensation statutes. Still, the compensation agencies and courts that apply such laws may often interpret the law as if such a clause was present. However, in jurisdictions that have tended to be somewhat restrictive in their legislation regarding eligibility for benefits, the courts have tended to widen it. The phenomenon has been observed in Australia: "The Commission found that there has been a tendency for legislators to limit what qualifies as a compensable injury or illness, while judicial interpretation has tended to expand coverage."²

Benefits in Victoria are similar to those found in most industrialised jurisdictions. That is, injured workers may be entitled to medical and like benefits, as well as cash benefits paid in weekly or lump sum form for temporary or permanent disabilities. Their dependents are eligible for benefits in cases of injury or illness that result in the death of the worker. An entitlement exists also for occupational rehabilitation benefits, a subject reserved for discussion in Chapter 7.

Medical Benefits

As in most jurisdictions, medical and like benefits (these include the various health care providers as well as hospitalization, pharmaceutical, and prosthetic appliances) are provided under the workers' compensation programme. There can be an advantage to a worker to have medical benefits provided under this programme, rather than by the Commonwealth health

²Industry Commission, *Workers' Compensation in Australia*, Report No. 36, 4 February 1994, p. 99.

programme. First, certain benefits are available to the worker at no charge only if it is a compensable work injury, e.g., physiotherapy. Second, under the workers' compensation programme, and unlike the Commonwealth health plan, the law precludes action against a worker for the payment of balances charged by providers for medical services. However, "agreements" between workers and providers for the payment of balances do occur. Employers have been known to pay balance bills as well.³

The medical provider may also prefer that the treatment or service is paid for under WorkCover as the insurance fee for the service is likely to be greater. All this suggests that some incentives exist for cost shifting to occur on the part of the worker or the provider. An employer, on the other hand, may have an incentive to shift the medical costs to the Commonwealth scheme so as to avoid having its experience affected for WorkCover insurance rating purposes.

Initiating Benefits

A worker may receive medical and like services from the provider of the worker's choice (this does not include occupational rehabilitation services). The employer is responsible to pay the first \$426 of these services, with any costs above this the responsibility of the insurer. (This maximum, which is indexed, was applicable from 1 July 1998.)

An injured employee or a person acting on behalf of the employee must give notice of the injury to the employer as soon as practicable. Until proper notice has been given to the employer, there is not an entitlement to compensation. A claim for compensation for weekly benefits must be served as soon as practicable, for death benefits within two years after the date of death, and for medical and like services within six months after the date of the service. All of these time thresholds can be waived or extended for cause. A claim for weekly benefits must be accompanied by a certificate issued by a medical practitioner, though a worker without such a certificate may ask that the County Court consider his/her entitlement to compensation.

In a claim for weekly payments, the employer must accept or reject the claim within 10 days of its receipt. The employer must forward to the insurer any claim for benefits for death, maims, or medical and like services within 10 days of receipt of the claim. Claims for weekly

³Balance billing occurs where the service provider bills the recipient of the service or the employer for any unpaid balance, where the insurer pays less than the amount invoiced.

benefits need to be forwarded to the insurer where either the employer rejects the claim or the claim is likely to exceed the employer's responsibility of \$426.

The initial medical certificate which accompanies the claim is issued for up to 14 days. In exceptional cases where the injury is obviously very severe, e.g., spinal cord injuries, heart attacks, etc., the initial certificate can be applicable for more than 14 days. For weekly benefits beyond this initial 14-day period, a continuing certificate of capacity must be issued, for a period of up to 28 days. Unlike the initial certificate, which can be issued only by a medical doctor, the continuing certificate can also be issued by a registered physiotherapist, chiropractor, or osteopath. A certificate of capacity can relate only to a period of time no more than 90 days from the date of the certificate.

An employer's decision to accept or reject a claim does not prejudice the insurer's decision as to liability. The insurer has 28 days from the date of receipt of the claim to accept or reject the claim and to give the worker written notice of the decision. If no written notice is given within that time the claim is deemed to be accepted. Reasons for a decision to reject the claim must be given. If the insurer accepts the claim, or if it is deemed accepted by the insurer's non-response within 28 days, the decision is binding upon the employer for purposes of its liability to pay medical and weekly benefits. No time limit is provided for the insurer to accept or reject claims for medical benefits only. If a claimant disputes a rejection of such a claim (Section 99), the matter must be taken to conciliation (see Chapter 6).

The data in Table 5.1 are based on the number of claims reported in each year for the past 11 years. These are so-called "Standard Claims," that is, they have been standardised to take account of changes that have occurred in the law. Standard claims exclude both journey claims (no longer compensable for injuries after 1 December 1992), and nonfatal closed claims with up to 10 days compensation and medical and like payments below the threshold. (In July 1993, the employer became liable for up to the first 10 days of weekly benefits; prior to that the employer was responsible to pay only up to the first 5 days of incapacity.) Note that these claims are not as of the year of injury but as of the date reported.

The data in Table 5.1 reflect the substantial decline in claims reported in the past decade. The drop is especially evident beginning in 1992/93. Several factors contributed to this decline. First, certain types of claims were no longer compensable for injuries after 1 December 1992. (Of course, this includes journey claims, but the data in the table have standardised for this.)

Certain claims for stress-induced injuries related to personnel activities, for example, ceased to be compensable. Additionally, the threshold for compensability was raised by requiring that employment be a “significant contributing factor” to the injury. A more intangible factor was the widely held perception that workers’ compensation claims would be harder to obtain under the new regime. To the degree that this attitude caused some marginal claims not to be made, the new law was a factor in the decline, regardless of whether or not the entitlement was actually changed.

Weekly Benefits

An injured worker entitled to weekly compensation under WorkCover will receive a benefit that is tied to his or her pre-injury average weekly earnings (PIAWE). The PIAWE is the worker’s average weekly earnings for the previous 12 months if employed continuously by that employer. It is calculated at the worker’s ordinary time rate of pay, for the worker’s normal number of hours per week. Representatives of organised labour object to the fact that allowances such as overtime payments, shift differentials, hazard duty allowances, or dirt money are not included in considering the injured worker’s PIAWE. Workers employed less than 12 months with the injury employer have their PIAWE calculated based on the lesser period, while workers with less than four weeks in the job have their PIAWE calculated based on deemed earnings. All weekly benefit payments are treated as ordinary taxable income.

Until the law was changed in 1997, weekly benefits were paid according to three distinct phases, i.e., the first 26 weeks of incapacity, after 26 weeks of incapacity, and after 104 weeks in which a weekly benefit has been paid or is payable to the worker. During the first 26 weeks of incapacity, the worker was entitled to the lesser of 95 percent of his or her PIAWE or the weekly maximum benefit (\$680 per week as of January 1997). Cash benefits for the first 10 days of incapacity were the responsibility of the employer, not the insurer. Though employers may select a “buy-out” option that will insure them for the first 10 days of benefits, few employers choose to purchase it. It is the practice in some industries for employers to “top-up” the benefit to 100 percent of pre-injury earnings, at least for the first 26 weeks.

If the worker was partially incapacitated, he or she was entitled to either the difference between \$680 and the worker’s earnings or the difference between 95 percent of the PIAWE and

earnings, whichever was less. Earnings refer to current weekly earnings of the worker either as a worker or as a self-employed individual. The concept legally also refers to what the worker could earn in employment in his or her previous employment or in suitable employment (notional earnings), but this basis for compensation is not currently being used.

After 26 weeks of incapacity, the wage-replacement rate was lowered, in line with the practice in New South Wales, Queensland, the Northern Territory, and A.C.T. Though these rate drop-offs after specified periods are widespread across Australia, they are very rare in North America.⁴

After 26 weeks of incapacity, a worker entitled to weekly benefits was likely to have a reduction in those benefits. Essentially, the worker's benefits were set according to one of four possibilities:

- 1) If the worker was found to have a "serious injury" (defined below), and the worker had no current weekly earnings, the worker was entitled to 90 percent of the PIAWE subject to a maximum amount.
- 2) If the worker was found to have a "serious injury" and the worker had some current weekly earnings, the worker received the difference between 90 percent of the PIAWE and current weekly earnings, subject to a maximum amount.
- 3) If the worker had no "serious injury" but was totally incapacitated, the worker received 70 percent of the PIAWE subject to a maximum amount.
- 4) If the worker had no "serious injury" and was not totally incapacitated, the worker was entitled either to the difference between 60 percent of the PIAWE and 60 percent of current weekly earnings or the difference between 60 percent of the maximum benefit and 60 percent of current weekly earnings, whichever is lower.

Note that the reduction in the wage-replacement rate would have no effective impact on workers with a very high PIAWE. The worker with a high enough PIAWE, even with a reduction at 26 weeks from 95 percent to 70 percent, might remain at the weekly maximum benefit.

The meaning of "serious injury" for purposes of adjusting the PIAWE replacement rate at 26 weeks was found in the statute (Section 93B(5)). The "serious injury" threshold for purposes of the 26-week rate adjustment was that the worker had been found to have an impairment that

⁴ Ohio is one of the exceptions.

was rated at 30 percent or more by the standard of the *AMA Guides*. The “serious injury” decision for the 26-week determination was based solely on impairment and not on any broader notion such as disability.

The weekly benefits rate determination at 26 weeks was the basis for any continuing weekly benefits paid. However, the 1992 law provided that for injuries occurring on or after 1 December 1992, weekly benefits would be terminated after 104 weeks of incapacity, except if either of two situations existed at that point. Weekly benefits would not be terminated automatically at 104 weeks if the worker was either “seriously injured” or totally and permanently incapacitated. The 104-week determination was a very large target, that is, a threshold with several very important implications for the parties. First, it may or may not have ruled out the possibility of the worker being paid very long-term benefits. Further, it could determine whether or not the worker had access to the County Court for a common-law remedy.

Weekly Payments According to the 1997 Law Changes

The system of weekly payments was significantly changed as a result of the December 1997 amendments. Under the new legislation, there is a shift from benefit entitlement predicated upon injury status to one based upon work capacity. The relevant distinction is between workers who have a current work capacity and those who do not. The legislation defines “current work capacity” as being “a present inability arising from an injury such that the worker is not able to return to his or her pre-injury employment but is able to return to work in suitable employment.”

For claims lodged on or after 12 November 1997, where entitlement arises after that date, injured workers receive a benefit of 95 percent of PIAWE for the first 13 weeks of benefit entitlement (called the first entitlement period) where they have no current work capacity subject to the maximum payment of \$850 a week (125 percent of average weekly earnings). For workers with a current work capacity, payments during the first entitlement period are the difference between 95 percent of the worker’s PIAWE and the worker’s notional earnings, again subject to a ceiling of \$850 a week.

During the second entitlement period (an aggregate period of 104 weeks of benefit entitlement including the first entitlement period), the benefit payable to workers with no current work capacity is 75 percent of PIAWE, subject to the weekly maximum of \$850. For workers with a current work capacity, the benefit payable is the lesser of the difference between 60

percent of the worker's PIAWE and 60 percent of the worker's notional earnings, or the difference between \$510 and 60 percent of the worker's notional earnings, whichever is the lesser of these two calculations.⁵

In both the first and second entitlement periods, a worker's entitlement to benefits is dependent upon compliance with a series of statutory obligations. These obligations include making reasonable efforts to participate in an occupational rehabilitation service or return-to-work plan, making reasonable efforts to return to work in suitable employment, and participation in various assessments of work capacity, rehabilitation progress, and the like. Failure to so comply can lead to loss of benefits.

After 104 weeks, a worker's entitlement to benefits ceases unless the worker is assessed as having no current work capacity and is likely to continue indefinitely to have no current work capacity. Where these conditions are satisfied, weekly benefits continue to be paid at the rate of 75 percent of PIAWE, subject to a ceiling of \$850 a week. Workers receiving these post-104-week benefits must comply with a similar range of obligations as pertain to benefit entitlement in the earlier periods. Failure to do so is similarly visited with cessation of benefits. There is a requirement for ongoing assessment of workers receiving these benefits "as often as may be reasonably necessary," or at least once every two years.

Generally, benefits for workers with a current work capacity cease after 104 weeks. An exception applies to workers who have returned to work for a period of not less than 15 hours a week, and who are in receipt of current weekly earnings of at least \$100 and, additionally, because of their injuries, are incapable of undertaking further or additional work or employment which would increase their current weekly earnings (and are like to continue indefinitely to be so.). Such workers are entitled to benefits at the rate for workers with a current work capacity during the second entitlement period.

In accordance with the "no disadvantage" policy which characterises the Government's approach to benefit changes in this legislation, workers whose claims were lodged prior to 12 November 1997, and who are either on or are subsequently determined to have an entitlement to weekly payments, will continue to be paid at their existing rate. They will be evaluated in accordance with the new classifications and periodically assessed under the new classification

⁵ It should be noted that the notional earnings provision, while authorised by statute, is not being applied at present in Victoria.

requirements. Thus, workers formerly classified as totally and permanently incapacitated are deemed to have no current work capacity, and those formerly assessed as partially incapacitated are deemed to have a current work capacity. Workers classified as “seriously injured” will continue to receive weekly payments based on 90 percent of PIAWE for as long as they continue to meet the 30 percent impairment threshold.

A worker is not entitled to weekly benefits when the person attains retirement age. (This measure was in effect even prior to the 1997 law change.) Retirement age means either age 65 or the normal retirement age in that occupation, whichever is earlier. For example, if commercial airline pilots routinely retire at age 60 in Victoria, weekly benefits would be terminated at that age. However, if a worker is injured on the job after reaching retirement age, that person is entitled to receive weekly payments but only for the first 52 weeks of incapacity.

Table 5.2 shows the level of payments for weekly benefits over the past decade. With the enactment of the 1992 legislation and the subsequent amendments, aggregate payments for weekly benefits fell sharply. First, the number of new claims for benefits fell in the period after 1 December 1992 for the reasons given earlier. Second, the number of long-term recipients fell sharply, a major goal of the 1992 change. Additionally, WorkCover was able to shorten the average length of time that persons stayed on weekly benefits, another central focus of the 1992 law. Also, in mid 1993 the employer became responsible for the first 10 days of weekly benefit payments, up from the previous level of 5 days. After declining sharply from 1990/91 to 1994/95, aggregate weekly benefits payments began moving up. In 1997/98, total weekly benefits paid were 36.5 percent above the level paid in 1993/94. During the same period, wages increased and the weekly benefit maximum increased as well.

Terminating Weekly Benefits

A sticking point in every workers’ compensation system occurs where the insurer seeks to alter (reduce) weekly compensation payments or terminate paying them altogether based on a perceived change in the worker’s condition. Systems that have become especially sensitive to matters of cost recognise that prompt alteration or termination of payments where circumstances call for this can represent a significant source of potential cost reductions. Balancing this concern is the need to treat the injured worker justly. Thus, if the insurer has no restraint on its ability to

change benefits, it can place the injured worker in a very difficult position, especially if any appeal process is slow or back-logged.

There are numerous provisions of the law, some of which have been noted above, which provide reasons to terminate benefits. These include

- the expiration of a fixed period of benefits, e.g., at 104 weeks;
- the attainment of retirement age;
- the worker has left Australia (unless “seriously injured” or totally and permanently incapacitated);
- the recipient serves a prison sentence;
- the worker has received a lump sum on termination of employment for redundancy or severance, or for certain superannuation or retirement lump sums;
- the worker has returned to any work;
- the worker’s notional earnings have increased;
- the worker’s benefits were obtained fraudulently.

In most cases, the worker must be provided with written notice of the decision to terminate or alter weekly benefits, and in some instances there are fixed periods for which benefits must be continued, subsequent to the provision of notice.

If a worker has received weekly payments of compensation for at least 12 weeks and has provided the insurer with a certificate of capacity, the benefit cannot be terminated or lowered for the period covered by the certificate without giving proper notice. For a worker who had been receiving weekly benefits for a continuous period of at least 12 weeks but less than one year, the period of notice is 14 days. For a worker who has received weekly payments for a continuous period of one year or more, the period of notice is 28 days.

Disputes regarding termination of benefits tend to be commonplace in workers’ compensation systems. The insurer, for example, may believe that the worker’s condition is such that return to work is possible. In such instances, in Victoria the insurer has the worker examined by either the treating medical provider or one that the insurer selects. These disputes are moved quickly into the Conciliation Service, where the Conciliation Officer is able to direct that

benefits be continued (discussed in some detail in Chapter 6). Presently, a worker can obtain a Conciliation Conference quickly, i.e., typically under 28 days, but if the parties cannot settle voluntarily, lengthy delays can ensue either at the Medical Panel stage or as the dispute is litigated in the courts. In 1997/98, the median time to disposal at conciliation was 32–34 days from the receipt of the application.⁶

The relatively rapid access to Conciliation, the requirement that some notice be given to the worker of the intent to terminate (at least where benefits have been paid for some time), and the ability of the Conciliator to direct that payment be made for some previous or prospective time periods appear to serve the needs of both sides. By contrast, some other jurisdictions either require that payments continue until an adjudicator has made a determination (which may mean that many months pass with benefits being paid) or permit insurer termination at will with no weekly benefits until the adjudicator, perhaps many months later, orders resumption.

The extraordinary success in curbing long-term claims (claims with more than 260 days of compensation) is evident in Table 5.3. Long-term claims were developing at a rate of 5,000–6,000 per year in the years before WorkCover's enactment. By 1993/94, the number had fallen below 2,200, though the number climbed above this in 1994/95. The number grew again, slightly, in 1995/96. Because of the limited time involved, one cannot yet make any judgement about the number of new long-term cases for claims reported in 1996/97. In December 1992, there were 16,600 long-term claims open. As of 30 June 1993, this had fallen to 13,300 claimants, and by 30 June 1998, the number of open long-term claims was 10,725. That represented about 50 percent of the number that existed in 1991.

In addition to issues relating to the termination of weekly benefits, parallel issues arise regarding their alteration. It has been noted that weekly benefits may be altered due to changes in the worker's notional earnings or any current weekly earnings. Payments will also be adjusted to reflect any payments that a worker might have received from the Department of Social Security. These social security benefits paid will also serve as the basis for offsets against any lump sum benefits with a pecuniary loss component.

⁶ VWA 1997/98 Annual Report.

Death Benefits

Where an injury that arises out of or in the course of employment materially contributes to or results in death, the worker's dependents are entitled to compensation. From 1 December 1992 to 30 June 1994, death claims were processed by the insurer, and any disputes were referred to the County Court. Since 1 July 1994, death claims have been determined by the County Court.

The December 1997 legislation made significant changes with respect to death benefits. These changes apply to both the nature and level of the statutory lump sum payable to the dependent spouse and children of a deceased worker (which is the traditional form of death benefit in Australian workers' compensation schemes). Further, as an additional benefit, the legislation introduced an income-support pension related to the worker's PIAWE that is paid to dependent spouses and children.

The defining date for the changes to death benefits is again 12 November 1997. In the case of the statutory lump sum payable to dependents for a worker who died in compensable injury or illness prior to that date, a maximum amount of \$134,430 is payable for all dependents, other than children of the deceased worker. A separate amount for each dependent child or full-time student is payable according to their ages. Thus, a child under 1 year of age would be entitled to \$25,620, while a full-time student between 16 and 21 years of age would be entitled to \$5,790.

In the new regime for claims arising from deaths on or after 12 November 1997, the system is significantly different with the statutory lump sum received varying according to the number of dependent children. For instance, where the worker leaves a dependent spouse (or dependent spouses) and only one dependent child, the amount of compensation payable is \$157,500 to the dependent spouse (or if more than one dependent spouse to those spouses in equal shares) and \$17,500 to the dependent child. Where there are two to five dependent children, there is a total pool of \$175,000, out of which \$8,750 is payable to each dependent child with the balance payable to the dependent spouse(s). Where there are more than five dependent children, the total pool of \$175,000 is divided into two subpools, with an amount of \$131,250 payable to the spouse(s) and a second pool of \$43,750 divided among the dependent children in equal shares.

For compensable deaths on or after 12 November 1997, there is also a system of income support pensions for dependent spouses and children. As with the lump sum payments, this system is subject to a number of permutations depending upon the family configuration left behind by the deceased worker. If a worker leaves behind a dependent spouse, the spouse's entitlement is 95 percent of the worker's PIAWE, capped at \$850 a week, for a period of 13 weeks, at which time there is a step down to 50 percent of the worker's PIAWE, again capped at \$850 a week. This payment continues for a period of three years, and it is not means tested against any personal earnings of the spouse. If there are dependent children, each child has an entitlement (beginning 13 weeks after the death of the worker) to a pension at the level of 5 percent of the worker's PIAWE, to a maximum total amount of 25 percent of PIAWE if there are more than 5 children. This pension continues until the child reaches 16 years of age or, if a full-time student, until he or she ceases to be a student or the end of the calendar year in which he or she turns 21 years of age, whichever is the earlier. There are further permutations to this system in the case where the worker leaves more than one dependent spouse and in the situation of orphan children.

Data on fatality claims for the past 10 years are shown in Table 5.4. The number of workers' compensation claims for fatality have fallen in recent years. Overall, they represent a rather small proportion of system payments. During the past 10 years there has been an average of 169 claims per year, though for the past 3 years ending in 1997/98, there have been only an average of 124 claims. (Both averages are by report year. The numbers have been standardised by excluding journey claims.) In 1997/98, there were 38 deaths that resulted from traumatic injuries. In 1997/98, payments of compensation for death claims (excluding any damages awarded) were less than 1.2 percent of all benefits and lump sum payments that year (including damages). Though average lump sum payments per death claim were well above the averages found earlier in the decade, the smaller number of claims has meant that total expenditures were considerably below earlier levels.

Benefits for Maims and Permanent Disabilities

It is only the rarest jurisdiction that finds that it can operate a workers' compensation scheme with little or no difficulty in respect to permanent disabilities compensation. All systems

use one of three bases for making permanent disability awards, or they apply some combination of them. In some jurisdictions, the permanent disability award is based, exclusively or nearly so, on the degree of medical impairment that the worker is found to have sustained. Thus, workers with equal degrees of impairment are entitled to equal or parallel levels of benefits. The same principle is utilised where a particular injury is found on a schedule or a list. Most commonly, such scheduled losses apply only to body extremities and to eyes. In either case, some jurisdictions use this basis but may adjust the benefit levels, automatically, in line with the worker's age. In some, an adjustment is made, also by formula, for the worker's occupation. Some jurisdictions will take this impairment-based determination and translate it to a benefit amount, while other jurisdictions will adjust it further by the worker's PIAWE.

A very different basis for determining the level of permanent disability benefits is to base it on the anticipated loss of earnings due to the worker's injury. Since projecting what future earnings losses will be is highly subjective, a variety of methods is employed to gauge those losses. Commonly, consideration is given to the degree of medical impairment, the worker's age, education, work experience, and language limitations, with different weights (informally) applied to each.

A third basis for setting compensation benefits for permanent disability is one identified as wage loss. Unlike the previous approach that forecasts what the loss of wage-earning capacity might be, the wage-loss approach compensates on the basis of actual incurred losses. Consequently, there would be no benefits paid under wage loss for permanent disability, even where the worker sustained a considerable impairment, if that employee had returned to work at the PIAWE level, or higher.

Each method has certain drawbacks. To some extent, the shortcomings have caused some jurisdictions to mix their approaches so as to avoid the worst features of each and to utilise the strengths of each approach. Until the statute was changed in 1997, benefits for permanent disabilities that were not totally incapacitating were compensated in Victoria in one of four ways according to the specific nature of the injury. Most permanent impairments were compensated according to a table of enumerated bodily losses, traditionally referred to in Victoria as the Table of Maims. The Table had been part of Victorian workers' compensation legislation since the original statute was enacted in 1914. Indeed, before 1985 this was a dominant form of compensation for permanent partial disabilities. The Table of Maims listed 46 impairments

ranging in severity from quadriplegia or the total loss of two limbs or both eyes, to the loss of a joint of a lesser toe.

A second basis for awarding a permanent impairment benefit was for impairments to the back, neck, or pelvis. These were compensated according to an impairment rating based on the *AMA Guides*. Alternatively, hearing-loss claimants were compensated for the permanent disability according to the *Improved Procedure for Determination of Percentage Loss of Hearing*, prepared by the National Acoustic Laboratory, with the evaluation done only by an approved specialist. Fourth, a worker with a permanent impairment could receive a benefit for the pain and suffering experienced as a result of the compensable injury or illness.

During the last decade and a half, the basis and function of the Table of Maims has undergone a considerable transformation. Under the former Workers' Compensation Act 1958, payment of a benefit under the Table of Maims acted to cutoff receipt of weekly benefits, whereas the Accident Compensation Act 1985 made such payments additional to any other compensation payable under the act. Further, in its WorkCare manifestation, compensation under section 98 was characterised as being "in respect of permanent impairment and other non-pecuniary loss." Following the WorkCover changes in 1992, the section 98 Table reverted to the terminology of "Compensation for Maims," but at the same time supplemented this table with a separate statutory provision for compensation for pain and suffering (section 98A).

Table 5.5 indicates payments made for maims over the past decade. It indicates a consistent pattern of growth in payments, with especially rapid growth in 1995/96 and 1996/97. Some of the growth in that period was the result of the 1996 amendments, particularly the end of the blockage caused by the delays in the Medical Panels.

Table 5.6 shows the relative importance of various types of maims according to payments made for them. Back injuries and injuries to the upper extremities are consistently among the major sources of maims payments. While hearing loss and the loss of mental powers are also significant bases for maims payments, both have fallen significantly in the past two years. For example, in 1993/94, almost 39 percent of maims payments went for hearing loss compared with less than 9 percent of maims payments in 1997/98.

The November 1997 legislation has made significant changes with respect to compensation for permanent impairment. The legislation returns to the language of "compensation for non-economic loss." However, its most radical departure from the past is in

moving beyond the enumerated list of impairments to a system of whole-person impairment. While injuries incurred prior to 12 November 1997 will continue to be assessed in accordance with sections 98 and 98A of the act (Table of Maims and pain and suffering), new claims (i.e., those incurred on or after 12 November 1997) will be determined by either section 98C or section 98E. The primary provision is section 98C. A worker who suffers a compensable injury which results in a permanent impairment, as assessed in accordance with the regime outlined in section 91 of the act, is entitled to compensation for noneconomic loss according to the terms of section 98C. This is not automatic since section 98C sets certain threshold conditions, screening out claims where the degree of impairment is less than 10 percent in the case of physical impairment, and where the degree of impairment is less than 30 percent in claims for permanent psychiatric impairment.

The 10 percent whole-person impairment threshold for physical injuries is consistent with the level currently applying under the Transport Accident Act (the scheme of no-fault and common-law benefits for motor vehicle accidents in Victoria), and under the federal Comcare system (the workers' compensation system for federal public sector employment). Having overcome the threshold, the compensation payable under section 98C is streamed to a number of bands according to the assessed degree of impairment.

The first band encompasses situations where a worker's degree of impairment is assessed as being between not less than 10 percent and not more than 30 percent. In such cases there is a base payment of \$5,000 and an additional amount of \$2,000 for each percentage point of impairment in excess of 10 percent. The second band (greater than 30 percent and less than 70 percent) has a base sum of \$45,000, and percentage point increments of \$3,250, while for the third band (greater than 70 percent and less than 80 percent) the base amount is \$175,000 with percentage increments of \$12,500. For an assessed impairment in excess of 80 percent there is a single stipulated payment of \$300,000.

Again, in accordance with the Government's "no disadvantage" policy, section 98E may provide some form of safety net, at least in situations where the worker's injury is of a type which is encompassed in the traditional Table of Maims. Section 98E has appended to it a table which is largely reflective (although differing in some respects) of the losses detailed in the section 98 Table of Maims. The compensation amounts in the section 98E table range from \$3,228 for the loss of a toe at the joint to \$161,390 for eight specified conditions such as total

loss of the sight of both eyes (or of an only eye), quadriplegia, and paraplegia. It provides an alternative in circumstances where a worker suffers a compensable injury resulting in a total loss under the section 98E Table, and where the amount which would be payable under section 98C for this condition would be less than that provided for under the section 98E table. In such situations, the worker can claim under (the more generous) section 98E rather than 98C.

The December 1997 act also lays the basis for significant changes in the manner in which payments for noneconomic loss are to be made. This follows upon the initiatives in the Accident Compensation (Further Amendment) Act 1996, which provided for the installment payment of maims payments in excess of \$5,000 over five years. That 1996 initiative was not activated, and this later legislation revisits the issue in a somewhat different way. This is not, however, immediately evident since section 36 of the 1997 act inserts a new section 98D into the ACA, which simply states that “compensation for non-economic loss calculated under section 98C or 98E is to be paid as a lump sum.” This is clearly intended as an interim measure since section 38 of the same statute is headed “Section 98D substituted.” This new section 98D has not been proclaimed but, when activated, will provide an entirely different regime for the payment of compensation for noneconomic loss under sections 98C and 98E.

Under the proposed new regime, noneconomic loss payments up to \$10,000 will be paid in a lump sum. For a payment between \$10,000 and \$30,000, it will be paid by an initial lump sum of \$10,000 and monthly installments of \$600 in accordance with a statutory formula. In cases where the noneconomic loss payment is greater than \$30,000, one-third of this sum will be paid as an initial lump sum (rounded up to the nearest \$100), with the balance in monthly installments of \$600, in accordance with one or other of the statutory formulae depending upon the number of such monthly payments. The act provides for time lines for payments and for procedures for making payments that essentially mirror those proposed in the initiative for installment payment of maims and statutory pain and suffering entitlements in the Accident Compensation (Further Amendment) Act 1996.

There are two reasons for not immediately implementing this new system of payment of noneconomic loss benefits by a combination of initial lump sum and subsequent monthly installments. One issue is linked to the taxation treatment that would be accorded to distributions made on an installment basis. Another matter is the impact that such installment payments would have upon a worker’s entitlement to social security payments. As stated in the second reading

speech, the Victorian Government continues to argue that “. . . impairment payment remains a capital sum whether paid as a lump sum or by installment. This has been accepted by the Commonwealth in relation to taxation.” Further, the Victorian Government “...is continuing to press the Commonwealth to treat installments as having no effect on any social security entitlement.” Accordingly, “until such time as the Government receives a favourable response to this request, all payments will be made as a single lump sum as currently occurs.”

It should be noted that the 1998 Federal Budget included changes to social security arrangements which impinge upon this area. Although these changes do not precisely dovetail with the Victorian approach, nevertheless, they appear drafted in conscious regard of the section 98D arrangements. The federal initiatives will treat lump sum payments made solely for noneconomic loss of up to \$10,000 as a lump sum and also provide that such a lump sum will not affect Commonwealth pension or allowance entitlement. Any noneconomic loss lump sum payments in excess of \$10,000 will be assessed as ordinary income spread over the 26 fortnights (one year) from receipt and accordingly will affect Commonwealth benefit entitlement. However, if the amount in excess of \$10,000 was not paid as a single lump sum but as a series of installments, then such entitlement may not be affected since the federal changes allow installment of up to \$2,000 within a 28-day period to be disregarded for benefit assessment. These federal initiatives are scheduled to take effect from 1 July 1999. Some amendment of the new section 98D seems needed to align it with the federal changes, but a major impediment for the introduction of the section 98D proposals appears to have been removed by the 1998 Federal Budget.

Impairment Assessment

The December 1997 measure provides that the principal instrument for impairment assessment from 1 September 1998 will be the fourth edition of the *AMA Guides*. However, different approaches from that taken in the fourth edition of the *AMA Guides* are stipulated in three areas of assessment. First, with respect to psychiatric impairment, the relevant instrument will be the *Clinical Guides to the Rating of Psychiatric Impairment*, prepared by the Medical Panel (Psychiatry). Second, hearing losses will be assessed using current National Acoustic Laboratory methods, which will be converted to a whole-person impairment percentage. Third, the chapter of the fourth edition of the *AMA Guides* dealing with pain will be excluded. The

reason for this exclusion is that the chapter is considered to have no workable methodology for setting a percentage impairment for chronic pain. Further, each separate chapter on a body system includes a component for pain.

Lump Sum Settlements

Workers with compensable injuries or illnesses may be able to receive certain benefits in the form of lump sum payment. (This does not consider a lump sum paid for any weekly benefits to which the worker had been entitled but that had not been paid previously.) Lump sum payments are paid for Section 98 and Section 98A benefits (maims and pain and suffering), Section 92 payments (death cases), and for any damages won at common law, though the changes in the statute in 1997 eventually will have an impact here. Additionally, the law permits lump sum settlements to be made in a very limited set of other claims. (Section 115)

If a worker is over the age of 55, has been receiving weekly benefits for 104 weeks or more, and is totally and permanently incapacitated, the worker can receive a lump sum settlement if the total amount is \$10,000 or less. (The \$10,000 figure is set by regulation, not by statute.) A worker that has received 104 weeks of benefits and is found to be “seriously injured” may also be paid in a lump sum settlement, for purposes of using that sum for some income-producing project. If the Authority is not persuaded that the funds will be used for such a project, or if it appears that the project has a high risk of failure, the Authority is not likely to approve the settlement. In practice, such settlements are granted only in exceptional circumstances.

Lump sum settlements are calculated based on several factors. First, any future medical payments for the compensable injury are calculated, taking account of the worker’s condition, age, and life expectancy (according to Australian mortality rates by gender). For purposes of appropriately discounting future expenditures, the Authority uses a discount rate of 3 percent. Future weekly benefits, net of income taxes that are estimated to be payable, are also discounted at 3 percent. (Recall that future weekly benefits would be terminated at age 65 or the regular age of retirement in that occupation). Thus, the lump sum payment is the present (discounted) value of any future medical and weekly benefits to which the worker is projected to be entitled plus, where appropriate, any lump sum benefits under Section 98 and Section 98A.

Typically, if the worker believes that there may be some potential damages to be awarded, no Section 115 lump sum settlement is sought. The reason is that acceptance of the lump sum settlement extinguishes the worker's right to any future compensation or damages for the injury in question. Nothing prevents a worker from first settling under common law and then applying for a lump sum settlement under Section 115.

Table 5.7 indicates the value of all the lump sum payments paid under workers' compensation over the past 12 years. Column 1 is the aggregate amount paid per year, and it reflects an extremely rapid rate of growth in such payments. From 1986/87 to 1991/92, the last full year under WorkCare, aggregate lump sum payments grew from \$11.5 million to over \$220 million. In 1992/93, payments exploded to over \$376 million, substantially due to common-law damages payments associated with the large runoff of claims brought about by the 1992 legislation. Lump sum payments levelled off for the following three years until they grew rapidly in the following two years.

One way to gauge the growth of lump sum payments is to compare them to weekly benefit payments, which also grew substantially after 1987/88 (see Table 5.2). Column 2 of Table 5.7 traces the ratio of lump sum payments to aggregate weekly benefit payments over the past 12 years. Lump sum payments increased from about 5 percent of the level of all weekly benefits in 1986/87 to 52.2 percent in 1991/92, and then jumped to equality in 1992/93. As the runoff of common-law cases results in fewer settlements, the percentage fell back until they took off in 1996/97 and 1997/98, easily topping the amount of weekly benefits paid in both years.

The allocation of payments as lump sums are shown in Table 5.7. Column 3 is death-benefit payments as a percentage of lump sum payments showing that death benefits have become an even smaller proportion of total lump sum payments. Column 4 is the percentage of total lump sum payments that were paid for maims. (Included in the maims payments are benefits for pain and suffering under Section 98A. Those benefits were paid only in the past five years and represented a negligible sum in 1993/94.) Maims benefits declined, proportionately, after 1987/88 until 1992/93, due to the growth in importance of common-law payments.

After 1992/93, maims payments began to grow rapidly, due in part to the limited availability of other lump sum settlements (column 6). They peaked, relatively, in 1995/96, declining thereafter as common-law lump sums dominated them. Common-law benefits have grown dramatically over time, reaching a peak in 1992/93. Even over the early years of

WorkCover, however, the large bulk of lump sum payments under common law are based on claims for injuries under WorkCare. By 1995/96, WorkCare claims still accounted for \$79 million in lump sum benefits (about 35 percent of the total), but this was well below the amounts paid in each of the three preceding years.

Medical Examinations - Section 112

There are a variety of matters that may cause an insurer to seek to have a worker examined by a medical person that it selects. Such matters could include, for example, whether or not a compensable injury or illness has occurred, the continuing incapacity of the worker, and the existence of and degree of any permanent impairment. Any claim or proceeding commenced by or for the worker and the worker's entitlement to benefits can be suspended if the worker unreasonably refuses to have or obstructs an examination.

Medical examiners under Section 112 are asked by an insurer to conduct their examinations, typically, at one of three times in the life of the claim. If the examination occurs within the first two weeks of the claim, typically the insurer is inquiring into the matter of compensability. If an examiner is asked to see a worker in the period four to five weeks into the claim, the insurer is seeking some information about the prognosis for the condition and the claim. Some examinations are conducted in the weeks after the claim has begun, to determine the issue of "serious injury" or "work capacity" at the 26-week or 13-week thresholds.

Medical examiners are selected by insurers from a list of persons who have been approved by the Authority. Examiners must be drawn from the ranks of the medical practitioners or registered physiotherapists, chiropractors, osteopaths, or psychologists. Some treating medical persons who were not medical practitioners disapproved of having medical examinations conducted only by practitioners. In their view, medical practitioners were not the best persons to examine workers being treated by other types of professionals. Hence, the set of medical examiners has been expanded to enable, in most cases, these examinations to be conducted by persons with training that is similar to that of the treating persons. However, only medical practitioners are approved to conduct examinations for purposes of rating the degree of impairment.

Similar to the situation in most jurisdictions, these medical examiners are viewed with suspicion by some of the workers that they see, and by worker representatives. Perceived as “insurance doctors,” these examiners can make findings that will lead to the reduction or termination of weekly benefits and can affect the possibility of receiving any lump sum payments. When insurers continue to use the same individuals again and again to conduct these medical examinations, and their opinions appear consistently to be injurious to the (financial) well-being of the worker, the process will inevitably draw some criticism.

From the perspective of the Authority, the ideal would be for all medical examiners to be widely regarded as objective and professionally respected. No doubt this is the case for some significant proportion of the medical examiners. Difficulties arise, however, for several reasons. First, where a medical examiner no longer treats patients and limits his or her practice to conducting insurance examinations, questions arise over both competence and objectivity. The latter issue will arise where a significant portion of a medical examiner’s income depends upon being called upon by insurance companies for these purposes. Practically, it has been difficult for the Authority to remove such examiners from the approved list of examiners.

Additionally, the Authority and insurers recognise that it is difficult to attract the quantity of service needed from some medical persons; that is, those who are regularly heavily demanded. The timelines in the law do not permit insurers to have the luxury of scheduling a needed medical examination far into the future when that is the first available open date. Further, some medical persons prefer not to do such medical examinations because they wish to eschew potentially confrontational situations.

Other medical persons limit or avoid doing Section 112 medical examinations on the grounds that they view the fees as inadequate. The fee paid to examiners depends upon the person’s credentials. As of June 1996, the fee paid to a specialist medical practitioner was \$303 with an added \$85.60 if an impairment assessment was prepared. The fee covers both the examination and the preparation of the report for the insurer.

Some criticism has surfaced regarding the rapidity with which some practitioners conduct their Section 112 medical examinations. Some of them schedule these examination at 15-minute intervals, while others may give considerably more time to the worker examination.

Some medical examiners believe that they can be helpful to the treating medical person in either of two ways. First, they may observe something in their examination that was not observed

initially by the treating doctor. Second, the treating practitioner may find it difficult to communicate something to the worker that the worker does not wish to be told. Presumably, this is less difficult for the medical examiner to do, or for the treating person to do upon the recommendation of the Section 112 examiner.

Medical Issues

The focus of this section is on a variety of issues relating to medical benefits that have not been addressed thus far. It is difficult to overestimate the importance of the role of medical services for a workers' compensation system. Persons and businesses that provide injured workers with medical services play a pivotal role in the system, from the determination of elements of the compensability issue to factors that establish the size and duration of cash benefits. Some jurisdictions have observed with alarm their high rates of growth in the cost of medical services in workers' compensation. Some have also observed the growing share of litigation costs that are paid for medical/legal services.

The worker is entitled to have the reasonable costs of medical and like services paid fully. Medical services are defined in the law (Section 5) and include the attendance, examination, or treatment of any kind of medical practitioner, or a (registered) dentist, optometrist, physiotherapist, chiropractor, osteopath, or chiropodist. In addition, medicines, appliances, and prostheses are covered, as are other services that are not defined but can be provided if requested by a medical practitioner. Injured workers may also be entitled to occupational rehabilitation services, which are described in Chapter 7.

In summary, the Authority recognises four categories of health care providers whose services are covered under the law. First, there are medical practitioners, who are the only ones who can issue initial certificates of capacity in claims for weekly benefits. Second, there are those registered professionals (dentists, optometrists, physiotherapists, chiropractors, osteopaths, and chiropodists), who may be accessed by the injured worker directly. Third, there are those who may provide a subsequent certificate. Such providers must be medical practitioners, physiotherapists, chiropractors, or osteopaths. Fourth, there are other providers, who have been approved by the Authority, whose services must be requested by a medical practitioner. These include persons providing services in acupuncture, dietary analysis, home help, massage,

naturopathy, occupational therapy, pharmacy, psychology, remedial gymnasium, social work, and speech pathology. In the cases of all four sets of providers, they have the Authority's approval by dint of membership in specific professional associations.

As of 1 July 1998, an employer's insurance required that it pay a deductible of \$426 before any liability for medical and like services exists for the authorised insurer. A worker's entitlement to medical and like services ceases 52 weeks after an entitlement to weekly benefits ceases except where

- the worker has returned to work but
 - could not remain at work without medical and like services, or
 - surgery is required, or
 - the worker has a "serious injury" (a 30 percent or greater impairment); or
- the worker requires a modification of a prosthesis; or
- the service is essential to ensure that the worker's health or lifestyle does not significantly deteriorate.

In the event that none of these conditions is met, the worker may have to resort to the general health insurance that exists outside of the workers' compensation system. However, that insurance may be less attractive to a worker because of the presence of a deductible, because certain medical services available under workers' compensation are not covered under the Commonwealth plan, e.g., physiotherapy, and because only in workers' compensation is an action against a worker for the payment of balances precluded.

Medical and Like Services Costs

Medical and like services costs have been the source of concern for some time in Victoria. Many jurisdictions, including Victoria, have sought to control the growth of these costs through fee schedules that limit the amount that service providers will be paid for their services. The process of setting "reasonable" fees, as called for by the law, had been highly contentious in recent years, though by 1998, matters appeared to be less so.

In 1990, following some continuing dispute over medical fees between the WorkCare administration and medical groups, including the Australian Medical Association, the Victorian Government named a Compensable Patients Fees Review Committee chaired by Dr. Ian Siggins.

Following the report of the committee, the Government agreed to pay medical fees beginning 1 January 1991 based on the Commonwealth Medical Benefits Schedule (CMBS) rates plus a loading that ranged between +24 percent and +49 percent. The loadings, reflecting Siggins, were based on two sets of factors. First, there were special circumstances in workers' compensation (and transport accident) cases that imposed costs on the treating providers. Specifically, the loading factor included a factor for bad debts (soon dropped), extra duration, extra service, practice disruption, slow payment, and list adjustment. Second, the CMBS fee schedule allows for balance billing. Balance billing refers to the practice of billing the injured worker directly for the "balance" of the bill after the primary payer has made payment. Thus, that fee schedule is different from the actual or market rate for medical services. The fee schedule under workers' compensation, where balance billing is less likely, was stepped up to reflect the market rates that doctors were receiving outside of workers' compensation.

Though a fee-schedule increase had been negotiated immediately after the election of October 1992, the enactment of the WorkCover law and the changed circumstances surrounding that kept the newly agreed-upon schedule from going into effect. Since that time there have been off-again on-again negotiations between the Authority and the Australian Medical Association. In January 1995, the Authority announced an increase in the fee schedule in the range of 1 percent to 1.5 percent. On 1 July 1995, as a result of the VWA's agreement with the Australian Society of Orthopaedic Surgeons, a 5 percent increase was approved for orthopaedic surgery. However, no agreement was reached at the time with the Australian Medical Association.

Rates were revised as of 1 January 1996 based on the current CMBS fee schedule plus the two sets of loadings (market rates and Siggins factors). The change was not the product of any agreement reached with the Australian Medical Association and there was considerable dissatisfaction felt by some parts of the medical community toward the VWA. However, fees have since been increased, and there currently appears to be less antipathy to the VWA on the part of the doctors.

To the extent that rancor exists over the issue of the medical fee schedule, it stems primarily from two problems. First, the doctors (through their representatives) believe that their fees have been inadequate, with special concern over the lack of increases in the earlier years of WorkCover. In contrast, some in the Authority saw a need for little or no growth on the grounds that the fees had been set too high in 1991/92. Another source of friction emanates from the

process of setting these fees, with some of the doctors believing that bargaining power rests entirely with the Authority. From their perspective, the Authority has acted unilaterally.

Disputes over medical fees are increasingly common in many jurisdictions. And in each of them other issues surround these controversies that tend to make their resolution more difficult to achieve. Some of the pressure from the medical providers emanates from their claims that medical bills are often paid only many months after their submission. The Authority acknowledges that in the past, late payment of medical bills did occur too frequently, but that the standard has been greatly improved in the last several years. As such, complaints about late payments and disputed bills are considered to be past history, and (some at the Authority believe) are simply a handy argument to justify fee increases.

A tripartite arrangement has developed for the payment of hospital costs. Public hospitals operate in Victoria under a fee schedule set by the state. Several years ago, a dispute between WorkCare and the public hospitals resulted in an agreement whereby the Authority would pay those hospitals based on diagnosis-related groups (DRGs). State Government now pays also on the basis of DRGs, although the TAC does not. Private hospitals are still not paid based on DRGs. A third group of (eight) private hospitals was selected to participate in a short-term pilot programme six years ago. Though the pilot project ended five years ago, that programme continues. It involves providing financial incentives to each of these hospitals to have workers treated and released more promptly than had been the norm. Though only a small number of hospitals participate in this scheme, they have a disproportionately large share of the hospitalized patients under workers' compensation.

The experience in many jurisdictions has been that tight controls over fee schedules have been inadequate as a means to limit medical cost growth. Instead, control over utilisation, in conjunction with a fee schedule, may be more effective. In the United States, at least, control over utilisation can come from several initiatives, primarily the adoption of managed care programs.⁷ At this time, managed care has not been developed in Victoria's workers' compensation system. However, it is certainly true that insurers can challenge whether the

⁷See for example, P. Burstein. 1996. *Benchmarks for Designing Worker's Compensation Medical Fee Schedules*, Cambridge, MA: Workers Compensation Research Institute. See also Ramona Tanabe. 1998. *Managed Care and Medical Cost Containment in Workers' Compensation: A National Inventory, 1998-99*. Cambridge, MA: Workers Compensation Research Institute.

provision of certain medical services was necessary, and whether the service is required as a consequence of a compensable injury.

The managed care movement, which has played an important part in American health care arrangements for some time now, has been slow to develop in Australia. A provision in the December 1996 legislation, a new Section 99AAA, deals with coordinated care programmes and is one of the first steps in this direction. It is viewed as an experiment, with the legislation providing that it will cease to operate on 1 January 1999. Since the measure commenced operation on 1 July 1997, there will be only an 18-month period to assess its effect and effectiveness.

Under this system, a worker may be required to submit a written coordinated care programme outlining the medical, hospital, nursing, personal and household, occupational rehabilitation, and ambulance services required for the worker's injury. Details as to the type, extent, and frequency of such services must be specified. This programme is prepared by a medical practitioner nominated by the worker, or, if the worker does not comply with this requirement, a medical practitioner may be appointed to prepare the programme.

The second reading speech indicates the circumstances under which a worker may be required to submit a coordinated care programme. These include situations where the worker has not recovered sufficiently to return to work within the normal recovery period, and current treatment is considered inappropriate or ineffective, where there has been an inappropriate use of opioid analgesics, or where there is evidence of "doctor shopping."

Another step with some potential to control costs and to provide appropriate treatment has been the adoption recently of a protocol for use in back injury cases. Borrowing from an earlier effort in South Australia, a medical advisory committee to the Authority recommended this protocol. For other jurisdictions, medical protocols have been utilised in several different ways, including as a basis for insurers to determine whether inappropriate or superfluous services were being rendered. For example, where the provider renders services inappropriately, according to the protocols this can be a justification to deny medical payments, as well as to identify providers that tend to deviate from accepted practices. The back protocol in Victoria has not been developed for these purposes. Instead, it is to be and already has been employed as an instructional or advisory tool for practitioners. Additionally, the protocol may aid the practitioner

in persuading an injured worker that the services being provided are appropriate ones, and that other treatments or more frequent applications of services are not called for medically.

Currently, there are no medical and like services for which a provider or an injured worker must seek pre-authorisation from an insurer (excluding occupational rehabilitation services). However, there are procedures to seek pre-authorisation from insurers, and they are being utilised. Where a provider fears that it may not be paid by an insurer for a service requested by or for an injured worker, the preauthorisation can assure it that it will be paid for the services.

The data in Table 5.8 provide an indication of Victoria's experience with medical and like services costs. Column 1 reveals the rapid growth in these costs from 1986/87 to 1991/92, with much of the growth occurring earlier in that period. After levelling off, costs fell sharply after 1992/93, though they have risen substantially again over the past two to three years. Much of the decline in the early years of WorkCover was associated with the reduction in claims for compensation that occurred in the wake of the 1992 legislation. Some of the decline reflects the increased employer deductible for medical and like services that occurred after 30 June 1992, when it was raised from \$360 to \$378 for injuries after that date. (That deductible has been increased annually since 1 July 1986 through indexation. As of 1 July 1998 it has reached \$426.) Even in years when aggregate expenditures paid for medical and like services declined, they did not decline as rapidly as claims did. Consequently, the costs per claim for medical and like services have grown every year over the past 10 years (column 2). In the latest two years, average per claim costs for medical and like services jumped by more than 45 percent.

How are medical and like services costs spent? The last five columns of Table 5.8 show the percentage of total costs, allocated across five major categories. Not surprisingly, the largest share of these costs are paid to medical practitioners. During the past five years, this group accounted for 30 percent to 32 percent of the medical and like services expenditure. There has been a relatively steady growth of payments for physiotherapy services at least until 1995/96. By 1997/98, physiotherapists received about 12 percent of all medical and like services expenditures (or about 40 percent of the amount paid to medical practitioners). Expenditures for hospitals have ranged between 22 percent and 29 percent during the 10-year period, and have been declined from 27 percent to 22 percent during the past five years.

The most significant changes in medical and like costs have been in the areas of rehabilitation and ancillary medical services. There has been consistent growth, proportionately, in ancillary medical services in the past decade. It represents an area that the Authority will want especially to monitor. Rehabilitation costs had fallen substantially after the enactment of the 1992 legislation, though they have increased again after 1993/94. However, it should be noted that certain expenditures that were classified as medical costs by WorkCare are now considered as rehabilitation or ancillary medical services. Thus, the figures across the decade are not completely comparable.

Concluding Observations

The supporters of the 1992 legislation hoped to achieve a number of goals. Certainly, a reduction in system costs was a motivation, but that was not their only goal. Other concerns were that benefits were not adequate in certain, more serious injury cases, and that the system was forcing employers to pay for injuries over which they had no control. Another obvious concern was the length of time that people remained on benefits and the incentive structure that contributed to this. Some of these issues are discussed elsewhere in this report. However, certain observations regarding the changed approach to benefits since 1 December 1992 are appropriate to discuss here.

First, it has become clear that the effort to limit access to the common-law remedy through the use of the serious injury threshold was frustrated, both as a product of judicial interpretations and as the 30 percent impairment level became more readily attainable. The use of psychological injury impairment as an add-on to the impairment level for a physical injury was especially instrumental here.

Disputes over benefits for maims and pain and suffering were not eliminated, even after Medical Panels became involved routinely. In fact, the Medical Panels were weakened by their frequent utilisation, as they became completely overloaded. The incentive structure for workers, and for their solicitors, encouraged the issuance of proceedings, primarily as a route to a settlement, with the worker's costs largely paid by the insurer. Settlements at the courthouse steps for maims and for pain and suffering could also be utilised in order to reach some understanding with regard to any continuing weekly benefits or damages that might otherwise be

sought at common law. Thus, despite the aim of the supporters of the 1992 effort to limit the use of lump sum settlements, this goal was not fully met. It is very difficult to seal off one area of benefits from another where the parties are able to arrive at a mutually agreed upon outcome in one of them. Compounding this was the incentive to move benefits from a taxable source (weekly benefits) to a tax-free source (lump sum).

Table 5.1 Standard Claims by Report Year*

Year	Claims Reported
1987/88	60,034
1988/89	60,202
1989/90	54,842
1990/91	56,726
1991/92	55,112
1992/93	47,863
1993/94	38,384
1994/95	33,282
1995/96	33,757
1996/97	32,808
1997/98	29,495

* All claims arising from self-insured employers as of 30 June 1998 are excluded.
Source: VWA

Table 5.2 Weekly Benefits, Annual Totals*

Year	Weekly Benefits Paid (\$, millions)
1986/87	244,871
1987/88	348,444
1988/89	426,451
1989/90	415,554
1990/91	416,140
1991/92	422,448
1992/93	377,057
1993/94	229,262
1994/95	226,080
1995/96	257,735
1996/97	303,923
1997/98	313,489

* All claims arising from self-insured employers as of 30 June 1998 are excluded.
Source: VWA

Table 5.3 Long-Term Claims By Year Reported*

Year	Long-Term Claims	
	Standard **	Total
1986/87	9,087	9,717
1987/88	6,309	6,742
1988/89	5,725	6,139
1989/90	4,929	5,350
1990/91	5,766	6,170
1991/92	5,231	5,547
1992/93	2,801	2,906
1993/94	2,151	2,152
1994/95	2,734	2,736
1995/96	2,979	2,979
1996/97	2,189	2,189
1997/98	104	104

* All claims arising from self-insured employers as of 30 June 1998 are excluded.

**Standard claims exclude journey claims and nonfatality closed claims with up to 10 days compensation and medical and like payments below the threshold.

Note: "Long-term claims (greater than one year)" are claims which have more than 260 days compensation.

Source: VWA

Table 5.4 Fatality Claims*

Year	Standard Claims**	Total Claims	Death Benefits (\$, millions)	Average Lump Sum Payment (\$)
1986/87	223	265	5.2	53,406
1987/88	225	291	7.0	46,248
1988/89	262	338	12.9	51,055
1989/90	231	294	14.2	55,982
1990/91	193	242	13.8	60,110
1991/92	203	255	16.4	70,553
1992/93	168	192	10.5	71,032
1993/94	135	138	7.9	78,197
1994/95	121	121	7.0	92,377
1995/96	134	134	8.9	91,738
1996/97	120	120	10.0	80,962
1997/98	119	119	11.2	86,149

* Claims arising from self-insured employers as of 30 June 1998 are excluded.

** Standard claims exclude journey claims.

Source: VWA

Table 5.5 Maims Payments*

Year	Total Payments (\$, millions)	Maims Payments/ Weekly Payments (%)
1986/87	5.2	2.1
1987/88	15.9	4.6
1988/89	24.7	5.8
1989/90	34.5	8.3
1990/91	47.1	11.3
1991/92	61.0	14.4
1992/93	79.6	21.1
1993/94	77.9	34.0
1994/95	90.1	39.8
1995/96	116.4	45.2
1996/97	145.0	47.7
1997/98	147.5	47.0

*Includes payments for Section 98A in the latest four years. Claims arising from self-insurers as of 30 June 1998 are excluded.

Source: VWA

Table 5.6 Percentages of Maims Payments by Type of Maim, 1986–1998*

	1986/87 (%)	1987/88 (%)	1988/89 (%)	1989/90 (%)	1990/91 (%)	1991/92 (%)	1992/93 (%)	1993/94 (%)	1994/95 (%)	1995/96 (%)	1996/97 (%)	1997/98 (%)
Vision, sight loss	3.6	3.2	3.3	1.7	2.8	2.5	1.4	1.3	1.4	1.3	1.1	1.0
Upper extremities	10.4	13.3	21.5	21.1	23.0	23.2	16.9	15.1	20.4	20.6	22.9	26.7
Lower extremities	5.1	4.3	6.7	10.4	10.3	11.8	10.5	10.1	13.0	14.1	15.2	17.0
Hearing disorders	70.2	62.4	34.4	35.3	27.1	25.5	36.9	38.9	21.1	19.0	11.7	8.6
Back impairment	1.9	5.0	15.4	19.3	23.2	22.5	20.1	17.1	19.4	20.5	25.9	29.2
Neck impairment	0.0	0.7	0.8	2.0	2.2	2.3	2.6	2.4	3.9	4.0	4.7	6.4
Pelvis impairment	0.0	0.2	0.3	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.2
Severe injuries including: paraplegia, and quadriplegia, loss of mental powers	2.5	2.3	1.6	1.0	1.4	1.3	0.5	0.9	0.4	0.6	0.3	0.3
Other	-	-	-	-	-	-	3.7	8.1	18.5	19.2	17.6	10.2
	6.2	8.6	15.9	9.0	10.0	10.7	7.3	6.0	1.8	0.5	0.4	0.5

* Claims arising from self-insurers as of 30 June 1998 are excluded.

Source: VWA

Table 5.7 Lump Sum Benefits Payments

Year	Lump Sum Payments (\$, thousands)	Lump Sum Payments/ Weekly Benefits (%)	Death Benefits (%)	Maims Benefits (%)	Common-Law Damages (%)	Other Lump Sums (%)
1986/87	11,347	4.6	46.1	45.6	3.2	5.1
1987/88	26,953	7.7	25.9	59.0	12.8	2.3
1988/89	48,116	11.3	26.7	51.2	20.2	1.8
1989/90	76,224	18.3	18.6	45.3	34.5	1.6
1990/91	121,253	29.1	11.4	38.8	45.5	4.3
1991/92	220,419	52.2	7.5	27.7	49.5	15.4
1992/93	376,525	99.9	2.8	21.2	63.6	12.5
1993/94	221,185	96.5	3.6	35.2	50.4	10.8
1994/95	217,647	96.3	3.2	41.4	54.0	1.4
1995/96	225,609	87.5	3.9	51.6	44.3	0.2
1996/97	327,495	107.8	3.1	44.3	52.5	0.2
1997/98	367,266	117.2	3.0	40.2	56.4	0.4

Source: VWA

Table 5.8 Medical and Like Services Costs

Year	Total (\$, millions)	Per Claim* (\$, millions)	Medical Practitioner (%)	Rehabilitation (%)	Hospital (%)	Ancillary Medical Services (%)
1986/87	57.9	645	36	14	29	0
1987/88	103.2	1,228	29	20	28	0
1988/89	139.9	1,656	28	23	25	2
1989/90	145.2	1,880	28	22	27	3
1990/91	159.4	2,158	29	22	25	3
1991/92	171.7	2,527	30	20	22	4
1992/93	174.2	3,106	30	15	24	5
1993/94	129.9	3,178	32	5	26	6
1994/95	119.5	3,365	32	3	26	7
1995/96	132.5	3,699	32	5	24	7
1996/97	153.9	4,408	31	7	23	8
1997/98	168.6	5,373	30	10	22	8

* Total claims reported in that year. All claims arising from self-insured employers as of 30 June 1998 are excluded.

Chapter 6 Disputes and Resolutions

Goals

Disputes arise in all systems of insurance, be they social insurance or a purely private arrangement. Workers' compensation programmes have developed a rich mixture of approaches to cope with disputes. In recent years an increasing number of jurisdictions have sought to minimise the incidence of these disputes, as awareness of their costliness has surfaced. Additionally, a common goal has been to seek to settle the disputes that do arise in a prompt and, preferably, informal fashion. The purpose of this chapter is to describe the methods employed in Victoria to deal with disputes in workers' compensation. The approach taken is to focus on the various subsystems that have been established to resolve and settle disputes as they develop.

A consistent goal of the WorkCover programme has been to reduce the litigation costs of the system, without necessarily paring back benefits to injured workers. If the resources spent on litigation could be lowered, the outcome could be lower insurance costs for employers and higher benefits for workers. Indeed, if the approach was successful, it would allow the paying down of the unfunded liability. In general, litigation costs can be lowered by reducing the frequency of controversy and the intensity of dispute, as represented by the stage at which the dispute is ultimately resolved. Moreover, if direct costs of disputes, i.e., legal and forensic medical costs could be cut back from where they had been, it would result in a win-win outcome for both employers and for workers.

In order to reduce the system's litigation costs, the WorkCover scheme was designed to limit the number of disputes, deal with disputes that do arise in an expeditious manner, and discourage extended and costly litigation. The strategy depended upon prompt access to a conciliation process, and it sought to minimise solicitor involvement at that level. Indeed, many issues that arise initially as little more than questions or misunderstandings can mushroom into serious disputes and court involvement if they are not dealt with promptly and satisfactorily. As such, a somewhat informal and prompt conciliation process could help to limit extended disputes and assist the scheme in achieving its goals.

A second method of limiting controversy and holding down litigation costs was to rely upon the core concept of "serious injury." This was defined as a compensable injury or illness

that was rated at 30 percent or more of the whole person according to the American Medical Association's *Guides to the Evaluation of Permanent Impairment* (second edition [originally]). Among other things, the serious injury finding was needed by workers seeking access to the courts to pursue a common-law remedy. A number of things served to undermine the effectiveness of the serious injury concept as a barrier to widespread utilisation of the common-law remedy. One of these was the emergence of psychological impairment ratings, stacked up on top of the rating for a physical impairment to push impairment ratings up to or over the critical 30 percent threshold. Placing a quantitative rating on a psychological impairment can be particularly subjective, and is bound to involve a higher variance than in the case of most—if not all—physiological impairments. Certainly, the development of what some call physical-mental cases appeared to reduce the screening power that was expected of the serious injury criterion.

A third method for attacking litigation costs depended upon the use of medical experts who served as neutral arbiters in disputes over medical issues. It was understood that many of the controversies in workers' compensation schemes revolve around medical issues. By using medical panels to decisively resolve "medical questions," it was hoped that extended controversy over medical matters could be avoided by prompt referral to and decisions from impartial doctors. The expectation was that if the medical panels could accomplish these tasks, there would be less need for court involvement.

Other measures were designed to limit the degree of costly litigation. For example, disputes over relatively small sums of money were directed to the Magistrates' Courts, rather than the costlier, and more formal, County Courts.

The Approach to Dispute Resolution

The role of a workers' compensation agency in matters of disputes can be arrayed along a continuum. At one end are those public agencies that play a central and decisive role in the resolution of disputes. Such agencies make the initial determination of factual matters, and they may also be nearly the ultimate appellate body as well, if further review in the courts is rare and difficult to obtain. At the other edge of the continuum are those agencies that utilise direct and indirect measures to induce the parties to mutually resolve their differences. Indeed, such an

agency itself may not make determinations in disputes, but instead have the independent court system serve that function.

Since 1 December 1992, Victoria's approach to dispute resolution has placed it squarely in the latter camp. The agency does not adjudicate disputes; rather, the WorkCover Authority seeks both to minimise the incidence of disputes if they arise, and to have them settled rapidly by the parties with a minimum of transaction costs where they do occur. Where there is no rapid resolution, as must occur on occasion, the dispute is resolved in the courts. To assist the parties and achieve their goals, workers' compensation has depended heavily on a system of Medical Panels in order to bring to bear some objectivity and professional expertise on disputes arising over medical matters. An independent Conciliation Service is empowered to assist the parties in finding common ground. Disputes that are not resolved at that stage, and those emanating from common-law actions, enter the court process. Even here, as noted, the WorkCover law seeks to drive some cases to the Magistrates' Court rather than the County Courts. Until the 1997 law change, a small number of disputes over some specialised issues were resolved either at the Conciliation Service or the Administrative Appeals Tribunal.

The Conciliation Service

In many jurisdictions outside of Australia, particularly in North America, there is a general pattern or approach to dispute resolution in workers' compensation cases. While specifics differ among those systems, a common formula places decision making for dispute resolution in the hands of the workers' compensation agency. This is true even when there is no allowance of private insurance (or even self-insurance), and the Government insurance fund may reside within the same agency that adjudicates disputes. Also, a more or less autonomous appeals board or tribunal will frequently take appeals of decisions reached by the workers' compensation agency. Though all such approaches may permit appeals of the decisions of such bodies to be taken to court, it is common to limit such appeals solely to matters of law and not to disputes over facts. In some jurisdictions, access to the courts is strictly limited to those matters, and workers' compensation disputes rarely are decided at that level.

Quite at odds with this approach is the model found in Victoria, and most of the other jurisdictions in Australia. Under WorkCover, the Authority does not adjudicate disputes over eligibility for, or the extent of, compensation benefits. Essentially, disputes related to these issues

have traditionally been decided by tribunals in Victoria. Resorting to the courts to decide such issues can burden the parties with significant transactions costs— it also might create important delays in their arriving at some resolution, and it can lead to backlog problems for the courts, which are already coping with large caseloads from other fields.

As a way to hasten the resolution of disputes over claims, and to avoid throwing all of them into a court-centred process, the WorkCover legislation created the Conciliation Service. The purpose of the Conciliation Service, essentially, is to help the parties to resolve their disputes, thereby eliminating the need to take the next step; that is, to litigate the matter at court. It functions by involving workers, employers, and insurers in an informal and nonadversarial process that aims to lead to a mutually acceptable agreement. The Ministerial Guidelines for the Conciliation Officers identify the goals of the Conciliation Officer to be to

- assist the parties to achieve durable resolutions and agreements, where possible;
- be even-handed and fair, and address matters on their merits;
- maximise flexibility and informality;
- facilitate return-to-work opportunities;
- enhance ongoing worker/employer employment relationship—be prompt and timely in the conduct of the conciliation process and in dealings with the parties; and
- reduce cost implications for the parties and the scheme and ensure that matters do not unnecessarily proceed to the courts.

Procedures

From 1 July 1994, all disputes over compensability or benefits were referred to the Conciliation Service, except those over death claims (Section 92), for maims (Section 98), and for pain and suffering (Section 98A). Beginning in July 1996, however, disputes over maims and pain and suffering also required mandatory conciliation.

Most requests for conciliation are initiated by workers who have been advised by the insurer of a decision that they regard as adverse. However, any party to a dispute, i.e., the insurer, the employer, the worker, or the Authority, may refer the matter to Conciliation. A party has 60 days from notice by the insurer of its decision to lodge a “Request for Conciliation” form. The Senior Conciliation Officer may allow this 60-day limit to be waived. Indeed, this is usually

done when such a request is made to insist that the request fall within the 60 days may result in the applicant seeking relief from a court.

When a Request for Conciliation form is submitted, a referral certificate is issued within seven days, putting all parties on notice. On occasion, this will be sufficient to cause the disputing parties to agree to settle, particularly where such cases may involve not a dispute so much as the need for clarification, or a better explanation of a decision. After the initial seven days have passed, a date is set for a conciliation conference. The worker and the employer (if it is the first time that the employer is to attend such a conference) are each sent a video (available in four languages) and a brochure (available in multiple languages) describing what such a conference entails. This step was taken to allay any apprehension that participants might have in advance of the conference and to allow them to better prepare for it. Additionally, the worker is advised that a translator can be made available to assist the worker at the conference.

The act requires that the parties produce any document or information that the Conciliation Officer considers necessary to resolve the dispute. The insurer is required to submit any information or medical reports to the Conciliation Service within 48 hours of receipt of notice that a Request for Conciliation has been lodged. The Conciliation Officer may attempt to have the dispute resolved even prior to the conference if sufficient information has been made available and a settlement seems possible.

The Conciliation Conference will bring together the insurer, the worker, and frequently the employer. The worker and the employer are entitled to be accompanied by a friend or relative or some other person to assist them at the conference. A union representative, for example, often will serve as an assistant for the worker. Significantly, a worker or an employer is not entitled the accompaniment of a solicitor. If a party wishes to have a solicitor present, approval must be given by both the contending party and the Conciliation Officer. On occasion, requests by workers to have a solicitor accompany them to a conference have been rejected, however, this is seldom done, particularly in recent years. There is little for anyone to gain by denying the worker the opportunity to have a solicitor present, particularly where it seems clear that the opportunity to reach a settlement is greater where the worker has ready access to counsel.

If a solicitor does join the worker at a Conciliation Conference his or her fee cannot be paid by the contending party. Since costs are not allowed as part of the conciliation process, either the worker must pay the solicitor or the solicitor must offer to serve without pay. Some

solicitors say that they charge no fee for conciliation work where the client is a member of certain labour unions.

The Conciliation Conference may enable the parties to move to an agreement. In some cases, the agreement is shaped at the conference. In other instances, negotiations between the parties may occur after the conference has occurred, possibly prior to a previously scheduled second or subsequent conference. If the dispute involves a medical question, the Conciliation Officer may refer it to a Medical Panel. The opinion of the Medical Panel must be accepted by the parties as conclusive. However, the courts have not always enforced this provision, and settlements are made frequently following receipt of the opinion by negotiation between the parties.

On some occasions, the parties are able to reach some understandings but are unable to arrive at an actual agreement. In such cases, the Conciliation Officer is able to make recommendations regarding how the dispute may be resolved. The parties are not obligated to accept the recommendations; instead, the Conciliator is simply extending his or her role as a facilitator.

The Conciliator may be placed in the position of a decision maker. Where the dispute relates to weekly compensation benefits and no agreement is reached, the Conciliator may “direct” that payments be made or continue to be made. The Conciliator may only issue directions where he or she finds that no genuine dispute exists. If there is a decision that a genuine dispute exists, the matter of any past and future payments is left to the parties either to settle or to proceed to court. Directions can be revoked by a Conciliation Officer or the County Court.

The Conciliation Officer may direct payment of weekly payments for the period prior to the direction, but that period must not exceed 24 weeks. (Prior to the 1997 amendments, this had been limited to 10 weeks.) The Conciliation Officer is authorised to direct that future weekly benefits be paid for a period not to exceed 12 weeks. After the 12 weeks have passed, the Conciliation Officer may direct that up to 12 more weeks of payments be made, though this is not permissible where the earlier direction was revoked by the County Court. The 1997 amendments also authorise the Conciliation Officer to direct that the reasonable costs of medical and like payments begin or continue to be paid. However, if there is a dispute over the liability for medical and like services costs in a claim, and the Conciliation Officer determines that there

is no genuine dispute, he or she can direct that the reasonable costs of medical and like payments be made by the insurer up to \$2,000. (A genuine dispute does not exist if the Conciliation Officer is satisfied that there is no arguable case in support of the denial of liability, according to a definition provided in the 1997 amendments.)

Clearly, it is a tricky matter for a Conciliator to fulfill the task of a facilitator while retaining the role of a potential decision maker. However, this represents an accommodation to the reality that no other decision maker is present in the process, and the worker may be forced to wait for the outcome of a court proceeding before receiving any weekly compensation or medical benefits. The accommodation here is tempered by the inability to direct that weekly benefits be paid where a genuine dispute is perceived to exist. If a direction that weekly benefits be paid has been issued, the worker is not required to refund those payments if the County Court determines subsequently, that the insurer was/is not liable to pay those benefits. However, if the claim was wholly or partly fraudulent or made without proper justification, the court may order that repayment be made.

The Conciliation Officer

Conciliation Officers are appointed by the Minister of Finance and engaged by the Authority. One of the officers is appointed as the Senior Conciliation Officer, with responsibility for the administration of the Service. A Conciliation Officer is not subject either to the control or the direction of the Authority. The Authority is not able to overrule any decision made by the Officer in conciliating a dispute. As of July 1998, there were 21 full-time Conciliation Officers, 7 sessional and part-time Officers (including 2 physicians), plus 3 executives of the Service who carry small caseloads as Conciliation Officers as well. The total permanent staff was 61 persons as of 1 July 1998. Over the past three years, only three Conciliation Officers had left the Service.

There is no single preferred background for a Conciliation Officer as evidenced by the broad range found in existing officers. Clearly, strong interpersonal skills, good judgment, an ability to listen carefully, a sense of fairness and the ability to appear fair, and an understanding of the law and skills in organising one's workload, all appear to be important characteristics.

The Conciliation Officers are organised into three teams. Once a claim is successfully lodged with the Service, it is randomly assigned to a team. An exception to that exists where a team has responsibility for the country district, with that assignment rotated among the teams

every 9 to 12 months. Once a case is assigned to a team, it is referred on a random basis to one of the Conciliation Officers.

The Experience of the Conciliation Service

The responsibilities of the Service have evolved considerably in the seven years of its existence. A sizable portion of the Conciliation Service's caseload in its first year involved the transition from WorkCare to WorkCover. Under the legislation, eligibility for weekly benefits was terminated for some persons who had been recipients under the WorkCare scheme for 52 weeks or more at the time that WorkCover was enacted. Among those persons considered not to be "seriously injured" or totally and permanently incapacitated, benefits were terminated after the worker had been incapacitated for 104 weeks, including any period prior to commencement of the WorkCover Act. Additionally, weekly benefits for other recipients who were considered not "seriously injured" and not totally and permanently incapacitated were terminated 52 weeks after the commencement of the act. In addition, from 1 December 1992 to 30 June 1993, a total of 12,814 conferences were concluded and 9,728 cases were settled under Section 135B. However, these were handled as a transitional situation at the VWA, separate from the emerging Conciliation Service. A team of transitional conciliators was also engaged in the clearing out of cases that had been filed at the Accident Compensation Tribunal (whose role was largely eliminated by the WorkCover Act), but where the Tribunal either had not commenced to hear the matter or had commenced to hear the matter but had not completed the hearing or determined the matter. These transitional cases were to proceed to the County Court but only after a Conciliation Conference had been held on the dispute (Section 42). Approximately 3,600 matters were affected by this requirement, providing considerable activity for conciliators through much of 1993.

Mandatory conciliation, except for disputes over Section 92, Section 98, and Section 98A, expanded the Service's responsibilities beginning in July 1994. As of July 1996, all disputes over both maims (Section 98) and pain and suffering (Section 98A) had to be referred to the Service before commencing proceedings.

The early years of conciliation under WorkCover witnessed highly uneven flows of cases. Such shifts can create difficulties in terms of planning, training, and possible backlogs or excess capacity for the Conciliation Service. In fact, the start-up period for the Service was a

difficult one, with large numbers of claims heaped onto a new organisation that was still taking shape. The results were large backlogs and delays. The Service overcame these, and in a few years it began to operate with good timeliness and no large backlog.

The data in Table 6.1 reflect the number of applications for and disposals of cases by the Conciliation Service. It shows the large difference between applications and disposals that was created in 1992/93 but that was largely eliminated by the end of 1993/94 and fully disposed of by the end of 1994/95. By the end of June 1998, there were 2,605 cases outstanding, well below the comparable figure (3,360) for the previous year. The number of new and reopened cases at the Conciliation Service in 1997/98 was 18,097. As such, the outstanding caseload was only 86 percent of the average of a 60-day intake ($1/6 \times 18,097 \times .86 = 2,605$). Cases disposed of by the Conciliation Service in 1997/98 (18,552) were 1.4 percent above the number disposed of in the previous year.

As of 1997/98, approximately 71 percent of applications that were disposed of involved issues other than lump sum payments. Other than the lump sum matters, the Conciliation Service reported that 42 percent were disposed of in 28 days or less, and 84 percent were disposed of in under 61 days. Matters conciliated involving lump sum settlements tended to take somewhat longer to dispose of, with 34 percent disposed of in under 61 days, and 47 percent that were closed taking more than 90 days.

It must be noted that the number of applications and the number of disposals are less than complete indicators of the Conciliation Service's activity. First, not all applications result in a conference. A dispute may be resolved or dropped prior to the holding of a conference, for example. In 1–2 percent of applications, the Conciliation Service finds that it does not have jurisdiction. A small percentage of cases represent reopenings of cases.

Additionally, there is a sizable number of disputes involving maims and pain and suffering that are being resolved in “facilitated discussions.” In such disputes, a worker solicitor may meet with insurers and a Conciliation Officer to settle a batch of that solicitor's unresolved lump sum claims. The solicitor meets with each insurer separately, perhaps spending an entire morning seeking to settle a score or more of unresolved cases. Subsequently, the solicitor will contact the injured workers advising them of the offer that the insurer has made. In most instances, the worker will, upon the solicitor's recommendation, accept the offer. These

facilitated discussions permit large numbers of maims cases to settle without the need to directly involve the courts.

From December 1992 through June 1998, 20,640 (or 25 percent) of 83,028 applications to the Conciliation Service were for maims disputes. Beginning in mid 1995, a dispute over a maims claim could be referred to conciliation by a worker concurrently with, or as an alternative to, a referral to a Medical Panel. Also, an insurer could refer a Section 98 case to Conciliation if a worker rejected an insurer offer. (This change resulted from the large backlogs at the Medical Panels.) Other major sources of dispute that result in applications (as shown in Table 6.2) are rejections of claims by insurers, terminations of benefits, insurer reductions of benefit payments, and medical issues, e.g., services for which the insurer will not pay.

An Assessment

The workers' compensation community has provided us with mixed reviews on the performance of the Conciliation Service. Initially, at least, the Service appears to have been overwhelmed by the number of cases that it received, a particularly difficult situation for an agency that was entirely new. The agency had to deal with hostility from some solicitors who charged that the service was actually an operating arm of the Authority. Solicitors were not pleased with their inability to have their fees paid by costs from insurers for their work at this level. The changing responsibilities of the Conciliation Service during the past four years have added to the challenge that the agency has had to meet, and it is clear that the overall caseload that the Service has encountered has been imposing.

It seems quite remarkable that this agency now operates with little backlog and that it can accommodate, generally, the rigorous requirement that applications be conferenced within 28 days of their receipt. In the past year, about 62 percent of its cases were resolved. However, a sizable portion of those cases that were unresolved did not proceed with further disputation to the courts. As such, the resolution rate can be estimated, actually, to be in the range of 75 percent to 80 percent. This is an impressive performance.

The legislation requires that matters may not proceed to court (except fatality claims) unless first referred to Conciliation. Until the 1997 amendments, all matters, other than maims cases, could proceed to court if not resolved within 28 days of being lodged with the Conciliation Service. Most solicitors were willing to allow matters to proceed beyond the 28 days before

issuing proceedings, so long as they could see some progress with the conciliation. However, some solicitors delayed providing information after the Request for Conciliation has been submitted, so that resolution could not be effected within the 28-day period. When that period expired they issued proceedings. To prevent such tactics to evade the process, the 1996 amendments required that the Conciliation Officer certify that the claimant has made a reasonable attempt to settle in disputes over mains. Together with the 1997 amendments, the passage of 28 days from the time of filing with the Conciliation Service is no longer sufficient by itself to permit the issuing of proceedings.

It is difficult to assess the quality of a Conciliation Service on purely quantitative bases. Where the agency does deal expeditiously with its cases, and where a sizable proportion of them resolve without resort to the courts, the agency clearly is providing an acceptable level of service. As to its inputs, the Service appears to have an excellent information system to serve its staff and executives, it has demonstrated its recognition of the importance of staff development, and it has been allowed to adjust the number of its Conciliators as needed. The agency also has demonstrated a degree of introspectiveness, and a willingness to modify its practices when they have appeared to be in need of change. In some instances, a solicitor seeks to proceed beyond conciliation in order to obtain a lump sum settlement at the “courthouse steps.” Such instances necessarily keep the Conciliation Service’s resolution rate from being higher.

Surveys of workers, insurers, and employers have been conducted periodically by an independent market research firm. The results of a 1998 survey indicate that 85 percent of conference attendees were satisfied with the Service, up from 78 percent in 1997 and 83 percent in 1996. These rates are very impressive, particularly as they emerge from participants who are engaged in controversy, and where zero-sum outcomes, or simply no outcomes except further litigation, are often the result at this level.

Some criticism about the process, but not of the Service itself, seems to surface regularly. First, some disputes appear to result from an insurer’s reluctance to engender the wrath of their insureds. Thus, the insurer makes a decision that is highly likely to generate a dispute in order for the Conciliation Service to be identified as the source of an outcome that the employer resists. The insurer knows what the outcome will be but deflects away from himself the anticipated employer dissatisfaction. This practice is certainly familiar from other jurisdictions. Its incidence is difficult to measure and, hence, to compare. Because of the unusual nature of the relationship

between insurers and employers, the problem may be somewhat greater in Victoria than in most jurisdictions.

A second criticism is that the parties, and in particular the insurer, may attend Conciliation Conferences unprepared and/or unable to commit to a settlement. These observations also appear to be universal in workers' compensation dispute resolution. It might be possible for the Conciliation Officer to report instances of this sort to the Authority, which in turn could bring some greater pressure to bear on the authorised insurers. Such a role, however, might put the Conciliator into an evaluative role, undermining his or her primary responsibility to conciliate and to mediate the dispute.

Beginning in July 1996, disputes over permanent impairment had to be referred to Conciliation. In conjunction with the 1997 amendments, this means that these cases are not to proceed to court until a Conciliator certifies that the claimant has made a reasonable attempt to conciliate the matter. All medical evidence which any party relies upon must be exchanged either at the time the claim is made or by the conciliation stage. Unless the Conciliation Officer is satisfied that all reasonable steps have been taken by the claimant to settle the dispute, and that certain measures called for in 1997 with regard to Medical Panels (see below) have been taken, the matter will not proceed to Court. The certificate must identify copies of medical information provided by one party to the other, as well as any information obtained by the Conciliation Officer (including the opinion of a Medical Panel). It seems clear that the 1996 and 1997 amendments enhance the power of the Conciliator, but it remains to be seen whether this occurs at the expense of the Officer's role as a mediator or serves to strengthen it.

Medical Panels

An increasingly important element in the dispute resolution process in Victoria is the system of Medical Panels. In recent years an increasing number of jurisdictions have created and utilised such Panels, in one form or another, to assist in the resolution of disputes involving medical issues.¹ The goal of this approach, generally, is to have these issues decided by neutral persons with appropriate medical expertise, who have no financial or other interest associated

¹For example see Barth. 1985. *Resolving Occupational Disease Claims: The Use of Medical Panels*. Cambridge, MA: Workers Compensation Research Institute.

with the outcome. Currently, such Panels are found in Victoria, New South Wales, and Western Australia; Queensland employs a Medical Assessment Tribunal.

The use of the Medical Panel approach can provide several outcomes that many parties would consider to be salutary. Aside from bringing some neutral professional expertise into the process, the very existence of such Panels may serve to discourage excessive amounts of litigation, as parties avoid disputing matters where they have little or no effective medical evidence to support them. Additionally, the parties may have more satisfaction with the entire process when the contending positions are evaluated by qualified neutrals.

Jurisdictions that have created Medical Panels have had to wrestle with many significant issues concerning the procedures that they employ. Specifically, interest groups may give support to, or oppose, such Panels depending upon the answers to a number of questions, including:

- What issues are to be taken to a Panel?
- Who can serve on a Panel?
- Who selects the Panel members?
- What is the size of a Panel?
- How binding are the findings of the Panel?
- In what form does the Panel report its findings?
- On what basis does the Panel determine its findings?
- To what extent does the Panel delay the dispute resolution process?

Medical Panels were established in December 1992 with the introduction of WorkCover. The system is independent of the Authority though its budget flows from it. The primary responsibility of the scheme is spelled out in the statute Section 67(1): “The function of a medical panel is to give its opinion on any medical question in respect of injuries arising out of, or in the course of or due to the nature of employment before, on or after the commencement of section 10 of the Accident Compensation (WorkCover) Act 1992 . . .”

The definition of “medical question” consists of twelve items identified in the statute (Section 5). In 1994, the function of the Medical Panels was expanded under Section 104 (see below). Consequently, the function of the Medical Panels was extended beyond that which is found in Section 67.

Under Section 67, a Conciliation Officer, the County Court, the Authority, or an authorised insurer or a self-insurer may require a worker—either one claiming compensation or one who is receiving weekly payments under the act—to submit themselves for examination by a Medical Panel. If the worker unreasonably refuses to meet the Panel and answer its questions, supply relevant documents to the Panel, or submit to a medical examination by a member of the Panel, the worker may lose the right to payments or have them suspended.

The law provides that where the County Court exercises jurisdiction, the court may refer a medical question to a Medical Panel for an opinion, and it must refer a medical question if a party to the proceedings so requests (Section 45). In either case, the opinion of the Panel is binding, subject to the County Court's finding either that new information on the medical question has emerged since the time of the Panel's opinion or that the worker's medical condition has changed since the opinion was rendered.

Panel Members

One Panel member is appointed by the Minister as Convenor. The Convenor is appointed to oversee the business of the Panels and give directions as to procedures of the Panels. Members of Medical Panels are appointed by the Governor in Council. They must be medical practitioners, i.e., a registered medical practitioner within the meaning of the Medical Practice Act of 1994. In 1998, there were 100–120 persons so designated in Victoria.

As noted above, the selection of Medical Panel members can be a source of dissatisfaction by parties, who may question their neutrality (fairness) or their quality. A number of issues have surfaced in this regard. First, it can be difficult to recruit certain medical practitioners to the Medical Panel. If potential members are already very heavily committed, or if they perceive that Panel work may involve them in excessive contention or that such work inadequately compensates them, it may be difficult to fill the Panel with highly regarded professionals. Further, some persons may be willing to serve on the Panel but substantially limit the degree of their involvement.

In actual practice, the Victoria Medical Panel has had several specific issues to contend with. First, the number of medical practitioners in some specialties is hardly adequate for the number of cases requiring those skills, while there exists an excess supply in other fields of specialisation. Second, while some Panel members allow themselves to serve only in a handful

of Panels, others will serve in many more in a month. Critics of the Panel point to these Panel members who serve frequently as an indicator of a lack of quality, although no evidence has been produced to show that frequency of service bears any relation to quality. A third issue that has arisen has been the difficulty that might exist in removing any person previously selected to serve on the Panel. Specifically, even if the Convenor sought to have a Panel member removed, the Convenor was vulnerable to having a legal action brought against him. However, Section 65(10) of the act, inserted by the Accident Compensation (Amendment) Act 1996, appears to provide the Convenor some protection in this regard.

Procedures

The party that refers the dispute to the Panel indicates the issue(s) that is (are) in dispute. The Convenor then puts this issue(s) to the Panel for its findings. The issues that can go to the Panel are either “medical questions” or other matters (see below) that the statute directs can or must go to a Medical Panel. When an issue is referred to a Medical Panel, the Convenor identifies the appropriate Panel member(s) on the basis of specialty, given the medical issue in dispute, and availability. If a member has treated or examined the worker previously, or is engaged to do so, he or she may not be appointed to that Panel.

The Panel can consist of one to three members. In cases involving multiple medical conditions for which more than one type of medical specialty is called for, a three-member panel is typically convened. Otherwise, the panel normally will consist of two members. The numerical composition of panels is shown in Table 6.3. In Victoria, each Panel member examines the patient, usually separately. One member of the Panel is designated as the Presiding member. In 1998, a Panel member was paid \$400 per case with the presiding member paid \$500. A psychiatrist is paid \$100 above these rates.

After examination of the claimant, and an evaluation of any relevant material supplied by the Convenor, each Panel member prepares a preliminary report. These reports are exchanged and, based upon subsequent communication between or among the panelists, a consensus is reached, which serves as the basis for the Panel’s findings. These are reported and certified by the presiding member.

An issue has arisen over the preliminary reports of the Panels and their availability as evidence. The preliminary opinions need not be released, nor must members provide additional

opinions. Ultimately, they must simply respond to the question(s) put to them. Moreover, the consensus reports are often quite brief and provide little or no explanation for the Panel's findings. What is clear, however, is that the parties need the findings themselves if they are to reach some resolution. What the Panels seek to do is provide these findings while avoiding becoming involved in the litigation themselves.

A goal of the Medical Panels has been to not delay the resolution of disputes. The statute provides some tight timelines for this process. A Medical Panel must form its opinion, in the form of a certificate, within 21 days after the reference is made. Further, the Panel has seven days after forming its opinion to provide it to the relevant persons. This has proven to be unworkable, and at various times there have been sizable delays in the process. There are several reasons for this, but a key has been that the system was vastly overburdened with maims disputes from 1994 through 1996.

In the 1994 law change, the role of the Medical Panels was modified and greatly expanded. Specifically, where a claimant disputed an insurer's offer for a claim under Section 98 or 98A, the claimant could not commence proceedings until the claimant first referred the dispute to a Medical Panel for an opinion, both as to entitlement to compensation and to the extent of any loss in terms of impairment, disfigurement, or pain and suffering. Until 1996, claims made under Section 98 or 98A went to a Medical Panel if the insurer's offer was disputed. However, where the insurer did not respond with a determination regarding entitlement to the claim and its extent within 60 days of receipt of the claim, the claimant could proceed to court.

The opinion of the Medical Panel has been binding, essentially, on the insurer. Once the Panel's certificate is issued, the insurer must make an offer under Section 98 within 14 days of receiving the opinion of the Panel that is consistent with (or better than) the Panel's findings. Similarly, it must do so with Section 98A claims, though this may involve some subjectivity. The Panel's opinion was not binding on the claimant. If a dispute remained, i.e., the offer was not acceptable, the Conciliation Service could become involved. Though the Conciliation Officer could refer disputes over "medical questions" to a Medical Panel, and the opinion of the Panel is binding on the parties, determining the extent of impairment under Section 98 or of pain and suffering under Section 98A were not "medical questions" prior to the 1997 amendments. Further, the courts have not been completely supportive regarding the binding nature of the findings on the parties.

Medical Panels in Practice

The data in Table 6.4 show the number of referrals according to referring party during the past three years. The numbers could hardly be clearer in terms of the changed character of the Medical Panels. From 1993/94 to 1995/96, the number of referrals grew by almost nine times. This reflects the impact of the 1994 amendments. The dramatic drop-off of referrals thereafter is a result of the 1996 amendments (Section 104), which directed disputes over maims to the Conciliation Service and no longer, initially, to the Medical Panels. Secondly, Table 6.4 reveals that the activity of Medical Panels had been generated almost entirely by claimants, who must request a Medical Panel as a step on the path to the courts in disputes over maims. For practical purposes, the courts do not refer cases to the Medical Panel. This reflects the fact that very few disputes over maims actually get to trial. It likely reflects also the courts' belief that the Panel's opinions are not needed. Moreover, a court is bound, essentially, by the Panel's opinion when it has been referred by the court. The Conciliation Service's use of the Panel is mandatory in cases involving disputes over medical questions.

Table 6.5 is confirmation of the impact of the 1994 amendments and the changes made in 1996. In 1995/96, 98 percent of referrals to Medical Panels were made under Section 98/104, that is, disputes over maims. It seems fair to conclude that the use of Medical Panels for all issues other than maims benefits were negligible. In 1996/97, the number of referrals to medical Panels had fallen from 3,401 to 144 (a reduction of 96 percent) and was still low in 1997/98 compared with 1995/96.

Table 6.6 reflects the professional specialisation of those appointed to a panel in 1996/97 and 1997/98. Hardly surprisingly, the dominant specialty required is orthopaedics. Note the sizable number of specialists drawn from rheumatology and psychiatry. The lack of availability of psychiatrists to serve on Medical Panels in Victoria was noted by a number of parties. The decline in disputes over hearing loss accounts for the reduction in the use of otolaryngologists.

The explosion in Medical Panel activity after the 1994 amendments exacted a price. Delays and backlogs grew from 1993/94 to 1995/96. In 1995/96, the median delay for the return of an opinion reached 160 days. By July 1995, there was a backlog of 1,173 files; as the number of lodgements grew, the backlog in July 1996 had grown to 1,345 files. By 1996, it was apparent

that disputes over maims were swamping the Medical Panel approach. Moreover, many of the disputes did not appear to resolve as a result of the opinions of a Medical Panel.

As a result of these problems, the system was modified through the 1996 amendments. Thus, if a worker disputed an insurer decision with respect to a claim for a maims benefit, no longer would the matter have to be referred to a Medical Panel. Instead, it would be referred to the Conciliation Service. The Conciliation Officer may then choose to refer the matter to a Medical Panel. The 1996 change did not require that the insurer make an offer consistent with the Panel opinion where the disputed issue is not a “medical question.” However, in most cases it was expected that the insurer would make such an offer. The result was a decline in the number of cases going to Medical Panels, somewhat more prompt resolution of claims that did go there, a decline in backlog for the Panels, and an increase in responsibilities for the Conciliation Service. In 1997/98, 254 cases were referred to Medical Panels, 53 percent of which were referred by the Conciliation Service and 36 percent referred by a Magistrates’ Court (see Table 6.2). Twelve cases (5 percent of the total) were referred by a County Court. The average time from referral to opinion was 57 days. The huge backlog that was built up from 1994 to 1996 had been eliminated.

Medical Panels and the Future

A significant aim of the 1996 amendments was to reduce the burden on the Medical Panels. Without doubt, the Government hoped that the Panels could report their opinions promptly and that backlogs would not build up again. Limiting the number of Medical Panels convened could enable the Government and the VWA to accomplish another aim, which was to have the workers’ compensation community respect the quality of the medical evaluators who serve on panels. Members of the medical community who tend to be held in the highest regard often prefer to have only a limited number of such cases to add to their existing practices. By limiting the number of Panels needed, the perceived quality of the doctors involved could be increased, earning the respect of the community of interested parties.

The amendments to the statute in 1997 have given the Medical Panels a central role once again in the dispute resolution process. The opinions of a Medical Panel are now conclusive and binding on all parties. Regardless of the stage at which the opinion is sought, or who seeks the opinion (the courts, a Conciliation Officer, the Authority, or one of the parties in the dispute), it

is a binding decision on the courts. A new procedure is required to be followed in disputes over the existence and the degree of permanent impairment, such that disputes must go to a Medical Panel prior to the matter proceeding to the courts.

The Common Law

In many jurisdictions, workers' compensation is the "exclusive remedy" that an injured worker or dependant has vis-à-vis the employer. In virtually all of the United States and Canada, for example, the employer is shielded from common-law actions against it by employees or dependents with rights to benefits under workers' compensation. Actions for damages due to negligence can be sought by workers not covered under a workers' compensation law, or from parties other than the employer. (However, actions against fellow employees, labour unions, insurance carriers, Government inspectors, and some others are also generally not permitted, thereby leaving workers' compensation as the exclusive remedy.)

Though access to the common law on behalf of employees against their employers is absolutely barred in many jurisdictions, the Australian experience is more of a continuum with such actions barred in South Australia and the Northern Territory; limited access or benefits in Victoria (to be terminated shortly), the Commonwealth (Comcare, SeaCare), New South Wales, and Western Australia; and unlimited access or benefits in Queensland, Tasmania, and the Australian Capital Territory.

The first workers' compensation law in Victoria (1914) preserved the common-law rights of employees. An injured worker had the option to claim workers' compensation or take proceedings for damages; the employer could not be liable under both remedies. Due to legislative changes and judicial decisions, by 1970 an injured worker was able to claim both workers' compensation and common-law damages, although an offset of dual benefits was applied.

In 1985, the passage of the Accident Compensation Act spelled out and set certain constraints on workers' access to dual benefits or compensation. Essentially, there was to be no recovery for damages for pecuniary losses, except in death cases and in certain third party proceedings where the employer was not a party. Workers were allowed to seek damages from their employers for their pain and suffering and loss of enjoyment of life due to negligence. In 1987, the Accident Compensation Act was amended to place limits on the damages for

nonpecuniary loss. A ceiling of \$140,000 was placed on these damages, and any amount paid for maims under workers' compensation was to be deducted from awarded damages.

Common Law Under Section 135B

The most significant change brought about by the 1997 amendments was the elimination of the right to recover damages at common law for compensable injuries occurring on or after 12 November 1997. After some stormy political debate, the law was fundamentally altered in this regard, with its impact likely to be felt in a variety of possible outcomes. It remains for the parties to run off the common-law claims that apply to injuries and illnesses whose occurrence preceded 12 November 1997.

The legislation creating the WorkCover scheme created a sharply bifurcated approach to the common law in the case of work injuries. The law sought to spell out common-law entitlements for injuries occurring before (Section 135B) and after (Section 135A) 1 December 1992. Though a gray area exists for some claims in terms of the applicable section of the law, there are very significant differences between Section 135A and Section 135B. Under Section 135A, for injuries arising after 1 December 1992, access to the common law was substantially narrowed. Though Section 135B was less restrictive than 135A, workers had a brief period of time to commence proceedings under the less restrictive Section 135B, with any subsequent suits to be covered, if applicable, under Section 135A. A flood of proceedings was commenced under Section 135B to avoid the possibility of being unable to do so under Section 135A.

Initially, workers who wished to claim common-law damages for injuries incurred before 1 December 1992 were required to file their claims by that date. A grace period of three months was allowed for injuries that occurred in the three months prior to 1 December 1992. In the last 10 days of WorkCare, approximately 10,000 writs were issued. By February 1993, more than 18,000 common-law writs had been issued. A court decision in December 1993, followed by remedial legislation, moved the final date for filing claims for injuries prior to 1 December 1992 to 30 June 1994.² Ultimately the VWA was faced with having to run off 22,000 claims.

The Authority had the enormous task in resolving more than 22,000 common-law claims for these "old" cases. Yet by July 1996, more than 97 percent had been settled. In the three

²See Robart v Matchplan Pty Ltd., Supreme Court of Victoria - Full Court, 7267 of 1993.

(fiscal) years beginning with 1992/93, WorkCover settled 9,690, 5,046 and 4,974 claims. The Authority utilised a number of techniques to resolve this monumental number of common-law claims, including the use of alternative dispute resolution, and the involvement of independent expert evaluators.

An interesting measure employed to resolve these claims was one that discouraged claimants from forcing some actual court involvement. The law required that common-law claims under Section 135B (but not Section 135A) be brought to Conciliation, and that the court must not commence such proceedings unless the parties had attended a conference at which an offer was made, either within three months of December 1992 or the commencement of proceedings. If the Authority's final offer was not accepted by the worker at the conference, the Authority's settlement offer could not be increased. The worker would be required to pay both parties' costs unless the amount awarded by judgment exceeded 120 percent of the Authority's final offer.

Fewer than 1.5 percent of the writs lodged resulted in a formal court determination. The size of the settlements paid averaged \$23,000.

Common Law Under Section 135A

Access to common law was generally narrowed by the 1992 WorkCover legislation, though elements of the law did broaden some parts of it. The law was enlarged to give workers access to common law for damages to their loss of earning capacity. However, damages could be awarded against an employer in such cases only where they exceeded \$29,860. Recall that proceedings for the loss of wage-earning capacity had been permitted in Victoria prior to 1985. A cap on such damages was set at \$671,960.³ Common-law damages for pain and suffering also were not to be awarded if damages were assessed at less than \$29,860. The ceiling on common-law awards for pain and suffering remained at the existing level of \$184,740, to be modified annually by indexation (\$341,640 for the period 1997/98).

The most significant change with WorkCover was the requirement that the injury be found to be a "serious injury" in order for the workers to have access to damages under common law. The inflow of claims for damages in 1992 and 1993 primarily were from those who

³These dollar amounts are subject to annual indexing. As of 1997/98, these amounts were \$32,860 for the threshold and \$757,930 for the maximum allowed.

believed that they would not be found to have a serious injury, thereby being ineligible for common-law recovery. No such “serious injury” barrier existed under Section 135B (“old” cases).

The legislation, substantially modeled after the Transport Accident Act 1986, defined “serious injury” in several ways. Most attention was focused on a requirement that the injured worker be found to be impaired by 30 percent or more, on the basis of an assessment made according to the *AMA Guides*, second edition. Persons familiar with the *Guides* recognise that a 30 percent impairment level or higher represents a very significant impairment. Thus, despite reopening access to damages for the loss of earning capacity, it was anticipated that the volume of common-law cases would drop off substantially from where it had previously been. The expectation was that the reduction would occur amongst the claims for relatively minor injuries and perhaps nuisance claims as well. Though such claims may not carry large awards or settlements, their volume combined with their transactions costs were seen as burdensome.

Essentially, there are four possible mechanisms that allow a worker to successfully seek common-law damages. First, if the insurer determines that the worker has sustained an impairment of 30 percent or more according to the *AMA Guides*, the worker has met the threshold for “serious injury.” However, the insurer may be satisfied that the worker has a “serious injury,” even absent the 30 percent determination, under the “narrative” definition of disability. In that case the insurer is able to issue a certificate consenting to the bringing of proceedings. This might occur where the insurer believes that the court is quite likely to find “serious injury” and chooses to avoid litigating the issue. A third mechanism is where a court gives leave to bring proceedings. A final mechanism that enables the worker to bring proceedings follows from Section 135A(19) and is described later. Of course, the question of “serious injury” simply deals with the issue of access, and not with the need to prove negligence, the amount of damages, or the need to prove that the employment was a “substantial contributing factor.”

At the outset of WorkCover, the expectation was that the number of common-law cases would drop off precipitously. However, although a substantial reduction did occur over what would have been the volume in the absence of the 1992 legislation, worker solicitors learned how to widen access to the common law. This, in combination with certain judicial

determinations, meant that common law still represented an important component of work injury compensation in Victoria.

Procedures and the Expansion of Accessibility For Injuries Occurring Prior to
12 November 1997

The process that may lead to a common-law determination begins, typically, with the rating of an injured worker's impairment. The insurer will have the worker sent to a medical examiner of its choosing, preferably a specialist in the field relating to the injury. The worker is rated based on the *AMA Guides*. As indicated above, the worker is classified as being "seriously injured" only if the rating is 30 percent or higher. If the worker is not found to be "seriously injured," and no certificate is issued by the insurer consenting to the bringing of proceedings, the worker still may apply to court for leave to bring proceedings.

It is important to note that a worker with no certificate consenting to his or her bringing proceedings for damages was thought to face two sets of proceedings. First, the worker would have to persuade a county court to give leave to bring proceedings for damages and then, if this hurdle was overcome, would have to win a separate damages action. This creates an added hurdle for the worker—a situation where winning at the initial level of dispute could leave the worker with some costs—and it extended the time that the entire process could take. However, it did parallel the process found in the Transport Accident Act.

Workers or dependents have six years in which to commence an action for personal injury or death. (The time periods has been modified with the 1997 amendments.) For an occupational disease, however, the worker has six years from the date that the worker becomes aware both of the existence of the disease and that another person is responsible for it. Similarly, where a worker dies without knowing they have a cause of action, the dependent has six years from the date that they became aware of the condition and its source to commence an action. Courts are able to extend the statutory limits on the issuing of a writ.

Since 1993, the common-law procedures have been defined by several important judicial determinations. We note here only three that are considered to have had a major impact on common-law cases. In Bowles v Coles-Myer Ltd. (Bowles case), Judge Ashley found that a worker was free to bring proceedings for damages where the insurer had not made a

determination on the matter of “serious injury” before the issuance of the writ.⁴ The defendant asserted that a determination had been made before the writ was issued; however, Judge Ashley rejected that argument and ruled that absent such a determination, the worker was able to proceed to seek damages. The consequence of the Bowles case is to reduce the burden on the plaintiff, by eliminating the need for the first trial, where the court finds that the insurer has not made a (proper) determination of the existence of “serious injury.” The worker is still obliged to establish “serious injury” at trial.

Sections 135A(2A)–(2D), which were inserted by the Accident Compensation (Amendment) Act 1996 and made applicable to any proceedings brought on or after 25 June 1996, create a procedure to deal with certain issues raised by Bowles. Subject to one exception, a worker may not bring proceedings unless a determination has been made of the degree of impairment. If the written application by the worker is received within 104 weeks after the injury, the insurer may refuse to make a determination if the condition has not stabilised. If the condition is stable, or it is beyond 104 weeks, the insurer has 60 days from receipt of the application to make a determination of the degree of impairment. If the insurer does not advise the worker in writing of the determination within 60 days, or of its refusal to do so within the 104-week window, the worker is entitled to bring proceedings and have the matter of “serious injury” determined in the proceedings.

No doubt, some insurers found this 60-day clock to be a challenge to meet in all applications. Where the insurer does not do so, workers will find themselves with access to the court to have both “serious injury” and damages decided in a single trial, due to an insurer’s inability to act within the time limits imposed.

In the L. J. Hanrahan v Terrence John Davis (Hanrahan case), the Court of Appeal of the Supreme Court of Victoria found that a determination of “serious injury” under Section 93B(5) by the insurer satisfied the requirements of Section 135A(3), thereby deeming the injury to be a “serious injury” for purposes of the common-law action as well.⁵ Recall that a determination regarding “serious injury” is made by the insurer for purposes of setting the weekly benefits rate after 26 weeks of incapacity (Section 93B). In the Hanrahan case, the court found that the post-

⁴Bowles v Coles-Myer Ltd. (1995) 1 VR 480.

⁵L.J. Hanrahan v Terrence John Davis, Supreme Court of Victoria, No. 5312 of 1995.

26-week benefit determination which found that the employee had a “serious injury” enabled the worker to satisfy the test of serious injury, for purposes of proceeding to seek damages against his employer.

The significance of the Hanrahan case was considerable, as it essentially opened access to common-law relief for workers who were found to be “seriously injured” by the 26th week of incapacity, but whose incapacity would have fallen below the all-important 30 percent threshold subsequently, as their healing continued and their condition improved. Section 135A(3A) of the act, inserted by the Accident Compensation (Amendment) Act 1996, sought to rectify this. It provided explicitly that an insurer’s decision that the worker had a serious injury for the purposes of Section 93B was not to be taken to be a determination for purposes of Section 135A (common law) unless the decision specifically so stated.

That change overturns the Hanrahan result and is deemed to have commenced on 1 December 1992. However, this did not end any proceedings commenced and determined before 16 May 1996. Much as the enactment of WorkCover triggered a flood of actions brought for damages, a smaller but considerable number of claims for damages have been initiated in cases where workers were determined to be “seriously injured” at 26 weeks, but were not or would not have been found to be “seriously injured” subsequently under Section 135A. Section 135 (A) (3A) may have been effective in accomplishing its ends. The response by injured workers and their solicitors suggests that Hanrahan would lose its importance once these previous claims were run off.

The third case—actually a set of cases—stems from the discussion above regarding the mechanism that could be employed by an injured worker to seek damages. Specifically, Section 135A(19) provided a definition:

In this section, serious injury means

- 1) serious long-term impairment or loss of a body function;
- 2) permanent serious disfigurement;
- 3) severe long-term mental or severe long-term behavioural disturbance or disorder; or
- 4) loss of a foetus.

This section of the law, combined with Section 135A(4)(b), that says “a court, on the application of the worker, gives leave to bring the proceedings,” poses the greatest opportunity to expand access to the common-law remedy for workers with less than a 30 percent level of

impairment. A critical decision in this regard is drawn from an attempt to seek damages under the Transport Accident Act 1986, whose wording and application very closely parallel the (amended) Accident Compensation Act of 1985. In that case, the court found that the plaintiff could bring proceedings without consideration of the 30 percent AMA *Guides* threshold.⁶

The court found that the preponderance of medical evidence established that there was an aggravation of a preexisting back condition, which constituted “. . . a serious long-term impairment of a body function—the function of the spine.” Practically, persons familiar with workers’ compensation matters recognise the widespread, frequent character of claims for back injuries, with or without the complication of a preexisting condition. In Petkovski v Galetti, the court allowed the claimant to seek common-law damages as it found:

The unassailed evidence established that before the accident the applicant was able to work full-time and effectively, albeit interrupted in occasions by back problems. While the evidence of economic loss is skimpy, to say the least, and the evidence is imprecise as to the normal working hours, it safely can be inferred that they must have totalled significantly more than 30 per week; the accident has effectively reduced them to 20. We accept as correct the submission ... that such an interference with working capacity may fairly be regarded as a “serious consequence” for the applicant ... (at 444)

In Nichols v. Victorian WorkCover Authority, the plaintiff sought leave of the county court pursuant to Section 135A(4)(b) to issue proceedings for recovery of damages in a workplace injury.⁷ Judge Ravech found in favour of the plaintiff, Nichols, allowing him to move to the next stage in his quest for damages. The judge did so for several reasons. One doctor reported that the plaintiff’s injury and subsequent pain contributed to his depression. He accepted the doctor’s explanation that a person with an injury who is also depressed is likely to have difficulty in obtaining employment. Judge Ravech noted other cases where “serious injury” was found based on disablement from work or interference with the enjoyment of life. Because the plaintiff appeared headed both for “difficulty” in obtaining future employment and to future periods of unemployment, and due to his loss of enjoyment of life, “serious injury” was found.

⁶Petkovski v Galetti, 1994 I VR 426.

⁷Glen Alexander Nichols v Victorian WorkCover Authority, et al. No. MC 9409103.

What Petkovski, Nichols, and other comparable decisions have done is to find “serious injury” on the basis of disability and not impairment. As such, decisions of this sort created an enormous opportunity for workers with injury dates prior to 12 November 1997 to access the common-law remedy, despite their inability to meet the 30 percent impairment threshold in the statute. In fact, decisions of this kind could have moved access back to where it was before 1 December 1992. However, for injuries that occurred prior to 12 November 1997, there is also an entitlement to damages for pecuniary loss, which did not exist immediately prior to enactment of WorkCover.

Petkovski, Nichols, and related cases do not represent a phenomenon unique to Victoria. In a number of jurisdictions in and outside of Australia, legislation has tended to move the basis of permanent disability compensation for injured workers from one method to another. Specifically, with a view toward eliminating subjective evaluations of present and future disability—primarily an assessment of the vague concept of the loss of future earning capacity—a number of laws have tended to shift to a more uniform basis (assessing the degree of medical impairment only). However, compensation agencies and/or courts have been difficult to wean from the previous (disability) standard. Victoria sought to move to the impairment basis in 1992, at least for purposes of limiting access to the common law. Clearly, if that was the intent, it was not entirely successful.

Yet another assault on the “serious injury” standard found in Section 135A arose from the 30 percent threshold itself. A widely held perception is that the threshold is not as difficult to reach or overcome as was envisioned in 1992. Specifically, some workers have been able to reach or surpass the 30 percent barrier because of the combined effects of the workplace injury and any psychological sequelae of the accident, the injury and/or the pain that results. This practice was legislatively prohibited in the December 1996 amendments to the act. Unlike many injuries, considerable subjectivity is involved in assessing the degree of psychological impairment.

Damages

The damages under common law are described in Chapter 5, and the floor and ceilings have been noted earlier. It needs to be observed that the potential damages are related to the probability of attempting to secure them. For example, any benefits paid to a worker under

Section 98 or 98A (maims or for pain and suffering) are deducted from damages awarded, respectively, for pecuniary loss or for pain and suffering. As such, the greater the payment under either of these provisions, the lower the net expected value of an action for damages. It is alleged that the parties have gamed the scheme accordingly. Insurers may have paid higher levels of benefits under Section 98 and/or Section 98A in order to reduce the likelihood of common-law actions. Workers and their solicitors will not turn down these higher payments, and they avoid the protracted and more challenging characteristics of a suit for damages. The Authority does not condone this practice.

Yet another practical consideration works precisely against such a practice. Insurers are under some pressure from employers to minimise the costs of any injuries their employees sustain, due to experience rating. Because expenditures that are not made within three years of the injury are not considered in setting the employer's experience modifier, the employer has a direct incentive to have the insurer delay payments until the three-year window has been closed. As such, were a Section 98 or Section 98A benefit to fall within the three-year period, and a common-law action result in damages that fall outside the three-year period, an incentive exists not to bulk up the workers' compensation benefit so as to preclude having a subsequent action for damages.

Any contributory negligence by the worker can proportionately reduce the amount of damages paid. Because of the no-fault character of workers' compensation, contributory negligence plays no role in benefits awarded there. Contributory negligence is considered by the defence in proceedings, but it is said to be a difficult matter to win. Among other things, the employer owes a duty to care for all its employees. It is the employer that has the duty both to instruct and supervise the performance of the work. Consequently, contributory negligence need not be found, even where the worker's conduct has caused or aggravated the injury. Nevertheless, where contributory negligence may be a significant factor, it will reduce the probability of a suit.

The Future of Common Law

Although the access to common-law damages has been substantially ended, it will remain a part of workers' compensation in the immediate future. First, claims for damages arising from injuries or illness that arose before 12 November 1997 must be run off. Second, an exception to

the elimination of access exists for cases involving the death of a worker which arises out of a transport accident, and where there would be an entitlement to compensation under the Accident Compensation Act. Further, a dependant of a worker may recover damages (capped at \$500,000) under Part III of the Wrongs Act (1985) “in respect of the death of a worker arising otherwise than out of a transport accident ...”⁸ Workers injured before 12 November 1997 have up to three years from the date of their injury to initiate proceedings for damages at common law. No proceeding is to commence after 31 December 2000. In cases where the incapacitating effects became known only after 12 November 1997, the three-year time limit begins from the date when knowledge occurred. The 1997 amendments also preclude an injured worker from seeking common-law damages from parties other than the employer. However, the VWA is able to seek to recover from a negligent third party the amount of statutory compensation paid to the worker.

Administrative Appeals Tribunal

Certain categories of disputes could involve the Administrative Appeals Tribunal (AAT), a body with a broad range of dispute resolution responsibilities that extends well beyond workers’ compensation matters. Indeed, only one of this Tribunal’s judges heard all, or nearly all, disputes arising out of the workers’ compensation arena. In recent years, relatively few matters came before the AAT.

The largest number of issues that have come to the AAT in recent years related to disputes over bills and appropriate services provided for medical and like services and occupational rehabilitation services. However, disputes over medical bills and services did not have to go before the AAT. In instances where both parties consented, the dispute could be taken to the Magistrates’ Court or County Court.

In the past few years, the numbers of applications to the Tribunal fell off sharply, primarily due to a decline in Division 6 cases (arising from certain disputes from the outset of WorkCare) and Section 120 cases (employer aggrieved by agents). In the 1997 amendments, the jurisdiction of the AAT with respect to disputes over medical and like services was removed. The jurisdiction in such disputes has been transferred to the County and the Magistrates’ Courts.

⁸ Sec. 135 (C)(1)

The Courts

With only a few exceptions, the Courts (Magistrates' and County) of Victoria are empowered to determine any matter or question under the Workers' Compensation Act 1958 or the Accident Compensation Act 1985 (as amended). (A significant exception, described above, is where a medical question has been decided by a Medical Panel.) The Magistrates' Court cannot hear cases arising from Section 92 (death claims), and it is limited to matters and directions concerning sums not to exceed \$40,000 or 104 weeks of weekly benefits. These two threshold values had been \$25,000 and 52 weeks, respectively, prior to enactment of the 1996 amendments. In so doing, the Government sought to move more cases into the Magistrates' Court than otherwise would have been commenced in County Court. It also aimed to reduce the number of overall disputes that were taken to the courts. This issue is described further below.

Before the change in the law in 1997, except for claims for death benefits, proceedings were not to commence in Magistrates' or County Courts unless the matter had been referred to Conciliation, and either 28 days had expired since the date of referral or a Conciliation Officer had issued a certificate indicating that all action in respect of conciliation has been taken. Prior to the changes brought about by the Accident Compensation (Amendment) Act 1996, disputes involving Section 98 or 98A claims, maims, and pain and suffering, could commence proceedings without the need to go through Conciliation. Instead, beginning in 1995, a worker who was dissatisfied with an insurer's offer under either Section was obligated to use either conciliation or a Medical Panel before seeking a remedy at court. With the 1997 amendments, disputes over such claims must use the offices of the Conciliation Service, and if a medical question is present, will likely be referred to a Medical Panel for an opinion that is binding upon the courts and the parties.

Procedures

In proceedings relating to workers' compensation, the County Court is not bound by the rules or practice as to evidence. Evidence given in such cases must not be used in another civil or criminal proceedings, except for issues of fraud, perjury, or making false statement. The court may refer a medical question to a Medical Panel. If a party to the proceeding so requests, a medical question must be referred to a Medical Panel. In either case, the court is bound to adopt

the Panel's opinion, except where there is evidence that the worker's condition has changed or new information has emerged since the opinion was rendered.

Medical reports that arise from a medical examination are admissible in evidence, and the author(s) may be required to attend the proceeding and be cross-examined on the report. By contrast, however, though a member of a Medical Panel is competent to give evidence in the proceeding, a Panel member may not be compelled to give any evidence.

A party to proceedings before the County Court may appeal a decision to the Court of Appeal/Supreme Court on a question of law. That party has 21 days from the date of the determination to serve notice of their intent to appeal. The appeal application must be lodged within six months of either the determination being appealed or the leave obtained to appeal by the Supreme Court. The County Courts' determination is not stayed by the filing of a notice of an intent to appeal or the lodging of the appeal. However, if a County Court's determination to pay compensation benefits (other than weekly benefits) is appealed, it will allow payment to be postponed, depending upon the progress of and the outcome of the appeal.

The law spells out the basis of allocating costs in proceedings. Where a party (other than the Authority or insurer) has brought proceedings, the court must award costs, including costs directly related to conciliation, against the party who lost the judgment or decision. The court may include an order to award costs to the representative of a worker who has succeeded in a decision.

In proceedings regarding maims (Section 98) and pain and suffering (Section 98A), where the judgment for payment of compensation by the court is equal to or less than the final offer made by the insurer (Section 98B), the court must order that the worker pay the insurer's costs, and it must not order that the insurer pay the costs of the worker. Where the insurer's final offer (Section 98) is less than the amount ordered by the court, the County Court must order that the insurer pay the worker's costs.

The County and Magistrates' Courts and the AAT each have their own scale of costs. The scale is higher in the County Court than in the Magistrates' Court, in part because the latter is regarded as less formal and requiring less preparation on the part of solicitors. Claims are heard more quickly in the Magistrates' Court, yet the difference in scales provides an incentive for solicitors to prefer the County Court. Some solicitors argue that the County Courts tend to be

more familiar with the Accident Compensation Act and to approach these disputes with more sophistication.

The Future

If a matter is to go to proceedings, in most cases the Authority prefers that it go to the Magistrates' Court. In so doing, disputes are resolved more promptly, costs are lower, and there is less incentive for workers' solicitors to go to court. As such, the law has been written so as to discourage substantial utilisation of the County Court. In 1993, a provision was added to the act that required that costs be awarded to the worker or claimant according to the Magistrates' scale (lower), if the worker or claimant brought the proceeding in the County Court and the decision or judgment could have been made by the Magistrates' Court.

In 1996, the effort to weaken the incentive to use the County Court was strengthened. First, the jurisdiction of the Magistrates' Court was expanded by raising both the amount of money (from \$25,000 to \$40,000) and the number of weeks of benefits (from 52 to 104 weeks) that it could award. Additionally, if a settlement or a compromise "is made in respect of proceedings in the County Court" and the outcome could have been achieved by the judgment or decision made in Magistrates' Court, then the agreement cannot provide for costs to be paid by the insurer that exceed the amount that could have been awarded by the (lower) scales of costs of the Magistrates' Court.

Any limits on costs awarded to the worker or claimant are expected to reduce the demand for litigation, primarily at the County Court level. However, the claimant's solicitor is largely free to enter into an agreement with the claimant for a fee that will be greater than costs payable by the insurer. Thus, the disincentives to litigate at the County Court and at any level could be partly mitigated as the privately set fee structure between worker and solicitor is modified.

An exception to this laissez-faire approach, however, emerged in the Accident Compensation (Amendment) Act 1996. Its impact could be highly significant, depending upon its application. Specifically, Section 50A provides that the County Court may order that the legal practitioner be disallowed any costs from the client, and that the legal practitioner pay the costs of other parties where a proceeding has commenced under the following circumstances:

- 1) it was brought without reasonable cause;
- 2) the matter could have been brought to Magistrates' Court; or

- 3) costs were incurred improperly or wasted due to undue delay, negligence, misconduct, or default.

Section 50A can be considered as a continuation of the battle to reduce litigation and its costs by the Government. Along with the other amendments noted above, it can contribute to a shift of disputes out of the County Court. It will reduce the incidence of disputes that are resolved “on the Court House steps,” i.e., where the parties have little or no intent to actually engage in trial but simply use the threat of doing so to raise the settlement value of cases. In large measure, the effectiveness of the Accident Compensation (Amendment) Act 1996 will depend upon the attitude of the County Court judges. If they view the County Court as the appropriate venue to decide disputes in workers’ compensation disputes, even relatively minor disputes, the impact of the law changes could be minimised.

Table 6.1 Conciliation Service Applications and Disposals

Year	Applications and Reopened Matters	Disposals
1992/93	10,791	4,034
1993/94	9,418	16,010
1994/95	10,763	11,434
1995/96	14,968	14,457
1996/97	18,991	18,290
1997/98	18,097	18,552
Total	83,028	82,777

Table 6.2 Conciliation Service Lodgements by Type of Case
1 December 1992 to 30 June 1998

Type of Case	Number	Percentage
Rejection of Claim	14,238	17
Terminations (104 weeks and 52 weeks)	5,024	6
Terminations of Weekly Benefits	9,033	11
Alterations of Rate of Compensation	2,685	3
Reductions of Rate of Compensation	10,308	12
Lump Sum Payments under Table of Maims	20,640	25
Medical and Like Expenses	15,650	19
Other	5,450	7
Total	83,028	100

Source: VWA

Table 6.3 Medical Panel by Composition

	1996/97		1997/98	
	(%)		(%)	
One Member	0	0	5	2
Two Member	111	80	164	68
Three Member	27	20	72	30
Total	138	100	241	100

Source: VWA

Table 6.4 Medical Panel Referrals by Referring Party

Referring Party	1993/94		1994/95		1995/96		1996/97		1997/98	
	(%)		(%)		(%)		(%)		(%)	
Conciliation Service	362	94	258	13	52	2	93	66	134	53
Authorised Insurer	13	4	12	1	11	0	3	2	10	4
Magistrates Court	9	2	32	2	21	1	37	26	97	38
County Court	1	0	6	0	3	0	7	5	12	5
Self-Insurers	0	0	3	0	2	0	0	0	1	0
Claimant	0	0	1,729	85	3,312	97	0	0	0	0
Total	385	100	2,040	100	3,401	100	140	100	254	100

Source: VWA

Note: Columns may not sum to 100% because of rounding.

Table 6.5 Medical Panel Referrals by Section of the Act

Section of Act	1993/94 (%)		1994/95 (%)		1995/96 (%)		1996/97 (%)		1997/98 (%)	
98, 98A, 104 (Maims)	156	41	1,859	91	3,343	98	56	40	89	35
111/111A	82	21	17	1	4	0	1	1	2	1
99 Medical and Like	43	11	41	2	16	0	16	11	29	11
93 Weekly Benefits	69	18	56	3	21	1	38	27	74	29
114 Termination	0	0	28	1	6	0	10	7	18	7
Other	35	9	39	2	11	0	19	14	42	7
Total	385	100	2,040	100	3,401	100	140	100	254	100

Source: VWA

Table 6.6 Medical Panel Appointments, by Specialty, 1996/97 and 1997/98

Specialty	1996/97 (%)		1997/98 (%)	
Orthopaedic Surgery	111	37	179	33
General Surgery	7	2	12	2
Otolaryngology	44	15	34	6
Psychiatry	53	17	122	22
Rheumatology	29	10	59	11
Neurology	8	3	9	2
Rehabilitation Medicine	16	5	21	4
Plastic Surgery	10	3	13	2
Neurosurgery	9	3	30	5
Other	16		70	13
Total	303	95	549	100

Chapter 7 Occupational Rehabilitation in Victoria

Introduction

In the Victorian context, *occupational rehabilitation* (OR) covers specific, defined services within the general rubric of rehabilitation. Physical, psychological, and occupational rehabilitation are all provided for within the legislation. Practitioners in general medicine, occupational medicine, physiotherapy, chiropractic, naturopathy, as well as many other health and allied health professions are key providers of treatment services directed toward the return-to-work objective. However, it is the registered providers of occupational rehabilitation that deliver most of the defined occupational rehabilitation services with which this chapter is concerned.

The objective of “return to work” with the accident employer is the overriding goal, and this message is reflected in legislation, publications, and policies. As a regulator rather than a provider of rehabilitation services, the VWA’s primary mission is to set standards of service, monitor compliance, and ensure equitable outcomes. As the manager of the central fund, the scheme must also pay for the services (through the insurers), maintain adequate reserves for current and future rehabilitation costs, and monitor utilisation and outcomes. (See Chapter 4 for details.)

The status of OR services in Victoria must be read in light of the evolution of WorkCover from its predecessor, the WorkCare scheme. Many of the features, processes, and outcomes of WorkCover are a direct reaction to the perceived excesses of earlier systems. (See Chapter 2 for details.) The current VWA system of occupational rehabilitation reflects the concerns of the past while attempting to realise the current legislated mandate of rehabilitation and return to work for all injured workers.

We begin our review and analysis of occupational rehabilitation with a look backward at the history of rehabilitation in Victoria. In particular, we will focus on the design and performance of the Victorian Accident Rehabilitation Council (VARC) under the WorkCare regime from 1985 through 1992. Next, we describe the legislative framework for occupational rehabilitation, and the roles and responsibilities of various parties under the act. We will

specifically examine the organisational and administrative structure dedicated to the delivery of OR services and the independent agents who deliver those services. The chapter concludes with a review of the limited data available on occupational rehabilitation outcomes in Victoria as of 1996, and some final thoughts.

History

Occupational rehabilitation is a relatively recent component of Australian workers' compensation systems. As mentioned in Chapter 2, this largely reflected the imprint of the British legacy of the role of workers' compensation as simply being a circumscribed monetary recompense for injury. For instance, the Seamen's Compensation Act 1911 contained no reference to rehabilitation until its replacement with the Seafarers Rehabilitation and Compensation Act 1992, and the Australian Capital Territory Workers Compensation Act 1951 similarly did not refer to rehabilitation until amending legislation in November 1994.¹ Even where there was explicit statutory recognition of rehabilitation, the cultural ambience was such that this was little utilised in practice.

Section 52 of the New South Wales Workers' Compensation Act 1926 (part of that legislation from the time of its enactment) authorised the then-Workers' Compensation Commission to draw from the Commission's funds such sums as were necessary for the purposes of the vocational reeducation and rehabilitation of disabled workers. However, no sum was ever drawn under this provision until 1969, and that small payment remained, for some time thereafter, an isolated example.²

Clearly, rehabilitation of the occupationally disabled was a relatively late development within the Australian workers' compensation systems, only really emerging as an issue following the pioneering Conybeare Report in 1970.³ By 1977, Judge Harris would note that submission

¹Alan Clayton, "The Structure and Operation of Occupational Disability Arrangements" in John Urbano and Alan Clayton, *Review of International and Jurisdictional Best Practice in Return to Work*. Canberra: Comcare Australia, 1996, at p. 5.

²Workers' Compensation Commission of New South Wales, *Report of the Inquiry into the Feasibility of Establishing a System for the Rehabilitation of Injured Workers in New South Wales*. December 1970. (Judge A. T. Conybeare, QC) Sydney: Government Printer, at p. 1.

³This process is traced in Alan Clayton, "Attack upon the citadel: reform of Australia's anti-rehabilitative statutes," *Journal of Occupational Health and Safety—Australia and New Zealand*, 1986, 3(4): 351-364.

after submission made to his Inquiry had stressed the need for a proper system of rehabilitation. This was not a simple matter, however, and the Harris Report alluded to the difficulties facing the implementation of such a programme; in particular, a lack of trained rehabilitation personnel, and a jurisdiction where the financing of workers' compensation was in the hands of 70 insurers.⁴

One of the distinguishing features of the Victorian WorkCare scheme, which took effect from 1985, was the emphasis placed upon rehabilitation. The previous Victorian legislation, the Workers' Compensation Act 1958 contained only one reference to rehabilitation; Section 26(2)(d)(iii), which simply provided that the reasonable costs of treatment and assistance with respect to a worker's industrial rehabilitation was a compensable item. By contrast, one entire Part of the Accident Compensation Act 1985 (23 sections) was devoted to the operations of the VARC. At least another five provisions in this act related to the area of rehabilitation. As well, it was clearly spelled out in the act that the legislative intention bespoke a commitment to vocational and social rehabilitation.

Structure of WorkCare Rehabilitation

The initiatives which did develop from the late 1970s cast their own shadows. These initiatives were largely undertaken by a few larger private insurers and had drawn the ire and suspicion of some persons in the labour movement who felt that occupational rehabilitation was simply being employed as a form of benefit control. They suspected that information gained from the insurer's rehabilitation activities was being fed to the claims department, to the worker's apparent detriment. Thus, while there was strong union support for rehabilitation in the new scheme, these prior concerns helped dictate the structural and operational features of WorkCare rehabilitation.

Possibly in response to such concerns, the primary responsibility for rehabilitation would reside with the VARC, a body largely independent of the Accident Compensation Commission (ACC), though its funding came from the ACC. A comprehensive Government statement, issued soon after the announcement of the WorkCare reforms, referred to VARC as a body which would

⁴Board of Inquiry into Workers' Compensation. Report, March 1977 (Judge C. W. Harris, Chairman) Melbourne: Government Printer, 1977; para. 24.1, p. 107-108.

initially be “responsible to the Treasurer but it is expected that a fully integrated system will be developed in the long run.”⁵

One of the consequences of this division was that the claims and rehabilitation processes became largely separate systems. In particular, while VARC could access information on the ACC database, there were very strong controls on reciprocal flows of information. These differences were reinforced by a significantly different culture within the two organisations. As Mark Considine observed:

The ACC was run as an insurance fund which inevitably wished to minimise costs. Many of its staff, including the managing director and the general manager responsible for the claims agents, were recruited from the insurance industry. VARC, in contrast, was from the start an organisation motivated by clearly articulated welfare values. Staff were recruited from the human service professions and viewed their job as being to provide every support to injured workers.⁶

Despite the ACA’s strong mandate for a comprehensive system of rehabilitation for occupational disability, problems were soon apparent due to the lack of an effective vocational rehabilitation infrastructure and persons trained in the various needed disciplines. Accordingly, one of the primary concerns for VARC, at least in the earlier years, was to build this system.

VARC established a number of public WorkCare Rehabilitation centres to approved private providers in order to establish a network of services in both metropolitan and rural Victoria. In its first 10 months of operation, it opened four WorkCare Rehabilitation services in major industrial areas and approved nine private rehabilitation providers. Over the next 6 years this network would grow to 82 service locations, involving 8 WorkCare Rehabilitation centres and an additional 5 WorkCare Rehabilitation suboffices, and 69 locations operated by the 25 approved rehabilitation providers. The public WorkCare Rehabilitation service facilities came to provide about one-third of the market for vocational rehabilitation services.

In relation to the supply and training of rehabilitation professionals, VARC, alone or in conjunction with the ACC, funded a range of initiatives, such as the establishment of a Chair of

⁵*Victoria - Workers’ Compensation Reform: Government Statement*. Economic Strategy for Victoria Statement No. 5. Melbourne: Government Printer (December 1984), at p. 50.

⁶Mark Considine, *The Politics of Reform: Workers’ Compensation from Woodhouse to WorkCare*. Centre for Applied Social Research, Deakin University, 1991 (Deakin Series in Public Policy and Administration, No. 1), at p. 91.

Rehabilitation Medicine at the University of Melbourne, the funding of undergraduate and graduate positions in various courses at the Lincoln Institute of Health Sciences, and assisting the Australian Physiotherapy Association in its overseas recruitment campaign. Ongoing training programmes for rehabilitation professionals were an important part of VARC's activities throughout its tenure.

Operation of WorkCare Rehabilitation

The Victorian WorkCare rehabilitation system became very large. In mid 1987, VARC decided as a matter of policy that all workers off work for 12 weeks would be offered rehabilitation. At that time this would have captured about one-fourth of all time-compensated standard claims. In fact, by the end of June 1988, this had happened for around 28 percent of workers with time-compensated claims during 1987/88, with more than 28,000 injured workers formerly employed by some 6,500 employers involved in rehabilitation. As Table 7.1 shows, this high level of rehabilitation involvement was a distinctive feature of the WorkCare system. The total cost of rehabilitation in 1987/88 was \$32.9 million, or 3.2 percent of total WorkCare expenditures.

VARC was also the regulator and gatekeeper for the provision of rehabilitation services. The issue of quality and appropriate utilisation control was an ongoing one. In April 1986 VARC instituted a central referral system, ostensibly for ensuring effective management of the referral process and to encourage early referral and intervention. Under this system, approved rehabilitation providers were required to submit a rehabilitation plan to the VARC for approval prior to proceeding with its implementation. In preparing the plan, approved rehabilitation providers were able to incur up to \$200 of expenses, either in assessing the client or engaging in the immediate delivery of services. However, authorisation for any further payments was dependent upon approval from VARC. This approval process became an unwieldy bureaucratic exercise and resulted in considerable delay in the provision of services.

Just as the ACC experimented with controls and incentives for the claims administration agents, the VARC monitoring and control procedures and provider remuneration arrangements went through a number of refinements and configurations. A problem was that the monitoring and control system was largely process oriented and "check box" in nature. To remedy this, in

October 1991, VARC implemented its Rehabilitation Case Management Strategy, an attempt to ensure quality control and compliance with scheme goals by placing the approval and monitoring process in the hands of experienced rehabilitation professionals.

While VARC was primarily wedded to a centrally controlled case management model of rehabilitation, Dr. Jane Greacen, who headed its Programme Development and Training unit and would for a time be the Acting CEO of VARC, had from around 1987 begun developing a workplace-focused Injury Management Programme. This programme was launched in February 1988 with the approval of two firm-based rehabilitation services (Nissan Motor Company and Smorgon Consolidated Industries) and a range of grants and other supports for companies to set up workplace-based rehabilitation arrangements. This model began to gain increasing acceptance, and in the last year of VARC's operation, the companies involved in this approach to rehabilitation were able to achieve almost total return-to-work results (compared to that of 47.7 percent success for VARC operations overall), and average rehabilitation costs associated with such return to work of only \$417 (compared to that of \$2,337 overall). While one could expect better performance from participants in this programme, being larger enterprises with better control and greater potential for the implementation of return-to-work measures, nevertheless, the extent of the differential clearly illustrated the potential of workplace-oriented programmes.

The Legacy of WorkCare Rehabilitation

The enduring legacy and impressions left by the "VARC experience" were, in a number of quarters, powerful and negative. In fact, "VARC" and "rehabilitation" have come to be regarded as dirty words to employers. This was a strong influence on the manner in which rehabilitation was approached in the WorkCover system.

First, there were very few strong champions of rehabilitation outside of some parts of the trade union movement. While very few people expressed outright opposition to rehabilitation, its support, particularly from business and employer organisations, was often tinged or qualified with reservations about its effectiveness, and the wisdom of placing too much effort into a process controlled by "do-gooders" and "social workers." As time progressed, the essentially tepid support of employer groups for rehabilitation would change to concern and eventually outright derision for a system over which they felt little sense of ownership or participation.

Secondly, the scale of the changes to rehabilitation practice under WorkCare provided a set of formidable challenges. A quantum leap was made from a situation where occupational rehabilitation hardly existed to one that would represent one of the most extensive systems of rehabilitation sponsored by workers' compensation anywhere in the world. In this process, especially in the early years, the degree of managerial oversight and attention to the dynamics of scheme operation which could be exercised by VARC was continually challenged and deflected by the needs to create the necessary infrastructure and to train the requisite personnel to serve the new system.

Also, the strong control approach adopted by VARC and its desire to micromanage all aspects of the system was a major cause of the bad feelings that came to surround rehabilitation under WorkCare and lay behind much of the reaction under WorkCover. The central referral system, which operated from April 1986, required all approved rehabilitation providers to provide detailed rehabilitation plans before any significant rehabilitation action could be undertaken. It became a torment for most parties in the system, including employers and insurers as well as the providers. Because anything more than minor action was subject to VARC approval, the system created a bureaucratic monster which institutionalised inflexibility and delay.

The delays induced by this approval system often ran to 12 weeks, so that both initiation of rehabilitation action and changes to it were hampered by a 3-month period of inertia during which proposals were processed. Unfortunately, the approval process was very much of the mechanistic box-checking variety, and it added little in the way of quality control or utilisation control to the system. In functional terms, its major impact was to engender cynicism and resentment among a range of scheme participants.

The effects of this extreme micromanagement were exacerbated by the decision in mid 1987 to attempt to provide rehabilitation to all workers with injury durations in excess of 12 weeks. As mentioned above, and illustrated in Table 7.1, the consequences were a relatively high participation rate in rehabilitation, and rehabilitation costs became a sizable part of overall scheme costs. A further complicating factor was the open access to the system in terms of the source of referral to rehabilitation, as illustrated in Table 7.2. This compounded the impression of employers and insurers that rehabilitation was a system that was largely out of control.

This issue of control was one that loomed large in the criticisms of VARC and the rehabilitation system from a number of quarters. As already mentioned, the manner in which VARC and the rehabilitation system was configured under WorkCare reflected trade union concerns that structural and operational barriers should be established to prevent rehabilitation from being used as a weapon of benefit control. The arm's-length arrangements between the ACC and VARC resulted in an uneasy, and often acrimonious, relationship between these two bodies with strikingly different corporate cultures.

Most of the VARC staff saw themselves as the guardians of a holistic conception of rehabilitation encompassing the entire range of medical, vocational, and social rehabilitation. They were very suspicious of ACC tendencies to see it as a handmaiden of the claims process—a way to secure closure of a claim through return to work. These philosophical differences existed over a number of issues. One illustration of the difference was the attempt in the first draft of the bill, which was to become the Accident Compensation (Amendment) Act 1987, to banish the term “rehabilitation” totally from the Accident Compensation Act and replace it wherever it appeared in that statute with the term “return to work.”

As employers and insurers came to feel great antipathy toward the very concept of rehabilitation, rational discourse over the appropriate level of OR activity essentially ended. When the Victorian Liberal and National Party coalition came to power late in 1992, the scene was set for the wholesale replacement of the VARC approach with a narrower concept of rehabilitation as, primarily, a focus on the final goal of return to work. The remainder of the chapter describes this current system of occupational rehabilitation in Victoria.

Legislative Framework, Entitlements, and Responsibilities

Mandate and Legislative Framework

The Accident Compensation Act 1985 includes the following objectives for the Authority “[to] . . . promote the effective occupational rehabilitation of injured workers and their early return to work; [and to] . . . encourage the provision of suitable employment opportunities to

workers who have been injured.”⁷ The legislation defines OR services in very particular terms to include only the following:

- 1) initial rehabilitation assessment;
- 2) functional assessment;
- 3) workplace assessment;
- 4) job analysis;
- 5) advice concerning job modification;
- 6) occupational rehabilitation counseling;
- 7) vocational assessment;
- 8) advice or assistance concerning job-seeking;
- 9) vocational reeducation;
- 10) advice or assistance in arranging vocational reeducation;
- 11) preparation of a return-to-work plan;
- 12) the provision of aids, appliance, apparatus, or other materials likely to facilitate the return to work of a worker after an injury;
- 13) modification to a work station or equipment used by a worker that is likely to facilitate the return to work of the worker after an injury; and
- 14) any other service authorised by the Authority.⁸

Operationally, the VWA has set in place a series of General Operating Principles to guide insurers, providers, and employers. These principles, outlined in the *Claims Manual*, provide focus to the general legislative mandate. In particular, they assign direct responsibilities to each party for occupational rehabilitation and return to work.

Insurer Responsibilities

The *Claims Manual* lays out the specific occupational rehabilitation and return-to-work responsibilities for insurers in the General Operating Principles, numbers 10 through 13. Among these are the following, which clearly place the role of the insurer as central to the rehabilitation and return-to-work effort.

Principle 10: Specific Objective

- Insurers must have direct ownership of a specific objective . . . to return injured workers to work as soon as possible after the injury.
- Insurers must actively support return to work by assisting and encouraging employers to develop workplace-based occupational rehabilitation

⁷Section 19(d) and (e) of the act.

⁸Section 5, Accident Compensation Act 1985.

policies, initiatives, and procedures that determine how return-to-work injury management is seen, delivered and managed. Insurers must also encourage employers to develop reemployment or retraining practices highlighting the employers role in prevention and rehabilitation and the control of costs.

- Insurers must also make every endeavour to ensure that their employers adhere to the legislative requirements of occupational rehabilitation and return to work.

Principle 11: Workplace Assessments

- Insurers must undertake/facilitate workplace assessments so as to ensure that a worker returns to work with suitable duties and, if pertinent, with any necessary workplace modifications made to their work environment. Workplace assessments will also be used to achieve a full return to work for partially incapacitated claimants. Insurers must liaise with all relevant parties during all phases of the workplace assessment process.

Principle 12: Rehabilitation/Enhancing Job Opportunities

- Insurers must be committed to the promotion of rehabilitation programmes where they contribute to successful and effective claims management. Insurers must develop a comprehensive programme with specific case referral procedures to ensure that rehabilitation services are available in a timely manner that target the rehabilitation needs of workers. Programme emphasis must be given to the return to work of partially incapacitated workers, the capacity of employers to reemploy, vocational training, status reporting, and work placement.
- Insurers must be committed to increase the willingness and ability of employers to support and maintain return-to-work objectives. The benefits of a successful return to work through the offer of suitable employment will be highlighted to employers.

Principle 13: Job-offers, Reemployment, and Retraining

- Insurers must aim to return workers to their full-time pre-injury employment, wherever possible, by liaising with the employer to facilitate their return to work through modifications, as required, to the pre-injury employment workplace and/or work procedures. Continuing support and assistance will be given to workers during return to work to maximise their income recovery potential.

- Insurers must liaise with employers, workers, treating doctor/s, and rehabilitation providers to provide reemployment through a suitable job offer where a worker regains a capacity for work.
(*VWA Claims Manual*, General Operating Principles, July 1994, p. 2)

Worker Entitlements and Responsibilities⁹

Under the legislation, workers enjoy certain entitlements with respect to the general themes of rehabilitation and return to work. Financial benefits for workers engaged in rehabilitation activities are identical to the benefits prescribed for all workers under the act. The cooperation of the worker is mandated in Sections 93A(3) and (4), which require a worker to make every “reasonable effort” to return to work and to participate in occupational rehabilitation service or a return-to-work plan. If rehabilitation efforts are successful and the worker returns to work, financial benefits cease. There is also a provision for benefit reduction for partial incapacity¹⁰ taking into account “notional earnings.”¹¹ Key to these provisions is the worker “making every reasonable effort to return to work” in “suitable employment.”

Subsection 93D(2) defines where the worker is deemed not to be making “every reasonable effort” in the following instances: refused to have an assessment made of the worker’s employment prospects, refused or failed to take the steps to obtain suitable employment, refused an offer of suitable employment, or failed to participate in an OR service or return-to-work plan. Section 162 of the act requires the worker to attend interviews with appropriate representatives of the Authority or insurer “for the purpose of ascertaining whether workers’ opportunities for employment can be enhanced.”

“Suitable employment” is defined in Section 5 of the act as work for which the worker is suited having regard to the nature of the worker’s incapacity and pre-injury employment, age, education, skills, work experience, place of residence, medical condition, return-to-work plan,

⁹Effective with Royal Assent on 17 December 1996, the Accident Compensation (Further Amendment) Act 1996 allows the worker to choose an OR provider if the Authority, insurer, self-insurer, or employer does not offer or provide such a service.

¹⁰Section 93A(1) and (2) covers the first 26 weeks.

¹¹Notional Earnings are defined in Section 5 of the act and the method of assessing these is defined in 93DA.

and occupational rehabilitation services being provided. Note that the definition specifically adds “whether or not that work is available.”

Even if the worker is eventually found not to be entitled to compensation, expenditures that have been made for occupational rehabilitation purposes are allowed, and reasonable notice must be given before these are discontinued. Benefits continue under Section 99 for a period of up to one year, unless under 99(14) the worker has returned to work but could not continue by virtue of surgery, prosthesis modification, and services to stabilise the worker’s health or lifestyle.

Survivors of workers fatally injured have no specific rehabilitation entitlements under the legislation. While (family) grief counseling was introduced in July 1996, regulations to implement this were not published as of late 1996. Assistance in managing the financial settlement with WorkCover and vocational counseling are not offered by the scheme, although anecdotal information from some insurers indicate that such services are sometimes informally offered.

Employer Responsibilities ¹²

A notable aspect of the current system is the high level of responsibility that the scheme places on employers. Where the Disability Management movement internationally and the Total Injury Management concept defined by the Heads of Workers Compensation Authorities’ National Consistency Programme (HWCA, 1996) encourage internalisation of return to work and occupational rehabilitation, the legislation and policies of the VWA clearly mandate these as employer responsibilities. The *Claims Manual* specifically states that “The employer is responsible for injury management, including the identification and implementation of occupational rehabilitation services.”¹³ The insurer’s role is supportive and facilitative to the employer’s ultimate responsibility. This philosophy is also evident in the General Operating Principles for insurers quoted earlier.

¹²The Accident Compensation (Further Amendment) Act 1996 gives approval responsibility for OR expenditures solely to the insurer.

¹³Section 6.10.1 Workplace Based Occupational Rehabilitation.

Part VI of the legislation specifically outlines the requirements for employers with respect to occupational rehabilitation, return-to-work plans, and risk management. Under Section 156(1) employers with payrolls of greater than \$1 million must establish an OR programme. By 30 calendar days following an injury, every employer must prepare a return-to-work plan and nominate a return-to-work (RTW) coordinator. (Section 156(2)(a)) Within a 90-day period after that, an employer must establish and maintain an OR programme (Section 156(2)(b)(i)).

The written OR programme, which must be produced in consultation with workers, must include a statement of the employer's return-to-work policy, the name of the RTW coordinator and at least one provider of OR services. (Section 158) The specific return-to-work plan for an injured worker must include an estimated return-to-work date, an offer of suitable employment, and the steps to be taken to facilitate the worker's return, including any OR services that are reasonably necessary to assist the worker in returning to and remaining at work. (Section 160)

Reinstatement of the worker is required by Section 122. Workers are entitled to return to work within 12 months with the accident employer in suitable employment. The employer, however, can be relieved of the responsibility if he or she can satisfy the Authority that it is "not possible for the employer to provide suitable employment." Failure to reemploy a worker may result in penalties of up to \$25,000, although this provision has rarely been invoked.

With few exceptions, employers are required to make all initial payments for medical and like costs, including OR costs. These expenditures count toward the employer's "deductible." (See Chapter 5) Prior to 1 July 1996 employer expenditures for OR services could be excluded from the calculation of the employer's excess with the "employer excess" for occupational rehabilitation separately limited to \$1,200 maximum.¹⁴ Since that date, expenditures for occupational rehabilitation have been separately tabulated, but all such costs are included in meeting the threshold for a claim to be paid by an insurer and still subject to approval by the employer or insurer.

Beyond their responsibilities under the Accident Compensation Act, employers are bound by the provisions of health and safety regulations, and industrial relations and human rights

¹⁴ It has been common practice for insurers to exclude employer expenditures for OR services from the calculation of the employer's excess. This was not the legislative intent of Section 99B but was accepted insurer practice. Section 99B allowed employers to incur costs of up to \$1,200 (indexed to \$1,290 at time of repeal—effective 1/7/96) for approved OR services without reference to their insurer. Amounts beyond this limit were to be approved by the insurer where the services are found to be reasonable and necessary.

legislation. Some employers expressed concern over the apparent lack of consistency across these responsibilities, noting that in determining how best to deal with a particular situation, an employer may have to ultimately consider which piece of legislation will be least costly to offend.

Rehabilitation Process

Rehabilitation is far from a linear process. During the “life” of a claim, a worker may experience several rehabilitation-oriented services and personnel. Each of the personnel also has a specific relationship with some aspect of the VWA and its authorised insurers. Figure 7.1 illustrates the complexity that may be involved in any rehabilitation case. From both the mandate and the diagram, the central role of the RTW coordinator to the rehabilitation process is clearly evident. Equally important is the relationship between the insurer and the OR provider. Although the employer may be required to name an OR provider, the main reporting relationships are to the insurer and the RTW coordinator. Similarly, the physician, chiropractor, or naturopath may develop a relationship with the worker, but referrals to rehabilitation must occur through the insurer and in consultation with the employer.

With so many “players” in the system, the concern for confidentiality of information was raised by a number of stakeholders. In order for insurers and employers to have adequate information on which to base a decision, there must be information sharing. Many aspects of medical and vocational history may be needed in the rehabilitation process. Despite strong admonitions against inappropriate transfers of sensitive or personal information, the potential exists for violations of individual privacy.

The rehabilitation process may initially be the purview of the employer and the RTW coordinator, but for serious injuries, others will be involved in the rehabilitation of injured workers. The various services and personnel are described in later sections while the following section takes a more global and theoretical view of the entire rehabilitation process.

Identification and Referral for Services

The vast majority of workplace injuries will result in little or no time loss and will require no rehabilitation intervention beyond medical treatment. For more prolonged cases, however, physical rehabilitation may be needed. Identification of this need usually follows medical

assessment. In the typical case, the general practitioner will recommend or refer an individual for physiotherapy. In some cases, the worker will self-refer for physiotherapy or chiropractic treatment.

Beyond this initial referral, the VWA model is designed with the employer's RTW coordinator as the central contact between the employer and the worker. The RTW coordinator is usually responsible for fulfilling the employer's requirement of creating a return-to-work plan for the injured worker. Such a plan must be prepared within 10 days following 20 calendar days of a worker's total incapacity. Of course, such a plan does not necessarily include OR services. It may also fall to the RTW coordinator to be the main contact for the authorised insurer. Where a worker, treating medical practitioner, or insurer believes a referral to OR services is in order, approval will be sought from the employer. It will likely be the RTW coordinator who is involved in approving a referral for OR services.

A referral for OR services is a very specific activity. Unlike vocational rehabilitation systems in North America that generally allow the OR provider to determine the techniques and services likely to optimise the assessment, intervention, or outcome, in Victoria every service must be separately authorised. This often involves several transactions including returned phone calls, faxes, and consultations. These add to overhead and may delay actual service delivery. Of course, this also reflects the reaction to earlier WorkCare experience as described earlier.

Where retraining or alternate placement is involved, OR providers may well continue their relationship and interaction beyond the employer–employee relationship, notwithstanding the requirement for an employer to take a worker back within a year of injury. Figure 7.2 demonstrates the general sequence of events. The figure indicates the general timing of the various treatments and interventions over the life of a workers' compensation claim. In Victoria, the 20-day threshold for naming a RTW coordinator and developing a return-to-work plan creates the opportunity for earlier review for potential occupational rehabilitation than in most other systems. However, representatives of organised labour have been very critical of the actual results observed. Some of them argue that RTW coordinators see the plan as only a piece of paper to be sent to the insurer, rather than as an action statement. Of course, the goal of all such interventions should be to move the injured worker back more quickly to a higher level of overall health and functionality.

In rehabilitation, it is relatively easy after the fact to see that early intervention was needed in a case that has failed. *Ex ante*, however, identification of need is far more complex and problematic. Success at such identification comes with experience and professional judgment. For employers with a significant and continuous frequency of injury, it is possible for the RTW coordinator to develop such judgment. Where there are few injuries, however, this is not the case. In the critical first few weeks following an injury, it usually falls to the medical practitioner to identify the need for rehabilitation services.

For the insurers, there are a variety of mechanisms in place to see that the VWA mandate for considering OR referrals are followed. These measures may include review of claims by a rehabilitation professional, consultation with claims managers to identify cases that might benefit from an OR referral, or use of computer-matched profiling to flag the claims officer to consider such a referral. Interviews, however, indicate that profile-matching is not common in Victoria, although some insurers are developing proprietary software that may include this capacity.

The above model depicts the typical short-term disability case. In Victoria, there are also a significant and growing number of workers whose injury is very profound, resulting in total permanent impairment. These workers have special needs for rehabilitation, activities of daily living, accessibility (adaptive, mobility, and similar devices, as well as other adaptations and modifications), and avocational counseling. Many of these cases have been inherited from previous incarnations of the workers' compensation system in Victoria. Frequently, the employer is no longer active. The direction, management, and administration of the worker's ongoing needs is a shared responsibility between the authorised insurer and the VWA. Either may contract for occupational rehabilitation or other rehabilitation services for these workers.

Claimants that have needs beyond the defined OR services may also be referred to community-based programmes and services. These agencies may offer support and services to the injured worker, his or her family, and others who may be affected by the injury but who are beyond the scope of the act or direct payment by the VWA. Several such community-based organisations receive financial support from the VWA. Interviews indicated that these organisations focus on advocacy and social rehabilitation of disabled clients rather than occupational rehabilitation or return-to-work objectives. As such, they probably play a significant role in improving the lives of their clients, even if they do not achieve a return to work.

Organisational and Administrative Structures ¹⁵

There are three distinct structural aspects to the provision of OR services in Victoria: administration, claims management, and service delivery. The overall administration, scheme design, and regulation take place within the VWA. Claims management initially falls to the employer but, once the employer excess is reached, the insurer usually becomes the claims manager. Services are contracted for by insurers, employers, and workers, and they are delivered by registered providers. This latter group is discussed in detail in the section on Service Delivery Personnel.

Administration within the VWA

Within the VWA, the Scheme Regulation Department has primary responsibility for rehabilitation issues. The Health and Rehabilitation Branch administers most aspects of “medical and like” services as prescribed by Section 99 of the act and provides registration, analysis, and guidance to both insurers and providers. Table 7.3 summarises all the rehabilitation services administered by the VWA as of 1996. The list of services is quite broad and fairly typical of other workers’ compensation systems. However, it is the narrower list of OR services that are the focus of this chapter. Medical and like services are discussed in Chapter 5 of this report.

Registration

As noted in the table, only OR services provided by an approved OR provider may be paid as a medical and like expense. The approval process requires potential providers to submit an application and a fee to the VWA.¹⁶ The application requires the provider to record information that demonstrates experience in occupational rehabilitation, shows evidence of their

¹⁵In considering these structural features of occupational rehabilitation in Victoria, an important caveat must be kept in mind. The market for rehabilitation services is not limited to situations controlled by the VWA. There exists within the broader community both suppliers and consumers that are outside the formal relationships identified here. Workers injured in non-work-related events, private citizens in need of rehabilitation services, and individuals directed to services by non-workers’ compensation insurance programmes make up a broader market for rehabilitation services. In addition, both workers and employers who seek services outside the scheme are beyond the scope of this analysis. The extent to which activity in this broader market overlaps, augments or provides substitutes for those services and relationships described below has not been analysed.

¹⁶The application fees for OR providers effective from 1 May 1996 are \$500 for approval of up to 10 individuals and \$750 for approval of more than 10 individuals.

capacity to deliver these services, and gives an undertaking to ensure these services are provided by qualified staff.

Providers able to meet these criteria may be given “unrestricted” status. “Restricted” providers may not meet all of the criteria, may lack expertise in a particular area, or be otherwise limited due to the availability of certain services in their particular (often rural) area. There is also another category of provider that is employer-based and generally part of a self-insured employer’s operation. An approved provider may consist of a full interdisciplinary facility or a single practitioner. Once approved, providers are expected to handle at least 20 cases per year. Providers are also urged to attend a one-day training programme designed and delivered by the VWA. In 1996 there were approximately 80 registered providers with about 700 individuals approved to deliver services.

The registration process has been criticised by some as bestowing upon those who are registered a *de facto* form of accreditation. Unlike other provisions that rely on registration with (or eligibility for registration with) a professional governing body, the OR registration process only requires the VWA to make a minimal assessment of a provider’s credentials. Apparently some providers use the term “approved VWA provider” as a means of promotion or validation of their level of practice, expertise, or service. In the absence of any professional governing body offering accreditation, there are few alternatives open to the VWA. There may be an opportunity, however, for the Victorian OR providers (VCORP) to institute such a system at arm’s-length from the VWA.¹⁷

Occupational Rehabilitation Services in Victoria

For any regulator, analysis is a key function. The ACCtion system provides the main source of information for reports and analyses. Most reports are used in monitoring system performance with analysis directed to specific studies, trend analysis, or to provide model data for testing the effects of scheme design. The system outcomes section later in this chapter will

¹⁷The suggestion that VCORP take on the role of an accrediting body was raised by David Gadiel and Lee Ridoutt, “A Review of the Occupational Rehabilitation Services Industry in Victoria,” *Health Care Intelligence*, December 1995, p. 75. The worldwide trend to quality and standard setting is exemplified by Australian Quality Standards, ISO 9000 movement in manufacturing, and, more specifically, the Australian Physiotherapy Association’s practice accreditation, Council for the Accreditation of Rehabilitation Facilities (CARF), and the Commission on Rehabilitation Counselor Certification (CRCC), which deal with various vocational rehabilitation providers.

comment more fully on the adequacy of the data; however, for the following discussion it is important to realise that services provided by nonregistered providers, internal rehabilitation professionals, and self-insured providers are not fully accounted for.

Since all payment transactions made by insurers are coded and captured by the ACCtion system, occupational rehabilitation “inputs” may be identified by provider, service, date, or any combination of these or other fields within the system. Table 7.4 provides the level of OR services for fiscal year 1995/96 at the VWA. In terms of the number of individuals who received services, the initial OR assessment (code RC100) was the most frequent, with 3,254 individuals receiving such assessments during the fiscal year.¹⁸ A total of \$921,325 was spent on OR assessments during 1995/96. Some 2,418 individuals received OR counseling (code RC225), at a cost of \$843,260 during the same period. There were 2,171 workplace assessments (code RC295) conducted at a cost to the VWA of \$783,026, and a total of 2,023 vocational assessments (code RC315) were performed on injured workers at a cost of \$662,578 for 1995/96.

Job search assistance (code RC125) was provided to 1,446 clients at a cost of \$683,540, and a total of 885 functional assessments (code RC113) were done at a cost of \$288,146 during the year. In addition, 357 individuals received functional education (code RC245) at a cost of \$110,039, and 322 individuals received advice or assistance in obtaining vocational reeducation (code RC119). Some 210 individuals received vocational reeducation services (code RC330) at a cost of \$162,873. With the return-to-work focus of occupational rehabilitation in Victoria, it is quite surprising that only 202 individuals received work conditioning services (code RC199) at a cost of \$77,885, and only 136 workplace modifications (code RC300) were done during the 1995/96 fiscal year at a cost of just \$53,237.

A worker may, of course, receive more than one service in any category, and services in more than one category may be provided to a single individual. Services to workers are also likely to be provided over time, so any snapshot will record services being provided for cases having arisen in both the current year and previous years. For the 12 months ending 30 June 1996, a total of 7,042 individuals received services under the above codes. Table 7.5 indicates

¹⁸While it cannot be assumed that every individual receives an assessment upon entering the OR system, this number of 3,254 would provide an approximation to the number of individuals who first qualified for OR during 1995/96. This can be contrasted with the roughly 9,000–10,000 individuals entering rehabilitation annually during the VARC era (see Table 7.1).

the year of injury for cases receiving occupational rehabilitation during 1995/96. About 65 percent of OR claims involve injuries from the past three years.

As may be noted from the OR services codes in the table, some common rehabilitation interventions are not well defined. Group counseling, psychometric and functional testing, and job search programmes—activities often performed in group sessions—are not identified in any unique way. We heard varying opinions both internally and externally on how such services should be recorded. This apparent confusion may reduce the reliability of the data for analysis purposes.

Data Resources

To the extent that the ACCtion system accurately records necessary data, the analysis performed within the VWA can be accurate and reliable. If the data are incomplete, inaccurate, or ill-defined, the reliability of any analysis will be suspect. For the VWA, there are competing purposes in the design and utilisation of the data resources. The ACCtion system is accessed by insurers and the VWA with the majority of the input coming from the insurer operations. There are several limitations to the system:

- services performed internal to an employer's or insurer's operation are not recorded by the ACCtion system (although records may well exist in proprietary applications within the employer or insurer operation);
- services provided by nonregistered providers are not captured;
- services provided to workers employed by self-insured employers are not captured on an individual or case basis;
- occupational rehabilitation "activities" (including vocational counseling) provided by physicians, physiotherapists, or others may not be recorded in the ACCtion system.

The net result of these limitations is that the ACCtion system will provide accurate payment information for officially "sanctioned" services, but is not likely to capture all the services provided. Interview information confirms that each of these limitations has some impact on the reliability of the data from a service measurement point of view. These limitations cause the extent of rehabilitation activity to be understated. It is not possible to identify the degree of understatement, nor can we measure the rehabilitative or cash value of these services.

Committees

Interviews revealed that various committees have been active in rehabilitation and that the VWA does work with provider groups (such as VCORP and the Australian Physiotherapy Association (APA)) to negotiate agreements, exchange information, and develop specific programmes and services. For instance, the APA and the VWA have been working together on guidelines for the treatment of low back injuries.

With the cooperation of the AMA and the APA, the Authority has established a “peer review” process. Essentially, a committee of professionals from the appropriate discipline reviews the practices of providers identified through analysis as having patterns of service provision outside normal boundaries. In essence, providers identified as consistently billing for services beyond the normal duration or frequency are reviewed by the committee. The objective of the review is, in the first instance, to determine the reasons for the extensive use. If the service provision is determined by professional peers to be beyond the norm, the committee works with the provider to bring utilisation to within normally accepted levels.

Although this system is currently structured as “utilisation” review, the understanding of at least some of the participants is that the process will be expanded to include both a general performance review through sampling and a parallel review of practices that may be providing suboptimal service to injured workers. The VWA also employs some medical practitioners on a sessional basis to work on reviews and special projects. Other professionals serve with VWA authority staff on specialised committees to develop educational material and guidelines.

The Authority also works with a stakeholder committee known as the Occupational Rehabilitation Advisory Forum. This group has nominations from employer associations (Australian Chamber of Manufacturers and Victorian Chamber of Commerce and Industry), labour organisations (Victorian Trades Hall Council), insurers, self-insurers, and OR providers (VCORP). The Forum was initially established to oversee the transition from WorkCare to WorkCover and has maintained a high profile by assisting the Authority to determine the future strategies/direction of occupational rehabilitation within the scheme. Significant input and assistance has been received regarding possible legislative changes, implementation and resolution of scheme operational and administrative issues, and the WorkCover Incentive Scheme for Employers (WISE) programme.

Range of Rehabilitation Services and Programmes

OR services are primarily directed at promoting/facilitating maintenance or early return to work as soon as is practicable. Returning the injured worker to pre-injury duties or suitable employment is preferred. Throughout our interviews, the terms “return to work” and “rehabilitation” were used almost interchangeably, although the latter was used with some reservations, apparently because of connotations from the WorkCare and VARC experience.

Physical, occupational, and remedial therapy may all be important in providing the basis for a successful return to work. Under the direction of the worker’s physician or by worker consultation with chiropractic, naturopathic, or physiotherapy practitioners, these services are all available within the scheme. For those requiring orthotics and prosthetics, the service, fitting, and supply of these adaptive devices are also covered. The VWA is a sponsor of the paralympic programme, and some of Australia’s elite athletes with disabilities have become spokespersons for WorkCover. The depth of commitment of the organisation to this ideal is reflected in policies that allow for the purchase of such items as specialised prosthetics and wheel chairs for competition.

There is no defined “early intervention” programme within the jurisdiction, although several insurers report that they routinely review all employer claims either upon establishment of the claim or within the first six months to identify cases that may benefit from such a referral. OR providers report lengthy delays in referral after injury, often well beyond six months. Integrated, interdisciplinary treatment programmes that involve physiotherapy, vocational counseling, and education components are not generally supported.¹⁹ Chronic pain programmes, back education and evaluation services, and group work are not generally funded although pilot programmes and specific arrangements have been funded in some cases. Rehabilitation services for prescription-drug addiction, chronic pain syndrome, and post-injury self-image or vocational identity counseling are not specifically defined as occupational rehabilitation services. Other services that are more “educational” and “counseling” oriented are similarly undefined by the legislation but are, apparently, offered to some individuals within the system. Physiotherapists, for example, sometimes offer “counsel” and “education” incidental to or in combination with “treatment.”

¹⁹A project is now under way to determine opportunities for more widespread recognition of integrated programmes.

For some workers, the iatrogenic, noncompensable and combined psychosocial impact of injury and other life issues form effective barriers to occupational rehabilitation and return to work. Whether covered by the scheme or not, the sequelae to workplace injury have played pivotal roles in the course of many lives. If medical treatment, physical rehabilitation, and occupational rehabilitation form the primary and secondary interventions, then community resources play an important tertiary role.

Through discretionary grant programmes, community-based “rehabilitation” programmes are also funded by the Authority. These programmes, often offered through social organisations and community health centres, provide both specified return-to-work preparation programmes and, more importantly, the supportive milieu that may prevent further deterioration. They seek to consolidate and stabilise the worker’s current situation, and encourage the reestablishment of a positive self-image and an appropriate disability identity that may eventually lead to successful vocational or avocational outcomes.

Some cases require reeducation as part of rehabilitation. Educational institutions provide services that are paid for as “rehabilitation” expenses. These cases are not always easily identified in the database, but tuition, books, equipment, and like expenses are provided under the scheme. Workers engaged in training programmes are identified in the ACCtion system as “not incapable” and are not differentiated from others in receipt of benefits. Without detailed file review it is not possible to determine which specific retraining programmes workers most often use.

Over and above these directly funded services are services provided by other aspects of the social safety net. Commonwealth Rehabilitation Services (CRS), for example, provide rehabilitation to the broader community on a national basis. While some VWA cases are referred directly to CRS programmes and services, a number of cases that have a work-related injury (often involving a significant or protracted dispute but occasionally involving stoic or passive individuals) find their way to CRS for rehabilitation services. These cases and the services provided are not funded by the VWA.

The WISE Programme

The WISE programme is aimed at workers who are unable to return to their accident employer. An employer receives an up-front grant of up to \$2,000 and a wage subsidy payable at

weeks 12 and 24 of a placement. The subsidy is equal to 50 percent of the gross weekly earnings to a maximum of \$390 per week. A further \$2,000 may be sought in weeks 45 and 52 as work stability payments.

The VWA has promoted the programme in various media and has produced booklets encouraging potential employers to register vacancies for specific jobs. The central registry is housed with the Victorian Employers Chamber of Commerce and Industry (VECCI) and the programme is funded by insurers in proportion to their market share. VECCI provides a coordinator, computer service, and telephone support. Job opportunities are faxed daily to registered providers, with summaries provided weekly. Providers receive a placement fee of \$500 in week one and a durability fee of \$500 in week 12 if the placement is successful. Additional funds for workplace modification and the fees paid to providers to assess and implement these may also be covered.

According to VWA, 226 registrations were made during 1995/96, with 73 of these resulting from job opportunities actually nominated through the Central Job Register. It is reported that many employers have discontinued use of the register because the system is unable to provide suitable candidates. Organised labour claims that the average referral to the WISE programme occurs some 20 months after injury. Assuming these workers are partially incapacitated, that means their benefits will likely be terminated in only four months. Under these circumstances, it is difficult to motivate insurers to invest in workplace modification or other supportive services; it is cheaper to just let the benefits expire.

However, the VWA reviewed the average cost of WISE placements against estimated weekly benefits that would have been payable if the worker had not been placed using WISE. They estimated that nearly \$2 million in weekly benefits had been saved. For the 32 percent of cases that received weekly benefits after WISE placement, i.e., another disability spell, the average weekly benefit amount was reduced by 70 percent.

Other Internal Services

For the long-term, seriously injured workers, there may be little attachment to an insurer or an employer. For this population, there are also unique issues that require long-term monitoring and periodic intervention. Determining the appropriate level of personal care, assessing drug use, and maintaining these injured workers in the highest enabling environment

are challenging issues. For these workers, there likely will be a continuing need for assessment and reassessment. Even with a falling claims rate, the number of individuals in this category will continue to grow over time due to extremely long durations. They may also pose an additional moral and fiscal challenge to the VWA, since it is unlikely many of them will be able to return to their former employment.

The Authority has one manager devoted to the task of facilitating and coordinating services in these special cases. This can include independence and home maintenance services such as vehicle modifications and housing renovations. Unlike some jurisdictions which provide an ongoing allowance for independence and home maintenance issues, each case in Victoria is decided on an individual basis as the need arises. The Authority also provides an information line that may be a point of contact for a despondent worker or family member. A sessional contract psychologist is available for consultation but, for the most part, cases are directed back to the authorised insurers. The most complex cases are referred to the internal VWA manager to address. The Authority is currently developing pilot coordinated care programmes for the most complex cases in the system in an effort to provide the worker and medical practitioner with the appropriate means, mechanisms, and support to ensure that these cases receive quality effective care.

Other External Services

Authorised insurers make a variety of resources and services available to claims officers, employers, and others. Some insurers have in-house rehabilitation staff while others use contracted or wholly owned subsidiaries to provide rehabilitation services or claims management advice. Those that have internalised rehabilitation resources into their own administration provide these services as part of the claims process and not as a billed service. Counseling, basic assessment, and, in some cases, the direct contracting of services, may be approved and provided within an authorised insurers' operation. Since there are no separately billed expenditures, the quantity and nature of services actually provided cannot be determined.

Some employers and authorised self-insurers also use the services of employee assistance plans (EAPs) to augment the services covered by the scheme. These plans are generally staffed by professional counselors who can address the full range of counseling services including vocational and occupational issues. Again, there is no formal recording of these services with

respect to the VWA. Similarly, any service contracted by an employer for the benefit of his or her employees generally is not reported to the VWA. While the policy requires use of registered OR providers for VWA purposes, there are no restrictions on the use of nonregistered personnel for services not charged against the scheme.

Rehabilitation-Oriented Research

Various research initiatives funded by VWA have taken a broader view of the system and the impact of current policies on rehabilitation issues. In cooperation with the Victorian Trades Hall Council (VTHC), the VWA recently sponsored a review of the barriers to effective rehabilitation.²⁰ In addition, a detailed analysis of the OR services industry in Victoria was completed by Gadiel and Ridoutt.²¹ This review applies standard market analysis to the industry and raises issues of accreditation, market concentration, and data sufficiency. The willingness of the VWA to participate in such examinations is indicative of a sincerity of purpose in furthering the understanding of rehabilitation issues.

Several groups complained that the research produced by the organisation was not readily available or widely published. Many professionals expressed the opinion that the VWA should be more proactive in doing internal research and sponsoring appropriate academic research that would be authoritative, reproducible, and publishable. Such research, particularly if designed in cooperation with key professional groups, would command a greater degree of credibility amongst these groups. This may be of particular importance to the development of clinical practice guidelines for physiotherapy, chiropractic, and occupational medicine, for example.

Substantial analysis is currently based on the ACction database. The utility of this data system for research purposes is currently being explored through work at the University of Melbourne.²² The VWA has funded nearly \$500,000 in rehabilitation research over the past three years and has a continuing commitment to this programme. This interest in academic research, prospective studies, and empirical research that contributes to the development of knowledge

²⁰Jeanette Sdrinis, *VTHC/VWA Rehabilitation and Return to Work Project Identifying the Barriers to Effective Rehabilitation and Return to Work of Injured Workers, Final Report and Recommendations*, Melbourne, Victoria, May 1995.

²¹David Gadiel and Lee Ridoutt, "A Review of the Occupational Rehabilitation Services Industry in Victoria," *Health Care Intelligence*, December 1995.

²²Dr. Peter Disler.

beyond any immediate business gain has the potential to be an important contribution to the rehabilitation professions in Australia and elsewhere.

Service-Delivery Personnel

This section describes the range of individuals involved in the delivery of rehabilitation services. Also, it highlights some of the key procedures and tools employed and summarises some of the key issues and views presented by representatives of these service-delivery personnel.

Return-to-Work Coordinators

More than any other position, the RTW coordinator is key to the access to occupational rehabilitation in Victoria. The act requires the employer to nominate a RTW coordinator. This individual need not have training in rehabilitation. Section 161 of the act prescribes the following functions for the RTW coordinator:

- 1) assist injured workers, where prudent and practicable, to remain at or return to work as soon as possible after injury;
- 2) liaise with any parties involved in the occupational rehabilitation of, or provision of medical or hospital services to, an injured worker;
- 3) monitor the progress of an injured worker's capacity to return to work;
- 4) ensure that, where reasonably necessary, an injured worker is given access to OR services; and
- 5) take steps as far as practicable to prevent recurrence or aggravation of the relevant injury upon the worker's return to work.

Of necessity, terms such as “prudent” and “reasonably necessary” involve judgments based on knowledge and experience. In practice, the role of RTW coordinator is carried out by a variety of personnel. In many smaller firms, the task falls to a pay clerk. In some larger organisations, a human resources or safety officer is delegated this responsibility. While it was acknowledged that most RTW coordinators were well meaning, there were general concerns among those we interviewed over the confidentiality, knowledge, and skill demands placed on

these individuals. There were also concerns that, in an effort to hasten early return to employment, well-meaning but uninformed personnel could adversely affect recovery in some cases. Similarly, the wide variability in experience, skill, and knowledge could result in late involvement or referral to OR providers. Again, these concerns are likely more valid among smaller employers or those where the RTW coordinator position is subject to excessive rotation or turnover.

Since this position has been made pivotal to the occupational rehabilitation of injured workers in Victoria, there is an implicit requirement for a knowledge base and an understanding of the requirements for confidentiality as well as appropriate support. The VWA produces a variety of publications that outline how the functions should be carried out, but no formal training is required for those in this position.

For employers with few injuries, regardless of payroll size, there may be insufficient incentive to develop effective RTW coordinators. Even if the investment is made in training those assigned the task, skills may not be used for many months or even years, diminishing both the effectiveness and utility of the advanced training. For those employers with relatively frequent injuries or with well-established disability management programmes, the appointment of an appropriate and knowledgeable individual is less of an issue. These firms frequently will have selected an individual to deal with disability issues regardless of the requirement.

Tools employed by RTW coordinators include graduated return-to-work programmes and alternate duty programmes. These can be particularly useful in assisting a full return to work, maintaining the employer–worker relationship, and mitigating the costs of disability both to the worker and the employer. Many labour representatives supported the general concept of both programmes. They pointed out, however, that these programmes only work well with specific employers in specific industries, usually where the utilisation of such programmes is part of a complete rehabilitation process and disability management plan. Employers’ representatives, too, voiced some concerns regarding the RTW coordinator skills and the difficulties in providing alternate employment for injured workers.²³

²³VWA-approved training programmes are offered through TAFE and VECCI. The availability of the training was less of an issue than the difficulties from an employer point of view in determining who to train and when. The difficulties noted in the previous paragraph are not diminished by the fact that training is available.

General Practitioners / Family Physicians

For the majority of injured workers, the family physician will be the primary medical contact during recovery. The VWA has aggressively sought to inform the general public of the physician's role in rehabilitation and return to work. Mass media campaigns, for example, have been based on the theme, "What kind of doctor sends an injured worker back to work? . . . A doctor who cares." The VWA has backed up this message with a physician-developed booklet outlining the role of the general practitioner in WorkCover cases.²⁴

As described earlier, the physician is the person normally charged with the responsibility of completing medical certificates. These are critical to receiving weekly benefits and tend to maintain the contact with the general practitioner. Physicians are encouraged to emphasize what the worker can do and draw comparisons with sports injuries. Although encouraged to maintain contact with the worker and facilitate positive dialogue amongst the various players in the system, some physicians complained that the phone call demands of insurance adjudicators, RTW coordinators, and others were an interruption to their normal practices. While some acknowledge that the fee structure provided by the VWA schedule offsets some of these costs, many found the fee premium to be inadequate.

Physicians are the main source of referral to other rehabilitation personnel. Referrals to physiotherapists and others that provide physical rehabilitation treatment are consistent with typical professional practice. This is not the case, however, when it comes to referral to OR providers. The following is the advice provided to physicians regarding occupational rehabilitation:

General practitioners and employers may refer the worker to a provider, but the referral has to be approved by the employer. Funding is often only granted for a specific amount and for specific services.

Unreasonable refusal to attend could result in cessation of benefits for the worker. Employers now have nominated preferred rehabilitation providers.

You should expect to be kept informed about the rehabilitation provider's recommendations and an opportunity for the worker to discuss matters with you should be offered before rehabilitation starts.²⁵

²⁴Dr. Ray Moore, *The Role of General Practitioners in WorkCover*, VWA: November 1995.

²⁵Ibid., p. 15. Note also that the rehabilitation provider no longer has to be approved by the employer.

One specific concern raised by physicians in the course of our interviews was the practice of employer or insurer substitution of provider. In some cases, a physician will specifically name an OR provider in his or her referral. This named-referral may be based on the physician's previous experience, specific knowledge of the provider's success in dealing with certain injury types, or other reasons based on professional judgment. At some point, however, the referral is redirected to the employer's or insurer's preferred provider or other registered provider. This substitution was called "unethical" by some and ill-advised by others.

Physiotherapists

In Victoria, continuing certification of incapacity is under the control of physiotherapists as well as physicians. In fact, workers are free to seek treatment directly with the therapist of their choice without referral from a physician. However, the initial certification of incapacity must be provided by a physician. Physiotherapists provide manual therapy techniques, including mobilisation and manipulation, therapeutic exercise, physical agents and mechanical modalities, electrotherapeutic modalities, microwave and diathermy, hydrotherapy, and massage. They often are involved in assisting injured workers in adjustment to disability. The rather arbitrary line between "treatment" and "counseling," with the latter being assigned to OR providers, is often crossed in clinical practice. While this may compromise statistical analysis, such encroachments are likely to be a positive rather than negative influence on the worker's recovery.

The APA represents some 2,000 physiotherapists in professional practice in Victoria. About 80 percent of registered physiotherapists are covered as members of this association. The high degree of membership provides a strong collegial and professional body which represents the interests of physiotherapists to the VWA. There is also a separate registration board and organisation for massage practitioners.

As a professional body, the APA has worked closely with the VWA, and they participate in the peer review process for physiotherapists described above. The APA endorses a full programme of peer review rather than just directing attention to high-end utilisation. They also expressed concern over the development of treatment protocols for back injuries, recommending adherence to clinical practice guidelines produced by the National Health and Medical Research

Council. They believe that the VWA should be more proactive in doing clinical research and sponsoring appropriate academic research in conjunction with professional bodies like the APA. Such research would then give a greater degree of credibility to such things as practice guidelines, and would be more readily adopted by their membership as well as injured workers.

Occupational Medicine Providers

There are few physicians with occupational medicine specialty designation in Victoria. These specialists offer services to workers and employers and are occasionally aligned with a registered OR provider, physiotherapy provider, or integrated treatment programme. While they have very specific skills and knowledge, they are faced with similar problems to those of the general practitioners and the additional challenges of OR providers. Substitution of referrals, the lack of rehabilitation and occupational medicine knowledge amongst insurers, and a general lack of autonomy were often mentioned as concerns by these professionals. The “second guessing” by employers and insurers of what should be routine decisions to refer a case for rehabilitation services was said to be an unnecessary step that actually delayed interventions and could prolong patient recovery and return to work.

Some occupational medicine specialists also act as Independent Medical Advisers. These physicians perform medical examinations at the request of insurers in order to assist in decision making on individual cases. The medical reports of these physicians, however, are not routinely shared with the treating physicians. This imbalance or asymmetry in information is often based on a concern for confidentiality; yet, for the treating physician, these reports could be helpful in determining the appropriate rehabilitation activities that may be required in individual cases.

Occupational Rehabilitation Providers

The term *occupational rehabilitation* in Victoria describes a set of services, not a profession. OR providers include personnel drawn from a number of disciplines: Physiotherapists (15 percent), Vocational and Rehabilitation Counselors (19 percent), and Occupational Therapists (42 percent), to name a few. Figure 7.3 shows the distribution graphically. Between 700 and 800 occupational health professionals are associated with the 100

or so approved OR providers; however, the full-time equivalents number about 650.²⁶ There are several large registered OR providers, with the top five producing about 60 percent of the aggregate billings. Three registered providers are owned and operated by insurance companies, while the remainder are either private (for profit) operations or not-for-profit (and public) agencies.

VCORP represents some but not all of the providers. Some providers are active in the Australian Society of Rehabilitation Counselors or other professional groups, but membership or accreditation is not a requirement of registration as indicated earlier. Providers are registered by the VWA. This registration involves review of credentials and is tantamount to an “approval” system. Unlike some states or provinces in North America that require rehabilitation personnel to be certified by professional associations or licenced by a governing college or body, there is no analogous system in Victoria.

However, many providers are members of professional bodies and are subject to periodic accreditation and continuing education programmes to maintain professional standing. The Australian Society of Rehabilitation Counselors, for example, has developed core competencies and a code of ethics similar in content to the Commission on Rehabilitation Counselor Certification (CRCC) in North America. The absence of an outside independent body with the responsibility to accredit providers, however, makes VWA the *de facto* accreditation body in the jurisdiction.

Effective assessment is another key determinant of successful rehabilitation. Providers use the typical range of professional tools and methods to assist in rehabilitation. Some facilities are equipped with work sampling stations, psychometric testing facilities, and even an ERGOS²⁷ computerised assessment installation. The technical counseling ability and competencies in vocational assessment, training and job placement, and rehabilitation philosophy are well represented within the provider community.

²⁶Gadiel and Ridoutt, op. cit., p. 23.

²⁷ERGOS work simulators are free-standing, computer-monitored, task sampling units used for standardised evaluation and assessment.

Community-Based Return-to-Work Projects and Services

The VWA offers grants for specific projects sponsored by community-based organisations. These grants are targeted at workers who have or had an accepted claim and who have exhausted all other avenues of support under the VWA scheme. Eligible workers are those without an employer or current employment and 18 months without regular employment. Generally, other barriers to employment must also exist. The VWA lists the following “disadvantages”: age, occupation, employer, language, literacy or geographic location, and a risk of long-term detachment from the labour force.²⁸ The grants support programmes to assist in placement or self-placement, facilitate access to vocational training, and provide relevant information on worker rights. Projects are run by nonprofit, community-based organisations, often specialising in support and health programmes for a geographic or cultural community.

These organisations operate in centres that are close to the people they serve and are often less imposing than the formal clinical and office settings in which most other service delivery personnel operate. The range of services offered are generally more holistic and reflective of the community. For example, VWA clients may be in support groups with individuals recovering from car accidents and sports injuries. Family members are often included in such programmes at the community level.

While appreciative of the grants they receive, community-based resources seek a greater recognition of the contribution they make to mitigating the collateral consequences of injury. Even cases that result in a failure from a return-to-work point of view may be successful in raising the potential of the individual to eventually succeed, preventing a further deterioration of functioning, or fostering adjustment to the permanent effects of a disability.

Authorised Insurers

The 14 authorised insurers have varying arrangements with respect to rehabilitation services. As authorised insurers, they are responsible for ensuring the compliance of those policy holders they underwrite with the requirements of the legislation, including the creation of rehabilitation policies. Most offer some assistance to their employers in such compliance, and in

²⁸VWA, “Community Based Return-to-Work Projects: Policy Guidelines—Return-to-Work Services,” a companion document to the “Guidelines for Applicants 1995/96 Funding.”

working with the RTW coordinators on developing rehabilitation and return-to-work plans. As the “claims” managers, they are responsible for the adjudication and ongoing management of claims. This includes referral to OR providers.

A challenge for the insurers is to identify cases that will benefit from an OR referral. In a reactive mode, those insurers can wait for the identification to be made by the treating medical practitioner, the employer, the union, or the worker. Physiotherapists and others involved in medical treatment may also suggest that such a referral may be in order. In a more proactive mode, the claims agent will identify cases that would benefit from a referral. The mechanism for this latter process varies amongst authorised insurers.

Some insurers have dedicated rehabilitation professionals (rehabilitation counselors, occupational health nurses, counseling psychologists, occupational therapists, and the like) on staff. They can be used to monitor the need for OR services. In some cases, initial assessments are conducted by these personnel. In others, they may be empowered to make referrals directly to an OR provider. More commonly, however, it is the claims officer or manager who has the decision-making authority with respect to such referrals.

The number of these insurer in-house OR resources is growing. Interviews reveal three main reasons for this: increased recognition of the value of earlier rehabilitation interventions, growing monitoring and audits by the VWA, and a greater understanding of the complexity of rehabilitation issues, both in terms of long-term cost drivers and worker outcomes. It is important to note that the time and activities provided in-house by insurers are not captured by the ACCtion system. These services form part of the overhead costs of authorised insurers. Only external expenditures are coded by the insurer on an item, case, and provider basis.

Several insurers have allied themselves with specific providers. Several stakeholders raised ethical issues around these arrangements. Unlike the “managed care” models in private insurance, where there are complete referral networks or health management organisations that provide integrated care programmes as part of the policy offering, the Victorian system involves a higher degree of choice. The practice of employer or insurer substitution of one particular provider for the named referral of a physician or occupational medicine specialist was raised as a significant issue by a number of those interviewed.

The issue of “self-referral,” that is, referral by an authorised insurer to its own OR provider, raises some ethical and principal-agent problems as well. Absent specific regulations to

the contrary, it is possible for an insurer to direct more cases to its own subsidiary than to any other provider. The fear is that the profit motive can guide such referrals. The VWA is aware of this potential problem. Although pattern analysis by the VWA has determined little difference in either the referral rates or actual service provision, one study claimed that the main referral source for insurer-linked OR providers was insurers (52 percent of referrals). This is nearly four times the insurer-referral rate overall (at 13.1 percent).²⁹ Later data from VWA indicate that the three insurers with organisational links to OR providers in 1995/96 accounted for between 26 percent and 60 percent of all OR services to their claimants.

Self-Insurers

Typically, self-insured employers have an administrative unit responsible for claims. In some organisations, this unit reports through a human resources structure, but in others the function is combined with risk management, occupational health and safety, or operations. The administrative unit may have a manager or staff familiar with rehabilitation, but it is not required. Many have rehabilitation policies that extend beyond the mandated measures of the VWA and are more reflective of the full disability management philosophy emerging internationally. Employee assistance programmes, graduated return-to-work plans, and ergonomic adaptations and modifications apply equally as well to those injured in the workplace and those whose injury or disease is of nonworkplace origins.

Several interviews revealed that self-insurers are relatively pleased with the autonomy offered by the self-insurance scheme. In particular, the ability to use all the employer's benefits programmes and policies to assist a disabled worker was highlighted. However, some critics reported that this same flexibility can be used to "buy-out" a worker in such a way as to relieve the employer of potential costs. Although such options would also exist among some non-self-insured firms, insured firms are subject to a higher degree of outside monitoring and reporting through their insurers and, by way of insurer audits, the VWA.

²⁹Gadiel and Ridoutt, op. cit., p. 24. The analysis draws upon data from a provider self-assessment survey.

Integrated Programmes

Most workers' compensation jurisdictions have providers that offer integrated rehabilitation programmes. These are often associated with pain clinics, back programmes, or general rehabilitation facilities. Victoria has several such facilities. Some provide consolidated services that may include programmes from postsurgical convalescence through pain management, occupational therapy, rehabilitation workshops, speech pathology, to complementary therapy programmes in stress release, physical and remedial exercise, and group support sessions. These facilities also may offer general counseling, functional capacity assessment, worksite assessments, and modifications. Technology, including Kin Com, B200, and other assessment/diagnostic/treatment tools, is often integrated into the programmes. In general, the programmes offered by these facilities are in accord with the rehabilitation programmes accredited through CARF in North America.

These facilities illustrate most acutely the artificial line between medical and occupational rehabilitation programmes. Holistic programmes are established by the facilities, which are interdisciplinary by nature and not easily segmented for approval on a "coded line item basis," as required by the VWA. This creates barriers to admission with some such facilities requiring detailed approval before admission. Prior approvals, restricted provider status, and lengthy payment procedures are seen as the major hurdles to more effective use of these facilities. One administrator suggested that development of "programme-based" as opposed to "service-based" codes could facilitate more appropriate use of these facilities.

Outcomes

For the majority of workers and employers, "outcomes" in rehabilitation mean successful, cost-effective, and durable return to work. Measurement of these outcomes is never easy. Each of these terms—"successful," "cost-effective," and "durable"—are subjective and highly dependent on the question asked, the timeframes considered and the definitions used. The VWA has invested in a series of evaluations and studies that attempt to quantify outcomes. Many of these studies have been reflected in the preceding discussion or directly cited elsewhere in this report.

Occupational Rehabilitation Outcomes

One of several possible outcome criteria is the return-to-work rate. Reported to be 86 percent, the figure compares well with other jurisdictions including South Australia (at 82 percent)³⁰ and New South Wales³¹ and is a startling improvement over the 54 percent return-to-work rate reported under the WorkCare system in 1992.³² Further, the quality of these return-to-work rates are relatively high, with same employer/same duties continuity at 66 percent.³³ However, there are still a significant number of persons who, by definition, were workers at the time of injury but have not succeeded in a full return to work. Therefore, it seems worth pushing beyond the numbers to report the perceptions of system participants.

Surveys and Interview Findings

In more than 60 interviews we conducted, stakeholders were asked the following question: “What has the VWA got right?” Almost without exception, employers, worker representatives, academics, and providers stated that the VWA has correctly emphasized the connection between worker and employer as the fundamental relationship. Taken in the historical context of workers’ compensation in Victoria, this agreement constitutes a significant accomplishment. Current disability management theory professes this relationship as a fundamental tenet. (see Akabas, Gates and Galvin 1992) Through the reshaping of its compensation and rehabilitation programmes in 1992 and its aggressive advertising since, this message is clearly getting through to employers, workers, physicians, OR providers, and others.

Part of the message presented by the VWA is the connection between injury and costs. The experience rating system, 10-day employer “excess,” and the required prior approval for OR expenditures reinforce this message. Employers connect the expenditures and system costs with their own premium rates. The message, however, may not be perfectly understood. Many

³⁰Campbell Research & Consulting, “Return to Work: A Benchmark Comparison of South Australian and Victorian Return-to-Work Rates,” July 1996, p. 8.

³¹The Boston Consulting Group, “Workers’ Compensation in Victoria: Case Study of a Major Turnaround,” February 1996, p. 12.

³²Ibid.

³³Campbell, op. cit., p. 13.

employers believe that a rehabilitation expenditure paid through the system will have a three-fold impact on total costs, because of the experience rating calculation. One employer representative said that, before a decision was taken regarding a certain OR expenditure, consultants were called in to consider the dollar impact on the firm's rate and to weigh the rate consequences of turning down the plan.

There is also a dichotomy in outcomes when it comes to assessing the success of the mandated OR programmes, return-to-work plans, and the RTW coordinator function. Survey data indicate a high degree of compliance, "ownership" and, indeed, successful return to work.³⁴ There were, however, significant criticisms of performance from both workers and employers. On rehabilitation outcomes, workers supported early return-to-work initiatives but indicated that, where alternate duties are meaningless or unavailable, the return-to-work policy, can actually have a negative effect on self-esteem. Employers, too, generally approved of the early return-to-work policy but found its success to be highly dependent on the individual worker and his or her characteristics. They also reaffirmed the difficulty many employers have in finding suitable alternate employment for their injured workers.

While the VWA has been very successful in communicating the idea of early return to work, previously commissioned survey results and the interviews conducted as part of this study indicate that OR services are not highly valued by employers. Expenditures were seen as "costs" rather than as investments that could result in positive, cost-saving outcomes. On the other hand, workers who had been exposed to OR services were, according to survey results, highly complimentary and suggested that these services played a key role in both their rehabilitation and early return to work.

Another recurring theme among employers, physicians, and OR providers was a concern about the lack of rehabilitation knowledge amongst insurance claims staff. Some insurers admit this limitation but point to their creation or expansion of internal professional rehabilitation resources to augment their claims management. They also have made efforts to develop greater claims officer knowledge to ensure that workers receive appropriate OR services.

³⁴Two "waves" of participant survey data were prepared for the VWA by Klein & Associates in 1994 and 1995. These showed a higher degree of compliance in larger employers. A subsequent survey (Study No. 1669, July 1996) by the same market research group investigated employer and worker attitudes toward return to work in the Melbourne small business sector. This study and another (Study No.1608, June 1996, which focused on a similar population in Ararat) found highly consistent attitudes among all stakeholders.

The VWA has made significant efforts to ensure that workers are returned to work as soon as practicable. The key role of the RTW coordinator and the necessity to have an occupational rehabilitation plan in place as mandated by the legislation have been identified as strengths. It appears, however, that there is wide disparity in compliance among smaller employers. There is evidence that more than a third of small employers are not in compliance with the requirements of the act.³⁵ The corollary is also documented; larger firms generally do comply with the requirements of the legislation.

The WISE programme is the one operationally based initiative fostered by the VWA to address those workers who cannot return to their accident employment. While the concept is laudable and the investment to support the programme is extensive, it has fallen far short of expectations and potential. There are varying explanations offered for this. Some suggest that competition by other agencies for scarce job opportunities, coupled with relatively conservative incentives, place VWA clients at a disadvantage. The lack of transferable skill analysis and the paucity of skill matching within the programme may further contribute to the low level of success of this programme. An examination of the design or operation of this programme may be in order.

The use of retraining is an appropriate rehabilitation strategy. There are clear examples of “success stories” as a result of retraining. Data are not available on the degree to which this intervention is utilised and to what success. There was a general perception that retraining is no longer taking place despite some media ads produced by the VWA that might indicate otherwise. This perception may be addressed through research.

Concluding Observations

There is general agreement in Victoria that early identification and intervention can be effective in reducing duration of disability and improving return-to-work outcomes. Providers indicate strong support for the return-to-work focus and the efforts of the VWA to maintain the connection between worker and employer in the workplace. These initiatives are seen as supportive of a general disability management philosophy and consistent with a more integrated

³⁵Ibid., p. 4. A summary of the two survey “waves,” (“Assessment of Employer Compliance to Occupational Rehabilitation Program Requirements,” VWA, 10 October 1995, p. 4), notes that noncompliance among small work places (1-10 workers) was 35 percent.

model of rehabilitation. Unfortunately, the value of the approach is seen as compromised by the length of time it typically takes for cases to be referred to occupational rehabilitation. Anecdotal accounts indicate that “early” referrals for OR assistance are virtually nonexistent. As is all too common in workers’ compensation systems, time elapsed between injury and referral for an initial vocational assessment typically is in excess of six months. One retrospective study using VWA data found that the average time elapsed between accident and referral was 1.42 years.³⁶ More recent analysis by the VWA indicates that the median elapsed time between claim report date and first referral to OR services has been 152 days for the 12,169 OR referrals to date under WorkCover.

Another important technique for improving worker outcomes in rehabilitation is case management. This worker-focused approach provides a clear responsibility for the case manager and is characterised by a consistent, progressive series of interactions that lead to optimal case resolution. The current structure of the Victorian system prevents most providers from becoming “case managers.” Providers are often used on strictly time-limited interventions with no promise of continuity. An assessment or individualised rehabilitation plan may be completed, but unless the insurer or the employer approves the plan, no further action can be taken. Some providers report it is typical to see a rise in activity on an earlier rehabilitation plan as a case nears conciliation or settlement. However, in the absence of a complete case management model, these activities are often not well-integrated into a continuing, individualised rehabilitation plan.

For a few seriously injured workers, employment outcomes will be limited at best. For others, avocational outcomes may be the only realistic option. However, these individuals have little ongoing contact with an OR provider. Generally, the insurer or the VWA itself becomes the claims manager for prolonged, permanent total, or near-total disability claims. Services of an OR provider may be engaged by either the VWA or the insurer, particularly for assessment or specific project management. A case management approach could be beneficial to workers in this category. Various jurisdictions have initiated “late intervention” projects in order to meet the needs of injured workers whose claims are of extended duration. The goals of such projects may not be full return to work, but such initiatives can provide improvements in quality of care and

³⁶Ibid., (1994), p. 29. This figure applies to December 1994 Quarter. A footnote on the same page compares this to December 1994 statistics from NSW WorkCover Authority, which estimated the average period from injury to referral to an occupational rehabilitation provider as 6.6 months.

potential for protected or productive employment. Some OR providers are assisting in isolated projects of this type. A similar approach may prove beneficial for individuals with a higher than expected frequency of claims.

Table 7.1 Summary of WorkCare Rehabilitation Activity: 1985/86–1991/92

	1985/86 ¹	1986/87	1987/88	1988/89	1989/90	1990/91	1991/92
ACC Claims Reported ²	61,531	93,261	86,979	87,493	80,159	75,438	68,442
Referrals to Rehabilitation	4,806	12,257	25,179	14,735	10,354	10,987	10,251
Cases Entering Rehabilitation ³	4,274	9,707	14,044	11,455	9,327	9,426	9,667
Rehabilitation Cases as % of ACC Claims	6.9	10.4	16.1	13.1	11.6	12.5	14.1
Rehabilitation Plans Approved	n/a ⁴	5,832	11,341	11,968	10,898	10,054	10,540
Case Closures	384	4,558	10,301	12,949	13,535	12,280	12,044
Open Cases	n/a	n/a	9,317	10,807	8,885	8,601	9,032

Source: Victorian Accident Rehabilitation Council, Annual Reports

¹10 months only, from 1 September 1985

²Actual claims reported. These figures differ from those for estimated incurred claims in Table 3.1 in that the latter contains an estimate of incurred but not yet reported claims (IBNRs).

³The difference between these figures and those for referrals to rehabilitation are accounted for by factors such as not being able to contact the worker, the worker having returned to work, the worker having declined rehabilitation, and the sufficiency of existing treatments.

⁴Plan approvals data introduced in October 1986.

Table 7.2 Source of Referral to Rehabilitation Under WorkCare

Source of Referral	1988/89 (%)	1989/90 (%)	1990/91 (%)	1991/92 (%)
Employer	40.8	42	41.4	33.8
Doctor	20.3	19.6	19.7	17.7
Insurer	--	--	4.3	7.7
Worker	15.1	16.3	13.7	14.1
VARC	15.4	11	7.7	5.6
Other	8.4	11.1	13.3	21.1

Source: VARC Annual Reports

Table 7.3 Rehabilitation Services Covered by the VWA

Nature of Service	Payment for	Provided by
Medical Services	attendance, examination, or treatment of any kind; medicines or curative apparatus, appliances, or materials; repairs, adjustments, or replacement of crutches, etc.; certificates or reports required or authorised	medical practitioner, registered dentist, registered optometrist, registered physiotherapist, registered chiropractor and osteopath or registered chiropodist, registered pharmacist
Health Services	acupuncture, dietary analysis, hydrotherapy, massage or tactile therapy, naturopathy, occupational therapy, psychology, remedial gymnasium, social work, speech therapy	professional eligible for membership with the relevant professional body
Hospital Services	maintenance, attendance and treatment including medical attendance and treatment, nursing attendance, medicines, medically related materials, appliances and apparatus	any public, denominational, or private hospital or day procedure centre, psychiatric inpatient service including out-of-state hospitals approved by the VWA
Inpatient Charges		public or private hospitals with special agreements
Outpatient Charges		public or private hospitals

Table 7.3 Rehabilitation Services Covered by the VWA

Nature of Service	Payment for	Provided by
Personal and Household Services	attendant care, counseling, modifications to a home or car, household help, transportation costs, aid, assistant or other medical service	subject to an arm's-length, ³⁷ nonvocational assessment from someone other than the proposed service provider, persons approved by the Health and Rehabilitation Branch, normally approved in advance. No payment is made to a spouse or family member for services provided. These are considered part of their familial responsibilities.
Nursing Services	nursing outside a hospital setting	registered nurses
Ambulance Service	any (return) transportation required for the purposes of receiving medical or hospital services	any public, private, or other transportation service, provided it is the most economical and practical given the worker's condition. Whereby private vehicle, no parking expenses accepted.
Occupational Rehabilitation Services	as set out in Section 5 of the act	approved providers who are either Restricted (RR) or Unrestricted (UR)
Hearing Aids	aids, batteries, cleaning kits	subject to prior approval, any provider

Source: summarised from *Claims Manual*: Chapter 5

³⁷The "arm's-length nonvocational assessment" is usually defined as a serious injury assessment for certain workers. This is an administrative arrangement, not a legislative requirement. Not all personal and household services are provided subject to such an assessment.

**Table 7.4 Summary of Occupational Rehabilitation Codes
and Descriptions with Recent Volumes ***

Code	Service Type	Description	Service Paid on Hourly Rate (H) or Actual Cost (A)	Number of Individuals who Received Services	Total Number of Units of Service Paid	Value of Services
RC100	Initial Occupational Rehabilitation Assessment	An examination of the current medical situation and employment status to determine specific occupational and rehabilitation needs to maximise functional recovery and achieve maintenance at or return to suitable employment.	A	3,254	12,455	\$921,325
RC113	Functional Assessment	The objective measurement of the injured workers' physiological functioning to identify work capabilities. This code is only to be used for objective and verifiable tests.	H	885	1,806	\$288,146
RC119	Advice or Assistance to a Worker in Obtaining Vocational Reeducation	Assistance to the worker in obtaining appropriate vocational reeducation relevant to the identified employment goal.	H	322	1,300	\$ 78,289
RC125	Advice or Assistance in Job-seeking	Teaching job-seeking skills, such as job application practice, interview role plan, and personal presentation.	H	1,446	14,034	\$683,540

**Table 7.4 Summary of Occupational Rehabilitation Codes
and Description with Recent Volumes***

Code	Service Type	Description	Service Paid on Hourly Rate (H) or Actual Cost (A)	Number of Individuals who Received Services	Total Number of Units of Service Paid	Value of Services
RC199	Work Conditioning	Individually prescribed, work-oriented process involving the worker in simulated or actual work tasks and activities that are structured and graded to progressively increase physical capacity, tolerance, stamina, endurance, and productivity with the goal of remaining at work or returning to suitable employment.	H	202	1,033	\$ 77,885
RC225	Occupational Rehabilitation Counseling	Counseling service to the worker throughout the course of occupational rehabilitation, focusing on the totality of the worker's needs.	H	2,418	18,296	\$843,260
RC245	Functional Education	Educating the injured worker to maintain good physical habits to strengthen the body and/or mind to avoid reinjury.	H	357	1,326	\$110,039
RC295	Job/Workplace Analysis and/or Assessment	Visit to the workplace to meet the employer, worker, return-to-work coordinator, or supervisor to identify suitable duties to facilitate maintenance at or return to work following injury. This may also include advice regarding workstation or equipment modification or the provision of aids, appliances, apparatus, or other materials.	H	2,171	12,228	\$783,026

**Table 7.4 Summary of Occupational Rehabilitation Codes and
Description with Recent Volumes***

Code	Service Type	Description	Service Paid on Hourly Rate (H) or Actual Cost (A)	Number of Individuals who Received Services	Total Number of Units of Service Paid	Value of Services
RC300	Workplace Modification	Actual cost of modifying workstation or equipment to be used by the worker including the cost of aide, appliances, apparatus or other materials to facilitate maintenance at or return to work following injury.	A	136	269	\$ 53,237
RC315	Vocational Assessment	Objective assessment of the worker's transferable vocational skills to determine appropriate employment goals.	H	2,023	4,626	\$662,578
RC330	Vocational Re-Education	Actual cost of vocational reeducation or training course(s) approved by the Authority, including text books or other course needs which are part of the course or payable to the worker.	A	210	614	\$162,873

Source: VWA

*For 12 months ending 30 June 1996. A worker may, of course, receive more than one service in any category, and services in more than one category may be provided to a single individual. Services to workers are also likely to be provided over time so any one-year snapshot will record services being provided for cases having arisen in both the current year and previous years. For the 12 months ending 30 June 1996, 7,042 individuals received services under the above codes.

Table 7.5 Distribution of 1995/96 Occupational Rehabilitation (OR) Expenditures
by Year of Injury

Year of Injury	Number of Claims Receiving OR Services	OR Expenditures (\$)	Percent of Total OR Expenditure in 1995/96	Average Cost (\$)
1995/96	1,213	792,152.11	17.03	637.29
1994/95	2,162	1,604,313.55	34.50	742.05
1993/94	1,236	813,876.62	17.50	658.48
1992/93	674	414,833.34	8.92	615.48
1991/92	574	345,793.80	7.44	602.43
1990/91	340	209,676.72	4.51	616.40
1989/90	237	139,983.18	3.01	590.65
1988/89	171	101,501.54	2.18	593.58
1987/88	138	82,105.90	1.77	594.97
1986/87	159	89,994.47	1.94	566.00
1985/86	107	56,187.94	1.21	525.12

Source: VWA

Figure 7.1 Rehabilitation Reporting Relationships Map

Figure 7.2 Generalised Model of Injury and Recovery with Rehabilitation Process

Point A: A worker suffers a work-related injury.

h_1 : But for the injury, the worker's health or functioning would have remained constant over time.

—: With the injury, the worker's health takes a sudden drop. Medical practitioners manage the acute phase of the recovery and, generally, refer the worker to physical rehabilitation.

■: First two weeks following injury; the employer is responsible for the worker's wages and accident costs up to a statutory limit. Beyond this time or financial limit, an authorised insurer manages the claim. Services and liaison between the employer and the worker are coordinated by the RTW coordinator.

h_2 : Where a worker's injury is such that the former level of health/function cannot be attained, the worker is permanently impaired and occupational rehabilitation services may be enlisted to assess capacity and transferable skills, provide counseling and direction for vocational purposes, or arrange retraining or placement.

- - -: Dotted boxes indicate discontinuous activity or involvement

Figure 7.3 Distribution by Qualification of Occupational Rehabilitation Personnel in Victoria

Source: Adapted from Gadiel and Ridoutt, (1995)

Chapter 8 The Field Services Division

Introduction

This chapter addresses issues of importance to the delivery of occupational health and safety (OHS) and public safety in Victoria. Among the questions to be answered are the following:

- What are the historical antecedents of the system?
- What is the legal basis for OHS and public safety?
- How is the system presently organised?
- How are regulations and codes of practice established and updated?
- How is compliance with regulations accomplished?
- What activities complement the OHS and public safety mandate of the Field Services Division (FSD)?¹
- What information is available to guide and monitor the effect of OHS activities?
- How are the major stakeholders involved, and what are their concerns?

A brief history of workplace safety in Victoria will provide an understanding of the institutional framework and background for prevention activities. Then, we proceed to the legal authority and the structure of the FSD of the VWA. We will review the policies and strategies for promoting OHS, including both enforcement activities and education and consultation activities. Next, we will report the concerns of external stakeholders and internal staff as expressed to the research team in the course of our interviews. The chapter concludes with some final observations.

Historical Antecedents

The earliest Australian initiatives on workplace safety occurred in Victoria. In large part this was because until very late into the nineteenth century, Victoria was the only colony with significant manufacturing activity, and it was also due to a radical tinge in Victorian politics. The

¹ Previously, this was known as the Health and Safety Division (HSD).

latter feature was reflected in such efforts as the colony being the first jurisdiction in the world to achieve the eight-hour day and later the adoption of wages boards.² The very first OHS measure, the *Supervision of Workrooms and Factories Statute 1873*, was a limited enactment of six sections restricting the hours of work by females and enabling the use of regulations in respect of warmth, ventilation, cleanliness, and sanitation. It was largely a response to revelations in a regional newspaper, the *Ballarat Courier*, of conditions in local clothing factories with “sewing girls” working up to 18 hours a day in deplorable conditions for extremely low wages.³

However, the general foundations of OHS practice in Victoria for most of the last hundred years stem from the Factories and Shops Act 1885. This enactment, which was drafted by Alfred Deakin, the Victorian Solicitor-General who later became Prime Minister of Australia, resulted from a number of pressures, including a prominent tailoresses strike and reformist agitation aided by a strong campaign by *The Age* newspaper.⁴ It was a measure which was highly derivative of the English Factory and Workshop Act 1878, with 40 of its 61 sections being taken from that statute. Among its provisions were an absolute prohibition on employment of children in factories, the requirement that persons in charge of boilers hold a certificate of competency, and for the fencing of certain machinery. Of particular importance was the appointment of inspectors to administer the legislation, thus effectively creating an enforcement mechanism for the first time. The general structure of this legislation provided the framework for subsequent legislative measures and governed the approach to OHS which was to hold sway until the 1980s, not just in Victoria but in Australia generally.

²See Geoffrey Searle, *The Rush to be Rich: A History of the Colony of Victoria 1883–1889*. Melbourne: Melbourne University Press (1971), especially Chapter 3.

³See James Hagan, “Employers, Trade Unions and the First Victorian Factory Acts,” *Labour History*, 7:3-10 (1964).

⁴Tasman George Parsons, “Alfred Deakin and the Victorian Factory Act of 1885: A Note,” *Journal of Industrial Relations*, 14: 206-208 (1972).

This approach was characterised by a plethora of individual measures and a strong attachment to the English tradition of factory legislation.⁵ The legacy of the fragmented nature of legislative and other regulatory initiatives in this area, and their voluminous extent, was highlighted by the 1995 Industry Commission report into OHS, which found over 150 statutes which regulate health and safety at work in Australia and an even greater number of regulations and codes of practice. All together there are some 200 Australian Standards which are referred to in the OHS legislation or in the codes of practice.⁶ In relation to fealty to the English model of law and practice, the record of OHS measures was even more striking than that concerning workers' compensation arrangements, the history of which is traced in Chapter 2 of this report. This similarity of form and approach also helps explain the relatively rapid adoption by the various Australian jurisdictions of the new approach to OHS represented by the *Report of the Committee on Safety and Health at Work* (the Robens Report) in the United Kingdom and the Health and Safety at Work Act 1974 (UK) which followed that Report.

What is equally significant is the almost total historical division in many jurisdictions between workers' compensation and workplace safety arrangements. While the legislation governing the two was often administered by the same Government department, there was virtually no interaction between these operations

The Robens Approach

The traditional approach to workplace safety typically revolved around prescribed minimum standards of safety practice outlined in legislation or regulations, the breach of which constituted a criminal offence. The enforcement of these standards was vested in an independent public inspectorate with a right to enter and inspect workplaces and to initiate prosecutions following detection of a failure to conform to the prescribed requirements.⁷

⁵The classic account of this tradition is B. L. Hutchins and A. Harrison, *A History of Factory Legislation*. London: Frank Cass (1926); reissued 1966. Also M. W. Thomas, *The Early Factory Legislation*. Leigh on Sea: Thomas Bank Publishing (1948).

⁶Industry Commission, *Work, Health and Safety Inquiry into Occupational Health and Safety*. Canberra: Australian Government Publishing Service (1995), vol. 1, p. 44.

⁷Breen Creighton and Peter Rozen, *Occupational Health and Safety Law in Victoria*, 2nd edition. Sydney: Federation Press (1997) p. 2. The following discussion of the implementation of the Robens approach in the United Kingdom and Australia draws heavily upon this work.

Concerns about the relevance and effectiveness of this approach led the British Government in 1970 to set up a Committee of Inquiry under the chairmanship of Lord Robens. The Committee submitted its Report in June 1972. This report proved to be a catalyst for change in Britain, Australia, and elsewhere. It argued that among the problems of the then current system was “too much law of the wrong type” and that “there are severe practical limits on the extent to which progressively better standards of safety and health at work can be brought about through negative regulation by external agencies.”⁸ The Committee argued that there was need for “a more effective self-regulating system” with “the acceptance and exercise of appropriate responsibilities at all levels within industry and commerce.”⁹

The Health and Safety at Work Act 1974 (UK) was the legislative response to the principal recommendations of the Robens Committee and provided for

- a series of general duties on employers, occupiers, manufacturers, suppliers, and employees;
- the making of regulations and codes of practice to support these broad duties;
- safety representatives and safety committees; and
- the establishment of two new statutory bodies, the Health and Safety Commission and a Health and Safety Executive to administer and enforce the new scheme.

Victoria was the third Australian jurisdiction to attempt Robens-type legislation with the Industrial Safety, Health and Welfare Act 1981. This legislation more closely resembled the Robens model than either the earlier South Australian or Tasmanian Acts. It is true that it did not make any serious attempt to unify or integrate existing legislative or administrative arrangements, or to adopt more responsive and effective enforcement techniques; rather, it reenacted, with only slight amendments, the principal safety provisions of the Labour and Industry Act 1958 (Vic). On the other hand, it did provide for the establishment of a tripartite Industrial Safety, Health and Welfare Advisory Council (Sections 5-10); and included a series of “general duty” provisions (Sections 11(1)-(2), 13 and 14) together with a very broad regulation-

⁸Committee on Health and Safety at Work, Health and Safety at Work Report of the Committee 1970-72. London: HMSO (1972), para. 41.

⁹Ibid.

making power (Section 33). It also provided for the preparation of health and safety policy statements by employers (Section 11(3)), and envisaged that employees should be given the right to elect health and safety representatives who would, in turn, have the right to require their employers to set up a health and safety committee (Section 12). For a variety of reasons, the only parts of the act which were ever activated were those which reproduced the 1958 provisions, and those which dealt with the so-called “general duties.” The latter appear to have been very little used in practice. In other words, in terms of giving effect to the Robens philosophy, the Victorian Act appears not to have had significantly more practical impact than its forerunners in South Australia and Tasmania, even though it undoubtedly had greater potential than either of these measures.¹⁰

As with the earlier South Australian and Tasmanian enactments, the Industrial Safety, Health and Welfare Act 1981 would be repealed and replaced with a more thoroughgoing measure, in this case the Occupational Health and Safety Act 1985.

The Enactment of the Occupational Health and Safety Act 1985

As discussed in Chapter 2, Victorian voters in April 1982 elected a Labor Government for the first time in almost three decades. This Government, under the leadership of John Cain, was committed, particularly in its earliest years, to a vigorous reform agenda. Part of this agenda was the overhaul of the system of workplace safety in the state. Prior to the assumption of Government, however, the Victorian branch of the Labor Party had, in October 1981, endorsed a comprehensive OHS programme. This programme included the establishment of an Occupational Health and Safety Commission; the bringing together into one administrative unit of the various inspectorates and allied personnel dealing with OHS; giving statutory recognition to worker involvement in workplace safety decisions at the enterprise and workplace level; increasing the powers of inspectors and the penalties for workplace safety breaches; and providing for a comprehensive licensing system embracing all workplaces and work processes and all substances used in them.

The proposal was controversial, particularly over the powers of health and safety representatives and the proposal for comprehensive workplace licensing. The then Minister for Labour and Industry, Mr. Ramsay, attacked the proposed role of health and safety representatives

¹⁰Creighton and Rozen, op. cit. at p. 9.

as something which “would amount to a reign of terror on employers by trade union organisers with almost unlimited powers in the name of industrial safety.”¹¹ The debate continued into the election campaign in early 1982, and OHS policy was specifically included in John Cain’s opening campaign speech.

Initial responsibility for OHS policy in the new Labor Government was with the Minister for Labour and Industry¹² as was previous practice. However, in September 1982 this responsibility was given to the Minister for Employment and Training, the portfolio held by Jim Simmonds, who had been closely involved in the development of the OHS policy when Labor was in Opposition. Almost immediately the Minister determined upon a public consultation policy and, in late March 1983, the Government released a public discussion document. This document set out in detail the Government proposals in this area and invited comment prior to the final development of legislation envisaged for the 1983 Spring Session of Parliament.

Occupational Health and Safety Bill 1983

Some 211 submissions were received, including 28 from trade unions, 30 from employer associations, and 73 from individual employers. The Minister undertook a busy schedule of addressing meetings and seminars on the proposals. Meetings were held in all major metropolitan and provincial centres. A special subcommittee of the Victorian Employment Committee (including representatives from the Victorian Trades Hall Council, Metal Trades Industry Association, Master Builders Association, and the Department of Labour and Industry) considered the various submissions and identified the major areas of agreement and disagreement. Following this report, the Minister issued, in late September 1983, a “Response to

¹¹The Sun, 30 September 1981; cited in Jennifer Doran, “Implementing the Victorian Government’s Policy on Occupational Health and Safety - 1982-1984” in Breen Creighton & Neil Gunningham (eds) *The Industrial Relations of Occupational Health & Safety*. Sydney: Croom Helm Australia (1985) at p. 138. The following account of the developments concerning the original attempt to enact new occupational health and safety legislation between 1982 and 1984 draws heavily on this excellent insider account. Jennifer Doran was a ministerial adviser on occupational health and safety to the Minister for Employment and Training.

¹²Whereas most other Australian jurisdictions had one Department dealing with “labour” issues, Victoria, prior to the election of the Labor Government and for some years following, had at one stage three such departmental bodies, namely the Department of Labour and Industry, the Ministry of Employment and Training and the Ministry of Industrial Affairs. As well, over time and even after a rationalising of the number of bodies, there was a confusing change of departmental nomenclature from the Department of Employment and Industrial Affairs to the Department of Labour. When the new Liberal coalition Government assumed power in October 1992 there was a further change to the Department of Business and Employment.

the Submissions on the Government's Public Discussion Paper on Occupational Health and Safety," which included significant modification of the Government's original proposals.

This was followed, in early October 1983, with the circulation of a draft Occupational Health and Safety Bill to major stakeholders for comment, which again resulted in significant modifications. Then, on 17 November 1983, the Occupational Health and Safety Bill was introduced into the Legislative Assembly and given its second reading, although there were still matters of concern unresolved with some employer groups. Debate was then adjourned until March 1984 to allow further consultation with the major interest groups. When Parliamentary debate resumed in March 1984 the Government had agreed to move amendments which would clarify the duties of employers under the legislation and provide further limitation upon the powers of health and safety representatives, together with further rights of appeal. The bill passed the Legislative Assembly, where the Government had a majority, and was introduced into the Legislative Council, where it was in a minority, near the end of the Parliamentary session.

Given the entrenched resistance of the Opposition parties, the Government decided not to proceed with the legislation in the Legislative Council. On 9 October 1984, the Minister announced that, "Without tripartite support for the Bill and faced with the inevitable action by the Opposition to use its numbers in the Upper House to mutilate the legislation, we have had no choice. This is regrettable in view of the Government's willingness to substantially amend the legislation in order to get that tripartite support."¹³

The Industrial Route and the Legislative Window of Opportunity

It had become apparent to the trade union movement that the prospect of achieving substantial statutory overhaul of workplace safety arrangements was unlikely even before the Government surrender in October 1984. Accordingly, trade unions had prepared the way to secure equivalent processes to those outlined in the proposed legislation, particularly in respect to health and safety representatives and committees and the powers and functions of such persons and bodies, through negotiated health and safety agreements between individual unions and employers. A model for such activity was the agreement signed between unions and management at the Williamstown Naval Dockyard in 1982.

¹³Simmonds, Jim, the Minister for Employment and Training, Press release dated 9 October 1984; cited by Doran, op. cit., p. 160.

Significant early agreements were concluded by relevant unions with the State Electricity Commission of Victoria (then the state monopoly electricity utility), the Gas and Fuel Corporation (which occupied a similar position to the State Electricity Commission of Victoria in the gas industry), the Government Aircraft Factories and Comeng Pty Ltd (a large metal manufacturing enterprise). The Victorian Trades Hall Council, in May 1984, circulated a “Negotiating Exhibit on Occupational Health and Safety Agreements” to its affiliates. The move to industrially bargained agreements gained added impetus following the collapse of the 1983 bill; by July 1985 there were 17 health and safety agreements formalised in Victoria and many more under negotiation.¹⁴

Then, as the result of a conjunction of political circumstances, the Labor Government achieved a majority in the Legislative Council for a brief period in mid 1985. During this window of opportunity, the Government was able to secure passage of the Accident Compensation Act 1985, giving force to its workers’ compensation proposals, plus the Occupational Health and Safety Act 1985 and the Dangerous Goods Act 1985, effecting its workplace safety agenda. The latter two statutes were assented to on 30 July 1985 and entered into force on 1 October 1985.

WorkCare Responsibilities and Linkages

Prior to the enactment of the Occupational Health and Safety Act 1985, the Government had moved administratively in the direction of implementing its policy of centralising the activities of the various inspectorates within one body. From 1 July 1984, the Ministry of Employment and Training assumed control of the health and safety responsibilities of the Department of Labour and Industry, as well as those of the Occupational Health Division of the Health Commission and part of those carried out in the Department of Minerals and Energy. In turn, these responsibilities were vested in the Department of Employment and Industrial Affairs from October 1985. Thus, with the coming into effect of the Occupational Health and Safety Act, the operational aspects of workplace safety in Victoria were largely centred upon the Department of Employment and Industrial Affairs, which housed the inspectorate, while the policy-related

¹⁴Department of Employment and Industrial Affairs, Working Environment and Policy Division, Review of Occupational Health and Safety Agreements (July 1985).

aspects of the scheme were largely the function of the Occupational Health and Safety Commission.

As indicated in Chapter 2, the WorkCare system was intended to provide a coherent approach to all aspects of workplace safety and occupational disability in terms of injury and illness prevention, rehabilitation, and compensation. While there were three agencies created to advance these aims and provide regulatory oversight—namely the Occupational Health and Safety Commission, the Victorian Accident Rehabilitation Council, and the Accident Compensation Commission—it was intended that there would be a greater degree of scheme synergy than in fact occurred. However, one of the objects of the Accident Compensation Act was “to reduce the incidence of accidents and diseases in the workplace,”¹⁵ and pursuant to this mandate, the workers’ compensation component of WorkCare became the major underwriter of the costs of the new workplace safety arrangements. This funding rose from \$4.4 million in 1988–1989 (around 44 percent of budget) to \$17.6 million in 1992/93 (about 70 percent of budget). The remaining funding, mainly in later years to fund dangerous goods activities, was derived from the Government’s central consolidated revenue.

As well as sustaining the OHS infrastructure, these funds also supported a range of workplace safety initiatives. Prominent among these was the provision of seed funding to the Victorian Trades Hall Council and individual trade unions, as well as employer associations, to establish or extend training for health and safety representatives and managers/supervisors, respectively, in OHS matters. Some ancillary workplace safety initiatives by external bodies were also funded. This element of funding reached \$4 million in 1988/89 but declined to \$2.1 million in 1990/91, a move which largely reflected the phasing out of the seed funding initiatives.

Personnel and Organisational Arrangements

During the period of WorkCare prevention, there was a dramatic change in the size and composition of the inspectorate. In October 1985 there were some 55 inspectors; over the next five years the number of inspectors almost tripled to 150 in 1991. This increase continued into

¹⁵ Accident Compensation Act 1985, Section 3(a).

the WorkCover period with the inspectorate reaching 170 by 1994.¹⁶ As well, there was a conscious effort to widen the background of the inspectorate from its traditional male, Anglo-Celtic, trade-based origins with the recruitment of some new inspectors among women, persons from non-English speaking backgrounds, and persons with tertiary qualifications. Also, technical staff such as ergonomists, hygienists, and risk-management experts were recruited in greater numbers.

There was also a range of other organisational and structural changes designed to enable more effective delivery of services. Most prominent among these was the institution of a central OHS division responsible for policy development, standard setting, programmes and targets, and a Regional Services Division charged with service delivery. Thus, in 1986/87, workplace inspection and advice services were decentralised to 10 regional centres around the state. The perceived special circumstances relating to the building and construction industry also meant that this activity should be dealt with separately, with its own inspectorate and policy development unit.

A more dramatic reorganisation took place in 1991 when the OHS responsibilities of the department were separated from its industrial relations and other functions into a separate body, the Occupational Health and Safety Authority (OHSA). In an effort to provide better coordination of WorkCover prevention activities, the Victorian Occupational Health and Safety Commission (VOHSC) assumed the role of board of management of OHSA along with its other roles. Structurally, the new body was organised around three major divisions. The major workplace inspection and advice services were to be delivered through the Workplace Management Division with a consolidation of the previous regionalised structure into three geographic zones. The Plant and Chemical Safety Division provided specialist technical services directly to external clients as well as to and through OHSA field staff. The Planning and Communications Division provided strategic planning, performance monitoring, marketing, and certification/licensing functions for the organisation.

Role of the Inspectorate

Despite this series of organisational and other changes, it appears that it took time for them to have an appreciable effect upon organisational performance. At least over the period

¹⁶ Industry Commission, op. cit., vol. 2, Table M17.

1985–1990, there was little general change in the nature of the operations of the inspectorate. There was a continuation of its traditional concerns and enforcement approach, which focused upon breaches of particular safety regulations, especially the failure to guard dangerous machinery. The vast bulk of prosecution activity revolved around amputation injuries sustained through the use of such machinery, particularly power presses and circular saws. It was uncommon for prosecutions to be brought for breaches of the act which did not result in either injury or death. Also, it was almost unknown for prosecutions to be launched against employees, managers, or manufacturers and suppliers of plant and substances.¹⁷

From 1990, there was a noticeable change in this situation with a much greater reliance placed upon the employer's "general duty" (in Section 21 of the act) as the basis for prosecution. By 1995, almost all prosecutions under the Occupational Health and Safety Act were founded upon such general duty breaches. It appears that much of this change relates to the establishment in 1989 of a Central Investigation Unit within the department to coordinate the investigation of workplace fatalities and serious accidents and incidents, develop special programmes to ensure compliance and prevention, and develop an overall prosecutions strategy. It is striking that while in Victoria around 60 to 80 prosecutions a year were instituted, in New South Wales, between 1990/91 and 1993/94 an average of 422 prosecutions a year were undertaken.¹⁸

WorkCover Changes

In October 1992 the Liberal and National Party Coalition came to power in Victoria. The new government amended the Occupational Health and Safety Act to disband VOHSC, discontinue seed funding to non-Government bodies, and vested the administration of the legislation in the new Department of Business and Employment (DBE). OHS was retained as a trading name, but Government OHS and dangerous-goods services were delivered through two divisions within DBE. The Health and Safety Division and the Chemicals and Plant Safety Division reported to the Minister for Industry Services. An OHS Advisory Committee

¹⁷Creighton and Rozen, op cit., p. 118, drawing on the unpublished 1994 Ph.D. thesis of Richard Johnstone, *The Court and the Factory: The Legal Construction of Occupational Health and Safety Offences in Victoria* (University of Melbourne).

¹⁸Ibid., citing Industry Commission figures.

(consisting of representatives of employers, workers, and the Minister) was established to advise the Deputy Secretary for Industry Services on health and safety matters.

In 1994 the Minister for Industry Services commissioned Deloitte Touche Tohmatsu to conduct a review of OHSA and to recommend changes to its structure.¹⁹ As a consequence of the consultant's report, a new structure was implemented in May 1995; the trading name was changed to the Health and Safety Organisation, Victoria (HSO).²⁰ The need to maintain a health and safety function separate from the VWA was increasingly coming under scrutiny. The consultant's report on OHSA suggested that in time amalgamation might be viable and beneficial. Similar comments had been made by the Auditor-General in his portfolio review of DBE in 1994.²¹ In November 1995 the Industry Commission's report on OHS arrangements in Australia recommended integration of OHS and workers' compensation policy making.²²

Following the return of the Liberal/National Coalition Government in March 1996, the health and safety functions of DBE were merged with the VWA on 2 July 1996. The Health and Safety Division of the VWA, subsequently called the Field Services Division (FSD), retained the structure and functions of the former HSO.

Legal Authority

The FSD derives its authority from several pieces of legislation—including the Occupational Health and Safety Act 1985, Equipment (Public Safety) Act 1994, Dangerous Goods Act 1985, and the Road Transport (Dangerous Goods) Act 1995. Collectively, the principal acts impose general duties on employers, manufacturers and suppliers of plant and chemicals, and occupiers to achieve and maintain general health and safety standards. The acts provide a broad framework for the imposition of specific regulatory controls.

¹⁹Deloitte Touche Tohmatsu: Report to the Minister for Industry Services—Review of the Occupational Health and Safety Authority (Melbourne, July 1994).

²⁰A new Equipment (Public Safety) Act was also enacted in 1994. In addition, there is a significant public safety aspect to the Dangerous Goods Act, and the Occupational Health and Safety Act imposes duties on employers, self-employed persons and occupiers of workplaces in relation to the health and safety of non-workers.

²¹Victorian Auditor-General's Office: Report on Ministerial Portfolios (May 1984), p. 85.

²²Industry Commission Report: *Work, Health and Safety* (Canberra, 1995), Volume I, p. 270.

The mining industry is within the mandate of the Department of Natural Resources and the Environment under the Mineral Resources Development Act 1990; certain hygiene issues (e.g., legionella) are the responsibility of the Public Health Department under the Health Act . Federal enterprises within the state are the responsibility of Comcare, and the Environmental Protection Authority also has some responsibilities for dangerous goods. While overlaps or gaps of jurisdiction are possible, agreements and understandings between the FSD and these other jurisdictions seem to have adequately defined the roles.

Principal Legislation

OHS Act

As indicated earlier, the Victorian OHS Act is based in large part on the United Kingdom's Health and Safety at Work Act 1974. The style of the act is performance-based, i.e., it sets out broad duty of care provisions and requires the achievement of performance outcomes without specifying how these outcomes should be achieved, thus establishing a framework which allows employers and workers to be flexible in their approach to achieving the standards set out in legislation. In addition, it provides the machinery to establish standards and enforcement. Details of issues covered by the act are provided in regulations and codes of practice.

General duties.

The act imposes duties on employers and workers; the self-employed; occupiers of workplaces; and designers, manufacturers, importers, and suppliers of plant, equipment, and substances used in the workplace. This is to ensure that those with authority or control over particular aspects of the working environment exercise that authority in a manner that is not harmful to the health and safety of any person.

Worker participation.

The participation of workers in decisions concerning their health and safety is central to the act's strategy for prevention. This is achieved through the election of health and safety representatives (HSRs) and the establishment of health and safety committees in individual

workplaces. Through negotiation between employers and their workers, designated work groups (DWGs) may be established in workplaces from which HSRs are elected by the workers.

The act provides representatives the right to inspect any part of the workplace at which members of the DWG work, to receive relevant information, and be consulted on proposed changes to the workplace that may affect health and safety. HSRs may issue a provisional improvement notice to the employer if they believe that the act or regulations are being contravened. This requires the employer to rectify the breach within a specified time frame. The employer has the right of appeal to an FSD inspector.

The act also provides for HSRs to be involved in the resolution of health and safety issues in the workplace. It envisages employers and workers agreeing on procedures for the resolution of issues; if there are no agreed procedures, the OHS (Issue Resolution) Regulations 1989 provide a procedure. Where there is an immediate threat to the health and safety of any person, the HSR may stop the work following consultation with the employer's representative. Health and safety committees may be established at the request of the HSR. The composition, role, and function of these committees is flexible in the act, which sets out only minimum requirements. It is for the parties in the workplace to agree on what is most appropriate for their circumstances.

Inspectors.

The act assigns a number of roles to VWA inspectors. They have powers to

- enter the workplace at any reasonable time;
- make any necessary examination and inquiry in the workplace to determine whether the act or regulations have been complied with;
- remove any equipment or materials or take copies of any document that may be required;
- direct that the workplace or a part of it be left undisturbed;
- issue an Improvement Notice where they believe that the act or regulations are being contravened—this requires the breach to be rectified within a stipulated time;
- issue a Prohibition Notice where they believe that an immediate risk exists in a workplace—this prohibits the relevant activity until the matters that give rise to the risk are remedied;

- bring a prosecution for an offence against the act, on the authority of the Minister.

Penalties.

The act provides penalties for contravention of the act or regulations. In amendments to the law in 1997 these potential penalties were increased from a maximum of \$40,000 to \$250,000 for employers and from \$10,000 to \$50,000 for individuals. For certain offences, the maximum is set at \$250,000 for bodies corporate and \$50,000 and/or imprisonment for up to five years for individuals. Additional penalties, with these same maximums for indictable offences and maximums applying to most summary offences, may be imposed for repeat offences. The act also has a provision for infringement notices (on-the-spot fines). The 1997 amendments included the duty of the VWA to issue general guidelines with respect to prosecution under the law. Meanwhile, the level of prosecution activity is somewhat higher than in earlier years.

Codes of Practice.

The Minister may approve codes of practice to give practical guidance to parties with duties under the act. Where a code is relevant and has not been observed, a court, during a prosecution, will find the offence proved unless the alleged offender can demonstrate that the duties are being carried out by some other means.

Dangerous Goods Act

A separate act covering dangerous goods covers the special nature of risks arising from dangerous goods (e.g., explosives, flammable materials, and corrosive substances). The act's main objectives are to minimise the possibility of serious incidents involving dangerous goods, and to mitigate the impact of any such incidents which occur. It applies generally both to the workplace and nonworkplace situations. The act consolidates legislation covering dangerous goods and activities associated with them, such as manufacture, storage, handling, transport, transfer, use, and sale.

The Act's objectives are achieved by

- imposing responsibilities on certain identified parties;
- establishing legal procedures to support prosecutions (offence, penalty, and evidentiary provisions);

- creating the framework for a licensing regime;
- establishing an inspectorate with comprehensive powers of inspection and enforcement;
- providing for the power to make regulations and other orders to stipulate the detail of the legislative scheme.

Inspectors have powers to enter and inspect premises, make inquiries and remove items. Inspectors may issue Written Directions to require any action which the inspector believes on reasonable grounds is necessary to ensure the safety of people or property. In addition, inspectors may require or arrange the safe disposal of dangerous goods. The act permits the delegation of certain inspector powers to officers of the state road safety agency, the police force, the fire authorities, and local government.

Penalties for breaches of the Dangerous Goods act are generally in line with those under the OHS Act. Furthermore, in relation to certain duties, there are daily penalties for continuing offences. There is a provision for infringement notices here also which has not been brought into effect.

Equipment (Public Safety) Act

The Equipment (Public Safety) (E(PS)) Act mirrors the provisions of the OHS Act in relation to prescribed equipment operated in nonworkplace situations. It places duties on proprietors, manufacturers, designers, importers, suppliers and persons in charge of prescribed equipment. Proprietors' duties are similar to those of employers under the OHS Act in relation to prescribed equipment, while the duties of persons in charge of prescribed equipment are similar to those of workers.

Inspectors appointed under the E(PS) Act have identical powers to those appointed under the OHS Act. There are provisions for regulations and codes of practice. Penalties are identical to those under the OHS Act. There is also a provision for infringement notices which has not been brought into effect.

Regulations

There is an ongoing programme to move from a prescriptive to a performance-based regulatory environment in Victoria. The advantages of the performance-based approach are seen to be that it provides simplicity. The general duties are much less complex than the technical specifics required to be included in prescriptive legislation, and they need to be amended much less often. Other advantages include

- flexibility in meeting health and safety outcomes: the particular circumstances of each workplace can be taken into account;
- encouragement for the development of innovative technologies for risk management;
- a focus on health and safety outcomes rather than on the methodology for achieving them; and
- encouragement for a systematic approach to the management of risk.

In 1996, the Department of State's Office of Regulation Reform issued a document entitled *Principles of Good Regulation*, in which it stated, "Much of the recent reform work in Victoria has been directed to developing more effective and lower cost policy instruments compatible with economic realities. This has resulted in a move towards performance-based regulation in key areas such as occupational health and safety and environmental protection."

In 1995, a new set of performance-based regulations covering plant replaced 3 prescriptive acts and 11 prescriptive principal regulations. The new regulations abolished the requirement for VWA inspectors to carry out regular inspections of certain types of plant, thus freeing resources for programmed inspections in targeted industries and reactive workplace visits.

While the flexibility provided by a performance-based approach is welcomed by many employers, some (particularly small business) express a preference for the prescriptive approach, where Government tells them what they have to do. The VWA has sought to deal with the tension between the two approaches by issuing codes of practice as well as an extensive range of publications.

The VWA's decisions about the suitability of health and safety issues for regulation are primarily guided by decisions taken through the National Occupational Health and Safety Commission (NOHSC). In 1991, a meeting of Australian heads of government identified OHS as

an area in which all jurisdictions should seek to work toward national uniformity. NOHSC, which comprises representatives of the Commonwealth, State, and Territory Governments, the employer associations, and trade unions, is the vehicle for facilitating the achievement of national uniformity in OHS. NOHSC develops national standards which are then implemented by the various jurisdictions in the way that is most appropriate within their own legislative frameworks.

Critics of uniform adoption of NOHSC standards contend that national standards are developed as model regulations which the States and Territories are expected to translate directly into their own regulations. The VWA would prefer that national standards be statements of understandings that the jurisdictions would translate into acts, regulations, and codes of practice according to their own legislative frameworks.

The Subordinate Legislation Act 1994 stipulates that all Victorian regulations sunset after 10 years. At that point a detailed evaluation of the effectiveness of the revoked regulations is carried out. The VWA is currently reviewing and replacing the OHS (General Safety) Regulations 1986. The OHS (Manual Handling) Regulations 1988 are being evaluated as part of a national process. The OHS (Lead Control) Regulations will be reviewed prior to its sunset date in 1998. (See Table 8.1.)

The Industry Commission states in its Report No. 47 that the true costs of workplace injury and disease are much greater than that represented by worker's compensation payments. The report suggests that the costs are borne in the following approximate proportions: 30 percent by injured workers and their families; 40 percent by employers through the compensation system, lost productivity, and overtime; and 30 percent by the community. Other studies have estimated the true cost is from 2 times to 11 times the compensation cost, depending on the industry and size of the enterprise.

The Subordinate Legislation Act 1994 also requires that a Regulatory Impact Statement (RIS) be prepared and circulated to accompany any proposed changes in the regulations. The division invests considerable resources in the development of RISs. The goal of such an exercise, to calculate the costs and benefits of the proposed regulations, is important in justifying the need for their imposition. This practice is commonly carried out in other health and safety jurisdictions around the world, such as the Occupational Safety & Health Administration in the United States.

It is the position of FSD that the required RIS analysis has improved the policy development process for OHS. For example, during the preparation of the OHS (Plant) Regulations 1994, the cost–benefit analysis demonstrated that inclusion of manually powered and handheld plant could not be justified on cost–benefit grounds. Other nonregulatory alternatives were considered more appropriate for addressing these hazards. This analysis resulted in the scope of the regulations being restricted to exclude this type of plant. Current examples where the RIS review has influenced policy development include the pending proposal for Incident Notification Regulations, and the development of proposals covering the scope of health surveillance requirements and employer duties under hazardous substances regulations.

In all regulatory impact statements prepared by the Division, assumptions are defined and sensitivity analysis is undertaken where information gaps are identified. As a result of external review processes, the Division prepares cost projections using worst-case assumptions and highest expected cost of compliance predictions. Because of the risk of bias when undertaking RIS analysis, the Division acquires information from a range of sources, including those who will be directly affected by the proposed regulation outcome.

The draft RIS is submitted to a rigorous public review and comment process. In addition to a 60- or 90-day public comment period, the Division obtains independent advice as to the adequacy of the RIS and of the assessment included in the RIS. There is also a Parliamentary Committee, which scrutinises proposed regulations and their accompanying RIS before implementation. This committee places significant weight on the RIS and also receives copies of all public comments and submissions received by the Division.

Codes of Practice

There are 20 Codes of Practice established under the Occupational Health and Safety Act for the purpose of providing practical guidance for compliance with the duties and obligations outlined in the act, as listed in Table 8.2. The legal status of approved codes is that provisions in a code of practice may constitute compliance with the provision of the act or regulation to which the code is addressed. However, the provisions do not give these instruments mandatory status. Indeed, the status of approved codes of practice enables persons with obligations to have flexibility regarding their method of complying with performance-based duties under the act or

regulations. All codes approved by the Minister include in the preface an explanation regarding their advisory legal status.

Where appropriate, some employers are choosing to follow associated industry codes or guidelines. Use of Australian Standards or other technical standards is also commonly relied upon to supplement or substitute for the advice contained in approved codes to achieve compliance with the relevant obligation. Alternatively, employers can and do rely on aspects of the code but vary from it to develop their own comprehensive risk assessment and control systems, which may be more relevant to their workplace. A further possibility, allowable under the current legislative framework, is reliance on relevant documentation developed by NOHSC or other Australian jurisdictions, or perhaps an overseas OHS agency. Recent VWA cost-of-compliance employer surveys have indicated this approach is being adopted by some firms.

Policy and Procedure

The Division invests in development and documentation of policies and procedures that are presented in a series of manuals. The most important FSD manuals are:

Quality Manual - This sets out management responsibilities in relation to quality, and standards and procedures for the operation of the quality system.

FSD Manual - This sets out standards and procedures common to all staff, such as in relation to policy and planning, human resource management, OHS, and business administration.

Operations Manual - This sets out standards and procedures for field staff activities, such as in relation to emergency services, operational activities, and approaches to risk control. During 1996, an external audit was conducted of the Division's manuals against the requirements of Australian Standard 3904 (ISO 9004), parts one and two (Quality management and quality system elements). The audit demonstrated total compliance with the requirements of this standard.

The manuals are available on-line via the FSD intranet and in printed format. The *Operations Manual* is very complete and constitutes an effective mechanism to provide staff with timely and up-to-date advice and directives on sensitive and complex issues and priorities. It forms the basis of consistent service delivery. An *Orientation Manual* has also been developed to

assist newly hired staff to acquaint themselves with the organisational and service accountabilities of the various sections within the Division. Each section within the Division produces an annual business plan.

The thoroughness of the documentation suggests a significant resource investment within each of the sections and the Division to develop and maintain these manuals. The substantive volume of these documents speaks to a highly process-driven organisation that is committed to quality service delivery. To better utilise its scarce resources, the FSD has scaled back its efforts to develop and maintain these manuals. Also, the newly formed Operations Planning Unit is preparing a field officer's handbook intended to provide succinct guidance to the staff.

Figure 8.1 shows the organisation of FSD as of 1 January 1998. The director of FSD has four managers reporting to him. There is a director of field operations with four regional groups reporting to him. Additionally, there is a manager for the Technology unit, another who heads up the Licensing unit and one in charge of Field Support.

Professional Associations

Professional societies also have an important role in the continuing development of OHS professionals. These societies include the Ergonomics Society of Australia, the Australian Institute of Occupational Hygiene, the Safety Institute of Australia, the Australian Physiotherapy Association, the Australian College of Occupational Medicine, and the Australian Occupational Nurses' Association.

Collection and Use of Data

The FSD has an extensive database for the period from 1985, which it uses to target its prevention activities. The principal elements of the database are as follows.

- The VWA claims database described earlier in this report. This contains basic identity information and claims data on the approximately 200,000 Victorian workplaces which are part of the workers' compensation scheme. Self-employed persons and self-insurers are not included in this database.
- Information available from the FSD's INSPIRE database (e.g., visits to workplaces, reasons for visits, results of visits such as Notices and Written Directions issued). This includes data on all workplaces and sites visited by VWA field staff, including

the workplaces of self-employed persons and self-insurers, dangerous goods sites, and nonworkplaces visited pursuant to the Equipment (Public Safety) Act.

- Data on serious incidents, prosecutions, dangerous goods licences, certificates of competency to operate plant and equipment and registered plant and plant designs.

FSD field staff access the database to obtain workplace profiles prior to visiting a workplace. However, in practice there are difficulties in linking data in the claims database and other data gathered by VWA. The address or name of the establishment as described in the claims database does not always match with its actual location or name when the establishment is visited by an inspector. Inspectors can create new records of workplaces in INSPIRE and as such some firms have several files under different names. It is estimated that INSPIRE records and the WorkCover claims database cannot be matched in relation to 20 percent of workplaces. Work is under way to resolve this problem.

INSPIRE has been in place since 1988 and is based on outdated technology. While enhancements have been made to it from time to time, it is recognised that INSPIRE should be integrated with other parts of the VWA's overall database. A new system for tracking incidents reported to the VWA and investigations was implemented in 1996 as a forerunner to the redevelopment of INSPIRE.

A statistical section within the Planning and Review unit (PRU) provides data to internal and external clients. Some 400 requests for information are dealt with annually. The section also produces an annual statistical profile analysing WorkCover claims, fatalities investigated by the VWA, and the VWA's compliance and enforcement activity. In 1996 this publication was merged with the VWA's statistical supplement to its annual report.

As in many federated nations, Australia does not have consistent national injury and disease statistics, and thus comparison of injury rates and the success of interventions is difficult within the country. The NOHSC publishes annual estimates of national OHS statistics based largely on workers' compensation data. Victorian data are generally excluded from this publication as Victoria's employer excess coverage threshold (greater than 10 days off work) is not in accordance with the National Data Set (NDS). The NDS is currently being reviewed, with VWA participation, and inclusion of Victorian data may resume in the future.

It is unlikely that any of the reporting systems capture all of the workplace injuries or diseases. The FSD database contains approximately 200,000 workplaces; however, it is estimated

that up to 100,000 additional may exist that are not captured. The WorkCover database does not contain statistical information on injury and disease incidence at self-insured employer worksites, nor for injuries that have durations below the 10-day excess. The VWA database has also been criticised as lacking a decision support system to facilitate valid and reliable causality research.

FSD uses the data to develop the top injury-producing industries each year to assist in targeting both high-risk industries and specific high-incidence injuries within these. The Division recognises that this system is not easily capable of providing targeting data by enterprise or workplace. To correct this shortcoming, a new system called SATS (Site Assessment Targeting System) has been developed to record inspector assessments of a workplace's risk elements (hygiene, plant, manual handling, dangerous goods, location), health and safety management system, compliance performance, and risk control measures. The objective is to develop a profile or scorecard for each site and to use this as a guide to target future interventions.

Incident Notification Regulations are proposed as a means of capturing all of the data on dangerous occurrences and injuries from accidents. Approaches used in other jurisdictions to solve this information deficiency include the development of a menu-driven PC-based system that is provided to employers so that precoded data are transmitted electronically to the system. This approach avoids expending what might be a great deal of resources in data entry and coding. For large employers who are already capturing the data, interchange specifications are provided and the system can be made available on the Internet.

The Licensing Coordination unit has a significant database that tracks all of the licences, permits, approvals, certificates and registration required under the various pieces of legislation. This unit has responsibility for all licence and registration processes, except for 2,500 approvals for asbestos removalists, lead and carcinogen medical surveillance programmes and audiometrists that are the responsibility of the Work Environment Coordinating unit.

Under the Dangerous Goods Act there are 23 different licences issued, including 3 for transport, 12 for explosives and fireworks, and 8 for storage. Approximately 7,100 such licences were issued in 1995. Twenty-eight different certificates of competency are issued to equipment and plant operators; these are nationally accepted certificates. A common database for all Australia facilitates verification. Approximately 23,000 of these are issued each year, of which 19,300 are for forklift operators.

A registration system to track the location of plant and equipment contains five different registration groups and registered approximately 70,000 items when the new plant regulations came into effect in 1995. Current registrations run about 4,000 per month. The various registrations, certificates, and licences are issued on a fee-for-service basis, and the unit collects about \$7 million annually.

Securing Compliance Through Inspection and Enforcement

In enforcing health and safety legislation, the VWA's goal is to achieve consistency, transparency, and predictability. The enforcement policy emphasizes that

- the tools used to enforce compliance should be appropriate to the circumstances and actions required proportionate to the risk;
- there should be consistency in response—a similar approach is taken in similar circumstances to achieve similar ends;
- a targeted approach should be taken to ensure that the greatest attention is given to the highest risk situations and to those duty holders who are responsible for the risk and are best placed to control it;
- transparency in process should be maintained so that duty holders understand what is expected of them and what they should expect of the VWA—this also relates to clear avenues to appeal actions of the enforcing authority;
- the primary purpose of enforcement action is to prevent injury, illness, and disease and to make noncomplying businesses accountable to act as a deterrent to others.

Resource Utilisation

The FSD provides a full range of services including inspection, investigation, information, advisory, licensing, and training. FSD had a staff of 272 in 1997/98, of which 193 were operational staff. Of these, 50 are identified as specialists in areas such as occupational hygiene, chemistry, and ergonomics. Field activity is recorded on the INSPIRE database. During 1997/98, 58,159 visits were made to Victorian workplaces, an increase of 30 percent over the previous year. About 99,000 hours were spent by field staff in workplaces, up 36 percent from 1996/97. A 20 June 1996 policy directive on enforcement required that inspectors issue

improvement and prohibition notices whenever they observe noncompliance. Apparently this was in response to the low number of enforcement notices issued at that time.

The Inspection Process

WorkCover inspectors have the power to visit any place in Victoria covered by the three health and safety acts. The legislation provides inspectors with broad and far-reaching legislative powers. They have the right of entry, without the need for a search warrant, to workplaces and sites where there is high-risk equipment or dangerous goods. They can exercise this right at all reasonable times, by both day and night. It is an offence for anyone to refuse access to an inspector, or to obstruct, hinder, or oppose an inspector. In conducting a visit, an inspector can be assisted by other people, including technical or scientific experts, interpreters, or police officers.

Inspectors also have statutory powers to

- conduct interviews and inquiries;
- take photographs, recordings, and measurements;
- seize property;
- take samples;
- examine and copy documents; and
- issue whatever directions are necessary for them to carry out their functions.

When inspectors come to a workplace or site, wherever possible they will notify the employer, person in charge, or site manager and any health and safety representative of their entry, and show their identification card before acting or proceeding under the law.

If inspectors see a dangerous situation or a potentially dangerous situation, or a breach of the law or a potential breach, they may issue one or more of the following:

- Improvement Notices,
- Prohibition Notices, or
- Written Directions.

Improvement Notices and Prohibition Notices may be issued under the Occupational Health and Safety Act and the Equipment (Public Safety) Act. An Improvement Notice is a written direction

requiring a person or organisation to fix a breach or likely breach of the law; a time limit for the required improvement is included on the notice. A Prohibition Notice is a written direction prohibiting an activity that the inspector believes involves or will involve an immediate risk to the health and safety of any person. The activity cannot be started again until an inspector certifies that the risk has been removed. A dangerous goods Written Direction may be issued for a breach of the Dangerous Goods Act or its regulations, or where the inspector believes that action is needed to ensure the safety of people or property. The Written Direction may be for immediate compliance or compliance within a stipulated time as the inspector considers appropriate.

Inspectors may include directions in Notices and Written Directions, saying how the breach of the law or the threat to health and safety may be fixed. These hand-written documents are the Inspection record—providing the detail for all of the pertinent employer and site location data and the inspectors' observations. The Infringement Notice—more commonly referred to as on-the-spot-fines—is not applicable at this time, as regulations for these have not been promulgated.

When the inspector returns to the office, he or she may enter the data into the INSPIRE database, and information to create a profile of the firm is also recorded in SATS. As a general rule, however, inspectors do not enter the data themselves. The inspector will conduct a follow-up visit where Improvement and Prohibition notices have been issued. Inspectors appear to have a predetermined inspection/follow-up schedule for the day. In the case of a complaint, they attend to the narrow issue being addressed, provide some overall guidance for the employer, and move on to the next programmed visit. The impression is that they are pushing to obtain a quota of activities, and this can detract from being able to do a quality, in-depth inspection of the site or adjacent sites.

The VWA Enforcement Policy sets out the circumstances in which Notices and Written Directions are used. This policy was reviewed in 1996, and the review found areas where the existing policy was not being followed or needed clarification. In particular, inspectors were often using their powers to issue written requirements under general statutory powers instead of issuing Notices and Written Directions. Following the review, a revised Enforcement Policy was issued, which was essentially a restatement of the existing policy but with more emphasis on ensuring that it be consistently and effectively applied in workplaces.

The revised Enforcement Policy states that Notices and Written Directions must be issued where a breach of the legislation or an immediate risk is identified, whether or not any other enforcement tool is also to be used. The exceptions to this rule are

- where compliance is achieved immediately while the inspector is at the premises or on site, and the record of the observed noncompliance, the requirement and the compliance with the requirement are included in the inspection record form;
- where a Notice or Direction cannot, for a technical reason, be used to achieve compliance, and requirements issued under the inspector powers provision in the legislation are more appropriate (e.g., for taking of samples or seizure of property); or
- where WorkCover has issued a licence, approval, certificate, or authorisation (e.g., in relation to asbestos removal, or operating a crane or forklift), an inspector who sees a person or organisation not complying with the law or with any of the conditions that are relevant to the licence, etc., may initiate action to suspend or cancel it.

Inspectors also respond to requests to arbitrate

- disputed Provisional Improvement Notices issued by workers' health and safety representatives;
- disputed work stoppages due to alleged immediate threats to health and safety; and
- disputed Provisional Directions related to dangerous goods matters issued by delegated officers such as fire services officers.

The follow-up workplace visit to a comprehensive audit is focused on specific, agreed-to improvements and consultation. Some inspectors advise that the new enforcement policy will eliminate this approach since they believe they are now required to issue notices in each case. On follow-up where compliance has not been achieved or recurring noncompliance exists, they must issue a compliance notice or proceed to prepare the file for prosecution.

Prohibition and Improvement Notices steadily increased during the late 1980s to reach their highest levels in 1990 to 1991. Table 8.3 shows they gradually fell from 1991 to 1994, approximately back to the levels of the late 1980s. However, the number of Improvement and Prohibition Notices has risen substantially beginning in 1995/96.

Investigations and Prosecutions

Each of the three principal health and safety acts requires the Minister to issue general guidelines to inspectors about the prosecution of offences. The guidelines identify the following matters for consideration for prosecution, and prosecution proceedings will generally be instituted if investigations identify breach of legislation in respect of them:

- fatalities;
- incidents resulting in serious injury or ill-health;
- incidents with potential for fatality, serious injury or health effects;
- repeat offenders (e.g., previous prosecution, including where Notices and Written Directions have been issued);
- obstruction or other offences in relation to inspectors;
- noncomplied Provisional Improvement Notices or Provisional Directions, or inspectors' Notices or Written Directions;
- Discrimination against persons in respect to OHS issues (under the Occupational Health and Safety Act only);
- where other tools such as Notices and Written Directions are not considered appropriate for ensuring compliance or where there are repeated offences.

Prosecution proceedings may be instituted for breaches of Governor-in-Council Orders, under the Dangerous Goods Act and the Equipment (Public Safety) Act. Prosecution for manslaughter or offences under the Crimes Act 1958 is considered (in conjunction with the Director of Public Prosecutions) where, in the case of a work-related death or serious injury, there is evidence of gross negligence by a body corporate or persons in the workplace.

The trend for prosecutions follows the same general pattern as in the Prohibition and Improvement Notice data shown in Table 8.4. The number of successful prosecutions increased each year to a peak in the 1991/92 fiscal year and, after falling off dramatically for two years, appears to be on the rise again. In the four years beginning with 1994/95, prosecutions each year were in the range of 76 to 86 cases. A policy directive on enforcement (issued on 20 June 1996) requires inspectors to investigate and prepare a file for potential prosecution for circumstances

listed in the policy. A record of the number of files investigated for prosecution each year is not available; however, an estimate of between 200 and 300 was given.

As with all field work, investigation time is logged on INSPIRE. The prosecution process consumes a considerable amount of the resource of the Division. A survey was recently conducted by an independent consultant, which resulted in the estimate that about 15 percent of FSD's resources went to investigation and prosecution activities. The same study estimated the average cost of investigation at \$30,000 against an average fine of \$10,000. However, by the first half of 1997/98, the average fine exceeded \$13,000. A very high success rate is achieved, indicating a thorough and exhaustive investigative and selection process. The average time from accident/incident to issue of charges is 15 months and to decision about 21 months.

All offences against the Occupational Health and Safety Act and the Equipment (Public Safety) Act and some against the Dangerous Goods Act are indictable offences, i.e., the organisation or person charged with an offence has the right to a trial before a judge and jury in County Court. However, with the agreement of the organisation or person charged and the court, offences can be heard summarily in the Magistrates' Court. Except for 25 cases heard by a judge and jury in the last 10 years, all were actually heard by the Magistrates' Court.

Where there has been a previous conviction under the relevant act, the court has the power to impose another penalty in addition to the penalty for the second or further offence. The Dangerous Goods Act also has penalties on a daily basis for continuing offences. The VWA has increasingly sought to pursue charges of manslaughter in appropriate cases. In 1994 a company was successfully prosecuted on a charge of manslaughter, and a director of the company of two charges, under the Occupational Health and Safety Act.

There are several evident weaknesses in such a large investment in prosecution. First, the fines are typically at a relatively low level, in the range of \$10,000 to \$20,000, and cannot be seen as a significant deterrent. Magistrates are not sure that such prosecutions rank as serious criminal offences and are therefore reluctant to levy higher fines or use good behaviour bonds. Second, the prosecutions are event-focused. Prosecutions are initiated when a serious injury or death or a "near miss" occurs, and they almost exclusively focus on the corporate employer and not the individual directors, managers, or supervisors. Thirdly, the lengthy time between the event and the application of the penalty serves to delink the event from the consequence.

The Industry Commission Report calculated the probability of a penalty being applied in Victoria at 2 percent and, even though the average fine is higher than other jurisdictions, this results in a calculated expected penalty of only \$29. It is difficult to assess the argument that the publicity of successful prosecutions will create the deterrent effect desired for other similar employers, but at the level of penalty currently being levied, this is a dubious proposition.

Appeal Process

An employer who has been issued a Notice under the Occupational Health and Safety Act may appeal to the Industrial Division of the Magistrates' Court.²³ The court may affirm, modify, or cancel the Notice. Typically, fewer than 1 percent of Notices issued are appealed. A person who has been issued a Written Direction under the Dangerous Goods Act or a Notice under the Equipment (Public Safety) Act may appeal to the Administrative Appeals Tribunal. Such appeals are very rare.

Employers who have been issued with a Provisional Improvement Notice (PIN) by a health and safety representative under the Occupational Health and Safety Act may appeal to an inspector. In 1995/96 there were 94 such appeals.²⁴ In 58 of these cases the PIN was cancelled by the inspector. A person who has been issued a Provisional Direction by a delegated officer under the Dangerous Goods Act may appeal to an inspector. No such appeals have been recorded.

SafetyMap

SafetyMap is an audit tool developed by the former Health and Safety Division and launched in 1993. In 1997 it was revised and a third edition was published. WorkCover received a Recognition Achievement Award from the Safety Institute of Australia in 1997 for this programme. The audit was specifically designed to evaluate safety management systems at enterprises; the tool does not audit compliance for site specific health and safety issues. The product has been marketed extremely well and has enjoyed a good reception. Staff estimate that

²³Prior to 1997, this responsibility had been that of the Employee Relations Commission of Victoria.

²⁴Neither health and safety representatives nor employers are required to advise the VWA when a PIN has been used.

several thousand copies have been sold throughout Australia and in other countries. Accreditation under SafetyMap is a requirement for all self-insured employers under WorkCover. Many large employers also are now requiring that the contractors they hire be accredited under SafetyMap as a form of due diligence.

The tool is aligned with quality assurance principles and therefore the expectation is that most medium and large firms will be able to achieve at least the entry level certification. The coordinating unit is somewhat apprehensive about their marketing success, since they feel they may not have sufficient auditors available to meet the demand.

Marketing

The VWA's Corporate Affairs Division has become increasingly active in marketing health and safety in recent years. It has run a series of high-profile advertising campaigns aimed at promoting a pervasive culture of safety within Victorian workplaces. The campaigns are grounded in comprehensive research and market testing. Their effectiveness is tested by market awareness surveys and changes in recorded claims numbers. Campaigns include television and radio commercials, posters, displays, and outdoor advertising. Major safety promotion displays are held at shows, exhibitions, and field days throughout Victoria, including the Royal Melbourne Show and the "Victoria on Show" exhibition. Safety videos are produced, and there has also been a range of activities to promote safety in the farming community. Market awareness recently was found to be 80 percent, and a continued decrease in claims reported is attributed partly to this marketing effort.

By North American standards, VWA maintains an extremely aggressive and successful outreach programme which is validated by strong support from both labour and employer representatives. VWA's aggressive strategy reflects a strong focus on prevention by encouraging employers to utilise the skills of field officers to assist them with strategies for managing hazards and risks. Further, a current major media campaign is targeting the importance of the combined efforts of workers, employers, and medical practitioners to combat back injuries and facilitate successful return to work. Employer representatives interviewed applauded the outreach campaigns focused on health and safety and injury management for creating an extremely positive community profile for VWA. Both labour and employers strongly support these efforts.

Also, they provide the framework for a fuller integration of FSD with the VWA, leveraging the organisation's resource potential and facilitating the development of synergistic strategies that lower workplace injuries and illnesses in Victoria.

Stakeholder Feedback

In this section of the report, feedback from employers and labour on the Victorian health and safety efforts is provided. Since we talked to a significant number of such stakeholders in the course of carrying out this study, it seems appropriate to record their reactions to the system as they experience it. Of necessity, these comments are more subjective, and they are also subject to less cross-referencing than other material in this report. Nevertheless, they are an important part of our review and analysis. Ultimately, the stakeholders will get the system they want, and their perceptions are an important part of an evaluation of the performance of the VWA.

General observations by employer representatives reflect the perception of a strong initiative to get the field staff out of their offices so that their time is focused on workplaces. This is in marked contrast with organised labour's perception that the field staff have vanished and are of little assistance when there is interaction. The reality is that the amount of field time and activity has increased significantly since the 1996 review. The field officers are reported to be visiting the workplaces with the greatest safety and health challenges and thus may not be as visible to organised labour. Many employers indicated they valued the advice and assistance of FSD field officers. Other employer representatives fear that FSD has been "swallowed up" by the insurance side of VWA and as a result lost its profile as the champion for workplace health and safety in Victoria. This is in contrast to the significant investment being made by VWA to boost the prevention effort through a more highly trained and skilled staff that is field-active a much greater percentage of their time.

Union representatives reported that they believed FSD had lost its independence and autonomy since the merger with VWA and that service has continually deteriorated over the last two years. They view the officers as not being proactive in enforcing the legislation. They report that when officers are investigating serious accidents, complaints, and PINS, they are not involving worker OHS representatives. Further, they allege that officers produce reports that are frequently biased in favour of the employer, not factual, and contain flawed conclusions. Union

representatives believe there might be unwritten directives that result in officers only performing a consultative and advisory role and not enforcing legislative requirements. As a result, some union representatives said they have lost confidence in FSD and have given up on seeking their assistance to resolve workplace issues.

In our 1996 study, we found that many FSD field staff had not yet made the change to enforcing the performance-based legislative standards. It appears now that they have made the change. The significant concerns articulated by those interviewed may be more reflective of the union's reaction to recent legislative amendments than to a significant change in service delivery.

Further reorganisation has shifted the resources for investigations that might lead to prosecution from the FSD to the Operations Management Division. FSD field officers provide the initial response and investigation for serious and fatal accidents and are joined by investigators from the Evaluation and Compliance unit. These investigators make a decision whether they will take an in-depth enforcement-focused approach or withdraw and leave the field officer alone to conclude an investigation based on what can be learned and how to prevent reoccurrence. Currently the number of prosecutions is about 120 per year. Since this is as many as has ever been achieved in recent years, the perceptions of some organised labour representatives that FSD has become less enforcement oriented is somewhat of a puzzle. A service goal of the Division aims to reduce the time lag between investigation and laying charges to eight weeks.

Although the FSD focus is on stronger and swifter enforcement, this commitment is not apparent to the union representatives; this suggests a greater dialogue with the stakeholders is required to keep them apprised of the Division's strategies. Both employer associations and union representatives suggested the establishment of some form of advisory or consultative committee focused on prevention to meet on a monthly basis. Since a standing subcommittee on health and safety already exists and could provide a forum for issues to be raised with VWA, the union and employer representatives interviewed are either unaware of the committee, or perceive its purpose differently. The FSD reportedly updates the subcommittee, on all of its activities and plans.

Service Quality Assurance

In November 1997, Ron Klein and Associates conducted an independent survey of employers and health and safety representatives who had been in contact with FSD over the previous six months. The sample involved 500 respondents and was designed to provide a cross-section of metropolitan and rural services, as well as the range of reasons for a workplace visit (accident investigation, complaint, programme evaluation, dangerous goods audit, etc.).

Overall, the survey indicated a very high level of satisfaction with the service provided by FSD officers (87 percent favourable). The survey result is comparable although produced somewhat better satisfaction ratings than that seen in surveys of North American jurisdictions. Ongoing surveys of this type will assist FSD to assess the effectiveness of officer training initiatives and the workplace reception of new prevention strategies.

Our June 1998 interviews with employers validated these survey results. Employers indicated they often called in field staff as advisors and valued them as conduits of best practices. Several employers indicated a strong interest in participating in a more consultative way with FSD management. They would like the opportunity to make recommendations on policy and practice.

In contrast, union representatives interviewed were unanimous in their view that service quality, at least for worker/union interests, had seriously deteriorated. They expressed concern that FSD management is making a concerted effort to de-emphasize the role of unions and worker representatives. They cited as key concerns the lack of communication and consultation on change, difficulty accessing information and data, and a credibility gap between legislation and published policy and practice. They say they experienced either extreme delays or failure to respond to worker representatives' workplace issues and, when response occurred, a perception that officers had been told not to take enforcement action.

Some union representatives stated they have "written off" FSD officers as the last resource they will call to assist in resolving workplace health and safety issues. Again, these views are in sharp conflict with the 1997 Klein survey of 243 workplace health and safety representatives who gave FSD officers a 91 percent satisfaction rating. Perhaps the political environment created by the changes to the WorkCover legislation may be somewhat responsible for the negative views expressed recently by organised labour, or perhaps we talked with a different, and possibly more politically active, group of labour representatives.

Consultant Comments

Independent health and safety consultants report that the Division is suffering from a long history of political influence, and there is a carryover of policy and behaviour from that history. They expressed concern that the integration with VWA might drive inappropriate prevention strategies that were exclusively founded on the costly claims. They believe the Division's efforts are hampered by a poor database in that all workplaces are not captured and only the excess claims are reported. Further, they have a grave concern that the information on workplace hygiene issues is either nonexistent or very poor.

The consultants also did not give high marks to the VWA prevention media campaigns. They acknowledge the effort achieved high audience awareness; however, the feeling is that they are not targeting the real hazards in the workplace. Another concern consultants have is that employers actually do not understand the new performance-based approach and still view FSD as an agency that provides the historic inspection and enforcement service. In addition, they are highly critical of industry associations. They are skeptical that these organisations have much interest in a proactive agenda for health and safety issues unless the effort is funded by grants or awards. On a positive note, these consultants believe improved targeting of the inspection resource could make a significant difference to the reduction of injury and disease.

SafetyMap is a leading-edge approach to fostering the development of safety management systems that drive employer and worker responsibility for workplace safety. At the same time, the approach ensures the regulator is monitoring the effectiveness of this strategy at each firm that is accredited. Victoria is years ahead of other jurisdictions around the world that are developing similar approaches. However, at the moment, Australian critics seem to be dubious about the long-term effectiveness of the safety management strategy in reducing injury and disease, even at large, well-resourced enterprises.

Strategy Development

The inspection resource is probably sufficient in numbers, but the staff are severely constrained in maximising their effectiveness by such things as the lack of vehicles, excessive paper and data entry work, the heavy focus on prosecutions, insufficient computer resources, and

ineffective software. Strategies should ensure inspectors are field-active for most of their day and almost every day of the month.

In addition, improved targeting strategies need to be developed. This will be in the hands of a new, Field Operations Planning unit. Some of the former HSO resources were integrated into the VWA Corporate Affairs Division and the Legislation and Policy Development Division, while others were utilised to create a Programme Development unit. In March of 1998 the Programme Development unit was reorganised and a Field Operations Planning unit established in FSD. This new unit has a mandate to develop a workplace-centred targeting system. Field officers will focus interventions on the 20,000 most challenged firms as follows:

- the top 5,000 workplaces with materials handling claims;
- the top 5,000 workplaces with other claims;
- the 5,000 firms with the most claims in the building and construction industry;
and
- the top 5,000 firms with dangerous-goods issues.

The target lists will be validated and supplemented by local officer knowledge. The measures of success will be the workplace's achievement of compliance with OHS legislation and the level of improvement in safety, health, and injury management performance. This is known as the "case management" approach. The field officer is expected to be a change agent, enhancing hazard awareness and facilitating changes in workplace culture, attitude, and behaviour. The officer will monitor the employer's progress or failure in developing programmes that achieve the expected outcomes. The Field Operations Planning unit also has responsibility for developing standard intervention tools, operational standards and procedures, and officer performance measurement systems.

Human Resource Skill Adjustments

FSD has responded to the need to improve the level of human resource skills by establishing a Development Office. Initially the office will concentrate on the induction and training of new field officers. The training will focus on skills that match a performance-based regulatory approach that promotes best practices and a systems approach to managing workplace health and safety. The Development Office will eventually conduct a skill-development needs

assessment of field staff and focus its energies on training and education required to align the human resources to the performance-based service-delivery model outlined in legislation.

Given the drive for frequent and rapid change within the Division, it seems apparent that this process must be more inclusive of group manager and team leader perspectives. Change needs to be sufficiently resourced to create conditions for successful implementation. Field staff and managers also highlighted the importance of developing succession plans and continuing the staff awareness surveys in order to monitor core competencies, awareness, and readiness to achieve strategic plans. In addition, an evaluation of the existing resource base is needed, and means must be developed to upgrade and replace as necessary. Remuneration levels should also be evaluated, so as to attract and maintain appropriately skilled staff.

Management Structure

HSD's management structure had many layers in 1996 and was seen to be very top heavy. Since then, very significant reorganisation has occurred (see Figure 8.1). The FSD reorganisation focused on a team service-delivery model featuring far fewer managers. Including the addition of 14 new field officers, the percent of managers to field staff has been reduced from 10 percent to 4.7 percent. The flat management structure has 10 fewer regional managers and 22 new team leader positions. There are response teams and programme teams in each regional office. Team leaders are expected to spend at least 200 hours in the field each year as field officers. However, the actual experience to date is that it has been difficult to establish the team leaders as officers and also keep them in the field.

Field officers traditionally relied heavily on their managers for advice and to direct and validate their proposed actions. The effect of swiftly removing this command and control management style and imposing a team-based, self-reliant approach on officers, without the benefit of supportive coaching, mentoring, training, and change-management skills, is that team leaders continue to serve as supervisors. This can create tension for group managers, who are sandwiched between competing priorities. As a result, group managers are putting in extra hours until team leaders and field staff have fully accepted and integrated the changes required to achieve the Division's new strategies.

The reduction in managers was perhaps, in hindsight, too severe and too fast, resulting in insufficient support and assistance to implement and manage such a significant change. Although the goals set for the percentage of field time by field staff appear ambitious, group managers indicate satisfaction at how well FSD has done in the last year, and they are optimistic that once field staff are fully equipped to spend almost all their working hours in the field, more aggressive targets will be achieved.

Investigations and Prosecutions

The significant investment in investigation with a view to prosecution is not supported by any of the stakeholders in our interviews. This is primarily due to the belief that the deterrent effect of the existing strategy is minimal. This does not mean that the enforcement effort should be abandoned. VWA is currently developing a new set of prosecution guidelines to complement the new penalty regime. It also is reported to be studying a complementary administrative penalty system.

Conclusions

Over the last decade, the FSD of the VWA has experienced constant change. In the past 15 years, the Division has been a part of six different Ministries or Authorities. In 1982 it reported to the Minister of Labour and Industry, and this seems to be where most in the general public still identify the prevention field staff, referring to them as DLI inspectors. However, in 1982, the new Labor Government moved the agency to the Minister for Employment and Training. With the passage of the Occupational Health and Safety Act 1985, the agency moved to the Department of Employment and Industrial Affairs. In 1991 an administratively autonomous OHSA was set up to oversee and consolidate the delivery of health and safety in Victoria. With the change in Government in 1992, the functions were delivered by two divisions within the Department of Business and Employment. In May 1995, the organisation was renamed the HSO, and on 2 July 1996 the responsibility was once again moved to become the Health and Safety Division of the Victorian WorkCover Authority. The Division actually may be suffering a kind of identity crisis resulting from the numerous name changes.

In addition to the movement through various Departments and Authorities, the organisational structure has been constantly evolving. This current study is among several the organisation has been subjected to over the last five years. All of this change is reflected in a high level of frustration and cynicism among the staff of the Division. There is a feeling that the mandate for health and safety is difficult and politically charged, and for these reasons the responsibility is constantly shifted. Each new reorganisation is seen as “the flavour of the month,” and the staff have developed a fortress mentality that to some degree deflects or resists the change. Lack of “buy in” is partly a result of the constant change, but also because it is driven from the top, providing little opportunity for involvement of those who are required to implement change.

Since the Division is still in the process of adjusting to the several reorganisations in recent years, any further reorganisation must be carried out carefully and skillfully. It should be inclusive of staff representatives from most levels in the division during the planning and transition process. The importance of the mandate for health and safety dictates the critical need for a period of stability for the division. Since “Prevention of Injury” is the primary challenge stated in the mission of the Victorian WorkCover Authority, there is now a golden opportunity to achieve a strong identity and stable service-delivery performance.

Our opinion is that the VWA has made remarkable progress since 1996 in integrating the FSD into the mainstream of WorkCover’s service delivery. Workplace injury claims continue to decline in Victoria. Significant efficiencies have been achieved through aggressive changes to the field service delivery strategy. The greatest remaining challenge is to embed the progressive changes into the operation. The record of progress on injury reduction will be increased through improvements to open communication and meaningful dialogue with field officers, unions, and worker representatives.

Table 8.1 Regulations under the Principal Health and Safety Acts

Occupational Health and Safety Act 1985	
OHS (Asbestos) Regulations 1992	Provide for control of risks of asbestos-related disease among workers working in process which uses asbestos and among workers likely to be exposed to airborne asbestos.
OHS (Certification of Plant Users and Operators) Regulations 1994	Establish minimum standards of competency for people working with cranes, forklift trucks, hoists, and other mechanical loadshifting equipment, pressure equipment and scaffolding, and implement a certification system to ensure that those standards are observed, in order to minimise the incidence and severity of serious incidents involving these types of plant.
OHS (Incident Notification) Regulations 1997	Specify notifiable incidents and prescribe procedures relating to notifiable incidents at a workplace for the purpose of identifying whether preventative action is necessary following an incident occurring at a workplace.
OHS (Issue Resolution) Regulations 1989	Prescribe a procedure for the effective resolution at workplaces of health and safety issues as they arise, where there is no agreed process for resolution.
OHS (Confined Spaces) Regulations 1996	Specify duties which apply to certain persons to protect people at work against risks associated with entry to, work in, or exit from a confined space.
E(PS) (Incident Notification) Regulations 1997	Specify notifiable incidents and prescribe procedures relating to notifiable incidents involving prescribed equipment for the purposes of identifying whether preventative action is necessary following an incident occurring at an equipment site.
OHS (Lead Control) Regulations 1988	Provide measures to protect people at work against risks to health or safety arising from exposure to lead.

Occupational Health and Safety Act 1985 (cont'd)	
OHS (Manual Handling) Regulations 1988	Provide measures to reduce the number and severity of injuries resulting from manual handling tasks in workplaces; require employers to assess and control risks arising from manual handling activities in workplaces.
OHS (Noise) Regulations 1992	Provide measures to protect people at work against risks to health or safety arising from noise.
OHS (Plant) Regulations 1995	Provide measures to protect people at work against risks to health or safety arising from plant and systems of work associated with plant.
Dangerous Goods Act 1985	
DG (Explosives) Regulations 1988	Provide for safety in the manufacture, transport, storage, sale, import, and use of explosives; provide for safety in the making of explosives mixtures other than at a factory; provide for safety in the filling of safety cartridges other than at a factory; provide for the safe location of ships containing explosives while in port; prescribe matters for the purposes of the act.
DG (Liquefied Gases Transfer) Regulations 1987	Specify various matters relating to liquefied gas containers and cylinders; set requirements for maintenance, alteration, and repair at liquefied gas storage installations.
DG (Storage and Handling) Regulations 1989	Provide measures to promote the health and safety of people and the safety of property in relation to the storage, handling, transfer, use, manufacture, and sale of dangerous goods at premises; prescribe matters for the purposes of the DG Act.

Dangerous Goods Act 1985 (cont'd)	
DG (Transport) Regulations) 1987	Provide for the licensing of vehicles used to transport dangerous goods in bulk; provide for the registration of persons who drive vehicles used to transport dangerous goods in bulk; adopt the Transport Code; specify requirements that must be observed to enhance safety in the transport of dangerous goods.
Equipment (Public Safety) Act 1994	
E(PS) (General) Regulations 1995	Declare certain equipment to be prescribed equipment for the purposes of these Regulations and the E(PS) Act; provide for the health and safety of people in relation to prescribed equipment.
Road Transport Reform (Dangerous Goods) Act 1995 (Commonwealth)	
Road Transport Reform (Dangerous Goods) Regulations 1997	Give effect to the standards, requirements, and procedures of the ADG Code. Provide for safety in the transport of dangerous goods by road as part of nationally consistent road transport laws.
Australian Code for the Transport of Dangerous Goods by Road and Rail (ADG Code)	Sets out technical requirements and guidelines relating to the transport of dangerous goods by road and rail.
Road Transport (Dangerous Goods) Act 1995	
Road Transport (Dangerous Goods) (Licence Fees) Regulations 1998	Prescribe fees for applications for the grant or renewal of bulk vehicle licences.

Source: VWA

Table 8.2 Approved Codes of Practice under the Occupational Health and Safety Act 1985

Code of Practice	Date of Operation
Tilt-Up Construction	1 October 1987
Foundries	30 June 1988
Workplaces	30 June 1988
Lead Control	1 July 1988
Temporary Electrical Installations on Building and Construction Sites	1 August 1988
Manual Handling	1 February 1989
Safety Precautions in Trenching Operations	1 September 1988
Safe Work on Roofs (excluding villa construction)	1 July 1989
Safe Use of Cranes in the Building and Construction Industry	1 March 1990
Safety in Forest Operations	1 March 1990
Building and Construction Workplaces	1 October 1990
Demolition	1 October 1991
Manual Handling (Occupational Overuse Syndrome)	1 January 1992
Provision of Occupational Health and Safety Information in Languages other than English	1 October 1992
Noise	1 October 1992
First Aid in the Workplace	1 June 1995
Plant	1 July 1995
Confined Spaces	1 March 1997
Demolition (Amendment No. 1)	26 February 1998
Safe Work on Roofs (Amendment No. 1)	26 February 1998

Source: VWA

Table 8.3 Inspections, Notices, and Written Directions, 1990–1996

Year	All Inspections	Improvement Notices	Prohibition Notices	Written Directions (requirements)
1989/90	43,663	2,940	1,409	52
1990/91	42,580	3,468	1,729	736
1991/92	50,315	3,918	1,437	3,059
1992/93	59,738	2,868	1,022	6,290
1993/94	70,635	1,810	879	4,916
1994/95	53,417	1,482	820	4,393
1995/96	45,330	2,001	975	8,595
1996/97	44,875	3,236	1,414	5,906
1997/98	58,189	3,599	1,318	7,669

* The high number of inspections in 1993 was related to a programme to identify unregistered boilers and pressure vessels.

Source: VWA

Table 8.4 Prosecutions with Average Fines Imposed

	1990/91	1991/92	1992/93	1993/94	1994/95	1995/96	1996/97	1997/98
Prosecutions	76	119	68	64	79	86	76	80
Average fine	\$6,449	\$5,374	\$7,509	\$12,682	\$8,918	\$11,333	\$10,845	\$12,518

Source: VWA

Figure 8.1 Field Services Division
as of 1 January 1998

Chapter 9 Attention Points

As in other comparable studies of workers' compensation systems in North America, we record in this chapter our summary observations about the workers' compensation system of Victoria in the form of "attention points." These attention points are noted because they represent special strengths of the system, or because they warrant additional attention by those who seek to improve the system.

We have depended very heavily on the available data, and on what people intimately familiar with the VWA have told us. It would not be possible to perform such system reviews without the wholehearted support of these people. Our reactions to what we have heard and the judgments that result are, of course, solely our responsibility. We hope that the issues we identify for attention here will resonate with decision makers in Victoria. However, we purposely do not prescribe cures for problems identified; we believe this is the responsibility of the policymakers and stakeholders in the system. We simply offer what we hope is a well-informed, independent perspective on the workers' compensation system in Victoria.

It is also important to emphasize that we have been unable to stay current with developments in Victoria beyond mid 1998 and mid 1996 in the case of insurer regulation and occupational rehabilitation. Hence, some of these attention points may already have been addressed with amending legislation or by actions of the VWA.

For purposes of exposition, we have grouped our observations into the broad categories of 1) insurer regulation issues; 2) compensation issues; 3) rehabilitation issues; 4) prevention issues and 5) general issues. Within each of these categories, our attention points are numbered for convenient reference. However, the points are not presented in priority order.

Insurer Regulation (I)

There are a number of issues which emerged from our review of the insurer regulation procedures at the VWA. They are complicated by the continuing changes that affect the regulatory process, and, until fairly recently, by the possibility that the system would be privatised.

I-1. Privatisation

Since 1992 the possibility of privatisation has been an issue of interest to all parties concerned with workers' compensation in Victoria. Privatisation is widely understood to mean that the underwriting risk is borne by the insurance carriers and not by an agency of state Government. The original blueprint for WorkCover anticipated the full privatisation of the system once the unfunded liability was retired and system funding was stabilised. The Insurance Council of Australia (ICA) circulated a proposal for a privatised Victorian system in the fall of 1997. Further, the Victorian Department of Treasury and Finance released a report in January 1998 recommending privatisation of the scheme, prompted by the National Competition Policy agreements.

However, in May of 1998 the Government announced that it would not move to privatise workers' compensation in Victoria. Not surprisingly, privatisation supporters do not regard the matter as entirely settled. However, the authorised insurers ought not postpone important decisions on investments in people and systems because of any uncertainty regarding the future of workers' compensation insurance. Further, any effort by the VWA to attract businesses to act as authorised insurers or agents will be set back if uncertainty affects those decisions. In this respect, we applaud the efforts of the VWA to move to extended contracts that will improve the ability of insurers to plan for the future.

I-2. Expansion of Self-Insurance

It is reasonable to consider ways to enhance employers' incentives to contain costs by allowing them to bear greater risk and/or be more actively involved in managing their claims. There are an array of options to consider: expanding access to individual self-insurance and self-administration; extending group self-insurance; permitting retrospective rating; increasing retention limits; or introducing large deductible policies. Enabling such options could help medium and smaller employers as well by increasing insurer competition for their businesses. However, there must be safeguards to ensure that only economically viable employers are allowed to self-insure and avoid unfunded obligations to the scheme. Other systems around the world have developed successful self-insured security funds to prevent transferring any cost

burden to the general population of insured employers. This experience should be reviewed by the VWA before offering significantly wider access to self-insurance.

Greater use of self-insurance will also inevitably result in some “adverse selection” (i.e., low-risk employers should find this option more attractive than high-risk employers). This could increase the average premium rate for the scheme even though it could lower overall social costs of occupational injury and illness by improving cost containment among self-insureds. The expansion of self-insurance will also exacerbate the “missing data” problem. Self-insured employer’s experiences should be part of the system database for analytical and comparative purposes. In addition, as the VWA recognises, it is mandatory to minimise cross-subsidies to avoid erosion of the pool of employers insured by the scheme. Expanding access to self-insurance will highlight any existing flaws in the premium pricing system.

Group self-insurance will undoubtedly become more of an issue following the initial extension of this concept to the municipal sector. Certain group self-insurance arrangements can offer legitimate economic efficiencies. However, this is a difficult philosophical issue for the VWA and policymakers to resolve because it raises numerous regulatory questions. The VWA would benefit by learning more from the experience of other jurisdictions with group self-insurance before it ventures into these relatively uncharted waters.

The desire to expand self-insurance derives from the generally favourable outcomes associated with its use, e.g., active and effective prevention programmes, positive return-to-work outcomes, and low costs. The very slow growth in the extent of self-insurance is a concern for some policymakers. The limited interest by eligible firms reflects several factors. First, some businesses simply wish to avoid the complicated process of applying for self-insurer status. SafetyMap was cited as a significant barrier, for instance. Other firms have given low priority to the subject, and to other risk-management matters as well, based on cost levels. Undoubtedly, with workers’ compensation costs low and very competitive by Australian standards, employers do not regard their possible savings from self-insurance as worth the effort and the potential risks. Many employers are undoubtedly very satisfied with the services rendered to them by their authorised insurer. In this sense the VWA may be a victim of its own success. If system costs begin to grow significantly, if the scheme appears to be going out of control, or if insurers cease to provide acceptable service to their insureds, self-insurance will grow accordingly.

I-3. Alternative Insurer Arrangements

The December 1996 legislation authorised “Agency Arrangements” whereby employers and insurers can vary the specific responsibilities between them. This permits experimentation with structure and performance arrangements in pursuit of the optimal insurance solution. The VWA also expects some alternative providers to develop in the market to meet specific needs. It is not yet clear exactly what this might mean. Such openness to innovation and experimentation is to be commended in a regulatory agency such as the VWA. We are confident that the VWA is capable of monitoring and evaluating such experiments.

I-4. Improvements in Scheme Performance

The regulatory scheme appears to have been successful in managing the transition from the limited insurer functions under WorkCare to the insurers’ expanded role under WorkCover. This has been a learning process for both regulators and insurers. The successes of the WorkCover scheme are at least partly attributable to more sophisticated regulatory mechanisms, as well as the development of insurers’ capabilities. Improvements in reserve analysis, pricing, and detailed scheme information are among the most notable accomplishments of this system. The VWA has continued to refine its regulatory mechanisms as problems are identified and insurers’ capabilities have evolved. Because of these efforts, we believe insurers will be in a better position to assume expanded functions and exercise greater authority if measures are implemented to effect such changes.

At the same time, these improvements have not occurred without significant tension between regulators and authorised insurers. Victoria may be approaching the limits of what can be achieved from the current principal–agent framework. In looking toward the future, policymakers will need to assess the potential further gains from this type of arrangement, as well as the use of organisations that are not traditional insurers to serve as agents.

I-5. Economic Incentives for Insurers

A number of our attention points focus on relations between the VWA and authorised insurers. The public-private workers' compensation insurance arrangement in Victoria is unique to Australia and, as such, warrants considerable attention from the outside world. Can the authorised insurers be induced to provide the level and quality of services that employers and workers would like within a framework where they bear no insurance risk? What types of incentive schemes will cause the insurers to maximise the various goals that the VWA has set for the programme?

Until now the VWA found itself frequently modifying the rules and the arrangements with the authorised insurers in the attempt to "get it right." The VWA is making what appear to be more fundamental changes in the incentive arrangements with the insurers. This follows the Government's decision that the Victorian system will not be privatised. The changes proposed aim to realign the bases of insurer incentive payments so as to give more weight to desired outcomes, e.g., prevention and return-to-work results, and less weight to premiums collected.

If insurer remuneration can be increased contingent upon outcomes, important system change is bound to follow. For example, the insurers may be induced to employ more loss-control staff than they currently believe they can justify. A key feature of the new programme is that it likely will be based on longer duration remuneration contracts. This will provide all parties with sufficient time to learn the programme and implement it, and to be able to evaluate its effectiveness. This is very important work for the future of the scheme that the VWA is carrying on, with the analytical support of the Boston Consulting Group.

I-6. Role and Expectations for Authorised Insurers

VWA staff expressed concerns that insurers are not being sufficiently proactive in helping employers identify and address problems. VWA staff also are critical of insurers' performance in managing long-term claims and returning these injured workers to productive employment. Of course, VWA's view of the role of insurers and what their objectives should be may be very different from insurers' views.

VWA documents, such as the licensing agreement, are intended to inform insurers as to what they are expected to do, but these documents cannot be specific enough in this regard. It is

not feasible either for regulatory documents to prescribe every aspect of insurers' functions or to address every contingency that may arise. There are likely to be expectations on the part of the VWA that are not fully articulated in the documents.

A certain degree of ambiguity is inherent in a system where the Government and insurers share responsibility for providing workers' compensation insurance. However, this ambiguity has been exacerbated by communication problems, political uncertainty about the future role of insurers, and economic incentives that are not always consistent with the expressed goals of the system.

I-7. Insurer Audits

The VWA's audit programme has been a major concern to insurers, and the VWA has recognised the need for its improvement. One critical element which the VWA can influence in the implementation of the programme is the experience and training of the auditors, which has been a matter of concern for insurers. Of course, the VWA and insurers need to be willing to retain well-qualified auditors, and to commit to longer-term contracts which would support additional capacity development by vendors of auditing services.

I-8. Pricing and System Costs

The Government has placed a high priority on maintaining a low overall workers' compensation insurance rate, which is considered to be a critical benchmark of scheme performance as well as an important policy objective. It is also a legislatively expressed system objective that the scheme be fully funded. It is critical to the perceived fairness of the system that scheme parameters are not manipulated to maintain the price objective if system costs begin to rise. While the goal of maintaining a low premium rate is laudable, it needs to be balanced against other scheme goals and the costs, which may be externalised to employers, workers, or others in the community.

We fear that the promotion of a low rate increases the pressure on the Government to sacrifice other objectives to maintain that rate. For example, the significant investments required to return severely injured workers to employment may not be compatible with minimising costs in the short run. However, they may represent the best long-term strategy for minimising the

social costs of work-related injury and illness, and for maximising injured workers' continued participation in an active lifestyle. Also, efforts to keep rates low should not be allowed to mask trends with respect to system costs or other emerging problems, which might delay recognition and implementation of remedial measures. It would be beneficial to direct public attention to other measures of scheme performance in addition to the premium rate.

I-9. Scheme Information

Insurers' ability to compete and provide high-quality service is heavily dependent on their access to information. However, some insurers complain that VWA information systems are not designed to allow them to easily extract and analyse data. Thus, insurers are forced to expend considerable resources to extract information from the VWA database or even develop their own systems. Smaller insurers are at a greater disadvantage than large insurers in this regard, which tends to increase market concentration and lessen competition.

The opportunities for "database synergy" with Field Services should also not be overlooked. The potential contribution of analysing claims information jointly with occupational health and safety information would seem to argue for retaining an establishment level database under VWA control. Thus, the VWA needs to carefully consider the strategic and tactical implications of the regulatory database proposals.

I-10. Consumer Information

Good consumer information (i.e., to employers who purchase workers' compensation insurance) is important in promoting effective competition and efficient market performance. Buyers need reliable, user-friendly information on the performance dimensions within which insurers compete. Lack of access to this information in the past has probably contributed to the inertia by employers in not migrating to the better performing insurers. The VWA's plan to publicise insurer performance data should help to address this deficiency and, thereby, enhance competition and scheme performance. Good consumer information will become even more important if insurers are encouraged to increase their competition through service differentiation. Using data to enable employers to evaluate their own claims experience relative to industry

averages, and to feed their potential interest in cost reductions, are other areas which the VWA may wish to evaluate if it wants to encourage more effective use of these mechanisms.

I-11. Relations Between the VWA and Insurers

The VWA and insurers are partners in providing workers' compensation insurance, but they do not always behave strictly like partners. The VWA acts toward insurers as both a regulator and a partner, and insurers respond accordingly. Obviously, the VWA cannot abrogate its regulatory responsibility, but the way it performs this role may contribute to confusion on the part of insurers. Some insurers believe that they are unfairly treated by the VWA, and that VWA actions towards them are unnecessarily heavy-handed and arbitrary. Insurers generally believe that the VWA is not sufficiently open with them and does not consider their views when addressing mutual concerns and proposed remedies.

On the other hand, many VWA staff believe that insurers have not demonstrated behaviour that would warrant easing regulatory pressure. Also, VWA staff do not acknowledge the communication problems that insurers experience. Clearly, there is a certain mutual suspicion and wariness.

We believe the relationship between the VWA and insurers need not be an adversarial one. The development of institutional mechanics that would facilitate better communication and joint-problem resolution could improve VWA–insurer relations and contribute significantly to improved scheme performance.

Compensation Issues (C)

We take the basic structure of compensation as a “given”; that is, we assume that the Government in Victoria has structured the benefits to accord with current Australian realities. To the best of our knowledge, a careful study of the equity of the benefit structure has yet to be undertaken. However, there are still a multitude of issues which arise, and we have a number of observations in the area of compensation.

C-1. WorkCover Goals Have Been Met

Many workers' compensation schemes are vague about the goals of their public agency. Certainly, the same cannot be said about the Victorian WorkCover Authority and its architects. The legislation that created this new scheme sought to remedy certain perceived problems. Among the objectives were to reduce the number of claims for compensation, to reduce the average period of time for which a worker would collect weekly benefits, and especially to pare back the number of long-term beneficiaries. The WorkCover system has accomplished each of these goals.

Many compensation agencies worldwide have sought to restrain various excesses that resulted in the growth of costs in their programmes. Some have not succeeded in doing so at all, and some have done so only by making their laws overly harsh. Critics of the Government and/or the Authority argue that their goals were accomplished at the expense of injured workers. That controversy certainly cannot be resolved here. However, we did not find that the Authority or the underlying law sought to accomplish system goals by disregarding or trammelling the needs of injured workers. Real improvements in efficiency have been realised in the past several years.

C-2. Elimination of the "Serious Injury" Threshold

The Government made several attempts to plug the various gaps in the serious injury threshold that resulted from certain court decisions, and by the utilisation of psychiatric impairment as an "overlay" in cases of occupational injury (so-called "physical-mental" cases in the vernacular of workers' compensation). The various measures taken to limit the access to "serious injury" were quickly rendered ineffective. With the 1997 amendments, the concept of "serious injury" was dropped for claims arising from injuries that occurred on or after 12 November 1997. After multiple efforts to repair the concept so as to maintain its effectiveness as a screening device, it was decided that an alternative method needed to be employed. This seems to us to demonstrate a rare flexibility in pursuit of policy goals. The rapidity with which this has been done is even more rare among workers' compensation jurisdictions.

C-3. New Approach to Long-Term Cases

A major goal of the 1992 law was to curtail the very long-term utilisation of workers' compensation as a source of income maintenance for those workers who were not seriously injured or totally and permanently incapacitated. The designers of WorkCover believed such individuals would be better off returning to work. The goal of shedding many of the cases inherited from WorkCare and limiting long-term claims arising under WorkCover was met successfully. However, a number of recent changes in the law may result in greater numbers of cases of persons entitled to weekly payments beyond 104 weeks. The elimination of the concept of "serious injury" removes one barrier (albeit not one that proved to be as effective as anticipated) to the extension of benefits beyond 104 weeks. Instead, most disputes over the continuation of weekly benefits beyond 104 weeks will involve a test of whether or not the worker has "no current work capacity and [is] likely to continue indefinitely to have no current capacity." The 1997 act defines these as "medical question[s]," meaning that they can be determined irrebuttably by a Medical Panel.

The courts have resisted the idea that a Medical Panel's finding is binding upon them. There will be litigation in the future over the meaning of "[no] current work capacity" and "suitable employment" (which appears in the definitions of "[no] current work capacity"). Questions will arise over whether the Medical Panel is willing and able to render binding opinions on what are essentially occupational rehabilitation and labour market questions, and whether they can do so in sufficient numbers. There will be disputes over long-term benefits in cases where a worker returns to work for at least 15 hours' work per week and has current weekly earnings of \$100. Heretofore, with access to common law, the parties could use that track as a way to forge settlements over disputes that were really rooted in other matters, such as the 104-week decision. In the absence of the settlement option, other things equal, more long-term cases can be expected. The cost impact of the 1997 law will depend heavily on the VWA's ability to control the incidence of long-term cases. The previous record suggests that they will.

C-4. Access to the Common Law has Been Eliminated

Since 1992, no change has occurred that looms so large and poses more uncertainties for the system than the removal of access to common law for occupational injuries and illnesses sustained after 11 November 1997. In response to the perception of a blowout of costs due to

common-law actions, the door was closed tightly by the Government after a bitter struggle. In addition to the cost motivator, WorkCover system architects felt strongly that common law settlements created perverse incentives for injured workers to remain off work to justify their claim, rather than returning to work as soon as safe and practicable. Large common-law settlements were also seen to create severe equity issues, as equally situated workers are not treated equally in such a tort liability system. The “lottery” aspect of common-law settlements, with one worker receiving a large settlement and another, seemingly just as deserving, receiving little or nothing, was particularly objectionable to the Government.

The abolition of common-law remedies places Victoria in the mainstream of state and provincial workers’ compensation systems, as no system in North America allows common-law access for workplace injuries and illnesses. However, there appears to have been a widely held view within Victoria that access to common law was the right of an injured worker. As such, there are certain to be efforts made to circumvent the statutory change. Representatives of injured workers can be expected to explore every avenue for obtaining benefits and compensation beyond that which is provided for in the Accident Compensation Act at the present time.

Some stakeholders have also expressed concern that removal of access to common law settlements for workplace injury contained in the Accident Compensation (Miscellaneous Amendment) Act 1997 will minimise or eliminate a key motivator for employers to provide healthy and safe workplaces. We believe prevention is driven by a combination of effective media awareness campaigns, occupational health and safety education programmes for workers and employers, and provision of well-resourced inspectorates to monitor workplace health and safety and investigate serious accidents. Financial incentives from effective experience rating programs for employers can also play a significant role. Stringent enforcement of regulatory violations through prosecution and application of administrative or additional assessment penalty systems (or a combination of these strategies) also serve as a deterrent for inappropriate behaviours. Effective education and enforcement systems with stiff but credible penalties provide better motivators for employers than large but infrequent common law settlements.

However, there is reason to be skeptical that the law change has brought about a new equilibrium in workers’ compensation. Previously, the effort to limit access to the common law remedy only to those who sustained a severe impairment was unsuccessful, as were steps to

repair the problems as they appeared. There will be a sizable population of claims to run off as the word gets around that access to common law has ended. Such proceedings must be commenced by 31 December 2000, and can be expected to take two years or longer to resolve beyond that date. So it will take time for these matters to be finally settled. Numerous challenges to the statute can be expected in the courts.

C-5. More Consistency and Comprehensiveness for the Table of Maims

The Table of Maims has played an important role in Victoria's workers' compensation program. However, there were certain anomalies associated with it. Specifically, the rating of impairments of the back, neck, and pelvis was done differently from all other conditions listed in the Table. Second, the *AMA Guides* were required to be used in rating certain impairments but not others. Third, certain conditions, and not simply obscure ones, were not listed in the Table of Maims. Thus, a worker with a compensable respiratory condition, for example, was ineligible to receive a maims benefit.

In the 1997 amendments, each of these issues was dealt with by requiring that almost all permanent impairments be rated according to the *AMA Guides*. This will provide a more consistent method of rating maims, and most impairments will be able to be rated since they are found in the *Guides*. Additionally, this new approach will utilise the current edition of the *Guides* (fourth edition) and not one that has been superseded. This represents another important development in the compensation of permanent disabilities under the WorkCover scheme.

C-6. There Will be Fewer Lump Sum Settlements

Many practitioners in workers' compensation around the world have strongly held views regarding lump sum settlements. Proponents of their use argue that they are needed as a means to resolve those claims with issues that are in dispute. Employees generally appear to prefer receiving benefits in a lump sum rather than in periodic payments that are spread over a long period of time. Workers' solicitors prefer schemes where they can use their skills to negotiate settlements on behalf of their clients, and where they can be paid all their fees in a lump sum. Insurers also seem to prefer to have the option of closing out a claim with a lump sum settlement, despite the suspicion that such payments can have the effect of soliciting "nuisance" claims.

Other observers argue that lump sum settlements that close out claims permit workers to “get on with their lives,” put their injuries behind them, and extricate themselves from the workers’ compensation system.

Some opponents of lump sum settlements argue that there is a sorry history of persons who were unable to successfully manage lump sums or behaved irresponsibly with large windfalls. These persons, it is argued, ultimately will become dependent upon social security or the largesse of Government. Another source of opposition arises from the argument that lump sum settlements are the “bait” that draws dubious claims that might not otherwise be made. It is argued, further, that these lump sum settlements are the source of much of the litigation and delay that sometimes characterises these systems.

In Victoria, the social inequity of large lump-sum settlements was cited by the Government early on in the debate as a rationale for restricting such payments. In addition, it was pointed out that seeking such a settlement was virtually certain to end the relationship with the injury employer, thereby reducing the likelihood of return to work. It was also argued that the transactions costs of such settlements were unacceptably high in comparison with an administrative system like WorkCover.

The WorkCover scheme has consistently aimed to thwart the use of lump sum settlements. However, there were two significant sources of lump sum settlements that existed prior to the 1997 legislation (putting aside death claims and the lump sum payments made under section 115). Common-law cases and payments for maims under Sections 98 and 98A both provided insurers and workers with the opportunity to reach agreements and settle them with lump sums.

There has been rapid growth over time in the size and number of lump sum payments under WorkCover. The elimination of access to the common-law remedy removes one source of lump sum benefits, as such settlements overwhelmingly result from negotiations of the parties, rather than from judgments made by the courts. This represents a very significant change in the manner of doing business for all the parties in the workers’ compensation system of Victoria. It remains to be seen what the ultimate impact of this change will be.

C-7. Terminating Weekly Benefits Under WorkCover

The process of terminating weekly benefits is frequently problematic for a workers' compensation agency. If it is simple for an insurer to unilaterally terminate benefits, it can do serious harm to an injured worker, and places the worker in a very vulnerable position relative to the insurer. By contrast, if terminating benefits is a slow and contentious process for the insurer, it can increase system costs and induce some workers to delay their return to work. Both are common in North American workers' compensation systems.

A key to finding a fair balance is to assure both sides that the system can respond promptly. The Conciliation Service has managed to arrange and conduct conferences very promptly, thereby limiting the difficulties that either side might have to endure from the termination process. The significance of maintaining this access should not be minimised. Most jurisdictions cannot approach the Conciliation Service's record of scheduling and conducting its conferences. While not all disputes are actually resolved, the contribution made to dispute resolution overall is very valuable.

C-8. The Injured Workers' Wage Level May Need Consideration

Weekly benefits under workers' compensation programmes aim to replace a large proportion of the lost earnings of an injured employee. The weekly benefit is based on the employee's pre-injury average weekly earnings (PIAWE). A feature of Victoria's law is that the calculation of the PIAWE takes no account of an employee's pay for overtime, shift differential, hazard duty allowance, or dirt money. For those workers accustomed to earning such payments, their true wage-replacement rate when they are injured is lower than that of a fellow employee who does not regularly receive such earnings.

This situation is mitigated, however, by the existence of industrial awards in many occupations and industries, which provide for the operation of "make-up" pay to the actual pre-injury level, inclusive of allowances. However, these provisions (particularly in relation to their duration) vary considerably across industries, and they do not operate at all in some sectors of the economy. In addition, with the deregulation of the labour market, many awards are being superseded by enterprise bargained agreements. Consequently, it is impossible to tell how significant this issue may be. However, it seems difficult to justify this disparate treatment, even

though it might lead to some administrative savings through simplifying the weekly benefit determination process.

C-9. The AMA *Guides* Play an Important Role in Disability Determination

The 1997 law introduced several significant changes in the determination of benefits for permanent impairments. As a result, all impairments (excluding hearing loss, psychiatric conditions, and chronic pain) are rated according to the AMA *Guides*. Further, the previously used second edition of the *Guides* was replaced by the most recent version, the fourth edition. It will be a challenge to provide suitable training in the use of the *Guides* to a sufficient number of persons in time for their application from 1 September 1998, but the VWA reports that they will have 200 doctors trained by the deadline. Obviously it will take much longer before all system participants become familiar with the new standards.

C-10. An Ever-Greater Role for the Medical Panels

There are several well-established principles regarding the effectiveness of Medical Panels, in Victoria or elsewhere. First, the acceptance of the decisions of Medical Panels by stakeholders of the system depends heavily on the perception of the professional calibre of the panelists and of their objectivity. Second, where Medical Panels contribute to delays in the resolution of disputes, they can create problems in other parts of the system. Prior to the enactment of the 1996 amendments, the Medical Panels in Victoria were heavily overburdened, resulting in serious delays. The number of medical practitioners who are well-regarded and who will serve on Medical Panels is clearly limited in the aggregate, and is especially so in certain specialties and regions.

We foresee that the Medical Panels will need to be limited in their numbers in order to avoid having to draw upon less than very highly qualified persons to serve on them. If their utilisation rises and delays increase, the likelihood of success of the Medical Panel system will fall. One informed Victorian source believes that about 80 panels per month, with an average of about 2.5 doctors per panel, is a realistic capacity maximum at the present time. Beyond that number the quality constraint will become a problem.

There is the potential for extremely high demand for Medical Panels in Victoria, both with regard to evaluating the degree of impairment, and the test of [no] current work capacity. The VWA believes they can control access to the Medical Panels through the insurers. However, the success of the Medical Panel system is critical if the 1997 amendments are to achieve their goals. Careful monitoring and evaluation are needed here.

C-11. Medical and Other (Treatment) Costs Are Growing Rapidly

Payments for medical and like (treatment) services have grown rapidly over the past few years. For example, over the past three years (1994/95 to 1997/98) total payments are up by more than 40 percent. The largest component is the medical practitioner payments, which account for almost 30 percent of these costs and has grown almost 32 percent over the three years. Physiotherapy and private hospital payments, both sizable components of the aggregate, have each also grown by 30 percent or more in the past three years. Growth rates have been highest in some of the ancillary services, such as chemists (up 86 percent) and psychologists (up almost 78 percent) in the past three years. Health care costs are rising rapidly across the country and in other state workers' compensation programmes. The VWA needs to assure the stakeholder community that its cost controls in these areas are adequate and appropriate.

One technique of medical cost control that has become extremely popular in the United States, though not in Canada, is "managed care." Nearly every U.S. jurisdiction has adopted some version of a managed care regime for workers' compensation medical costs in the past decade. Victoria's endorsement of "coordinated care" in the December 1996 legislation was a limited step in that direction. However, it seems likely that there will be additional legislative or regulatory attention needed in this area, particularly given the recent trends in costs of medical and like services.

C-12. Some Dissatisfaction Exists with the Section 112 Examinations

Independent medical examinations have been an important ingredient in the claims process and are likely to remain so. Under the 1997 amendments, for example, if the VWA or an insurer accepts liability for a noneconomic loss claim (section 98C), or if a court determines that such a liability exists, the worker is to be rated by an independent medical examiner (section

104B). The quality of this examination will likely affect the worker's willingness to accept, dispute, the insurer's assessment. This decision, in turn, will affect the need for a Medical Panel to assess the impairment. The VWA must assure itself that these independent examinations are being done competently.

We continue to hear dissatisfaction expressed over the objectivity and professionalism of some of the examiners. We have no empirical basis to evaluate these criticisms. Under section 104B, the importance of these examiners will grow. Indirectly, their work will also affect the ability of the Medical Panels to succeed. That matter aside, the VWA should also review the very substantial costs that it currently incurs for these independent medical examinations.

C-13. On the Role of Lawyers in An Evolving Scheme

In its efforts to reduce the system's transaction costs, the Government has taken a number of steps that were designed to reduce the extent of solicitor involvement in workers' compensation claims. The 1997 amendments extended this and, with the new procedures for dealing with section 98 claims and the phasing out of common law, claimants' lawyers may indeed leave the workers' compensation arena. Were that to materialise, an issue would arise regarding the need to provide qualified assistance to workers with claims. For example, it is understood that the processing of the needed materials for a future section 98 dispute will not be a simple matter for an inexperienced person. For this reason, a WorkCover Advisory Service for employees and for smaller employers is being developed. Other jurisdictions have used such services with mixed results. It is incumbent on the Government to insure appropriate access to the system for all Victorians. Workers' compensation remains a difficult system for the injured worker to negotiate.

Rehabilitation Issues (R)

Occupational rehabilitation in Victoria has a narrower and more constrained focus than in many other jurisdictions. This results in large part from the perceived excesses under the WorkCare regime from 1985–1992. Accepting this reality, we find there are also a number of issues in the occupational rehabilitation area that warrant attention.

R-1. Focus on Return to Work

Since WorkCover took over responsibility from WorkCare, some of the greatest changes to the scheme have occurred within the rehabilitation area. The VWA's success in changing expectations of both workers and employers toward early return to work is remarkable. As well, physicians and occupational rehabilitation providers now appreciate the importance of a timely return to work. The VWA has been remarkably effective in getting this key message across in its policies, media campaigns, and dealings with stakeholders. They have achieved a return-to-work focus second to none.

R-2. Rehabilitation as an Employer Responsibility

More than any other factor, the commitment between the employer and the worker will determine the success of rehabilitation. Employers in Victoria generally accept that they are responsible for returning workers to their employment. Many medium- and large-sized employers have very effective early intervention, case management, and return-to-work programmes. Insurers, large and small, are developing rehabilitation expertise to advise and consult on rehabilitation matters. In many ways, the policies of the VWA have operationalised the ideals of the disability management movement.

The effectiveness of such policies, however, is constrained in certain circumstances. Small enterprises, in particular, have struggled with rehabilitation issues and mandatory reinstatement laws. The size of an enterprise will inherently limit its flexibility to accommodate workers with disabilities. The relative infrequency of injury and disease for smaller employers (simply because of their size) also limits the opportunity of smaller enterprises to become familiar with occupational rehabilitation concepts and their use in coordinating an effective and timely return to work. Additional attention is needed in regard to smaller employers attaining the return-to-work goal as well.

R-3. Return-to-work Coordinator

The return-to-work (RTW) coordinator strategy works best in medium to larger firms, where the frequency of injury allows for the development of internal capability through

experience. This has proven true in the North American context as well. For firms with few accidents, the challenge of proficiency for RTW coordinators is very significant.

The lack of sufficiently skilled RTW coordinators may adversely affect rehabilitation outcomes, either through delay in recovery or through inappropriate early return to work. The experience rating and employer excess provisions of the scheme also may make training investments for RTW coordinators less attractive. To be effective, the delivery of training should be close to the time when such skills will be used. Wherever there is an infrequent need for such specialised skills, as with small employers, it may be more effective to encourage access to a rehabilitation professional.

R-4. Hard Costs and Soft Benefits

From the firm perspective, “hard cost” expenditures on RTW coordinator training or other occupational rehabilitation activities are real and immediate. The “soft benefit” of savings in terms of reduced injury severity and lower human suffering are distant and abstract benefits that do not easily translate to the bottom line. The VWA has taken the first step in overcoming this problem by returning to the injured worker limited rights of self-referral to occupational rehabilitation assistance, since the worker is in a better position to evaluate the benefits or at least to raise the question of long-term outcome.

Other adjustments to the scheme, such as removing some expenditures for occupational rehabilitation assistance from the experience rating formula (making the initial costs of rehabilitation a pooled rather than a rated expenditure) may foster earlier intervention and further assist in ensuring long-term success in meeting the return-to-work objective. This area needs additional work if the VWA is to achieve the disability management ideal.

R-5. Case Management for the Severely Disabled

For the long-term severely disabled workers, improvement in independence, avocational rehabilitation, and quality of life issues are important and continuing needs. Often, the rehabilitation objectives are to increase independence, reduce or eliminate drug dependencies, and maintain workers in the highest enabling environment possible. These persons may face mobility challenges and systemic barriers to achieving their highest potential. Some of these

barriers are accentuated by medication overuse, chronic pain, or depression. Case management techniques offer the greatest opportunity to serve this client group effectively. Some efforts to identify, treat, and provide for these workers through the insurers have been initiated. However, the need for a central case management role appears also to have been recognised by the VWA.

Existing social and community health centres may provide an effective delivery mechanism for some of these services. The VWA has made a good start in enlisting such not-for-profit agencies in the effort to assist individual workers with their rehabilitation needs. However, such programmes should not be held to the sole standard of evaluation of the number of job placements, since they are dealing with a much wider range of personal issues.

We believe that additional thought needs to be given to the most effective way to manage these cases. Further refinement to the guidelines (perhaps through stakeholder advisory groups) for mobility expenditure, access to pain clinics, the funding of home maintenance and independent living initiatives, and avocational training will help bring greater consistency of service to this group of severely injured workers.

R-6. Measured Outcomes and Research

Measurement and evaluation in rehabilitation are always challenging. There is a temptation to reduce each case to its dollar equivalent in expenditures, or to measure success purely in terms of initial return-to-work rates. In many cases, rehabilitation success must be measured in increments far removed from the ultimate return-to-work goal. Where data exist, as with the WISE programme, the level of utilisation of rehabilitation programmes appears low in Victoria. The measurement of expenditures, when reduced to some form of contact hours between client and occupational rehabilitation provider, also reflects lower than expected levels.

In addition, there is little in the way of analysis of the factors that might signal an earlier intervention. For example, the fact that a worker has had several previous back claims may be an important factor in determining the type of rehabilitation intervention necessary. There is no formal mechanism to flag such a case for early intervention, or to bring forward information regarding medical or rehabilitation interventions on previous cases that might be indicative of either successful approaches or blind alleys.

The record of the VWA in funding research on rehabilitation demonstrates a long-term commitment to improving measurement and outcomes. The VWA is uniquely placed to provide a rich source of data that can contribute to both prevention and rehabilitation goals. The design and integrity of the database and data-capture systems are critical investments that can assist in answering fundamental questions for Victoria.

R-7. Rehabilitation Provider Issues

The VWA plays a pivotal role in the rehabilitation professions in Victoria. The standards it sets for services will have an impact on the community at large. The existing dedicated internal rehabilitation administrative staff, the advisory and peer review committees, and the meetings with provider groups could form the institutional structure for a continuous improvement model. The VWA has a vested interest in fostering the professional development of the medical and rehabilitation community.

The hybrid public–private system that exists in Victoria poses particular policy and monitoring problems in medical and occupational rehabilitation. While occupational medicine has recently gained acceptance as a medical specialty, the expertise of occupational medicine and occupational providers is still treated more like a commodity than a professional service. The practice of service-provider substitution (where an insurer diverts the referral by a physician to a particular treatment programme or occupational rehabilitation provider to another provider) was widely reported. It is not documented that this practice has been detrimental to any individual worker, but the practice is not supportive of professional values. The vertical integration of some insurance carriers with wholly owned rehabilitation subsidiaries and the ownership of rehabilitation facilities by medical practitioners may exacerbate the problem. This raises an important policy question for the VWA: what guidelines or restrictions, if any, should exist for the referral of VWA cases to enterprises or facilities where the referral agent has a pecuniary interest in the referral?

Prevention (P)

The mandate of the VWA to prevent workplace injury and disease—and in some cases provide for the safety of the general public—is a daunting one, even if the resources to deliver

such services were fully sufficient. Many of these attention points are targeted towards improving the utilisation of the resources of the Field Services Division (FSD) dealing particularly with the efficiency and effectiveness of providing field services. The logic is that the organisation must be able to demonstrate maximum effect from the existing resource and strategies before it can be determined whether the resource level is appropriate.

P-1. Potential Synergies

We commend the HSD on its programmes, several of which represent cutting-edge strategies in this field. The management of the division is visionary, energetic, highly educated, and experienced in occupational health and safety (OHS) matters, and firmly committed to the challenge of reducing workplace injury and disease in Victoria. The merger of HSD with VWA provided a historical opportunity for the Division to develop new synergies within the organisation and leverage the resource potential. As experienced OSH professionals, the division management exhibit a strong belief that workplace injuries and illnesses are preventable.

VWA is to be further commended on its investment in extremely aggressive and successful outreach programmes based on sound research. These include initiatives such as the “Operation Safety” pilot in the Ballarat Region, the TruckSafe programme, the dissemination of best practices and practical solutions through the SHARE programme, and the SafePlant training package. Both employers and labour expressed their support of these initiatives and provided suggestions for future efforts.

P-2. Management Structure

The Divisional management has been flattened since the merger. It needs to be noted that group managers and field officers appear to be struggling with the pace of change. FSD should consider utilising the services of a change management consultant to assist Managers, team leaders, and officers to understand the personal reaction to change, the behaviours that can be expected, and equipping them with coping mechanisms. Group managers appear to be most affected by the change at this point. The swift conversion to a flattened organisation structure may have left the group managers/team leaders with insufficient capacity to manage the

implementation of the new strategic plan. Consideration should be given to adding some capacity to this management level, at least until the changes have become embedded.

P-3. Human Resource Skill Adjustments

The adjustment of the Division's human resources to the 1985 change from a standards-enforcement approach to a performance-based approach is not yet complete. We heard this from employers, inspectors and their managers, and informed outsiders. The division needs to evaluate whether each individual inspector's skills match a performance-based regulatory approach that promotes the use of best practices and a systems approach to managing safety. Retraining or replacement may be necessary to effect a change in service delivery that matches the requirements of the legislation. There is far more tertiary-level education available in health and safety matters than there was a decade ago in Victoria, so FSD has the potential to retrofit the human resource skills needed. However, compensation levels may need to be reevaluated in light of the specific skill sets required.

P-4. Resource Allocation

The Division might benefit from reevaluating the need for the significant resources invested in the development of the various procedure manuals. The volume and detail of these appear to have been excessive and incompatible with a performance-based regulatory approach. VWA has recognised this and has taken steps to limit these measures.

P-5. Community Collaboration

The Development Task Force has an opportunity to drive significant and durable improvement in the prevention of injury and disease in both the workplace and communities. Serious consideration should be given to continuing this effort, with a rigorous impact evaluation plan set for a certain date. Victoria is developing a wealth of private and public resources that can be enlisted to help with the prevention mission on a cost-effective basis. More use can be made of these resources. VWA and FSD also might build more collaborative relationships with

the State Coroner's Office, which possesses a wealth of information on occupational disease and injury causality. That could drive the development of targeted interventions and research efforts.

P-6. Service Quality Assurance

Service quality needs to be monitored regularly through surveys of employer and worker communities. It is particularly important in a regulatory environment that customers feel free to give their unfettered opinion. A random, anonymous survey conducted by an independent entity is the most reliable way of gathering information on service quality.

P-7. Specialist Skill Deployment

In light of the proliferation of new chemicals introduced into the workplace each year and the unknown long-term effects of exposure to combinations of them, the FSD requires an active worksite presence of trained industrial hygienists. Recently, FSD has deployed some hygienists in the field as inspectors, an important measure to assure greater health and safety at the workplace.

Manual handling injuries represent more than 50 percent of work-related injuries in most countries. This staggering number suggests a far greater proactive role for ergonomic expertise to assist at the workplace in identification and assessment of hazards. FSD should consider ways to enhance and deploy these resources as well, so that they can be more effective in delivery of monitoring and assessment services in the field.

P-8. Inspector Support

Each inspector needs a dedicated vehicle. This would maximise field inspection time and promote prompt, quality service to workplaces. The ability to begin their workday from home and return directly home at the end of the day, as well as being field-active for 9 of 10 working days, is essential to maximising the impact of these individuals. An added bonus is the ability of inspectors to carry brochures, pamphlets, posters, and other information they now advise employers to obtain by calling the information officers. Each inspector also should be provided with a laptop computer and portable printer. When combined with a dedicated vehicle and

cellular phone, the inspector essentially has a fully mobile office. Some jurisdictions in North America have successfully utilised this concept to make the inspector's contact with workplaces more effective, and to significantly extend the inspector's resources in the field.

P-9. Other Resource Allocation Issues

A significant effort is involved with the monitoring and inspection requirements of the prescriptive Dangerous Goods Regulations. The national uniformity process seems stalled in delivering a new model, although it is far enough along that the outcome may be approximated. VWA may want to consider moving ahead with policy revisions to achieve performance-based regulation on its own, with a view to synchronising with the national model when it becomes available.

VWA should also review the significant resource deployed in prosecutions, particularly in light of the generally held view that the deterrent effect is minimal. For example, prosecutions might be scaled back to cover only willful and blatant violations where workers are injured or killed. A swifter and financially more punitive approach likely could be developed in the form of an administrative penalty system.

P-10. Information Sources

A toll-free OHS information call-centre could be developed which would provide timely advice and answers to questions from the public. A few well-trained staff with access to computer information sources such as chemical safety data sheets, regulations, codes of practice, standards, etc., should be able to handle up to 80 percent of the calls. Those requiring special expertise or a field inspector could be routed to the appropriate person, perhaps via electronic mail. In addition to supporting the performance-based regulatory approach, such a facility creates good public relations for the agency when it is done effectively.

The division could also develop a series of industry specific, user-friendly guides to the regulations and codes that are written in plain language and offer practical solutions. These should be targeted to small business. For example, a guide to health and safety for an office employer or a small retail or wholesale trade employer would sift out the key hazard prevention

sections from the stack of regulatory documents and provide practical examples of how to deliver a safe and healthy workplace.

P-11. Internal Communication and Consultation

Mechanisms to improve internal communication and consultation that effectively reach and involve the FSD field officers are needed. Delivery of a consistent message to the field staff level is a common problem in health and safety regulatory organisations and difficult to achieve. The efforts by FSD senior management and the VWA executive to regularly tour the regional offices and make field trips with officers demonstrates a strong commitment to communicating the mission, values, and vision. Over the longer term it will achieve the desired results; but in this difficult transition period, extraordinary efforts to communicate are justified.

P-12. Stakeholder Input

Employers and especially unions express a strong desire for an advisory/consultative role with FSD. A concerted effort should be made to understand the issues and perceived service delivery failures expressed by organised labour and their workplace representatives. FSD should consider meeting at monthly intervals with employer and union representatives to revitalise lines of communication and to share the VWA vision, direction, and objectives with stakeholders.

P-13. A Review of SafetyMap is Needed

Despite some expression of enthusiasm earlier, employers now suggest a review of SafetyMap. Some employers find that the certification process requires a significant investment of resources in paper documentation, exercises that do not add value by improving health and safety at the workplaces. This may be the reaction of enlightened employers whose track records demonstrate a strong commitment to high standards for health and safety management. However, the VWA should consider whether it may be time for a general review of the SafetyMap process.

P-14. Systems, Data, Targets

It is still too early to assess the introduction of the new information management system, the deployment of lap top computers to field staff, and the development of focused field activity on the most challenged workplaces and predominant injury types. However, these strategies have been utilised successfully elsewhere, and should deliver enhanced service delivery, more effective resource utilisation, and further reductions in injury claims. It is also clear that each of these initiatives will require thoughtful implementation plans and schedules that recognise the difficulties that some in the field will have in adapting to the change.

P-15. Fine-Tuning Performance Measurement

The targets for field activity are currently set to measure the on-site time. Consideration should be given to including travel time in the measure of workplace visits, or adjusting the targets for workplace visits in rural regions. Urban workplaces have a smaller travel component. There is substantial discussion internally about the ability to achieve the workplace targets. The emphasis should be placed on keeping the officers in the field for the full 7.5 hours each day for at least 9 out of 10 days. Once the field staff are fully equipped with laptop computers, the new information system is operating, and officers develop a higher level of self confidence in their ability and decision making, FSD should see significant gains in field-active time. However, it is advisable not to set targets that are too aggressive until these systems are in place and the field staff is adept at using them.

Field officer performance measurement systems are also being developed by the Operations Planning unit. The staff is naturally suspicious of the way in which this system will be used in monitoring their activity. Consideration should be given to placing emphasis on this as an effectiveness gauge and a planning tool for the Division, as opposed to a measurement tool for individual performance.

General (G)

We conclude with a set of observations that relate to the general approach and the accomplishments of the VWA over the period from late 1992 to the present.

G-1. Amazing Transformation

In just a few short years, the VWA has transformed a workers' compensation system characterised by a "compo" philosophy, uncontrolled claims incidence, excessive durations of disability, and runaway costs. The picture that emerges from our review is of a system that is aiming to attain stability at a level of performance that would have been unimaginable a decade ago. Claims are down substantially, durations have been significantly reduced, the incidence of long-term claims has been cut considerably, and system costs are at the lowest level in Australia. The system is nearly fully funded compared to a substantial unfunded liability under the last full year of WorkCare.

The WorkCover scheme has succeeded in achieving the goals its architects set for it in 1992. Further, it has accomplished these remarkable goals in the face of a lukewarm economic environment, with relatively high unemployment levels and stagnant real wages, without an increase in administrative costs or substantial growth in staff. This is a remarkable achievement, and credit is due both to the system's legislative architects and its administrators.

We believe that Victoria has blazed a new trail and created a "third way" for workers' compensation systems. The blend of public underwriting and scheme regulation with private claims administration and service delivery is a model worthy of attention from other jurisdictions.

However, it is not uncommon in workers' compensation, or in other large social systems, to find that holding on to one's achievements is at least as difficult as initially attaining them. As of mid 1998 we see no evidence of this in the system. Nor do we find a system that has attained equilibrium; the workers' compensation system in Victoria is still evolving in very significant ways.

G-2. Cultural Change through Media

We are not aware of any other workers' compensation system in the world that has used media more aggressively or more effectively than has the VWA. Their fundamental faith in the power of the media to effect a change in the "compo" culture that characterised Victoria's workers' compensation system previously has paid off in a major way. From injured workers and their employers to the doctors and other medical practitioners that treat them, the VWA has

changed the expectations that participants have about the system. The media strategy of the VWA has been a leading element of this change. The merger with HSD has provided the opportunity to carry the media message into new areas, such as the major initiative in prevention to persuade the public and the employer–employee community of the need for workplace safety. Together with the programme designed to encourage practices to protect workers from back injuries, VWA is aiming to derive important synergies from its absorption of the HSO.

G-3. Stakeholder Input

Our interviews revealed that labour and management, as well as other stakeholders, have perceived a problem over consultation with the VWA and policymakers. The complaint has been that the “consultation” resembles a “briefing” on what the VWA or the Government has already decided to do. We believe the system in Victoria has matured sufficiently that further improvements will depend upon participation and ownership by stakeholders. Thus, it seems that it is time to move to a more open, consultative policy development process. This does not mean that VWA management abdicates its decision-making responsibility, but rather that they recognise the legitimate self-interest of stakeholders and allow for the input of those viewpoints before critically important decisions are made. While it may take a little longer, this will lead to more durable decisions and sounder policy judgments in the long run.

G-4. Historical Opportunity

While much has been accomplished, this is not the time for the VWA to rest on its laurels. After six years, it is apparent that the time is now ripe to rebalance the system and carefully adjust the various facets so that they reinforce each other to accomplish both strategic and tactical objectives. The merger of the former HSO and the VWA in 1996 created a historical opportunity for a thorough and careful rethinking of system parameters. Bringing the mission and operations of HSD into the VWA has not been easy, but with time it can be done in a way that furthers the Victorian achievements and sets a standard for the rest of the world.

G-5. How Benefits are Perceived in Victoria

The changes begun with the Accident Compensation (WorkCover) Act in 1992 have totally reconfigured Victoria's workers' compensation programme. How will history evaluate those changes? One obvious benchmark of programme success would be if the scheme's major features survive into the future, even were the Government to change. Certainly, subsequent Governments would be ill advised, politically and otherwise, to revamp a successful programme. Similarly, history tells us that a failed workers' compensation programme will be high on the list of areas that would be substantially restructured by a new Government.

It is not our task to predict when and how WorkCover will be evaluated in the political arena. We recognise here the impressive accomplishments of the programme since its inception. However, we also sense one area that must be given more attention if the programme is to succeed in the long run, at least by the criterion of its staying power. The public at large must believe that the scheme is delivering benefits that are adequate and equitable, as well as affordable. With the revisions made in the 1997 amendments to weekly payments and to section 98 benefits, with the elimination of section 98A benefits (pain and suffering in maims cases), and with the ending of access to common law for injuries after 12 November 1997, the public's opinion of the programme's fairness may have shifted.

We are aware that the actuaries who assisted in the redesign of the weekly benefit scheme were told to aim for a cost neutral outcome, and that this may well have been obtained. It is clear, for example, that eliminating noneconomic loss benefits for persons with impairments rated at less than 10 percent allows greater levels of benefits to be paid to those with higher levels of impairment. Still, the WorkCover programme's fairness was aggressively attacked in the debates that preceded the 1997 amendments.

If our assessment is correct, at least two things need to be considered over the near term. First, any future proposals for change in the WorkCover system should be scrutinised for the likely public response to them on the issue of "worker fairness." Second, the VWA needs to evaluate the actual consequences of the recent changes so as to demonstrate that they have not been too harsh on injured workers. Further, benefits can continue to be compared with those paid in other states to demonstrate that Victoria is no less generous than its peers.

There seems to be a current perception, certainly within organised labour, that the WorkCover scheme has been captured by employer interests, and that workers are forced to

“hang on” and endure a system that is inimical to their interests. Such a perception clearly undermines public confidence in a workers’ compensation system and will ultimately lead to periodic policy fluctuations, as one side and then the other gains the political majority. But the system that cares for injured workers and their families is too important to become a political football. The protection offered by workers’ compensation and other social insurance schemes is fundamental to a democratic society. We applaud the spirit of Minister Hallam’s statement, “The true test of our policies will be if they survive the next change of Government.” The workers and employers of Victoria deserve no less.

Table A-1

	A	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S
1		1987/88	1988/89	1989/90	1990/91	1991/92	1992/93	1993/94	1994/95	1995/96	1996/97	1997/98	10-Yr	% Change	% Change	% Change
2													Change	Per Year	from	Per Year
3													(%)		1991/92	
4	Average Employment (thousands, persons) ²	1,934	2,023	2,139	2,018	1,953	1,945	1,966	2,019	2,079	2,098	2,134	10.3	1.0	9.3	1.5
5	Unemployment Rate ² (%)	9.6	4.9	4.9	8.9	11.0	11.9	11.5	9.4	8.4	9.0	8.1	-15.6	-1.7	-26.4	-5.0
6	Total Wages Excluding Commonwealth (\$, million) ²	32,727	36,395	40,256	40,460	41,384	42,727	42,321	46,358	48,742	51,703	54,035	65.1	5.1	30.6	4.5
7	Consumer Price Index ² (%)	7.1	7.6	7.8	6.9	1.5	0.3	1.9	2.5	5.1	1.5	-0.2				
8	Average Weekly Earnings - Values ² (\$)	414.90	442.20	476.20	485.90	504.40	519.80	534.50	558.50	570.00	572.70	596.30	43.7	3.7	18.2	2.8
9	- Yearly change (%)	5.3	6.6	7.7	2.0	3.8	3.1	2.8	4.5	2.1	0.5	4.1				
10																
11	Statutory Maximum Weekly Benefits ¹ (\$)	457	481	506	550	575	603	603	621	650	664	680	48.8	4.1	18.3	2.8
12	Average Weekly Benefits (\$)	287	297	305	311	318	318	326	354	374	383	391	36.2	3.1	23.0	3.5
13	Claimants in Receipt of Weekly Benefits During Year	88,784	93,823	88,388	81,836	71,817	61,773	38,704	35,768	33,535	37,191	36,826	-58.5	-8.4	-48.7	-10.5
14	Table of Maims Payment - Statutory Maximum ¹ (\$)	70,620	74,260	78,100	84,840	88,750	93,080	93,080	95,810	100,300	102,460	104,900	48.5	4.0	18.2	2.8
15	Table of Maims Average Payment ³ (\$)	5,856	7,128	7,268	7,857	8,523	7,324	7,111	10,774	15,465	18,827	21,006	258.7	13.6	146.5	16.2
16	Claimants in Receipt of Table of Maims Payment	2,724	3,474	4,779	6,012	7,169	10,924	11,004	8,391	7,541	7,701	7,024	157.9	9.9	-2.0	-0.3
17	Statutory Maximum WorkCover Common Law - Pecuniary Loss ^{1,4}	N/A	N/A	N/A	N/A	N/A	671,760	671,960	691,650	724,070	739,690	757,930				
18	Statutory Maximum WorkCover Common Law - Nonpecuniary Loss (\$)	N/A	N/A	N/A	N/A	N/A	298,640	298,640	311,770	326,380	333,420	341,640				
19	Average WorkCover Common Law Settlements (\$)	N/A	N/A	N/A	N/A	N/A	-	-	-	158,705	190,649	198,785				
20	Number of WorkCover Common Law Settlements	N/A	N/A	N/A	N/A	N/A	-	-	-	113	733	1,014				
21	Statutory Maximum WorkCare Common Law - Nonpecuniary Loss ⁵ (\$)	140,000	147,210	154,810	168,390	176,150	N/A	N/A	N/A	N/A	N/A	N/A				
22	Average Common Law Settlement - Total Loss ² (\$)	11,706	13,738	14,913	15,935	22,216	22,832	21,216	26,484	47,751	52,070	53,309	355.4	16.4	140	15.7
23	Number of Common Law settlements - Total Loss	295	714	1,770	3,471	4,941	10,529	5,270	4,444	1,720	619	107	-63.7	-9.6	-97.8	-47.2
25	Statutory Maximum Settlement for Death ¹ (\$)	N/A	N/A	100,000**	108,640	113,640	119,180	119,180	122,670	128,420	131,190	175,000			54	7.5
26	Average Settlement for Death ² (\$)	47,506	52,204	57,859	62,366	72,417	73,006	87,755	97,509	93,669	85,806	88,884	87.1	6.5	22.7	3.5
27	Number of Settlements for Death	147	248	246	222	227	144	90	72	95	117	126	-14.3	-1.5	-44.5	-9.3
28																
29	Claims															
30	Weekly Benefit Claims (Claims lodged in period that have received weekly benefits)	53,203	56,246	51,166	48,463	43,384	30,613	15,543	15,852	16,894	16,429	12,741	-76.1	-13.3	-70.6	-18.5
31																
32	¹ Maximum payment available as compensation for head of damages as specified and indexed annually in the Accident Compensation Act															
33	² Source - Australian Bureau of Statistics - Employment Surveys		** Statutory maximum death benefit for widows was set at \$100,000 from 5/3/90													
34	³ Total payments for head of compensation divided by number of claimants in receipt of compensation during whole or part of period															
35	⁴ Pecuniary loss entitlement exists only after 1/12/92															
36	⁵ Common Law nonpecuniary settlements under WorkCare are only available for injuries prior to 1 December 1992															
37																
38																

[illegible]

Table A-2
1996 Interviews

Victorian WorkCover Authority

Andrew Lindberg, Chief Executive
Jane Barnett, Provider Liaison Officer, Insurance Branch
Allen Beacom, Industry Manager, Building and Construction Branch
Stephen Bourke, Manager, Personnel and Industrial Relations
Doug Campbell, Acting Manager, Health and Rehabilitation Branch
Sue Chambers, Actuarial and Statistical Services, Scheme Development
Brian Cook, Director, Scheme Development
Steve Cummins, Manager, Self-Insurance Regulation
Richard Fuller, Executive Officer
John Gillespie, Manager, Legislation Scheme Development Division
Ursula Hauser, Business Analysis, Scheme Development
David Hopkins, Telephone Operator
Lorraine Johnson, Director, Information Services
Joe Maher, Corporate Planning, Scheme Development
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References Cited

- Accident Compensation Commission, *Annual Report*. Various years. Melbourne: Government Printer.
- Asher, Robert. 1971. *Workmen's Compensation in the United States, 1880–1935*. Ph.D. dissertation, University of Minnesota.
- Barth, Peter S. 1985. *Resolving Occupational Disease Claims: The Use of Medical Panels*. Cambridge, MA: Workers Compensation Research Institute.
- Barth, Peter S., and Michael Niss. 1999. *Permanent Partial Disability Benefits: Interstate Differences*. Cambridge, MA: Workers Compensation Research Institute.
- Berkowitz, Monroe, and John F. Burton, Jr. 1987. *Permanent Disability Benefits in Workers' Compensation*. Kalamazoo, MI: W.E. Upjohn Institute for Employment Research.
- Board of Inquiry Into Workers' Compensation Report. 1977. (Judge C. W. Harris, Chairman) Melbourne: Government Printer (March).
- Boston Consulting Group. 1992. *Benchmarking Best Practice: Cost Drivers in Australian Workers' Compensation Systems*. Best Practice Research Program Policy Research Paper No. 1." Boston Consulting Group (July).
- Boston Consulting Group. 1992. "Best Practice Research Program Policy Research Paper No. 2." Boston Consulting Group (September).
- Boston Consulting Group. 1996. "Workers' Compensation in Victoria: Case Study of a Major Turnaround." Boston Consulting Group (February).
- Burstein, P. 1996. *Benchmarks for Designing Workers Compensation Medical Fee Schedules*. Cambridge, MA: Workers Compensation Research Institute.
- Campbell Research and Consulting. 1996. "Return to Work: A Benchmark Comparison of South Australian and Victorian Return to Work Rates." Campbell Research and Consulting (July).
- Clayton, Alan. 1986. "Attack Upon the Citadel: Reform of Australia's Anti-rehabilitative Statutes." *Journal of Occupational Health and Safety-Australia and New Zealand*. 3:4, 351–64.
- Clayton, Alan. 1996. "The Structure and Operation of Occupational Disability Arrangements" in John Urbano and Alan Clayton, *Review of International and Jurisdictional Best Practice in Return to Work*. Canberra: Comcare Australia.

- Committee on Health and Safety at Work. 1972. *Health and Safety at Work Report of the Committee 1970–1972*. London: HMSO, para. 41.
- Considine, Mark. 1991. *The Politics of Reform: Workers' Compensation From Woodhouse to WorkCare*. Centre for Applied Social Research, Deakin University (Deakin Series in Public Policy and Administration, No. 1).
- Creighton, Breen, and Peter Rozen. 1997. *Occupational Health and Safety Law in Victoria*, 2nd Edition. Sydney Federation Press.
- Deloitte Touche Tohmatsu. 1994. Report to the Minister for Industry Services—Review of the Health and Safety Authority. Melbourne (July).
- Department of Employment and Industrial Affairs, Working Environment and Policy Division. July 1985. *Review of Occupational Health and Safety Agreements*.
- Doran, Jennifer. 1985. "Implementing the Victorian Government's Policy on Occupational Health and Safety - 1982-1984" in Breen Creighton & Neil Gunningham (eds) *The Industrial Relations of Occupational Health & Safety*. Sydney: Croom Helm Australia, p. 138.
- Foenander, Orwell De R. 1956. *Developments in the Law Governing Workers' Compensation in Victoria*. Melbourne: Law Book Company.
- Fulton, Jane, and John Atkinson. 1993. *Medical and Rehabilitation Programs in Workers' Compensation: An Administration Inventory in British Columbia*. Richmond, British Columbia: Workers' Compensation Board of British Columbia.
- Gadiel, David, and Lee Ridoutt. 1995. "A Review of the Occupational Rehabilitation Services Industry in Victoria," *Health Care Intelligence* (December).
- Hagan, James. 1964. "Employers, Trade Unions and the First Victorian Factory Acts." *Labour History*, 7: 3–10.
- Heads of Workers' Compensation Authorities. 1996. *Promoting Excellence: National Consistency in Australian Workers' Compensation*. Final and Interim Reports to Labour Ministers' Council, May 1997.
- Hunt, H. Allan. 1992. *Workers' Compensation Board of British Columbia: Assessment Department Administrative Inventory*. Richmond, British Columbia: Workers' Compensation Board of British Columbia.
- Hunt, H. Allan, Peter S. Barth, Terry Bogyo, Alan C. Clayton, Robert W. Klein, and Ralph W. McGinn. 1997. *Victorian Workers' Compensation System: Review and Analysis*, Vol I. Kalamazoo, MI: W.E. Upjohn Institute for Employment Research.

- Hunt, H. Allan, Peter S. Barth, Alan C. Clayton, and Ralph W. McGinn. 1998. *Victorian Workers' Compensation System: Review and Analysis*, Vol II. Kalamazoo, MI: W.E. Upjohn Institute for Employment Research.
- Hunt, H. Allan, Peter S. Barth, and Michael J. Leahy. 1991. *The Workers' Compensation System in British Columbia: An Administrative Inventory at a Time of Transition*. Richmond, British Columbia: Workers' Compensation Board of British Columbia.
- Hunt, H. Allan, Peter S. Barth, and Michael J. Leahy. 1996. *The Workers' Compensation System of British Columbia: Still in Transition*. Richmond, British Columbia: Workers' Compensation Board of British Columbia.
- Hutchins, B. L., and A. Harrison. 1948. *A History of Factory Legislation*. London: Frank Cass (1926); reissued 1966.
- Industry Commission Report. 1994. *Workers' Compensation in Australia*, Report No. 36, p. 99.
- Industry Commission Report. 1995. *Work, Health and Safety. Inquiry into Occupational Health and Safety*. Report No. 47. Canberra: Australian Government Publishing Service.
- Klein, Robert W., Eric C. Nordman, and Julianne L. Fritz. 1993. "Market Conditions in Workers' Compensation Insurance." Interim Report, National Association of Insurance Commissioners, Kansas City, MO.
- Moore, Ray. 1995. *The Role of General Practitioners in WorkCover*. Melbourne: Victorian WorkCover Authority (November).
- Parsons, Tasman George. 1972. "Alfred Deakin and the Victorian Factory Act of 1885: A Note." *Journal of Industrial Relations*, 14: 206–208.
- Report of the Committee of Enquiry Into the Victorian Workers' Compensation System* (Cooney Report). 1984. Melbourne: Government Printer.
- Report of the Inquiry into the Feasibility of Establishing a System for the Rehabilitation of Injured Workers in New South Wales*. 1970. Workers' Compensation Commission of New South Wales (Judge A.T. Conybeare, QC). Sydney: Government Printer, at p. 1.
- Rest, Kathleen M., and Nicholas A. Ashford. 1992. *Occupational Safety and Health in British Columbia: An Administrative Inventory*. Richmond, British Columbia: WCB of British Columbia.
- _____. 1997. *Occupational Health and Safety in British Columbia: An Administrative Inventory of the Prevention Activities of the Workers' Compensation Board*. Richmond, British Columbia: WCB of British Columbia.

- Sdrinis, Jeanette. 1995. *VTHC/VWA Rehabilitation and Return to Work Project Identifying the Barriers to Effective Rehabilitation and Return to Work of Injured Workers, Final Report and Recommendations*, Melbourne, Victoria (May).
- Searle, Geoffrey. 1971. *The Rush to be Rich: A History of the Colony of Victoria 1883–1889*. Melbourne: Melbourne University Press.
- Simmonds, Jim, the Minister for Employment and Training, Press Release, 9 October 1984.
- Tanabe, Rachel. 1998. *Managed Care and Medical Cost Containment in Workers' Compensation: A National Inventory, 1998–99*. Cambridge, MA: Workers Compensation Research Institute.
- Thomas, M. W. 1948. *The Early Factory Legislation*. Leigh on Sea: Thomas Bank Publishing.
- Varian, Hal R. 1992. *Microeconomic Analysis*. 3rd ed. New York: W.W. Norton & Company.
- Victoria - Workers' Compensation Reform: Government Statement*. 1984. Economic Strategy for Victoria Statement No. 5. Melbourne: Government Printer (December).
- Victorian Auditor-General's Office: Report on Ministerial Portfolios. May 1984.
- Victorian WorkCover Authority, Annual Report*. Various years. Melbourne: VWA.
- Victorian WorkCover Authority Claims Manual*. (Various revision dates). Melbourne: Victorian WorkCover Authority.
- Victorian WorkCover Authority. "Community Based Return-to-Work Projects: Policy Guidelines - Return to Work Services," a companion document to the "Guidelines for Applicants 1995/96 Funding."
- WorkCare: Government Statement. 1987. Melbourne: Government Printer (July).

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