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Victorian Workers' Compensation System: Review and Analysis, Volume I

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W.E. UPJOHN INSTITUTE for Employment Research

VICTORIAN WORKERS’ COMPENSATION SYSTEM: REVIEW AND ANALYSIS

Volume I

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Table of Contents

ACKNOWLEDGMENTS ................................................................................................................... ii

EXECUTIVE SUMMARY ........................................................................................................... xiii

1 INTRODUCTION ...................................................................................................................... 1-1
   Background and Motivation ................................................................................................. 1-1
   The Scope of the Study ...................................................................................................... 1-4
   Research Approach ........................................................................................................... 1-5
   The Act and Its Implementation ......................................................................................... 1-5
   Data Collection .................................................................................................................. 1-6
   Interviews ......................................................................................................................... 1-6
   Reconciliation .................................................................................................................... 1-8
   Organisation of the Report .................................................................................................. 1-8
   Victoria’s Industrial and Employment Profile ..................................................................... 1-9

2 BACKGROUND TO THE VICTORIAN WORKCOVER SYSTEM ........................................... 2-1
   Introduction ......................................................................................................................... 2-1
   Australian Workers’ Compensation in Context .................................................................. 2-2
   Historical Origins .............................................................................................................. 2-3
   Stability and Change .......................................................................................................... 2-4
   The Crisis of Workers’ Compensation in Victoria .............................................................. 2-6
   Medium-Term Factors ....................................................................................................... 2-7
   Immediate Impetus ............................................................................................................ 2-9
   The Problem of Contested Claims ..................................................................................... 2-10
   The Road to WorkCare ....................................................................................................... 2-11
   The Cooney Committee ..................................................................................................... 2-11
   The DMB Blueprint ........................................................................................................... 2-14
   WorkCare in Operation ...................................................................................................... 2-16
   Components of Scheme Operation ..................................................................................... 2-17
   Administration of the WorkCare Scheme .......................................................................... 2-18
   Pricing System .................................................................................................................... 2-21
   Dispute Resolution ........................................................................................................... 2-24
   The Road to WorkCover .................................................................................................... 2-26
   WorkCare—a System under Review .................................................................................. 2-26
   WorkCare—the Internal Repositioning Process ................................................................ 2-28
   The Move to WorkCover ................................................................................................... 2-30
   Concluding Observations ................................................................................................... 2-31
3 GOVERNANCE AND ORGANISATION OF WORKERS' COMPENSATION IN VICTORIA ........................................ 3-1
The Legislative Mandate .............................................. 3-1
VWA Governance ......................................................... 3-2
Other Major Players in the Victorian Workers' Compensation System .......... 3-4
Conciliation Service .................................................. 3-4
Medical Panels .......................................................... 3-5
The Courts ............................................................... 3-5
Administrative Appeals Tribunal .................................... 3-6
Structure of the VWA .................................................. 3-6
Health and Safety Division ........................................ 3-6
Scheme Regulation Division .......................................... 3-8
Scheme Development Division ....................................... 3-10
Information Services Division ..................................... 3-11
Corporate Affairs Division ......................................... 3-12
Finance and Corporate Services Division .......................... 3-12
Claim Flow Analysis .................................................. 3-12
Claims Lodged .......................................................... 3-13
Active Claims ........................................................... 3-14

4 REGULATORY ASPECTS OF THE VICTORIAN WORKCOVER SYSTEM .............. 4-1
Chapter Objectives .................................................. 4-1
Relative Roles of Market and Regulatory Mechanisms ................ 4-2
Managing the Principal-Agent Relationship .......................... 4-3
Role of the Victorian WorkCover Authority ........................ 4-5
Administrative Role ................................................... 4-5
Insurance Role ......................................................... 4-6
Regulatory Role ......................................................... 4-6
Insurers' Role ........................................................... 4-7
Role of Other Market Participants .................................. 4-8
Description of Victorian Workers' Compensation Regulatory Scheme .......... 4-8
Authorisation of Insurers .......................................... 4-10
Reserving and Pricing ................................................. 4-13
Service Standards and Enforcement .................................. 4-15
Remuneration .......................................................... 4-16
Best Practice Incentive Scheme ...................................... 4-17
Monitoring and Statistical Reporting .................................. 4-17
Communications with Stakeholders .................................. 4-18
Self-Insurance Regulation ........................................... 4-19
Investment Management ................................................. 4-20
Market Structure .......................................................... 4-21
Federal Regulation ...................................................... 4-22
Number and Size of Insurers ......................................... 4-23
<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Entry and Exit</td>
<td>4-25</td>
</tr>
<tr>
<td>Insurer Differentiation</td>
<td>4-26</td>
</tr>
<tr>
<td>Market Performance</td>
<td>4-26</td>
</tr>
<tr>
<td>Underwriting and Availability of Coverage</td>
<td>4-27</td>
</tr>
<tr>
<td>Marketing</td>
<td>4-29</td>
</tr>
<tr>
<td>Reserving</td>
<td>4-29</td>
</tr>
<tr>
<td>Premium Collection</td>
<td>4-30</td>
</tr>
<tr>
<td>Premium and Claim Costs</td>
<td>4-30</td>
</tr>
<tr>
<td>Profitability</td>
<td>4-31</td>
</tr>
<tr>
<td>Products and Quality of Service</td>
<td>4-33</td>
</tr>
<tr>
<td>Solvency</td>
<td>4-35</td>
</tr>
<tr>
<td>Regulatory Program Assessment</td>
<td>4-36</td>
</tr>
<tr>
<td>Management of the Principal-Agent Relationship</td>
<td>4-37</td>
</tr>
<tr>
<td>Authorisation of Insurers</td>
<td>4-38</td>
</tr>
<tr>
<td>Service Standards and Enforcement</td>
<td>4-39</td>
</tr>
<tr>
<td>Pricing and Reserving</td>
<td>4-41</td>
</tr>
<tr>
<td>Remuneration</td>
<td>4-43</td>
</tr>
<tr>
<td>Best Practice Incentive Scheme</td>
<td>4-44</td>
</tr>
<tr>
<td>Monitoring and Statistical Reporting</td>
<td>4-45</td>
</tr>
<tr>
<td>Self-Insurance</td>
<td>4-46</td>
</tr>
<tr>
<td>Communications with Insurers</td>
<td>4-48</td>
</tr>
<tr>
<td>Employer Information</td>
<td>4-49</td>
</tr>
<tr>
<td>Other Regulatory Tools</td>
<td>4-50</td>
</tr>
<tr>
<td>Private Choice and Regulation</td>
<td>4-51</td>
</tr>
<tr>
<td>Full Privatisation</td>
<td>4-51</td>
</tr>
<tr>
<td>Altering the Reinsurance Arrangement</td>
<td>4-53</td>
</tr>
<tr>
<td>Capitated Payments to Insurers</td>
<td>4-54</td>
</tr>
<tr>
<td>Increasing Pricing Flexibility</td>
<td>4-54</td>
</tr>
<tr>
<td>Unbundling and Opening the Market for Insurance Services</td>
<td>4-55</td>
</tr>
<tr>
<td>Competitive State Fund</td>
<td>4-55</td>
</tr>
<tr>
<td>Concluding Observations</td>
<td>4-56</td>
</tr>
</tbody>
</table>

### 5 BENEFITS

<table>
<thead>
<tr>
<th>Category</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical Benefits</td>
<td>5-1</td>
</tr>
<tr>
<td>Initiating Benefits</td>
<td>5-2</td>
</tr>
<tr>
<td>Weekly Benefits</td>
<td>5-2</td>
</tr>
<tr>
<td>Terminating Weekly Benefits</td>
<td>5-4</td>
</tr>
<tr>
<td>Death Benefits</td>
<td>5-9</td>
</tr>
<tr>
<td>Benefits for Maims and Permanent Disabilities</td>
<td>5-11</td>
</tr>
<tr>
<td>Section 98 Losses</td>
<td>5-12</td>
</tr>
<tr>
<td>Back Cases</td>
<td>5-13</td>
</tr>
<tr>
<td>Hearing Loss</td>
<td>5-15</td>
</tr>
<tr>
<td>Compensation for Pain and Suffering</td>
<td>5-17</td>
</tr>
</tbody>
</table>
Medical Examinations - Section 112 ........................................... 5-20
Lump Sum Settlements ....................................................... 5-22
Medical Issues ................................................................... 5-24
Medical and Like Services Costs ........................................... 5-25
Concluding Observations ................................................... 5-30

6 DISPUTES AND THEIR RESOLUTION ........................................... 6-1
Medical Panels ................................................................... 6-2
Panel Members .................................................................. 6-4
Procedures ........................................................................ 6-5
Medical Panels in Practice ................................................ 6-6
Medical Panels and the Future ............................................ 6-8
The Common Law ............................................................ 6-9
Common Law Under Section 135B ....................................... 6-10
Common Law Under Section 135A ....................................... 6-11
Procedures and the Expansion of Accessibility ...................... 6-13
Damages ........................................................................... 6-18
The Future ........................................................................... 6-19

The Conciliation Service ....................................................... 6-20
Procedures ........................................................................... 6-21
The Conciliation Officer ...................................................... 6-24
The Experience of the Conciliation Service ......................... 6-25
An Assessment ................................................................... 6-27
The Future ........................................................................... 6-29

Administrative Appeals Tribunal ........................................ 6-29
The Courts ............................................................................. 6-31
Procedures .......................................................................... 6-32
The Future ............................................................................. 6-34

7 OCCUPATIONAL REHABILITATION IN VICTORIA ............ 7-1
Introduction .......................................................................... 7-1
History .................................................................................. 7-2
Structure of WorkCare Rehabilitation ................................ 7-3
Operation of WorkCare Rehabilitation .................................. 7-5
The Legacy of WorkCare Rehabilitation .............................. 7-7
Legislative Framework, Entitlements And Responsibilities .... 7-10
Mandate and Legislative Framework .................................... 7-10
Insurer Responsibilities ........................................................ 7-10
Worker Entitlements and Responsibilities ............................ 7-12
Employer Responsibilities .................................................. 7-13
Rehabilitation Process .......................................................... 7-15
Identification and Referral for Services ............................... 7-16
Organisational and Administrative Structures ..................... 7-19
# Table of Contents

- Information Network Unit (INU) .................................................. 8-43
- Development Taskforce .............................................................. 8-45
- SafetyMap ...................................................................................... 8-46
- Marketing Unit .................................................................................. 8-46

## Stakeholder Feedback

- Employer Comment ........................................................................... 8-48
- Consultant Comments ........................................................................ 8-51
- Labour Comments ............................................................................. 8-52
- Health and Safety Division Concerns ................................................ 8-54

## Conclusions

- ............................................................................................................. 8-61

## 9 ATTENTION POINTS

### General

- G-1. Amazing Transformation ......................................................... 9-2
- G-3. Cultural Change through Media ............................................... 9-3
- G-4. Stakeholder Input ..................................................................... 9-3

### Insurer Regulation

- I-1. Improvements in Scheme Performance ....................................... 9-4
- I-2. Role and Expectations for Authorised Insurers .......................... 9-4
- I-3. Relations Between the VWA and Insurers ................................. 9-5
- I-4. Economic Incentives ................................................................ 9-6
- I-5. Insurer Quality of Service and Performance .............................. 9-7
- I-6. Insurer Audits .......................................................................... 9-7
- I-7. Pricing and System Costs ......................................................... 9-8
- I-8. Scheme Information .................................................................. 9-8
- I-9. Consumer Information .............................................................. 9-9
- I-10. Self-Insurance and Self-Administration ..................................... 9-10
- I-11. Coordination of Federal and State Regulatory Responsibilities .... 9-11
- I-12. Other Issues With Respect to Privatisation .............................. 9-11

### Compensation Issues

- C-1. WorkCover Goals Have Been Met .............................................. 9-12
- C-2. The Erosion of the “Serious Injury” Threshold ......................... 9-12
- C-3. Consistency and Comprehensiveness of the Table of Maims .... 9-13
- C-4. Terminating Weekly Benefits .................................................... 9-14
- C-5. The Injured Workers’ Wage Level May Need Consideration .... 9-14
- C-6. Payments for Maims Have Been Growing ............................... 9-15
- C-7. Problems in the Setting of Reasonable Medical and Like Fees .. 9-16
- C-8. The Medical Panels Have Been Overburdened ...................... 9-16

### Rehabilitation Issues

- R-1. Focus on Return to Work .......................................................... 9-17
- R-2. Rehabilitation as an Employer Responsibility .......................... 9-17
- R-3. Return-to-work Coordinator ..................................................... 9-18
List of Tables

1.1 Industrial Distribution of Victoria Workforce and Enterprises, 1995 ............................. 1-12
2.1 Where the Premium Dollar Goes—Victoria ................................................................. 2-34
2.2 Performance of the WorkCare Scheme: 1985/86 to 1991/92 ........................................... 2-35
4.1 Premiums and Reimbursements ($M), FY 1986-1996 .................................................. 4-58
4.2 Market Concentration, FY 1993-1996 .......................................................................... 4-60
4.3 Insurer Market Share Trends (% Premiums), ............................................................... 4-61
4.4 Market Entries and Exits, FY 1986-1996 ....................................................................... 4-62
4.5 Premiums in Relation to Remuneration, FY 1986-1996 .................................................. 4-63
4.6 Scheme Financial Performance, FY 1986-1996 ............................................................. 4-64
4.7 Insurer Income, Report Year 1995 .................................................................................. 4-65
4.8 Insurer Service Performance, First Quarter 1996 .......................................................... 4-66
4.9 Insurer Assets and Liabilities ($, 000s), 1995 ................................................................. 4-67
5.1 Standard Claims by Report Year* ................................................................................... 5-32
5.2 Weekly Benefits, Annual Totals* .................................................................................... 5-33
5.3 Long-Term Claims By Year Reported* .......................................................................... 5-34
5.4 Fatal Claims* .................................................................................................................. 5-35
5.5 Maims Payments* .......................................................................................................... 5-36
5.6 Percentages of Maims Payments by Type of Maim, 1986-1996* ..................................... 5-37
5.7 Lump Sum Benefit Payments ......................................................................................... 5-38
5.8 Medical and Like Services Costs .................................................................................... 5-39
6.1 Medical Panel Referrals by Referring Party ................................................................... 6-36
6.2 Medical Panel Referrals by Section of the Act ............................................................... 6-37
6.3 Medical Panel Referrals by Injury Type .......................................................................... 6-38
6.4 Medical Panels by Composition ..................................................................................... 6-39
6.5 Medical Panel Appointments, by Specialty, 1995/96 ..................................................... 6-40
6.6 Conciliation Service Applications and Disposals ............................................................ 6-41
6.7 Conciliation Service Lodgements by Type of Case, 1 December 1992 to 30 June 1996 ...... 6-42
6.8 Accident Compensation Tribunal Files, and Other Applications Referred to the
   Administrative Appeals Tribunal, 1 December 1992 to 30 June 1996 ............................... 6-43
7.1 Summary of WorkCare Rehabilitation Activity: 1985/86 to 1991/92 .............................. 7-47
7.2 Source of Referral to Rehabilitation ............................................................................. 7-48
7.3 Rehabilitation Services Covered by the VWA ............................................................... 7-49
7.4 Summary of Occupational Rehabilitation Codes and Descriptions with Recent Volumes .... 7-51
7.5 Distribution of 1995-96 Occupational Rehabilitation (OR) Expenditures by Year of Injury ... 7-54
8.1 Regulations under the Principal Health and Safety Acts ................................................. 8-65
8.2 Approved Codes of Practice under the Occupational Health and Safety Act 1985 ........ 8-68
8.3 Inspections, Notices, and Written Directions, ............................................................... 8-69
8.4 Prosecutions with Average Fines Imposed ..................................................................... 8-70
A-2 List of Interviewees ....................................................................................................... A-4
<table>
<thead>
<tr>
<th>Figure</th>
<th>Description</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.1</td>
<td>Victorian Workers’ Compensation Administrative Structure</td>
<td>3-16</td>
</tr>
<tr>
<td>3.2</td>
<td>Claims Lodged in 1995/96</td>
<td>3-17</td>
</tr>
<tr>
<td>3.3</td>
<td>All Active Claims 1995/96</td>
<td>3-18</td>
</tr>
<tr>
<td>4.1</td>
<td>Victoria Workers’ Compensation Regulatory Scheme</td>
<td>4-68</td>
</tr>
<tr>
<td>4.2</td>
<td>Workers’ Compensation Premium Calculation</td>
<td>4-69</td>
</tr>
<tr>
<td>4.3</td>
<td>Structure - Conduct - Performance Framework</td>
<td>4-70</td>
</tr>
<tr>
<td>7.1</td>
<td>Rehabilitation Relationship Map</td>
<td>7-55</td>
</tr>
<tr>
<td>7.2</td>
<td>Generalized Model of Injury and Recovery with Rehabilitation Process</td>
<td>7-56</td>
</tr>
<tr>
<td>7.3</td>
<td>Distribution by Qualification of Occupational Rehabilitation Personnel in Victoria</td>
<td>7-57</td>
</tr>
<tr>
<td>8.1</td>
<td>Health and Safety Division, Victorian WorkCover Authority</td>
<td>8-71</td>
</tr>
</tbody>
</table>
EXECUTIVE SUMMARY

I. Introduction

The Victorian WorkCover Authority (VWA) contracted with the W.E. Upjohn Institute for Employment Research to conduct a thorough, independent study of the workers' disability prevention and compensation system in Victoria. The methodology of this study is derived from a decade-long series of over 20 studies published in the United States by the Workers Compensation Research Institute (WCRI) of Cambridge, Massachusetts. The overall series is designed to assist public policy makers and other interested participants in making 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.

The Upjohn Institute, in partnership with the Workers' Compensation Board of British Columbia, Canada, expanded the methodology over the past 5 years to encompass the Canadian workers' compensation environment, and also broadened it to include issues of funding, health care, rehabilitation, and occupational safety and health. Now we have adapted this model to accommodate the unique features of the Victoria, Australia, workers' compensation system. This report focuses the model for the first time outside North America and also broadens the scope over any single previous study.

The research and analysis team included six workers' compensation experts; one Australian, two Canadians, and three from the United States. The authors drew on their experience with numerous similar studies and brought a collective total of well over 100 years of experience with workers' compensation and prevention issues to this task. During the winter of 1996, we conducted over 300 interviews with some 260 individuals who had substantial experience in and around the Victorian workers' compensation and occupational safety and health systems.

The goal is to describe the operation of the system in such a way that the intelligent
layperson can understand what it does and how it operates. We also endeavour to provide some comparative perspective with other jurisdictions where that is relevant or necessary. The descriptive material is for the Victorian system as it existed in July 1996, but historical data are generally presented for the period 1985-86 to 1995-96. Because of the extensive changes in structure in 1992, this study offers an opportunity to review the operation of a workers' compensation system under two distinct regimes, as well as across varied economic and political climates. In the final chapter we also provide our perspective on areas that might need additional attention.

II. Structure

The Victorian WorkCover Authority (VWA) was created by the Accident Compensation (WorkCover) Act of 1992, which completely restructured the workers' compensation system in Victoria. The functions of the Authority are very comprehensive, ranging from administering the WorkCover Authority Fund and licensing and regulating authorised insurers to fostering a co-operative consultative relationship between management and labour in relation to the health, safety, and welfare of persons at work.

The Act also establishes the WorkCover Authority Fund. It receives premium income, investment income, penalties, and other income and is responsible for payment of compensation and other payments, such as the costs of the Health and Safety Division (and the predecessor Health and Safety Organisation), the costs of administration of the VWA, the costs of the Medical Panels, and the costs of the County Court, Magistrates' Court, and the Administrative Appeals Tribunal arising from the operation of the Act.

The WorkCover Authority Fund operates as a re-insurer bearing the full underwriting risk of the scheme. The day-to-day collection of premiums and payment of compensation benefits under the Act are conducted by "authorised insurers." The Authority has the power to appoint and terminate such agents. In July 1996, there were 14 authorised insurers operating in Victoria. Their performance is monitored and regulated by the Scheme Regulation Division of the VWA.

The Health and Safety Division (HSD) is responsible for administering health and
safety legislation in Victoria, primarily the *Occupational Health and Safety Act 1985*, the *Dangerous Goods Act 1985*, and the *Equipment (Public Safety) Act 1994*. HSD undertakes activities aimed at improving health and safety in workplaces, strives to improve health and safety in the agricultural and farming sector, and facilitates public safety. A significant focus of HSD is regulating the transport, handling, and storage of dangerous goods and hazardous substances, including the notification and registration of premises and the licensing of drivers carrying dangerous goods.

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; minimise the frequency, severity and cost of workplace injuries; increase the rate at which injured employees return to work and improve their maintenance at work; and encourage quality service by insurers and providers. The VWA’s Corporate Affairs Division has run a series of high-profile advertising campaigns aimed at establishing a sustained 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 the number of recorded claims. Market awareness recently was found to be 80 percent, and a continued decrease in claims reported is attributed partly to the communication effort.

III. Insurance Regulation

The underlying philosophy of the WorkCover scheme is important to understanding 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 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 serious problems encountered with the public WorkCare system from 1985 through 1992 and the government’s stated desire
to return more autonomy to the private sector have resulted in the current mixed public-private WorkCover system.

In addition to administering the WorkCover scheme, the VWA performs some of the functions that might otherwise be performed by private insurers. These functions include bearing risk through reinsurance, pricing, funding claims, reserve analysis, investment management, and compilation and analysis of claims data. 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.

The VWA confronts a significant “principal-agent” problem in inducing authorised insurers to promote scheme objectives. 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 regulatory issues for the VWA that are not present with pure private or pure government workers’ compensation insurance systems.

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 are more oriented towards conduct than outcomes.

The authority sets aside a certain amount of funds in a service fee pool which is allocated to insurers according to their market share for each quarter. For the 1995/96 financial year, the VWA allocated $72.3 million in service fees. The market share formula credits an insurer $115 for every policy it writes, plus 5.3 percent of the premiums derived from the policies. This effectively sets an average payment which each insurer receives for servicing a given policy or portfolio of policies.

xvi
The Best Practice Incentive scheme sets performance standards and provides financial rewards to insurers for meeting these standards and/or improving their performance. For 1995-96 the measures were (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 total BPI pool was $6 million although payments were reportedly less.

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 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, health care, and rehabilitation services function and compete much as they do in other systems.

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 "premiums order" every year. Victoria's pricing formula 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 against stability. The experience component is weighted by employer size (payroll), so that small employers' rates are based less on their own experience and more on the 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.

The overall cost of the WorkCover scheme is a principal concern of most stakeholders. Even workers and non-insurance providers have a stake in this, as rising costs will increase pressure to lower benefits and 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.

The decrease in the published rate from 2.4 percent of payroll in 1987 to 1.80 percent in 1997 combined with the elimination of a massive unfunded liability is a remarkable accomplishment; the latter is the lowest rate among Australian states. Over the period 1994-1996, the average annual ratio of claims payments to premiums was 81.1 percent. This ratio suggests a relatively efficient level of performance that is commensurate with the experience in competitive workers’ compensation insurance markets in North America.

Several factors have contributed to this improvement. One is system reforms under WorkCover supported by the public communication strategy mentioned earlier. Another is refinement of the pricing formula and experience rating system 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 the change in the culture pervading workers’ compensation insurance have also helped to discourage “rorting” of the system.

IV. Weekly Benefits

A worker is entitled to compensation under the Accident Compensation Act 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 in, results in, or materially contributes to the death of the worker.

There is a requirement that notice of injury be given to the employer. A claim for compensation for weekly benefits must be served as soon as practicable, for death benefits within 2 years after the date of death, and for medical and like services within 6 months after the date of the service. A claim for weekly benefits must be accompanied by a certificate issued by a medical practitioner.

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,
mains, or for medical and like services within 10 days of receipt of the claim. Claims for weekly 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 $416 in 1996-97 (indexed annually).

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.

An injured worker entitled to weekly compensation under WorkCover will receive a benefit that is tied to his/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. Allowances such as overtime payments, shift differentials, hazard duty allowances or dirt money are not included in considering the injured worker’s PIAWE. All weekly benefit payments are treated as ordinary taxable income.

Weekly benefits are 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 is entitled to the lesser of 95 percent of his/her PIAWE or the weekly maximum benefit ($664 per week as of 1 July 1996). Cash benefits for the first 10 days of incapacity are the responsibility of the employer, not of the insurer, and are referred to as the “employer excess.” 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 many 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 is partially incapacitated, the worker is entitled either to the difference between $664 and the worker’s earnings, or to the difference between 95 percent of the PIAWE and earnings, whichever is lesser.

The most significant feature of Victoria’s benefit scheme, and unique in Australia (or
elsewhere so far as we know), is an adjustment of the benefit at 26 weeks according to whether or not the worker has a "serious injury." Workers with a "serious injury" qualify for a weekly benefit of 90 percent of PIAWE, subject to the weekly maximum. Workers with a partial disability that is not deemed "serious" receive only 60 percent of PIAWE. Workers who are deemed "totally incapacitated" qualify for a weekly benefit of 70 percent of PIAWE. This means that a judgment needs to be made at this stage regarding the degree of the worker's impairment. This provision is designed to foster a significant incentive to return to work for those who might be able to do so after 26 weeks, without placing that pressure on persons with more significant impairments.

The "serious injury" threshold for purposes of the 26-week rate adjustment is an impairment that is rated at 30 percent or more by the standard of the American Medical Association's *Guides to the Evaluation of Permanent Impairment* (2nd edition). The presence of a "serious injury" is also a necessary condition for a worker to have access to the common law remedy. The 1992 law also provided that weekly benefits would be terminated after 104 weeks of incapacity, unless either of two situations existed at that point. Weekly benefits would not be terminated at 104 weeks if the worker was either "seriously injured" or totally and permanently incapacitated. Thus, only workers with 30 percent impairment or greater receive benefits beyond 2 years.

Since enactment of the 1992 legislation, aggregate payments for weekly benefits have fallen sharply. First, the number of new claims for benefits declined significantly in the period after 1 December 1992 to less than half the previous level by 1995-96. Second, the number of long-term recipients has been reduced by 40 percent, a major goal of the 1992 change. Additionally, WorkCover has been able to shorten the average length of time that persons stay on weekly benefits. Weekly benefit payments constituted 36 percent of claim costs in 1995-96 totalling $259 million.

The success in curbing long-term claims (claims with over 260 days of compensation) is quite remarkable. Long-term claims were developing at a rate of 5,000-6,000 per year in the decade before WorkCover's enactment. By 1993-94, the rate had fallen below 2,000 per year,
and it has continued to drop since. In December 1992, there were 16,600 long-term claims open in Victoria. By 30 June 1996, the number of open long-term claims was 9,997.

V. Maims

The Table of Maims lists 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. The maximum benefit payable for a maim, as of 1 July 1996 is $102,460. For each impairment, a percentage or range of percentages is listed. For example, the total loss of the right arm is listed as 80 percent. Thus, a worker who lost the right arm would be entitled to a lump sum benefit of $81,968 (0.8 x $102,460). If the worker lost a fraction of the arm, that fraction, applied to $81,968 would be the maims benefit paid as a lump sum. This would be in addition to any weekly benefits that the worker received, and the worker also might seek further compensation under common law.

In Victoria, no-fault pain and suffering benefits were expressly included in the 1992 legislation. Benefits under this section are available only to workers with injuries listed in the Table of Maims. In keeping with several significant features of the WorkCover law, a benefit for pain and suffering is available only to workers whose maim has been a significant one. As of 1 July 1996, the threshold for access to a benefit for pain and suffering is a maims award of $11,000 or higher. Thus, a worker with a non-back impairment rated at below 11 percent, or an 18 percent back impairment (yielding less than an 11 percent whole person rating) is not entitled to an award.

Lump sum maims benefits have grown substantially over time. One simple measure of this is the changing value of total maims payments per year from $5.2 million in 1986-87 to $104.1 million in 1995-96. In recent years, a significant portion of the increase has been associated with benefits for pain and suffering. However, it is also due simply to the growth in maims payment claims. Maims payments constituted 14 percent of claim payments in 1995-96.
VI. Medical and Like Benefits

Workers in Victoria who sustain a work injury have free choice of their medical provider. The injured worker is entitled to have the reasonable costs of medical and like services paid fully. Medical services are defined in the law 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 are available if they have been requested by a medical practitioner. For a worker who receives compensation only for medical and like services (i.e., no weekly benefits), benefits cease 52 weeks after the date of injury.

There was rapid growth in medical and like services costs from 1986-87 to 1992-93, with much of the growth occurring early in that period. In the past 3 years, under WorkCover, health care costs have fallen substantially. Much of the decline is 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, which has been increased annually since 1986 through indexation. As of 1 July 1996, it stood at $416. Though aggregate expenditures paid for medical and like services have declined, they have not declined as rapidly as claims have. Medical and rehabilitation costs constituted 18 percent of system claim costs in 1995-96.

VII. Dispute Resolution

The agency does not adjudicate disputes. Instead, the WorkCover Authority seeks to minimise the incidence of disputes and, when they arise, to have them settled rapidly by the parties with a minimum of transaction costs. Where that does not succeed, as must occur on occasion, the dispute is resolved in the courts.

To assist the parties and achieve their goals, the VWA depends heavily on a system of Medical Panels, in order to bring to bear some objectivity and professional expertise on disputes arising over medical matters. A quasi-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. A small number of disputes over some specialized issues can be resolved, if not at the Conciliation Service, at the Administrative Appeals Tribunal.

The purpose of the Conciliation Service is to help the parties resolve their disputes, thereby eliminating the need to litigate the matter at court. It functions by involving workers, employers, and insurers in an informal and non-adversarial process that aims to lead to a mutually acceptable agreement.

Most requests for conciliation are initiated by workers who have been advised by the insurer of a decision that is regarded as adverse to them. However, any party to a dispute, i.e., the insurer, the employer, the worker, or the Authority, may refer a matter to conciliation. A party has 60 days from notice by the insurer of its decision to lodge a request for conciliation. When a “Request for Conciliation” form is submitted, a referral certificate is issued within 7 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 7 days have passed, a date is set for a conciliation conference.

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. Union representatives, for example, often serve as an assistant for the worker. Significantly, neither a worker nor an employer is entitled to be accompanied by a solicitor. If a party wishes to have their solicitor present, approval must be given by both the contending party and the Conciliation Officer. Such requests can and have been granted, 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/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 scheduled subsequent conference. If the dispute involves a medical question, the Conciliation Officer may refer it to a Medical Panel.

It is quite remarkable that this agency operates with virtually no backlog and that it can generally accommodate the rigorous requirement that applications be conferenced within 28 days of their receipt. In its first 2 years, between 80 and 85 percent of its cases (excluding applications where conciliation did not proceed or there was no jurisdiction) were resolved, dropping to 65 percent in 1994-95 and 67 percent in 1995-96. This is an impressive performance.

Medical Panels are independent of the VWA, though their budget flows from it. The primary responsibility of a medical panel is to give its opinion on any medical question. The definition of “medical question” consists of 9 items identified in the statute. A Conciliation Officer, the County Court, the VWA, or an authorised insurer or self-insurer may require a worker seeking or receiving compensation to submit themselves for examination by a Medical Panel. If the worker unreasonably refuses to meet the Panel and answer its questions, to supply relevant documents to the Panel, or to submit to a medical examination by a member of the Panel, the worker may lose the right to payments or have them suspended.

The Panel can consist of one to three members. Each Panel member examines the patient, usually separately. After examination of the claimant and an evaluation of any relevant material supplied, 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.

The opinion of the Medical Panel is binding on the insurer. Once the Panel’s certificate is issued, the insurer must make an offer within 14 days that is consistent with (or better than) the Panel’s findings. However, the Panel’s opinion is not binding on the claimant. If the dispute remains, i.e., the insurer’s offer is not acceptable to the claimant, the Conciliation Service may become involved.
One goal of the Medical Panels has been to expedite the resolution of disputes. The statute provides some tight time lines for this process. A Medical Panel must form its opinion, in the form of a certificate, within 21 days after the referral is made. Further, the Panel has 7 days after forming its opinion to provide it to the relevant persons. This has proven to be infeasible, and sizable delays exist in the process. In 1995-96, the median delay had grown to 160 days. There are several reasons for this, but a key has been that the system has been vastly overburdened since 1994 by a requirement (introduced in 1994) that maims disputes be referred to a Medical Panel before proceeding to court.

In 1996, the Act was amended to refer claims for maims to the Conciliation Service rather than Medical Panels. Though the Conciliation Officer may refer disputes over “medical questions” to a Medical Panel and the opinion of the Panel is binding on the parties, determining the extent of disability under Section 98 or of pain and suffering under Section 98A are not “medical questions.” Also, the courts have not been completely supportive regarding the binding nature of the findings on the parties.

VIII. Common Law

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; such actions are barred completely in South Australia and the Northern Territory; with limited access or benefits in Victoria, the Commonwealth (Comcare, SeaCare), New South Wales, and Western Australia; and unlimited access or benefits in Queensland, Tasmania, and the Australian Capitol Territory.

Access to common law was generally narrowed by the 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 can be awarded against an employer in such cases only where they exceed $32,860; a cap on such damages is set at $739,690 for 1996-97. Common law damages for pain and suffering also are not to be awarded if damages are assessed at less than $32,860. The ceiling on common law awards for pain and suffering is $333,420 as of 1 July 1996.
The most significant change with WorkCover was the requirement that the injury be found to be a “serious injury” in order for the worker to have access to damages under common law. A huge inflow of claims for damages in late 1992 and early 1993 primarily were from those who believed that they would not be found to have a serious injury, thereby becoming ineligible for common law recovery for injuries after the effective date of WorkCover. 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.”

With WorkCover, the expectation was that the number of common law cases would drop off precipitously. Although a substantial reduction has occurred over what would have been the expected volume in the absence of the 1992 legislation, workers’ solicitors have learned how to widen access to the common law. This, in combination with certain judicial determinations, has meant that common law still represents an important component of work injury compensation in Victoria. Common law damage payments and associated legal costs constituted about 19 percent of claim costs in 1995-96.

IX. 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). The Magistrates’ Court cannot hear death claims, and it is limited to matters and directions concerning sums not to exceed $40,000 or 104 weeks of weekly benefits. Except for claims for death benefits, proceedings must not commence in Magistrates’ or County Courts unless the matter has been referred to conciliation and either 28 days have expired since the date of referral or a Conciliation Officer has issued a certificate indicating that all action in respect of conciliation has been taken.

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 6 months of either the determination being appealed or the leave obtained to appeal by
the Supreme Court. The County Court’s 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.

In proceedings regarding maims and pain and suffering, where the judgment for payment of compensation by the Court is equal to or less that the final offer made by the insurer, the Court must order that the worker pay the insurer’s costs, and it must not order that the insurer pay the worker’s costs. Where the insurer’s final offer is less than the amount ordered by the Court, the County Court must order that the insurer pay the worker’s costs.

X. Occupational Rehabilitation

Physical, psychological, and occupational rehabilitation are provided for within the legislation; in the Victorian context “occupational rehabilitation” refers to specific, defined services within the general rubric of rehabilitation. The current status of occupational rehabilitation services in Victoria also must be read in light of the evolution from its predecessor, the WorkCare organisation. Many of the features, processes, and outcomes are a direct response to the perceived shortcomings of earlier systems.

Return to work with the accident employer is the over-riding goal, and this message is reflected in legislation, publications, and policies. As a regulator rather than a provider of rehabilitation services, the VWA’s imperative 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 both utilisation and outcomes.

Financial benefits for workers engaged in rehabilitation activities are identical to the benefits prescribed for all workers under the Act. Benefits continue for a period of up to 1 year, while engaged in authorised occupational rehabilitation activities. The cooperation of the worker is mandated by the Act, which requires a worker to make every “reasonable effort” to return to work “in suitable employment” and to participate in occupational rehabilitation service or a return-to-work plan. “Suitable employment” is defined 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, and occupational rehabilitation services being provided. The definition specifically adds “whether or not that work is available.”

One of the most notable aspects of the 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 return-to-work and occupational rehabilitation, the legislation and policies of the VWA mandate these as employer responsibilities. The insurer’s role is supportive and facilitative to the employer’s responsibility. With few exceptions, employers are required to make all initial payments for medical and like costs, including rehabilitation costs. These expenditures count towards the employer’s “deductible” of $416 in 1996-97.

By 20 calendar days following an injury, an employer must prepare a return-to-work plan and nominate a return-to-work coordinator. Within a 90-day period after that, an employer must establish a written occupational rehabilitation plan in consultation with the worker. It includes a statement of the employer’s return-to-work policy, the name of the return-to-work coordinator, and at least one provider of occupational rehabilitation services. The plan 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 occupational rehabilitation services that are reasonably necessary to assist the worker in returning to and remaining at work.

Workers are entitled to return to work within 12 months with the accident employer in suitable employment. The employer, however, can be relieved of this responsibility if it can satisfy the Authority that it is “not possible for the employer to provide suitable employment.” Failure to re-employ a worker may result in penalties of up to $25,000.

In Victoria, there is also a significant number of workers whose injury is profound, resulting in total permanent impairment. Many of these cases have been inherited from previous incarnations of the workers’ compensation system in Victoria. In many cases, 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.

Cases that have needs beyond the defined occupational rehabilitation services may be referred to community-based programmes and services, some of which are funded by the VWA. These agencies may offer support and services to the injured worker, family members, and others who may be affected by the injury but who are beyond the scope of the Act.

The overall “return to work rate” (RTW) for the VWA is reported at 86 percent for 1995-96—a figure that compares well with other jurisdictions (including South Australia and New South Wales) and is a startling improvement over the 54 percent RTW rate reported under the WorkCare system in 1992. The quality of these RTW rates are also relatively high, with same employer/same duties placement at 66 percent.

XI. Prevention


The participation of workers in decisions concerning their own health and safety at work is central to the 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 health and safety representatives are elected by the workers. The Occupational Health and Safety Act 1985 provides such representatives the right to inspect any part of the workplace at which members of the relevant DWG work, receive relevant information, and be consulted on proposed
changes to the workplace that may affect health and safety. HSRs may even 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 HSD 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 also 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.

The law provides for penalties for contravention of the Act or regulations. These penalties are currently set at a maximum of $40,000 for bodies corporate and $10,000 for individuals. For certain serious breaches the maximum is set at $250,000 for bodies corporate and $50,000 and/or imprisonment for up to 5 years for individuals. Additional summary penalties may be imposed for repeat offenders. There is also a provision for infringement notices (on-the-spot fines), but regulations to give effect to this provision have not been promulgated.

A separate Dangerous Goods Act covers the special nature of risks arising from dangerous goods (e.g., explosives, flammable materials, and corrosive substances). It applies generally both to workplace and non-workplace situations. The Equipment (Public Safety) Act mirrors the provisions of the OHS Act in relation to prescribed equipment operated in non-workplace situations. It places duties on proprietors, manufacturers, designers, importers, suppliers, and persons in charge of prescribed equipment.

The VWA’s decisions about the suitability of health and safety issues for regulation are primarily guided by decisions taken by the National Occupational Health and Safety Commission (NOHSC). NOHSC develops National Standards which are then implemented by
the various jurisdictions in the way that is most appropriate within their own legislative frameworks.

WorkCover inspectors have the power to visit any place in Victoria covered by the health and safety Acts. The legislation provides inspectors with broad and far-reaching powers. They have the right of entry, without the need for a search warrant, to workplaces and to sites where there is high-risk equipment or dangerous goods. They can exercise this right at all reasonable times, both day and night. It is a violation 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.

The VWA has an extensive database which it uses to target its prevention activities. HSD uses the data to develop a list of the top 20 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 capable of providing targeting data by enterprise or workplace, however. 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.

HSD provides a full range of services including inspection, investigation, information, advisory, licensing, and training. They are resourced with 304 people, of which 170 are field inspectors and 15 are information officers. These 185 positions deliver the front-line service. In the period March 1995 through February 1996, inspections totalled 46,141.

XII. Attention Points

These attention points are identified as such because they represent special strengths of the system or because they warrant, at least in our opinion, additional attention by those who seek to improve the system. 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 stakeholders in the system.

For purposes of exposition, we have grouped our observations into the broad categories of (1) general issues; (2) insurer regulation issues; (3) compensation issues; (4) rehabilitation issues; and (5) prevention issues. Within each of these categories, the attention points are numbered for convenient reference. However, the points are not presented in priority order.

**General (G)**

We begin 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 to one that appears to be sustaining a level of performance that would have been unimaginable 5 years ago. The leadership of the VWA and the Ministry deserve much of the credit for this turnaround. Their vision and consistency of purpose have been remarkable.

G-2. Historical Opportunity

While much has been accomplished, this is not the time for the VWA to rest on its laurels. The merger of the former Health and Safety Organisation and the VWA in 1996 creates a historical opportunity for a thorough and careful rethinking of system parameters. Bringing the mission and operations of HSD into the VWA will prove challenging, but if it can be done with the kind of creative thinking that has characterised the past 5 years, it can move the entire organisation to new heights of achievement.
G-3. 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 use of the power of the media to effect a reversal in the “compo” culture that characterised Victoria’s workers’ compensation system previously is unprecedented, and a valuable model for other systems around the world.

G-4. Stakeholder Input

Our interviews revealed that labour and management, as well as other stakeholders, have perceived a problem over consultation with the VWA and policy makers. 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.

Insurer Regulation (I)

There are a number of issues which emerged from our review of the insurer regulation procedures at the VWA. It is difficult to forecast how future policy changes may impact the role of the VWA, given the uncertainties about possible changes in regulatory policies and mechanisms and the possibility of further privatisation of the provision of insurance services. We have tried to formulate attention points that address these uncertainties, as well as the eventual operational issues that will emerge from the political decisions about the relative roles of the insurers and the VWA.

I-1. Improvements in Scheme Performance

The success of the WorkCover scheme is partly attributable to more sophisticated regulatory mechanisms, as well as the development of insurers’ capabilities. But Victoria may be approaching the limits of what can be achieved from the current principle-agent framework. In looking towards the future, policy makers will need to carefully assess the potential further
gains from this arrangement against those offered by alternative models, including those that return greater responsibility and choice to the private sector.

I-2. Role and Expectations for Authorised Insurers

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 sometimes inconsistent with the expressed goals of the system. It would be very helpful if these uncertainties could be resolved and all insurers understood the shape of the future in Victoria’s workers’ compensation market.

I-3. Relations Between the VWA and Insurers

We believe the relationship between the VWA and insurers is more adversarial than is appropriate for their shared responsibilities. The development of institutional practices that would facilitate better communication and joint problem resolution could improve VWA-insurer relations and contribute significantly to improved scheme performance.

I-4. Economic Incentives

The combination of experience rating and competition among insurers for employers’ business is intended to encourage insurers to provide high-quality service, and to work with employers to contain costs. However, it is not clear that the incentives contained in VWA’s pricing, remuneration, and regulatory schemes always encourage the return-to-work goal. The management of long-term claims and severely injured workers also will continue to be a problem without incentives specifically focused to address these objectives.

I-5. Insurer Quality of Service and Performance

VWA statistics indicate significant variation among insurers in several important service measures. If better service performance (considering an insurer’s specific risk and claim portfolio) can be adequately compensated, insurers would have a greater incentive to
pursue the performance goals of the system. We would urge the adoption of a continuous improvement model for all insurers, in addition to the implicit benchmarking and relatively crude financial incentives currently underlying the regulatory regime.

I-6. Insurer Audits

Fully engaging insurers in a collective evaluation of the programme could help to ease their concerns and further support partnering with VWA. Of course, the VWA and insurers also need to be willing to pay to recruit and retain better qualified auditors, and to commit to longer-term contracts which would support additional capacity development by vendors of auditing services.

I-7. Pricing and System Costs

We fear that the promotion of a low workers' compensation insurance rate increases the pressure on the government to sacrifice other objectives to maintain that rate. 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. 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.

I-8. Scheme Information

Insurers’ ability to compete and provide high-quality service is heavily dependent on their access to information. It is not clear to us that a summary database would provide sufficient detail to enable insurers to supplement their own data to develop a proper rate structure, nor allow the VWA sufficient insight into insurer performance to support their regulatory functions. The opportunities for “database synergy” with HSD 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, we urge the VWA to carefully consider the strategic and tactical implications of the regulatory database proposals.

I-9. Consumer Information

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 in employers’ movement to better performing insurers. The VWA’s plan to publicize insurer performance data should help to address this deficiency and, thereby, enhance competition and scheme performance.

I-10. Self-Insurance and Self-Administration

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. Of course there must be safeguards to ensure that only economically-viable employers are allowed to self-insure and to avoid unfunded obligations for the scheme. 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.

I-11. Coordination of Federal and State Regulatory Responsibilities

If changes are made that would permit authorised insurers to bear more risk, the VWA and the ISC will need to reconcile their respective oversight functions to ensure that solvency issues would not slip between jurisdictions and place the VWA or policyholders at risk.

I-12. Other Issues With Respect to Privatisation

The prospects for privatisation initiatives are uncertain, but the VWA will likely implement several measures to improve economic incentives and increase insurers’ responsibilities even if full privatisation is not achieved. Uncertainty about the future may be the most significant challenge facing insurers. Resolving this issue and developing a shared
vision of the future structure of the scheme among all the stakeholders would facilitate better planning, investment, and other changes necessary to achieve scheme goals.

Compensation Issues (C)

We take the basic structure of compensation as "given"; that is, we assume that the political leaders in Victoria have structured the benefits to accord with current Australian realities. 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

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 shorten the average period of time for which workers would collect weekly benefits and, especially, to decrease the number of long-term beneficiaries. The WorkCover system has accomplished each of these goals.

C-2. The Erosion of the "Serious Injury" Threshold

The potential expansion of the concept of serious injury is a considerable threat to the current cost levels of the system. Leaving this decision in the hands of the court system also may not be the most effective way of dealing with the social equity and efficiency issues involved.

C-3. Consistency and Comprehensiveness of the Table of Maims

There are a number of inconsistencies in the treatment of maims in Victoria. There are also some surprising omissions from the Table of Maims. Combined with an update to a later edition of the AMA Guides, it would be appropriate to reexamine the equity aspects of the current benefit structure for maims.
C-4. Terminating Weekly Benefits

Terminating weekly benefits is a difficult problem for most workers' compensation systems because of the difficulty of balancing the needs of workers and employers. The Conciliation Service in Victoria has managed to arrange and conduct conferences very promptly, thereby minimizing the difficulties that either side might have to endure from the termination process. The significance of maintaining this access should not be minimized.

C-5. The Injured Workers' Wage Level May Need Consideration

A feature of Victoria's law is that the calculation of the weekly benefit takes no account of an employee's pay for overtime, shift differential, hazard duty allowance or dirt money. For workers that are accustomed to such payments, their true wage replacement rate is lower than that of a fellow employee who does not regularly receive such earnings. It seems difficult to justify this disparate treatment.

C-6. Payments for Maims Have Been Growing

The WorkCover law has been able to reduce the availability of lump sum payments. However, it has not been able entirely to eliminate lump sum settlements. Other jurisdictions have found that where the practice of lump sum settlements has existed, it becomes a familiar and convenient tool for the parties to use, and is extremely difficult to eradicate. Clearly these issues need to be reexamined in the current, successful workers' compensation environment.

C-7. Problems in the Setting of Reasonable Medical and Like Fees

Negotiations over fee schedules have been contentious. The process of rationalizing and negotiating these fees needs attention. All parties will benefit if these changes materialized as part of a carefully considered package, with extensive public consultation, rather than emerging on a piecemeal ad-hoc basis.
C-8. The Medical Panels Have Been Overburdened

The medical panel scheme has been well designed and could be a highly useful source of dispute resolution. However, the extraordinary bulge in the workload of panels because of their use in maims disputes has exacted a severe price. It would seem more appropriate to confine the Medical Panels to areas where their expertise could really make a difference.

Rehabilitation Issues (R)

Occupational rehabilitation in Victoria has a narrower and more constrained focus than in some other jurisdictions. This results in large part from the perceived excesses under the WorkCare regime from 1985-92. Accepting this reality, we find there are also a number of issues in the occupational rehabilitation area that need scrutiny.

R-1. Focus on Return to Work

The VWA’s success in changing expectations of both workers and employers towards early return to work is remarkable. The VWA has been highly effective in getting this key message across in its policies, its media campaigns, and in its dealings with stakeholders. They have achieved a return-to-work focus second to none.

R-2. Rehabilitation as an Employer Responsibility

In many ways, the policies of the VWA have operationalised the ideals of the disability management movement. Employers in Victoria generally accept that they are responsible for returning workers to their employment. However, the size of an enterprise will inherently limit its flexibility to accommodate workers with disabilities. Additional assistance will be needed if smaller employers are to attain the return-to-work goal as well.

R-3. Return-to-work Coordinator

This innovation has been successful with large employers where the investment is justified. But the lack of a sufficiently skilled RTW coordinator can adversely affect rehabilitation outcomes either through delay in recovery or through an inappropriate early
return to work. 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. 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, improvements in independence, avocational rehabilitation, and quality of life issues are important and continuing needs. Many such workers face mobility challenges and systemic barriers to achieving their highest potential. Case management techniques offer the greatest opportunity to serve this client group effectively. Existing social and community health centres may also provide an effective delivery mechanism for some of these services.

R-6. Measured Outcomes and Research

    In many cases, rehabilitation success must be measured in increments far removed from the ultimate return-to-work goal. The record of the VWA in funding research on rehabilitation demonstrates a long-term commitment to improving measurement and outcomes. However, the VWA still has a unique unexploited opportunity to utilise its rich source of data and other resources to contribute to both prevention and rehabilitation goals.
R-7. Rehabilitation Provider Issues

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. The practice of service-provider substitution was widely reported. The vertical integration of some insurance carriers with wholly-owned rehabilitation subsidiaries and the ownership of rehabilitation facilities by medical practitioners may also represent emerging problems.

Prevention (P)

Many of these attention points are targeted towards improving the utilisation of Health and Safety Division (HSD) resources, 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, experienced, and firmly committed to the challenge of reducing workplace injury and disease in Victoria. The merger of HSD with VWA provides a historical opportunity for the division to develop new synergies within the organisation and leverage the resource potential.

P-2. Management Structure

The Divisional management count is over 40, or about 10 percent of the total staff. Any future reorganisation should seek to reduce the number of managers and re-deploy resources at the field inspection or service delivery level.
P-3. Human Resource Skill Adjustments

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.

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 excessive and incompatible with a performance-based regulatory approach.

P-5. Community Collaboration

The Development Taskforce has an opportunity to drive significant and durable improvement in the prevention of injury and disease in both the workplace and communities. Victoria is developing a wealth of private and public resources that can be enlisted to assist with the prevention mission on a cost-effective basis.

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. Thus, 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

We believe that more specialist skills are needed in the field. HSD should consider the field deployment of hygienists as inspectors, and as vacancies arise in the field increase the number of hygienists. HSD should also find ways to enhance and deploy ergonomic consulting resources, 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 could provide up to a 64 percent increase in field active time over current practice. An added bonus will be 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 might also 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. This makes the inspector contact with workplaces more effective and significantly extends the inspector resource in the field.

P-9. Other Resource Allocation Issues

In the dangerous goods arena, VWA may want to consider moving ahead with policy revisions to achieve performance-based regulation on its own, with a view to regularise 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 in the community that the deterrent effect is minimal.

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. The division would also benefit from developing a series of industry-specific, user-friendly guides to the regulations and codes that are written in plain language and offer practical solutions specifically aimed at small business.

Conclusion

The VWA with its new responsibilities for occupational safety and health has outstanding potential to exploit the synergies between prevention, compensation, and rehabilitation. Further, the well-established VWA communication resource has the demonstrated capability to bring this vital message to the general public. As champion of both
prevention and rehabilitation, the VWA now directs the two programmes with the largest potential to leverage financial and human cost savings in workers’ disability. We look forward to seeing how the VWA responds to this challenge over the next several years.
Chapter 1

INTRODUCTION
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Background and Motivation

Improving the effectiveness of workers’ compensation programmes is an urgent theme in legislative debates across the entire developed world, and developing countries are becoming increasingly concerned as well. Workers in every country with a compensation programme for workers disabled by their employment are concerned that benefits be adequate, prompt and delivered in an equitable manner. Increasingly, employers also are paying attention to these programmes, especially as international competitiveness issues have driven them to examine every source of cost variation across jurisdictions. Thus, employers are concerned that workers’ compensation systems are affordable. In addition, in some states of Australia, the past decade has seen workers’ compensation insurance go through a wrenching series of changes from private dominance to public monopoly to the current compromise between privatisation and public insurance. These issues have concerned policy makers and stakeholders in Victoria, as elsewhere, and the search for the “holy grail” of equitable and economical methods of managing this universal social problem continues.

The statutory changes in Victoria in the last decade constitute a grand policy experiment that should enlighten and inform other countries of the world about the effectiveness of different workers’ compensation strategies. Victoria operated a privately underwritten system (up to 1985), a public monopoly system (from 1985 to 1992), and a mixed model (since 1992) in organising the administrative and insurance requirements for compensating workers disabled in the course of their employment.

The Victorian WorkCover Authority (VWA) contracted with the W.E. Upjohn Institute for Employment Research (Upjohn Institute) to conduct a thorough, independent study of the workers’ disability prevention, compensation and rehabilitation system in Victoria. The Authority had the vision and the courage to open itself to scrutiny from the outside, in the expectation that such an examination would lead to policy improvements in Victoria. Our hope
is that this examination also has policy implications for other jurisdictions, in Australia and elsewhere.

The methodology of this study is derived from a decade-long series of such studies published in the United States by the Workers Compensation Research Institute (WCRI) of Cambridge, Massachusetts. Such studies have been completed by WCRI on some 18 U.S. states to date.\(^1\) In addition, the Workers' Compensation Board (WCB) of British Columbia initiated a series of closely related studies of the British Columbia, Canada 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 studies have been repeated after 5 years in order to provide a "second look" at the progress made in British Columbia.\(^3\)

The overall series was designed to assist public policy makers and other interested participants in making 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 and also broadens the scope significantly over any single previous study.

We pay special attention to the unique regulatory regime in Victoria where private insurers perform claims administration and policy administration duties under the supervision


\(^3\)See Hunt, Barth and Leahy (1996) and Rest and Ashford (1997), for the second round of studies in British Columbia.
of the VWA as public regulator. In addition to regulating private insurers, in a way that would be familiar to U.S. readers, although a good deal more invasive, the VWA operates a public reinsurance fund, bearing all the insurance underwriting risk of the scheme, while the private insurers bear no underwriting risk. Essentially, the private insurers operate as sales and servicing agents of the VWA, who actually carries the risk. This method of insurance organisation is unique in the world, to the best of our knowledge.

We also focus on the prevention of worker injuries and illnesses through inclusion of the former Health and Safety Organisation (HSO), now the Health and Safety Division (HSD) of the VWA, in our study. This was somewhat difficult, since the merger of the two formerly independent organisations was occurring in the winter of 1996, just as we were observing them.

Because of the wide variety of institutional arrangements in Victoria in the past decade, we also include outlines of the policy history of workers' compensation (Chapter 2), rehabilitation (Chapter 7), and prevention (Chapter 8) efforts in the state. These histories will be particularly useful to non-Victorian readers, who may need the broader perspective that they can provide for understanding the Victorian story and, perhaps, to applying the lessons in their own jurisdictions.

This study originated because of the interest of Andrew Lindberg, Chief Executive Officer of the VWA. Andrew's determination to improve the workers' compensation system in Victoria has led him around the world in search of "best practice." He saw the potential gain from an independent evaluation of VWA operations, one that would measure Victorian performance against an international standard. He requested that the Upjohn Institute assemble an international team of experts to perform this study of the Victorian system, using the basic format established in North America, but adapting it to the Australian environment as necessary.

This volume represents our response to that challenge. Our research and analysis team included six workers' compensation experts; one Australian, two Canadians, and three from the United States. The authors drew on their experience with numerous similar studies, including eight such studies in five North American jurisdictions which were authored by one
or another member of the team, about a dozen other U.S. studies where one or more of the authors served as technical reviewer or in some other consultative capacity, and scores of research efforts in the general field of disability prevention and compensation. The six authors brought a collective total of well over 100 years experience with workers' compensation and prevention issues to this task.

The report summarizes the insights the six authors gained over a six-month study period, including eight separate visits to Victoria of at least two weeks each by the North American authors. The VWA supported our efforts by arranging most of our interviews and by supplying requested documentation and data. In addition, they 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 indebted to all the informed observers and participants in the Victorian scheme for sharing their observations and confidential judgments with us. They enabled us to multiply our efforts severalfold, by incorporating the "redigested" thoughts of local experts. We sincerely hope our efforts are worthy of their contributions.

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 which 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. Our goal is to describe the operation of the system in such a way that the intelligent layperson can understand what it does and how it does it. We also endeavour to 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?
- 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 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?

These questions are addressed for the Victorian system as it existed in July 1996, but historical data are generally presented for the period 1985-86 to 1995-96. Because of the extensive changes in structure in 1992, this study offers a unique opportunity to review the operation of a workers' compensation system under two distinct regimes, as well as over varied economic and political circumstances. Because of the desire to facilitate comparisons across regimes, some analyses will use explicit comparisons between the 1986-1992 WorkCare and 1993-96 WorkCover periods.

Research Approach

We conducted this study using a 4-step approach. The elements are (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 have made about the system with the viewpoints of others.

The Act and Its Implementation

We began the study 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 Health and Safety Division of the VWA, 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, HSO Branch Manuals, HSO 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 very interesting and thorough 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 1994-95, as well as other published and unpublished literature on the Victorian workers' compensation programme. The bulk of these were provided by VWA staff, but a great deal was also provided to us by the 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 past 10 years of system performance. These data are designed to provide a clear perspective on the present status of the system, but also to assist with an understanding of the antecedents of today’s system; in other words, to provide some historical perspective. However, gathering consistent and comparable data for the last decade in Victoria proved to be significantly more difficult than anticipated. Because of the dramatic changes in system structure and performance, and organisational changes, many time series are not available on a truly consistent basis. The report gathers the data that are available, but less reliance should be placed on the numbers in this study than in others the authors have been involved with. The workers’ compensation system in Victoria has been a rapidly evolving one. Most of these data are displayed in Appendix Table A-1.

Interviews

The interviews were designed to probe beyond the statutory language and policy manuals, to discover how the statutes actually are implemented in practice and how stakeholders experience the system. We conducted over 300 interviews with some 260 separate individuals who had substantial experience in and around the Victorian workers’ compensation system. They represent a wide variety 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 HSD 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 management of the VWA.

Labour stakeholders 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.

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 talked with administrators of two other state workers’ compensation schemes in Australia, three federal agencies, and six other State of Victoria agencies. All the individuals we interviewed are listed in Appendix Table A-2. 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 Draft Final Report was circulated to about 50 persons for their review and comment in June of 1997. Their cooperation 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 to completion of the study. The authors, however, remain responsible for any errors of fact or interpretation.

One limitation of the research approach is that we did not have the opportunity to survey or to interview a large number of individual injured workers. Since injured workers are the major beneficiaries of the workers’ compensation system, that could be a serious shortcoming. However, our extensive contacts with organised labour and worker advocacy groups served the same purpose, with obvious gains in efficiency. In addition, the VWA is already collecting feedback from external stakeholder communities, and we were allowed to share this information. Thus, this report relies on the representatives of organised labour, injured-worker advocacy groups, the formal client surveys sponsored by the VWA, the staff of the VWA and its authorised insurers, and our own instincts to represent the views of injured workers in Victoria.

Organisation of the Report

The report follows the list of basic questions given above. This chapter concludes with a brief overview of Victoria’s industrial environment. Chapter 2 presents the recent history of the scheme, including an analysis of the perceived failures of WorkCare between 1985 and 1992, which shaped the new WorkCover scheme so decisively. 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 workers’ compensation system. It also contains a brief overview of the claims process, including the rate at which claims flow through the entire workers’ compensation system.
The fourth chapter contains a description and analysis of the unique workers' compensation insurance scheme in Victoria. It employs a principal/agent model and uses techniques of analysis from industrial organisation economics to explore the structure and performance of the scheme. 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 Conciliation Services, Medical Panels, the Administrative Appeals Tribunal, and the courts. The seventh chapter is concerned with the occupational rehabilitation function in Victoria, including the historical antecedents of the current system.

Chapter 8 examines the structure and operation of the Health and Safety Division of the VWA as it pursues its critical mission of preventing injuries and illnesses. A brief history of health and safety regulation in Victoria helps to illuminate the important determinants of these policies and approaches. Finally, Chapter 9 presents the study's Attention Points, the professional judgments of the authors about those areas that might need additional examination by policy makers, in Victoria and elsewhere. Attention Points were formulated after the Draft Final Report had been reviewed by interviewees, i.e., those who were capable of correcting our interpretation of the facts.

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 is important 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 2.0 million persons working in approximately 221,000 enterprises. The average unemployment rate during 1995-96 was about 8.4 percent. Small employers (under $800,000 payroll) represent 88 percent of the enterprises but employ only 26 percent of the workforce. On the other hand, large enterprises (over $800,000 payroll) represent just 12 percent of the total but they employ 74 percent of the workforce.
Both the enterprises and the employees are heavily concentrated in the urban areas of the state. Greater Melbourne contains 81 percent of the workforce and 71 percent of the enterprises. Regional cities account for about 6 percent of the enterprises and the workforce. The remaining 13 percent of the workforce is employed in the 23 percent of the 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 or the state Industrial Relations Commission. Formerly, these were basically industry agreements over the terms and conditions of employment. With deregulation of industrial relations in Australia, they have become more a statement of the basic recognition of the union and its areas of authority, including dispute resolution procedures, etc. Built upon the Award is the "Enterprise Agreement," which is a collectively bargained agreement for a specific term between the union and the employer. It adds to and amends the basic terms of the award to accommodate the requirements of the individual enterprise. The Enterprise Agreement also sets out the collectively bargained terms and conditions of employment.

Australia is being swept by the "privatisation" movement. In everything from telecommunications to prisons, the trend is toward the private sector initiative and away from government production. The Liberal Party has been riding this movement and using it against the Australian Labour Party in the political realm. This has been successful in several states and ultimately, in 1996, at the national level. As will be discussed below, this wave has
notably included the state of Victoria, where the Liberal coalition won political dominance in November 1992. Changing the “inflexibility” of Australian industrial relations based upon the award system has been very much a part of this change.¹ One of the first actions the Liberal-National Coalition took in Victoria was to “reform” the workers’ compensation system. Thus, the issues discussed in this report are at the core of the intense political competition over “privatisation” in Australia during the past several years.

With this background in place, let us proceed to review the current workers’ compensation system in Victoria and how it operates. As indicated earlier, we begin with an overview of the history of workers’ compensation in Victoria.

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

<table>
<thead>
<tr>
<th>Industry Sectors</th>
<th>Workforce %</th>
<th>Enterprises %</th>
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</thead>
<tbody>
<tr>
<td>Agriculture, Forestry</td>
<td>4.7</td>
<td>7.4</td>
</tr>
<tr>
<td>Fishing &amp; Mining</td>
<td>0.2</td>
<td>0.2</td>
</tr>
<tr>
<td>Manufacturing</td>
<td>17.2</td>
<td>9.2</td>
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<tr>
<td>Utilities</td>
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<td>0.3</td>
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<td>Construction</td>
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<td>Wholesale Trade</td>
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<td>16.8</td>
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<tr>
<td>Hotels, Cafes, Restaurants</td>
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<td>n/a</td>
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<td>Government Administration</td>
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<td>0.3</td>
</tr>
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<tr>
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<tr>
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Source: Australian Bureau of Statistics
Chapter 2

BACKGROUND TO THE VICTORIAN WORKCOVER SYSTEM
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Introduction

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.

In this report, such contextual material will be presented in three different sections, corresponding to the three broad missions of workers’ compensation systems; prevention, compensation, and rehabilitation. In the present chapter, the history of compensation will be laid out in considerable detail. Chapter 7 uses the recent history of occupational rehabilitation in Victoria to explain the policy environment in which occupational rehabilitation is practiced today. Chapter 8 contains a brief history of the origins of injury and illness prevention legislation in Victoria. In each instance, the historical material helps to illuminate the “policy setting” which shapes current practice. We expect this material will be particularly useful to non-Australian readers, for whom this information is much less familiar.
Australian Workers' Compensation in Context

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 rather than the national level. As a result there are ten 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 territory systems plus 2 federal schemes in Canada, and the 50 state systems plus that 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 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 ten Australian schemes, is involved in a process of trying to achieve greater national consistency. 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

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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 that Australia came to the debates on alternative approaches to workers' compensation which 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. Nor was there a figure such as Sir William Meredith, the Chief Justice of Ontario, whose investigations and reports to the 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. 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

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(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 provision of rehabilitation services was a prominent feature of workers’ compensation administration from the beginning.

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 2 decades, there have been at least 16 official inquiries into the reform of workers’ compensation schemes and that, since 1985, there have been nine new legislative schemes introduced.

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. 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 that insurers were operating in. This enactment introduced a more competitive commercial environment that required some years of adjustment, and 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 which 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 over-capacity in the international re-insurance 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 and this 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) who 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, collectively, these insurers had made provisions of $501 million for outstanding claims, the required figure was some $723 million; that is, as a group, they were under-reserved by some 31 percent.

The Problem of Contested Claims

While this roller coaster behaviour of the premium system over the period between 1975 and 1983 shook the confidence of the business community 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

5Ibid., p. 2.
1.6 percent of cases following this average 2-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 Workers’ Compensation Board. 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 Workers’ Compensation Board, 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

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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.
specialist knowledge and expertise. The stakeholder representation included injured workers, employer and trade bodies, trade unions, insurers and brokers, doctors, lawyers, rehabilitation providers, and risk managers.

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 Workers' Compensation Board; 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 co-author of a book on this area. The Committee also met informally with Judge Harris, who had conducted a review of Victorian workers' compensation 7 years previously.

7 North Richmond Workers' Compensation Support Group.
9 Australian Railways Union, Building Workers' Industrial Union of Australia, Federated Liquor Industries Union and the Victorian Trades Hall Council.
11 Australian Medical Association.
12 Victorian 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.
13 Industrial Rehabilitation Service and Vocational Rehabilitation Service.
14 Association of Risk and Insurance Managers of Australia.
While the clear intention of some within Government was that the Committee would simply "dust off the Harris recommendations and add some refinements," the Committee in fact undertook a comprehensive investigation of almost all aspects of the Victorian workers' compensation system. This was sometimes a tortuous process, 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." 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)

On a number of important issues the Committee divided 3-2 in its decisions. 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


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

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.

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 which 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, 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 scope to reduce the level of labour costs to Victorian producers, without reducing the level of benefit to employees.” 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, 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 State Insurance Office, and that premium collection would be

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19 Ibid., pp. 129-130.

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, who were 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 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

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

22Accident Compensation Act 1985, Section 19(c).
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, from 1 December 1992. It is this concept of WorkCare which is addressed in the following sections of this chapter.

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 4 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 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.

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 Department of Management and Budget 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. 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

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23 It 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 Accident Compensation Commission.

24 The 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.
return to work or referral to the Tribunal [and failing] to respond to employer’s inquiries, complaints and requests for information.\textsuperscript{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 agents with increased return to work rates and more effective claims management. In its 1988-1989 annual report, the Accident Compensation Commission 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.\textsuperscript{26}

The crafting of a package of remuneration provisions which more appropriately met that balance proved to be a continuing challenge for the Accident Compensation Commission 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.

\textsuperscript{25}WorkCare: Government Statement, 31 July 1987, para. 4.10.

\textsuperscript{26}Accident Compensation Commission, Annual Report 1988/89, p. 23.
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 which 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 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 state-wide basis would not exceed 2.4 percent of employee remuneration over the first 5 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 2 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.

This shortfall was contributed to by a number of factors. 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 under-registration of employers was skewed towards high levy rate industries.

A reallocation of industries and levy rates on the basis of actual claims experience over the first 2 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 Workers' Compensation Board, 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 2 years of WorkCare's operations, the percentage of total claims which were disputed in this manner was 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 their 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 7 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 9-month review by the Department of Management and Budget of the scheme. 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.\textsuperscript{27}

The Government Statement announced a 10-point reform programme, the major elements of which became part of the \textit{Accident Compensation (Amendment) Act 1987} which came into force on 1 December 1987 and which were 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

\textsuperscript{27}\textit{WorkCare: Government Statement, 31 July 1987, para 1.6.}
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 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, over 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


29 Ibid., p. 7.
(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.\textsuperscript{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 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.\textsuperscript{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

\textsuperscript{30}Boston Consulting Group, \textit{Benchmarking Best Practice: Cost Drivers in Australian Workers' Compensation Systems} (July 1992).

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. The new WorkCover system and its performance are the subjects of the remaining chapters of this review.

Concluding Observations

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 (usually through prescribed monetary limits) of income loss, 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.

The 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 become 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 legislation.
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 upon 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 data base 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 and 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. It is to that system that we now turn our attention.
Table 2.1 Where the Premium Dollar Goes—Victoria (circa 1983)

<table>
<thead>
<tr>
<th>Weekly Payments</th>
<th>22%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Redemptions</td>
<td>16%</td>
</tr>
<tr>
<td>Common Law</td>
<td>10%</td>
</tr>
<tr>
<td>Death</td>
<td>3%</td>
</tr>
<tr>
<td>Table of Maims</td>
<td>1%</td>
</tr>
<tr>
<td>Hospital and Medical</td>
<td>17%</td>
</tr>
<tr>
<td>Administration</td>
<td>15%</td>
</tr>
<tr>
<td>Legal</td>
<td>12%</td>
</tr>
<tr>
<td>Brokerage</td>
<td>4%</td>
</tr>
<tr>
<td>TOTAL</td>
<td>100%</td>
</tr>
</tbody>
</table>

Source: Cooney Report, Table 1-16.
Table 2.2 Performance of the WorkCare Scheme: 1985/86 to 1991/92

<table>
<thead>
<tr>
<th></th>
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<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Estimated Incurred Claims²</td>
<td>81,883</td>
<td>100,116</td>
<td>95,069</td>
<td>91,965</td>
<td>83,745</td>
<td>77,113</td>
<td>70,479</td>
</tr>
<tr>
<td>Total Income³ ($M)</td>
<td>471</td>
<td>747</td>
<td>632</td>
<td>854</td>
<td>1,250</td>
<td>1,407</td>
<td>1,321</td>
</tr>
<tr>
<td>New Claim Payments ($M)</td>
<td>65</td>
<td>333</td>
<td>538</td>
<td>715</td>
<td>694</td>
<td>749</td>
<td>910</td>
</tr>
<tr>
<td>Operating Surplus/ (deficit)⁴ ($M)</td>
<td>353</td>
<td>335</td>
<td>(9)</td>
<td>(12)</td>
<td>374</td>
<td>472</td>
<td>193</td>
</tr>
<tr>
<td>Net Outstanding Claims Liabilities ($M)</td>
<td>535</td>
<td>2,300</td>
<td>2,720</td>
<td>4,865</td>
<td>3,532</td>
<td>3,347</td>
<td>3,583</td>
</tr>
<tr>
<td>Net Assets⁵ ($M)</td>
<td>369</td>
<td>704</td>
<td>694</td>
<td>682</td>
<td>1,056</td>
<td>1,528</td>
<td>1,721</td>
</tr>
<tr>
<td>Unfunded Liabilities ($M)</td>
<td>165</td>
<td>1,596</td>
<td>2,025</td>
<td>4,182</td>
<td>2,476</td>
<td>1,819</td>
<td>1,862</td>
</tr>
<tr>
<td>Funding Ratio (%)</td>
<td>69.0</td>
<td>30.6</td>
<td>25.6</td>
<td>14.0</td>
<td>29.9</td>
<td>45.7</td>
<td>48.0</td>
</tr>
</tbody>
</table>

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.
Chapter 3

GOVERNANCE AND ORGANISATION OF WORKERS’ COMPENSATION IN VICTORIA
Chapter 3 GOVERNANCE AND ORGANISATION OF WORKERS' COMPENSATION IN VICTORIA

This chapter will provide a brief introduction to the structure and functions of the VWA as of July 1996. While many of these topics will be explored in more detail later, it is useful to provide an overview, particularly for the reader who is not already familiar with the Victorian workers' compensation scheme. The chapter will conclude with an analysis of the volume of claims in Victoria.

The Legislative Mandate

The Victorian WorkCover Authority (VWA) was created by the Accident Compensation (WorkCover) Act of 1992, which completely restructured the workers' compensation system in Victoria, as recounted in the previous chapter. According to the Accident Compensation Act 1985, as amended (the Act), the objectives of the Authority are to

(a) manage the accident compensation scheme as effectively and efficiently and economically as is possible;
(b) administer . . . [the Act] . . . and any other relevant Act;
(c) assist employers and workers in achieving healthy and safe working environments;
(d) promote the effective occupational rehabilitation of injured workers and their early return to work;
(e) encourage the provision of suitable employment opportunities to workers who have been injured;
(f) ensure that appropriate compensation is paid to injured workers in the most socially and economically appropriate manner and as expeditiously as possible;
(g) develop such internal management structures and procedures as will enable the Authority to perform its functions and exercise its powers effectively, efficiently and economically. (Section 19)

The functions of the Victorian WorkCover Authority are very comprehensive. It oversees the workers' compensation insurance system, including regulating authorised insurers and superintending the operation of the WorkCover Authority Fund, which acts as a 100 percent re-insurance fund, and thus bears the actuarial risk of the Victorian scheme. As part of
its workers’ compensation responsibilities, the VWA also regulates the public and private system that accomplishes the medical, physical, and occupational rehabilitation of injured workers. It is largely responsible for maintaining the focus of this system on the effective, economical, and durable return-to-work objective.

It manages (effective 2 July 1996) the occupational health and safety system in Victoria, including standards setting, inspection, enforcement, education, and prosecution activities. It is responsible for public safety under the Dangerous Goods Act, the Road Transport (Dangerous Goods) Act, and the Equipment (Public Safety) Act. The VWA also acts as the main policy development and evaluation body for the areas of workers’ compensation and occupational safety and health in Victoria. As such, it works closely with the Ministry for Finance in formulating public policy in these critical areas. It also has general responsibility for fostering a co-operative consultative relationship between management and labour in relation to the health, safety and welfare of persons at work (Section 20). According to the Victorian WorkCover Authority, 1995-96 Annual Report, “WorkCover exists to prevent work injuries, achieve return to work after injury, provide fair compensation and deliver quality service to both workers and employers at a competitive cost to business.” (p. 7)

VWA Governance

The VWA is headed by a Board of Management, which includes a full-time Director, who acts as Chief Executive of the Authority, and not more than six part-time Directors, appointed by the Governor in Council (Sections 24-26). Directors serve at the pleasure of the Governor in Council for terms not exceeding 5 years and are eligible for re-appointment. It is also provided that the Governor in Council may appoint one of the Directors to be Chairperson (Section 27). The Board of Management meets at least 10 times in each calendar year at the call of the Chairperson, and a majority of Directors in office constitute a quorum. Questions are decided by a majority of votes of the Directors present and voting on the question. The Chairperson, or other person presiding, has a second, or casting, vote in the event of a tie vote (Section 28).
The Director of the Board and Chief Executive of the VWA is appointed by the Governor in Council and "... any act, matter or thing done in the name of, or on behalf of, the Authority, by the Chief Executive is to be taken to have been done by the Authority." (Section 25) The remuneration and terms and condition of appointment of the Chief Executive of the VWA are not set by statute, but are determined by the Governor in Council.

The Act also establishes the WorkCover Authority Fund. It receives premium income, investment income, penalties, and other income and is responsible for payment of compensation, rehabilitation, and any other payments required under this or any other Act. This specifically includes the costs of the Health and Safety Division (and the predecessor Health and Safety Organisation as described in Chapter 8). In addition, the Fund is responsible for the payment of the costs of administration of the VWA (including the Board of Directors and the WorkCover Advisory Committee), the costs of the Medical Panels, the County Court, Magistrates' Court and the Administrative Appeals Tribunal arising from the operation of the Act. (Section 32(4)) In addition, "the Authority may obtain financial accommodation subject to and in accordance with the powers conferred on it under the Borrowing and Investment Powers Act 1987." (Section 33)

The statute also calls for a WorkCover Advisory Committee, appointed by the Minister, to advise the Board in relation to its objectives:

(a) to promote a healthy and safe work environment; and
(b) to ensure that appropriate compensation is paid to injured workers in the most socially and economically appropriate manner and as expeditiously as possible; and
(c) to promote the occupational rehabilitation and early return to work of injured workers. (Section 31A(1))

The Advisory Committee is to include persons with a sound knowledge of the law relating to accident compensation, persons with experience in hospital services or medical services, occupational health and safety, occupational rehabilitation, and persons with experience in accident compensation who are nominated by Victorian employer and employee groups. (Section 31A(2))

In its insurance role, the VWA operates, in essence, as a re-insurer that bears the full underwriting risk of the scheme. The day-to-day collection of premiums and payment of
compensation benefits under the Act are conducted by authorised agents, generally referred to as “authorised insurers.” See Chapter 4 for a full discussion of this relationship, perhaps the most unique feature of workers' compensation in Victoria. The Authority has the power to appoint and terminate such authorised insurers. In July 1996, there were 14 authorised insurers operating in Victoria. Authorised agents must keep appropriate accounting records relating to transactions under the Act, and the Authority may compel the production of such accounting records for audit and inspection as necessary. (Section 23 (6) and (7)) In fact, the VWA has exercised considerable oversight and control over the authorised insurers (see Chapter 4).

Other Major Players in the Victorian Workers’ Compensation System

The Governor in Council, the Parliament, and the Minister are the ultimate sources of authority in the Victorian workers' compensation system. The VWA is the major administrative agent, but not the only major player. The County Courts and the Magistrates' Courts review decisions of the VWA and its authorised insurers. The Administrative Appeals Tribunal also hears certain disputes about workers' compensation matters. The Conciliation Service attempts to prevent disputes in workers' compensation cases from spreading to the courts. Medical Panels are constituted for individual disputes and hold sway over the decisions that will ultimately determine compensability of individual conditions. The function of all these entities is described in full in Chapter 6, Disputes and Their Resolution. They will only be briefly highlighted here.

Conciliation Service

The Act specifies that “... the Authority must engage persons nominated by the Minister as Conciliation Officers.” (Section 54) However, the VWA appoints “... such other officers and employees as are necessary ...” (Section 54) Thus, the Conciliation Service has a unique status and reporting relationship as they are employees of the VWA, but answering directly to the Minister for their performance. According to the Act, “... the Senior Conciliation Officer ... must observe any guidelines issued by the Minister.” The Conciliation Service had a staff of 81 at 19 March 1996 and a 1995-96 administrative budget of
Conciliation Service had a staff of 81 at 19 March 1996 and a 1995-96 administrative budget of $4.1 million.

Medical Panels

Medical Panels are nominated by the Convenor, who is appointed by the Minister. The Panels are drawn from a list of medical practitioners appointed by the Governor in Council and may consist of one, two or three members as determined by the Convenor of the Medical Panels. As discussed in Chapter 6, a Medical Panel is charged with giving 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 . . . (Section 67) Cases may be referred to a Medical Panel by a Conciliation Officer, the County Court, an authorised insurer or self-insurer, or the VWA. Medical Panels had a 1995-96 administrative budget of $485,000.

The Courts

The courts in Victoria have broad jurisdiction over workers' compensation matters. Since workers' compensation in Victoria is not an exclusive remedy for the worker against his/her employer, there is a considerable amount of court activity. However, a matter may not be taken to court in Victoria unless it has first been through Conciliation Services. This is an attempt to prevent expensive litigation over matters that could be resolved more directly between the parties. The Magistrates' Court may not hear matters involving death claims and is limited to matters involving less than $40,000 or 104 weeks of weekly benefits. (Section 43) County Court is somewhat more formal than Magistrates' Court, but still not bound by rules of evidence. (Section 44) Either Magistrates' Court or County Court may refer a matter in dispute to a Medical Panel, and is bound by the determination of such a panel. Decisions of the Court can be appealed to the Supreme Court, but only on questions of law. (Section 52)
Administrative Appeals Tribunal

The Administrative Appeals Tribunal also adjudicates disputes emanating from the workers’ compensation system. The Tribunal’s jurisdiction extends to the following range of matters:

(a) various disputes about medical and like services under Sections 99, 99A or 99B (bearing in mind that Section 99B is now repealed) after the Conciliation requirement has been observed;
(b) contribution matters under Sections 129A-129M.

There are other disputes over the funding of claims and other various issues that will be discussed later in Chapter 6. The VWA transferred some $4.6 million to the Department of Justice in 1995-96 to support the operation of the Courts and the Administrative Appeals Tribunal with respect to workers’ compensation matters.

Structure of the VWA

The VWA was reorganised in July of 1996 when it absorbed the former Health and Safety Organisation (HSO) as the new Health and Safety Division (HSD) of the VWA. (see Chapter 8) This consolidation represented an attempt by the government to provide closer coordination between prevention efforts and monetary incentives. Figure 3.1 shows the organisation of the VWA as of July 1996. The major operating arms of the VWA are the Health and Safety Division, the Scheme Regulation Division, and the Scheme Development Division. In addition, there are a number of important corporate service groups that are part of the central administration of the VWA. These include Corporate Affairs, Information Services, and Finance and Corporate Services. There are also the normal corporate functions of Human Resources and Legal Services, attached directly to the office of the Chief Executive. Figure 3.1 depicts the broad structure of the VWA as of July 1996 (i.e., right after the reorganisation).

Health and Safety Division

The Health and Safety Division (HSD) of the Victorian WorkCover Authority is responsible for administering health and safety legislation in Victoria, primarily the
Occupational Health and Safety Act 1985, the Dangerous Goods Act 1985, and the Equipment (Public Safety) Act 1994. HSD undertakes activities aimed at improving health and safety in workplaces, strives to improve health and safety in the agricultural and farming sector, and facilitates public safety. A major focus of HSD is regulating the transport, handling, and storage of dangerous goods and hazardous substances, including the notification and registration of premises and the licensing of drivers carrying dangerous goods. Licensing of fireworks displays and the manufacture, use, importation, storage, transport, and sale of explosives are also the responsibility of HSD. The structure and function of HSD will be dealt with in detail in Chapter 8.

There are three Operations Sections organised geographically as Eastern, Central and Western, with each headed by a Director. In addition to the Melbourne headquarters operations, there are a total of 11 offices around the state, with each staffed by Inspectors and (generally) an Information Officer and headed by a Manager. In addition, each of the Directors has state-wide responsibility for a particular type of hazard. The Director of Eastern Operations has state-wide responsibility for Work Environment Hazards; the Director of Central Operations has state-wide responsibility for Plant Hazards; and the Director of Western Operations has state-wide responsibility for Dangerous Goods. This matrix management structure resulted from a 1994 independent consultant review of the organisation and its mission.

In addition to the Operations Sections, there are three specialist sections that primarily serve internal HSD needs. The Technology Section provides scientific, engineering and other technical advice and support for the other sections. It also provides technical research and analysis to identify and provide advice on current and emerging technical issues with potential to impact on health and safety. It is composed of the Hygiene Unit, Mechanical Engineering Unit, Occupational Medicine Unit, Chemical Technology Unit, and Ergonomics Unit.

The Strategy Section manages key policy, standards and strategy processes to achieve HSD objectives. In association with other divisions it undertakes policy development, research and review, standards development and coordination, strategic planning, management information systems, marketing and awareness, corporate performance support, and
investigations and prosecution. It is composed of a Legislation Policy Unit, Planning and Review Unit, Standards Development Co-ordination Unit, Central Investigation Unit, Organisational Development Unit, and Marketing Unit.

The third specialist section is called the Development Taskforce. It undertakes initiatives aimed at identifying and developing creative approaches to the establishment and marketing of HSD services. It manages projects to leverage HSD’s impact externally with business sectors, including employer and employee associations, educational institutions and the general community. The key objective is the use of private sector and community sector infrastructure to improve health and safety outcomes. This section was initiated as an experiment in leveraging the expertise of the HSD through external organisations and processes. It will be evaluated at the end of the experimental period for its overall impact on HSD mission achievement.

Scheme Regulation Division

The Scheme Regulation Division has responsibility for the regulation of scheme participants, including authorised insurers, self-insurers, medical and like providers, occupational rehabilitation providers, and others. The Insurance Section deals with the traditional regulatory issues that would be familiar in most workers’ compensation systems in North America, including the regulation of self-insurers. The relationship between the VWA and authorised insurers is especially complex. The participation and oversight responsibilities of the VWA in the insurance functions are greater than in a typical private workers’ compensation insurance system (as in most U.S. states). Moreover, they are more complex than those of a typical exclusive public workers’ compensation fund (as in Canada and several U.S. states), because private organisations are performing the basic client service functions. This relationship and the general performance of the insurance system will be examined in detail in Chapter 4.

Scheme Regulation’s basic mandate is to regulate the performance of the authorised insurers. It does this through its Insurance Section, which licenses insurers, audits their performance, and monitors their outcomes with the Authorised Insurer Quarterly Performance
Table. They also manage the Best Practice Incentive scheme which provided some $6 million (about 10 percent supplement to base fees) in performance-based compensation for authorised insurers in 1995-96. Scheme Regulation negotiates annually with the authorised insurers over the terms of their compensation (both base and incentive-based).

The approval of self-insurers is also the responsibility of the VWA. Self-insurance is treated as a privilege in Victoria and the VWA is mandated to determine whether an applicant for self-insurance is fit and proper to be self-insured. (Section 142) The Self-Insurer Regulation Unit of the Insurance Section does the staff work for the approval of self-insurers under the Act. This does not just involve the question of whether the body corporate is able to meet its workers’ compensation liabilities and has the resources to administer claims on its own, but also questions of the level of incidence and the aggregate cost of injuries, and the safety of the working conditions maintained by the self-insurer. Only 23 self-insurers were authorised as of July 1996.

The Investigations & Compliance Section is in charge of conducting such investigations into questions of fraud and abuse as might be necessary. In addition, this unit conducted the massive run-down of some 22,000 pre-WorkCover common law cases. The Investigations & Compliance section also conducts the VWA payroll audits (or Wage Audits). The authority for collecting the employer payment for workers’ compensation insurance coverage was transferred from the State Taxation Office to the VWA in 1993. As a result, the VWA had to inaugurate a system of payroll audits, to insure that employers give accurate reports of their employment and payroll levels. This has been done through a contracted external audit system with a performance-based fee for the auditors, based on the amount of payroll they discover that was not covered by VWA premium. In the first year of this program (for 1993-94 payrolls, completed during calendar year 1996), the VWA paid out $4.6 million in audit fees for the recovery of $15 million in unreported premium and some $5 million in penalties.

The Health and Rehabilitation Branch reviews and implements policy on rehabilitation providers (which, in Victoria, includes a wide variety of professionals, from physiotherapists and chiropractors to naturopaths and massage therapists in addition to vocational or occupational rehabilitation practitioners). The Health & Rehabilitation Branch also regulates
the prices of medical and like services, conducts utilisation reviews, and promulgates practice
guidelines. These issues are reviewed in Chapter 5 below. Some of the functions have been
transferred to Provider Services section in the Insurance Branch, effective March 1996.
Chapter 7 examines the working of the occupational rehabilitation system.

The utilisation review consists primarily of a review of the frequency of treatment by
individual practitioners (medical, physiotherapy, chiropractic, psychological and others). “Bad
players” are identified internally by the VWA and resolution is sought in cooperation with the
relevant professional licensure group. In the past, one practitioner has had a licence to practice
suspended for a year and several have been fined and directed to conduct specific remedial
efforts.

Scheme Development Division

The Scheme Development Division is responsible for research and development,
business planning, legislation and policy issues, and the actuarial functions of the VWA. The
Legislation unit is responsible for drafting and interpretation of legislation; essentially it is the
legal eyes and ears of the VWA. The Policy unit provides support for policy development,
including intelligence on scheme practices in other states and other countries. This unit has
also been supporting VWA participation in the national Heads of Workers’ Compensation
Authorities (HWCA) organisation and their drive toward greater standardisation of workers’
compensation law and practice among Australian states. The Business Planning unit produces
special reports and analyses for senior management at the VWA. It also calculates the key
performance indicators for the VWA and measures that performance against the annual
corporate plan.

The Research & Development unit supports external research designed to improve the
overall efficacy of the scheme in reducing injuries, or mitigating their effects. It had an
external grant budget of $700,000 in 1995-96. There have been some stimulating research
results generated, including the Ballarat Project, which sought to test the impact of general
awareness media ads on specific injuries in particular industries. It appears that significant
reductions in injury incidence and severity were obtained in a media campaign aimed at back
strain in the hospital and trucking sectors in Ballarat. This unit also administers grants to community-based organisations seeking to assist disabled workers with recovery and return to work. This aspect is discussed more thoroughly in Chapter 7.

The Actuarial & Statistical Services unit is responsible for the actuarial assessment of the Fund and the adequacy of the premium level to support the scheme. They use two outside actuarial consultants with contrasting methodologies to inform these issues. In addition, this unit is involved in developing the F factors for individual insurers. These F factors are used to adjust individual authorised insurer claim reserve estimates to offset the historical tendency to underestimate future costs. In essence, this prevents the scheme from tending to under-funding by virtue of underestimation of future commitments emanating from current claims. This issue is discussed in Chapter 4 below.

Information Services Division

Information Services had a 1995-96 budget of $21.2 million; but only about 20 percent of this was spent on internal systems, as the rest was contracted out to Continuum, Australia. Continuum administers the ACCtion main frame transaction processing system and a related management reporting database that the VWA and the authorised insurers use for claims and premium processing. Development and operation of ACCtion by VWA began in 1987, and it was outsourced to Continuum in 1993. There has been a great deal of controversy about the future of the ACCtion system, interlinked with the issue of further privatisation of the Victorian scheme. Plans have been under development, and redevelopment, since 1992 for replacing the aging ACCtion database. However, there has been no agreement to date within the VWA, or between the VWA and the authorised insurers, as to the optimum strategy to follow. The Authority also maintains PC and UNIX applications supporting internal operation of the organisation. The VWA uses package-based payroll, financial, and records management systems and has built Oracle-based systems in house to support specialised functions such as audit management and conciliation.
Corporate Affairs Division

Corporate Affairs does the public relations and public information work of the VWA. It had a 1995-96 budget of $9.9 million, most of which was for media purchase. The Division has maintained a very high profile in recent years with a series of public awareness campaigns stressing the themes of return-to-work and prevention of workplace accidents. These advertising efforts are given much of the credit for the turnaround in system performance and the fundamental change in the workers' compensation culture in Victoria since 1992.

Finance and Corporate Services Division

The Finance and Corporate Services Division does the accounting, budgeting and financial performance monitoring for the VWA. The Division had oversight responsibility for claims payments of $670.4 million, payments to insurers and agents of $80.4 million, a total VWA administrative budget of $69.4 million, and payments to other agencies of $24.5 million in 1995-96. The management of the VWA fund reserves was transferred from this Division to the Victorian Funds Management Corporation in late 1995, in an attempt to obtain greater economies of scale in investment management. This agency manages about 3 billion in VWA reserves, which generated net investment income for the VWA during 1995-96 of $286 million.

Claim Flow Analysis

There are three very different ways of looking at the dynamic population of claims in any workers' compensation system. One can take a common point of origin approach, grouping together all claims that originate in the same period. For the most part, such claims will have common injury dates as well, but that is not always true since some claims may take considerable time to be reported, for a wide variety of reasons. It is also possible to take a common closing date approach, looking backward from the time that the claim is "resolved" and developing aggregate measures over the duration of the claim. We put resolved in quotes because the degree of finality of closure depends ultimately on the legal system, and because of the potential for claims that seem resolved to resurface or reopen as conditions change. Third,
it is possible to take a stock approach and just count the number of claims active at any point in time. We will employ both the first and last of these methods to examine the flow of claims in the workers’ compensation system of Victoria.

Claims Lodged

Figure 3.2 shows the number of claims lodged with the VWA and its authorised insurers during fiscal year 1995-96 (1 July 1995 through 30 June 1996) and their outcomes, at least so far as these are known at this point. Of a total of 33,291 claims lodged, some 29,261 (or 88 percent) were paid by the authorised insurers and a total of 4,030 (or 12 percent) were rejected. Of those rejected during 1995-96, only 374 (or 9 percent) had appealed that decision as of 30 June 1996. This should not be regarded as the final appeal rate, however, as some additional appeals can be expected after the end of the fiscal year on claims arising during 1995-96. As shown in the figure, very few of these disputes had yet settled by 30 June 1996; with only nine resolved by that date, five successful and four unsuccessful from the claimant’s perspective.

Among the paid claims, disputes developed among 1,587 (or 5.4 percent) on some matter subsequent to basic compensability. This could be over the level of the benefit, the degree of impairment, the point of recovery, suitable work, rehabilitation issues, etc. The 29,261 paid claims included 7,491 (or 35 percent) “Medical Only” claims. These claims did not involve loss of more than 10 days of work time (the “employer excess” or retained risk), but did involve more than $407 in medical costs. Disputes developed among 108 (or 1.4 percent) of these claims.

There were 21,770 claims lodged in 1995-96 that received weekly payments, i.e., disability exceeded the employer excess of 10 days. This represented 65 percent of the paid claims during the period. Among these, disputes developed between the worker and the insurer in 994 cases (4.6 percent). As in the case of the other dispute rates, this should be regarded as a minimal estimate, since some disputes are likely to be filed after the end of the fiscal year.

Victoria had 2,099 cases that received some occupational rehabilitation services during the year (or 7.2 percent of paid claims). There were no disputes recorded among these claims,
but again it is necessary to remember that insufficient time has passed for these claims to have finally resolved, so it can be expected that additional disputes will be recorded in the future against the 1995-96 cohort of claims. See Chapter 7 for a full description of occupational rehabilitation in Victoria.

There were 3,143 cases that received compensation for maims under Section 98 of the Act during the year (see Chapter 5). This represented 10.7 percent of the paid claims in 1995-96. Among those receiving payment, 583 (or 18.5 percent) showed a dispute sometime during the life of the claim. Finally, 179 proceedings were commenced under common law for damages. This is very preliminary, given the usual time delays with such claims, and can be expected to expand severalfold before the ledger is closed on 1995-96 injuries.

Active Claims

Figure 3.3 gives a very different idea of the number of injuries that flow through the Victorian workers’ compensation system. It shows all “active” claims during 1995-96, or the claims where some payment occurred during the fiscal year. The long duration of many workers’ compensation claims is readily apparent in the fact that there were over 100,000 active claims in 1995-96, as against only about 33,000 lodged during the year (from Figure 3.2).

Of the 100,124 active claims in 1995-96, 74,530 (or 74 percent) received weekly payments during the year. Collectively, they received $258.4 million in weekly benefits, or about $3,467 per claim. The figure shows that these cases received about 36 percent of all VWA payments during the year. Further, it is shown that 9,780 (or 13 percent) of these claims had conciliation services at some time and 42 involved Medical Panel referrals. In addition, there were a total of 1,738 appeals to County Court and 558 to Magistrates’ Court during the year. Most of these appeals were not resolved by the end of the period, but among those that had resolved during the year, 62 percent of Magistrates’ Court and 60 percent of County Court appeals had been accepted in favour of the worker.

Among the 25,594 medical only claims that were active during fiscal 1995-96, a much lower rate of disputation was evident. Only 704 of these claims involved Conciliation Services
and 16 were referred to Medical Panels. Further, there were 136 appeals to the Administrative Appeals Tribunal during the year with a success rate of 57 percent for the worker. These relatively simple claims (less than 10 days lost from work) were paid a total of $64.0 million, or about 8.8 percent of total payments during 1995-96.

Figure 3.3 indicates that there were 8,077 Section 98 (table of maims) claims active during 1995-96 (or 8.1 percent of all active claims). However, these claims involved much more than a proportionate amount of litigation, as the figure indicates that 4,856 of these (or 60.1 percent) involved Conciliation Services, and 3,343 (or 41.4 percent) involved Medical Panel referrals. They also accounted for 385 appeals to Magistrates' Court and 633 appeals to County Court. About 85 percent of both Magistrates' Court and County Court appeals were accepted in favour of the worker. Total payments for maims in 1995-96 amounted to $116.6 million, or about 15.7 percent of all system payments. Of this amount, about $12.6 million (or 10.8 percent) was for pain and suffering under Section 98A.

Last, Figure 3.3 shows that there were 727 common law actions "active" during 1995-96. While the number of these cases is not great, they are very expensive, with an average payment of $137,689. In aggregate, payments to such cases involved $100.1 million during the year, or about 13.8 percent of total payments. It is important to note that this number includes some of the "run-off" of pre-WorkCover common law claims, which were being settled in bulk during the period. Furthermore, it could be expected that since these were among the last "old" cases to settle, that they involved the most intractable issues. In fact, the figure shows that $82.2 million went to these old cases. Of course, 100 percent of such cases involve litigation; a total of 667 common law actions were filed in County Court and 60 with the Supreme Court. As indicated in the figure, a small minority of these cases had resolved by the end of the year.

With these preliminary elements in place, let us proceed to examine the specific performance areas of the workers' compensation system in Victoria, beginning with the insurance regulatory mechanisms in Chapter 4.
Figure 3.1

Victorian Workers' Compensation Administrative Structure
### CLAIMS LODGED IN 1995/96

<table>
<thead>
<tr>
<th>Category</th>
<th>Claims Lodged</th>
<th>Dispute</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>33,291</td>
<td>374</td>
</tr>
<tr>
<td>Claims Rejected</td>
<td>4,030 (12%)</td>
<td>• Successful 5</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Not Successful 4</td>
</tr>
<tr>
<td>Paid Claims</td>
<td>29,261 (88%)</td>
<td>1,587 (5.4%)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Subcategory</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Weekly Payments</td>
<td>21,770 (65%)</td>
<td>994 (4.6%)</td>
</tr>
<tr>
<td>Medical Only</td>
<td>7,491 (35%)</td>
<td>108 (1.4%)</td>
</tr>
<tr>
<td>Occupational Rehabilitation</td>
<td>2,099 (7%)</td>
<td>- Nil (Nil%)</td>
</tr>
<tr>
<td>Maims S.98</td>
<td>3,143 (10.7%)</td>
<td>583 (18.5%)</td>
</tr>
<tr>
<td>Common Law</td>
<td>179* (0.6%)</td>
<td></td>
</tr>
</tbody>
</table>

* All Common Law commenced as a result of Writ Lodgement
Figure 3.3

ALL ACTIVE CLAIMS 1995/96

Active Claims: 100,124
Total Amount: $726 million

Weekly Payments: 74,530
Conciliation: 9,780
Medical Panels Referrals*: 42
Magistrates' Court: 558
  • Accept**: 255
  • Reject: 156
County Court: 1,738
  • Accept: 343
  • Reject: 231
Total Amount: $258.4M
Total Payments: 35.6%

Medical Only: 25,594
Conciliation: 704
Medical Panels Referrals*: 16
Administrative Appeals: 136
  • Accept: 77
  • Reject: 31
Total Amount: $64.0M
Total Payments: 8.8%

S.98: 8,077
Conciliation: 4,856
Medical Panels Referrals*: 16
Magistrates' Court: 385
  • Accept: 242
  • Reject: 43
County Court: 633
  • Accept: 251
  • Reject: 46
Total Amount: $116.6M
S98: $104M S98A: $12.6M
Total Payments: 15.7%

Common Law: 727
N/A
County Court: 667
  • Accept: 143
  • Reject: 23
Supreme Court: 60
  • Accept: 4
  • Reject: 4
Total Amount: $100.1M
Old: $82.2M New: $17.9M
Total Payments: 13.8%

* Refers to all referrals to Medical Panels including Conciliation Referrals. Total Medical Panels=3,401 (98% are S98/104 plus S98A) (1% S99) (1% S93A, S93C)

** Accept means accepted in favour of the worker

Matters going to "Appeal" in 95/96 may not be included as they are unresolved at 30/6/96.
Chapter 4

REGULATORY ASPECTS OF THE VICTORIAN WORKCOVER SYSTEM
Chapter 4 REGULATORY ASPECTS OF THE VICTORIAN WORKCOVER SYSTEM

Chapter Objectives

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 understanding 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 21st 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. 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 differ and create 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 decisions 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 problem" 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’ behaviour.

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 towards 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 U.S.A. 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 non-traditional 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 U.S. except that VWA-authorised insurers go on
to compete for accounts, whereas in the U.S.A., 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. The VWA's ability to direct insurers' behaviour at this level is more limited, however.

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. 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.

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 Scheme

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

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1By law, insurers are prohibited from making monetary kickbacks to employers to get their business. However, it is commonly known that insurers do 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.
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 (see Figure 2.1). There are 4 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 sub-units, each supervised by a manager: (1) Business Systems; (2) Self-Insurers; (3) Licence Management 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 re-insurance agreement, supporting manuals, and policy documents that outline what is required of insurers. The Division also implements the Best Practice Incentive (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.

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 1995/96.2 As can be seen from this table, premiums, claims costs, and operating costs

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2Unless 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.
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 to a detailed set of obligations in performing workers' compensation services. Regulators use this mechanism to supervise insurers' activities and compel good performance with respect to scheme objectives. 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 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 also 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 3-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, and 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; and
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:

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

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 3-year period.

The experience factor also is adjusted by individual insurer F factors which are designed to correct insurers’ tendency to underestimate reserves.\(^3\) This is also intended to prevent insurers and employers from gaming the system by underestimating incurred losses to improve their experience adjustment. In theory, F factors are based on insurers’ initial estimates of reserves compared to 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

\(^3\)The VWA indicates that, historically, reserves have been underestimated by 30 percent.
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 semi-annual 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 include 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., 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 (1) a well-informed employer? (2) the provision of adequate and timely information by insurers? or (3) insurer responses to written requests within 10 working days? The difficulty in measuring (1) and (2) may incline the VWA to set a more specific, objective and measurable test as reflected in (3). Regardless of how they are viewed, the 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 penalizing 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 share 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 which 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 Best Practice incentive 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.

The VWA moved 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 perform statistical analysis used by the VWA for management and public information. The Regulation, Monitoring and Planning unit, in the Scheme Regulation Division, is responsible for statistical information and reports, Best Practice Incentive scheme calculations, market share calculations, remuneration fee calculations, and special requests. The Actuarial and Statistical Services unit, in the Scheme Development Division, also prepares
statistical analyses used for management information and planning, as well as premium and reserve calculations. The Business Analysis unit in the Scheme Development Division 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 2 years, but this function may revert to the Scheme Development Division in the future. These 3 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 believes is essential for the type of analyses that are performed. The database is divided into 200 tables, which facilitates analysis within a table but which requires more effort to join data across tables. Almost all data from ACCTion is 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 programs using various media to implement this strategy. Among its programs, 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 the most 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; discussions are underway 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 (previously they 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 HSD audit results.

Self-insurance authorisation is granted for an initial 3-year period, and every 4 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. Within the last year, the self-insureds have begun reporting data which the VWA uses to monitor and benchmark their performance. Self-insureds are not allowed to use 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 currently 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 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 emphasises growth and income within certain prescribed constraints. The VFMC’s inflation-adjusted return is between 4 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 2 to 3 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 unclear, 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 enforcing 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. An Australian Valuation Office is used to confirm real estate values.

The ISC system establishes three progressive layers of financial tests: (1) a solvency margin; (2) a capacity margin; and (3) 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. The ISC is now 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 emphasise 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' purchase 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

As noted above, there are currently 14 authorised insurers providing WorkCover services. 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 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 since 1993. 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 was 1,618 for 1993 and 1,374 for 1996.4 The 1993 levels of concentration would be considered relatively high by conventional standards, but the decrease in concentration over the last 4 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

4The Herfindahl-Hirschman Index (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 anti-trust guidelines define HHI's between 1,000 and 2,000 as constituting moderate market concentration and HHI's 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 U.S.A. have HHI's between 1,000 and 2,000 but are viewed as highly competitive.
to be more concentrated, all else equal (Klein, Nordman, and Fritz, 1993). It is not uncommon for larger state workers' compensation markets in the U.S. to have comparable levels of concentration.

Table 4.3 tracks insurer market shares over the last 4 years. 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 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 licencing 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 strategy is different than their competitors and essential to increasing their market share. 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. 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. Under the WorkCare scheme, the system was plagued by runaway costs, excessive durations, and a growing class of dependent injured workers. As discussed below, under WorkCover, prices have been stabilized, costs have decreased, and the availability of coverage is not an issue.

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

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

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

7 At the same time, recent developments in New South Wales indicate that this mixed public/private model is not immune to these problems.
attracting more high-risk employers. However, under WorkCover, insurers do not face this problem. 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 towards 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 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 workforce. 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 this is a serious problem or not. 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, less than 1 percent annually. 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 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 IBNR. Studies indicate that a significant portion (60 percent) of losses are not paid until 5 years after the injury year, so it is easy to see how insurers might underestimate needed reserves.

The VWA acknowledges that some insurers are getting better at analysing their losses and their risk 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 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

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8 This 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).
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 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 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 the 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 non-insurance providers have a stake in this, as increasing costs will increase pressure to lower 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, and is currently 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. Over 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 “rorting” the system.

The ability of Victoria to sustain this low cost is a 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 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 and benefiting from privatisation. A third possible 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 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 over this period. The scheme sustained a net loss every year during the 1986-1989 period. Since then, income has exceeded expenditures in all but 2 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. 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 and 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, insurers’ profits after income taxes varied 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. The question of what insurers require in terms of a fair rate of return on investment will depend heavily on the changes that Victoria will make in increasing private choice under WorkCover.
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 more innovative and better 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 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 the 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. Insurers do not have their money at stake and 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 towards employment-related coverages that involve human resource considerations. They feel 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 not be sufficiently responsive to small employers. The VWA indicated that the loss prevention advice that is provided 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. 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 is 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 status is unknown. The VWA will 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 towards 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 also 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 will become more relevant when the VWA publishes 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 or create a deficit that would have to be covered by other stakeholders. On the other hand, the failure of a WorkCover insurer, at the very least, would 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. Insurer solvency and financial solidity may become more important if privatisation measures delegate more responsibility to insurers and increase their level of financial risk.

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 on 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 their 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 for insurers’ role under
WorkCover may be somewhat different now than what was envisioned when the current
regulatory system was implemented. Is the regulatory system still optimally designed given the
present 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 evaluator. 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 licencing 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 penalizing 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 penalized 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 clearly 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 that 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 towards 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.9

9 Market 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. It is the primary mechanism which 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 (Z) factor 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. A 1995 VWA working paper (WorkCover Premium System) discusses these and a number of other issues and options.

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 costs; 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.

There also are questions with respect to the simplicity and transparency of the pricing formula. There appears 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 penalize 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 then it tended to “bleed premium” and, hence, it was raised to $360,000 in 1995-96 which it 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 under-reserving. 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 Best Practice Incentive 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 to 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 signalling aspect. This perception may change if employer performance statistics are published. Still, as long as the VWA bears the burden of claim costs, the 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 or 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 have 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 U.S.A. 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 has been a source of contention and 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.

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 tend to improve their experience although this, in part, 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 towards 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 5-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 U.S.A., cross-subsidies and other factors have helped to push approximately 30 to 40 percent of the workers’ compensation insurance market into self-insurance. 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
pursorts 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 program 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. So far the program has had 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.
Private Choice and Regulation

Another option for Victoria is delegating more insurance functions to the private sector. This has been a subject of considerable debate and great uncertainty. When WorkCover was first implemented, it was contemplated to be a transitional system that would eventually evolve into a largely privatised system. That plan is apparently being reconsidered in light of the concerns of employers and workers that such a change would not be in their best interests and might reverse some of the gains that have been made. This report is not intended to analyse or resolve the issues surrounding privatisation but it is useful to offer some observations on how some privatisation options might affect and possibly ease the principal-agent problem faced by the VWA.

Privatisation is not an either/or proposition in the Victorian context, but rather a matter of degree. Although full-scale privatisation is one of the options that have been proposed, less comprehensive measures also have received considerable discussion. Victoria is evaluating the degree of private choice and the significance of private incentives in promoting scheme performance. Many believe that the VWA has obtained the most it can get from an agency arrangement. Insurers do not have their money at risk, which diminishes their incentives to contain costs and serve the global objectives of the scheme. Modifying incentives and balancing regulatory mandates and private choice in a mixed system to achieve optimal performance raises a number of difficult issues that will have to be resolved. For example, if insurers bear more risk, then their ability to exercise underwriting judgment and pricing flexibility and the resulting implications for the availability of insurance coverage would have to be addressed.

Full Privatisation

The most radical proposal that has been put on the table is to return Victoria to a private market system with limited regulatory oversight. This would entail having insurers assume underwriting risk as well as the responsibility for setting prices and managing investments. Prices could be regulated in some fashion, but privatisation proponents express different opinions on how this should be handled. One approach would be to enforce, at least
initially, uniform rates established by the VWA and/or a rating organisation with limited opportunities for deviations. Constraints on insurers’ pricing discretion could be eased over time as insurers gain experience with the new system and its performance can be evaluated.

Insurers’ rates could be subject to prior regulatory approval before they go into effect, or some form of file and write or write and file system, which would rely more heavily on market forces to regulate rates. These approaches are often characterised as “competitive rating” systems but this term is used differently by different people. In reality, the type of approval process has less to do with competition than the extent to which regulators rely on market forces. In this discussion, the term competitive rating is used to characterise systems where regulators essentially let the market set prices and only intervene if they perceive that competition is lacking. Under a competitive rating system, advisory organisations might still develop “advisory” rates or loss costs which insurers might reference in determining their specific price structures.

Depending on one’s perspective, full privatisation and competition could effectively eliminate much of the principal-agent problem faced by the VWA. In theory, with full pricing flexibility, employer choice and competition should regulate insurers’ performance in controlling costs. More efficient insurers could offer lower prices to employers who demonstrated a commitment to loss prevention and effective claims management. The regulatory function could be limited to policing insurers’ financial soundness and compliance with the requirements of the workers’ compensation law and insurance contracts. The VWA also could increase the information provided to stakeholders to enhance the effectiveness of private choice.

However, the experience with the private system in place prior to WorkCare has produced a healthy skepticism among many employers, workers and regulators with respect to

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10 To illustrate, prior approval does not necessarily mean that regulators disapprove or require modifications to rates. This policy effectively lets the market set prices. Conversely, under file and write or write and file systems, regulators may frequently disapprove rates retroactively or threaten to do so if filed rates do not conform to certain parameters. Under this policy, regulators effectively interfere with market forces and do not rely solely on competition to govern prices.
whether such a system would follow the theoretical model. Cyclical movements in the supply of workers' compensation insurance are common in private markets, as is price discrimination between small and large employers. Regulatory measures can be employed to mitigate these problems but to some extent they are unavoidable aspects of private markets where information is constrained and buyers differ in their bargaining power. While full privatisation would reduce the costs of regulation and compliance, it is unclear whether it would improve scheme performance in terms of cost containment and assisting injured workers.

**Altering the Reinsurance Arrangement**

An alternative or complement to full privatisation would be to modify the reinsurance arrangement between the VWA and authorised insurers to reduce the moral hazard problem that arises with full reinsurance. The reinsurance arrangement could be structured more like typical private reinsurance arrangements with retention levels, limits and pro-rata loss sharing so that ceding insurers bear some risk and have an increased incentive to control loss costs. If the VWA continues to set the premium rate, it would need to determine the amount of premiums that an insurer would be allowed to retain to cover their increased risk and share of losses. If insurers were to set prices, then the VWA would need to determine the price of the reinsurance that it would provide to insurers. This would allow insurers to earn greater profits in return for accepting more risk.

This approach would raise issues with respect to insurer solvency and their ability to meet obligations to claimants and the VWA that would have to be addressed. If the government were to continue to guaranty the payment of an insurer's loss obligations in the event of its insolvency, the reduction of the moral hazard problem and the enhancement of private incentives would be diminished. It would be better to require an insurer to maintain adequate reserves to cover its net claims obligations and possibly require it to bolster its liquidity through devices such as surplus notes to cushion unexpected increases in claims obligations.
Capitated Payments to Insurers

A third option would be to borrow the concept of capitated payments from health insurance managed care and apply it to workers' compensation. Under a capitated payment system, insurers would retain the obligation to pay benefits to injured workers and would receive a pre-determined payment to cover a given risk based on the risk's characteristics and expected losses. If actual claims payments are less than the capitated payment, then the insurer would pocket the difference as profit. If actual claims payments exceed the capitated payment, then the insurer would bear the loss.

The primary advantage of this system is that it would maximise an insurer's incentive to control costs through loss prevention and effective case management. At the same time, it would impose all of the risk on insurers and increase their incentive to avoid paying benefits to injured workers. This tendency would have to be controlled through monitoring and regulation of insurers' compliance with statutory requirements and possibly additional incentive payments to promote scheme outcomes other than cost containment. This might or might not be more cost-effective than the current regulatory system. In addition, insurers would find this less desirable than setting their own premiums.

Increasing Pricing Flexibility

The current system requires insurers to charge a uniform rate to force competition on service. In practice, insurers have circumvented this restriction, to some extent, through "in-kind" services to employers. Many regulators hold the view that unfettered price competition would result in excessive price cutting to secure employers' business at the expense of quality of service. However, it also is recognised that employers' incentives to switch to more efficient insurers are diminished because employers do not gain a greater immediate reduction in their premium costs. Another approach would be to allow insurers to negotiate premium reductions with employers subject to employers' commitments to take steps to reduce their risks. Experience-based dividends to insureds or alternative forms of employer risk sharing (e.g., large deductibles, retrospective rating plans, and other discounts) also might be permitted, as in the U.S.A.
These devices could enhance insurers’ and employers’ incentives to control costs, but they also would impose greater downward pressure on the payment of statutory benefits to injured workers. Any change such as this might be implemented slowly over time to help ensure that insurers’ analytical capabilities are commensurate with the pricing flexibility that they would be allowed and that adverse effects on workers would be prevented through other performance controls and incentives.

Unbundling and Opening the Market for Insurance Services

Under the present system, a select group of insurers are authorised and required to provide a full set of insurance services to employers and workers. An alternative approach would be to allow different providers (including insurers) to offer various packages of insurance services. For example, an employer could elect to purchase basic workers’ compensation insurance services from an insurer for short-term injuries and claims but purchase management of long-term cases and rehabilitation services from another provider. Self-insureds might purchase certain claims administration services from insurers or other third-party administrators. This would allow providers to specialise in what they do best, with resulting improvements in service efficiency and effectiveness.

Competitive State Fund

The public sector relinquished the role of being a direct provider of workers’ compensation insurance services which it performed for a time under WorkCare. However, Victoria could explore the possibility of establishing a separate state workers’ compensation fund that would compete with private insurers. In the U.S.A., where about one-third of the states maintain such funds, some have been very successful, while others have performed badly. The primary reason for establishing a state fund is to provide a source of insurance to employers rejected by the voluntary market, e.g., small employers. A second objective has been to increase competitive pressure on private insurers. State funds have performed best when their pricing and underwriting is not subject to political manipulation and they specialise
in serving market niches, such as small retail establishments, that have been eschewed by the voluntary market.

The current WorkCover regulatory scheme does not require a residual market function, but there may still be advantages to a properly-structured competitive state fund. Such an entity could be chartered to prioritise the objectives of WorkCover and demonstrate the best practices in loss prevention, claims management and rehabilitation. It could test the view held by some that it is economically feasible to improve upon insurers' current service performance. Its mission also could include serving any group of employers that is not well served by private insurers. To avoid political manipulation, a state fund should be separate from the government and managed according to sound business principles by a board of directors representing employers, labour and the general public. To maintain a level playing field, it should be subject to the same level of taxes and assessments as would any mutual insurance company.

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 performance 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 by WorkCover under the present system. Indeed, 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 at least deserve 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, policy makers 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 clear eye in determining the future course of workers' compensation.
Table 4.1 Premiums and Reimbursements ($M), FY 1986-1996

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

* Claims expenses minus claims recoveries.

Source: VWA
<table>
<thead>
<tr>
<th>Fiscal Year</th>
<th>No. of Insurers</th>
<th>CR4*</th>
<th>HHI**</th>
</tr>
</thead>
<tbody>
<tr>
<td>1992/93</td>
<td>8</td>
<td>73.6</td>
<td>1,618</td>
</tr>
<tr>
<td>1993/94</td>
<td>17</td>
<td>68.0</td>
<td>1,476</td>
</tr>
<tr>
<td>1994/95</td>
<td>16</td>
<td>64.2</td>
<td>1,321</td>
</tr>
<tr>
<td>1995/96</td>
<td>14</td>
<td>67.3</td>
<td>1,374</td>
</tr>
<tr>
<td>Annual Avg.</td>
<td>13.8</td>
<td>68.3</td>
<td>1,447</td>
</tr>
</tbody>
</table>

* 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),
FY 1993-1996

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

Source: VWA
Table 4.4 Market Entries and Exits, FY 1986-1996

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

Source: VWA
Table 4.5 Premiums in Relation to Remuneration, FY 1986-1996

<table>
<thead>
<tr>
<th>Fiscal Year</th>
<th>Premiums ($M)</th>
<th>Remuneration ($M)</th>
<th>Premiums/Remuneration</th>
<th>Published Rate</th>
<th>Claims Payments/Premiums</th>
</tr>
</thead>
<tbody>
<tr>
<td>1985/86</td>
<td>478.2</td>
<td>20,830.6</td>
<td>2.30%</td>
<td>2.20%</td>
<td>13.1%</td>
</tr>
<tr>
<td>1986/87</td>
<td>707.9</td>
<td>27,049.7</td>
<td>2.62%</td>
<td>2.40%</td>
<td>47.1%</td>
</tr>
<tr>
<td>1997/88</td>
<td>735.3</td>
<td>30,878.9</td>
<td>2.38%</td>
<td>2.40%</td>
<td>71.5%</td>
</tr>
<tr>
<td>1988/89</td>
<td>828.4</td>
<td>34,839.5</td>
<td>2.38%</td>
<td>2.40%</td>
<td>85.7%</td>
</tr>
<tr>
<td>1989/90</td>
<td>1,208.2</td>
<td>38,070.3</td>
<td>3.17%</td>
<td>3.30%</td>
<td>62.9%</td>
</tr>
<tr>
<td>1990/91</td>
<td>1,298.7</td>
<td>37,941.9</td>
<td>3.42%</td>
<td>3.30%</td>
<td>66.5%</td>
</tr>
<tr>
<td>1991/92</td>
<td>1,141.2</td>
<td>37,598.0</td>
<td>3.04%</td>
<td>3.30%</td>
<td>90.3%</td>
</tr>
<tr>
<td>1992/93</td>
<td>1,100.0</td>
<td>37,960.1</td>
<td>2.90%</td>
<td>3.00%</td>
<td>101.8%</td>
</tr>
<tr>
<td>1993/94</td>
<td>838.6</td>
<td>39,637.2</td>
<td>2.12%</td>
<td>2.25%</td>
<td>83.8%</td>
</tr>
<tr>
<td>1994/95</td>
<td>889.3</td>
<td>42,759.0</td>
<td>2.08%</td>
<td>2.25%</td>
<td>77.2%</td>
</tr>
<tr>
<td>1995/96</td>
<td>883.4</td>
<td>45,026.5</td>
<td>1.96%</td>
<td>1.98%</td>
<td>82.2%</td>
</tr>
</tbody>
</table>

Source: VWA
Table 4.6 Scheme Financial Performance, FY 1986-1996

<table>
<thead>
<tr>
<th>Financial Year</th>
<th>Premium Revenue</th>
<th>Claims Expense</th>
<th>Underwriting Expenses</th>
<th>Underwriting Result</th>
<th>Investment Revenue</th>
<th>General Admin. Expenses</th>
<th>Profit/Loss Before Abnormals</th>
<th>Profit/Loss After Abnormals</th>
</tr>
</thead>
<tbody>
<tr>
<td>1985/86</td>
<td>$457.5</td>
<td>14.2%</td>
<td>4.7%</td>
<td>-35.8%</td>
<td>3.0%</td>
<td>6.9%</td>
<td>-39.7%</td>
<td>-39.7%</td>
</tr>
<tr>
<td>1986/87</td>
<td>$586.8</td>
<td>56.7%</td>
<td>5.7%</td>
<td>-263.2%</td>
<td>25.0%</td>
<td>7.9%</td>
<td>-243.8%</td>
<td>-241.0%</td>
</tr>
<tr>
<td>1987/88</td>
<td>$705.9</td>
<td>76.2%</td>
<td>3.8%</td>
<td>-39.5%</td>
<td>-10.6%</td>
<td>10.9%</td>
<td>-60.8%</td>
<td>-60.8%</td>
</tr>
<tr>
<td>1988/89</td>
<td>$795.1</td>
<td>90.0%</td>
<td>6.3%</td>
<td>-266.0%</td>
<td>8.4%</td>
<td>16.6%</td>
<td>-273.9%</td>
<td>-273.9%</td>
</tr>
<tr>
<td>1989/90</td>
<td>$1,170.8</td>
<td>59.3%</td>
<td>5.4%</td>
<td>149.1%</td>
<td>7.0%</td>
<td>10.1%</td>
<td>145.8%</td>
<td>145.8%</td>
</tr>
<tr>
<td>1990/91</td>
<td>$1,261.3</td>
<td>59.4%</td>
<td>4.8%</td>
<td>50.5%</td>
<td>11.5%</td>
<td>9.9%</td>
<td>52.1%</td>
<td>52.1%</td>
</tr>
<tr>
<td>1991/92</td>
<td>$1,129.2</td>
<td>80.5%</td>
<td>5.7%</td>
<td>-16.5%</td>
<td>17.0%</td>
<td>10.5%</td>
<td>-10.0%</td>
<td>-3.8%</td>
</tr>
<tr>
<td>1992/93</td>
<td>$1,127.8</td>
<td>93.1%</td>
<td>n.a.</td>
<td>125.6%</td>
<td>19.4%</td>
<td>15.4%</td>
<td>129.6%</td>
<td>129.6%</td>
</tr>
<tr>
<td>1993/94</td>
<td>$838.6</td>
<td>74.3%</td>
<td>8.4%</td>
<td>17.6%</td>
<td>11.5%</td>
<td>11.4%</td>
<td>18.6%</td>
<td>13.7%</td>
</tr>
<tr>
<td>1994/95</td>
<td>$889.2</td>
<td>67.8%</td>
<td>8.0%</td>
<td>-6.1%</td>
<td>24.2%</td>
<td>10.1%</td>
<td>8.4%</td>
<td>39.7%</td>
</tr>
<tr>
<td>1995/96</td>
<td>$883.4</td>
<td>82.0%</td>
<td>8.7%</td>
<td>-32.0%</td>
<td>32.4%</td>
<td>11.0%</td>
<td>-10.3%</td>
<td>-1.9%</td>
</tr>
<tr>
<td>Annual Avg.</td>
<td>$895.1</td>
<td>68.5%</td>
<td>5.6%</td>
<td>-28.8%</td>
<td>13.5%</td>
<td>11.0%</td>
<td>-25.8%</td>
<td>-21.8%</td>
</tr>
</tbody>
</table>
Table 4.7 Insurer Income, Report Year 1995

<table>
<thead>
<tr>
<th>Insurer</th>
<th>Premium Revenue ($, 000)</th>
<th>Claims Expense</th>
<th>Underwriting Expenses</th>
<th>Underwriting Result</th>
<th>Investment Revenue</th>
<th>General Admin. Expenses</th>
<th>Profit/Loss Before Tax</th>
<th>Profit/Loss After Tax</th>
</tr>
</thead>
<tbody>
<tr>
<td>AIG</td>
<td>3,635</td>
<td>123.6</td>
<td>0.9</td>
<td>-7.6</td>
<td>2.1</td>
<td>0.7</td>
<td>-6.1</td>
<td>-6.1</td>
</tr>
<tr>
<td>AMP</td>
<td>13,562</td>
<td>113.7</td>
<td>0.0</td>
<td>0.0</td>
<td>0.4</td>
<td>0.4</td>
<td>0.0</td>
<td>0.0</td>
</tr>
<tr>
<td>CATH</td>
<td>73,066</td>
<td>57.9</td>
<td>0.6</td>
<td>11.1</td>
<td>0.1</td>
<td>0.0</td>
<td>-0.4</td>
<td>-0.4</td>
</tr>
<tr>
<td>CIC</td>
<td>144,336</td>
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<td>-7.4</td>
<td>7.4</td>
<td>0.1</td>
<td>4.7</td>
<td>2.8</td>
<td>2.8</td>
</tr>
<tr>
<td>CU</td>
<td>14,463</td>
<td>30.3</td>
<td>47.7</td>
<td>21.0</td>
<td>11.5</td>
<td>0.0</td>
<td>32.5</td>
<td>20.0</td>
</tr>
<tr>
<td>FAI</td>
<td>79,955</td>
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<td>0.0</td>
<td>0.6</td>
<td>6.9</td>
<td>1.5</td>
<td>1.0</td>
</tr>
<tr>
<td>GUILD</td>
<td>37,795</td>
<td>67.5</td>
<td>18.7</td>
<td>-1.3</td>
<td>7.2</td>
<td>3.5</td>
<td>2.3</td>
<td>1.7</td>
</tr>
<tr>
<td>GIO</td>
<td>118,561</td>
<td>79.1</td>
<td>0.0</td>
<td>0.0</td>
<td>0.2</td>
<td>0.0</td>
<td>-0.5</td>
<td>-0.3</td>
</tr>
<tr>
<td>HIH</td>
<td>36,304</td>
<td>55.5</td>
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<td>0.0</td>
<td>0.3</td>
<td>0.3</td>
<td>0.0</td>
<td>0.0</td>
</tr>
<tr>
<td>MERC</td>
<td>13,738</td>
<td>98.3</td>
<td>-3.2</td>
<td>-40.3</td>
<td>-5.7</td>
<td>5.5</td>
<td>-51.5</td>
<td>-34.2</td>
</tr>
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<td>MMI</td>
<td>232,093</td>
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<td>0.0</td>
<td>-4.4</td>
<td>4.0</td>
<td>-6.7</td>
<td>-5.5</td>
</tr>
<tr>
<td>NZI</td>
<td>58,304</td>
<td>162.4</td>
<td>0.0</td>
<td>0.0</td>
<td>8.9</td>
<td>7.8</td>
<td>1.1</td>
<td>0.7</td>
</tr>
<tr>
<td>QBE</td>
<td>102,285</td>
<td>132.9</td>
<td>0.0</td>
<td>0.0</td>
<td>0.1</td>
<td>0.0</td>
<td>0.1</td>
<td>0.1</td>
</tr>
<tr>
<td>SUN ROYAL</td>
<td>8,787</td>
<td>255.8</td>
<td>-9.3</td>
<td>9.3</td>
<td>-0.7</td>
<td>0.0</td>
<td>8.7</td>
<td>9.3</td>
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<td>VACC</td>
<td>166,088</td>
<td>74.6</td>
<td>24.9</td>
<td>2.1</td>
<td>-3.9</td>
<td>5.3</td>
<td>-7.1</td>
<td>-4.0</td>
</tr>
<tr>
<td>ZURICH</td>
<td>10,131</td>
<td>180.8</td>
<td>0.0</td>
<td>0.0</td>
<td>7.4</td>
<td>7.4</td>
<td>0.0</td>
<td>0.0</td>
</tr>
<tr>
<td>Median</td>
<td>48,050</td>
<td>88.7</td>
<td>0.0</td>
<td>0.0</td>
<td>0.2</td>
<td>2.1</td>
<td>0.0</td>
<td>0.0</td>
</tr>
</tbody>
</table>

Source: ISC
Table 4.8 Insurer Service Performance, First Quarter 1996

<table>
<thead>
<tr>
<th>Insurer</th>
<th>Premium Collection (%)</th>
<th>Claim Duration 104 Weeks (%)</th>
<th>Disputes (%)</th>
<th>Claim Cost Ratio (%)</th>
<th>Timeliness (%)*</th>
<th>Time Loss (%)**</th>
<th>Case Reserve Accuracy (% 1993/94 Claims)</th>
<th>Medical Panel Delays (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>AIG</td>
<td>99.2</td>
<td>37.5</td>
<td>13.0</td>
<td>52.8</td>
<td>0.0</td>
<td>49.5</td>
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<td>26.5</td>
<td>18.2</td>
<td>50.9</td>
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<td>10.6</td>
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<td>60.6</td>
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<td>96.4</td>
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<td>0.0</td>
<td>56.7</td>
<td>98</td>
<td>78.6</td>
</tr>
</tbody>
</table>

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 3 months.

Source: VWA Authorised Insurer Performance Table
Table 4.9 Insurer Assets and Liabilities ($, 000s), 1995

<table>
<thead>
<tr>
<th>Insurer</th>
<th>Assets</th>
<th>Liabilities</th>
<th>Net Assets</th>
<th>Assets/Net Assets</th>
<th>Liabilities/Net Assets</th>
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<tr>
<td>AIG</td>
<td>17,773</td>
<td>16,271</td>
<td>1,502</td>
<td>1183.3%</td>
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<tr>
<td>AMP</td>
<td>37,531</td>
<td>35,531</td>
<td>2,000</td>
<td>1876.6%</td>
<td>1776.6%</td>
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<tr>
<td>CATH</td>
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<td>48,999</td>
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<td>257.4%</td>
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<tr>
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<tr>
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<td>4,748</td>
<td>324,866</td>
<td>101.5%</td>
<td>1.5%</td>
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<tr>
<td>GUILD</td>
<td>59,883</td>
<td>46,757</td>
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<td>456.2%</td>
<td>356.2%</td>
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<tr>
<td>GIO</td>
<td>310,100</td>
<td>307,418</td>
<td>2,682</td>
<td>11562.3%</td>
<td>11462.3%</td>
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<tr>
<td>HEATH</td>
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<tr>
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<tr>
<td>QBE</td>
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<td>2,153</td>
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<tr>
<td>ZURICH</td>
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<td>33,604</td>
<td>2,000</td>
<td>1780.2%</td>
<td>1680.2%</td>
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<tr>
<td><strong>Median</strong></td>
<td>168,633</td>
<td>46,757</td>
<td>2,682</td>
<td>1631.1%</td>
<td>1531.1%</td>
</tr>
</tbody>
</table>

Source: ISC
Figure 4.1
Victoria Workers' Compensation Insurance Regulatory Scheme

OTHER SERVICE PROVIDERS
- Medical Care
- Rehabilitation
- Legal Services
- Risk Management

VWA
- Administration
- Risk Bearing
- Regulation

INSURERS
- Policy Services
- Claims
- Risk Management

EMPLOYERS
- Coverage Compliance
- Insurer Selection
- Risk Management
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

Basic Conditions

Supply
- Raw materials
- Technology
- Unionisation
- Product durability
- Value/weight
- Business attitudes
- Public policies

Demand
- Price elasticity
- Substitutes
- Rate of growth
- Cyclical and seasonal character
- Purchase method
- Marketing type

Market Structure
- Number of sellers and buyers
- Product differentiation
- Barriers to entry
- Cost structures
- Vertical integration
- Conglomerateness

Conduct
- Pricing behaviour
- Product strategy and advertising
- Research and innovation
- Plant investment
- Legal tactics

Performance
- Production and allocative efficiency
- Progress
- Full employment
- Equity

Source: Scherer and Ross (1990)
Chapter 5

BENEFITS
Chapter 5 BENEFITS

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, results in, or materially contributes to the death of the worker.

The language in this statute parallels that found in many other jurisdictions, in so far 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."1

Benefits in Victoria are similar to those found in most industrialised jurisdictions. 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. 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 program. There can be an advantage to a worker to have medical benefits provided under this program, rather than by the Commonwealth health program. 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 program, 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.2 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 $416 of these services, with any costs above this the responsibility of the insurer. (This maximum, which is indexed, was applicable from 1 July 1996.)

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 2 years after the date

2Balance billing occurs where the service provider bills the recipient of the service or the employer for any unpaid balance, should the insurer pay less than the amount invoiced.
of death, and for medical and like services within 6 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 for medical and like services within 10 days of receipt of the claim. Claims for weekly 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 $416.

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 medical benefits only claims. A rejection of such a claim (Section 99), if disputed by a claimant, must be taken to conciliation and if not resolved at that level, to the Administrative Appeals Tribunal. (see Chapter 6)

The data in Table 5.1 are based on the number of claims reported in each year for the past 10 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 journey claims (no longer compensable for injuries after 1 December 1992), and non-fatal 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 over 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 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/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. Organised labour representatives 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 4 weeks in the job have their PIAWE calculated based on deemed earnings. All weekly benefit payments are treated as ordinary taxable income.
Weekly benefits are 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 is entitled to the lesser of 95 percent of his/her PIAWE or the weekly maximum benefit ($664 per week as of 1/7/96). Cash benefits for the first 10 days of incapacity are the responsibility of the employer, and not of 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 many 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 is partially incapacitated, s/he is entitled either to the difference between $664 and the worker’s earnings, or to the difference between 95 percent of the PIAWE and earnings, whichever in lesser. 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/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 is lowered. This is in line with the practice in New South Wales, Queensland, the Northern Territory, and A.C.T. In Tasmania, the initial compensation rate is lowered after 6 weeks and again at 25 weeks. The Commonwealth and South Australia have rate reductions that occur at 45 weeks and 52 weeks respectively. Though these rate drop-offs after specified periods are widespread across Australia, they are not typical in North America.

After 26 weeks of incapacity, a worker entitled to weekly benefits is likely to have a reduction in those benefits. Essentially, the worker’s benefits will be set according to one of four possibilities:

(a) If the worker is found to have a “serious injury” (defined below), and the worker has no current weekly earnings, the worker is entitled to $664/week or 90 percent of the PIAWE, whichever is lower.

(b) If the worker is found to have a “serious injury” and the worker has some current weekly earnings, the worker will receive the difference between 90 percent of the
PIAWE and current weekly earnings or, if lower, the difference between $664 and current weekly earnings.

(c) If the worker has no "serious injury" but is totally incapacitated, the worker receives the lesser of $664 or 70 percent of the PIAWE.

(d) If the worker has no "serious injury" and is not totally incapacitated, the worker is entitled either to the difference between 60 percent of the PIAWE and 60 percent of current weekly earnings or the difference between $399 and 60 percent of current weekly earnings, whichever is lower.

The cut in the wage replacement rate may have no effective impact on workers with a very high PIAWE. For a worker with PIAWE of $948 or more, even with a reduction at 26 weeks from 95 percent to 70 percent, the worker's benefit would remain at the weekly maximum $664. However, this worker would have experienced a lower rate of wage replacement initially, since the maximum benefit of $664 is only 70 percent of his/her PIAWE.

The significant feature of Victoria's benefit scheme, and unique in Australia (or elsewhere so far as we know) is to adjust the 26 weeks benefit according to whether or not the worker is judged to have "serious injury." It means that a judgment needs to be made at this stage regarding the degree of the worker's impairment. Obviously it can precipitate a controversy between the insurer and the worker. This determination also will affect the opportunity that may exist for the worker to seek a common law remedy. (This is discussed in Chapter 6.) Though each of these considerations might discourage the use of the concept of "serious injury" at the 26-week mark, there is an important reason for its use. Clearly, it is meant to foster a significant incentive to return to work for those who might be able to do so after 26 weeks, without placing that pressure excessively on persons with more significant impairments.

The meaning of "serious injury" for purposes of adjusting the PIAWE replacement rate at 26 weeks is found in the statute (Section 93B(5)). The "serious injury" threshold for purposes of the 26-week rate adjustment is that the worker is judged to have an impairment that is rated at 30 percent or more by the standard of the American Medical Association's *Guides to the Evaluation of Permanent Impairment* (second edition).
The “serious injury” decision for the 26-week determination is based solely on impairment and not on any broader notion such as disability. The rating at 26 weeks is for purposes of knowing whether the worker is impaired above or below the 30 percent level only. It is not used, therefore, to determine the extent of the worker’s permanent impairment or disability level for the purpose of awarding some benefit for permanent disability. It is also arguable whether the 26-week decision regarding “serious injury” was intended to be used for purposes of allowing the worker access to the common law for the work injury. However, the presence of a “serious injury” is a necessary condition for a worker to have access to the common law remedy.

To clarify this issue, discussed in more detail in the next chapter, the law was amended in 1996 so as to differentiate, explicitly, the 26-week determination of “serious injury,” from the subsequent determination made for the purpose of deciding eligibility to use the common law remedy. The “serious injury” determination is also utilised for the purpose of deciding whether or not weekly benefits can be paid beyond some maximum period established in the law for the receipt of such benefits. Again, the 26-week determination of “serious injury” is not the basis, customarily, for that decision.

The weekly benefits rate determination at 26 weeks is 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 represents a very large target, that is, a threshold with several very important implications for the parties. First, it may or may not rule out the possibility of the worker being paid very long term benefits. Further, as observed above, it determines whether or not the worker has access to the County Court for a common law remedy.

Some persons have argued that the 104 weeks of incapacity created an unfair situation for certain workers who had sought to return to work, possibly for modified duty or for limited hours only. Where a worker had engaged in such activity, considered to be laudable and
consistent with the spirit of the 1992 law, this time was considered to be within the period of incapacity. As such, 104 weeks of incapacity might provide the diligent employee less than 104 weeks of compensation, since benefits would terminate according to the law. In 1996, this concern was eliminated. As a result of the amendments enacted, weekly benefits are terminated (save for the two exceptions noted above) after 104 weeks of compensation benefits have been paid or an entitlement existed, and not based on 104 weeks of incapacity.

The 1992 legislation also provided limits on compensation for workers already receiving weekly benefits on its effective date. For a worker who had received weekly benefits for less than 52 weeks, the weekly benefit would be terminated after 104 weeks of incapacity, including any period prior to the effective date of the law, unless found to be “seriously injured” or totally and permanently incapacitated. For a worker who had received 52 weeks or more of weekly benefits, the worker’s entitlement would cease after 52 additional weeks of incapacity, except if the worker had a “serious injury” or was totally and permanently incapacitated. Needless to say, this guaranteed that there would be numerous disputes over “serious injury” and total and permanent incapacity determinations, as the Authority sought to resolve the claims of many long-term recipients that had been added to the rolls under WorkCare.

A worker is not entitled to weekly benefits when the person attains retirement age. 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.

Another measure to tighten up eligibility for purposes of curbing certain perceived system abuses involved claims for benefits after the worker ceased to be employed by an employer wherein the injury was said to occur. No longer will such a claim be accepted unless the worker can satisfy the insurer that the claim reasonably could not have been made while employed with that employer.

Table 5.2 shows the level of payments for weekly benefits for 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.

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. 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 fairly.
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 52 or 104 weeks;
• The attaining 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 1 year, the period of notice is 14 days. For a worker who has received weekly payments for a continuous period of 1 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 Victoria, in such instances, 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 may direct that benefits be continued (discussed in some detail in Chapter 6). Presently, a worker can obtain a Conciliation Conference quickly, i.e., 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.

However, the relatively rapid access to Conciliation, the requirement that some notice be given 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, under certain circumstances, appears to serve the needs of both sides. By contrast, some other jurisdictions 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 over 260 days of compensation) is evident in Table 5.3. Long-term claims were developing at a rate of 5000-6,000 per year in the years before WorkCover’s enactment. By 1993/94, the number had fallen below 2,000, and it continued to drop in 1994/95. Because of the limited time involved, one cannot yet make any judgement about the number of new long-term cases for claims reported in 1995/96. 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 1996, the number of open long-term claims was 10,013. That represented about 50 percent of the number that existed in 1991.

In addition to issues relating to the termination of weekly benefits, parallel ones 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, and the 26-week threshold. Payments will be adjusted, also, 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 (Section 135A, Section 115, and certain claims under Section 135(1)).

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.

Eligible dependents must meet one of three conditions:

- The person, at the time of the worker’s death, was partly, mainly or wholly dependent on the earnings of the worker.
- The person would have been partly, mainly or wholly dependent on the worker’s earnings, but for the incapacity due to the work injury.
- The person is the worker’s spouse (common law or actual) and lived with the worker on a permanent and bona fide domestic basis. No account is to be taken of a spouse’s earned income or to any savings from such earnings.

If there are no dependents wholly or mainly dependent on the worker’s earnings, the County Court may award benefits, which it considers to be reasonable, to partial dependents. Where the worker has left both total and partial dependents, the County Court will allot compensation as it sees fit. The possibility that a spouse could be denied compensation because of the spouse’s financial independence due to non-earned income is unusual. It introduces a
means test of sorts into workers’ compensation for a spousal benefit, a rarity in workers’ compensation programs.

The death benefit that the County Court can award is a fixed amount set by statute (and then indexed). As of 1 July 1996, the death benefit was $131,190. Beyond that amount, each dependant child is entitled also to compensation, with the sum based on the child’s age. As of 1 July 1996, a child below the age of 1 year could receive $25,000, while any children age 16 up to age 21 (and a full-time student) would receive $5,650, if they were wholly or mainly dependents of the worker. In addition to workers’ compensation benefits, a dependant of a worker may recover damages under the Wrongs Act (1958) in respect of the death of a worker. The Court must not award in excess of $500,000 in respect to the work fatality.

Data on fatal 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. Over the past 10 years there has been an average of 186 claims per year, though for the past 3 years ending in 1995/96, there have been only an average of 127 claims. (Both averages are by report year. The numbers have been standardised by excluding journey claims.) In 1995/96 payments of compensation for death claims (excluding any damages awarded) were less than 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,
amatically, 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 pre-injury average weekly earnings.

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 pre-injury average weekly earnings 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. In Victoria, benefits for permanent disabilities that are
not totally incapacitating are compensated in one of four ways according to the specific nature
of the injury.

Section 98 Losses

The Table of Maims lists 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. The maximum benefit
payable for a maim, as of 1/7/96 is $102,460. For each impairment, a percentage or range of
percentages is listed. For example, the total loss of the right arm is listed as 80 percent. Thus,
a worker who lost the right arm, totally, would be entitled to a lump sum benefit under Section 98 of $81,968 (0.8 x $102,460). If the worker lost a fraction of the arm, that fraction, applied to $81,968 would be the maims benefit paid as a lump sum. This would be in addition to any weekly benefits that the worker received, and the worker might seek further compensation under common law. The award would likely be an offset against certain damages under common law, discussed later in this chapter.

This basic benefit under the Table creates areas for dispute, especially on medical matters. The loss of a member or extremity includes the (permanent) loss of its use. Thus, for example, a dispute can arise both over the issue of whether there has been any loss of use of a leg, as well as the quantitative assessment of that loss. There can be a dispute over whether or not the loss entails an "industrial loss," that is, the ability to use the member for industrial purposes.

Medical differences that generate disputes may also emanate from a preexisting condition. Any permanent loss that existed prior to the work injury would not be compensated. Thus, an injury that is rated at 10 percent to a leg with a 40 percent preexisting impairment would be rated at .10 divided by .60 (the preexisting level of non-impairment) or 17 percent. This is in contrast to some jurisdictions that might rate the same worker as 50 percent impaired (.10 + .40).

Several things should be noted about the Table of Maims. First, the rating of an impairment need not be done through the use of any specific guide or criteria. (An exception is noted below.) Various bases can be found for determining the degree of loss of use of a member. Concepts such as "industrial use" only provide more latitude for assessing the degree of impairment. Second, the degree of impairment, for purposes of setting the maim benefit under Section 98, is not likely to be the same as the estimate of impairment for purposes of determining whether or not the worker is "seriously injured." A judgment regarding impairment for purposes of determining whether "serious injury" has occurred can affect the size of the weekly benefit after 26 weeks, the possible continuation of benefits after 104 weeks, and the accessibility to the common law remedy.

The Table of Maims provides benefits that are based almost purely on impairment. The
injured worker’s age, occupation, and subjective factors have virtually no bearing on the worker’s benefit. Moreover, if two workers sustain the same injury, their lump sum benefit will be the same, despite any difference in their pre-injury average weekly earnings. And if one worker has returned to work and the other has not, it is likely to be immaterial for purposes of setting the maims benefit. Of further note, in addition to the list of 46 impairments, disfigurement of the face and of the body are listed on the table. While many jurisdictions use schedules that are in form similar to the Table of Maims, few of them explicitly list disfigurements.

Back Cases

In the 1985 WorkCare legislation, impairments to the back, neck, and pelvis were incorporated into the Table with special treatment in such cases for evaluating and compensating any permanent disability. (For brevity, these will be called “back cases”). The special treatment for back cases begins with the requirement that they be rated in accordance with the American Medical Association’s Guides to the Evaluation of Permanent Impairment, (2nd edition). Note, that this is the same source to be used in determining whether or not a worker has a 30 percent impairment or more, thus qualifying the worker as being “seriously injured.”

Because back cases must be rated according to the Guides, and the Guides are based on a whole person basis, not consistent with the 46 impairments found in the same schedule, an adjustment is made. Impairments of the back, neck, or pelvis are listed in the Table as being within a range, respectively of 0 - 60 percent, 0 - 40 percent and 0 - 15 percent. Consequently, the maximum benefit for a back, neck, or pelvis impairment as of 1/7/96 would be $61,476, (60% x $102,460), $40,984 (40% x $102,460), or $15,369 (15% x $102,460), respectively.

The back, neck, and pelvis cannot be rated as more than 60%, 60%, and 50% of the whole person according to the AMA Guides (2nd edition). The Authority has interpreted the application of Section 98 as it pertains to back cases to mean that the specific rating is not the percentage of the maximum dollar benefit specified in the Table. Instead, it is the rating divided by the maximum whole body percentage suggested in the Guides. For, example, a
pelvis impairment rated as 10 percent loss of the whole person would entitle the worker to
10%/50% (the pelvis’ whole body maximum), meaning a 20 percent loss of the pelvis with 100%
percent of the pelvis valued at $15,369. Thus, a benefit would be paid of

\[
10\% / 50\% \times (15\% \times $102,460) = $3,074.
\]

Similarly, a 30% whole person rating of a neck injury would yield a maims benefit of

\[
30\% / 60\% \times (40\% \times $102,460) = $20,492.
\]

That back cases are evaluated differently than extremities for disability compensation is
not altogether surprising. Many jurisdictions have traditionally had scheduled benefits for
injuries to extremities and other bases for determining benefits to backs, including necks, and
to internal organs. Yet it must also be pointed out that some other jurisdictions do not employ
this distinction, relying instead on some scheme that is consistent for all injuries. Certainly the
AMA Guides could be employed to evaluate body member or eye injuries as they are now used
in the cases of back, neck and pelvis injuries.

A second noteworthy characteristic of this Table is its exclusions. There are no maims
benefits for injuries to most internal organs, including—strikingly—those of the respiratory
system. Thus, workers with any of the pneumoconioses are not entitled to a lump sum maims
benefit, nor are persons with comparable claims for cancer and other occupational diseases,
though weekly benefits can be paid for such conditions. At best, if workers with such
conditions successfully pursue a common law remedy, there is no offset for a previously paid
maims benefit. While few jurisdiction would place such conditions on a benefits schedule, they
generally would compensate such conditions as an unscheduled loss, essentially parallelling the
manner in which back cases are compensated.

It must also be noted that there is no maims benefit for mental injuries, except where
they may involve permanent brain damage. Thus, while a worker may be able to claim weekly
benefits, common law damages, or be rated as “seriously injured” due to the result of some
mental stress, there is no maims benefit under the existing Table. However, prior to the
passage of the 1992 change in the law, a worker could receive a maims benefit for the “loss of
mental powers.”
Hearing Loss

Claims for loss of hearing have been frequent and have represented a significant share of the benefits paid for maims. As such, hearing loss claims are treated somewhat differently from other permanent disabilities due to injuries that arise out of or in the course of employment, with the employment being a significant contributing factor. The benefit rate associated with total loss of hearing is 65 percent in the Table. Any compensable partial loss of hearing is set as that percentage loss times 65 percent times the maims maximum at the time ($102,460 as of 1/7/96). However, there is no benefit if the degree of hearing loss that is attributed to the employment is rated below 7 percent.

Hearing loss must be rated by one of the 56 or so specialists approved by the Minister on the recommendation of the Convenor of the Medical Panels. The rating of hearing loss must be done in accordance with Improved Procedure for Determination of Percentage Loss of Hearing by the National Acoustic Laboratory. A determination made by an approved person in accordance with the procedures set out in the legislation and the regulations is conclusive evidence of hearing loss.

In hearing loss claims, the date of injury is the date of the claim, if the worker is still employed in the employment out of which the claim arose. However, if the claimant is no longer working in the employment out of which the claim arose, the injury date is the last day of employment at that establishment. The implication of that difference is that the aggregate sum available for an injury from the Table is adjusted (upwards) annually. A difference in injury date can result in a higher or lower maims benefit being awarded.

Compensation for Pain and Suffering

Most jurisdictions do not provide compensation, expressly, for pain and suffering. Indeed, losses for pain and suffering are often considered inapplicable in workers’ compensation claims, at odds with one of the bases for damages in tort or common law proceedings. This fine line is at best academic. The existence of and the degree of pain, at least, must have some effect in many instances where awards are made for permanent disabilities. In a jurisdiction that awards such benefits on the basis of either the projected loss
of earning capacity or the actual loss of earnings, pain can serve to limit a worker's range of employment options or the quantity of employment that can be obtained. For jurisdictions that award permanent disability benefits strictly on an impairment basis, pain is often the factor that can limit a person's range of motion, their ability to undertake lifting or bending and so on. Hence, it is somewhat unrealistic to argue that pain and suffering are not a part of a permanent disability benefit, even where the law would seem to rule that out.

In Victoria, pain and suffering under Section 98A were expressly included in the 1992 legislation. Benefits under this section are available only to workers with injuries listed in the Table of Maims. In keeping with several significant features of the WorkCover law, a benefit for pain and suffering is available only to workers whose maim has been a significant one. As of 1/7/96, the threshold for access to a benefit for pain and suffering is a maims award of $11,000 or higher. Thus, a worker with a non-back impairment rated at below 11 percent, or an 18 percent back impairment (yielding less than an 11 percent whole person rating) is not entitled to an award under Section 98A. A pain and suffering award is not available to a person with diseases or injuries affecting internal organs, since such conditions, as noted, are not listed on the table.

Awards under Section 98 are designed to be determined in an objective manner. In large part, one should expect that, aside from any vested interest that a rater might have, ratings done by different raters would cluster closely around some central tendency. This quest for consistency, be it for back cases or any other maim, is one justification for employing an impairment-based approach to permanent disability compensation. That issue stands out when considering the benefits available under Section 98A. There is almost no guidance in the Act as to how to determine the size of such an award. As of 1/7/96, the maximum benefit that can be paid for pain and suffering is $55,040. The law states that this maximum amount is to be payable "only in a most extreme case and the amount payable in any other case shall be reasonably proportionate to that maximum amount having regard to the degree and duration of pain and suffering and the severity of the injury or injuries." (Section 98A(3))

It seems clear that there is considerable room for negotiation (subjectivity) in setting the award for Section 98A. In some instances, the parties appear to have settled on an award under
Section 98A based on a rule of thumb of 50 percent of the settlement value for the Section 98 benefit. In some instances, the flexibility that exists in setting the benefit amount under Section 98A is utilised to bring over-all resolution to a claim where a dispute exists over some other issue(s).

Lump sum maims benefits have grown substantially over time. One simple measure of this is the changing value of total maims payments per year from 1986/87 till 1995/96, as seen in Table 5.5. The growth of maims lump sum payments is also evident in the second column, which shows the ratio of maims payments, including pain and suffering payments since 1993/94, to the total of weekly benefit payments. Part of the very rapid growth of this ratio is due to the decline since 1991/92 in the value of weekly benefits payments, associated with the enactment of WorkCover. In recent years a portion of the increase has been associated with benefits for pain and suffering under Section 98A of the law, introduced after 30 November 1992. However, it is also due simply to the growth in maims payments claims.

The data in Table 5.6 reflect the types of injuries for which maims payments have been paid over the past 10 years. As noted in the text, hearing disorders have been a major source of maims claims, particularly before the latest 2 years. Indeed, over the 10-year period, fully 51 percent of all compensated maims claims were for hearing disorders, though these claims accounted for only 28 percent of aggregate payments. Part of this disparity reflects the relatively low cost per claim for hearing loss, compared to other maims, and because so many of the hearing loss claims occurred in earlier years when benefits payment tended to be lower.

Of special note is the rapid growth over the past 3 years in the payments for the loss of mental powers. This reflects payments made for work injuries that occurred prior to 1 December 1992, at which time the loss of mental powers was removed from the Table of Maims. Curiously, prior to 1992/93 maims benefits for the loss of mental powers were so small that any such maims were simply included in the category "other." One well publicized case involving a police officer's injury served to open the flood gates for maims for the loss of mental powers.
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 examination, typically, at 1 of 3 times in the life of the claim. If the examination occurs within the first 2 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 4 to 5 weeks into the claim, the insurer is seeking some information about the prognosis for the condition and the claim. Many of the examinations are conducted at about 20 weeks after the claim has begun, to determine the issue of “serious injury” at the 26-week threshold. This will be a point where the insurer has the medical practitioner rate the degree of impairment of the worker.

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 many 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 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, inevitably, will 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 time lines 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 $289 with an added $82.45 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 persons conduct their Section 112 medical examinations. Some persons 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 treater. Second, the treating person may find it difficult to tell the worker something 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.

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. 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, and 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 for this 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 decade. 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 $221 million. In 1992/93, payments exploded to over $378 million, substantially due to common law damages payments associated with the large run-off of claims brought about by the 1992 legislation.

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 decade. 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 run-off of common law cases results in fewer settlements, the percentage has begun to fall back.

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. Such benefits were paid only in the past 3 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). Common law benefits have grown
dramatically over time, reaching a peak in 1992/93. Even over the past 3 years, 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 3 preceding years.

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 med/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 are available if they have been requested by a medical practitioner. Injured workers may also be entitled to occupational rehabilitation services, but these are covered 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 that 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 gymnasiunm, social work, and speech pathology. In the cases of all four sets of providers, they are approved by the Authority by dint of their membership in specific professional associations.

As of 1 July 1996, an employer's insurance required that it pay a deductible of $416 before there is any liability for medical and like services by an authorised insurer. A worker's entitlement to medical and like services ceases 52 weeks after an entitlement to weekly benefits ceases, unless certain exceptions exist:

- 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 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, has been highly contentious in recent years.
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 1-1.5 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. One set of fees that was not
revised at the time was that for anaesthetists. A separate negotiation over their rates had broken down.

To the extent that rancour 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 past 4 to 5 years. 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. A second 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 claim that medical bills are often paid only many months after their submission. The Authority acknowledges that late payment of medical bills did occur in the past 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) simply a handy argument to justify fee increases.

One group with a particularly strong criticism of the fee schedule is the anaesthetists. In their view, the role that they play has changed, becoming more sophisticated and more important. They contend that the fee schedule does not recognise the added complexity and responsibility of their roles. At this writing, three individual cases are pending at the Administrative Appeals Tribunal, and the VWA is expected to revise the schedule based on the findings in these cases.

There has developed a tripartite arrangement 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 Transport Accident Commission 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 program 6 years ago. Though the pilot project ended 5 years ago, that program 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. 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 provision of certain medical services was necessary, and whether the service is required as a consequence of a compensable injury.

One 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. The protocol, in such instances can serve as a justification to deny medical payments, as well as to identify providers that may (frequently) 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.

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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 pre-authorisation 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. In the last 3 years, under WorkCover, health care costs have fallen substantially. Much of the decline is 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 1996 it has reached $416.) Though aggregate expenditures paid for medical and like services have declined, they have not declined as rapidly as claims have. Consequently, the costs per claim for medical and like services have grown every year over the past 10 years (column 2).

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. Over the past 5 years, this group accounted for 30-33 percent of the medical and like services expenditure. There has been a small steady growth of payments for physiotherapy services. By 1995/96 physiotherapists received about 14 percent of all medical and like services expenditures (or about 44 percent of the amount paid to medical practitioners). Expenditures for hospitals have ranged between 22 and 29 percent over the 10-year period, and have been concentrated between 24 and 27 percent over the past 4 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 over 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 over the latest 2 years. It should be noted that these figures include personal and household services ($6.1 million in 1995-96) and the cost of the WISE re-employment program (about $1.0 million in 1995-96), in addition to the occupational rehabilitation services ($4.9 million in 1995-96) that will be described further in Chapter 7. The costs of personal and household services, including attendant care, counselling, household help, and modifications to home or car were included in medical costs rather than rehabilitation under the WorkCare system. Thus, the figures across the decade are not completely comparable.

Concluding Observations

There are a number of goals that the supporters of the 1992 legislation hoped to achieve. Certainly, a reduction in system costs was a motivation, but that was certainly not its 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 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 has been weakened, both as a product of judicial interpretations and as the 30 percent impairment level has become more readily attainable. The use of psychological injury impairment as an add-on to the impairment level for a physical injury has been instrumental here.

Disputes over benefits for maims and pain suffering were not eliminated, even after Medical Panels became involved routinely. In fact, their frequency weakened the Medical Panels by utilising them so heavily as to backlog them completely. The incentive structure for workers, and for their solicitors, encouraged the issue 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, it seems apparent that this has not been fully successful. It is very difficult to seal off one area of benefits from another where the parties are able to arrive at a mutually agreed outcome in one of them. Compounding this is 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*

<table>
<thead>
<tr>
<th>Year</th>
<th>Claims Reported</th>
</tr>
</thead>
<tbody>
<tr>
<td>1986/87</td>
<td>64,768</td>
</tr>
<tr>
<td>1987/88</td>
<td>60,229</td>
</tr>
<tr>
<td>1988/89</td>
<td>60,437</td>
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<tr>
<td>1989/90</td>
<td>55,103</td>
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<td>1990/91</td>
<td>56,917</td>
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<td>1991/92</td>
<td>55,247</td>
</tr>
<tr>
<td>1992/93</td>
<td>47,966</td>
</tr>
<tr>
<td>1993/94</td>
<td>38,334</td>
</tr>
<tr>
<td>1994/95</td>
<td>32,981</td>
</tr>
<tr>
<td>1995/96</td>
<td>31,318</td>
</tr>
</tbody>
</table>

* All claims arising from self-insured employers as of 30/6/96 are excluded

Source: VWA
Table 5.2 Weekly Benefits, Annual Totals*

<table>
<thead>
<tr>
<th>Year</th>
<th>Weekly Benefits Paid ($, 000)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1986/87</td>
<td>$245,589</td>
</tr>
<tr>
<td>1987/88</td>
<td>349,205</td>
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<tr>
<td>1988/89</td>
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<tr>
<td>1989/90</td>
<td>416,498</td>
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<td>1990/91</td>
<td>417,026</td>
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<tr>
<td>1991/92</td>
<td>423,364</td>
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<td>1992/93</td>
<td>377,887</td>
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<td>1993/94</td>
<td>229,648</td>
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<tr>
<td>1994/95</td>
<td>226,450</td>
</tr>
<tr>
<td>1995/96</td>
<td>258,364</td>
</tr>
</tbody>
</table>

* All claims arising from self-insured employers as of 30/6/96 are excluded

Source: VWA
Table 5.3 Long-Term Claims By Year Reported*

<table>
<thead>
<tr>
<th>Year</th>
<th>Long-Term Claims</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Standard **</td>
<td>Total</td>
<td></td>
</tr>
<tr>
<td>1986/87</td>
<td>9,094</td>
<td>9,727</td>
<td></td>
</tr>
<tr>
<td>1987/88</td>
<td>6,304</td>
<td>6,739</td>
<td></td>
</tr>
<tr>
<td>1988/89</td>
<td>5,718</td>
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<td></td>
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<tr>
<td>1989/90</td>
<td>4,909</td>
<td>5,330</td>
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<tr>
<td>1990/91</td>
<td>5,735</td>
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</tr>
<tr>
<td>1991/92</td>
<td>5,147</td>
<td>5,461</td>
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</tr>
<tr>
<td>1992/93</td>
<td>2,629</td>
<td>2,730</td>
<td></td>
</tr>
<tr>
<td>1993/94</td>
<td>1,904</td>
<td>1,905</td>
<td></td>
</tr>
<tr>
<td>1994/95</td>
<td>1,817</td>
<td>1,818</td>
<td></td>
</tr>
</tbody>
</table>

* All claims arising from self-insured employers as of 30/6/96 are excluded.

**Standard claims exclude journey claims and non-fatal closed claims with up to 10 days compensation and medical and like payments below the threshold.

Source: VWA
Table 5.3 Long-Term Claims By Year Reported*

<table>
<thead>
<tr>
<th>Year</th>
<th>Long-Term Claims</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Standard</td>
</tr>
<tr>
<td>1986/87</td>
<td></td>
<td>9,094</td>
</tr>
<tr>
<td>1987/88</td>
<td></td>
<td>6,304</td>
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<td>1988/89</td>
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<td>5,718</td>
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<td>4,909</td>
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<td>1990/91</td>
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<td>5,735</td>
</tr>
<tr>
<td>1991/92</td>
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<td>5,147</td>
</tr>
<tr>
<td>1992/93</td>
<td></td>
<td>2,629</td>
</tr>
<tr>
<td>1993/94</td>
<td></td>
<td>1,904</td>
</tr>
<tr>
<td>1994/95</td>
<td></td>
<td>1,817</td>
</tr>
</tbody>
</table>

* All claims arising from self-insured employers as of 30/6/96 are excluded.

**Standard claims exclude journey claims and non-fatal closed claims with up to 10 days compensation and medical and like payments below the threshold.

Source: VWA
Table 5.4 Fatal Claims*

<table>
<thead>
<tr>
<th>Year</th>
<th>Standard Claims**</th>
<th>Total Claims</th>
<th>Death Benefits ($ thousands)</th>
<th>Average Lump Sum Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>1986/87</td>
<td>209</td>
<td>248</td>
<td>$5,321</td>
<td>$53,750</td>
</tr>
<tr>
<td>1987/88</td>
<td>223</td>
<td>289</td>
<td>6,983</td>
<td>46,248</td>
</tr>
<tr>
<td>1988/89</td>
<td>262</td>
<td>338</td>
<td>12,947</td>
<td>51,172</td>
</tr>
<tr>
<td>1989/90</td>
<td>229</td>
<td>292</td>
<td>14,233</td>
<td>56,037</td>
</tr>
<tr>
<td>1990/91</td>
<td>191</td>
<td>240</td>
<td>13,845</td>
<td>60,197</td>
</tr>
<tr>
<td>1991/92</td>
<td>197</td>
<td>249</td>
<td>16,439</td>
<td>70,553</td>
</tr>
<tr>
<td>1992/93</td>
<td>164</td>
<td>188</td>
<td>10,513</td>
<td>71,032</td>
</tr>
<tr>
<td>1993/94</td>
<td>134</td>
<td>137</td>
<td>7,898</td>
<td>78,197</td>
</tr>
<tr>
<td>1994/95</td>
<td>120</td>
<td>120</td>
<td>7,020</td>
<td>92,377</td>
</tr>
<tr>
<td>1995/96</td>
<td>127</td>
<td>127</td>
<td>8,903</td>
<td>89,924</td>
</tr>
</tbody>
</table>

* Claims arising from self-insured employers as of 30/6/96 are excluded.

** Standard claims exclude journey claims.

Source: VWA
Table 5.5 Maims Payments*

<table>
<thead>
<tr>
<th>Year</th>
<th>Total Payments ($ millions)</th>
<th>(Maims Payments) / (Weekly Payments)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1986/87</td>
<td>$5.2</td>
<td>2.1%</td>
</tr>
<tr>
<td>1987/88</td>
<td>15.9</td>
<td>4.6</td>
</tr>
<tr>
<td>1988/89</td>
<td>24.7</td>
<td>4.9</td>
</tr>
<tr>
<td>1989/90</td>
<td>34.7</td>
<td>8.3</td>
</tr>
<tr>
<td>1990/91</td>
<td>47.2</td>
<td>11.3</td>
</tr>
<tr>
<td>1991/92</td>
<td>61.1</td>
<td>14.4</td>
</tr>
<tr>
<td>1992/93</td>
<td>80.0</td>
<td>21.2</td>
</tr>
<tr>
<td>1993/94</td>
<td>78.2</td>
<td>34.1</td>
</tr>
<tr>
<td>1994/95</td>
<td>89.0</td>
<td>39.9</td>
</tr>
<tr>
<td>1995/96</td>
<td>104.1</td>
<td>45.2</td>
</tr>
</tbody>
</table>

*Includes payments for Section 98A in the latest 3 years. Claims arising from self-insurers as of 30/6/96 are excluded.

Source: VWA
Table 5.6 Percentages of Maims Payments by Type of Maim, 1986-1996*

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Vision, Sight Loss</td>
<td>10.4%</td>
<td>13.3%</td>
<td>21.5%</td>
<td>21.1%</td>
<td>23.0%</td>
<td>23.2%</td>
<td>16.9%</td>
<td>15.1%</td>
<td>20.4%</td>
<td>20.6%</td>
</tr>
<tr>
<td>Upper Extremities</td>
<td>5.1%</td>
<td>4.3%</td>
<td>6.7%</td>
<td>10.4%</td>
<td>10.3%</td>
<td>11.8%</td>
<td>10.5%</td>
<td>10.1%</td>
<td>13.0%</td>
<td>14.1%</td>
</tr>
<tr>
<td>Lower Extremities</td>
<td>70.2%</td>
<td>62.4%</td>
<td>34.4%</td>
<td>35.3%</td>
<td>27.1%</td>
<td>25.5%</td>
<td>36.9%</td>
<td>38.9%</td>
<td>21.1%</td>
<td>19.0%</td>
</tr>
<tr>
<td>Hearing Disorders</td>
<td>7.0%</td>
<td>5.0%</td>
<td>15.4%</td>
<td>19.3%</td>
<td>23.2%</td>
<td>22.5%</td>
<td>20.1%</td>
<td>17.1%</td>
<td>19.4%</td>
<td>20.5%</td>
</tr>
<tr>
<td>Back Impairment</td>
<td>0.0%</td>
<td>0.7%</td>
<td>0.8%</td>
<td>2.0%</td>
<td>2.2%</td>
<td>2.3%</td>
<td>2.6%</td>
<td>2.4%</td>
<td>3.9%</td>
<td>4.0%</td>
</tr>
<tr>
<td>Pelvis Impairment</td>
<td>2.5%</td>
<td>2.3%</td>
<td>1.6%</td>
<td>1.0%</td>
<td>1.4%</td>
<td>1.3%</td>
<td>0.5%</td>
<td>0.9%</td>
<td>0.4%</td>
<td>0.6%</td>
</tr>
<tr>
<td>Severe injuries includ.</td>
<td>6.2%</td>
<td>8.6%</td>
<td>15.9%</td>
<td>9.0%</td>
<td>10.0%</td>
<td>10.7%</td>
<td>7.3%</td>
<td>6.0%</td>
<td>1.8%</td>
<td>0.5%</td>
</tr>
<tr>
<td>Paraplegia, Quadriplegia</td>
<td>3.7%</td>
<td>8.1%</td>
<td>18.5%</td>
<td>19.2%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Loss of Mental Powers</td>
<td>2.6%</td>
<td>2.4%</td>
<td>3.9%</td>
<td>4.0%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>2.5%</td>
<td>2.3%</td>
<td>1.6%</td>
<td>1.0%</td>
<td>1.4%</td>
<td>1.3%</td>
<td>0.5%</td>
<td>0.9%</td>
<td>0.4%</td>
<td>0.6%</td>
</tr>
</tbody>
</table>

* Claims arising from self insurers as of 30/6/96 are excluded

Source: VWA
Table 5.7 Lump Sum Benefit Payments

<table>
<thead>
<tr>
<th>Year</th>
<th>Lump Sum Payments ($, 000)</th>
<th>Lump Sum Payments/Weekly Benefits</th>
<th>Death Benefits</th>
<th>Maims Benefits</th>
<th>Common Law Damages</th>
<th>Other Lump Sums</th>
</tr>
</thead>
<tbody>
<tr>
<td>1986/87</td>
<td>$11,454</td>
<td>4.7%</td>
<td>46.4%</td>
<td>45.2%</td>
<td>3.1%</td>
<td>5.2%</td>
</tr>
<tr>
<td>1987/88</td>
<td>29,991</td>
<td>7.7</td>
<td>25.9</td>
<td>59.0</td>
<td>12.8</td>
<td>2.3</td>
</tr>
<tr>
<td>1988/89</td>
<td>48,371</td>
<td>11.3</td>
<td>26.8</td>
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<tr>
<td>1989/90</td>
<td>76,498</td>
<td>18.4</td>
<td>18.6</td>
<td>45.4</td>
<td>34.4</td>
<td>1.6</td>
</tr>
<tr>
<td>1990/91</td>
<td>121,555</td>
<td>29.1</td>
<td>11.4</td>
<td>38.8</td>
<td>45.5</td>
<td>4.3</td>
</tr>
<tr>
<td>1991/92</td>
<td>221,267</td>
<td>52.2</td>
<td>7.4</td>
<td>27.6</td>
<td>49.6</td>
<td>15.4</td>
</tr>
<tr>
<td>1992/93</td>
<td>378,037</td>
<td>100.0</td>
<td>2.3</td>
<td>21.2</td>
<td>63.6</td>
<td>12.5</td>
</tr>
<tr>
<td>1993/94</td>
<td>221,821</td>
<td>96.6</td>
<td>3.6</td>
<td>35.3</td>
<td>50.4</td>
<td>10.8</td>
</tr>
<tr>
<td>1994/95</td>
<td>218,186</td>
<td>96.4</td>
<td>3.2</td>
<td>41.4</td>
<td>53.9</td>
<td>1.4</td>
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<tr>
<td>1995/96</td>
<td>226,050</td>
<td>87.5</td>
<td>3.9</td>
<td>51.6</td>
<td>44.3</td>
<td>0.2</td>
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</tbody>
</table>

Source: VWA
**Table 5.8 Medical and Like Services Costs**

<table>
<thead>
<tr>
<th>Year</th>
<th>Total (in millions)</th>
<th>Per Claim*</th>
<th>Medical Practitioner</th>
<th>Physiotherapy</th>
<th>Rehabilitation</th>
<th>Hospital</th>
<th>Ancillary Medical Services</th>
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<tbody>
<tr>
<td>1986/87</td>
<td>$57.9</td>
<td>$644</td>
<td>36%</td>
<td>12%</td>
<td>14%</td>
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<td>1,228</td>
<td>29</td>
<td>12</td>
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<td>28</td>
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<tr>
<td>1988/89</td>
<td>140.2</td>
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<td>28</td>
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<tr>
<td>1989/90</td>
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<td>28</td>
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<tr>
<td>1990/91</td>
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<td>2,158</td>
<td>29</td>
<td>11</td>
<td>22</td>
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<td>1991/92</td>
<td>171.3</td>
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<td>30</td>
<td>12</td>
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<td>1992/93</td>
<td>172.9</td>
<td>3,077</td>
<td>30</td>
<td>12</td>
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<tr>
<td>1993/94</td>
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<td>32</td>
<td>13</td>
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<td>1994/95</td>
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<td>33</td>
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<td>14%</td>
<td>9%</td>
<td>25%</td>
<td>8%</td>
</tr>
</tbody>
</table>

*Total claims reported in that year. All claims arising from self-insured employers as of 30/6/96 are excluded.

Source: VWA
Chapter 6

DISPUTES AND THEIR RESOLUTION
Chapter 6 DISPUTES AND THEIR RESOLUTION

Disputes arise in all systems of insurance, be they social insurance or a purely private arrangement. Workers’ compensation programs 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 that is taken is to focus on the various sub-systems that have been established to resolve and settle disputes as they develop.

The role that a workers’ compensation agency takes 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. Further, the agency itself may not decide disputes at all 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; instead, the WorkCover Authority seeks to minimise the incidence of disputes, and when they arise, to have them settled rapidly by the parties with a minimum of transaction costs. Where that does not succeed, as must occur on occasion, the dispute is resolved in the courts. To assist the parties and achieve their goals, workers’ compensation depends 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, however, the WorkCover law seeks to drive some cases to the less formal (and less expensive) Magistrate’s Court rather than the County Courts. A small number of disputes over some specialised issues can be resolved, if not at the Conciliation Service, at the Administrative Appeals Tribunal.

Medical Panels

An 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 with the outcome. Currently, such Panels are found in Victoria, New South Wales and Western Australia; and 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 if 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?

\(^{\text{1For example see Barth. 1985. Resolving Occupational Disease Claims: The Use of Medical Panels. Cambridge, MA: Workers Compensation Research Institute.}}\)
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. It 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 nine items identified in the statute (Section 5). In 1994, the function of the Medical Panels was expanded under Section 104 (see below). That section does not refer explicitly to a “medical question.” Consequently, the function of the Medical Panels extends 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, to supply relevant documents to the Panel, or to 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 opinion that new information on the medical question has emerged since the Panel’s opinion or 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 to 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. Currently, there are about 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, if they perceive that Panel work may involve them in excessive contention or, if they believe 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 matters to deal 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 30 or 40 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, they cannot be appointed to that Panel.

The Panel can consist of one to three members. In Victoria, each Panel member examines the patient, usually separately. One member of the Panel is designated as the Presiding member. 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 panellists, 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 it is the findings themselves that the parties need, if they are to reach some resolution. What the Panels seek to do is to 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 time lines 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 7 days after forming its opinion to provide it to the relevant persons. This has proven to be unworkable, and sizable delays exist in the process. There are several reasons for this, but a key has been that the system has been vastly overburdened since 1994.

In the 1994 law change, the role of the Medical Panels was modified and greatly
expanded. Specifically, where a claimant disputes an insurer's offer for a claim under Section 98 or 98A, the claimant must not commence proceedings until the claimant first refers the dispute to a Medical Panel for an opinion as to entitlement to compensation and 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 is 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 is not binding on the claimant. If the dispute remains, i.e., the offer is not acceptable, the Conciliation Service may become involved. Though the Conciliation Officer may refer disputes over "medical questions" to a Medical Panel, and the opinion of the Panel is binding on the parties, determining the extent of disability under Section 98 or of pain and suffering under Section 98A are not "medical questions." 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 6.1 show the number of referrals according to referring party over the past 3 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 9 times. This reflects the impact of the 1994 amendments. Secondly, Table 6.1 reveals that the activity of Medical Panels is 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. That 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 6.2 is confirmation of the impact of the 1994 amendments. By 1995-96, 97 percent of referrals to Medical Panels were made under Section 98/104, that is, disputes over maims. It seems fair to summarize that the use of Medical Panels for all issues other than maims benefits was negligible.

The data in Table 6.3 reveal the little that is known about the type of bodily injury involved in disputes that are referred to a Panel. In 1993/94, about 44 per cent of referrals involved “backs,” and though the number of such cases grew, they were overtaken by the ballooning of hearing loss claims/disputes in the next 2 years. However, as maims cases swamped the Medical Panels in 1994/95 and 1995/96, increasingly the types of injuries were coded as “multiple.” Of course, “multiple” injuries can be the source of problems in constituting a single panel of medical specialists. However, the Panel may obtain consultation from other specialists, where needed, to assist it in reaching an opinion.

In almost all cases in 1995/96, two-person Panels were employed. (Table 6.4) Over the past 2 years, not a single Panel was constituted on the basis of a single member. This reflects the preferences of both the Panel members and the Convenor for a Panel that permits some consultation within the Panel process. Table 6.5 reflects the professional specialisation of those appointed to a panel in 1995/96. Hardly surprisingly, the dominant specialty required is orthopaedics. Note the sizable number of specialists drawn from otolaryngology and psychiatry. The lack of availability of psychiatrists to serve on Medical Panels in Victoria was noted by a number of parties.

The explosion in Medical Panel activity has exacted a price. Delays and backlogs have grown from 1993/94 to 1995/96. In the most recent year 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.

Consequently, the system has been modified. Specifically, the 1996 amendments of
Section 104 mean that if a worker disputes an insurer decision with respect to a claim for a maims benefit, it no longer must be referred to a Medical Panel. Instead, it must be referred to Conciliation. The Conciliation Officer may then refer the matter to a Medical Panel. The 1996 change does not require that the insurer make an offer consistent with the Panel opinion where the disputed issue is not a “medical question.” However, it seems likely that the insurer will still be expected to make such an offer.

Medical Panels and the Future

The unknown is the extent to which Conciliation Officers will refer maims benefit disputes to a Medical Panel. The 1996 law changes are likely to lead to some reduction overall in claimant disputes over maims. That aside, Conciliators may or may not seek the intervention of a Medical Panel. One view is that the 1996 law will lead to some reduction in the proportion of claims resolved by the Conciliation Service. Indirectly, this may place some pressure on the Service to show a higher rate of resolutions, and referrals to Medical Panels may be utilised as a means to achieve a higher success rate. Early indications are that the use of Medical Panels will be very limited in maims disputes.

A reduction in the utilisation of the Medical Panels is seen as a highly desirable outcome. First, as the demand for Panels is reduced, it can lead to some reduction in the delays that have resulted from excessive demands. Second, it would reduce the problem created by the inadequate number of practitioners available in certain specialties. Third, it would reduce the need to depend so heavily on some practitioners, which previously created perceptions that the quality of Panel members had slipped.

Relieving the pressure on the Medical Panels is regarded as vital. However, there still appears to be something of an artificial distinction that exists regarding “medical questions.” It seems to stretch things to exclude disputes over the existence and extent of maims from the set of “medical questions.” Few workers’ compensation schemes have found a generally accepted method of resolving maims disputes. Many of the differences between claimant and insurer regarding maims do involve medical matters, if not “medical questions.” A rational and objective method to resolve these matters must be found.
A related question is the type of issue on which the Panel may report. Prior to 1996, the law required the Panel to provide “an opinion as to (a) the entitlement of the claimant to compensation,” in Section 104 disputes. It requires little imagination to see that so broad a question could have medical specialists reporting on issues that were fundamentally beyond their domain. Some parties argued that this had occurred, and that particular language has been replaced in 1996. It remains to be seen if Panel members will be made sensitive to the somewhat less open-ended responsibilities that they will encounter in maims disputes.

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 U.S.A. and Canada for example, the employer is shielded from common law actions 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, 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, the Commonwealth (Comcare, SeaCare), New South Wales, and Western Australia; and unlimited access or benefits in Queensland, Tasmania, and the Australian Capitol Territory.

The first worker’s 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 would 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 employer 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 non-pecuniary loss. A ceiling of $140,000 was placed on these damages, and any amount paid for maims under worker's compensation was to be deducted from awarded damages.

Common Law Under Section 135B

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 grey 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. 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 3 months was allowed for injuries that occurred in the 3 months prior to 1 December 1992. In the last 10 days of WorkCare, approximately 10,000 writs were issued. By February 1993, over 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. Ultimately the VWA was faced with having to run off 22,000 claims.

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2See Robart v. Matchplan Pty Ltd., Supreme Court of Victoria - Full Court, 7267 of 1993.
The Authority has had an enormous task in resolving more than 22,000 common law claims for these “old” cases. Yet by July 1996, over 97 percent had been settled. In the 3 (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 hear such proceedings unless the parties had attended a conference at which an offer was made, either within 3 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. However, it is likely that the cases that remain unsettled may involve not only more intractable issues, they may also involve, on average, cases that will settle for amounts greater than that previously established.

Common Law Under Section 135A

Access to common law was generally narrowed by 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 ($333,420 as of 1 July 1996).

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 believed that they would not be found to have a serious injury, thereby being ineligible for common law recovery. Under Section 135B, "old" cases had no such "serious injury" barrier.

The legislation, substantially modelled 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 American Medical Association’s Guides to the Evaluation of Permanent Impairment, 2nd 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 will 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 a "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

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3These dollar amounts are subject to annual indexing. As of 1 July 1996, these amounts were $32,860 for the threshold and $739,690 for the maximum allowed.
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.”

With WorkCover, the expectation was that the number of common law cases would drop off precipitously. However, although a substantial reduction has occurred over what would have been the volume in the absence of the 1992 legislation, worker solicitors have learned how to widen access to the common law. This, in combination with certain judicial determinations, has meant that common law still represents an important component of work injury compensation in Victoria.

Procedures and the Expansion of Accessibility

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*, 2nd Edition. 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/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 another hurdle for the worker, a situation where winning at the initial level of dispute can leave the worker with some costs, and it extends the time that the entire process will take. However, it does parallel the process found in the Transport Accident Act.

Workers or dependents have 6 years in which to commence an action for personal
injury or death. For an occupational disease, however, the worker has 6 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 dependant has 6 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, or will have, a major impact on common law cases. In Bowles v. Coles-Myer Ltd. (Bowles Case), J. 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. Though the defendant asserted that a determination had been made before the writ was issued, J. Ashley rejected that 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 which were 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 stabilized. 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.

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No doubt, some insurers will find this 60-day clock to be a difficult one to meet in all applications. As such, some 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 is made by the insurer regarding “serious injury” 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-26-week benefit determination which found that the employee had a “serious injury” enabled him to satisfy the test of serious injury, and to proceed 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 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, seeks to rectify this. It provides that a decision by the insurer that the worker has a serious injury for the purposes of Section 93B is not to be taken to be a determination for purposes of Section 135A (common law), unless the decision specifically so states.

That change overturns the Hanrahan result, and is deemed to have commenced on 1 December 1992; however it does not eliminate it for 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,

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5L.J. Hanrahan v. Terrence John Davis, Supreme Court of Victoria, No. 5312 of 1995.
but did not or would not have been found to be "seriously injured" subsequently under Section 135A.

It is too early to judge how effectively Section 135A(3A) will serve to limit common law actions. The response by injured workers and their solicitors suggests that Hanrahan is no longer of importance, at least once these new claims are run off. Yet it remains that a finding of "serious injury" at 26 weeks may serve to influence a court in deciding the presence or absence of "serious injury" for purposes of a Section 135A determination. Thus, a worker's solicitor can be expected to ask how a worker is not "seriously injured" currently when the insurer itself found the worker's injury to be "serious" previously.

The third case, actually a set of cases, stem from the discussion above regarding the mechanism that can be employed by an injured worker to seek damages. Specifically, Section 135A(19) provides a definition whose impact is still not fully understood:

In this section, serious injury means
(a) serious long-term impairment or loss of a body function; or
(b) permanent serious disfigurement; or
(c) severe long-term mental or severe long-term behavioural disturbance or disorder; or
(d) loss of a foetus.

This section of the law, combined with Section 135A(4)(b), which 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 pre-existing back condition, which constituted "... a serious long-term impairment of a body function—the function of the spine." Practically, persons familiar with

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workers' compensation matters recognise the widespread, frequent character of claims for back injuries, with or without the complication of a pre-existing 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 the Nichols Case, 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. 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.

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 create an enormous opportunity for injured workers 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 move access back to where it was before 1 December 1992. However, today 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 matter that is unique to

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7Glen Alexander Nichols v. Victorian WorkCover Authority et al. No. MC 9409103.
Victoria. In a number of jurisdictions in and outside of Australia, legislation has tended to move compensation of injured workers with permanent disabilities from one basis 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—laws have been changed 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 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 has not been entirely successful.

Yet another assault on the "serious injury" standard found in Section 135A arises 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, workers with injuries may be 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 on benefits, 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 game the scheme accordingly. Insurers may pay higher levels of benefits under Section 98 and/or Section 98A 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 not made within 3 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 to all its employees. It is the employer that has the duty both to instruct and to 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

A critical question for workers' compensation, in terms both of its recent experience and its future, relates to the future of common law actions. Clearly, a goal since 1992 has been to bring down the volume of such actions. Setting aside the run-off of the 20,000 claims for injuries under WorkCare, there has been a decline in such cases. However, there are mixed views as to the importance of that observation. Some solicitors appear to believe that it is not productive to rush to common law. Instead, they argue, the passage of time usually enriches a claim for damages. According to this, there are cases where, currently, writs could be issued
or leave sought to proceed to doing so. Instead, the cases have not emerged and are being held back to maximise their value.

One basis for assessing the degree to which a potential exists for future actions for damages is the number of cases where “serious injury” has been found by the insurer. Of course, some of these will not result in proceedings since no basis for employer negligence may exist. More importantly, the erosion of the “serious injury” barrier has already been noted, and the potential number of damages actions may be much larger than the number of previously determined “serious injured” workers. However, as of 30 June 1996, the Authority reported that there were 3,277 claimants who had been found to be “seriously injured.” As of August 1996, the Authority believes that 1,423 common law matters have been lodged under the WorkCover law. Some of these are obviously based on the legislative response to the Hanrahan decision, discussed above.

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 from one system to another, 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. Frequently, also, a more or less autonomous appeals board or tribunal will 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 transaction costs, it will likely 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 non-adversarial process that aims to lead to a mutually acceptable agreement. The Ministerial Guidelines for the Conciliation Officers identify the following goals of the Conciliation Officer:

- 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 on-going worker/employer employment relationship;
- be prompt and timely in the conduct of the conciliation process and in dealings with the parties;
- 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 must be referred to Conciliation, 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 require mandatory conciliation.

Most requests for conciliation are initiated by workers who have been advised by the insurer of a decision that is regarded as adverse to them. 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. The Senior Conciliation Officer may allow this 60-day limit to be waived. Indeed, this is usually done when such a request is made, for 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 7 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 7 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 (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. Union representatives, for example, often serve as an assistant for the worker. Significantly, a worker or an employer is not entitled to be accompanied by a solicitor. If a party wishes to have their solicitor present, approval must be given by both the contending party and the Conciliation Officer. On occasions requests by workers to have a solicitor accompany them to a conference have been rejected. However, such requests can and have been granted, 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/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 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/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/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 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.

Clearly, it is tricky matter for a Conciliator to fulfill the task of a facilitator while retaining the potential role of a 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 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 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 to the direction of the Authority. The Authority is not able to overrule any decision made by the Officer in conciliating a dispute. As of June 1996, there are 21 full-time Conciliation Officers, nine sessional and part-time Officers plus three executives of the Service who carry small caseloads as Conciliation Officers as well. The total staff is 62 persons on a full-time equivalent basis.

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, 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. In 1996, some Officers had 80 to 90 cases assigned to them, and that is viewed as an excessive caseload.

The Experience of the Conciliation Service

The responsibilities of the Service have evolved considerably in the 4 years of its existence. 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. These cases represented a sizable portion of the Conciliation Service’s caseload in its first year.

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 (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 maims (Section 98) and over pain and suffering (Section 98A) must be referred to the Service before commencing proceedings.
One must conclude that the first several years of conciliation under WorkCover have 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 has overcome these and now is operating with good timeliness and no large backlog. However, the requirement that Section 98 and Section 98A disputes must be brought to Conciliation before proceeding to court could have some impact on the balance that had been successfully achieved by mid 1996.

The data in Table 6.6 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 eliminated, largely, by the end of 1993/94 and fully disposed of by the end of 1994/95. By the end of June 1996, there were 2,671 cases outstanding, slightly below the number of new applications (2,568) plus reopened cases (182) for May and June 1996, i.e., a 60-day backlog.

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 1995, 5,799 (or 19 percent) of 30,972 applications to the Conciliation Service were for maims disputes. In 1995/96, 4,670 applications (or 31 percent) involved maims disputes out of 14,968 applications for all causes. 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, or an insurer could refer a Section 98 case to Conciliation where 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 6.7) 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 over the past 4 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 virtually no backlog and that it can accommodate, generally, the rigorous requirement that applications be conferenced within 28 days of their receipt. In its first 2 years between 80 and 85 percent of its cases (excluding applications where conciliation did not proceed or there was no jurisdiction) were resolved, dropping to 65 percent in 1994-95 and 67 percent in 1995/96. This is an impressive performance.

The legislation requires that matters may not proceed to court (except fatality claims) unless first referred to Conciliation. All matters, other than maims cases, can proceed to court
if not resolved within 28 days of being lodged with the Conciliation Service. Most solicitors are willing to allow matters to proceed beyond the 28 days before issuing proceedings, so long as they see some progress with the conciliation. However, some solicitors will delay providing information after the Request for Conciliation has been submitted, so that resolution cannot be effected within the 28-day period. As that period expires they will issue proceedings. To prevent such efforts to evade the process, the 1996 amendments require that the Conciliation Officer certify that the claimant has made a reasonable attempt to settle in disputes over mains.

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.

Surveys of workers, insurers, and employers were conducted in November 1994 and June 1995 by an independent market research firm. It found that 86 percent of conference attendees were satisfied with the Service (June 1995, compared with 80 percent in November 1994). About 80 percent were satisfied with the skills of the Conciliation Officer. 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 itself 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 her/his primary responsibility to conciliate and to mediate the dispute.

The Future

Beginning in July 1996, disputes over permanent impairment must be referred to Conciliation. These cases may not 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. The claimant will not be able to commence court proceedings unless the Conciliation Officer is satisfied that all reasonable steps have been taken by the claimant to settle the dispute. 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 the 1996 amendments will enhance the power of the Conciliator. Whether it does so at the expense of the Officer’s role as a mediator, or serves to strengthen it, remains to be seen.

Administrative Appeals Tribunal

Certain categories of disputes may 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 hears all, or nearly all, disputes arising out of the workers’ compensation arena.

One set of disputes under workers’ compensation arises from the transition to the
Accident Compensation Act of 1985. Prior to the law's effective date, 1 September 1985, private insurers sold coverage to Victoria employers for workers' compensation. Subsequently, insurance was provided by the state's Accident Compensation Commission (ACC). Not surprisingly, disputes arose over whether injury claims were the financial responsibility of the private insurers (old cases) or whether the state fund was to pay (new cases). A "Division 6" was created at the ACC to assure that private insurers did not succeed in shifting the burden of benefit payments from themselves. Disputes over this issue have largely been eliminated due to the passage of time, though a sizable number were adjudicated at the Tribunal in 1992 and 1993. (Table 6.8)

A second set of disputes that have dimmed because of the passage of time are referred to as Section 120 cases. Though private insurance for workers' compensation was ended with the Accident Compensation Act of 1985, some private insurance carriers served as the Accident Compensation Commission's "agents" to provide a variety of claims services for employers. Disputes have arisen over whether or not these agents acted in the best interest of the employers that they were paid to service. At stake is the experience modification factor that an employer carries. Where an employer could demonstrate that its agent failed to serve its interest appropriately, the employer's costs of insurance could be adjusted downwards. Section 120 has been repealed but a sunset provision has caused some claims to continue to be brought to the Tribunal for adjudication, though none were brought from 1 July 1995 to 30 June 1996.

A third set of disputes arises from employer appeals arising from their insurance rates and classification for rate setting purposes. The decision of the Tribunal in such disputes cannot be overturned in court except over matters of law. The overall number of such cases is small, at about 3 percent of total referrals.

The largest number of issues that have come to the AAT relate to disputes over bills and appropriate services provided for medical and like services and occupational rehabilitation services. A dispute over such an issue will not cause a review from the AAT unless the matter has first been referred to Conciliation. Only 28 days after it has been referred to Conciliation, or a certificate has been issued by a Conciliation Officer, can the matter be referred to the Tribunal. Where one of its decisions is appealed to the AAT, the WorkCover Authority is
required to reconsider its decision within 28 days of its receipt of an application for review by the Tribunal.

Where the Tribunal exercises jurisdiction, it may refer a medical question to a Medical Panel. If a party to the proceeding requests, the Tribunal must refer the question to a Medical Panel. The opinion of the Panel is binding upon the Tribunal.

Disputes over medical bills and services need not go to the AAT. In some instances, if both parties consent, the dispute can be taken to Magistrates' Court or County Court. Bifurcating disputes can result in some multi-issue disputes being adjudicated separately, both in a court and at the Tribunal.

In the past 2 years, the numbers of applications to the Tribunal have fallen off sharply, primarily due to a decline in Division 6 and Section 120 (employer aggrieved by agents) cases. It seems likely that the AAT's role in workers' compensation cases will be reviewed for purposes of determining the desirability of eliminating its responsibilities in this domain.

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). 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 that otherwise would have been commenced in County Court. It also aimed at reducing the number of disputes, overall, that were taken to the courts. This issue is described further below.

A number of exceptions exist to the generalization that the dispute resolution process ends with the Courts. Matters relating to contributions and to the collection and recovery of levies are adjudicated at the final stage by the Administrative Appeals Tribunal. Similarly, the determination of the AAT is not subject to County Court review on disputes over Sections 99, 99A, and 99B, that is, compensation for medical, hospital and like services, the amounts that
the Authority or insurer may pay for occupational rehabilitation, or the rates applicable for occupational rehabilitation. An exception to this is found in Section 43, which enables the County Court to inquire into, hear and determine any matter arising out of these areas if it is related to another matter that is before the Court and arises from workers' compensation.

Except for claims for death benefits, proceedings must not commence in Magistrates' or County Courts unless the matter has been referred to Conciliation, and either 28 days have expired since the date of referral or a Conciliation Officer has 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.

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.

In many workers' compensation cases disputes over medical questions and related matters arise. Several experienced practitioners pointed out that the Courts tend to be especially responsive to the opinions of the treating doctor, much more so than the medico-
legal experts that may give evidence that points to a contrary outcome. At issue here are matters that are evident in many other workers’ compensation jurisdictions, essentially the competence and integrity of the opinions of certain members of the medical/health care community. Specifically, where a medical person is frequently called upon by the same side in compensation disputes, their opinions may be discounted on the grounds that they approach their work with preconceived views or biases. The most curious aspect of this phenomenon is that they continue to be called upon by one side, though their views are given less weight by the determiner of facts.

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 6 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 that 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 Administrative Appeals Tribunal 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

The Authority prefers that more matters that do go to proceedings be moved to 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 limit 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) 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 scales of costs from the Magistrates’ Court.

Any limits on costs awarded to the worker or claimant may be 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 how it will be applied. Specifically, this new section (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 will certainly cause 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 Medical Panel Referrals by Referring Party

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Conciliation Service</td>
<td>362</td>
<td>94%</td>
<td>258</td>
</tr>
<tr>
<td>Authorised Insurer</td>
<td>13</td>
<td>4</td>
<td>12</td>
</tr>
<tr>
<td>Magistrates' Court</td>
<td>9</td>
<td>2</td>
<td>32</td>
</tr>
<tr>
<td>County Court</td>
<td>1</td>
<td>0</td>
<td>6</td>
</tr>
<tr>
<td>Self-Insurers</td>
<td>0</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>Claimant</td>
<td>0</td>
<td>0</td>
<td>1,729</td>
</tr>
<tr>
<td>Total</td>
<td>385</td>
<td>100%</td>
<td>2,040</td>
</tr>
</tbody>
</table>

Source: VWA
Note: Columns may not sum to 100% because of rounding.
See also other tables (6.3, 6.7, 6.8)
Table 6.2 Medical Panel Referrals by Section of the Act

<table>
<thead>
<tr>
<th>Section of Act</th>
<th>1993/94</th>
<th>1994/95</th>
<th>1995/96</th>
</tr>
</thead>
<tbody>
<tr>
<td>98, 98A, 104 (Maims)</td>
<td>156</td>
<td>1,859</td>
<td>3,343</td>
</tr>
<tr>
<td>111/111A</td>
<td>82</td>
<td>17</td>
<td>4</td>
</tr>
<tr>
<td>99 Medical and Like</td>
<td>43</td>
<td>41</td>
<td>16</td>
</tr>
<tr>
<td>93 Weekly Benefits</td>
<td>69</td>
<td>56</td>
<td>21</td>
</tr>
<tr>
<td>114 Termination</td>
<td>0</td>
<td>28</td>
<td>6</td>
</tr>
<tr>
<td>Other</td>
<td>35</td>
<td>39</td>
<td>11</td>
</tr>
<tr>
<td>Total</td>
<td>385</td>
<td>2,040</td>
<td>3,401</td>
</tr>
</tbody>
</table>

Source: VWA
Table 6.3 Medical Panel Referrals by Injury Type

<table>
<thead>
<tr>
<th>Injury Type</th>
<th>1993/94</th>
<th>1994/95</th>
<th>1995/96</th>
</tr>
</thead>
<tbody>
<tr>
<td>Back</td>
<td>169</td>
<td>296</td>
<td>398</td>
</tr>
<tr>
<td>Hearing Loss</td>
<td>41</td>
<td>477</td>
<td>460</td>
</tr>
<tr>
<td>Arms</td>
<td>36</td>
<td>139</td>
<td>252</td>
</tr>
<tr>
<td>Back/Neck</td>
<td>25</td>
<td>46</td>
<td>74</td>
</tr>
<tr>
<td>Stress</td>
<td>19</td>
<td>16</td>
<td>3</td>
</tr>
<tr>
<td>Multiple</td>
<td>16</td>
<td>587</td>
<td>1,362</td>
</tr>
<tr>
<td>Loss of Mental Powers</td>
<td>0</td>
<td>142</td>
<td>257</td>
</tr>
<tr>
<td>Other</td>
<td>79</td>
<td>337</td>
<td>594</td>
</tr>
<tr>
<td>Total</td>
<td>385</td>
<td>2,040</td>
<td>3,400</td>
</tr>
</tbody>
</table>

Source: VWA
Table 6.4 Medical Panels by Composition

<table>
<thead>
<tr>
<th></th>
<th>1993/94</th>
<th>1994/95</th>
<th>1995/96</th>
</tr>
</thead>
<tbody>
<tr>
<td>One Member</td>
<td>135</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Two Member</td>
<td>155</td>
<td>1,283</td>
<td>2,075</td>
</tr>
<tr>
<td>Three Member</td>
<td>60</td>
<td>17</td>
<td>61</td>
</tr>
<tr>
<td>Total</td>
<td>350</td>
<td>1,457</td>
<td>2,136</td>
</tr>
</tbody>
</table>

Source: VWA
Table 6.5 Medical Panel Appointments, by Specialty, 1995/96

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Total</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Orthopaedic Surgery</td>
<td>1,838</td>
<td>35%</td>
</tr>
<tr>
<td>General Surgery</td>
<td>934</td>
<td>18</td>
</tr>
<tr>
<td>Otolaryngology</td>
<td>892</td>
<td>17</td>
</tr>
<tr>
<td>Psychiatry</td>
<td>734</td>
<td>14</td>
</tr>
<tr>
<td>Rheumatology</td>
<td>261</td>
<td>5</td>
</tr>
<tr>
<td>Neurology</td>
<td>133</td>
<td>3</td>
</tr>
<tr>
<td>Rehabilitation Medicine</td>
<td>114</td>
<td>2</td>
</tr>
<tr>
<td>Plastic Surgery</td>
<td>110</td>
<td>2</td>
</tr>
<tr>
<td>Neurosurgery</td>
<td>101</td>
<td>2</td>
</tr>
<tr>
<td>Other</td>
<td>126</td>
<td>2</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>5,243</td>
<td>100%</td>
</tr>
</tbody>
</table>

Source: VWA
Table 6.6 Conciliation Service Applications and Disposals

<table>
<thead>
<tr>
<th>Year</th>
<th>Applications</th>
<th>Disposals</th>
</tr>
</thead>
<tbody>
<tr>
<td>1992/93</td>
<td>10,791</td>
<td>4,034</td>
</tr>
<tr>
<td>1993/94</td>
<td>9,418</td>
<td>16,010</td>
</tr>
<tr>
<td>1994/95</td>
<td>10,763</td>
<td>11,434</td>
</tr>
<tr>
<td>1995/96</td>
<td>14,968</td>
<td>14,457</td>
</tr>
<tr>
<td>Totals</td>
<td>45,940</td>
<td>45,935</td>
</tr>
</tbody>
</table>

Source: VWA
Table 6.7 Conciliation Service Lodgements by Type of Case, 1 December 1992 to 30 June 1996

<table>
<thead>
<tr>
<th>Type of Case</th>
<th>Number</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rejection of Claim</td>
<td>8,155</td>
<td>18%</td>
</tr>
<tr>
<td>Terminations (104 weeks and 52 weeks)</td>
<td>2,880</td>
<td>6</td>
</tr>
<tr>
<td>Terminations of Weekly Benefits</td>
<td>5,681</td>
<td>12</td>
</tr>
<tr>
<td>Alterations of Rate of Compensation</td>
<td>1,740</td>
<td>4</td>
</tr>
<tr>
<td>Reductions of Rate of Compensation</td>
<td>5,270</td>
<td>11</td>
</tr>
<tr>
<td>Maims</td>
<td>10,468</td>
<td>23</td>
</tr>
<tr>
<td>Medical and Like Services</td>
<td>9,299</td>
<td>20</td>
</tr>
<tr>
<td>Other</td>
<td>2,447</td>
<td>5</td>
</tr>
<tr>
<td>Total</td>
<td>45,940</td>
<td>100%</td>
</tr>
</tbody>
</table>

Source: VWA
See also other tables (6.1, 6.3, 6.8)
Table 6.8 Accident Compensation Tribunal Files, and Other Applications Referred to the Administrative Appeals Tribunal, 1 December 1992 to 30 June 1996

<table>
<thead>
<tr>
<th>Issue</th>
<th>Referred</th>
<th>Determined</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contribution - Division 6</td>
<td>691</td>
<td>666</td>
</tr>
<tr>
<td>S.120 Employer Aggrieved</td>
<td>873</td>
<td>638</td>
</tr>
<tr>
<td>Levy</td>
<td>87</td>
<td>85</td>
</tr>
<tr>
<td>S. 99 Medical, Hospital, and like Expenses</td>
<td>1,387</td>
<td>1,320</td>
</tr>
<tr>
<td><strong>Totals</strong></td>
<td><strong>3,038</strong></td>
<td><strong>2,709</strong></td>
</tr>
</tbody>
</table>

Source: VWA
See also other tables (6.1, 6.3, 6.7)
Chapter 7

OCCUPATIONAL REHABILITATION IN VICTORIA
Chapter 7 OCCUPATIONAL REHABILITATION IN VICTORIA

Introduction

Physical, psychological and occupational rehabilitation are all provided for within the legislation. In the Victorian context, “occupational rehabilitation” covers specific, defined services within the general rubric of rehabilitation. 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 (OR) 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 over-riding 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.

The current status of occupational rehabilitation 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. The current VWA system of occupational rehabilitation reflects the concerns of the past while attempting to realize the current legislated mandate of rehabilitation and return to work for all injured workers.

Thus, we will 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. Employer and insurer reaction to the perceived
excesses of rehabilitation under WorkCare have been a critical determinant of current policy and practice in this area. Then, we will move on to 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 occupational rehabilitation 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, 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 whatsoever 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. It is also significant that, even where there was explicit statutory recognition of rehabilitation, the cultural ambience was such that this was little utilised in practice.

Thus, 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 may be necessary for the purposes of the vocational re-education and rehabilitation of disabled workers. However, no sum was in fact ever drawn under this provision until 1969, and that small payment remained, for some time thereafter, an isolated example.2


Indeed 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 Victorian Accident Rehabilitation Council. At least another five provisions in this Act related to or intersected with 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.

So rehabilitation of the occupationally disabled was a relatively late development within the evolution of 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 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.\(^4\)

**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 the union movement. They felt that occupational rehabilitation was simply being employed as a form of benefit control and raised confidentiality concerns that information gained from the activities of the insurer’s rehabilitation arm was being fed to the claims.

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department to be used to the worker's 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.

Whereas in the Canadian provincial schemes the rehabilitation function is located within the Workers Compensation Board, it was decided that primary responsibility for rehabilitation would reside with the Victorian Accident Rehabilitation Council (VARC), a body largely independent of the Accident Compensation Commission (ACC) even though that was the body which provided its funding. A comprehensive Government statement, issued soon after the announcement of the WorkCare reforms, referred to VARC as a body which would initially be “responsible to the Treasurer but it is expected that a fully integrated system will be developed in the long run.”

One of the consequences of this division was that the claims process and the rehabilitation process became largely separate systems. In particular, while VARC could access information on the ACC data base, 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.

While the Government, through the Accident Compensation Act, had given a strong mandate for a comprehensive system of rehabilitation for occupational disability, there were immediate problems due to the lack of an effective vocational rehabilitation infrastructure and persons

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trained in the various disciplines (for instance, occupational therapy, rehabilitation counselling and ergonomics) associated with this field. Accordingly, one of the primary concerns for VARC, at least in the earlier years, was to build this system.

VARC proceeded to establish a number of public WorkCare Rehabilitation centres and to approve 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 rise to 82 service locations, involving eight WorkCare Rehabilitation centres and an additional five WorkCare Rehabilitation sub-offices, and 69 locations operated by the 25 approved rehabilitation providers. The public WorkCare Rehabilitation service facilities came to provide about a third of the market for vocational rehabilitation services.

In relation to the supply and training of rehabilitation professionals, VARC, either individually or in conjunction with the ACC, funded a range of initiatives, such as the establishment of a Chair of 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 grew to be one of the largest, in terms of workers involved, of any comparable workers' compensation system. A decision was taken by VARC, in mid 1987, that it would attempt to ensure 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, which represented about 3.2 per cent of total WorkCare expenditure in that year.

VARC was also the regulator and gatekeeper in respect of the provision of rehabilitation services. The issue of quality and appropriate utilisation control was an ongoing issue. In April 1986 VARC instituted a central referral system, ostensibly for ensuring effective management of the referral process and encouraging 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 work, 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, so the VARC monitoring and control procedures and provider remuneration arrangements went through a number of refinements and configurations. One of the problems, particularly in the system of mass rehabilitation which VARC was overseeing, was that the monitoring and control system was largely process oriented and "check box" in nature. In a response to this, VARC in October 1991 implemented its Rehabilitation Case Management Strategy which attempted 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

While there was some discernible evolution in the approaches and practices of VARC
over its seven-year history, nevertheless, 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. Some of the
reasons for this have already been alluded to, but this phenomenon, which was to influence the
manner in which rehabilitation was approached in the WorkCover system, has a varied and
complex aetiology.

First, there were very few strong champions of rehabilitation outside of some parts of
the trade union movement. Whilst almost nobody 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.” The structure and
form that rehabilitation took under WorkCare was influenced very much by trade union input
into the business/labour compact which acted as midwife to the new system, with the employer
influence being felt in other areas such as the halving of the premium imposed upon business.
(see Chapter 2) As time progressed, the essentially tepid support of employer groups for
rehabilitation would change to concern and eventually outright derision for a system of 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. In fact, “changes” is probably too neutral a word. What was being attempted was a quantum leap from a situation where occupational rehabilitation hardly existed at all 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 exigencies of creating the necessary infrastructure and training the requisite personnel to serve the new system.

That is not to say that, even during this establishment phase, VARC adopted a laissez-faire approach to scheme operations; quite the contrary, in fact. The strong control approach adopted by VARC and its desire to micro-manage 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, under which all approved rehabilitation providers had to provide detailed rehabilitation plans before any significant rehabilitation action could be undertaken, became a torment for most parties in the system, including employers and insurers as well as the providers. As 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 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 micro-management 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, with the concomitant feature of rehabilitation costs becoming a significant element 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 being used, in an instrumentalist sense, as a weapon of benefit control. The largely arms-length arrangements between the ACC and VARC resulted in an uneasy, and often acrimonious, relationship between these two bodies that developed 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 magnitude of such 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.”

The point is that employers and insurers came to feel great antipathy toward the very concept of rehabilitation, and rational discourse over the appropriate level of occupational rehabilitation 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 occupational rehabilitation services in very particular terms to include only the following:

(a) initial rehabilitation assessment;
(b) functional assessment;
(c) workplace assessment;
(d) job analysis;
(e) advice concerning job modification;
(f) occupational rehabilitation counselling;
(g) vocational assessment;
(h) advice or assistance concerning job-seeking;
(i) vocational re-education;
(j) advice or assistance in arranging vocational re-education;
(k) preparation of a return-to-work plan;
(l) the provision of aids, appliance, apparatus or other materials likely to facilitate the return to work of a worker after an injury;
(m) 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;
(n) 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.

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7Section 19(d) and (e) of the Act.
8Section 5, Accident Compensation Act 1985.
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 policies, initiatives and procedures that determine how return to work injury management is seen, delivered and managed. Insurers must also encourage employers to develop re-employment 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 re-employ, 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, Re-Employment and Re-training**
- 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 re-employment through a suitable job offer where a worker regains a capacity for work.


Worker Entitlements and Responsibilities\(^9\)

Under the legislation, workers enjoy certain entitlements with respect to the general themes of return to work and rehabilitation. 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 incapacity\(^10\) 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 occupational rehabilitation 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

\(^9\)Effective with Royal Assent on 17 December 1996, the \textit{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.

\(^10\)Section 93A(1) and (2) covers the first 26 weeks.

\(^11\)Notional Earnings are defined in Section 5 of the \textit{Act} and the method of assessing these is defined in 93DA.
the purpose of ascertaining whether worker’s 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, 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 1 year, unless under 99(14) the worker has returned to work but could not continue by virtue of surgery, prosthesis modification, and services to stabilize the worker’s health or lifestyle.

Survivors of workers fatally injured have no specific rehabilitation entitlements under the legislation. While (family) grief counselling was introduced in July 1996, the regulations are not yet published for its implementation. Assistance in managing the financial settlement with WorkCover and vocational counselling are not offered by the scheme, although anecdotal information from some insurers indicate that such services are sometimes informally offered.

Employer Responsibilities\textsuperscript{12}

One of the most notable aspects of the VWA 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

\footnote{The \textit{Accident Compensation (Further Amendment) Act 1996} gives approval responsibility for OR expenditures solely to the insurer.}
and implementation of occupational rehabilitation services." 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.

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 occupational rehabilitation programme. By 30 calendar days following an injury, every employer must prepare a return-to-work plan and nominate a return-to-work coordinator. (Section 156(2)(a)) Within a 90-day period after that, an employer must establish and maintain an occupational rehabilitation programme. (Section 156(2)(b)(i))

The written occupational rehabilitation programme, which must be produced in consultation with workers, is required to include a statement of the employer’s return-to-work policy, the name of the return-to-work coordinator and at least one provider of occupational rehabilitation 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 occupational rehabilitation 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/she can satisfy the Authority that it is “not possible for the employer to provide suitable employment.” Failure to re-employ 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 occupational rehabilitation costs. These expenditures count towards the employer’s “deductible” of $416. Prior to 1 July 1996 employer expenditures for occupational rehabilitation services could be excluded from the calculation of the employer’s

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13Section 6.10.1 Workplace Based Occupational Rehabilitation.
excess with the “employer excess” for occupational rehabilitation separately limited to $1,200 maximum. After that date, expenditures for occupational rehabilitation are no longer 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 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 have specific relationships 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 above 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 Occupational Rehabilitation (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

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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 $1200 (indexed to $1290 at time of repeal - effective 1/7/96) for approved Occupational Rehabilitation services without reference to their insurer. Amounts beyond this limit were to be approved by the insurer when the services are determined to be reasonable and necessary.
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 initial rehabilitation process may be the purview of the employer and the return-to-work coordinator, but in the longer term, 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, therefore, 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 the insurer believes a referral to occupational rehabilitation 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 occupational rehabilitation services.

A referral for occupational rehabilitation services is a very specific activity. Unlike vocational rehabilitation systems in North America that generally allow the occupational
rehabilitation provider to determine the techniques and services likely to optimize the
evaluation, intervention or outcome, in Victoria every service must be separately authorised.
This often involves several transactions including returned phone calls, faxes and consulta-
tions. 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 re-training 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 return-to-work coordinator and developing a
return-to-work plan creates the opportunity for earlier review for potential occupational
rehabilitation than in other systems. However, organised labour has been very critical of the
actual results observed. It is alleged that many RTW coordinators see the plan as only a price
of paper to be sent to the insurer, rather than as an action statement. Of course, the goal of all
such interventions is to move the injured worker back more quickly to a higher level of overall
health and functionality.

In rehabilitation, it is relatively easy _ex post_ to recommend early intervention in a case
that has gone awry. _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.

Within the insurers, there are a variety of mechanisms in place to see that the VWA
mandate for considering occupational rehabilitation 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 counselling. Many of these cases have been inherited from previous incarnations of the workers’ compensation system in Victoria. In many cases, 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/her family and others who may be affected by the injury but who are beyond the scope of the Act or the 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

There are three distinct structural aspects to the provision of occupational rehabilitation 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. Services 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 summarizes rehabilitation services covered by the VWA. The list of services is quite broad and fairly typical of other workers' compensation systems. Of course, it is the 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 occupational rehabilitation services provided by an approved OR provider may be paid as a medical and like expense. The approval process requires

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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 above. 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.
potential providers to submit an application and a fee to the VWA. The application requires the provider to record information that demonstrates experience in occupational rehabilitation, shows evidence of their 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. At this writing, there are approximately 80 registered providers with about 700 individuals approved to deliver services.

The registration process has been criticized 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.

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16 The 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.

17 The suggestion that VCORP take on the role of an accrediting body was raised in the David Gadiel and Lee Ridoutt paper, “A Review of the Occupational Rehabilitation Services Industry in Victoria,” Health Care Intelligence, December 1995, p. 75 and in various interviews. 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.
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 analysis. 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 comment more fully on the adequacy of the data, however, for the following discussion it is important to keep in mind that services provided by non-registered 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 occupational rehabilitation services for fiscal year 1995-96 at the VWA. In terms of the number of individuals who received services, the initial occupational rehabilitation assessment (code RC100) was the most frequent, with 3,254 individuals receiving such assessments during the past fiscal year. A total of $921,325 was spent on OR assessments during 1995-96. Some 2,418 individuals received OR counselling (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 re-education services (code RC330) at a current year cost of $162,873.

While it cannot be assumed that every individual receives an assessment upon entering the occupational rehabilitation 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).
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 June 30, 1996, a total of 7,042 individuals received services under the above codes. Table 7.5 indicates the year of injury for cases receiving OR during 1995-96. About 65 percent of OR claims involve injuries from the past 3 years.

As may be noted from the Occupational Rehabilitation Services codes in the table, some common rehabilitation interventions are not well defined. Group counselling, 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

The adequacy of any data system is the prime determinant of the quality and utility of the data generated by the system and the analysis that can be done with these data. To the extent that the ACCtion system accurately reports recorded data, the analysis performed within the VWA will be accurate and reliable. To the extent that 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. For assessing the utilisation of OR services, there are several limitations to the system, however:

- Services provided directly by the insured employers may not be captured;
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 non-registered 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 counselling) 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 less 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. The nature of these limitations will tend to understate the rehabilitation activity that is actually provided to injured workers in Victoria. It is not possible to estimate to what extent this understatement may be occurring in individual expenditure areas nor to estimate the rehabilitative or cash value of these services.

Committees

Interviews revealed that various committees have been active and that the VWA does work with provider groups (such as VCORP and the APA) to negotiate agreements, exchange information and to 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 inform and educate the professional in ways in which to bring utilisation to within normally accepted levels.

Although this system is currently structured as a "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 sub-optimal 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 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 WISE programme.

**Range of Rehabilitation Services and Programmes**

Occupational Rehabilitation Services are primarily directed at promoting/facilitating maintenance at 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 practitioner, 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 6 months to identify cases that may benefit from such a referral. OR providers report lengthy delays in referral after injury, often well beyond 6 months. Integrated, interdisciplinary treatment programmes that involve physiotherapy, vocational counselling, and education components are not generally supported. 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 counselling are not specifically defined as occupational rehabilitation services. Other services that are more “educational” and “counselling” 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.”

For some workers, the iatrogenic, non-compensable and combined psycho-social 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.

\[\text{\textsuperscript{19}}\text{A project is now underway to determine opportunities for more wide-spread recognition of integrated programmes.}\]
Through discretionary grant programmes, community-based “rehabilitation” programmes are also funded by the Authority. These programmes, often offered through social and community health centres, provide both specified return-to-work preparation programmes and, more importantly, the supportive milieu that may prevent further deterioration, consolidate and stabilize the worker’s current situation, and encourage the re-establishment of a positive self-image and an appropriate disability identity that may eventually lead to successful vocational or avocational outcomes.

Some cases require re-education 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. It is not possible, without detailed file review, to determine in which specific programmes workers have been directed for re-training most often.

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 WorkCover Incentive Scheme for Employers (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 the 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 that their benefits will likely be terminated in only 4 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. These cases, many totally incapacitated for one reason or another, have very special needs. 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 re-assessment. Unfortunately, even with a falling claims rate, the numbers 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 overseeing these special cases. As a facilitator and coordinator of services, this manager consults and advises on the services provided to these cases. Services may include independence and home maintenance services such as vehicle modifications and housing renovations, even painting. Unlike some jurisdictions which provide an on-going 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. Counselling, 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 counsellors who can address the full range of counselling 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 non-registered 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 sponsored a review of the barriers to effective rehabilitation. In addition, a detailed analysis of the occupational rehabilitation services industry in Victoria was completed by Gadiel and Ridoutt. 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, however, 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 pro-active 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

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development of clinical practice guidelines for physiotherapy, chiropractic and occupational medicine, for example.

As pointed out earlier, much analysis is currently based on the ACCtion database. The utility of this data system for detailed research is currently being explored through work at the University of Melbourne.\textsuperscript{22} The VWA has funded nearly $500,000 in rehabilitation research over the past 3 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 beyond any immediate business gain has the potential to be an important contribution to the rehabilitation professions in Australia and elsewhere.

Service Delivery Personnel

Rehabilitation services are provided by a variety of professional, semi-professional and designated staff. The following section parallels the rehabilitation process from the employer, through the authorised insurers, health care professionals and authorised providers. This is not intended to describe all possible individuals involved in the delivery of rehabilitation services but, rather, to illustrate the range of personnel involved in the process. This section also highlights some of the key procedures and tools employed and records 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 Return-to-Work Coordinator is key to the access to occupational rehabilitation in Victoria. The Act requires the employer to nominate a return-to-work coordinator. This person is not necessarily a professional in rehabilitation or related discipline, nor is there a requirement for such individuals to have specific training. There are, however, mandatory functions assigned to this individual. Section 161 of the Act prescribe the following functions for the RTW coordinator:

\textsuperscript{22}Dr. Peter Disler.
(a) assist injured workers, where prudent and practicable, to remain at or return to work as soon as possible after injury;
(b) liaise with any parties involved in the occupational rehabilitation of, or provision of medical or hospital services to, an injured worker;
(c) monitor the progress of an injured worker’s capacity to return to work;
(d) ensure that, where reasonably necessary, an injured worker is given access to occupational rehabilitation services;
(e) take steps to as far as practicable 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 may 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 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 taking on this position.\(^2\) 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

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\(^2\)The TAFE system offers a 5-day training programme for RTW Coordinators, and VECCI offers formally structured training programmes of shorter duration. Such training although developed with the VWA remains voluntary.
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 generally 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 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.24

General Practitioners / Family Physicians

For the majority of injured workers, the family physician will be the prime 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 guide booklet outlining the role of the general practitioner in WorkCover 
cases.25

As described earlier, the physician is the person normally charged with the 
responsibility of completing medical certificates. These are critical to receiving weekly benefits

24VWA-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.

and tend to maintain the contact with the GP. Physicians are encouraged to emphasise what the worker can do and to 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, there was a general complaint that any fee premium was more than offset by additional cost.

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 occupational rehabilitation providers. The following is the advice provided to physicians regarding occupational rehabilitation:

GPs 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.26

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 occupational rehabilitation provider in his/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 reason based on professional judgment. At some point, however, the referral is re-directed 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.

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26Ibid., p. 15. Note also that the rehabilitation provider no longer has to be approved by the employer.
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, electro therapeutic 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 “counselling,” 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 Australian Physiotherapy Association (APA) represents some 2000 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 pro-active 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 relatively few physicians with occupational medicine specialty designation in Victoria. These specialists offer services to workers and employers and are occasionally aligned with a registered occupational rehabilitation provider, physiotherapy provider or integrated treatment programme. While they have very specific skill 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 may be extremely useful in determining the appropriate rehabilitation activities that may be required in individual cases.

Occupational medicine has much to offer both the injured workers and other medical and rehabilitation personnel in the WorkCover system. VWA is currently developing a training cycle for physicians. This may take some time to implement but is believed to be an important initiative. There was a common call for greater consultation and involvement of professionals from occupational medicine and rehabilitation on training, education, ethics, confidentiality and treatment topics. The VWA Advisory Committee, if more actively utilised, was cited as an appropriate forum for such consultation.
Occidental Rehabilitation Providers

The term “Occupational Rehabilitation” in Victoria describes a set of services, not a profession. While those engaged in delivering the services defined under the Act are Occupational Rehabilitation providers, the personnel are drawn from a number of disciplines: Physiotherapists (15 percent), Vocational and Rehabilitation Counsellors (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 are somewhat lower than that—around 650.27 There are several large registered occupational rehabilitation 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.

The Victorian Council of Occupational Rehabilitation Providers (VCORP) represents some but not all of the providers. Some providers are active in the Australian Society of Rehabilitation Counsellors or other professional groups, but membership or accreditation is not a requirement of registration. 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 an professional association or licenced by a governing college or body, there is no analogous system in Victoria.

This does not mean that the professionals providing service are in any way inferior to their counterparts in other jurisdictions. Many are, in fact, members of such professional bodies and are subject to periodic accreditation and continuing education programmes to maintain professional standing. The Australian Society of Rehabilitation Counsellors, for example, has developed core competencies and a code of ethics similar in content to the Commission on Rehabilitation Counsellor Certification (CRCC) in North America. The

[27Gadiel and Ridoutt, op. cit., p. 23.]

7-36
absence of an outside independent body with the responsibility to accredit providers, however, makes VWA the *de facto* accreditation body in the jurisdiction.

In the absence of a universally accepted accrediting body, there is no objective or professional assessment of the quality of services provided to VWA clients. Some providers have services that extend beyond occupational rehabilitation towards the closely allied areas of physiotherapy treatment or occupational health and safety (or both), while others augment their service repertoire to include geriatric assessment, pre-employment screening and rehabilitation of non-VWA clients.

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 ERGOS\(^{28}\) computerized assessment installation. The technical counselling ability and competencies in vocational assessment, training and job placement, and rehabilitation philosophy are well represented within the provider community.

**Community-Based RTW 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 form the labour force.\(^{29}\) 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 non-profit, community-based organisations,

\(^{28}\) ERGOS work simulators are free-standing, computer-monitored, task sampling units used for standardized evaluation and assessment.

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 working with the RTW coordinators on developing rehabilitation and return-to-work plans. As the “claims” managers, they are responsible for the adjudication and on-going management of claims. This includes referral to OR providers.

One of the challenges for the insurers is the identification of 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 pro-active 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 counsellors, occupational health nurses, counselling psychologists, occupational therapists and the like) on
staff. These are often called upon or are involved in routine file review to monitor the need for occupational rehabilitation services. In some cases, initial assessments are conducted by these personnel. In others, these in-house specialists 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 occupational rehabilitation 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 such referrals could be made for profitability reasons as much as for professional requirements. 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). Later data from VWA indicates that the three insurers with organisational links to OR providers in 1995-96 accounted for between 26 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 safety and health, 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 may be applied equally as well to those injured in the workplace and those whose injury or disease is of non-workplace 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.

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 facilities in this category that offer

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consolidated services that may include programmes from post-surgical 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 may also offer general counselling, functional capacity assessment, worksite assessments and modifications. Technology including Kin Com, B200 and other assessment/diagnostic/treatment tools are 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, however, is never easy. Each of these terms—“successful,” “cost-effective” and “durable”—are subjective and highly dependent on the question asked, the time-frames 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

The following discussion carries with it an important caveat. There is no statistic that will indicate whether a system is working optimally. Any measure may be disputed and any
number discredited if the assumptions that underlie it are not accepted. The following discussion of outcomes, therefore, includes the perceptions of the stakeholders as well as the statistics and percentages associated with outcome analysis.

The "Return-to-Work rate" for the VWA is reported at about 86 percent—a figure that compares well with other jurisdictions including South Australia (at 82 percent)31 and New South Wales32 and is a startling improvement over the 54 percent RTW rate reported under the WorkCare system in 1992.33 Further, the quality of these RTW rates are relatively high, with same employer/same duties continuity at 66 percent.34 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 emphasised 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 positive outcome. 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, occupational rehabilitation providers and others.


33Ibid.

34Campbell, op. cit., p. 13.
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 occupational rehabilitation 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 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 occupational rehabilitation 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 Occupational Rehabilitation programmes, RTW plans, and the RTW Coordinator function. Survey data indicate a high degree of compliance, “ownership” and, indeed, successful return to work.\(^{35}\) 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 RTW policy can actually have a negative effect on self-esteem. Employers, too, generally approved of the early RTW policy but found its success to be highly dependent on the individual worker and his/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 RTW, commissioned survey results and the interviews conducted as part of this study indicate that Occupational Rehabilitation 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

\(^{35}\)Two “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.
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 occupational rehabilitation services.

The VWA has made significant efforts to ensure that workers are returned to work as soon as practiciable. 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.36 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 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 measure. There are clear examples of “success stories” as a result of retraining. Little data, however, is available to indicate the

36Ibid., p. 4. A summary of the two survey “waves,” (“Assessment of Employer Compliance to Occupational Rehabilitation Program Requirements,” VWA, October 10, 1995, p. 4), notes that non-compliance among small work places (1-10 workers) was 35%. 
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 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 occupational rehabilitation assistance are virtually non-existent. As is all too common in worker's compensation systems, time elapsed between injury and referral for an initial vocational assessment typically is in excess of 6 months. One retrospective study using VWA data found that the mean time between accident and referral was 1.42 years. 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 individualized rehabilitation plan may be completed, but unless the insurer or the employer approves the plan, no further

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37Ibid., (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.

7-45
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, individualized 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 occupational rehabilitation provider. Generally, the insurer or the VWA itself becomes the claims manager for prolonged, permanent total or near-total disability claims. Services of an occupational rehabilitation 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 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 to 1991/92

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>ACC Claims Reported2</td>
<td>61,531</td>
<td>93,261</td>
<td>86,979</td>
<td>87,493</td>
<td>80,159</td>
<td>75,438</td>
<td>68,442</td>
</tr>
<tr>
<td>Referrals to Rehabilitation</td>
<td>4,806</td>
<td>12,257</td>
<td>25,179</td>
<td>14,735</td>
<td>10,354</td>
<td>10,987</td>
<td>10,251</td>
</tr>
<tr>
<td>Cases Entering Rehabilitation3</td>
<td>4,274</td>
<td>9,707</td>
<td>14,044</td>
<td>11,455</td>
<td>9,327</td>
<td>9,426</td>
<td>9,667</td>
</tr>
<tr>
<td>Rehabilitation Cases as % of ACC Claims</td>
<td>6.9</td>
<td>10.4</td>
<td>16.1</td>
<td>13.1</td>
<td>11.6</td>
<td>12.5</td>
<td>14.1</td>
</tr>
<tr>
<td>Rehabilitation Plans Approved</td>
<td>n/a4</td>
<td>5,832</td>
<td>11,341</td>
<td>11,968</td>
<td>10,898</td>
<td>10,054</td>
<td>10,540</td>
</tr>
<tr>
<td>Case Closures</td>
<td>384</td>
<td>4,558</td>
<td>10,301</td>
<td>12,949</td>
<td>13,535</td>
<td>12,280</td>
<td>12,044</td>
</tr>
<tr>
<td>Open Cases</td>
<td>n/a</td>
<td>n/a</td>
<td>9,317</td>
<td>10,807</td>
<td>8,885</td>
<td>8,601</td>
<td>9,032</td>
</tr>
</tbody>
</table>

Source: Victorian Accident Rehabilitation Council, Annual Reports

1 10 months only, from 1 September 1985

2 Actual 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).

3 The 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.

4 Plan approvals data introduced in October 1986.
<table>
<thead>
<tr>
<th>Source of Referral</th>
<th>1988/89 (%)</th>
<th>1989/90 (%)</th>
<th>1990/91 (%)</th>
<th>1991/92 (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employer</td>
<td>40.8</td>
<td>42</td>
<td>41.4</td>
<td>33.8</td>
</tr>
<tr>
<td>Doctor</td>
<td>20.3</td>
<td>19.6</td>
<td>19.7</td>
<td>17.7</td>
</tr>
<tr>
<td>Insurer</td>
<td>--</td>
<td>--</td>
<td>4.3</td>
<td>7.7</td>
</tr>
<tr>
<td>Worker</td>
<td>15.1</td>
<td>16.3</td>
<td>13.7</td>
<td>14.1</td>
</tr>
<tr>
<td>VARC</td>
<td>15.4</td>
<td>11</td>
<td>7.7</td>
<td>5.6</td>
</tr>
<tr>
<td>Other</td>
<td>8.4</td>
<td>11.1</td>
<td>13.3</td>
<td>21.1</td>
</tr>
</tbody>
</table>

Source: VARC Annual Reports
Table 7.3 Rehabilitation Services Covered by the VWA

<table>
<thead>
<tr>
<th>Nature of Service</th>
<th>Payment for</th>
<th>Provided by</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical Services</td>
<td>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</td>
<td>medical practitioner, registered dentist, registered optometrist, registered physiotherapist, registered chiropractor and osteopath or registered chiropodist, registered pharmacist</td>
</tr>
<tr>
<td>Health Services</td>
<td>acupuncture, dietary analysis, hydrotherapy, massage - tactile therapy, naturopathy, occupational therapy, psychology, remedial gymnasia, social work, speech therapy</td>
<td>professional eligible for membership with the relevant professional body</td>
</tr>
<tr>
<td>Hospital Services</td>
<td>maintenance, attendance and treatment including medical attendance and treatment, nursing attendance, medicines, medically related materials, appliances and apparatus</td>
<td>any public, denominational, or private hospital or day procedure centre, psychiatric in-patient service including out-of-state hospitals approved by the VWA</td>
</tr>
<tr>
<td>In-Patient Charges</td>
<td></td>
<td>public or private hospitals with special agreements</td>
</tr>
<tr>
<td>Out-Patient Charges</td>
<td></td>
<td>public or private hospitals</td>
</tr>
</tbody>
</table>

7-49
Table 7.3 Rehabilitation Services Covered by the VWA

<table>
<thead>
<tr>
<th>Services</th>
<th>Description</th>
<th>Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>Personal and Household</td>
<td>attendant care, counselling, modifications to a home or car, household help, transportation costs, aid, assistant or other medical service</td>
<td>subject to an arms-length,(^{38}) non-vocational 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.</td>
</tr>
<tr>
<td>Nursing Services</td>
<td>nursing outside a hospital setting</td>
<td>registered nurses</td>
</tr>
<tr>
<td>Ambulance Service</td>
<td>any (return) transportation required for the purposes of receiving medical or hospital services</td>
<td>any public, private or other transportation service provided it is the most economical and practical given the worker’s condition. Where by private vehicle, no parking expenses accepted.</td>
</tr>
<tr>
<td>Occupational Rehabilitation</td>
<td>as set out in Section 5 of the Act</td>
<td>approved providers who are either Restricted (RR) or Unrestricted (UR)</td>
</tr>
<tr>
<td>Services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hearing Aids</td>
<td>aids, batteries, cleaning kits</td>
<td>subject to prior approval, any provider.</td>
</tr>
</tbody>
</table>

Source: summarized from *Claims Manual: Chapter 5*

\(^{38}\)The “arms-length non-vocational 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>
<thead>
<tr>
<th>Code</th>
<th>Service Type</th>
<th>Description</th>
<th>Service paid on hourly rate (H) or actual cost (A)</th>
<th>Number of individuals who received services</th>
<th>Total number of units of service paid</th>
<th>Value of Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>RC100</td>
<td>Initial Occupational Rehabilitation Assessment</td>
<td>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.</td>
<td>A</td>
<td>3,254</td>
<td>12,455</td>
<td>$921,325</td>
</tr>
<tr>
<td>RC105</td>
<td>N/A</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>RC113</td>
<td>Functional Assessment</td>
<td>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.</td>
<td>H</td>
<td>885</td>
<td>1,806</td>
<td>$288,146</td>
</tr>
<tr>
<td>RC119</td>
<td>Advice or Assistance to a Worker in Obtaining Vocational Re-education</td>
<td>Assistance to the worker in obtaining appropriate vocational re-education relevant to the identified employment goal.</td>
<td>H</td>
<td>322</td>
<td>1,300</td>
<td>$78,289</td>
</tr>
<tr>
<td>RC125</td>
<td>Advice or Assistance in Job-seeking</td>
<td>Teaching job-seeking skills, such as job application practice, interview role plan and personal presentation.</td>
<td>H</td>
<td>1,446</td>
<td>14,034</td>
<td>$683,540</td>
</tr>
<tr>
<td>Code</td>
<td>Service Type</td>
<td>Description</td>
<td>Service paid on hourly rate (H) or actual cost (A)</td>
<td>Number of individuals who received services</td>
<td>Total number of units of service paid</td>
<td>Value of Services</td>
</tr>
<tr>
<td>--------</td>
<td>-------------------------------------</td>
<td>---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>--------------------------------------------------</td>
<td>------------------------------------------</td>
<td>-------------------------------------</td>
<td>-------------------</td>
</tr>
<tr>
<td>RC199</td>
<td>Work Conditioning</td>
<td>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.</td>
<td>H</td>
<td>202</td>
<td>1,033</td>
<td>$77,885</td>
</tr>
<tr>
<td>RC220</td>
<td>N/A</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>RC225</td>
<td>Occupational Rehabilitation Counselling</td>
<td>Counselling service to the worker throughout the course of Occupational Rehabilitation, focusing on the totality of the worker’s needs.</td>
<td>H</td>
<td>2,418</td>
<td>18,296</td>
<td>$843,260</td>
</tr>
<tr>
<td>RC245</td>
<td>Functional Education</td>
<td>Educating the injured worker to maintain good physical habits to strengthen the body and/or mind to avoid re-injury.</td>
<td>H</td>
<td>357</td>
<td>1,326</td>
<td>$110,039</td>
</tr>
<tr>
<td>RC295</td>
<td>Job/Workplace Analysis and/or Assessment</td>
<td>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.</td>
<td>H</td>
<td>2,171</td>
<td>12,228</td>
<td>$783,026</td>
</tr>
</tbody>
</table>

Table 7.4 Summary of Occupational Rehabilitation Codes and Descriptions with Recent Volumes*
<table>
<thead>
<tr>
<th>Code</th>
<th>Service Type</th>
<th>Description</th>
<th>Service paid on hourly rate (H) or actual cost (A)</th>
<th>Number of individuals who received services</th>
<th>Total number of units of service paid</th>
<th>Value of Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>RC300</td>
<td>Workplace Modification</td>
<td>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.</td>
<td>A</td>
<td>136</td>
<td>269</td>
<td>$53,237</td>
</tr>
<tr>
<td>RC310</td>
<td>N/A</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>RC315</td>
<td>Vocational Assessment</td>
<td>Objective assess of the worker's transferable vocational skills to determine appropriate employment goals.</td>
<td>H</td>
<td>2,023</td>
<td>4,626</td>
<td>$662,578</td>
</tr>
<tr>
<td>RC330</td>
<td>Vocational Re-Education</td>
<td>Actual cost of vocational re-education 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.</td>
<td>A</td>
<td>210</td>
<td>614</td>
<td>$162,873</td>
</tr>
</tbody>
</table>

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 1-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

<table>
<thead>
<tr>
<th>Year of Injury</th>
<th>Number of Claims Receiving OR Services</th>
<th>OR Expenditures</th>
<th>Percent of Total OR Expenditure in 1995-96</th>
<th>Average Cost $</th>
</tr>
</thead>
<tbody>
<tr>
<td>1995-96</td>
<td>1,213</td>
<td>$ 792,152.11</td>
<td>17.03</td>
<td>$ 637.29</td>
</tr>
<tr>
<td>1994-95</td>
<td>2,162</td>
<td>$1,604,313.55</td>
<td>34.50</td>
<td>$ 742.05</td>
</tr>
<tr>
<td>1993-94</td>
<td>1,236</td>
<td>$ 813,876.62</td>
<td>17.50</td>
<td>$ 658.48</td>
</tr>
<tr>
<td>1992-93</td>
<td>674</td>
<td>$ 414,833.34</td>
<td>8.92</td>
<td>$ 615.48</td>
</tr>
<tr>
<td>1991-92</td>
<td>574</td>
<td>$ 345,793.80</td>
<td>7.44</td>
<td>$ 602.43</td>
</tr>
<tr>
<td>1990-91</td>
<td>340</td>
<td>$ 209,676.72</td>
<td>4.51</td>
<td>$ 616.40</td>
</tr>
<tr>
<td>1989-90</td>
<td>237</td>
<td>$ 139,983.18</td>
<td>3.01</td>
<td>$ 590.65</td>
</tr>
<tr>
<td>1988-89</td>
<td>171</td>
<td>$ 101,501.54</td>
<td>2.18</td>
<td>$ 593.58</td>
</tr>
<tr>
<td>1987-88</td>
<td>138</td>
<td>$ 82,105.90</td>
<td>1.77</td>
<td>$ 594.97</td>
</tr>
<tr>
<td>1986-87</td>
<td>159</td>
<td>$ 89,994.47</td>
<td>1.94</td>
<td>$ 566.00</td>
</tr>
<tr>
<td>1985-86</td>
<td>107</td>
<td>$ 56,187.94</td>
<td>1.21</td>
<td>$ 525.12</td>
</tr>
</tbody>
</table>

Source: VWA
Figure 7.1

Rehabilitation Reporting Relationships Map

Victorian WorkCover Authority

Formal channels of report or responsibility following a workplace injury. Note the central role of the RTW Coordinator.

Main client/ or patient/practitioner relationships.

Source: Adapted from Gadiel and Ridoutt (1995)
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.

$h_2$: 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 counselling and direction for vocational purposes or to 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 Ridout, (1995)
Chapter 8

THE OCCUPATIONAL HEALTH AND SAFETY DIVISION
Chapter 8 THE OCCUPATIONAL HEALTH AND SAFETY DIVISION

Introduction

This chapter addresses issues of importance to the delivery of occupational health and safety (OSH) and public safety in Victoria, Australia. Among the questions to be answered are the following:

- What are the historical antecedents of the system?
- What is the legal basis for occupational health and safety 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 compliment the occupational health and safety and public safety mandate of the Health and Safety Division (HSD)?
- What information is available to guide and monitor the effect of OSH activities?
- How are the major stakeholders involved, and what are their concerns?

We will begin with a brief history of workplace safety in Victoria. This 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 Health and Safety Division (HSD) of the Victorian WorkCover Authority.1 We will review the policies and strategies for promoting occupational health and safety, including both enforcement activities and education and consultation activities. Last, 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.

1Throughout this chapter we will refer to the VWA Health and Safety Division (HSD), even though this is only the latest configuration of the administrative entity under discussion, dating to 2 July 1996. The reason for this will become apparent in the first section of the chapter, “Historical Antecedents.”
Historical Antecedents

The earliest Australian initiatives in relation to workplace safety occurred in Victoria. In large part this was due to the fact that, until very late into the nineteenth century, Victoria was the only colony with significant manufacturing activity; but it was also due to a radical tinge in Victorian politics. This 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. The very first occupational health and safety 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.

However, the general foundations of occupational health and safety 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 and later to become 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. 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.

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time. The general structure of this legislation provided the framework for subsequent legislative measures and governed the approach to occupational health and safety which was to hold sway until the 1980s, not just in Victoria but in Australia generally.

This approach was characterised by a plethora of individual measures and by a strong attachment to the English tradition of factory legislation. 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 occupational health and safety, 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 occupational health and safety legislation or in the codes of practice. In relation to fealty to the English model of law and practice, the record of occupational health and safety measures was even more striking than that concerning workers’ compensation arrangements, some of the history of which is traced in Chapter 2 of this report. This similarity of form and approach helps explain the relatively rapid adoption by the various Australian jurisdictions of the new approach to occupational health and safety 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 between workers’ compensation and workplace safety arrangements. While the legislation governing the two spheres of activity was often administered by the same Government department, there was virtually no interaction between these operations. It has only been since the 1970’s that workers’ compensation systems have included more than a slight regard for rehabilitation among their operational activities. Meaningful interaction between the agencies charged with

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occupational health and safety and occupational disability compensation has been an even more recent phenomenon.

The Robens Approach

The traditional approach to workplace safety 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

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 in the world. In a central paragraph of the Report it was 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) provided the legislative response which picked up the principal recommendations of the Robens Committee and provided for

- a series of general duties on employers, occupiers, manufacturers, suppliers and employees;

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9 Ibid.
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 original 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 (ss 5-10); and included a series of “general duty” provisions (ss 11(1)-(2), 13 and 14) together with a very broad regulation-making power (s 33). It also provided for the preparation of health and safety policy statements by employers (s 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 (s 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.” These 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 was discussed in Chapter 2, Victorian voters in April 1982 elected a Labor Government for the first time in almost 3 decades. This Government, under the leadership of John Cain, was committed, particularly in its earliest years, to a vigorous reform agenda. Part

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10 Creighton and Rozen, op. cit. at p. 9.
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 occupational health and safety programme. This programme included the establishment of an Occupational Health and Safety Commission; the bringing together into one administrative unit of the various disparate inspectorates and allied personnel dealing with occupational health and safety; 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 licencing system embracing all workplaces and work processes and all substances used in them.

The unveiling of this policy brought about a fiery public debate, particularly over the powers of health and safety representatives and the proposal for comprehensive workplace licencing. The then Minister for Labour and Industry, Mr. Ramsay, attacked the proposed role of health and safety representatives 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.” The debate continued into the election campaign in early 1982 and occupational health and safety policy was specifically included in John Cain’s opening campaign speech.

The initial responsibility for occupational health and safety policy in the new Labor Government was with the Minister for Labour and Industry as was previous practice. However, in September 1982, in a transfer of ministerial functions, this responsibility was


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.
given to the Minister for Employment and Training, the portfolio held by Jim Simmonds, who had been closely involved in the development of the occupational health and safety 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 sub-committee 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 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.”

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.

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 SECV 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 and the move to industrially bargained agreements gained added impetus following the collapse of the 1983 Bill. By July

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13 Simmonds, Jim, the Minister for Employment and Training, Press release dated 9 October 1984; cited by Doran, op. cit., p. 160.
1985 there were 17 health and safety agreements formalised in Victoria and many more under negotiation.\textsuperscript{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 \textit{Accident Compensation Act 1985}, giving force to its workers' compensation proposals, and the \textit{Occupational Health and Safety Act 1985} and the \textit{Dangerous Goods Act 1985}, effecting its workplace safety agenda. These latter two statutes were assented to on 30 July 1985 and entered into force on 1 October 1985.

\textbf{WorkCare Responsibilities and Linkages}

Prior to the enactment of the \textit{Occupational Health and Safety Act 1985}, the Government had administratively moved 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 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 1988-89 (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 occupational health and safety organisational 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 occupational health and safety 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 5 years the number of inspectors had almost tripled to 150 in 1991. This increase continued into 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,

\(^{15}\) *Accident Compensation Act* 1985, Section 3(a).

\(^{16}\) Industry Commission, op. cit., vol. 2, Table M17.
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 ostensibly 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 determined that this area of activity should be dealt with separately, with its own inspectorate and policy development unit.

A more dramatic reorganisation took place in 1991 when the occupational health and safety responsibilities of the Department were separated from its industrial relations and other functions in a separate body, the Occupational Health and Safety Authority (OHSA). In an effort to provide better co-ordination 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/licencing functions for the organisation.

Role of the Inspectorate

Despite these 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 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 focussed 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 recourse to 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 within the Department in 1989 of a Central Investigation Unit to co-ordinate 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 quite 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

The background to the WorkCover changes as they affected the workers’ compensation aspects of WorkCare have been sketched in Chapter 2. In October 1992 the Liberal and National Parties 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). OHSA was retained as a trading name, but government OHS and

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18 Ibid., citing Industry Commission figures.
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 (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. 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). 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. In November 1995 the Industry Commission's report on OHS arrangements in Australia recommended integration of OHS and workers' compensation policy making. 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 retained the structure and functions of the former HSO.

Legal Authority


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20 A 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.


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.

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 HSD 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 health and safety representatives are elected by the workers.

The Act provides representatives the right to inspect any part of the workplace at which members of the relevant 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 s/he believes 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 HSD 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 he or she believes that the Act or regulations are being contravened—this requires the breach to be rectified within a stipulated time;
- issue a Prohibition Notice where he or she believes 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. These penalties are currently set for most offences at a maximum of $40,000 for bodies corporate and $10,000 for individuals. For certain offences the maximum is set at $250,000 for bodies corporate and $50,000 and/or imprisonment for up to 5 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). However, regulations to give effect to this provision have not been brought into effect.

**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.

Since its enactment, the OHS Act was amended in 1990, 1992, 1993, and 1996. The principal amendments were:

1990 - increased penalties for offences against the Act;
1993 - strengthened the requirement for workers to co-operate with their employers in relation to health and safety, and removed the specific role of unions in the establishment of DWGs and the election of health and safety representatives;
1996 - transferred the health and safety functions of the Department of Business and Employment to the Victorian WorkCover Authority.

**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 non-workplace situations. The Act consolidates legislation covering dangerous goods and activities associated with them, viz. 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 licencing 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 DG Act are generally in line with those under the OHS Act. In addition, 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. The DG Act was amended in 1987, 1989, 1990 and 1995. The principal effects of the 1995 amendments were to provide:

- an extensive definition of dangerous goods, broadly in line with the Australian Code for the Transport of Dangerous Goods by Road and Rail;
- powers to exempt specific dangerous goods from the operation of the Act or regulations, and to declare substances or articles to be dangerous goods in public interest situations;
- inspectors with authorisation to issue an additional type of Written Direction (similar to Improvement Notices under the OHS Act);
- power for the Minister to approve codes of practice.

Most VWA inspectors are concurrently appointed under both the OHS and DG Acts.

The DG Act is currently under review since the rather prescriptive style of the legislation (i.e., specifying the actions to be taken, rather than referring to the desired performance outcome) makes it inconsistent with the OHS Act. There has been considerable effort during the last decade to change from prescriptive/restrictive legislation and regulation to
a performance or outcome based approach. Further, the DG Act covers a number of issues which are now addressed by draft National Standards developed by the National Occupational Health and Safety Commission (NOHSC).

**Equipment (Public Safety) Act**

The E(PS) Act mirrors the provisions of the OHS Act in relation to prescribed equipment operated in non-workplace 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 need to be amended much less often;
- 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 three 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 towards 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.

In 1992 NOHSC identified six priority issues for the development of National Standards: manual handling, noise, plant, certification of users and operators of plant, hazardous substances and major hazard facilities. National Standards have been declared in all these areas, and Victoria has implemented four and commenced work to implement the remaining two. In Victoria, the objective of national consistency is supported, however, there is a great deal of criticism of the end product. The view is that the national standards are far too prescriptive and detailed. Currently, there is a lack of agreement by state governments, and
little co-ordination of the implementation process. Thus, significant differences in OHS law exist between jurisdictions.

Victorians would like to see some reforms to NOHSC processes. In particular, they have concerns 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 within 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 in their Report No. 47 states 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 at 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 RIS’s. 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 carried out in other health and safety jurisdictions around the world, such as OSHA in the United States.

It is the position of HSD that the required RIS analysis has improved the policy development process for occupational health and safety. For example, during the preparation of the OHS (Plant) Regulations 1994, the cost-benefit analysis demonstrated that inclusion of
manually powered and hand held plant could not be justified on cost benefit grounds. Other non-regulatory 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 17 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 HSD manuals are:

Quality Manual - This sets out management responsibilities in relation to quality, and standards and procedures for the operation of the quality system.

HSO 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 1 and 2 (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 HSD 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. This does however raise questions about the appropriate balance of the resources necessary to deliver the documentation and the front line staff deployed to carry out the plans in accordance with the policy and procedure.

Structure of HSD

Figure 8.1 shows the organisation of HSD as at 2 July 1996. The Director, HSD has overall responsibility for the Division and with six reporting senior managers forms the Division Executive Committee. Three Operations Sections under senior managers provide inspection and informational services through a series of regional offices. In addition, each of these managers has responsibility for two or more Statewide Coordinating Units to ensure consistent service delivery through a matrix management process.

Strategy Group

The Strategy Group consists of the Planning and Review Unit, Standards Development and Co-ordination Unit, Legislation Policy Branch, Marketing Branch, the Central Investigations Unit, Organisational Development Unit and the Information Systems Division. The principal functions of the Strategy Group are to provide strategic planning services, implement the VWA's legislative reform programme, develop and review policy, drive the Division's enforcement strategy and programme, provide marketing services, represent the Division in external forums, and provide support services to the Division.

Key programmes for the Strategy Group in 1996-97 are

• assisting with the full implementation of the Site Assessment and Targeting System in the Operations Groups;
• conducting a compliance/OHS performance survey, the results of which will guide a public information programme;
• completing the regulatory package for hazardous substances;
• conducting a policy review of the Dangerous Goods Act 1985 and implementing legislative changes resulting from the review of the Act;
• completing the Incident Notification Regulations for implementation;
• completing the Infringement Notices Regulations for implementation;
• completing any associated regulatory impact statement, public comment and code of practice products;
• completing a code of practice for plant not covered by the already-approved Code of Practice for Plant;
• developing policy to give effect to the National Standard for major hazard facilities;
• providing policy advice on the Regulatory Efficiency Bill, national competition policy and other significant legislative reform processes;
• reviewing the investigations/prosecutions programme and implementing changes;
• increasing the level of prosecution with a reduction in the turnaround times of prosecution files;
• introducing simpler prosecutions options;
• completing the investigations training programme;
• providing authoritative advice to other Divisions on OHS legislation;
• developing and overseeing the implementation strategy for the revised Enforcement Policy;
• implementing a marketing plan;
• implementing a new publications production system;
• undertaking the VWA Awards and Health and Safety Week programmes;
• maintaining VWA and Ministerial publications, promotional and media campaigns; coordinating the briefing of representatives on major national and State bodies;
• coordinating VWA submissions on other agencies’ legislative proposals;
• providing training and organisational development services;
• coordinating the HSD’s corporate quality programme.

Technology Group

The Technology Group consists of the Chemical Technology Unit, Ergonomics Unit, Hygiene Unit, Occupational Medicine Unit and Mechanical Engineering Unit. Technology Group’s role is to provide engineering, scientific and other technical advice to assist the Strategy and Operations Groups of the Division to achieve their programme goals. The Group is staffed by chemical, mechanical and electrical engineers, chemists, occupational hygienists,
ergonomists, and an occupational medical practitioner. The Group's expertise covers plant
design and operational safety, all aspects of the storage, handling, transport and use of
dangerous goods, hazardous substances, lead and asbestos, work environment hazards such as
heat and noise, manual handling and other ergonomic issues and biological hazards.

Key Technology Group activities are

- assisting inspectors with workplace visits;
- carrying out research on emerging health and safety issues;
- carrying out risk assessments, e.g., in association with applications for licences
  or approvals, or with plant designs notified to the VWA;
- responding to telephone inquiries;
- representing the Authority on external committees, e.g., in relation to the
development of technical standards;
- supplying expert witnesses for prosecutions and cases in the Coroner’s Court;
- providing technical input into training programmes for VWA staff;
- providing technical advice on documents developed by the VWA or external
  bodies.

Operations Groups

There are three Operations Groups. Each of these groups includes a number of
statewide co-ordination units and regional offices. The inclusion of statewide co-ordination
units was part of the restructure of the HSD in 1995. These units co-ordinate programmes in
their specialist areas across the three Operations Groups, and provide information to internal
and external clients. Resources for implementation of statewide projects come from the field
operations areas of the three Operations Groups and are secured through negotiation between
the managers of statewide co-ordination units and the regional office managers.

Regional offices under the authority of regional managers are located in 12 locations
across Victoria. VWA inspectors, information officers and staff to process licencing and
certification applications are based at each regional office. The Operations Groups have
established the following key priorities and activities for 1996-97:

- programmes to assist workplaces to manage health and safety better: audits,
  provision of information/advice, provision of training, marketing;
- compliance programmes: inspection, prosecution, investigation, OHS legislative
  dispute resolution, statutory approvals;
- public safety programmes: activities to promote public safety in the areas within
  the VWA’s jurisdiction, emergency response;
**quality programmes:** training, audit activity, performance management, implementation of new procedures and services, focusing on clients and obtaining feedback from them;

**resource management programmes:** reducing costs and working within budget, strengthening the budget components in planning;

**people management programmes:** communicating effectively, establishing clear roles and accountabilities, establishing training and development opportunities.

The following information describes the structure and function of each Operations Group, including its statewide role.

**Operations Central (Plant) Group** consists of

- three statewide co-ordination units (the Plant Co-ordination Unit, the Building and Construction Industry Co-ordination Unit and the Information Network);
- the Design Notification Unit;
- regional operations at Metro Central and Preston in Melbourne, and Bendigo, Mildura, Shepparton, and Wangaratta in central Victoria.

**Plant Co-ordination Unit.** The roles of this unit are to reduce the risk to health and safety arising from plant and equipment through the co-ordination of statewide projects; develop and review guidance material for VWA operational policies, national and industry standards; provide specialist advice to both internal and external clients; and manage specified programmes. The Unit is responsible for authorising assessors of applicants for certificates of competency to operate specified types of plant, and for auditing assessments. It conducts about 100 audits each year. The Unit also assists field staff in the conduct of about 2,500 inspections annually.

**The Information Network.** The work of this unit will be described later in the section on Injury and Disease Reduction through Consultation, Education and Technical Assistance.

**The Building and Construction Industry Co-ordination Unit.** This specialist unit aims to reduce the incidence of work-related illness, injury and death on building sites through the delivery of an integrated range of services. The building and construction industry is seen as sufficiently different from other industries to justify a specialist inspectorate resource. Decisions about which building and construction sites to visit are made in accordance with criteria set out in the Building and Construction Industry Manual. Resources allowing, most
large commercial sites in metropolitan Melbourne are visited. The Unit carries out about 5,000 inspections a year and responds to about 2,000 requests for information and advice.

The Design Notification Unit. This technical unit receives notifications of plant designs, answers inquiries relating to plant design notification, and arranges for audits of plant requiring design notification. About 600 plant notifications are received each year.

Operations Eastern (Work Environment) Group consists of

- three statewide co-ordination units (the Work Environment Co-ordination Unit, the Management Systems Unit and the Licencing Unit);
- regional operations at Mulgrave in Melbourne, and Traralgon and Sale in eastern Victoria.

Work Environment Co-ordination Unit. This co-ordinating group brings together a number of scattered functions relating to hazards in the work environment. The unit is responsible for identifying work environment issues that need a VWA response as well as planning, monitoring, and reporting on all Divisional activities relating to work environment hazards. Some important current programmes relate to asbestos removal, manual handling, noise, confined spaces, hazardous substances and heat-induced illness. The Unit conducts about 100 audits of approved asbestos removalists and assists field staff with about 3,500 inspections each year.

The Management Systems Unit (MSU). The MSU has evolved over time towards facilitating clients’ capability to manage their own health and safety responsibility. A key part of MSU’s role is the promotion of SafetyMAP, the Safety Management Achievement System. SafetyMAP is described in the section on Injury and Disease Reduction through Consultation, Education and Technical Assistance. The Unit carries out approximately 300 audits of workplace health and safety systems, including those at self-insurers and prospective self-insurers, each year. The SafetyMAP audit criteria are used as the basis for carrying out these functions.

The Licencing Unit. The function of this group is to co-ordinate the Division’s licencing activities, and ensure the effective administration of all licencing, registration, certification and
approval processes. Most of the Unit’s staff are centrally located, but there are also staff members at the major regional offices.

The principal types of licences and certificates dealt with by the Unit are:

- certificates of competency for operators of cranes, hoists and forklift trucks, scaffolders and riggers; and operators of pressure equipment (23,093 in 1995-96);
- registration of items of high-risk plant (28,393 in 1995-96);
- dangerous goods licences (8,410 in 1995-96);
- asbestos removalist’s licences (about 40 per year).

Operations Western (Dangerous Goods) Group consists of:

- two statewide co-ordination units (the Dangerous Goods Co-ordination Unit and the Enforcement and Public Safety Unit);
- regional operations in the Metro West region of Melbourne, and Geelong, Ballarat and Warrnambool in western Victoria.

The Dangerous Goods Co-ordination Unit. This group identifies and co-ordinates appropriate VWA activities in relation to dangerous goods. The Unit aims to co-ordinate 12 projects in 1996-97. Prominent among them are the conduct of emergency preparedness audits in premises not previously audited, the inspection of licenced premises which had not been inspected in the previous 12 months, and joint inspections with the Environment Protection Authority (EPA) and fire authorities of high-risk premises.

The Enforcement and Public Safety Unit. This unit provides quality assurance in relation to the VWA’s compliance and enforcement activities and places a great focus on the organisation’s public safety role. It is responsible for promoting, reviewing, and advising on the VWA’s enforcement profile and activity, and for identifying public safety issues and developing strategies to address these issues. It establishes and audits service standards for the delivery of the VWA’s field services.

The EPSU also co-ordinates the VWA’s 24-hour emergency response service for both OHS and dangerous goods incidents, including where a fatality or serious incident is involved. The service aims to respond to emergencies within 1 hour in the Melbourne metropolitan area and 2 hours in other areas.
Development Taskforce

The role of the Development Taskforce is described in the section on Injury and Disease Reduction through Consultation, Education, and Technical Assistance.

Other VWA Divisions with a Health and Safety Role

Apart from the Health and Safety Division, two other VWA Divisions conduct activities in the area of health and safety. The Corporate Affairs Division carries out high-profile marketing activities. These are described in the section on Injury and Disease Reduction through Consultation, Education, and Technical Assistance.

The Scheme Development Division carries out research which is used to find practical ways of improving workplace safety. Major recent projects conducted by the Division are

• **Operation Safety** - Launched as a pilot project at Ballarat in rural Victoria in August 1995, Operation Safety was based on extensive research. Road transport and nursing were identified as the industries in Ballarat with the highest claims costs per million dollars of remuneration. Both industries had a high proportion of back injuries resulting from lifting, loading and unloading. Operation Safety combined a number of interventions including worksite visits, telephone surveys, a mobile display of lifting devices, a promotional safety bus, ongoing publicity in the Ballarat media and an intense advertising campaign. Engineering, design and work practice solutions were recommended at individual worksites and through media publicity. The preliminary results of the research suggest there has been a remarkable reduction of injuries and their costs in the Ballarat region during the period Operation Safety was conducted.

• **TruckSafe** - A Joint initiative between WorkCover and the Road Transport Forum, TruckSafe aims to reduce injuries and improve workers' compensation management throughout the road transport industry. Best practice safety and claims management strategies in the road transport industry are identified and promoted through publications and videos.

Role of other Organisations in Prevention

There are a number of important roles played by organisations other than the VWA in prevention and analysis of workplace injuries and illnesses.
The State Ombudsman

The State Ombudsman receives and investigates complaints from individuals when all other avenues of complaint have been exhausted. The Ombudsman has broad powers to obtain information and conduct hearings. The Ombudsman can make recommendations and request that the agency provide notification of its plans to implement the recommendation.

The State Coroner

The State Coroner has the responsibility to examine all reportable deaths\(^{23}\) and determine, generally at inquest, the causes and circumstances of death and the identity of any person found to contribute to the death. In addition the Coroner has jurisdiction to deal with fire. The Coroner has the power to comment and make recommendations on public health and safety or the administration of justice which relates to the death or fire. The Coroner’s Act 1985 gives a statutory basis for coronial findings and recommendations to be used for prevention of future deaths or fires. VWA investigators and inspectors are frequently called upon to assist the Coroner in the investigation of work-related deaths. In recent years the State Coroner’s Office has taken an increasing interest in the prevention of work-related deaths.

Employer Associations

The major employer associations—the Victorian Employers’ Chamber of Commerce and Industry (VECCI), the Australian Chamber of Manufactures (ACM), the Metal Trades Industry Association (MTIA) and others—employ health and safety professionals to provide OHS services to their members. These services include information, advice, health and safety audits, training and representation in consultative forums. The information and advice services cover the legislative requirements, OHS management systems, and risk control. Training is provided for managers, supervisors, safety professionals, health and safety representatives and members of health and safety committees. Courses run by VECCI are approved by the VWA.

\(^{23}\) In general terms, violent and unnatural deaths.
Trade Unions

The Victorian Trades Hall Council (VTHC) has an OHS Services unit which provides training, health and safety audits, and assessments of compliance with legislation, plus information and advice to assist with the implementation of health and safety systems and risk control. These services are available to affiliated unions and to workplaces. The VTHC also represents unions and workers in consultative forums. The VTHC's training courses are tailored primarily for health and safety representatives and members of health and safety committees, but courses are also offered for workers and supervisors. Approximately 2,000 people are trained annually.

Most of the larger unions also provide health and safety services to their members, particularly information and advice. Some have dedicated OHS officers and/or run training courses for health and safety representatives and workers. Courses run by the VTHC and three other unions are approved by the VWA.

Tertiary Education Institutions

Victoria’s Technical and Further Education (TAFE) system provides relatively easy access to OHS diploma programmes, training for safe operation of plant and equipment (including training for certificates of competency to operate specified types of plant), and training for health and safety representatives. These functions are in addition to the TAFE colleges’ central role of delivering training to new entrants into the trades sector. The competencies for trade training courses delivered by the TAFE sector are identified by industry training boards, and include OHS competencies specific to the individual trades. The industry training boards include representatives of employers, workers and the TAFE sector.

Victoria’s universities run undergraduate and post-graduate courses in OHS, as well as professional and short courses (e.g., in ergonomics, hygiene); conduct research; and provide opportunities for continuing education through seminars and conferences. The Victorian Institute of Occupational Safety and Health at the University of Ballarat is an important centre of training and research. A number of academics publish articles, reports, and books dealing
with health and safety. These are based on their academic research and increase the overall information pool on health and safety issues in Australia.

Interest Groups

A number of groups representing particular business or community sectors run programmes in the area of health and safety. The Victorian Farmers’ Federation (VFF) has taken an active role in advising farmers and motivating them to improve their health and safety performance. In conjunction with the VWA and its predecessors, the VFF has run three subsidy programmes for farmers who fit roll-over protection devices to their tractors. The VFF has sponsored the establishment of FarmSafe action groups in rural centres across the State to promote awareness of farm health and safety. The Plastics and Chemical Industry Association (PACIA) runs a Responsible Care programme which seeks to raise the level of health and safety awareness and capability of PACIA members and to assist them to improve their performance by providing training, information and advice. Other interest groups which have provided information and advocacy services for their members include the Property Council of Australia and the Victorian Automobile Chamber of Commerce. Safety Groups in various parts of the State bring together safety professionals and employers to discuss topics of common interest.

Certificate Assessors

The VWA authorises persons to assess applicants for certificates of competency to operate certain types of plant and equipment. The VWA issues the certificate if the applicant has been assessed as competent in the relevant areas. There are approximately 180 certificate assessors who work for TAFE colleges, large employers, and private consultants.

Consultants

Consultants provide services to the workplace parties in areas such as management systems, occupational hygiene, risk engineering, OHS recording and reporting systems, training, ergonomics, health monitoring, stress management, and organisational development.
In a performance based regulatory environment, consultants' services are critically important to assist persons with duties under the legislation to meet the standards required. Section 21(4)(c) of the OHS Act requires employers to employ or engage suitably qualified persons to advise the employers in relation to the health and safety of his or her workers. The VWA maintains an electronic directory currently listing 390 consultants. However, consultants nominate themselves for inclusion in the directory. The VWA does not vouch for the accuracy of information provided by consultants.

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 HSD 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 in Chapters 3 and 4 of 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 HSD'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 non-workplaces 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.

HSD 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 underway 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 National Occupational Health and Safety Commission publishes annual estimates of national OHS statistics based largely on workers’ compensation data. Victorian data is 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 HSD 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 criticized as lacking a decision support system to facilitate valid and reliable causality research.

HSD uses the data to develop the top 20 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 pre-coded 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 Licencing Co-ordination 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 non-compliers accountable to act as a deterrent to others.

Resource Utilisation

The three Operations Divisions provide a full range of services including inspection, investigation, information, advisory, licencing, and training. They are resourced with 304 people, of which 170 are field inspectors and 15 are information officers. These 185 positions deliver the front-line service. Field activity is recorded on the INSPIRE database. During the two-year period July 1993 to June 1995 a total of 123,899 inspections were recorded for an average of 5,162 per month or 28 per inspector and information officer each month. Forty-five percent (2,323 per month) of the inspections involved training/information/advice and observation reports. In the period March 1995 through February 1996 inspections totalled

8-36
46,141 and consumed 64,039 inspection hours. This averages 350 hours per inspector assuming all of the 185 positions were field active, and 1.4 hours for each inspection.

Licencing/Certification/Registration accounted for about 20 percent of the inspections (1,032 per month). Inspection activity involving improvement notices, prohibition notices and dangerous goods directions averaging 170, 103, and 150 per month, respectively. It is somewhat surprising that less than 10 percent of the workplace activity results in the creation of an inspector’s direction to improve or prohibit use. A 20 June 1996 policy directive on enforcement requires that inspectors issue the improvement and prohibition notices whenever they observe non-compliance. Apparently this is in response to the low number of enforcement notices cited above.

Since the September 1995 reorganisation it is reported that the deployment of regional inspection staff is totally consumed by responding to the targets set by the various coordinating units and in the investigation of serious accidents and complaints. Furthermore, the regional teams report they have little if any time for locally planned inspection activity.

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 to sites where there is high-risk equipment or dangerous goods. They can exercise this right at all reasonable times both by day and by 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 potential 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
- 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, s/he may enter the data into the INSPIRE database, and information to create a profile of the firm is also recorded in SATS (Site Assessment and Targeting System). 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 sense is that they are pushing to obtain a quota of activities and this detracts 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 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 non-compliance, 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);
- 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 (PINS) 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 non-compliance 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 off from 1991 to 1994, approximately back to the levels of the late 1980s. This trend may reflect the movement through different Departments and the related reorganisation of HSD and its predecessor entities over this period. Changing inspection focus and reductions in the inspection resource may also explain the declining trend. However, the number of Improvement and Prohibition Notices has risen substantially in the past 2 years.

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;
- non-complied 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 as 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 2 years, appears to be on the rise again. A recent 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.

Investigations are co-ordinated by the Central Investigation Unit (CIU). They may be carried out by the CIU’s five senior investigators, or by the ten dedicated regional investigators, or by inspectors. 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 HSD’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. A very high success rate is achieved, indicating a very 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 the County Court. However, with the agreement of the organisation or person charged and the Court, offences can be heard summarily in the Magistrates’ Court. Most Dangerous Goods Act offences are summary offences dealt with 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 as such 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 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 publication of the 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 with a Notice under the Occupational Health and Safety Act may appeal to the Employee Relations Commission of Victoria (ERCV). 24 The ERCV may affirm, modify or cancel the Notice. In 1995/96, 12 Notices were appealed (fewer than 1 percent of Notices issued). 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

24 At the beginning of 1997 this jurisdiction was transferred to the Industrial Division of the Magistrates' Court.
Administrative Appeals Tribunal. Such appeals are very rare. There have only been two appeals under the Dangerous Goods Act in the last 3 years.

Employers who have been issued with a Provisional Improvement Notice (PIN) by a health and safety representative under the OSH Act may appeal to an inspector. In 1995/96 there were 94 such appeals.\(^{25}\) 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. The VWA is preparing to release a booklet on the powers of inspectors and the appeal rights of employers and others. This booklet aims to encourage a more open process to the benefit both of the parties who come in contact with inspectors and the agency itself.

**Injury and Disease Reduction through Consultation, Education, and Technical Assistance**

The VWA supplements its inspection and enforcement programme with a number of other activities designed to provide workers, unions, employers, equipment manufacturers, and others with the knowledge and information they need to maintain safe, healthy working conditions. This section of the report will give a brief description of these efforts.

**Information Network Unit (INU)**

The INU was established in 1989 to augment field resources by providing information officers whose sole task is to provide information and advice to workplaces. Information officers do not have the statutory enforcement powers of inspectors. The Information Network's services are directed to the key parties who can influence decision-making in the workplace: employers, managers, health and safety representatives, safety officers, and supervisors. The Information Network undertakes targeted prevention projects (e.g., assisting with the application of manual handling legislation); conducts industry briefings; provides assistance in workplaces; conducts seminars, displays and rural field days; distributes VWA

\(^{25}\) Neither health and safety representatives nor employers are required to advise the VWA when a PIN has been used.
publications; responds to telephone and over-the-counter inquiries; maintains a central library and regional resource centres; and carries out media activity.

The INU has a head office component and teams of regionally based information officers whose activities are overseen by a zone co-ordinator. The co-ordinator liaises with area managers to ensure consistency. INU responds to about 35,000 inquiries and conducts about 700 industry briefings each year. Since 1992 the Unit has run a shopfront at the HSDs headquarters building which responds to visitor and telephone inquiries and sends out written information.

The INU is also responsible for approving courses in health and safety which are conducted by external providers. The OSH Act permits health and safety representatives to take time off work with pay to attend approved courses. The following categories of courses are approved at present:

- five-day basic courses for health and safety representatives and managers/supervisors/others. Eighteen providers have been approved.
- a one-day post-introductory course (*Everyone's Business*) for managers/supervisors and health and safety representatives/committee members. Three providers have been approved.
- a training package (*SafePlant*) which provides an overview of the Plant and Certification Regulations and the responsibilities of all the parties. Five providers have been approved.

The SHARE Programme collects solutions for dealing with health and safety hazards and makes them more widely available to workplaces via a loose-leaf manual. Solutions are usually identified by inspectors and information officers, though workplaces are encouraged to nominate their own solutions for incorporation in the programme. The SHARE manual costs $75, and there are about 900 subscribers.

The Bilingual Information Programme (BIP) was established in 1985 within the Department of Labour. In 1991 the BIP was integrated into INU. The objective was to make it part of the mainstream programme while maintaining its special services to workplaces. BIPs current activities include providing information to workplaces on the Codes of Practice and the provision of OHS information in languages other than English, providing information to various communities via ethnic radio broadcasts and networks, assisting inspectors in
investigating incidents involving persons of non-English speaking background, conducting sessions on cross-cultural communication in external courses for health and safety representatives, and distributing publications in languages other than English. In recent years activity in this area has fallen off, due mainly to difficulties in coordinating the BIP’s work through regional offices as well as a focus on other projects.

Development Taskforce

The Division set up the Taskforce in October 1995 with a defined 18-month life. Its objectives are to develop sustainable partnerships focused on achieving improved health and safety performance, provide an enhanced advisory infrastructure and drive increased community awareness of OHS issues. Seven projects are currently underway and a long list of potential additional projects has been identified. The Development Taskforce’s current activities include the following projects.

- **Community relations:** do-it-yourself/home safety, off-the-job (24-hour) safety, promotion of community safety, safety at school;
- **Farm safety:** training days, promotion of farm safety action groups, tractor rollover protection rebate scheme, increasing farmers’ OHS skills and awareness;
- **Local government:** improved CEO/senior management accountability, safety management systems, development and expansion of OHS professional networks, contractor safety;
- **Small business:** collaboration with trade and professional associations to produce appropriate OHS tools, use of a panel of accountants, solicitors and financial advisers to increase small business commitment;
- **Partnering:** establishment of one-on-one partnering sets between companies to promote best practice in OHS (pilots are underway in the plastics and chemicals industry and in some regional centres);
- **Healthshare:** establishment of a SHARE-style programme within the health/hospital industry;
- **Building Construction:** co-operation with industry associations to improve work practices; and
- **Mechanical integrity:** transfer of best practice in predictive and preventive industrial maintenance to a wider range of workplaces.

The Taskforce strives to create opportunities that will mobilize and leverage local resources in partnerships for specific project initiatives. For example, a community relations project will promote off-the-job safety and health through the school system to enhance student
hazard awareness and enlist worker ambassadors to promote health and safety. The Taskforce presents an opportunity to develop greatly enhanced hazard awareness for workers and their families and in the long term cause a culture shift where the belief is that all workplace injury and disease is preventable.

SafetyMap

SafetyMap is an audit tool developed by HSD and launched in 1993. 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 2,000 copies have been sold throughout Australia and to 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.

While the number of units that have been marketed is high, there are less than 200 firms that are actually accredited under SafetyMap. The coordinating unit expects to increase the number of accredited firms significantly. 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 Unit

HSD has a Marketing Unit that provides a communication function. The focus of the material is driven by emerging technical issues and legislative amendments. These are in the form of brochures and pamphlets that are given away. The rights to distribute the Acts, Regulations and Codes of Practice are owned by other agencies and are marketed by them. This unit produces a publication called WorkWords and distributes 24,000 copies each quarter.
This publication keeps the readers informed on upcoming amendments to regulation, emerging issues in health and safety, and general news about HSD.

The planning and co-ordination of Health and Safety Week is also a responsibility of this unit. The programme for 1996 consisted of a wide range of events organised across Victoria by the VWA and individual workplaces and unions. These events included debates, workshops, seminars, displays, roadside tea breaks for truck drivers, a forklift derby, a moot court and an art display.

The annual Health and Safety Awards programme that has been operating for 8 years is also co-ordinated by this unit. The awards are given for achieving innovation or excellence in health and safety. Approximately 150 applicants are judged each year in seven categories of industry. The unit also carries out some media programmes when there are new regulations or standards and seeks regional media assistance to publicize successful prosecutions to achieve a deterrent effect.

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. Market awareness recently was found to be 80 percent, and a continued decrease in claims reported is attributed partly to this marketing effort.

Campaigns include television and radio commercials, posters, displays, and outdoor advertising. Recent campaigns are

- *WorkCover's working to stop injuries* - promoted better communication between management and workers, improved workplace environments, job rotation, training, workers’ exercise programmes and safety responsibility at the supervisor level;
- *Quiet Tragedy* - highlighted the number of deaths and severe injuries in Victorian workplaces;
- *Safety: think it, talk it, work it* - targeted the “black spots” of workplace injuries: working at heights, mixed pedestrian and vehicle traffic, manual handling, and insufficient management commitment.
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.

Stakeholder Feedback

In this section of the report, feedback from employers and labour on the VWA 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 are also subject to less cross-referencing than other material in the 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.

Employer Comment

Employers complain that the Division has an excessively intense interest in prosecution. They believe the preoccupation with putting the legal case together hinders the true preventive value of the accident investigation. Small- to medium-sized enterprises express concern that fines resulting from prosecution may in fact reduce their financial capacity to improve health and safety standards at the workplace. They argue for a system that would require the penalty to be invested in improvements to standards at the workplace.

Employers believe that the targeting system and the lack of field inspector capacity results in an uneven playing field. They argue that sporadic and arbitrary enforcement fuels a low expectation of detection of non-compliance and subsequent action. They believe this could result in good operators being driven out of business, especially in the building and construction industry where competition is stiff in the tendering process. Employers are reluctant to seek advice and assistance from the inspectorate. In spite of the establishment of an
Information and Advisory Network to deliver service in a non-threatening way, many employers still perceive a threat because the officers are part of the enforcement organisation.

Self-insured employers believe SafetyMap is an effective tool that will result in the development of a higher level of hazard awareness and drive behavioural change at the workplace. There is support for the Management System Coordinating Unit's belief that there is room for improvement to the audit process.

Some employer representatives were very critical of the knowledge and skills of the inspectorate. Low pay levels and lack of recognition for those with ability were blamed for many of the good inspectors leaving the Division. In addition, the cyclical variations caused by changes in government was seen to reward those who were politically astute as opposed to those with good skills in health and safety issues.

One employer association was extremely critical of the process they had been through to get approval of a course developed to train health and safety representatives. After 7 months of process, during which the goal posts were constantly moved, the impression was that the HSD did not wish to approve any courses, even though the legislation requires it. This frustration led to the comment that everything HSD did seemed to be very bureaucratic, convoluted and designed with the specific purpose of maintaining or increasing staffing levels.

One association stated the SATS system was another useless paper exercise in that it was too subjective and lacks consistency. They recommended the energy be applied to assisting small businesses who do not have access to health and safety professional assistance and also to providing these enterprises with best practices information.

In common with complaints from labour, employers found a lack of opportunity to communicate with HSD and believed some form of consultative process was needed. One regional office was said to be a problem because the staff were rude, not interested in being helpful and the inspectors were also found to be threatening to employers. Employers found inspectors often reluctant to provide advice, and that they would only point to the regulations or codes to indicate what was expected. Employers sensed that the problem might be systemic since they believe HSD really does not understand what employers need.
The Division provides a lot of information developed by specialists, however employers complain that they have difficulty getting a yes or no answer to a question. It appears to the employer as a fear of being held accountable for the advice given. The Division is not viewed as proactive or responsive to emerging health and safety issues. In a recent discussion paper, an employer association has called for major reform to the OHS legislation and further regulatory changes. They strongly recommend greater involvement by employers in OHS regulation and code of practice development.

Of course, this sentiment is echoed by the labour representatives and would mean reconstructing a tripartite committee that was only recently disbanded. Involvement of the community as advisors is critical to the regulation making process. However, recent experience in another jurisdiction in North America (British Columbia) where a consensus approach was tried led to a process that has taken many years, cost millions, and produced purposely vague regulatory language that had to be bargained over at every step. Each workplace party interprets the requirements differently and policy had to be developed to establish the intent. Achieving a balanced approach that has meaningful consultation and yet achieves timely and clear regulatory amendment must be the goal.

Employer associations complain that there is a lack of consistency in service delivery by inspectors. It should be noted this is a common concern of employers world-wide in dealing with OHS regulators. On the other hand, employers often point out that each workplace is unique and inspectors should be more flexible in determining the level of non-compliance. Regulators can ensure consistency through training and strong policy direction; however, the natural result is no exceptions in following policy and thus no flexibility.

The reorganisation of the Division was touted to provide a one-stop service to employers. Some employer's view is that the strategy is not working, since they find interaction with different parts of the Division still produces inconsistent advice and direction. The performance-based regulations are an area of concern because of the manner of application by the inspectors. Compliance with them is reduced to the individual inspector's view of what is required. To overcome many of the issues a suggestion was the formation of regular forums with employer representatives to discuss emerging issues.
Consultant Comments

Independent health and safety consultants believe 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 non-existent 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 do not understand the new performance-based approach and still view HSD as an agency that provides the historic inspection and enforcement service. In addition, they are highly critical of industry associations. They are sceptical 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 sceptical about the long-term effectiveness of the safety management strategy in reducing injury and disease, even at large, well-resourced enterprises.

Consultants view HSD as being over-organised, highly inefficient, and very politicized. The strong emphasis on prosecutions is viewed as an ineffective use of resources. Critics believe that corporations approach a prosecution with a heavy emphasis on making the good corporate citizen argument and also shifting the blame and responsibility. Furthermore, they believe enforcement by HSD must move more rapidly to a decision to penalize in order to
achieve corrective behaviour. The concern is that too much time and energy are expended in coaxing an enterprise into compliance.

Labour Comments

Worker representatives express a great deal of concern that they cannot get a speedy response from HSD inspectors when they have complaints at the workplace. They believe that there are too few unannounced inspections conducted. This observation was actually supported by HSD staff and managers. When an inspector does arrive at the workplace, they frequently do not invite participation of the health and safety representative in the inspection or seek out their views on workplace issues. When combined with a reduction in labour’s influence with employers, this means that workers are losing their opportunity for meaningful participation.

They also point out that inspectors continue to be focused on their area of specialization and often walk right past other hazards and serious safety issues during an inspection. They observe that inspectors arrive promptly to the scene of an accident where there is loss of life or limb but may take up to 6 weeks to investigate injuries such as crushing, falls or broken bones.

Labour views the advisory, training and information role of inspectors as something that reduces their core function of inspection and enforcement. They assert that less than 30 percent of available inspector time is spent actually undertaking workplace visits. This leads to their conclusion that most employers in Victoria have no expectation that they will ever be visited by an inspector. Thus the minimal risk of violations being detected has for all practical purposes left Victorian industry to self-regulate.

The high level of inspection resource invested in the prosecution of employers is not supported by labour. They argue that the monetary fine levels are so low and the elapsed time so lengthy that there is little deterrent effect. They would support a speedy, less resource consuming process, provided the freed-up inspection time was deployed on increased inspections. Labour also questions the value of the resources invested in tracking the movement and installation of plant and equipment compared to the prevention of injury and disease. Labour is concerned that the Infringement Notice proposal (on-the-spot fines) will not
have fines that are high enough to reflect the seriousness of non-compliance. Furthermore, they do not want any fines applied to workers.

The tripartite structure that gave the labour community the opportunity to provide advice and exert influence on HSD has been abandoned and lack of access is of great concern. However, labour concedes that the previous Health and Safety Commission was too consultative and that change was required. Reduced access and a perceived fortress mentality on the part of HSD results in their observation that opportunity for participation has virtually disappeared.

Labour points out that the budget of the Division is only 25 to 50 percent of that in other states of Australia. Plus, the resources are deployed in a reactive strategy of accident and incident investigation as opposed to a proactive random compliance strategy. They point out that Victoria has the highest number of workplaces per inspector of any of the states and even at one inspection per workplace the re-inspection cycle would take 8 to 10 years. They believe that compliance is only driven by the probability of being inspected and an expectation that severe punishment will follow. This is based on the understanding that employers face difficult competitive pressures and this drives the reluctance to invest in health and safety.

Those unions representing workers in federally regulated industries, as well as those representing workers in the education system, complain that the arrangement for HSD to provide services is not working. There is no inspection or enforcement activity. The primary concern is that education system employers are not taking responsibility for OHS. Under reporting of injuries, coercion of workers not to report, and a lack of expertise about violence in the workplace and environmental issues are key areas where improvement is needed. In addition, the reorganisation of the Division has resulted in the ergonomists and the hygienists no longer being available to assist them in identification and assessment of risks.

High marks are given to a noise measurement programme called Operation Decibel and the manual handling training programme carried out by the Division. Labour would like to see more preventive programmes of this nature. However, labour perceives a withdrawal of HSD inspections in this sector and believes this to be a significant contributing factor.
Unions recommend that training for safety and health representatives be prescribed in regulation and, further, that the value of worker participation in workplace OHS be the focus of media campaigns. They point out that at present, training falls mostly to trade unions and that those who have been trained require upgrading as regulations are amended. They feel strongly that the qualifications for inspectors needs upgrading such that the minimum requirement would include the 3-year OSH diploma programme.

The publications prepared by HSD are important to labour; however, they criticize them as being too glossy and difficult to decipher. They would trade the high production quality for a greater numbers of documents that are more available and user friendly. Many of the documents they need to meaningfully participate, they find too expensive and believe they should be provided free or at a subsidized price.

They point to the fact that the fatal injury toll at workplaces has not been reduced and recommend the focus should be on hazard reduction and awareness campaigns. More emphasis on research into working environment issues is also recommended.

Finally, labour is concerned that the merger of HSD with VWA might mean an emphasis on privatisation of the health and safety function and point to the VWA privatisation of the compensation scheme as evidence for their position.

Health and Safety Division Concerns

Senior staff in HSD expressed significant concern at the criticism they receive both from the employer and worker communities. They are at a loss to explain this. In addition, a concern exists that the Division and its mandate are one that no department of government wants. Over the years this has resulted in constant movement from Ministry to Ministry, to a stand-alone agency and now to WorkCover. This all leads to a pervasive morale and identity problem. Those who have been around awhile point to 15 changes of title for the organisation over 20 years! The impression left is that “this too will pass” and not much will change. Since HSD also has the responsibility for both public safety aspects and occupational health and safety, this Division should be viewed as the champion of health and safety and should be highly respected for their knowledge and professional and technical expertise.
The Technology Section is too reactive in its service to the Division. Some units, such as the chemical engineers, are fully utilised in support of the licencing and approval process for dangerous goods. The engineers are not able to undertake proactive prevention initiatives to achieve improvements in occupational health and safety. There is also a concern that they are "out gunned" in the licencing and approval process by the client's experts, largely because the Division has not promoted technical currency through attendance at international symposia, etc. The manager has been proactive in arranging secondment exchanges with the chemical industry to offset these concerns; however, this is not viewed as sufficient.

The occupational medicine unit has only one physician position. That is currently vacant, and there is some doubt whether this position will be staffed in future. The hygienists and ergonomists act as in-house consultants to the field inspectors. As part of the unit's business plan under the reorganised structure, these professionals spend time at the field offices on a rotational basis. This strategy is expected to make the inspectors more aware of their expertise and result in increased utilisation of their skills. However, these professionals do not make their own field visits to enterprises. When they are called upon by the inspector, their advice or findings are relayed through the inspector to the workplace. The individual professionals are concerned that the inspector may decide not to utilise the information, or may have difficulty in its application or explanation. Moreover, the expert is screened from the client.

Hygienists expressed a keen interest in secondment exchanges with other OHS agencies to maintain currency and experience other approaches. These professionals also no longer see themselves as part of the strategic planning process. They see their unit as a group still struggling with the reorganisation and trying to sort out how they fit, and how best to utilise their specialty skills. This is a common theme also expressed by some regional office staff. Hygienists are particularly concerned that the government laboratory will be closed and they will be left without one that has the credentials to do the analyses they require to carry out monitoring. One possibility suggested was the establishment of this analytical capability at the University of Melbourne. Moreover, the staff believe such a lab may require financial assistance and see this as an opportunity for consideration by VWA.
The current matrix organisational structure was initiated on 25 September 1995 upon the recommendation of management consultants Deloitte Touche Tohmatsu. Senior management's view is that the state-wide co-ordination in the areas of Plant, Dangerous Goods, Working Environment, Enforcement and Public Safety, Building and Construction, Information Programme, Standards Development, Management Systems, and Licencing and Certification is working well. However, regional managers and their staff say that they are being asked to provide the resources to meet targets for service that are not reasonable. The total inspector time needed for the targets in a region have been estimated at between 110 percent and 200 percent of the available resource. Regional managers believe they will be held responsible when the targets set by the statewide co-ordinators are not met. The planning sessions held to sort out the difficulties were viewed as a failure and, in the end, the state co-ordinators prescribed the targets. Adding to this dilemma for regional managers is the time required for their staff to attend training sessions mandated by the co-ordinators that are often scheduled on short notice. All of this leaves them with reduced control over the resources they manage.

Both inside and outside HSD the sense is that inspection of workplaces has the lowest priority. The minimum worksite time available per inspector has been set at 500 hours per year (about 25 percent) as a guide in allocating scarce field inspector resources. Investigation and preparation for prosecutions are estimated by some managers to consume 60 percent of some inspectors' time, and the balance is scheduled to projects assigned by the co-ordinators. Senior management indicate this is a gross exaggeration. However, it is agreed that workplace complaints have the lowest priority. The result is they may not be followed up for weeks or until there is sufficient heat generated to cause the complaint to rise to the top as a Ministerial Directive.

Staff are generally concerned about the high level of resources invested in the licencing of the manufacture, transport, storage and use of dangerous goods. It is widely believed that very little of this activity leads to prevention of injury and disease, or any added value to health and safety. The dangerous goods coordinating unit has six inspectors, currently being increased to 11 to deal with the transfer of the added responsibility for the Port of Victoria. The chemical
technical group estimates 70 percent of the 12 chemical engineers and chemist’s time is devoted to this process. The manager of the co-ordination unit is concerned that the number of inspectors with dangerous goods skills has diminished, and as a result only 40 percent of the targets set by this unit are being met by the regions. Everyone agrees that the revision of the regulations in this area to a performance-based approach will alleviate some of the problems.

Dangerous goods are seen as an area of apparent political interest and sensitivity. Service delivery has been criticized by the Auditor General, since, in spite of the activity, there is no understanding of the level of compliance with the existing legislation. Other agencies (Infrastructure and Planning and Environmental Protection) also have responsibilities for licencing and approval of dangerous goods, however, there is a lack of co-ordinated service delivery by the agencies. There is significant animosity within the organisation directed at the dangerous goods coordinating unit. The unit is viewed as a clearing house that orchestrates the hand-off of tasks to other areas and adds little value.

It appears that the reorganisation has not been well communicated throughout the organisation. The coordinating units are misunderstood and barriers have been erected between the regional front-line staff and the coordinating and technical units. The difficulty is described by some as a failure to define and document the roles of the various managers. Others attribute the problems to either poorly skilled resources in the field or their inability to adapt to changed responsibilities. The multiplicity of tasks and demands from the coordinating units is seen by many as inhibiting quality service delivery. The reorganisation has created an unhealthy competition by the coordinating units and technical unit staff for inspector’s time, either to carry out projects or to participate with them in workplace interventions.

The coordinating units apparently have higher staff pay levels. This concerns regional managers from an equity perspective, and also because vacancies in the units are sought after by skilled inspection staff from the regions. This results in a drain of resource from the field. The lowest paid positions in the coordinating units are at the same level as regional managers, who believe they have a greater workload and responsibility without appropriate compensation. Regional managers assert that if a position contains policy or co-ordination functions it pays far better and that this drives the proliferation of policy development functions in many units. Both
internal and external critics of the recent reorganisation believe the coordinating units are unnecessary.

Insufficient vehicles provided for field inspection is a significant complaint heard from all levels within the organisation. In the worst case there are three vehicles allocated for five inspectors. The result is a rotation where each inspector can only spend 3 days per week on field activity. This also means that the inspectors carry a minimum of supplies with them since they must carry the materials fairly long distances to and from the vehicles, especially in the central office. Inspector time is significantly under-utilised because of this serious under complement of vehicles.

While in the office, inspectors answer phones, input data into the database, and no doubt have some non-productive time. Failure to provide a dedicated vehicle for each inspector also means that they have to fight traffic travelling to the office in their own vehicle, park their vehicle, attend at the office to gather materials, fight traffic travelling to the first inspection, and repeat this in reverse after the last inspection. This seems to be a very inefficient application of scarce inspector time.

HSD also has a remarkable "starship" arrangement of one computer to four desks, i.e., one computer shared by four inspectors. Inspectors complain that this arrangement leads to great inefficiency since they often find there are more inspectors in the office than available computer terminals.

Some inspectors are also having a great deal of difficulty adapting to change. They are not comfortable with their revised roles as a result of the performance-based legislation. Many are accustomed to being "the expert" and providing the detailed inspection and audit functions associated with prescriptive regulation. Employers also have not fully realized or adapted to their new responsibilities under the revised regulations. This results in an expectation on their part for the old style of service from inspectors.

Many inspectors are not at all comfortable with the new (June 1996) get-tough enforcement policy. Senior management claims that this was merely a restatement of the existing guidelines, with more emphasis on ensuring that they are consistently and effectively applied in the workplace. In spite of this, some inspectors see this as a significant culture
change for them. They interpret the policy as giving them no flexibility in dealing with the employers. They must write improvement and/or prohibition notices whenever they observe non-compliance. When inspectors determine there has been a failure to comply or observe repeated non-compliance, they must proceed to recommend prosecution. They see this as detrimental to the maintenance of good employer relationships and the significant degree of cooperation achieved in the past. But when one observes that there are approximately 50,000 inspections each year and only a small fraction of these have generated improvement or prohibition notices, it is understandable that the executive has had to resort to this tough policy direction.

There is a great deal of energy expended in paperwork and entering data to track activity. Both inspector and technical staff raise significant concerns about the value of this exercise. The Job Tracker system is similar to that which would be used by a consulting firm to track billable hours. It apparently is not flexible enough to allow full tracking of multitasking. One professional complained that a 12-hour day had been worked and the system would only credit 8 hours of activity. The INSPIRE system is designed to track inspector activity by workplace, however there is skepticism that the data reflect what is actually happening in a region. Criticism is particularly levelled at Inspire’s inability to flag exceptions. A new system to track incident/accident investigation was criticized for not being user friendly.

In addition to Job Tracker and INSPIRE the technical staff also use Microsoft Scheduler and a correspondence tracking system. The output from Job Tracker is seen by some simply as great stacks of paper listing the tasks performed, and of little real value. Inspectors find they spend a great deal of time handwriting the paper work that is left after an inspection. If they were to observe 100 infractions they would produce 100 improvement notices and spend perhaps a day to complete the paperwork. This onerous burden may drive a practice of only recording the very serious infractions or even reducing the scope of the inspection so as not to observe too many infractions.

Inspectors and regional managers maintain that the inspector positions are underpaid by up to 25 percent when compared to equivalent private sector positions. Several have seen peers leave the organisation to set up shop as assessors or consultants. Outside inspection service is
in great demand by employers as they begin to understand their new responsibilities under the performance based regulations. Regional managers report an inability to attract appropriately experienced and trained replacements as a result of low pay levels. Given the difficulty some inspectors are experiencing in adapting to their revised roles under the new regulations, it may be that their skills need upgrading coincident with the development of a revised job classification and re-evaluation of compensation levels.

Most managers were sceptical that safety and health interventions could be linked to outcomes. One manager cited a conference where safety and health professionals presented papers to show how their programmes had led to measurable outcomes. However, all of the professionals were claiming responsibility for the same outcomes. The lack of a research capability or the funds to support a significant Grants and Awards scheme to foster fundamental research by the academic community into emerging health and safety issues was also seen as a significant concern.

Regional staff expressed concern that the organisation does not have sufficient data to provide an effective targeting system. The top-20 worst industry list is not seen as a particularly useful tool. Head office provides the list of industries and the regions are left to figure out which workplaces within the region to inspect. Some inspectors said this strategy resulted in them often inspecting the same workplaces over and over and preaching to the converted.

Some staff raised what they termed the workplace culture and industrial relations issues. They believe that these issues are detrimental to improvement of health and safety in some industries. In such instances they view strict enforcement of compliance with the regulations and codes as the only effective approach. These views when compared to earlier stated views of some inspectors that the enforcement policy is inflexible points to the inconsistency of approaches by individual inspectors. This is not uncommon and is found in most inspecting agencies.

Staff expressed concern that VWA and HSD were sending mixed or conflicting messages to the community about prevention of workplace death, injury and disease and the
responsibilities of employers and workers. Discussions held to co-ordinate strategies and integrate messages in the past apparently did not alleviate the problems.

A significant opportunity is seen by most staff to develop synergy between HSD and VWA to drive prevention initiatives. However, a concern was expressed that HSD was internally process-driven and that difficulties had arisen in previous collaborative attempts to develop and deliver important strategies in a timely manner. On the other hand it was recognised that HSD’s process strengths and activity focus would compliment what is seen as a lack of process strength in WorkCover.

There is a general feeling of apprehension at the integration of VWA and HSD. There is a common belief that VWA does not understand or appreciate the importance of the mandate and responsibility flowing from the legislation, nor HSD’s function as a service delivery organisation. In addition, the staff have a specific fear of further integration, even where they see the positive opportunities of consolidation. Staff point to an earlier amalgamation of some HSD/VWA departments as an example of their concern. They indicate this reorganisation was not handled very well and that most of the HSD staff were declared redundant.

Conclusions

Over the last decade, the Health and Safety Division (HSD) 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 Occupational Health and Safety Authority (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 Health and Safety Organisation (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 an 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 5 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 reorganisation as a result of the Deloitte Touch Tohmatsu report in 1994, any further reorganisation must be carried out carefully and skilfully. 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.

The HSD has a very broad mandate that includes occupational health and safety at almost all places of work in Victoria. In addition, HSD’s responsibility extends to public health and safety with respect to dangerous goods and plant and equipment. Given this significant scope, HSD needs to utilise resources in a way that maximizes their effect. The efforts of the Information Network Unit, the Development Taskforce, SafetyMap, SHARE, and the Marketing Unit are being successfully deployed to leverage resources in the community. These are successful and valuable strategies, however more effective co-ordination and service delivery efficiencies could be obtained.
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. HSD 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. The SATS programme will assist in targeting; however, a significant improvement in the collection of causality and source data, other than that needed to adjudicate an injury claim, would assist targeting strategies. The knowledge, skills and ability of the inspection resource needs to be refined to match the performance based regulatory focus. This should be followed with an evaluation of the existing resource base and means developed to upgrade and replace as necessary. Remuneration levels should also be evaluated, so as to attract and maintain appropriately skilled staff.

HSD’s management structure has many layers and as such is seen to be very top heavy. The plethora of coordinating units sets up an internal competition for resources, and will likely result in blame shifting as aggressively planned objectives are not achieved. The skills of technical specialists, especially the hygienists and ergonomists, could be deployed more effectively to achieve preventive measures. At the moment they are not empowered or stimulated to aggressively utilise their skills to drive results-oriented approaches.

The significant investment in investigation with a view to prosecution is not supported by any of the stakeholders. 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. However, a new strategy is needed that does not focus solely on events that have serious injury attached; rather one that has significantly greater fines for the occasions when prosecution is attempted and supplemented by a process linked to the premium system. The existing prosecution focus is reactive to an injury event as opposed to proactive/preventive where a serious risk or imminent hazard is observed.

Some services provided by HSD could be as effectively carried out by the private sector and some need further refinement. Legislative amendment may be required to achieve the
desired result in some instances. The community suggested there were mechanisms that should be either enhanced or established, included funding research into emerging occupational health and safety issues and the development of a meaningful consultative mechanism. Both employer and labour communities agree the previous tripartite mechanism was not working, however they now feel isolated from participation with HSD.

HSD has many cutting edge-strategies, and for the most part, a highly educated and skilled staff that knows its mandate and is dedicated to reducing workplace injury and disease. All of this positions the Division, in partnership with employers and workers, to achieve order of magnitude improvements to safety and health in Victoria.
<table>
<thead>
<tr>
<th><strong>Occupational Health and Safety Act 1985</strong></th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>OHS (Asbestos) Regulations 1992</td>
<td>Provide for control of risks of asbestos-related disease among workers working in processes which use asbestos and among workers likely to be exposed to airborne asbestos.</td>
</tr>
<tr>
<td>OHS (Certification of Plant Users and Operators) Regulations 1994</td>
<td>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.</td>
</tr>
<tr>
<td>OHS (General Safety) Regulations 1986 (to be replaced with the OHS [Incident Notification] Regulations 1997)</td>
<td>Prescribe criteria for the notification of accidents; prescribe criteria for the keeping of accident records; prescribe age prohibition for the employment of young persons.</td>
</tr>
<tr>
<td>OHS (Issue Resolution) Regulations 1989</td>
<td>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.</td>
</tr>
<tr>
<td>OHS (Lead Control) Regulations 1988</td>
<td>Provide measures to protect people at work against risks to health or safety arising from exposure to lead.</td>
</tr>
<tr>
<td>OHS (Manual Handling) Regulations 1988</td>
<td>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.</td>
</tr>
<tr>
<td>OHS (Noise) Regulations 1992</td>
<td>Provide measures to protect people at work against risks to health or safety arising from noise.</td>
</tr>
<tr>
<td>Regulations</td>
<td>Purpose</td>
</tr>
<tr>
<td>-------------</td>
<td>---------</td>
</tr>
<tr>
<td>OHS (Plant) Regulations 1995</td>
<td>Provide measures to protect people at work against risks to health or safety arising from plant and systems of work associated with plant</td>
</tr>
<tr>
<td>Dangerous Goods Act 1985</td>
<td></td>
</tr>
<tr>
<td>DG (Explosives) Regulations 1988</td>
<td>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</td>
</tr>
<tr>
<td>DG (Liquefied Gases Transfer) Regulations 1987</td>
<td>Specify various matters relating to liquefied gas containers and cylinders; Set requirements for maintenance, alteration, and repair at liquefied gas storage installations</td>
</tr>
<tr>
<td>DG (Storage and Handling) Regulations 1989</td>
<td>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</td>
</tr>
<tr>
<td>DG (Transport) Regulations) 1987</td>
<td>Provide for the licencing 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</td>
</tr>
<tr>
<td>Equipment (Public Safety) Act 1994</td>
<td></td>
</tr>
<tr>
<td>-----------------------------------</td>
<td></td>
</tr>
<tr>
<td>E(PS) (General) Regulations 1995</td>
<td></td>
</tr>
<tr>
<td>Declare certain equipment to be prescribed equipment for the purposes of these Regulations and the E(PS) Act</td>
<td></td>
</tr>
<tr>
<td>Provide for the health and safety of people in relation to prescribed equipment</td>
<td></td>
</tr>
</tbody>
</table>

Source: VWA
<table>
<thead>
<tr>
<th>Code of Practice</th>
<th>Date of Operation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tilt-Up Construction</td>
<td>1 October 1987</td>
</tr>
<tr>
<td>Foundries</td>
<td>30 June 1988</td>
</tr>
<tr>
<td>Workplaces</td>
<td>30 June 1988</td>
</tr>
<tr>
<td>Lead Control</td>
<td>1 July 1988</td>
</tr>
<tr>
<td>Temporary Electrical Installations on Building and Construction Sites</td>
<td>1 August 1988</td>
</tr>
<tr>
<td>Manual Handling</td>
<td>1 February 1989</td>
</tr>
<tr>
<td>Safety Precautions in Trenching Operations</td>
<td>1 September 1988</td>
</tr>
<tr>
<td>Safe Work on Roofs (excluding villa construction)</td>
<td>1 July 1989</td>
</tr>
<tr>
<td>Safe Use of Cranes in the Building and Construction Industry</td>
<td>1 March 1990</td>
</tr>
<tr>
<td>Safety in Forest Operations</td>
<td>1 March 1990</td>
</tr>
<tr>
<td>Building and Construction Workplaces</td>
<td>1 October 1990</td>
</tr>
<tr>
<td>Demolition</td>
<td>1 October 1991</td>
</tr>
<tr>
<td>Manual Handling (Occupational Overuse Syndrome)</td>
<td>1 January 1992</td>
</tr>
<tr>
<td>Provision of Occupational Health and Safety Information in Languages other than English</td>
<td>1 October 1992</td>
</tr>
<tr>
<td>Noise</td>
<td>1 October 1992</td>
</tr>
<tr>
<td>First Aid in the Workplace</td>
<td>1 June 1995</td>
</tr>
<tr>
<td>Plant</td>
<td>1 July 1995</td>
</tr>
</tbody>
</table>

Source: VWA
Table 8.3 Inspections, Notices, and Written Directions, 1990-1996

<table>
<thead>
<tr>
<th>Year</th>
<th>Inspections</th>
<th>Improvement Notices</th>
<th>Prohibition Notices</th>
<th>Written Directions (requirements)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1990</td>
<td>44,834</td>
<td>2,639</td>
<td>1,714</td>
<td>73</td>
</tr>
<tr>
<td>1991</td>
<td>48,146</td>
<td>4,062</td>
<td>1,659</td>
<td>2,099</td>
</tr>
<tr>
<td>1992</td>
<td>48,429</td>
<td>3,428</td>
<td>1,159</td>
<td>3,655</td>
</tr>
<tr>
<td>1993</td>
<td>78,913*</td>
<td>2,382</td>
<td>1,024</td>
<td>7,092</td>
</tr>
<tr>
<td>1994</td>
<td>55,904</td>
<td>1,393</td>
<td>814</td>
<td>4,008</td>
</tr>
<tr>
<td>1995</td>
<td>48,261</td>
<td>1,787</td>
<td>841</td>
<td>6,286</td>
</tr>
<tr>
<td>1996</td>
<td>43,678</td>
<td>2,889</td>
<td>1,285</td>
<td>7,288</td>
</tr>
</tbody>
</table>

* 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

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Prosecutions</td>
<td>76</td>
<td>119</td>
<td>68</td>
<td>64</td>
<td>79</td>
<td>86</td>
</tr>
<tr>
<td>Average fine</td>
<td>$6,449</td>
<td>$5,374</td>
<td>$7,509</td>
<td>$12,682</td>
<td>$8,918</td>
<td>$11,333</td>
</tr>
</tbody>
</table>

Source: VWA
Figure 8.1

HEALTH AND SAFETY DIVISION, VICTORIAN WORKCOVER AUTHORITY

General Manager

Director
Development Taskforce
  - Manager Community Relations
  - Project Leader

Director
Technology
  - Acting Manager
    - Hygiene Unit
  - Project Leader

(Deputy Gen. Mgr.)
Director
Strategy
  - Manager Legislation Policy
  - Manager Planning and Review Unit
  - Manager Standards Development Co-ordination Unit

Director
Operations - Central
(Plant)
  - State Co-ordinator Plant
  - Manager Design Registration/Review
  - State Co-ordinator Building & Construction Industry Program
  - Acting State Co-ordinator Information Program

Director
Operations - Western
(Dangerous Goods)
  - State Co-ordinator Dangerous Goods
  - Manager Enforcement & Public Safety
  - Manager Metro West

Director
Operations - Eastern
(Work Environment)
  - State Co-ordinator Work Environment
  - Manager Management Systems Unit
  - Manager Licensing
  - Manager Mulgrave
  - Manager Traralgon

Director
Strategy
  - Manager Metro Central
  - Manager Preston

Director
Operations - Central
(Plant)
  - Manager Metro Central
  - Manager Preston

Director
Operations - Western
(Dangerous Goods)
  - Manager Metro West

Director
Operations - Eastern
(Work Environment)
  - Manager Metro Central
  - Manager Preston

Manager
Mechanical Engineering Unit
  - Acting Manager
Manager
Occupational Medicine Unit
  - Manager
Manager
Chemical Technology Unit
  - Acting Manager
Manager
Ergonomics Unit
  - Acting Manager
Manager
Information Systems
  - Manager Marketing

Manager
Legislation Policy

Manager
Planning and Review Unit

Manager
Standards Development Co-ordination Unit

Manager
Central Investigations Unit

Manager
Organisational Development Unit

Manager
Marketing

Manager
Information Systems

Manager
Bendigo Mildura Sub Office

Manager
Wangaratta Shepparton Sub Office

Administration Manager

Administration Manager

Administration Manager
Chapter 9

ATTENTION POINTS
Chapter 9 ATTENTION POINTS

As in other comparable studies of workers’ compensation systems in North America, we have taken the liberty to record in this chapter our summary observations about the workers’ compensation system of Victoria in the form of “attention points.” These attention points are identified as such because they represent special strengths of the system or because they warrant, at least in our opinion, 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 stakeholders in the system. We simply offer what we hope is a well informed outside perspective on the workers’ compensation system in Victoria.

It is also important to emphasize that we were unable to stay current with very recent policy developments in Victoria. It was necessary to keep our focus on the “official” observation date of July 1996. While this means that some of our attention points may already have been addressed with amending legislation, it was simply not possible for us to keep up with the latest alterations in an environment as dynamic as that in Victoria.

For purposes of exposition, we have grouped our observations into the broad categories of (1) general issues; (2) insurer regulation issues; (3) compensation issues; (4) rehabilitation issues; and (5) prevention issues. Within each of these categories, our attention points are numbered for convenient reference. However, the points are not presented in priority order.
General (G)

We begin 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 equilibrium and stability at a level of performance that would have been unimaginable 5 years ago. Claims are down more than 50 percent, durations have been significantly reduced, the incidence of long-term claims has been cut by nearly 40 percent, and system costs are at the lowest level in Australia at 1.8 percent of payroll. The system is fully funded (actually with a small surplus) compared to a 42 percent unfunded liability under the last full year of WorkCare. The leadership of the VWA and the Ministry deserve much of the credit for this turnaround. Their vision and consistency of purpose have been remarkable. While the system has its critics, no one disagrees that this has been an amazing transformation.

G-2. Historical Opportunity

While much has been accomplished, this is not the time for the VWA to rest on its laurels. After 5 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 Health and Safety Organisation and the VWA in 1996 creates a historical opportunity for a thorough and careful rethinking of system parameters. Bringing the mission and operations of HSD into the VWA will prove challenging, but if it can be done with the kind of creative thinking that has characterised the past 5 years, it can move the entire organisation to new heights of achievement.
G-3. 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 creates the opportunity to carry the media message into new areas. This promises additional returns in the fight to prevent workplace injury and disease and to minimise its disabling consequences.

G-4. Stakeholder Input

Our interviews revealed that labour and management, as well as other stakeholders, have perceived a problem over consultation with the VWA and policy makers. 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.

Insurer Regulation (I)

There are a number of issues which emerged from our review of the insurer regulation procedures at the VWA. It is difficult to forecast how future policy changes may impact the role of the VWA, given the uncertainties about possible changes in regulatory policies and mechanisms and further privatisation of the provision of insurance services. We have tried to formulate attention points that address these uncertainties, as well as the eventual operational
issues that will emerge from the political decisions about the relative roles of the insurers and the VWA.

I-1. 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, and the success of the WorkCover scheme is 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 government interference with insurers’ activities and tension between regulators and authorised insurers. Victoria may be approaching the limits of what can be achieved from the current principle-agent framework. In looking towards the future, policy makers will need to assess the potential further gains from this type of arrangement against those offered by alternative models, including those that return greater responsibility and choice to the private sector.

I-2. 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 than 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

9-4
is not feasible for regulatory documents to prescribe every aspect of insurers' functions nor 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 sometimes inconsistent with the expressed goals of the system.

Within the last 2 decades in Victoria, insurers' levels of responsibility and discretion have varied considerably. Further, when WorkCover was implemented in 1992, it was expected that the system would ultimately move to full privatisation. However, today it is uncertain how far Victoria will go in increasing insurers’ responsibilities. In fact, our interviews suggest that insurers themselves have very different preferences and expectations regarding “privatisation” which are affecting their current behaviour. This uncertainty about further changes to the system complicates insurers' planning efforts and may cause them to defer investments that would improve their current efficiency and performance. It would be very helpful if these uncertainties could be resolved and all insurers understood the shape of the future in Victoria’s workers’ compensation market.

I-3. 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 towards insurers as both a regulator and a partner, and insurers respond accordingly. The VWA obviously cannot abrogate its regulatory role, 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 lack of mutual trust and respect.

We believe the relationship between the VWA and insurers is more adversarial than appropriate for their shared responsibilities. 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. However, this will have to wait until the privatisation issue is settled one way or the other, since this policy decision will fundamentally determine the nature of the future relationships.

I-4. Economic Incentives

Structuring economic incentives to promote scheme goals is complicated by the sharing of responsibilities between the VWA and insurers. One senior VWA executive asserts that they have brought economic incentives to "an art form." The combination of experience rating and competition among insurers for employers' business is intended to encourage insurers to provide high-quality service, and to work with employers to contain costs.

However, service is only one parameter on which insurers compete and the use of "kickbacks," in the form of special services or allowances, is alleged to be rampant in the industry. This implies that some insurers find it more economical to acquire business through in-kind price discounts (e.g., computer equipment) rather than through better service outcomes (e.g., loss prevention and claims management services). The audit programme and best practice incentives are intended to contribute to proper economic incentives but insurers complain that these programmes are not structured properly and the best practice incentives are insufficient to compensate for the deficiencies of the remuneration scheme.

Also, it is not clear that the incentives contained in VWA's pricing, remuneration, and regulatory schemes encourage the return-to-work goal which the VWA espouses. The VWA is contemplating new initiatives which may help to enhance proper economic incentives generally, but the management of long-term claims and severely injured workers will continue to be a problem without incentives specifically focused to address these objectives.
I-5. Insurer Quality of Service and Performance

VWA statistics indicate significant variation among insurers in several important service measures, including timeliness, case reserve accuracy, dispute rates, and medical panel delays. Some of the variation might be explained by differences in insurers' risk and claim portfolios, but sub-par performance by some insurers also could contribute to this variation. Multivariate analysis of available data should help to untangle these influences.

These issues, combined with the VWA's concern about loss prevention and long-term case management, require continued attention. New initiatives to improve economic incentives and employer information, as well as the new audit programme, are likely to improve the performance of below average insurers. If not, further measures will need to be considered. However, we would urge the adoption of a continuous improvement model for all insurers, in addition to the implicit benchmarking and relatively crude financial incentives currently underlying the regulatory regime.

If better service performance (considering an insurer's specific risk and claim portfolio) can be adequately compensated, then insurers would have a greater incentive to pursue the performance goals of the system. With this strategy, regulatory pressure can be more effectively targeted, and the performance of the entire scheme can be improved.

I-6. Insurer Audits

The VWA's audit programme has been a major concern to insurers, and the VWA has recognised the need for its improvement. Although some insurers are not fully satisfied with the design of the new audit programme, it may be prudent to defer judgment until its performance can be evaluated. However, fully engaging insurers in a continuing collective evaluation of the programme could help to ease their concerns and further support partnering with VWA. One critical element which the VWA can influence in the implementation of the new 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 pay to recruit and retain better qualified auditors, and to commit to longer-term contracts which would support additional capacity development by vendors of auditing services.
I-7. 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 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-8. Scheme Information

Insurers’ ability to compete and provide high-quality service is heavily dependent on their access to information. However, many 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. Strains on the ACCtion system have also prompted the VWA to pressure insurers to decrease their usage. On the whole, this tends to discourage the kind of analysis that insurers should be performing (and presenting to employers) to enhance loss prevention and effective claims management. Further,
insurers’ ability to calculate accurate reserves, one of the VWA’s concerns, is clearly affected by their ability to access and analyse claims information.

If privatisation were to delegate greater responsibility to insurers for pricing, reserving, and bearing risk, a summarised industry database might prove to be inadequate to meet insurers’ needs. Generally, insurers’ data on their own claims experience is not sufficiently credible for accurate pricing. This is recognised in “competitive rating” states in North America that maintain a pooled database with access by all insurers. It is not clear to us that a summarized database would provide sufficient detail to enable insurers to supplement their own data to develop a proper rate structure, nor allow the VWA sufficient insight into insurer performance to support their regulatory functions.

The opportunities for “database synergy” with HSD 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, we urge the VWA to carefully consider the strategic and tactical implications of the regulatory database proposals.

I-9. 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 in employers’ movement to better performing insurers. The VWA’s plan to publicize insurer performance data should help to address this deficiency and, thereby, enhance competition and scheme performance.

Some insurers are understandably nervous about this development and the potential for misleading performance indicators. However, the VWA should not shrink from this initiative and efforts should be directed toward refining the accuracy of the information that is provided to employers as experience is acquired, rather than suppressing this information. 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-10. Self-Insurance and Self-Administration

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 business. 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 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, if it improves cost containment among self-insureds, it could lower overall social costs of occupational injury and illness. 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 will need to minimise cross subsidies to avoid unnecessary erosion of the pool of employers insured by the scheme. Thus, 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 philosophical issue for the VWA and policy makers to resolve, because it raises numerous regulatory issues as well. The VWA would benefit by informing itself regarding other jurisdictions’ experience with group self-insurance before venturing into these relatively uncharted waters.

I-11. Coordination of Federal and State Regulatory Responsibilities

Victoria’s authorised insurers appear to fall into a gray area with respect to financial regulation. The VWA relies on the federal regulator’s oversight of the solvency of authorised insurers. However, the Insurance and Superannuation Commission (ISC) gives diminished attention to these insurers because they are formed solely to service WorkCover policies and cede all of their risk to the VWA. This is not a problem under the current framework, since these insurers do not bear any underwriting risk and generally have parent companies that could infuse capital, if necessary, to keep their subsidiaries solvent. However, if changes are made that would permit authorised insurers to bear more risk, the VWA and the ISC would need to reconcile their respective oversight functions to ensure that solvency issues would not slip between jurisdictions and place the VWA or policyholders at risk.

I-12. Other Issues With Respect to Privatisation

The prospects for privatisation initiatives are uncertain, but the VWA will likely implement several measures to improve economic incentives and increase insurers’ responsibilities even if full privatisation is not achieved. Uncertainty about the future may be the most significant challenge facing insurers. Resolving this issue and developing a shared vision of the future structure of the scheme among all the stakeholders would facilitate better planning, investment, and other changes necessary to achieve scheme goals.

If there is a move to transfer greater risk and responsibility to insurers, then a host of questions will arise as to the appropriate regulatory structure, as well as the transition strategy to support this move. Entry barriers, market concentration, price regulation, information needs, and solvency concerns would become much more significant issues under a privatised
scheme. Developing an appropriate balance between regulation and private choice would be critical to the success of such an effort.

Compensation Issues (C)

We take the basic structure of compensation as a “given”; that is, we assume that the political leaders in Victoria have structured the benefits to accord with current Australian realities. Of course, a careful study of the equity of the benefit structure has not yet been 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.

C-2. The Erosion of the “Serious Injury” Threshold

The concept of “serious injury” was a central feature in two main areas of the WorkCover reform legislation. First, it was introduced as an additional benefit category,
alongside “total incapacity” and “partial incapacity” with respect to statutory benefits. Second, it served as a screening device to limit access to the common law remedy to those instances where a work injury or illness had left the worker with a level of impairment equal to at least 30 percent, as measured by the *AMA Guides, 2nd edition*. However, parallel to the Transport Accident Act, a narrative threshold of serious injury was also permitted, so that the 30 percent threshold was not an absolute precondition to access the common law remedy.

In fact, a number of gaps have emerged that substantially open up access to the courts. One source of this has been the ability of claimants to achieve or surpass the 30-percent threshold through the “overlay” of a psychiatric impairment on a physiological one. Clearly, psychiatric conditions and the associated impairment ratings tend to be more subjective than those for physical injuries.¹

A second source of widening access to actions at law has been interpretation by the courts. A critical decision, *Petkovski v. Galetti*, essentially would permit damages to be sought where a claimant has suffered a “serious consequence” of an injury, without regard to the 30-percent threshold. Similar issues have arisen under the Transport Accident Act, and the law is not yet settled here. This potential expansion of the concept of serious injury is a considerable threat to the current cost levels of the system. Leaving this decision in the hands of the court system also may not be the most effective way of dealing with the social equity and efficiency issues involved.

C-3. Consistency and Comprehensiveness of the Table of Maims

In several respects, some attention to the Table of Maims may be warranted. At least three anomalies in the table are apparent. First, the basis for rating most maims are different from those applicable to the back, neck, and pelvis. Thus, the very formula for setting a rating is substantially different for these different classes of injury. (It should be noted that Victoria is hardly unique in this regard.) A consistent approach has the virtue, at least, of being

¹We offer no judgment on the adequacy or equity of the December 1996 amendments seeking to end this practice.
understandable to persons with little familiarity with workers’ compensation benefits, e.g., an injured worker.

A second difference occurs because uniform standards have been imposed in the rating of impairments of the back, neck, and pelvis through the requirement that the *AMA Guides* be utilised. No such uniformity is imposed where a worker suffers, for example, the partial loss of use of an arm. Third, the Table of Maims does not include impairments to most internal organs. For example, respiratory impairments are not found in the Table and, therefore, benefits for permanent impairment are less likely to be provided. Combined with an update to a later edition of the *AMA Guides*, it would be appropriate to reexamine the equity aspects of the current benefit structure for maims.

C-4. Terminating Weekly Benefits

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. Thus far, it appears that the Conciliation Service has managed to arrange and conduct conferences very promptly, thereby minimising 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-5. 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 some workers that are 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 between 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-6. Payments for Maims Have Been Growing

Though many elements of the WorkCover system have been successful and have curbed the growth in costs of workers’ compensation, there are certain areas that warrant scrutiny. Payments for maims have been growing under the new system. A variety of explanations can be given for this. The effort to limit lump sum payments may be the major driver behind this development. The role of solicitors is obviously important here as well. The maim benefit, including any benefit for pain and suffering (Section 98A), is flexible enough to be used as the basis for resolving other disputes between the parties. The pain and suffering benefit is especially subjective in character. Further, a larger maim benefit can be used to reduce the incentive to seek common law damages, subject to the potential offset of the lump sum.

The WorkCover law has been able to limit the availability of lump sum payments. However, it has not been able entirely to eliminate lump sum settlements. Other jurisdictions have found that where the practice of lump sum settlements has existed, it becomes a familiar and convenient tool for the parties to use, and is extremely difficult to eradicate. Clearly these
issues need to be reexamined in the current, successful workers' compensation environment.

C-7. Problems in the Setting of Reasonable Medical and Like Fees

A variety of issues exist in the setting of reasonable fees for medical and like services. While some providers believe that the fee schedule that applies to them is too low, the VWA believes that fees have been overly generous in recent years. The Authority also contends that complaints by health care providers about delays in making payments are overblown and no longer justified. Negotiations over fee schedules have been contentious. The process of rationalizing and negotiating these fees needs examination.

Managed care has not yet arrived in Victoria, but its spread elsewhere has raised the interest of those seeking to curb health care cost growth in workers’ compensation. All told, the current period appears to be one of transition; that is, where important system changes are imminent, but their exact configuration is not clear. All parties will benefit if these changes were to materialize as part of a carefully considered package of change, with extensive public consultation, rather than emerging on a piecemeal basis.

C-8. The Medical Panels Have Been Overburdened

The medical panel scheme has been well designed and could be a highly useful source of dispute management. However, the extraordinary bulge in the workload of panels because of their use in maims disputes has exacted a price. Delays and backlogs have resulted, both in arriving at determinations by panels and in resolving disputes. It remains to be seen how these maims disputes will be resolved in the future, with or without the use of medical panels. What seems clear at this point is that the panels, as now constructed, cannot be counted on to deliver decisions in thousands of disputes yearly. That level of need inevitably raises questions about the costs and the quality of decisions, and the impact that delays have on other programme elements. It would seem more appropriate to confine the Medical Panels to areas where their expertise could really make a difference.

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2The December 1996 reforms include authorisation of a managed care scheme by the VWA.
Rehabilitation Issues (R)

Occupational rehabilitation in Victoria has a narrower and more constrained focus than in some other jurisdictions. This results in large part from the perceived excesses under the WorkCare regime from 1985-92. Accepting this reality, we find there are also a number of issues in the occupational rehabilitation area that need scrutiny.

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 towards 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, its media campaigns, and in its 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, are 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
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. Yet there is no formal mechanism to flag such a case for early intervention, nor 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 the referral of a physician to a particular treatment programme or occupational rehabilitation provider is diverted to another provider by the insurer) was widely reported. It is not documented that this practice has been detrimental to
any individual worker, but the practice is an affront to 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 Health and Safety Division (HSD) resources, 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 safety and health (OSH) matters, and firmly committed to the challenge of reducing workplace injury and disease in Victoria. The merger of HSD with VWA provides 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 the workplace sources of personal pain and suffering experienced by workers are preventable.

VWA is to be further commended on its investment in extremely aggressive and successful outreach programmes based on sound research; highlighted by 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 support of these initiatives and provided suggestions for future efforts.

P-2. Management Structure

The Divisional management count is over 40, or about 10 percent of the total staff. Within the sub-sections and area offices there also exist further management levels with titles of manager, assistant manager, supervisor, senior consultant, technical consultant, and team leader; although it is true that many of these maintain an active field role. Any future reorganisation should seek to reduce the number of managers and re-deploy resources at the field inspection or service delivery level.

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 story from employers, from inspectors and their managers, and from 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 HSD has the potential to retrofit the human resource skills needed. However, compensation levels may need to be re-evaluated 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 excessive and incompatible with a performance-based regulatory approach. This may also be true of the time reporting system used by inspectors. When field resources are spread so thinly, any such allocation of valuable inspector time seems wasteful.
P-5. Community Collaboration

The Development Taskforce 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 date certain. Consideration might also be given to assist with provision of basic OHS information, training, auditing, and inspection services by external organisations. 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.

VWA and HSD 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 may help 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. Thus, 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

Given the proliferation of new chemicals introduced into the workplace each year and the unknown long-term effects of exposures to combinations of them, the HSD requires an active worksite presence of trained industrial hygienists. HSD should consider the field deployment of hygienists as inspectors, and as vacancies arise in the field increase the number of hygienists.

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. HSD 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 (rather than 6 of 10 at present), could provide a 64 percent increase in field active time over current practice (add 1 hour per day = 14 percent, move from 6 to 9 days in every 10 = 50 percent). This is equivalent to adding 109 inspectors to the current stated complement of 170.

An added bonus will be the ability of inspectors to carry brochures, pamphlets, posters, and other information they now advise employers to obtain by calling the information officers. At present, it is unlikely that the employer remembers what to ask for if they find the time to call, and on receipt of the information they are less likely to find and fully understand the relevant sections that simply could be highlighted by the inspector while he or she has the employer’s attention.

Each inspector might also be provided with a laptop computer and portable printer. Appropriate software could be developed to provide for data entry right at the worksite to produce professional-looking, readable, and consistently-worded documents. Added benefits would include the ability to upload information to HSD’s database, as well as refer to standards, regulations, policies, and procedures on disk or via telecommunication. 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 contact with workplaces more effective and to significantly extend the inspector resource 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 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 regularise 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 wilful 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.

Conclusion

The VWA with its new responsibilities for occupational safety and health has outstanding potential to exploit the synergies between prevention, compensation, and rehabilitation. Further, the well-established VWA communication resource has the demonstrated capability to bring this vital message to the general public. The start that has been made in funding applied research also will generate new understanding of the integrated
mission of the VWA. As champion of both prevention and rehabilitation, the VWA now directs the two programmes with the largest potential to leverage financial and human cost savings in workers’ disability. We look forward to seeing how the VWA responds to this challenge over the next several years.
Appendix
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<sup>1</sup>Source - Australian Bureau of Statistics - Employment Surveys

<sup>2</sup>Maximum payment available as compensation for heads of damages as specified and indexed annually in the Accident Compensation Act

<sup>3</sup>Total payments for head of compensation divided by number of claimants in receipt of compensation during whole or part of period

<sup>4</sup>Pecuniary loss entitlement existed only after 1/12/92
### Claims

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<td>84,887</td>
<td>77,664</td>
<td>74,253</td>
<td>68,302</td>
<td>56,381</td>
<td>40,841</td>
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<tr>
<td>Weekly Benefit Claims (Claims lodged in period that have received weekly benefits)</td>
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<td>68,111</td>
<td>59,191</td>
<td>62,036</td>
<td>56,497</td>
<td>51,983</td>
<td>45,510</td>
<td>31,947</td>
<td>16,547</td>
<td>16,549</td>
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<td>16,871</td>
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<td>14,265</td>
<td>15,966</td>
<td>16,893</td>
<td>19,557</td>
<td>19,546</td>
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<td>Journey Claims and Claims&lt;10 days</td>
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<td>24,223</td>
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<td>8,244</td>
<td>2,547</td>
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<td>334</td>
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<td>239</td>
<td>249</td>
<td>183</td>
<td>134</td>
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<td>Standard Claims Reported</td>
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<td>60,437</td>
<td>55,103</td>
<td>56,917</td>
<td>55,247</td>
<td>47,966</td>
<td>38,334</td>
<td>32,981</td>
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<td><strong>Claims Payments (SM)</strong> made in period</td>
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<td>$34.7</td>
<td>$47.2</td>
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<td>$171.3</td>
<td>$172.9</td>
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<td>WorkCover Administration Costs (SM)</td>
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<td>Year</td>
<td>Total Scheme Administration Costs</td>
<td>Total Payments</td>
<td>Permanent Commission Staff (including maternity, leave without pay)</td>
<td>WorkCare Compensation Services Staff</td>
<td>Total Staff</td>
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<table>
<thead>
<tr>
<th>Year</th>
<th>Assessable Payroll ($M)</th>
<th>Average Premium Rate</th>
<th>Premium/Levy income ($M)</th>
<th>Fund (Total Assets) ($M)</th>
<th>Rate of Return on Assets</th>
<th>Net Investment Income ($M)</th>
<th>Gross Outstanding Liabilities ($M)</th>
<th>Outcome for Year (Net profit/loss)($M)</th>
<th>Funding Position (Net assets)</th>
<th>Funding Ratio (WorkCover Fund)</th>
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<tbody>
<tr>
<td>1985-1986</td>
<td>$20,831</td>
<td>2.40%</td>
<td>$457</td>
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<td>$534.7</td>
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<tr>
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<td>101.9%</td>
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</tbody>
</table>
Table A-2

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
Sue Masters, Manager, Provider Services
Eileen McMahon, Director, Corporate Affairs
Gerard Moylan, Manager, Regulation, Monitoring and Planning, Scheme Development
Tom Mullins, Manager, Actuarial and Statistical Services
Jay Peries, Acting Director, Finance and Corporate Services
Ray Perks, Medical Panels
Jane Renshaw, Manager, Serious Injury
Bronwyn Richardson, Manager, Research and Development
Marilla Rootsey, Manager, Occupational Rehabilitation, Health and Rehabilitation Branch
Marjorie Taylor, Manager, Training and Information
Teresa Testarotta, Health and Rehabilitation Branch
Peter Tibbits, Manager, Medical Panel
Paul Tipping, Senior Solicitor, WorkCover Authority
Greg Tweedly, Director, Scheme Regulation
Max Vickery, Acting Director, Scheme Development
Con Vidinopoulos, Manager, Insurance
Kerri Whitehead, Manager, Licence Management and Insurance Regulation
Dick Wright, Manager, Investigations and Compliance
Health and Safety Division

Kaye Owen, Director
Halil Ahmet, Occupational Hygienist, Technology Division
Heather Baker-Goldsmith, Manager, Country West
Cliff Ball, Acting Manager, Mechanical Engineering Unit
Greg Bird, Inspector, Preston
Bryan Bottomley, Manager, Strategy
Rod Bray, Inspector, Metro West
Phil Court, Manager, Enforcement and Public Safety Unit
George Crick, Area Manager, Traralgon
Margaret Donnan, Manager, Operations East
Cath Duane, Manager, Legislation Policy and Implementation
David Ellis, Area Manager, Metro West
Mick Fallon, Manager, Information Services
Gerry Fitzpatrick, Senior Inspector, Preston
Clare Gallagher, Manager, Information Network Unit
Ken Gardner, Manager, Minerals with Energy
Jim Giddings, Administration Manager, Western Zone
Eric Glassford, Area Manager, Preston
Heather Hall, Inspector, Mulgrave
Derrick Harrison, Manager, Operations Central
John Hickey, Area Manager, Metro Central
Klaus Hoellfritsch, Area Manager, Mulgrave
Geoff Jones, Inspector, Brambles Tanker Division
Lou Kapeller, Manager, Licensing
Lance Kenningham, Ergonomist, Technology Division
Ros Kushinsky, Manager, Ergonomics Unit
Damien L’Huillier, Manager, Western Zone
Michael Little, Manager, Planning and Review
Graeme Maddiford, Inspector, Preston Office
Trevor Martin, Manager, Central Investigation Unit
Trevor McDevitt, Manager, Dangerous Goods Coordination Unit
Dennis Noonan, Inspector, Ballarat
Barbara Palmer, Manager, Systems Unit
Garry Radley, Manager, Standards Development and Coordination Unit
Peter Rankin, Manager, Management Systems Unit
Geoff Rivert, Inspector, Geelong
Glenn Sargent, Director, Technology Branch
Harold Scanlon, Manager, Work Environment Coordination Unit
Adrian Simonetta, Manager, Technology Unit
Irena Taylor, Assistant Manager, Licensing
Peter Vacouski, Information and Systems Management Group, Preston
Sreeni Vasan, Mechanical Engineer, Technology Division
Peter Vitali, Chemist, Technology Division
Sue Ward-McGuirt, Manager, Occupational Hygiene Unit
Neil Whittington, Manager, Development Taskforce
David Wong, Manager, Plant Coordination Unit
Colleen Young, Manager, Marketing

Insurers

Craig Bakker, Underwriting Manager, HIH
Bernie Bartels, Manager, Sun Alliance and Royal Insurance
Phil Bawden, Claims Manager, Workers’ Compensation, MMI
Rodney Bond, Sales Manager, Workers’ Compensation, MMI
Bruce Bowlby, General Manager, HIH
Trever Collette, Key Account Manager, GIO
Rayphe Collins, Manager, Risk and Rehabilitation, GIO
Peter Daly, Chief Executive, Insurance Council of Australia
Paul Eastman, Operations Officer, Mercantile Mutual
David Eggar, Chief Manager, QBE Workers’ Compensation Ltd.
Barry Ellis, Managing Director, HIH
Donna Evans, Medical Case Coordinator, HIH
Linda Evans, Injury Management Team, FAI Workers’ Compensation Victoria
Stephen Grant, General Manager, GIO
Ivan Handasyde, National Workers’ Compensation Manager, NZI Insurance
Michael Heagerty, Operations Manager, GIO
Leonie Higginbotham, Rehabilitation Advisor, GIO
Hilary Kerrison, Client Services Manager, GIO
Paul Kitch, VACC
Greg Lackman, Marketing Manager, HIH
Barry Lindgren, Manager, Victorian WorkCover, MMI
Stephen Loomes, Acting Manager, Workers; Compensation, MMI
Victoria Martin, Manager, National Workers’ Compensation, Catholic Church Insurances Ltd.
Glenda McCartney, Injury Management Team, FAI Workers’ Compensation Victoria
Peter McDonald, GIO
John McGuinness, Marketing Development Manager, Sun Alliance and Royal Insurance
Gary McMullen, Claims Supervisor, HIH
Tony Newlands, General Manager, Sun Alliance and Royal Insurance
Shane O’Dea, Manager of Work Safety, VACC
Andrea Own, Technical Services Manager, GIO
Mike Papuga, Administration, Premium, Credit Manager, Sun Alliance and Royal Insurance
Steve Regester, Conciliation Manager, GIO
John Schultz, Rehabilitation Manager, NZI Insurance
Lorraine Stabey, Rehabilitation, NZI Insurance
Cathy Thorne, Manager, Small Business Division, QBE
Dennis Trafford, National Manager, Workers’ Compensation, Insurance Council of Australia
Alan Whitehead, Business Development Manager, VACC
Susan Wiegel, Senior Claims Officer, HIH
Bruce Willey, Manager, Key Clients Division, QBE
Susan Wischer, Manager, VACC

Employers and Representatives

Trevor Armstrong, Manager, Corporate Services, Manufacturing, Engineering, and Construction Industry Association
Nan Austin, Safety Manager, University of Melbourne
Val Barry, Human Resources Officer, DuPont Fibres Bayswater
Rosemary Bavaresco, Manager, WorkCover, Amcor, Ltd.
John Bridge, Manager, Occupational Health, Safety and Welfare, Phillip Morris Ltd.
Malcolm Brown, Manager, Health, Safety and Environment, Shell Australia
Vanessa Castle, Senior Consultant, Safety, Health and Environment, Victorian Employers’ Chamber of Commerce and Industry (VECCI)
Illona Charles, Safety Manager, Australia National Bank
Joanne Clancy, Group Manager, Qantas Airways Limited
Sandra Cowell, Australian Chamber of Manufactures
David Edwards, CEO, Victorian Employers Chamber of Commerce and Industry (VECCI)
Sue Forsyth, Occupational Health and Safety Coordinator, Holeproof
Tony Graham, Unilever Corporation
Peter Greer, Director, Greer Industries Propriety Ltd.
Sandy Hamilton, DuPont Fibres Bayswater
Prue Hardiman, Health and Safety Coordinator, Royal Children’s Hospital
Brian Hope, Manager, National Workers’ Compensation and Risk Management Services, Coles-Myer Ltd.
Joe Jurisic, Manager, Human Resources, Nippondenso
Warwick Koochew, Manager, Workers’ Compensation, Mayne Nickless, Ltd.
Sid Levett, Group Insurance and Risk Manager, Amcor, Ltd
Elizabeth McFail, Manager, Health and Safety, Royal Children’s Hospital
Colin McLean, Senior Consultant on Safety, Health and Environment, Victorian Employers Chamber of Commerce and Industry (VECCI)
Larry Meager, Manager, Safety, Employee and Environment, Transfield Tunnelling
Liz Menwood, Chairperson of Southeast WorkCover User Group, Southcorp
Richard Russell, Division Manager, Safety, Health and Environment, ICI Australia
Laura Sillitto, Manager, Claims Management, Coles-Myer Ltd.
Jim Smith, Plastics and Chemicals Industry Association
John Smith, Senior Counsellor, Australian Chamber of Manufactures
Graeme Suckling, Risk Manager, University of Melbourne
Ian Swann, Plastics and Chemicals Industry Association,
Seyram Tawia, Manager, Safety, Health and Environment, Victorian Employers Chamber of Commerce and Industry (VECCI)
Anne Taylor, Metal Trades Industry Association
Geoff Thomas, Manager, Human Resources, Thiess Contractors, P/L
David Trenerery, Director, Employee Relations, Shell Australia
Karen Wild, National Manager, Occupational Health and Safety, Australia National Bank
Ivan Wilson, Kemcor
Graeme Wishart, Manager, Occupational Health and Safety Projects, Coles-Myer Ltd.

Conciliation Service

Peter Jackson, Director, Conciliation Service
David Bryson, Conciliation Service
Richard Green, Senior Conciliation Officer, Conciliation Service
Fay Yule, Conciliation Officer

Unions

Mick Avent, Australian Education Union
Dr. Yossi Berger, Director, National Occupational Health and Safety, Australia Workers’ Union
Graham Burgess, Transport Workers Union
Gayle Burmeister, National Union of Workers
Thea Calzoni, Victorian Trades Hall Council
Gary Cameron, Trainer, Victorian Trades Hall Council, Occupational Health & Safety Training Unit
Helen Casey, Divisional Branch Secretary, Australian Liquor, Hospitality, and Miscellaneous Workers Union
Judith Edwards, Australian Nursing Federation Injured, Nurses Support Group
Gwynnyth Evans, WorkCover Project Officer, Victorian Trades Hall Council
Sue Fuller, Australia Manufacturing Workers’ Union
Leigh Hubbard, Secretary, Victorian Trades Hall Council
Peter Kelly, President and Occupational Health and Safety Officer, National Union of Workers
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A-8
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