REPORT ON THE REVIEW OF WORKERS' COMPENSATION IN TASMANIA

FEBRUARY 2004

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WORKERS' COMPENSATION REVIEW

TERMS OF REFERENCE

The Workers' Rehabilitation and Compensation Amendment Act 2000 (the Amendment Act) was the culmination of a long process of consultation and evaluation over the policy options.

The aim of the Amendment Act was to balance the social and economic objectives of the system. The key objectives designed to meet this aim were: firstly, to make the system more efficient and affordable, bringing its costs into line with other States; secondly, to provide greater income security to injured workers; and, thirdly to improve prospects of rehabilitation and return to work.

An essential feature of the workers compensation scheme introduced in the Amendment Act is restriction of access to Common Law which is fundamental to achievement of the key objectives and does not form part of this review.

It is intended to conduct a broader review of the legislation upon conclusion of the present national matters in hand, which may impinge on the operation of the scheme. These comprise the Productivity Commission's inquiry into National Workers' Compensation and Occupational Health and Safety Frameworks and the additional developments noted in paragraph 4 of the Productivity Commission's terms of reference as appended.

While this review is therefore confined to examining unintended consequences of the benefits model, it will also identify matters for consideration in the subsequent broader review.

In light of this background, the Terms of Reference for this review are as follows:

1. While retaining the essential features of the workers' compensation scheme noted above, review and make recommendations on:

    - whether and to what extent the benefits model is resulting in unanticipated hardship;

    - whether in any other way the operation of the benefits model is resulting in outcomes at variance with the key objectives; and

    - any matters where legislative change or administrative action would improve the operation of the model.

2. To report and make recommendations on any matters of a minor legislative or administrative nature which would improve the efficiency of the scheme with respect to the key objectives.

3. In the course of addressing Terms 1 and 2, identify and make recommendations with respect to any issues that should inform the State's deliberations with respect

to those matters which should appropriately be considered in a broader review of the legislation.

The Review considered written submissions from more than thirty stakeholders and included widespread face to face consultation with injured workers as well as representatives of key stakeholder groups and local and interstate workers' compensation authorities.

EXECUTIVE SUMMARY

BACKGROUND

In response to escalating costs in workers' compensation in Tasmania, several waves of legislative reform have occurred over the past decade. The most recent suite of reforms to the *Workers' Rehabilitation and Compensation Act 1988* were passed in 2000 and implemented in July 2001. The changes were strongly influenced by a number of factors, including concern about the affordability of the scheme and the impact on Tasmania's economic position relative to other states and questions from some community groups about the fairness of the 2000 reforms for workers. The changes were also strongly informed by the findings of a national research project conducted by the Heads of Workers' Compensation Authorities (HWCA)[1] and a local inquiry undertaken by the Joint Select Committee (JSC) of Inquiry into Tasmania's Workers' Compensation System[2]. The critical matter of benefit reform, however, was one area that the JSC was unable to agree on, necessitating a further fifteen months of extensive consultation before the amendment package was passed by Parliament.

RATIONALE FOR THE REVIEW

The amendments principally represented a significant trade-off between the introduction of relatively generous, no-fault, without prejudice benefits under the statutory scheme, and the restriction of access to common law action to all but the most seriously injured workers. Authorities and experts in the field agree that it is far too early to evaluate the effectiveness of the recent reforms. However, a number of individuals and community groups have claimed that some of the recent changes — most notably the step down provisions in weekly benefits — may be causing serious hardship for workers. Clearly, this was not what the Government intended when it introduced the reforms two years ago.

As a consequence, the Minister for Infrastructure agreed to a review of the legislation, but with a principal focus on the current benefits model, particularly the structure of weekly benefits. Given that a number of national inquiries were underway, the Minister also felt that the review should also identify significant issues for consideration in a broader review of the legislation in the future, after the findings of the national developments were known.

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[1] HWCA (1996), *Promoting Excellence: National Consistency in Australian Workers' Compensation,* Report to the Labour Minister's Council

[2] JSC (1997), *Inquiry into Tasmania's Workers' Compensation System,* Report of the JSC of Both Houses

FINDINGS AND RECOMMENDATIONS

Term of Reference 1

A common feature of the statutory schemes in all Australian jurisdictions is an attempt to underpin the no-fault basis of the scheme with a non-adversarial structure which will drive the culture change necessary for superior outcomes. The aim is to balance a decent level of income support, including appropriate incentives to rehabilitation and return to work, against cost.

It is my belief that the Tasmanian structure is, on balance, at least as generous as the schemes operating in other States, when other features of those schemes are taken into account. Our scheme keeps injured workers 'whole' for thirteen weeks, does not apply weekly benefits caps which, in effect, operate as a step-down for higher income workers, or a dollar cap on total benefits, features a relatively long benefit entitlement period, and importantly, provides for mandatory 'without prejudice' weekly payments for workers upon claim lodgement. For most workers, the system serves them extremely well. However, there are particular issues which pertain to the small group of more seriously injured workers in the scheme who require longer-term support. These issues related to the application of step-downs to weekly benefits paid to the injured worker.

I found no evidence of any major problem with the first step-down which reduces the level of the injured worker's weekly benefits to 85 per cent of normal weekly earnings (NWE). There was general acceptance among stakeholders that it serves as an important incentive to return to work and is manageable in terms of the worker's ability to readjust expenditure to suit the changed circumstances.

However, I am convinced that the operation of the second step-down to 70 per cent of NWE is resulting in unanticipated hardship. The reduction of 30 per cent appears to go over an invisible domestic affordability threshold. That is, it impacts on the ability of most households to absorb the change through reduced expenditure without looking to dispose of significant assets and associated obligations. In particular, I was disturbed to learn that a substantial proportion of the relatively small percentage of workers who end up exposed to the second step-down are facing the prospect of selling the family home. Given that households adjust their asset holdings, including the family home, to their level of income, this is not simply a problem for the lowest paid.

I am also very concerned that a step-down of this magnitude may be a significant incentive for the worker to seek a cash settlement in order to secure sufficient funds to avoid the need to sell the home. By shifting the focus to one of seeking a lump sum settlement, it risks reintroducing incentives to exaggerate injury and lack of capacity as a means of improving the bargaining position with the insurer. In addition, the financial and emotional pressures may result in workers accepting settlements without looking sufficiently ahead and considering the long-term consequences.

From the perspective of an injured worker trying to comply with a return to work program, manage a serious injury and deal with a major reduction in living standards, the 70 per cent appears to be less an incentive and more a double punishment. I

believe its perceived harshness undermines support for the no-fault nature of the scheme and its quid pro quo philosophy. This has led me to the view that the second step-down should either be made significantly less stringent or abolished altogether. My analysis also led to the view that if the cost of the change needed to be offset then a reduction of the maximum term of entitlement is the best option.

In arriving at my recommended option for addressing the problems with the second step-down, I sought actuarial advice to assess the likely impact of various changes on scheme costs, and importantly, on premium rates. Given the centrality of affordability to the purpose of the previous amendments I was looking for the best option for both injured workers and employers which would not interrupt the likelihood of achieving the cost target set for the reform package: that is, an average premium rate of no more than 2.75 per cent of wages.

Based on the actuarial analysis, I am of the view that there is a sufficient margin of safety in the predicted cost estimates to reduce the size of the second step-down without the cost offset of reducing the entitlement period. I therefore recommend that the benefits model be amended with the level of the second step-down increased to 80 per cent, while retaining the ten-year maximum period of entitlement.

The safety net will be of less relevance and should be retained but the opportunity should be taken to deal with an anomaly. I recommend that the legislation be amended to remove the possibility that the present working of the safety net may mean that an injured worker previously on a training wage may be made better off on benefits.

Issues were raised with me over inconsistent application of the step-downs to partially incapacitated workers both in respect of the wage base to which the step down is applied and aggregation of the time period. While the first may be occurring through misinterpretation, I recommend that the WorkCover Tasmania Board investigate whether there are errors in interpretation occurring with regard to how stepped-down payments should be calculated for workers with partial incapacity or whether the legislative provision needs to be clarified. With respect to the second issue, in my view the elapse of calendar time, not aggregation of the effective period of time lost from work, is closer to the overall intent of the incentive structure. I recommend that provision 69B in respect of the aggregation of the period of incapacity in relation to the step-downs be amended to clarify intent.

Term of Reference 2

In addressing my second Term of Reference, I have looked at those matters I believe require attention to improve the workings of the existing scheme, irrespective of the outcome of the examination of broader issues that is occurring nationally. I have also been conscious that the WorkCover Tasmania Board has ongoing functions under Section 10 of the Act including making recommendations to the Minister on amending legislation and reporting on its effectiveness. In what follows, I have therefore distinguished between matters raised which merit a clear recommendation from this review, and those which I believe should be referred to the Board for further consideration. Given the centrality of dispute resolution to the critical worker-employer relationship, I have in particular examined Tasmania’s dispute resolution

system (DRS) at length. While there are strong natural incentives to maintenance of the relationship, when a serious injury occurs it comes under significant stress. We need to reinforce the incentives and cultural attributes which can sustain it.

Early Reporting

Early reportage of injury can be very important to rehabilitation and could be improved. The role of the employer excess was raised with me as a potential cause of under reporting. On the other hand there is an argument for the excess as an incentive to good occupational health and safety systems. It may also be that there is fear that reportage will strongly influence experience rating and flow through to a significant impact on the premium. Under reporting could occur because business, particularly small business, may not understand the principles of premium setting by insurers. Businesses may attempt to 'manage' through injuries they believe to be relatively minor, for instance, by resting a worker. ‘Flags’ for more serious adverse outcomes, that would be identified in reportage to an experienced insurer, might not be picked up.

It would seem desirable that market insurers, in consultation with the WorkCover Tasmania Board, should ensure that participants are educated in the principles of premium setting. In conjunction with removing the impediments to early intervention by insurers this may help drive a culture of early reportage.

In the future it might be appropriate to adopt elements of the approach being tried in the ACT, which has mandated early reportage of injury, once firm evidence of effectiveness becomes available.

Handholding

In many of the discussions I had, it was agreed that while large employers are likely to have significant experience in the area of workers’ compensation and be well informed over the processes that need to be followed subsequent to injury, this is not the case with individual workers and unlikely to be the case with smaller employers. Training of smaller employers and education of workers was suggested to increase understanding of their rights and obligations in the area of workers’ compensation and injury management. Given the low probability of injury for the individual worker and, similarly, that a small business will experience frequent claims, I cannot see there is significant incentive for either party to seriously invest in learning the details of the scheme before an accident. I suspect processes to support workers and small business after an injury has been incurred would be more cost effective. While I am not prepared to propose this as a solution effect at this stage, I recommend that the WorkCover Tasmania Board examines the value, from a cost-benefit basis, of funding appropriate parties to provide separate information services to support injured workers and small business after an injury has occurred.

Alternative Duties

In recognition of the value of workplace-based rehabilitation, all Australian jurisdictions place an obligation on the employer to provide suitable alternative duties for injured workers for a specified period of time. Finding alternative suitable duties

which are meaningful to the worker and the workplace is not always easy, particularly for small businesses with a narrow range of roles. In such case, rehabilitation providers will seek to place the worker in other workplaces. There are a number of difficulties in persuading an employer to take on an injured worker with another employer, for example, legal difficulties which arise if the injured worker aggravates the prior injury in the new workplace, which will be treated by the legislation as a new injury and often covered by another insurer.

Some states, including Tasmania, make provision for a ‘second injury scheme’ to offer incentives for host employers, such as indemnity against aggravation of prior injury, training and allowances and premium exemptions. This has not yet been implemented in Tasmania. Given the intent of 2000 legislation with respect to the shift to long term income support and rehabilitation, and recognising the problems for vocational rehabilitation, particularly for small business in the State, I recommend that the WorkCover Tasmania Board investigate the implementation of the second injury scheme already provided for in the legislation.

Dispute Resolution

Effective disputation systems must focus on the prevention of disputes. Internal review of the primary decision by the insurer to reject liability for a claim – which usually involves reconsideration of the dispute decision by a more senior claims manager – is an important first stage for better practice primary decision-making. (TMS, *Resolving Disputes* 1995, p68) At present there is no formal requirement for insurers to internally review claims decisions, although I heard from several insurers that the process was company policy. Given the critical importance of quality decision-making at this stage, I recommend that an internal review requirement be included in an insurer developed Code of Conduct. Failing this the WorkCover Tasmania Board could consider including ‘internal review processes’ in the performance standards for licensed insurers.

The 2000 reforms formalised an ongoing shift in emphasis to alternative dispute resolution (ADR), which focuses on informal, non-adversarial processes for resolving disputes. Conciliation was given much more support in the legislation, which appears to be improving dispute resolution outcomes generally. For a number of reasons, including the complexity of the scheme and dispute resolution system and a lack of detailed understanding among injured workers, employers and even union advocates, there is a heavy reliance on legal representation. The recommendations made here are aimed at creating a less adversarial process.

Despite the provision in the Act for full disclosure at conciliation of information to be relied on in subsequent hearings, there has been reluctance among some parties to comply with this requirement. The Tribunal has recognised that it can use its processes to assist compliance and has committed to taking steps to this end. I recommend that the WorkCover Board monitor and support the steps being taken by the Tribunal to ensure the full disclosure of information during the conciliation phase that will relied upon in arbitration.

Medical issues are a significant source of disputation and can be referred to a medical panel for resolution under the Act. Although the provision for medical panels has

been in the Act since 1988, in practice, they have been used rarely in Tasmania. The Tribunal has acknowledged that the opportunity to refer a matter to a medical panel has not been recognised at an early enough time during conciliation. It has committed to the early identification of 'medical questions' for subsequent referral, where appropriate. I strongly support this move and recommend that the WorkCover Tasmania Board monitors and supports the steps being taken by the Tribunal to ensure the early identification of medical questions and referral to medical panels.

The definition of a 'medical question' is very restrictive. According to the Act, a medical question is one that directly relates to the existence, nature or extent of an injury, the level of impairment or a worker's capacity for work. Questions regarding what is reasonable medical treatment are not included and therefore cannot be referred to a medical panel. I am strongly of the view that in the interests of early intervention, questions regarding medical treatment should, in certain circumstances, be referrable to a medical panel. I therefore recommend that:

- the definition of 'medical question' be expanded to include questions regarding 'significant medical treatment';
- a definition of 'significant medical treatment' be developed and incorporated into the legislation to enable the Tribunal to effectively screen matters for referral to a medical panel;
- processes be developed to ensure medical panels can be invoked promptly once a referral has been made; and
- the provision under section 77 of the Act – which allows the Tribunal to determine prospective questions regarding medical or rehabilitation services – be promoted to encourage its application in conjunction with the early referral of significant matters to a medical panel.

It is my view that the p*rocess* for disputing medical treatments could also be improved. In 2000, Section 77AA was introduced with the aim of simplifying and speeding up the process by which these expenses would be paid and reduce unnecessary disputation. The number of these disputes, however, remains significant, given the majority relate to a more significant dispute on fundamental issues of entitlement to workers' compensation generally. There is therefore little prospect of resolving these disputes individually, as they usually become subsumed by the broader issue associated with the claim. I also heard reports that repeated disputation over successive individual expenses was a substantial source of stress for injured workers. Several injured workers even claimed that employers and insurers were using the process vexatiously to 'wear them down' prior to offering unreasonably low settlements. While I am not asserting the latter is in fact the case, I am convinced that the situation causes undue stress for workers and an often unnecessary administrative burden for the Tribunal. I therefore recommend that the procedure for dealing with Section 77AA medical disputes be replaced by a process whereby the Tribunal make an Interim Order to relieve the employer/insurer of liability in respect of a particular account, a type or group of accounts, or all accounts with respect to treatment.

The processes around the initial decision to accept or dispute liability for a claim were the focus of much criticism from stakeholders during the review, warranting

significant attention in my investigations. As an introduction to my discussion, I note that I found the provision for compulsory without prejudice weekly payments in itself is a strength of our scheme which appears to be strongly supported by all parties. I note that the without prejudice payments provision does not include payments for medical treatment, which might include important diagnostic and treatment services. Where liability for a claim is not finalised quickly, injured workers may not be able to access the medical services they need as part of what is referred to as 'early intervention'.

I was pleased that several insurers I spoke to indicated that generally they do pay for medical expenses, regardless of the status of the liability decision. I am not aware of the extent of this practice across all insurers, but I can see the potential for some workers to be denied important medical interventions where questions around liability exist. In an ideal world, I would suggest that without prejudice payments be extended to include medical expenses. However, this would represent a major change to the scheme and I am sensitive to the difficulty of predicting the cost implications of the combination of recommendations in the area of dispute resolution. At this stage I therefore think it prudent to take a more moderate approach and harness natural incentives. I recommend any capacity to voluntarily engage in without prejudice intervention be taken advantage of by:

- encouraging the provision of without prejudice medical interventions, through for example, the industry developed insurer Code of Conduct;

- investigating and addressing any potential legal or administrative obstacles arising from the above recommendation which might prejudice the insurers' position regarding any subsequent liability dispute; and

- enabling the Tribunal to make an interim order for a medical expense to be paid in exceptional cases, where a medical practitioner deems that failing to provide the service would have a significant negative effect on the worker's health or employment outcomes; and the treatment meets specified criteria, for example, relating to cost.

Initial liability disputes

It was brought to my attention that the provision (Section 81AA) allowing recovery of overpaid benefits from a worker's sick leave may be interpreted by some insurers as permission to deduct overpayments from *future* sick leave entitlements. I believe that the legislation was that overpaid benefits only be deducted from a worker's existing sick leave balance available at the time that the overpayment is identified. On the subject of the re-crediting of sick leave deductions in the event of a dispute being subsequently quashed, the Act is silent. In my view, it is important that payment recovery through sick leave entitlements is reciprocal.

The employer's initial decision to accept or reject liability for a claim is of critical importance for employers and workers. For the worker, it signifies, among other things, the perceived validity of their injury, their value as a worker and a measure of the employer-worker relationship. For the employer, the significance of the initial decision relates to two factors. Firstly, a dispute at this point in time (under Section

81A of the Act) triggers a fundamental shift in the burden of proof to the worker. If the Tribunal finds that a 'genuine dispute' exists, payments cease, and the onus is on the worker to prove his/her initial entitlement to workers' compensation via the Tribunal procedures for general disputation. Secondly, failing to dispute liability within 28 days represents, by default, an admission of liability by the employer. As a result, historically there has been a tendency for employers/insurers to dispute liability in order to protect their position while considering the issues.

I was very concerned with the process by which a dispute of initial liability for a claim must be made. Close examination of the process highlighted a number of serious problems which are contributing to inefficiencies and inequities with the system. Most notably, the timeframe for the initial decision to dispute liability is too short, often forcing a Section 81A dispute to be lodged before the employer or insurer has obtained the information it needs to finalise the decision. As a consequence, many of these disputes are withdrawn prior to a hearing, or lodged with requests for hearings to be delayed for long periods, often months. The worker continues to receive without prejudice payments until a hearing occurs and the dispute found by the Tribunal to be 'genuine'. Any sign of disputation can severely damage the employer-worker relationship and subsequent outcomes, therefore quality decision-making is extremely important at this stage in the claim.

Once Section 81A disputes reach a hearing, the Tribunal must determine whether a 'genuine dispute' exists. At present, the threshold for what constitutes a 'genuine dispute' is very low, due to a precedent set by the court. Given that a genuine dispute finding has serious consequences for the injured worker – that is, weekly payments are ordered to cease and the burden of proof for liability shifts to the worker – I believe it is essential that the Tribunal be in a position to apply a reasonable test based on appropriate evidence.

Despite provisions in the Act to encourage open and effective communication between the employer and the worker in the event of a dispute over liability, the process remains highly impersonal and adversarial. I heard many reports from workers that there was little, if any, communication with the employer, that they did not understand the reasons for the dispute. As a result, the experience was extremely stressful and many workers feel confusion and anger at being left 'in the dark' and disadvantaged by the process. I believe that the longer timeframe for making the liability decision will allow employers and insurers to research liability questions thoroughly and, as a consequence, communicate the precise reasons for disputes to workers in plain English. The Tribunal's commitment to raising awareness and understanding of the disputation process will also help alleviate the stress evident among both workers and employers when a dispute arises.

Workers' compensation legislation is highly complex and implementing significant change brings considerable risk. I am acutely aware of the myriad interconnections and complex relationships between the broader scheme design and the dispute resolution system, which, when considering change, introduce additional risk. In my view, simple fixes should be considered against major reengineering. Under this term of reference, I recommend a suite of adjustments to the existing system which I believe should redress the issues of inequity and inefficiency:

- Section 81AA to be amended to clarify that overpaid benefits may only be deducted from a worker's *existing* sick leave entitlements, available at the time that the overpayment was identified;

- The legislation be amended so that where overpayments have been recovered from a worker's sick leave but liability is later found to rest with the employer, the employer must restore the deducted sick leave entitlements;

- The time limit for employers to decide initial liability and therefore make without prejudice payments be extended to 12 weeks;

- The WorkCover Tasmania Board to monitor the timeframes for scheduling genuine dispute hearings in the Workers' Rehabilitation and Compensation Tribunal to ensure delays are not occurring;

- Formal processes for internal review of all liability decisions be incorporated into an insurer developed Code of Conduct;

- The Tribunal be empowered to apply a more stringent test for what constitutes a genuine dispute, namely, whether a prima facie case has been made that there are reasonable grounds for dispute;

- All Section 81A referrals must be lodged with sufficient information to support a prima facie case;

- The WorkCover Tasmania Board to consider what steps can be taken to facilitate better communication between the employer, the insurer and worker during disputation, particularly in relation to the initial liability decision; and

- A coordinated approach to all scheme communications, including those relating to dispute resolution, activities be undertaken under the direction of the WorkCover Tasmania Board.

Given that a broader review of the scheme is likely when the legislation has matured, I offer for future consideration a more radical approach under Term of Reference 3 for future consideration, should this prove necessary.

Settlements

In 2000, access to common law damages was restricted to only the most seriously injured workers through the introduction of Section 138AB. As I understand, it was assumed that this measure would also prevent lump sum settlements by agreement – as distinct from redemptions or commutations of statutory benefits – accompanied with a common law deed of release. There appear to be differing views as to whether the legislation is effective in placing any requirements on these voluntary agreements. However, under Section 39 of the Act, the legislation is quite restrictive in the constraints it imposes on 'settlements by agreement'. The injury must be stable and stationary and twelve months must have elapsed since the claim was lodged.

It is difficult to assess whether the intent of the legislation is being undermined due to the relative immaturity of the provisions and limitations in the data available on

settlements. However, I think it critical that the legislative intent with respect to lump sums, as expressed in the restrictions under Section 39, is respected. It has been brought to my attention that the requirements of Section 39 have been ignored by some insurers. While the incidence may be small and even the result of a calculated judgement on the part of the worker, in my view this is not good enough. The community has the right to expect that insurers will comply with the restrictions. The point of the settlement conditions is to ensure all parties are focused, in the first instance, on rehabilitation and return to work.

Workers drew my attention to the perception that they were in a very poor bargaining position in the negotiation process regarding settlements. One of the contributing factors appears to be the pressure that can emerge around the current second step-down, which occurs around the same time as the settlement restriction is lifted, one year from the date the claim was lodged. I also heard reports of rehabilitation providers being involved in the settlement process, which to my mind, represents an obvious conflict of interest. Insurers must therefore commit to a clear separation of roles or it will be necessary to invoke regulations or licence conditions to ensure this is the case. An additional complaint directed at insurers was that they were using administrative nuisance tactics to ‘soften the worker up’ to accept a settlement offer. I would like to think that these things, if they do occur, are unfortunate exceptions. However, there appear to be no protections in place to prevent their occurrence.

I do not think it appropriate at this time to propose legislative change with respect to settlements. I note that the changes I am recommending to the benefits model should relieve some of the financial pressure, placing the worker in a position to take a more considered and empowered approach to settlements. In addition, there is insufficient experience with the pattern of settlements to draw firm considerations with respect to how the objectives of the scheme are being served. This is a matter for later consideration. However, I believe it is essential that insurers commit to observing the restrictions intended by the legislation. In addition, they should be given time to consider what elements of fair dealing should be appropriately contained in a Code of Conduct. Legislative controls, of course, remain an option should an effective Code not be developed.

I recommend that licensed insurers be given the opportunity to develop a Code of Conduct which clearly respects the intent of the legislation with regard to settlements and contains appropriate commitments to fair dealing and avoidance of perceptions of conflict of interest. This should be monitored by the WorkCover Tasmania Board with a view to enforcement through licence conditions or other means, if ineffective.

Term of Reference 3

While this review was underway, the Productivity Commission released its Interim Report. Much of the discussion has informed my findings under the first two terms of reference. I note also that, if the final report of the Productivity Commission is as ringing in its endorsement of the fundamental features of the Tasmania scheme, this may cast doubt on the value of proceeding with a major broad review in the medium term. Nevertheless, I have identified a number of matters which I believe should inform any future review process.

The Philosophy of Injury Management

Legislative changes made in 1995 included the insertion of a section on rehabilitation and the renaming of the Act the *Workers' Rehabilitation and Compensation Act 1988* to reflect the new focus. More recently, the objective of rehabilitation has become subsumed into a broader, integrated approach to facilitating recovery and restoring the worker to the workplace terms 'injury management'. It is apparent to me that there is still much to do in the Tasmanian scheme to build an holistic focus on injury management. Critical to this task is an understanding of what we are really trying to do.

The considerable common ground on injury management among the participants in the scheme needs to be developed into a coherent philosophy. I was acutely aware from my discussions that the injured worker encounters a number of different agents with substantially different 'voices' as he/she navigates the system. At best this can be confusing. At worst, it can lead to antagonism between the parties and a lack of commitment to the scheme and its principles. There are valuable lessons to be learned from the sporting analogy, which vividly illustrates the superior outcomes that result from a coordinated team approach, whereby the shared motivation drives trust and commitment.

However, I do not believe we should seek to divest the agents of their independence. While congruence in terms of voice and motivation is indeed fundamental, in a market-driven scheme such as ours, I believe the independence of the various agents is important for ensuring balance. In my view it is precisely in a privately underwritten scheme that we can harness this underlying tension in a creative way. Tension between the checks and balances and the harmonious voices gives the scheme its dynamism. I recommend that a future review have as a principal focus ensuring a coherent injury management philosophy is developed and that the accreditation of and incentive structure be refined to drive its ownership by all involved.

Access to Common Law

The interim position put forward by the Productivity Commission and currently enshrined in the Tasmania legislation is that common law access should be restricted to the more seriously injured workers, subject to meeting a minimum impairment threshold. However, a critical argument put to me during my review was that the existence of access to common law was an important and powerful incentive for employers to pay greater attention to workplace health and safety procedures. While the Productivity Commission concluded in its Interim Report that empirical studies do not support this, representations made to me questioned the data and evidence upon which such a position would be based. In this context, I can only urge any party that can provide persuasive evidence of a powerful incentive effect from common law to use the period prior to the final report to make this point clear.

Perhaps the greatest advantage of the common law approach is that it caters for individual circumstances, unlike statutory schemes, which must deal in averages or the standard set of circumstances. However, it is also costly and adversarial and therefore inimical to the values that underpin a no-fault statutory scheme.

An important issue raised by the Productivity Commission is that common law may provide workers with a sense of vindication through legally establishing fault for their injury . However, it should not be beyond the design of the legislation to ensure that action is taken against the negligent employer through other legislative channels. The worker could then be made aware that action was in fact taken as a consequence of the employer's breach. This touches on some very broad issues with respect to the relationship between workers' compensation legislation generally and the suite of legislation which governs occupational health and safety.

On the basis of the Commission's Interim Report, I recommend that a future review address itself only to any final national recommendations on common law access which are at variance with the present Tasmanian situation.

Scheme Access and Coverage Issues

In a dynamic economy structural change will occur in rapid response to opportunities that offer lower costs. Australian jurisdictions have relied on a common law definition of worker as this offers a flexible instrument which can be interpreted by the courts as circumstances change. More prescriptive definition of what constitutes a worker may result in the rearrangement of relationships in order to avoid the consequences of the legislation.

The essence of the common law approach lies in the nature of the relationship between the employer and the worker in terms of control. A contract between the parties is a contract *of* service because the employer exercises control over how the work is carried out, and a contract *for* service where it is delivered under the independent control of one party to another.

While at this level the difference is simple, in practice it can be exceedingly complex to determine whether a worker is a worker or an independent contractor. It seems to me important to be clear as to the purpose the common law definition serves in workers' compensation legislation. The point is surely to assign the costs of the system to those parties who control the risk environment in which the work takes place. A contract of service is a proxy for the degree to which those risks are outside the individual's capacity to control or manage, and are indeed within the capacity of the employer to control or manage.

I note that the Heads of Workers' Compensation Authorities report of May 1996 made the point that the common law is worked out from case to case and it is desirable to express the principles which flow from the common law cases in statutory form. I do not think that at this stage any more can be done than provide a watching brief on the role of the changing relationships in the use of contractors, and try to ensure the courts are not inhibited by statutory provisions from looking behind the written relationships to the fundamental relationship in determining employer or worker status.

I recommend that a future review examine whether the changing working relationships in the Tasmanian economy have implications for the principles governing coverage in the Tasmanian legislation.

Dispute Resolution – Initial Liability Dispute Resolution Process

Under Term of Reference 2, I discussed in detail problems identified during the review in relation to the dispute resolution system, most notably, the processes for resolving initial liability disputes under Section 81A of the Act. Bearing in mind the complex relationship between scheme design and dispute resolution and the risk associated with making major changes in several areas, my recommendation focused on fine-tuning the existing processes. However, because the initial liability disputation process can be critical to injury management and the current problems are significant, under this term of reference I offer my ideas for more radical change for consideration later in a broader review.

If significant problems with the process persist, it may be necessary to abolish Section 81A altogether and revise several related provisions. Under a reengineered process, I would expect the proposed extended period for without prejudice payments to continue and employers to refer initial liability disputes to the Tribunal with sufficient information to make a prima facie case for reasonable grounds for dispute. I would, however, suggest that the Tribunal be able to order whether payments to the worker should continue or cease. The burden of proof would also rest with the employer throughout, and, if reasonable grounds for dispute were found to exist, the Tribunal would initiate a conciliation conference as a matter of urgency.

I recommend that there be monitoring of the effectiveness of fine-tuning the dispute process with a view to looking again in a broader review if the changes are ineffective in reducing disputation.

Secondary Psychological/Psychiatric Injury

The exclusion of secondary psychiatric or psychological injury from impairment assessment was introduced in Tasmania in conjunction with the restrictions on common law access. This followed similar moves in other states which were seeking to retain the integrity of common law thresholds. This appears to be partly in response to apparent attempts by injured workers to claim relatively minor secondary psychiatric symptoms to ‘bump up’ their impairment assessment to the required level. It also seems to be based on the awareness that many relatively ‘healthy’ people might measure similarly low levels at various times in their lives and the subjectivity associated with both experience and assessment.

The argument was put to me that such exclusion is based on outmoded mind-body dualism and is inconsistent given that symptoms arising from secondary physical injury are not excluded from impairment assessment. At least part of the problem appears to be that it my be undesirable to exclude serious secondary psychiatric/psychological injury, but we want to avoid incentives to ‘gaming’ through the exploitation of greater subjectivity in assessment.

This is clearly an issue for all schemes and the situation may become clearer nationally. I recommend that a future review critically examine the rationale for exclusion of secondary psychiatric/psychological injuries.

Policies, Premiums and the Anti-Discrimination Act

During the course of my review I heard representations that in order to minimise their exposure to risk, insurers may require employers to provide information about their employees' workers' compensation histories and charge higher premiums accordingly. It was put to me that employers, in response to their insurers' requirements, may be requiring workers and prospective employees to disclose their workers' compensation histories and where there is such a history, they avoid hiring these people. The claim was that that both the disclosure requirement and the subsequent discriminatory action may be in breach of the Anti-Discrimination Act and may be in conflict with the intent of the National Privacy Principles.

If the law is being broken, then I urge the relevant authorities to enforce it. Alternatively, it may well be that the community can be given an adequate level of assurance on this matter through the suggested insurers' Code of Conduct. There may be a broader issue here. I do understand the pressures on insurers to obtain all the information they need to accurately assess and price risk, and the similar pressure on employers to protect themselves against consequent premium increase. This is a complex and important issue with national implications and may therefore need to be explored in the context of a broader review informed by the national developments.

I recommend that a future review examine the balance between insurers having access to appropriate information in assessing risks and issues of discrimination and rights to privacy.

Premium Rates

The connection between costs and premiums charged in Tasmania's privately underwritten scheme is not direct. Clearly also, affordability has been central in the debate which led to the recent amendments to the legislation. Chapter Nine of the Productivity Commission's Interim Report provides an excellent discussion of most of the issues. It can also be read as a broad endorsement of premium setting and monitoring as it occurs under the Tasmanian scheme. Nevertheless, it is worth commenting on some of the issues raised both to inform any future review and because it became apparent to me that the level of understanding of the principles or premium setting was generally low.

It is reasonable to start with the assumption that the industry is competitive. There are some perceptions of an 'insurance club' and some believe that there is a lack of competition in premium setting and price discrimination in some business classes. However, the changing market shares, the very volatility of premiums and poor profitability record of the industry are persuasive evidence of competitive pressures. Many of the jurisdictions are highly interventionist in premium setting, often with a view to affordability, however, they can end up with a premium structure which does not cover costs. While I do not assert that there are no potential benefits in premium controls – they allow, for instance the smoothing of volatility – I can see no evidence that government foresight can be expected to be superior to that of the market.

I did hear arguments similar to those put to the Productivity Commission to the effect that premium setting favours large business and that small employers with good claims experience had been faced with inexplicably large increases in premiums. The

point was made that insurers would discount workers' compensation insurance in order to win presumably more lucrative general insurance business with large companies. In essence, this argument still relies on the existence of collusion, otherwise the attempt by any single insurers to 'tax' small business to cross-subsidise larger business would expose a profitable opportunity to other insurers. This is a complex area within the expertise of the Australian Competition and Consumer Commission and the Productivity Commission. However, again, I can see no evidence of this lack of competition, rather the contrary.

I suspect much of the problem lies in a lack of understanding by employers, especially in small and medium sized business, of the principles of premium setting. It is not and can never be an exact science because there are always going to be limitations on what the insurer can know about the client business. The various methods used to classify workplace risk, including industry rating, experience rating and number of workers, are best seen as rather 'rough and ready' ways of framing up the risk assessment, presumably before applying the art of judgement. I suspect many, if not most businesses imagine a much higher weight is ascribed to experience rating than is in fact the case. I would be very reluctant to support any prescription around the use of these factors, precisely because it might inhibit the competitive pressure to 'sharpen the pencil'.

I suspect the way forward in Tasmania is twofold. Firstly the WorkCover Tasmania Board needs to build credibility for its suggested premium rates published under the Act in association with continued education over the meaning and value. Secondly, the insurance industry needs to acknowledge the gap of trust that exists because of the very complexity of premium setting. It should aim to be as transparent as possible over the principles being applied, in particular, so that the small business sector gains a greater understanding. Given the same problem exists in the other two jurisdictions with privately underwritten schemes, perhaps there is a role for the Insurance Council of Australia in developing educational materials from a whole of industry perspective.

The crucial point for a future review will be that, in examining any need for change, there is a need to be fully cognisant of the dynamic efficiency advantages of the present Tasmania system. I recommend that any future review which embraces premium setting explicitly include considerations of the dynamic efficiency with those of allocative efficiency and fairness.

LIST OF RECOMMENDATIONS

GENERAL RECOMMENDATIONS

- That the benefits model be amended with the level of the second step-down increased to 80 per cent, while retaining the ten year maximum period of entitlement. (p33)

- That the legislation be amended to remove the possibility that the present working of the safety net may mean that an injured worker previously on a training wage may be made better off on benefits. (p33)

- That provision 69B in respect of the aggregation of the period of incapacity in relation to the step-downs be amended to clarify intent. (p34)

- That an internal claims decision review requirement be included in an insurer developed Code of Conduct. Failing this the WorkCover Tasmania Board could consider including ‘internal review processes’ in the performance standards for licensed insurers. (p42)

- That the definition of ‘medical question’ be expanded to include questions regarding ‘significant medical treatment’. (p46)

- That a definition of ‘significant medical treatment’ be developed and incorporated into the legislation to enable the Tribunal to effectively screen matters for referral to a medical panel. (p47)

- That processes be developed to ensure medical panels can be invoked promptly once a referral has been made. (p47)

- That the provision under Section 77 of the Act – which allows the Tribunal to determine prospective questions regarding medical or rehabilitation services – be promoted to encourage its application in conjunction with the early referral of significant matters to a medical panel. (p47)

- That the procedure for dealing with Section 77AA medical disputes be replaced by a process whereby the Tribunal may make an Interim Order to relieve the employer/insurer of liability in respect of a particular account, a group or type of accounts, or all accounts in respect of treatment. (p47)

- That any capacity to voluntarily engage in without prejudice intervention be taken advantage of by:

    - Encouraging the provision of without prejudice medical interventions, through for example, the industry developed insurer Code of Conduct;

    - Investigating and addressing any potential legal or administrative obstacles arising from the above recommendation which might prejudice the insurers’ position regarding any subsequent liability dispute; and

- Enabling the Tribunal to make an interim order for a medical expense to be paid in exceptional cases, where a medical practitioner deems that failing to provide the service would have a significant negative effect on the worker's health or employment outcomes; and the treatment meets specified criteria, for example, relating to cost. (p49)

- That Section 81AA be amended to clarify that overpaid benefits may only be deducted from a worker's existing sick leave balance available at the time that the overpayment was identified. (p49/50)

- That the legislation be amended so that where overpayments have been recovered from a worker's sick leave, but liability is later found to rest with the employer, the employer must restore the deducted sick leave entitlements. (p50)

- That the time limit for employers to decide initial liability and therefore make without prejudice payments be extended to 12 weeks. (p51)

- That the Tribunal be empowered to apply a more stringent test for what constitutes a genuine dispute, namely, whether a prima facie case has been made that there are reasonable grounds for dispute. (p52)

- That all Section 81A referrals must be lodged with sufficient information to support a prima facie case. (p52)

- That licensed insurers be given the opportunity to develop a Code of Conduct which clearly respects the intent of the legislation with regard to settlements and contains appropriate commitments to fair dealing and avoidance of perceptions of conflict of interest. This should be monitored by the WorkCover Tasmania Board with a view to enforcement through licence conditions or other means, if ineffective. (p58)

- That a future review have as a principal focus ensuring a coherent injury management philosophy is developed and that the accreditation and incentive structure be refined to drive ownership by all involved in injury management. (p65)

- That a future review address itself only to any final national recommendations on common law access which are at variance with the present Tasmanian situation. (p67)

- That a future review examine whether the changing working relationships in the Tasmanian economy have implications for the principles governing coverage in the Tasmanian legislation. (p70)

- That there be monitoring of the effectiveness of fine-tuning the dispute process with a view to looking again in a broader review if the changes are ineffective in reducing disputation. (p70)

- That a future review critically examine the rationale for exclusion of secondary psychiatric/psychological injuries. (p71)

- That a future review examine the balance between insurers having access to appropriate information in assessing risks and issues of discrimination and rights to privacy. (p72)

- That any future review which embraces premium setting explicitly include considerations of the dynamic efficiency with those of allocative efficiency and fairness. (p74)

ADDITIONAL RECOMMENDATIONS FOR WORKCOVER TASMANIA BOARD

In addition to the above, I recommend that the WorkCover Tasmania Board:

- Investigate whether there are errors in interpretation occurring with regard to how stepped-down payments should be calculated for workers with partial incapacity or whether the legislative provision needs to be clarified. (p34)

- Examine the value, from a cost-benefit basis, of funding appropriate parties to provide separate information services to support injured workers and small business after an injury has occurred. (p39)

- Investigate the implementation of the second injury scheme already provided for in the legislation. (p41)

- Consider including 'internal review processes' in the performance standards for licensed insurers. (p42)

- Monitor and support the steps being taken by the Workers' Rehabilitation and Compensation Tribunal to ensure the disclosure of information during the conciliation phase that will be relied upon in arbitration. (p45)

- Monitor and support the steps being taken by the Workers' Rehabilitation and Compensation Tribunal to ensure the early identification of medical questions and referral to medical panels. (p46)

- Monitor the timeframes for scheduling genuine dispute hearings in the Workers' Rehabilitation and Compensation Tribunal to ensure delays are not occurring. (p51)

- Consider what steps can be taken to facilitate better communication between the employer, the insurer and worker during disputation, particularly in relation to the initial liability decision. (p53)

- Support a coordinated approach to all scheme communications, including those relating to dispute resolution, under its direction. (p54)

- Require that insurers provide a panel of rehabilitation providers from which the worker may choose, the detailed arrangements for which to be worked out in consultation with the industry. (p61)

- Seek ways to improve its data collection or settlements, so that a future broader review has a practical basis upon which to assess whether settlements are occurring in harmony with the scheme's objectives. (p68)

INTRODUCTION

OBJECTIVES OF THE SCHEME

In common with the rest of Australia, the Tasmanian workers' compensation scheme has as its central feature an employer-financed, 'no-fault' occupational injury support program for work related injury and disease. It also provides limited access to compensation via common law action where negligence on the part of the employer can be proven. `

A major driving force of the Joint Select Committee (JSC) inquiry of 1998 and the subsequent legislative changes was increasing community concern that the Tasmanian system was not meeting the objectives of a modern system. In coming to grips with what those objectives should be, the JSC endorsed, with minor amendment, the key principles developed by the Heads of Workers' Compensation Authorities (HWCA) as a best practice model for national consistency, which were accepted by the Labour Ministers' Council.

It is worth repeating the principles from the JSC inquiry, and the three key objectives drawn from them, which underpin a modern system of workers' rehabilitation and compensation and which have the authority of the earlier national reports behind them. These principles are:

- The workers' compensation system must reinforce the primacy of the employer-worker relationship in preventing and managing workplace injuries;
- The workers' compensation system must reflect a fair and equitable balance of the rights and interests of employers, workers and the community;
- The system must have a primary focus of ensuring that injured workers are returned to meaningful work; and
- Prevention and return to work objectives must be supported by the delivery of high quality claims management, medical, rehabilitation and other services. (para 6.3, p37)

It follows that the compensation system has three key objectives:

- To ensure that persons injured at work receive adequate financial support while recovering from work caused injury or illness;
- To ensure that wherever possible, a person injured at work is able to return to meaningful work as quickly as possible; and
- To reinforce the mutual responsibility of employers and workers to minimise the social and financial impact of work related injury or illness. (para 6.4, p37)

The JSC was concerned with emerging evidence that revealed that the key objectives were not being met. The evidence indicated: average premium rates higher than all other State schemes; volatile premium rates which often did not reflect actual risk; a

claim frequency higher than all other Australian schemes; average costs increasing well above inflation levels; and increasing claim disputation. (para 5.1, p31)

While it was recognised that the 1995 changes to the scheme and accident prevention initiatives were improving the picture, the JSC concluded that further improvements were necessary if the scheme was to be competitive with those operating in other jurisdictions. (finding 5.20(b) p35)

The principle objectives and recommendations of the JSC form a critical background to the changes made in 2000 to the *Workers' Rehabilitation and Compensation Act 1988*. The explicit purpose of these changes was to put the Tasmanian system on a modern footing, in line with these objectives, so that the scheme would encourage early rehabilitation and return to work, be economically sustainable in being affordable, and, through being competitive with other jurisdictions, support business growth and employment.

It is particularly noteworthy that the Second Reading Speech, in particular, stressed the need to provide financial security to workers who, as a consequence of their injury, require long-term income support. This echoed a critical concern expressed earlier by the JSC that injured workers can be classified into two distinct groups. Firstly, there is the vast majority of workers who return to work quickly after injury. Secondly, there is another group, who, because of their more serious injuries, require a system geared to longer-term support. (JSC para 8.5, p47)

RATIONALE FOR THIS REVIEW

It is, of course, unusual to review legislation which is relatively new, especially in an area as complex as that of workers' compensation and rehabilitation. The experts in the area have strongly reinforced the need to approach new legislation with caution, as it takes approximately five to eight years after changes before the scheme approaches maturity, even longer for full development. Only then can we have some certainty as to how changes are working in terms of the overall incentives and cost structures, and the resulting outcomes. In addition to this caution, a number of major national inquiries are underway at present. In particular, a major public inquiry is being carried out by the Productivity Commission[3], which potentially could have significant implications for the direction of workers' compensation systems in all Australian jurisdictions.

In concluding that there was a need for a review of this kind, the Minister balanced the above considerations against the importance of disquieting claims that some of the changes were working in ways which were producing significant hardship or having unanticipated effects which did not serve the objectives of the scheme. He determined that it was important at this time, in particular, to look at the impact and effectiveness of the recent amendments to the Act aimed at balancing the social and economic objectives of the system.

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[3] Inquiry produced its Interim Report in October 2003, 'National Workers' Compensation and Occupational Health and Safety Frameworks'

With all the reasons outlined above, the Minister took the view that a full review should wait on the outcome of the national reviews currently being conducted. The scope of the current review is therefore confined to examining the unintended consequences of the new benefits model, improvements in the efficiency of the scheme and identifying matters for consideration in any future broader review.

HISTORY

Rising costs have been a feature of Tasmania's workers' compensation arrangements for a number of years, despite several waves of legislative reform aimed at achieving stability and efficiency.

The scheme, introduced under the *Workers' Compensation Act 1988* (later renamed the *Workers Rehabilitation and Compensation Act 1988)* was designed to ensure workers with injuries/diseases which clearly resulted from their employment were fairly compensated by a system which minimised delays, costs and legal formality. The seven years that followed, however, saw claim costs and insurance premiums rise dramatically.

Although legislative reforms introduced in 1995 resulted in some cost reduction and improved stability, workers' compensation in Tasmania was still seen as one of the most expensive in Australia. There was growing concern about the affordability of the scheme, and the impact of rising insurance premiums on Tasmania's economic growth and consequent ability to attract business and investment relative to other states. In addition, community groups, particularly unions, were questioning the fairness of the 1995 reforms for workers.

The workers' compensation arena at the time was also influenced by the push for national consistency and the Heads of Workers' Compensation Authorities (HWCA) Interim Report, released in May 1996. The HWCA project, undertaken at the direction of the Labour Ministers' Council, was established to identify best practice in workers' compensation to guide the development of more consistent arrangements among Australian states and territories.

Later that year, the Tasmanian Parliament endorsed the establishment of the Joint Select Committee (JSC) of Inquiry into the Tasmanian Workers' Compensation System, in response to community concerns growing around workers' compensation in the State. Drawing upon the findings of the HWCA Interim Report and written and oral evidence from over 70 individuals and stakeholder groups, the Committee delivered its final report in 1998. The report included more than 80 recommendations designed to address scheme affordability, fairness and supported return to work appropriate for the Tasmanian scheme based on best practice principles.

The JSC, however, was unable to reach agreement on the critical issue of benefit reform. Over the next fifteen months, extensive consultation with employers, unions and other key stakeholders was undertaken to reach agreement on an appropriate benefit model and other legislative changes.

The *Workers' Rehabilitation and Compensation Amendment Act 2000* was subsequently drafted to strike a delicate balance between the social and economic objectives of the system. More specifically, the key objectives of the amendments

were to provide greater income security to injured workers, to improve prospects for workers' rehabilitation and return to work, and make the system more efficient and affordable, bringing costs into line with other States. The Amendment Act was subsequently passed and commenced operation in July 2001.

In summary, the key features of the amendments include:

- Compulsory commencement of weekly payments on a without prejudice basis upon receipt of a workers' compensation claim form
- Removal of dollar cap on weekly benefits and extension of period of entitlement to ten years
- Increase in the size of step-downs in weekly benefits to provide clear incentives for an injured worker's return to work and balance the extension in entitlement period
- Increased benefits to dependants of deceased workers
- Increase in maximum lump sum compensation for permanent impairment and replacement of the Table of Maims with the concept of whole of person impairment assessed according to guidelines based on the American Medical Association *Guides to the Evaluation for Permanent Impairment* (4th edition), with modifications made by the WorkCover Tasmania Board
- Restriction of access to common law action to all workers except those with a whole of person impairment assessment of 30 per cent or more
- Provision for the redemption of statutory benefits in certain circumstances
- Restructure of the Workers' Rehabilitation and Compensation Tribunal and its functions to accommodate two distinct streams: conciliation and arbitration
- Abolition of the Workplace Safety Board of Tasmania and establishment of the WorkCover Tasmania Board, featuring increased functions and increased representation of workers and employers

The amendments principally represented a significant trade-off between the introduction of relatively generous, no-fault, without prejudice benefits under the statutory scheme, and the restriction of access to common law action to all but the most seriously injured workers. Common law costs had been previously identified as one of the main cost drivers to the system, not just in Tasmania but also in other Australian jurisdictions. In 1999–2000, payments associated with common law action increased by 19.5 per cent and represented 44 per cent of total payments made under the Tasmanian scheme (*Workplace Safety Board of Tasmania Annual Report 1999–2000*, p80). The intended outcomes of these amendments were greater income security for workers and improved scheme affordability through the containment of common law payments.

While it is too early in the workers' compensation 'cycle' for any definitive conclusions to be drawn from the available data, it would appear that claim costs have

started to decline, particularly in the areas expected – common law and legal costs. According to the *WorkCover Tasmania Board Annual Report 2002–03*, the total amount paid on claims reported prior to and during the 12 month period ending June 2003 declined by $6 million, almost four per cent compared to the amount paid on claims the previous year. (3.1.1, p62) Common law payments reduced by 25 per cent during the same period and legal costs reduced by 17 per cent. (Table 9, p62) There are also signs of real premium reduction. During the 2002–03 financial year, the actual average premium rate charged by licensed insurers was 2.93 per cent, representing a decrease of more than six per cent. (3.1.3, p62) However, experience has shown that the relationship between scheme costs and premium rates is more complex and they are not directly related.

Authorities and experts in the field agree that it is far too early to evaluate the effectiveness of the recent reforms. It is generally accepted that workers' compensation trends take between five to eight years to develop and even longer to reach full maturity. To make major legislative change at this point in time would therefore have the potential to seriously undermine the intent of the legislation and detract from the long-term effectiveness of the scheme.

However, since the introduction of the amendments, a number of individuals and community groups have claimed that some of the recent changes — most notably the step down provisions in weekly benefits — may be causing serious hardship for workers. Clearly, this was not what the Government intended when it introduced the reforms two years ago. As a consequence, the principal focus of this review is that of the current benefits model, particularly the structure of weekly benefits.

The Minister also felt that, as a number of national inquiries were underway, the review should also identify significant issues for consideration in a broader review of the legislation in the future, after the findings of the national developments were known. The national activities which may impinge on the operation of the Tasmanian scheme include:

- Productivity Commission's Inquiry into National Workers' Compensation and Occupational Health and Safety Frameworks;

- House of Representatives Standing Committee on Employment and Workplace Relations inquiry into Aspects of Workers' Compensation;

- HIH Royal Commission, reporting, inter alia, on the adequacy and appropriateness of arrangements for the regulation and prudential supervision of general insurance, including workers' compensation;

- Response by governments to the report by joint Commonwealth and States panel on the law of negligence (the Ipp Report) and the Australian Health Ministers' Advisory Council work on legal process reform;

- Response by governments to the withdrawal of reinsurance for injuries resulting from terrorist attacks; and

- Royal Commission into the Building and Construction Industry reporting, inter alia, on OHS in that industry.

TERM OF REFERENCE 1

While retaining the essential features of the workers' compensation scheme noted above, review and make recommendations on:

- whether and to what extent the benefits model is resulting in unanticipated hardship;
- whether in any other way the operation of the benefits model is resulting in outcomes at variance with the key objectives; and
- any matters where legislative change or administrative action would improve the operation of the model.

THE BENEFITS MODEL

Background

Injury management and early return to work are central to the basic philosophy of a modern workers' compensation and rehabilitation scheme. All the evidence points to the fact that together these provide the best overall outcomes in terms of the end result for health and financial security for the worker, and for the employer in terms of productivity in the workplace.

It was impressed upon me time and time again during this review that the attitude and commitment of all the engaged parties are critical to this. An analogy was often drawn to a sporting injury. There is early intervention when a sportsman or woman is injured and all the forces are about getting the sportsperson back up to his/her game as quickly as possible. Everyone is motivated by the same goal. There is apparently ample evidence that, for similar injuries, the outcomes tend to be far superior when sport-related rather than work-related. The experts seem to agree that this is not explained by higher fitness, which plays only a minor part. The key is the culture and attitudes of all involved. There are important lessons to be drawn in how we might inculcate a common culture of commitment to rehabilitation. Appendix A draws out the lessons from this important analogy which have informed this review.

A common feature of the statutory schemes in all Australian jurisdictions is an attempt to underpin the no-fault basis of the scheme with a non-adversarial structure which will drive the culture change necessary for superior outcomes. The provision of statutory benefits, including adequate income support and rehabilitation services as entitlements, is of central importance. The aim is to balance a decent level of income support, including appropriate incentives to rehabilitation and return to work, against cost.

This is by no means easy. There have been many examples where over-generous benefits and poorly structured incentives have led to individuals perceiving they were better off on benefits than returning to work. The resultant perverse behavioural responses lead to major increases in cost and failure to achieve the desired social outcomes. Conversely, if the benefits are inadequate or the incentive structure too

harsh, not only may the social objective of preventing workplace injury resulting in excessive hardship be frustrated, but the individual's capacity to cope with transition back to work may be undermined. Society not only loses the benefit of their skills but injured workers may then fall as a burden on the broader social welfare net with poor prospects of escape.

Of course, the benefits model is also central to the costs of the scheme. The workers' compensation scheme must be affordable and competitive with other Australian jurisdictions to be economically sustainable and serve the employment outcomes important to the community. Affordability depends on premiums, which are driven by costs, though indirectly. Over the long-term, we would expect price to equal average cost in a competitive industry. However, we need to recognise that in the short and medium-term, this relationship is indirect, and at various times premiums need to be below or above costs for a healthy competitive dynamic to exist.

The clear intent of the legislation was to achieve scheme costs, and as a consequence, an average premium rate no higher than 2.75 per cent of wages. This would underpin affordability and Tasmania's competitive position.

Sitting behind this target is the relativity in affordability with other jurisdictions. I was concerned to understand how Tasmania's position might have moved in the period since the legislative changes. Importantly, costs pressures are, if anything, rising in the other Australian jurisdictions. In some cases, schemes are clearly carrying unfunded liability that will have implications for future premiums. In at least one other, there are proposals for policy change that will result in upward pressure on costs. I conclude from this that it is prudent and safe to continue to adhere to the original target. The crucial question is then how much room is afforded for fine-tuning the benefits model.

In what follows, I focus on the objectives of the legislative changes through an analysis of the incentive structure and behavioural outcomes that were intended to result. In so doing, I explicitly pick up on the important dichotomy raised by the JSC and echoed in the Second Reading Speech to the recent amendments. We should, at all times, distinguish between how the model is working for the vast majority of workers who return to work fairly quickly, and the second group of workers whose injuries are sufficiently serious that they require longer-term income support.

It is also very important to note that I am dealing with a very short period of evidence in respect of the effects brought about by the legislative changes, especially with regard to behavioural responses and scheme costs. While the changes appear to have produced an experience which has been more effective than initially envisaged in reducing costs, it is possible that as the scheme matures and is tested, behaviour will evolve producing upward cost pressures. For instance, while currently it would appear that the impairment threshold has been very successful in containing costs, it needs to be recognised that common law can still be accessed in the most severe cases. These are, of course, the cases where claim costs are largest, and we do not have mature cost experience of what the impact of this remaining set of claims will be on overall scheme costs. This will emerge over time.

In developing my recommendations, I have therefore attempted to balance the need to remedy perceived deficiencies with the need to be cautious about potential long-term consequences of change.

The Benefits Model – Step-downs in Weekly Payments

In the course of consultation it very quickly became apparent that the step-downs in the level of income support are the most controversial features of the benefits model.

In the history of the Tasmanian workers' compensation scheme, step-downs in weekly compensation payments are a relatively recent feature. They were introduced in 1995 with the following structure:

0-6 weeks:	100 per cent of Normal Weekly Earnings (NWE)
7-25 weeks:	95 per cent of NWE
Until upper dollar limit reached:	90 per cent of NWE

The legislative reforms passed in 2000 resulted in the following revised structure:

0-13 weeks	100 per cent of NWE
14-52 weeks	85 per cent of NWE
53 weeks – 10 years	70 per cent of NWE

(A statutory floor – 70 per cent of the 'basic salary' – on weekly benefits operates to protect the small proportion of workers on very low incomes. The basic salary is set by the Minister each year and for 2004 is $ 497.35)

To some extent the relatively recent existence of step-downs may be responsible for the perception that those currently in operation in the Tasmanian scheme are draconian in their effect. In fact, my investigations suggest that for the vast majority of workers the opposite is true.

It is my belief that the Tasmanian structure is, on balance, at least as generous as the schemes operating in other States, when other features of those schemes are taken into account. Our scheme keeps injured workers 'whole' for thirteen weeks, does not apply weekly benefits caps which, in effect, operate as a step-down for higher income workers, or a dollar cap on total benefits, features a relatively long benefit entitlement period, and importantly, provides for mandatory 'without prejudice' weekly payments for workers upon claim lodgement. However, there are particular issues which pertain to the second group of workers referred to earlier who require longer-term support.

It is important to understand the rationale behind step-downs in workers' compensation income support, as they are a fundamental feature of all modern statutory schemes and certainly of those in Australian jurisdictions.

There are two key arguments for having a step-down structure. The first is based on equity between employer and employee. Given that the system is no-fault, the existence of step-downs provides, as a quid pro quo, an element of sharing of the cost burden between the parties. The second, and to my mind more important line of reasoning, is one based on the efficiency argument for having an incentive to return to work. The Interim Report of the Productivity Commission alludes specifically to empirical evidence that suggests step-downs provide incentives for return to work (p195–6).

It was, however, put to me that step-downs do not serve as a useful incentive as there are other stronger mechanisms at work. The argument is that injured workers would rationally be aware of the need to get back to work to maintain their investment in the hard-won skills upon which their future prosperity depends. While away from the workplace they also risk losing the value of social networks important to both work and life. Furthermore, they face the loss of the employer's superannuation contribution and potentially serious implications for their level of comfort in retirement. As part of the evidence in support of this, it was asserted that there are cases where larger employers 'top-up' compensation payments, so that the step-downs are of no effect and that there is no discernible adverse effect on outcomes in these cases.

These arguments have the virtue of using the weight of the normal economic argument on incentives against itself and deserve to be taken seriously. However, it is well beyond the capacity of this review to test their empirical value and clearly they should be taken up nationally in the context of the current Productivity Commission inquiry.

My own view, pending further evidence, is that the step-downs are an important incentive. I note, for example, that South Australia has no step-downs in the first 12 months and, relative to other States, has below average performance on a number of return to work measures[4]. Most of the anecdotal evidence I heard supported the value of step-downs as an incentive and they had broad policy support in the other jurisdictions visited.

The step-downs are also an important parameter for affordability and any proposed changes would need to consider this carefully.

As I have noted, the link between scheme design change impacts on costs and premium rates set in a competitive market is indirect. The *WorkCover Tasmania Board Annual Report 2002–03* shows the actual average premium rate charged by insurers during the financial year ending June 2003 was 2.93 per cent, a considerable reduction on the previous year's 3.13 per cent (p72), but well above the target of 2.75 per cent. Moreover, the indirect nature of the cost link is well illustrated, in that the average suggested industry premium rate made available by the Board for 2002–03, as required by the legislation, was 2.62 per cent, as recommended by the consulting actuary, Trowbridge Consulting. As the Annual Report points out, the higher market rates can be viewed as 'indicating that insurers have a less optimistic view of the market.' (p.73) However, it does seem clear that the cost reductions brought about by the legislative changes are driving a downward trend in actual premium rates. As noted by another actuary, Bendzulla Actuarial, in providing an analysis of the impact of the legislative changes:

> "In another twelve months there may be sufficient data to make a preliminary estimate of the level of savings. The anticipated 11–13% overall savings may be

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[4] Data sourced from summary tables contained in the *2002/03 Australian and New Zealand Return to Work Monitor*, pvii–x.

> exceeded. The usage of weekly benefits is sufficiently clear to remove some of the pre-change fear that this change could lead to a massive blow out in this component. This produces the confidence to allow consideration of fine tuning of the step-downs should this be necessary, without concerns that recent cost gains will be lost."[5]

It is against this background that I have looked at whether the benefits model is resulting in unanticipated hardship.

The Benefits Model and Unanticipated Hardship

I found no evidence of any major problem with the first step-down. By and large, my discussions revealed that while a step-down to 85 per cent of normal weekly earnings is significant, it lies within the range – even for lower income groups – within which it is possible to readjust expenditure and cope, while being supported to an adequate level.

In addition, the first step-down now cuts in after thirteen weeks instead of at six weeks as it did previously. This also needs to be seen in the context of the shift to compulsory 'without prejudice' payments. By the time the first step-down comes into effect, 95 per cent of claimants have returned to work[6]. The changes in effect mean that the vast majority of injured workers are protected with no-fault support in a non-adversarial system to the level of their normal income for their full period of absence from work duties.

In my discussions with other jurisdictions regarding the operation of step-downs it was suggested to me that, to be effective as a return to work incentive, earlier application of the step-down is desirable. However, I do not believe that the performance of the Tasmanian system provides any evidence of this. I believe from discussions with workers that the expectation alone of the step-down coming in after 13 weeks is quite enough to operate as an incentive to return to work in the earlier period. There is also surely a major social benefit in that during this time workers and their families have the ability to cope with the stresses and strains of the situation while on their normal income.

In consequence, I am of the view that there are no important issues of principle with the operation of the first step-down. I believe it minimises the adjustment costs for families and brings in the right level of quid pro quo balance into the scheme.

I noted earlier that the step-down needed to be seen in the context of mandatory 'without prejudice' payments. This was a very important change in the recent amendments and I do not believe this has been widely acknowledged or understood. After the Northern Territory, Tasmania was the second State to introduce mandatory without prejudice payments. To date, only New South Wales has followed. I think this change should be regarded as courageous and innovative in supporting the fundamental objectives of the workers' compensation scheme. I found other

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[5] Cited from the report *Review of the Operation and Performance of the Tasmanian Workers' Rehabilitation and Compensation Scheme for the 2002–03 Financial Year*, published in the *WorkCover Tasmania Board Annual Report 2002–03*, p36

[6] *Workers' Rehabilitation and Compensation Amendment Bill 2000 Second Reading Speech*, p8

jurisdictions wary of the innovation because of the risks of rorting and consequent potentially costly implications. However, I believe that the Tasmanian experience belies this. The innovation has provided certain support to injured workers and significantly helped to lower the level of dispute. As a consequence, the fundamental employer-worker relationship is reinforced, supporting best practice injury management. From an income support point of view this change has been of major benefit to the vast majority of injured workers.

The second step-down brought in by the recent amendments is to 70 per cent of NWE from week 53 to ten years. The 70 per cent level was not plucked from the air. The HWCA recommended a second step-down to this level as part of the preferred national model. (1996, p.15) This was picked up in the benefits model recommended by the JSC for consideration in consultation. However, it is also apparent that there was no experience in any of the Australian jurisdictions of a step-down of this size. Upon inspection, none is as large, when other details of existing models, such as safety net payment floors, are taken into account.

The second step-down is also premised on a rationale of increasing the incentive for return to work for those workers whose injuries are more long-term and whose drive to return to work may need some reinforcement. The level of 70 per cent is clearly also an important cost parameter. The size of the second step-down is potentially very important to affordability and economic sustainability, since it is the small percentage of workers on long-term compensation on which it falls who are responsible for the greater part of scheme costs. Recent statistics provided to me suggest that the five per cent of long-term claims are attracting 54 per cent of scheme costs[7].

Nevertheless, in the course of consultation, I became convinced that the operation of the second step-down is resulting in hardship which was not anticipated at the time the legislation was introduced.

While the safety net provision goes some way to mitigate the financial stress on the lowest paid, I have come to believe that hardship is more widespread as people seek to get back into meaningful work while trying to deal with a major change in their standard of living. I have had several examples brought to my attention where workers endeavouring to fully comply with return to work programs and the aims of the scheme were nevertheless reduced to an income that produced significant hardship.

A broader and more complex issue also came to my attention. There is anecdotal evidence, supported by the opinions of authorities in other jurisdictions, that a reduction of 30 per cent appears to go over an invisible threshold which impacts on the ability of most households to absorb the change through reduced expenditure without looking to dispose of assets and associated obligations.

It would seem that it is, by and large, possible for workers and their families to adjust to a reduction in income of around 15–20 per cent through curtailing discretionary

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[7] Statistics provided to the Reviewer by the WorkCover Tasmania Board, based on claims with an accident date between 1 July 2001 and 31 August 2002 which were being paid weekly benefits at the level of the second step-down.

expenditure. However, when there is a significantly larger decrease in income, this is no longer the case. In particular, there is a risk that a significant proportion of the relatively small percentage of workers who end up exposed to the second step-down are facing the prospect of selling the family home. As one might expect, this raises a major emotional barrier in the minds of workers which may militate against a rational approach to change in circumstances. It may also act as a perverse incentive in terms of the scheme's overall objectives. Because households adjust their asset holdings, including the family home, to their level of income, this is not simply a problem for the lowest paid.

I am particularly concerned that a step-down of this magnitude may be a significant incentive for the worker to seek a cash settlement in order to secure sufficient funds to avoid the need to sell the home. By shifting the focus to one of seeking a lump sum settlement, it risks reintroducing incentives to exaggerate injury and lack of capacity as a means of improving the bargaining position with the insurer. In addition, the financial and emotional pressures may result in workers accepting settlements without looking sufficiently ahead and considering the long-term consequences.

As to the incentive value of the second step-down, I am unable to find persuasive evidence either way. While there appears to be no strong evidence of an increase in return to work as the second threshold is approached or after it comes into effect, this may be because the sub-group to whom it applies adjust behaviour in expectation well in advance. I found widespread support during discussions with other jurisdictions and insurers for the view that a second step-down did encourage the long-term injured to keep trying to improve their prospects. There were, however, doubts about the need for a second step-down of the current magnitude.

From the perspective of an injured worker trying to comply with a return to work program, manage a serious injury and deal with a major reduction in living standards, the 70 per cent appears less as an incentive than a double punishment. I believe its perceived harshness undermines support for the no-fault nature of the scheme and its quid pro quo philosophy.

The foregoing has led me to the view that the second step-down should either be made significantly less stringent or abolished altogether. If affordability is an issue, we should change an offsetting cost parameter. There are four main potential offsets:

1. To introduce capping of some sort;
2. To increase the size of the first step-down;
3. To bring forward the first step-down; and
4. To reduce the maximum benefit entitlement period from the current ten years.

For reasons that will become apparent below, I believe that the initial evidence suggests that, of these options, the best would be to reduce the time period for which benefits are available.

Caps on the amount of income support benefits paid weekly or on the total amount received have been a feature of previous Tasmanian schemes and are at present a feature of most other Australian schemes. I note also that a cap on weekly benefits was a feature of the model proposed for discussion by the JSC. Caps have been applied in a variety of ways by other jurisdictions. For example, in New South Wales

the cap on weekly earnings applies from the first weekly payment, whereas in the Northern Territory, weekly caps only apply after weekly benefits are stepped down at 26 weeks. (HWCA, 2002)

I believe caps on weekly benefits have some undesirable features. In particular, they serve to impose different arrangements between members of the first group of workers who largely return to work before any sort of step-down occurs. The existence of weekly caps for workers whose normal weekly earnings are above the threshold, in effect, operate as a step-down – a step-down which cuts in from inception. Given that households plan on the basis of their normal income, I am not persuaded that such a step-down does not impose significant difficulties, and does so at a time of other concerns over injury. Moreover, there is a serious risk that the resultant stress may undermine the focus on rehabilitation. These caps are also intrusive, in the sense that they imply judgements about the different circumstances facing different income groups. I believe the philosophical integrity of the scheme is better served by the absence of these internal redistributive devices that are put in place on a somewhat arbitrary basis.

Dollar caps on total weekly benefits payable can present another problem. By limiting the amount of compensation workers can receive in total, higher income workers will necessarily be entitled to benefits for a shorter period. To my mind this is inconsistent with the goal of long-term benefit support and is presumably why this feature of the previous scheme was abandoned.

I am very reluctant to use the mechanism of a larger first step-down. I am impressed by the fact that the level of the first step-down is well accepted by the community in terms of the household's ability to cope with the consequences. I note also that it is broadly in line with the model structure recommended in previous reports.

The third alternative of retaining the magnitude of the first step-down, but bringing forward the point of application to six weeks is, in effect, to return to what existed prior to the amendment of the legislation. While more attractive than changing the size of the first step-down, I am persuaded that the move to a longer period was significantly to the advantage of the vast majority of injured workers. I believe it is undesirable to change a feature of the scheme which enables it to be one of the best in Australia for most workers.

With regard to the fourth option, the effective extension to the maximum benefit entitlement period was brought in with a view to improving support to the long-term injured. The previous dollar cap effectively imposed a much shorter average entitlement period. For example, as noted in the Second Reading Speech for the 2000 amendments, for an injured worker with a salary of $36,000 entitlement ran to a maximum of five years. Notwithstanding the laudable aim of providing longer term support, it needs to be recognised that the term is finite and to some extent arbitrary. Many claims are in fact settled well in advance of expiry of entitlement and term is then only one element of the present value of the benefit stream. I consider therefore this to be the most appropriate parameter to change should cost offset be necessary.

Proposed Amendment of the Benefits Model

I have had six options for change to the weekly benefits structure tested for their implications in cost to the scheme by Bendzulla Actuarial Pty Ltd, the consulting actuary who prepared the report to the WorkCover Tasmania Board on scheme performance for 2002–03. My principal interest was to explore altering the level of the second step-down from 75 per cent through 80 per cent to complete elimination, and the cost offset value of reducing the term of entitlement by one or two years (see Table 1 below).

While the assumptions used are conservative, the actuarial analysis makes no allowance for the behavioural change which might flow from adjusting the step-down design. There is also the question of the appropriate base to use in assessing the likely effect on premium rates. As noted earlier, the cost analysis is best viewed as a long-run value round which market prices will oscillate according to the market dynamic. Mr Bendzulla's base is appropriately concerned with the way in which the cost implications of the legislative changes are working themselves through. His work demonstrates that the changes are exerting continued downward pressure on costs. For the year 2003–04, based on the wages pool covered by the licensed insurers of $4,002 million, the total required premium pool is $99.612 million. This gives a no policy change base of an average premium rate required of 2.48 per cent of wages.

Table 1: Comparison of expected effects of altering the second step-down using 2003–04 suggested average premium rate (2.48%) as base

	Design Costed Step-Downs	TIME CAP	Increased Weekly Benefit Cost %	Increased Overall Scheme Cost %	Average Premium Rate Required (% of wages)
1	100/85/75	10 yrs	2.8	1.12	2.51
2	100/85/80	10 yrs	5.6	2.24	2.54
3	100/85/80	9 yrs	3.7	1.48	2.52
4	100/85/85	10 yrs	8.4	3.36	2.56
5	100/85/85	9 yrs	6.4	2.56	2.54
6	100/85/85	8 yrs	4.3	1.72	2.52

Source: Bendzulla Actuarial Pty Ltd

The various design changes analysed are all more generous than the existing scheme and hence each has higher costs and results in a higher average premium rate required. Each percentage point increase in overall scheme cost is on this basis approximately equal to $1 million per year. Because weekly benefit costs are approximately 40 per cent of overall scheme costs, it takes a change of around 2.5 percentage points in weekly benefit costs to increase scheme costs by $1 million per year.

Because of this relationship, it takes significant changes in the weekly benefit costs to drive change in the average premium rate required expressed as a percentage of wages. It is important to understand that the annual costs of the design changes shown in the table range from $1.2 million to $3.4 million. While this gives us confidence with respect to normal cost relationships and relativities, that the changes considered may be affordable and sustainable over the long run, the situation with respect to short-term market premium rates is more problematic. It is most important that any fine-tuning does not disrupt the market adjustment to lower premium rates in terms of current affordability. I therefore believe it is necessary to take the analysis somewhat closer to market premium rates and also take account of sensitivity to behavioural change.

It might seem obvious that the appropriate base would be actual premium rates. However, these are in flux because they are still responding to the previous system changes and are, in any case, volatile because of the natural market dynamic. In particular, as the WorkCover Tasmania Board Annual Report (p73) makes clear, there is at present a major gap between the market rates and the rates which the Board believes should appropriately be charged. The problem is that the market rates are at present trending downward in response to the cost changes but do not as yet adequately reflect them.

Nevertheless, the Board is required under the Act to produce suggested market rates as an aid to transparency. In preparing these, the consulting actuary has given greater weight to the expected cost advantages flowing from the amendments. I regard the WorkCover Tasmania Board's suggested premium rate for that year of 2.62 per cent as more representative of the market rate we might expect over the next couple of years. I have produced the following table to show the effect of Mr Bendzulla's analysis of the cost change relativities using this figure as the base.

Table 2: Comparison of expected effects of altering the second step-down using 2002–03 suggested average premium rate (2.62%) as base

	Design Costed Step-Downs	Time Cap	Increased Weekly Benefit Cost %	Increased Overall Scheme Cost %	Average Premium Rate Required (% of wages)
1	100/85/75	10 yrs	2.8	1.12	2.65
2	100/85/80	10 yrs	5.6	2.24	2.68
3	100/85/80	9 yrs	3.7	1.48	2.66
4	100/85/85	10 yrs	8.4	3.36	2.71
5	100/85/85	9 yrs	6.4	2.56	2.69
6	100/85/85	8 yrs	4.3	1.72	2.67

(No change premium pool required $105.4m at 2.62% of wages)

On this basis, it seems clear that it would not be appropriate to abolish the second step-down without a cost offset as the 2.71 per cent of wages is far too close for comfort to the desired ceiling of 2.75 per cent.

We also need to consider how much room to allow for behavioural change. It is, of course, impossible to be precise. However, we can rely on some general rules of thumb to be reasonably sure of an adequate safety margin in ensuring that fine-tuning the structure accommodates the affordability target. The question is the extent to which an increase in weekly payments might encourage claimants to stay on benefits longer. An assumption often used in such circumstances is to allow for a final change in costs 1.5 times that which would occur without behavioural change. However, given the critical importance of the affordability objective, which, after all was the central driver to the previous amendments to the legislation, my preference is to test for sensitivity to a margin of 2.0 times the original change to ensure the results have a robust safety margin.

When this exercise is performed there are three clear alternatives which, even on this stringent test, can bring significant improvement in benefits to long-term injured workers without breaching the 2.75 per cent ceiling. The first option is presented in row 2 of Table 2, which improves the second step-down to 80 per cent and requires no change in entitlement term. The second is presented in row 3 and has a lower cost because of the reduced term. The third is presented in row 6, which abolishes the second step-down, but at the cost of reducing the term to eight years.

I believe the first and second options are to be preferred. Firstly, they unambiguously improve the situation of covered workers. It is possible with the third option that, at low household discount rates, a small percentage of workers would feel worse off under this arrangement than at present. Secondly, precisely because the first and second options involve retention of the second step-down in some form, they significantly lower the risk of a strong behavioural response with adverse cost implications.

I am strongly of the opinion that a model which retains the step-down, albeit in a modified form, offers a much more certain environment to insurers. The success of the amended legislation is premised on the cost reductions flowing through to premium rates as insurers become more confident in them. Complete removal of the second step-down, even if with a reduction in term of entitlement as an offset approximately equivalent or better as a cost driver, may induce sufficient uncertainty to slow, or even stall, the premium response to lower costs. In my view this could jeopardise the important affordability objective.

In my view there is a sufficient margin of safety to proceed with the first option. I therefore recommend that the benefits model be amended with the level of the second step-down increased to 80 per cent, while retaining the ten year maximum period of entitlement.

The Safety Net – Section 69B (3)

At the commencement of this review adjustment of the safety net looked like an attractive policy option to mitigate the hardship caused by the second step-down for low income workers. Given that I learnt that the problem was more widespread than simply this group I have chosen not to pursue this.

As part of my investigations, I have analysed examples of the safety net in operation and believe that it serves a valuable function and should be retained. It is, of course,

the case that if the recommendation made to adjust the second step-down is accepted, then the safety net will have a reduced role.

However, I note that the present operation of the safety net has the potential to result in anomalies. It is a fundamental principle of scheme design that it must not be possible to be better off on benefit than at work. Unfortunately, the present working of Section 69B does not allow for adjustment for those on an award training rate so the effect of the provision can be to provide a minimum payment in excess of the rate of pay prior to injury. This is clearly a matter needing attention.

I recommend that the legislation be amended to remove the possibility that the present working of the safety net may mean that an injured worker previously on a training wage may be made better off on benefits.

Application of the step-down in case of partial incapacity

From my discussions with injured workers and scheme stakeholders I am concerned that the step-downs are not being applied in the manner in which the legislation intended nor in a consistent way for all workers. It was put to me that in some cases of partial incapacity, the step-down is being applied to the total amount being paid to the worker. It appears to me that Section 69(1)(b) of the Act clearly states that 'in the case of the partial incapacity of the worker for work, weekly rate payments for the period of that incapacity equal to the difference between the worker's normal weekly earnings and the amount that the worker is earning or would be able to earn in suitable employment or business during that period of incapacity'. On my reading it is to the amount equal to this 'difference' that the step-down should be applied.

Inequity clearly results where similarly placed workers in the scheme are being treated differently depending on the interpretation of the step-down provisions. While this may seem a matter of operational detail, it is important that the step-down provisions are perfectly clear to ensure consistent interpretation and application. This perceived lack of fairness undermines the integrity of the scheme.

I recommend that the WorkCover Tasmania Board investigate whether there are errors in interpretation occurring with regard to how stepped-down payments should be calculated for workers with partial incapacity or whether the legislative provision needs to be clarified.

There appears also to be another source of ambiguity in the model and that is the meaning to be ascribed to 'in aggregate' under Section 69B. Some believe that in cases of partial incapacity the time periods should be interpreted as proportionately longer, that is aggregation should be of the effective period of time lost from work. Others believe that it refers to simple aggregation of incapacity for work, whether partial or total.

To my mind the second interpretation appears closer to the philosophy which informs the legislation. The point is surely the elapse of calendar time and ensuring there is an appropriate incentive structure to return to work. The first interpretation would appear to seriously undermine the incentive structure for partially incapacitated workers. I note that the relevant comparative provision in the NSW legislation makes absolutely clear that if a worker is back at work and in receipt of weekly payments then the

calendar period is what counts for the purpose of the step-down not the number of days lost from work. This is also the approach taken in other Australian jurisdictions.

I recommend that provision 69B in respect of the aggregation of the period of incapacity in relation to the step-downs be amended to clarify intent.

TERM OF REFERENCE 2

To report and make recommendations on any matters of a minor legislative or administrative nature which would improve the efficiency of the scheme with respect to the key objectives.

In addressing my second Term of Reference, I have looked at those matters I believe require attention to improve the workings of the existing scheme, irrespective of the outcome of the examination of broader issues that is occurring nationally. Nevertheless, where appropriate, I have noted instances where I believe national trends can inform how we act to improve the scheme now. It is also important to note that in conducting this review I have been conscious that the WorkCover Tasmania Board has ongoing functions under Section 10 of the Act including, among other matters, to make recommendations to the Minister on amending legislation and reporting on its effectiveness.

In what follows I have therefore distinguished between matters raised that I believe merit a clear recommendation from this review, and those matters, which I believe should be referred to the Board for further consideration. In addition, there were a number of additional issues raised, which could broadly be regarded as pertaining to the efficiency of the scheme, but go well beyond simple legislation or administrative issues. These are reported below, for the information of the WorkCover Tasmania Board and other interested parties, without detailed comment other than factual or contextual remarks and without recommendations.

In the discussion of the benefits model under Term of Reference 1, reference is made to the vital importance of the incentives in the scheme reinforcing the central object of rehabilitation and return to work. Employers, unions, insurers and policy people in all Australian jurisdictions I visited, impressed upon me the importance of reinforcing the injury management philosophy and the centrality of the employer-worker relationship. While there is broad agreement on the relevant philosophy, there are significant issues involved in translating it into a process that will effectively drive the desired outcomes.

This is not to say that the process in Tasmania is any worse than that in other jurisdictions. However, my consultations, in particular, talking to the injured workers caught up in the process and to the key agents around them responding to the difficulties posed, suggest a number of possible legislative and administrative improvements that can better reinforce the key outcomes. In order to tease out these issues, I attempt, in what follows, to examine the implications of the key employer-worker relationship for the process. Given the centrality of dispute resolution to this relationship, I have examined Tasmania's dispute resolution system (DRS) at length.

Before proceeding I wish to sound a warning. In many of my discussions it seemed too easily taken for granted that the objectives of rehabilitation through good injury management and keeping scheme costs down go naturally together. I think this should be regarded as the ideal rather than the reality. I accept that there are important circumstances where the incentives do come together. For instance, early intervention may often significantly improve rehabilitation outcomes and reduce costs. However, it is easy to see how good injury management and claims management, in the sense of keeping costs down, can diverge. Each agent in the chain, from injured worker,

employer, insurer and legal, medical and rehabilitation service providers, all face different incentives which, when they interact, can produce perverse outcomes. The conjuring trick of scheme design is a structure that will align the incentives to bring the objectives of each agent as close together as possible.

THE WORKER'S RELATIONSHIP WITH THE EMPLOYER AND THE WORKPLACE

When someone is injured at work, they not only have to cope with the direct consequences of the injury, but also with negotiating their way through the workers' compensation system. This is not peculiar to Tasmania. All such systems are of necessity complex and the injured worker needs guidance.

It is also quite clear, and probably inevitable, that until an injury occurs, very few workers have any idea of their rights and obligations with respect to the system. While I understand that some effort is made in terms of induction and training in some larger workplaces, I found no evidence of this having been effective. Workers I interviewed uniformly said they knew nothing of the scheme's basis until they were injured.

In a sense this may be a symptom of success. We have so effectively reduced the probability of workplace accidents that learning about the process and consequences of a low probability event is unlikely to appear of value. As a consequence, I suspect that getting across any detailed understanding of the workings of the scheme, prior to accident, would be unlikely to be ever effective. However, given the feelings that may arise after injury and the potential consequences, I believe it is important that, at the very least, the no-fault basis of the statutory scheme and the exclusions on common law are understood by both employer and worker prior to injury.

A common theme in my discussions with all parties was the importance of maintaining the worker's relationship with the employer and the workplace for achieving successful rehabilitation outcomes. In the context of an injury in the workplace and its repercussions, the relationship comes under significant stress. We need to reinforce the incentives and cultural attributes which can sustain it under that stress.

Incentives and Employer Behaviour

How ideally should the employer behave? The first lesson is the need for early reportage of any workplace injury to the insurer. Employers, other than very large employers, see so few such incidents that they are unlikely to have the expertise to correctly distinguish the serious from those that temporarily inconvenience. Insurers, on the other hand, are much better placed to pick up the risk 'flags' which suggest that a reported injury could develop into something seriously debilitating. The critical point here is that, in many of these cases, there is a short window where early intervention would have a major impact on both the prospects for rehabilitation and financial and social costs.

Insurers have impressed on me their wish to be informed early so that they can, in 'flagged' cases, promote and fund intervention on a without prejudice basis. It is in

their self-interest to do so to minimise the risk of major future costs and in the best interests of the worker in terms of rehabilitation.

However, there are significant obstacles to making early reporting part of the system. The employer needs to be in a position to understand the importance of the early reporting and its role in outcomes. In principle, this ought to be relatively easy with large businesses. Where scale permits sophisticated business systems, one would hope that the links between the preventative occupational health and safety procedures and those that come into play after injury would be seamless. Indeed, there is evidence of this in some of the State's best practice businesses, both those that self-insure and those who take market insurance.

The first and centrally critical element in such a seamless relationship is the maintenance of the workplace relationship. The second element is the ownership of and commitment to the rehabilitation process in partnership with the injured worker. Thirdly, underpinning the first two elements, is employer/insurer use of a full frame of reference with respect to the worker, in only using dispute processes as a last resort.

The fundamental importance of the employer-worker relationship to successful rehabilitation was stressed to me again and again in the course of consultation. Trust between the employer and the worker in a shared understanding of the problem and commitment to successful rehabilitation is the key to success.

There are strong natural incentives to maintenance of the relationship. Any business has a significant 'sunk' investment in its workers which it stands to lose. Obviously, this is particularly true where the workforce is highly skilled and the skills are specific to the business. Examples such as nurses, aluminium welders or underground miners come readily to mind. But, if one thinks of the simple test of how easy would it be to replace a worker and the processes and other costs involved, one quickly realises that for any business, where the quality of its workers is a key success factor, this is a potentially powerful driver. However, it is possible that its influence may be attenuated by a lack of understanding in business, in both private and public sectors, of this value-cost relationship. On the other side of the relationship workers have an investment in their skills and networks particular to their employment.

Given a strong basic relationship one would expect ownership and commitment to the rehabilitation process. However, we need to recognise that communication and negotiation skills are central in implementation of ongoing three-point contact between employer, doctor and worker. If this can provide a platform of trust, it greatly facilitates the subsidiary relationship with the insurer and providers of rehabilitation services.

Disputation can, of course, be very damaging to the underlying relationship between employer and worker. The ability to dispute claims, however, is a critical protection against abuse of the scheme. The costs of a claim are borne directly by the insurer, and only indirectly by business in terms of the experience component of premium setting. The insurer therefore has an essential role in disputation. However, just as earlier I noted that insurers are best placed to judge risk aspects of injury, it would appear employers are, in many cases, in a better position to judge when claims may be suspect. Employers possess a wealth of knowledge about the individual worker.

Where an insurer may see a possibility of 'rorting,' the employer may know this is a worker of good standing and commitment. A judicious last resort approach to dispute where the employer engages with the insurer is very important.

Early Reportage

It seems clear that early reportage of injuries could be improved. In this regard it is possible that there may be perverse incentives at work in the system. It has, for instance, been argued that the existence of the compulsory employer excess results in under-reporting of injuries. While excess provisions are a normal feature of insurance models, it is not obvious that in this case they serve their normal co-insurance role. The point of an excess in an insurance regime is to act as a disincentive to 'moral hazard'. Moral hazard exists when the taking out of insurance removes the incentive to try to avoid insured events, thus increasing the probability that they will occur . On this interpretation we would justify the excess as an incentive to good preventative behaviours. However, I do not find it persuasive that a cost at the margin like this can operate as a major incentive to effective occupational health and safety systems.

One would think that the sanctions available under legislation and potential future impact on premiums would be sufficient incentive. However, with new businesses of uncertain success and life there may be a stronger case for the employer excess.

It needs to be remembered that small business is very important in this area and small business in the start-up phase with an uncertain life may be significantly influenced by the existence of the excess in their behaviours. The Productivity Commission Interim Report identifies the main advantage of the excess as an incentive for employers to deal directly with small claims (p231), which I take to be an argument of administrative efficiency, but it also identifies the possible adverse consequence of under-reporting.

The major potential perverse incentive is that in seeking to avoid the excess, businesses may attempt to 'manage' through injuries they believe to be relatively minor, for instance, by resting a worker. ‘Flags’ for more serious adverse outcomes, that would be identified in reportage to an experienced insurer, might not be picked up.

It may also be the case that there is a fear that reportage of injuries will strongly influence experience rating and flow through to a significant impact on the insurance premium. This may mean that businesses seek to avoid either reportage or claim until they perceive there is no other option. The evidence that this is occurring is anecdotal, but it does seem to be the case that small business may not understand the principles upon which premiums are set and attach too great a weight to individual claim experience.

I note that some insurers actively engage in this area. It would seem desirable that market insurers, in consultation with the WorkCover Tasmania Board, should ensure that participants are educated in the principles of premium setting. In conjunction with removing the impediments to early intervention by insurers this may help drive a culture of early reportage. The Productivity Commission Interim Report refers to other measures that could be taken to ensure early reportage. (PC,p.231) It may well be that there are simple administrative mechanisms which can effect major

improvement in this area. For example, the Australian Capital Territory (ACT) has recently, in effect, separated processes of early reportage of injury, which are mandated, from the issue of claim. In the future it might be appropriate to adopt elements of the approach being tried in the ACT, once firm evidence of effectiveness becomes available.

Handholding

Small business faces special problems in workers' compensation. The small business is much more dependent on the insurer and there may be a tendency subsequent to injury to regard the problem as now being one of managing a claim and essentially a problem for the insurer. After all, that is what a premium is paid for. It is critical that employers understand that this is not the end of their role and they have an ongoing role in rehabilitation.

Involvement is undoubtedly facilitated by business scale and there are significant potential obstacles for small business, which may mean a more supportive structure needs to be put in place.

First of all, in the nature of being small, such businesses face a relatively low probability of an injury leading to claim. A typical small business is unlikely to have much, if any, experience of work related injury of a compensable nature. It would simply be irrational of the owner, given the other pressures to just survive, to invest significant resources in understanding the workers' compensation scheme and in business systems for rare events. However, at the very least it is important that the employer and workers have an understanding of the nature of the scheme, and in particular, its no-fault basis. In addition, as a consequence of the above, heavier reliance of the business on the systems of the insurer and early reportage of injuries, irrespective of their claim status are extremely important.

The employer-worker relationship may be even stronger in small business, particularly where it has been long standing. It is probable in Tasmania, where labour turnover is in any case significantly lower than in other parts of Australia, that underlying relationships are naturally stronger. The focus should be on how the post-injury process may stress this relationship.

In many of the discussions I had, the issue of education of workers and in particular of small employers was raised. The idea behind this is that, while large employers are likely to have significant experience in the area of worker's compensation and be well informed over the processes that need to be followed subsequent to injury, this is not the case with individual workers and unlikely to be the case with smaller employers. Suggestion was made that we need to invest in greater training of smaller employers so that they understand the processes to follow if an injury occurred to one of their workers, and also greater education to workers, possibly on induction, so that they better understood their rights and obligations in the area of workers' compensation.

While I have some sympathy with the view that it would be of value to make information on the general features of the statutory scheme more widely available in an easily comprehensible manner, I am not persuaded that it would be worth investing in a major education effort. Given the low probability of injury for an individual worker, I cannot see that there is a significant incentive for someone to invest serious

effort in learning the details of the scheme before an accident. Nor can I see how hard-pressed small business would think it worthwhile to invest the resources in such learning, given that the average life of many a small business is in fact less than the expected mean duration within which they could expect a claim.

I suspect a more cost effective approach is to look at processes to help guide workers in terms of their rights and obligations after they have been injured, and similarly for small business. It was put to the review that government should consider funding various parties to provide service in this regard. I am not at this stage prepared to make a recommendation to this effect. I rather recommend that the WorkCover Tasmania Board examine, from a cost-benefit basis, whether the application of funds to provide education services for injured workers and small business post-injury would have value.

I note again the distinction between those workers who return to work relatively quickly and are rehabilitated, and the small percentage of workers who end up with serious injury requiring long-term support. I believe that any such support should be focused on the process faced by this second group.

Alternative Duties

The value of *workplace-based* rehabilitation is widely accepted as a major contributor to successful recovery, providing benefits to both workers and employers. While statistics and anecdotal evidence indicate that most injured workers will return to their original position and employer quickly, some may not be able to return to their original duties, at least in the first instance.

In recognition of the value of return to work to recovery, all Australian jurisdictions place an obligation on the employer to provide suitable alternative duties for injured workers for a specified period of time. 'Suitable duties' should be determined on the basis of medical advice and must involve 'productive' employment; demeaning or token duties should not be offered. (Productivity Commission Interim Report, p148) From my discussions with injured workers and other stakeholders, it appears this is not always the case. I heard many stories from workers who returned to the workplace carrying out 'made up' tasks which they felt were not meaningful and which were, by their employer's admission, non-productive for the workplace.

It is not hard to understand the practical difficulties associated with finding meaningful alternative duties for an injured worker. There are clearly problems where a business is too small to provide alternative duties as part of rehabilitation, as the inability to return to work in the original workplace fractures the underlying relationship. Rehabilitation providers seek to place the worker in other workplaces. As far as I can see, this is, in most cases, the end of the matter for the original business, though I think good practice would include some role as a network of support and encouragement.

I suspect that the problem of placing injured workers in new workplaces is a growing one. It is clearly easier for large businesses to find an alternative set of duties, as these businesses encompass a wider range of roles. However, the changes that are occurring in the Tasmanian economy, in common with the rest of Australia, continue to increase the importance of small business. These forces that drive an increased emphasis on

small business are beyond our control. They include such things as a shift to a greater share of services in the economy, cutting back to focus on core activities by larger companies and the contracting out of many activities formerly done in-house. Most commentators believe these trends will continue.

There are, of course, natural difficulties in persuading an employer to take on a worker injured in another workplace. In addition, legal difficulties can arise as the legislation treats the aggravation of a prior injury in the new workplace as a new injury, which will often be covered by another insurer. This makes insurers and employers very wary of the potential risks.

The *Workers' Rehabilitation and Compensation Reform Act 1995* provides for a 'second injury scheme' to support return to work host employers. The JSC supported the establishment of the second injury scheme to provide incentives for host employers, such as indemnity against aggravation of prior injury, training allowances and premium exemptions in respect to workers engaged under the program. The JSC noted the importance of such incentives for schemes providing long-term income support, but that the common practice was to settle claims as soon as the medical prognosis was clear. (JSC, p66–67)

The second injury scheme has not been implemented in Tasmania. Given the intent of the 2000 legislation with respect to the shift to long term income support and rehabilitation, and recognising the problems for vocational rehabilitation, particularly for small business in the State, it would seem to me that re-consideration of the JSC's recommendations regarding the second injury scheme may be warranted. I therefore recommend that the WorkCover Tasmania Board investigate the implementation of the second injury scheme already provided for in the legislation.

I note that the legislation has the payment of entitlements through the employer as a means of keeping some contact. The legislation also gives the right of disputing liability to the employer even though this right is often passed to the insurer as a condition of the contract. This issue is taken up below in the discussion regarding dispute resolution.

DISPUTE RESOLUTION

Introduction

Dispute resolution is a critical element of the successful operation of any workers' compensation scheme. It aims to ensure the integrity of the system and its design and operation is strongly influenced by the nature of the scheme it serves.

As I outlined earlier, the key to successful injury management is a relationship of trust between the employer and worker. As vividly illustrated by 'The Sporting Analogy' (Appendix A), the best recovery outcomes are realised when all parties in the process feel and behave as if they are 'on the same team', and their 'voices' are in agreement. Disputation, however, inherently implies a lack of trust on behalf of at least one of the parties involved, and therefore has the potential to destroy the employer-worker relationship. The resolution of workers' compensation disputes 'should begin with the workplace, as inappropriate disputation is a powerful solvent to the workplace bond

between employers and workers'. (HWCA 1996, p147) Where the relationship between the employer and worker breaks down, recovery and return to work outcomes suffer greatly. The focus for effective dispute resolution should therefore be on preserving this relationship and using it as the vehicle for leveraging positive outcomes.

Complexity in terms of both the scheme and dispute resolution system (DRS) may also contribute to inconsistency in expectations and the 'voices' heard by the worker throughout the process. Where scheme boundaries lack clarity, disputation is likely to arise. Schemes should therefore focus on good design in order to prevent unnecessary disputation wherever possible. Where disputation does arise, but resolution processes are ineffective and/or inefficient, unnecessary stress and financial costs will be incurred.

Background

Effective disputation systems must focus on the prevention of disputes as well as effective and efficient resolution processes. Scheme design is therefore a key determinant. Features that work exceptionally well in some places cannot necessarily be picked up and dropped into the Tasmanian scheme.

The Productivity Commission Interim Report states that in no-fault workers' compensation schemes, disputation tends to arise not from the issue of negligence, but questions relating to access to, or the extent of, coverage, including: the work-relatedness of the injury; the extent of the injury; and access to entitlements. (p279) In respect of these, disputation is generally concerned with issues of liability: either the initial decision to accept or reject a claim; or, after a claim has been accepted, decisions and questions regarding aspects of a claim, such as payment for some medical treatment or changes in the level of benefit payable etc.

Primary decision-making regarding liability is a critical stage of a claim for the injured worker, and the employer and insurer making the decision. It is widely accepted and understood that early support and intervention for injured workers is a key determinant of positive recovery/return to work outcomes. It is easy to see why quality decision-making at this point is essential. Internal review – by the insurer in the case of privately underwritten schemes like Tasmania – is an important first stage for better practice primary decision-making. (TMS, *Resolving Disputes* 1995, p68) This activity usually involves reconsideration of the dispute decision by a more senior claims manager or member of a different claims team to provide an 'objective' view.

Currently there is no formal requirement for insurers to internally review claims decisions, although I heard from several insurers that the process was a critical part of their companies' business processes. I am uncertain how widespread this practice is, and, given the importance of quality decision making at this stage, I see no reason why we should not seek to encourage insurers in this direction. I recommend that an internal review requirement be included in an insurer developed Code of Conduct. Failing this the WorkCover Tasmania Board could consider including 'internal review processes' in the performance standards for licensed insurers.

Recognising the importance of the primary decision on liability, the 2000 amendments included the requirement for employers to commence paying weekly

benefits on a 'without prejudice' basis as soon as practicable after receiving a claim. The worker is therefore assured of his or her usual level of financial support while coming to terms physically, psychologically and practically with the injury and its consequences. Early support for injured workers is assured without prejudicing the employer's right to dispute liability, and provide time for the employer to gather information needed to come to an evidence-based judgement. The aim was to help facilitate a non-adversarial start to the claim, even where there might be some doubt in the employer's mind. This innovation has been well-received across all stakeholder groups, including employers and insurers, despite the increased risk it poses for cost recovery in the event of liability dispute being found in their favour. I believe the value of compulsory without prejudice payments cannot be overstated and its introduction should be applauded.

Alternative Dispute Resolution (ADR)

In an effort to improve the efficiency and effectiveness of dispute resolution, all Australian jurisdictions have incorporated alternative dispute resolution (ADR) processes in some form into their systems. ADR seeks to utilise informal, non-legal processes in the first instance, rather than traditional arbitration through the court system. The focus has therefore shifted from serving the rights of parties via legal process, to meeting the needs of parties through facilitated agreement. Better practice systems feature informal conciliation as the first step to resolve a dispute after the initial decision prompting the grievance, followed by determinative review, usually a formal hearing which enables accountability to the courts should a decision at this level be appealed to the courts. (TMS, *Resolving Disputes* 1995, p63)

This approach presents a number of benefits for scheme participants. Ultimately, ADR enables a broader range of tailored outcomes for individual cases than legal systems, which focus on narrow questions of rights and proof. (TMS, *Resolving Disputes* 1995, p2) The conciliatory approach allows and encourages parties to speak for themselves and explore solutions to their problems. Empowering the parties to resolve issues themselves promotes greater acceptance of outcomes and helps maintain the employer-worker relationship. Each level in the disputation process has successively higher costs, therefore effective ADR can also offer significant financial savings. The monetary and social cost savings can result in greatly improved rehabilitation and return to work outcomes. (c.f. Productivity Commission Interim Report 2003, p283)

Tasmania's Dispute Resolution System

Tasmania's current dispute resolution system is designed with best practice principles in mind. It has featured ADR for some time, which was further strengthened by the 2000 amendments. Disputation is dealt with by the Workers' Rehabilitation and Compensation Tribunal – funded by the WorkCover Tasmania Board and administered by the Tasmanian Department of Justice and Industrial Relations. Parties aggrieved by decisions made by the Tribunal at arbitration may make an appeal, on a point of law, to the Supreme Court.

The 2000 reform package formalised a shift in emphasis to conciliation as the primary focus for dispute resolution. With the exception of the employer's initial disputation

of liability, conciliation was made a mandatory first stage of the process. Conciliators were given greater powers, including the power to direct a party to provide any documents that may help resolution, refer a medical question to a medical panel, recommend interim orders to the Tribunal, and to recommend a dispute proceed to arbitration. These changes support the aim of best practice dispute resolution and as discussed below, appear to be improving dispute resolution outcomes.

Formalisation of ADR

In my view the new structure has greatly improved the efficiency and effectiveness of Tasmania's dispute resolution process. According to the 2002–03 *Workers' Rehabilitation and Compensation Tribunal Annual Report* (p7), approximately 65 per cent of disputes are now resolved through the conciliation process. Furthermore, the number of substantial matters requiring arbitration has declined (p10). The new structure therefore appears to be achieving its aim of ensuring the majority of disputes is dealt with via ADR, with only relative complex matters requiring arbitration.

Timeframes for Resolution

Timeframes for resolution, however, remain a problem. Significant delays are occurring in relation to the finding of a 'genuine dispute' of liability for a claim. These disputes, made under Section 81A of the Act, are subject to a different process to other disputes and will be discussed separately later.

I also heard anecdotal evidence of long delays in the time it takes for matters to be resolved in the Tribunal. This is confirmed in the *Workers' Rehabilitation and Compensation Tribunal Annual Report 2002–03*, which notes that despite reductions in resolution timeframes over the past two years, there is potential for further reduction. The report attributes the delays to external factors, such as delays in obtaining medical appointments and receiving medical reports. Acknowledging the problem, the Tribunal has committed to taking steps over the next 12 months to address these delays. (p12)

Representation at the Tribunal

In support of the ADR principles of informality, empowerment and non-legal processes, Tasmanian legislation permits representation during the conciliation process, but allows legal representation only where a party may be materially disadvantaged, or the process hindered. Victoria, Northern Territory and Western Australia have also taken steps to limit legal representation during ADR. Other states, however, continue to allow choice in terms of representation. Interestingly, after ten years of exclusion, Western Australia is planning to reintroduce participation of legal practitioners at all levels of the DRS. This move is based on the findings of an evaluation of workers' compensation in Western Australia by Robert Guthrie (2001, p148) that inequities result – particularly for the less powerful parties in the process, namely injured workers – when legal practitioners are excluded. The Western Australian Government hopes to control the consequent legal costs via a number of measures, such as a prescribed fixed price, task-based fee structure. However, this is controversial, and in any case, is premised on having appropriate non-adversarial processes. In my view it is more appropriate at this time to build on our existing

structure to improve process. It may be appropriate, in the longer term for the WorkCover Tasmania Board to revisit this issue, after the Western Australian changes have had time to be thoroughly tested.

In my view, while in line with good design principles, the attempt in Tasmania to limit legal representation appears not to be achieving its objective. It is apparent that the parties involved, particularly injured workers, are commonly represented by a lawyer at the Tribunal. From my consultations, I believe that a number of factors are likely to have contributed to this trend, including the complexity of the workers' compensation scheme as well as the dispute resolution system, lack of awareness of the process and a lack of readily available information and advice.

It is clear to me that injured workers generally have very little knowledge of the system. This is also the case for most small business employers. However, they are usually accompanied or represented by insurers, who have their extensive knowledge and experience of the system, if not a formal legal background. The knowledge deficit among workers creates a significant power imbalance, frequently leaving the worker little choice but to seek representation, usually a legal practitioner. Unions, traditionally the advocates for workers in dispute processes, have told me that in recent years they have felt ill-equipped to provide advice and represent injured workers where there are likely to be significant legal implications. It was put to me that where disputation arises, union officers almost always refer members to legal practitioners.

The heavy reliance on legal representation and adoption of a legalistic style of behaviour in dispute resolution is contrary to the legislative intent of recent changes to focus on ADR. The recommendations made here are aimed at creating a less adversarial process and reducing legalistic behaviour.

Confidentiality and disclosure of information at conciliation

Another provision in the legislation supporting ADR requires that all discussions held with a conciliator are to be confidential and conducted without prejudicing any subsequent stages of dispute resolution that may occur. Notes or documents presented at conciliation are not to be disclosed to the Tribunal unless used to support a recommendation by the conciliator, or in order to make a determination regarding costs. The aim of this is to encourage open and frank discussion of issues.

A provision also exists which requires the full disclosure at conciliation of any information to be relied upon at a subsequent arbitrated hearing. Both stakeholders and Tribunal staff have noted reluctance among some parties to comply with this requirement. It has been recognised that Tribunal processes could assist compliance with this provision and steps are being taken by the Tribunal. For example, 'the conclusion of the conciliation process will be formalised and at that time each party will be reminded of the restrictions as to the use of expert evidence not disclosed.' (WR&C Tribunal Annual Report 2002-03, p6).

It is encouraging to see the Tribunal seeking to provide a proactive response to this problem. In my view, it is critical that full disclosure is rigorously enforced at conciliation in the interests of building trust in the process. If, in practice, new material can be introduced at arbitration, then this may act as an incentive to

adversarial ‘game playing’ in the conciliation phase designed to delay ‘showing one’s hand’. This could fatally undermine conciliation and further reintroduce an adversarial structure and necessitate reliance on legal practitioners.

I recommend that the WorkCover Tasmania Board monitors and supports the steps being taken by the Tribunal to ensure the disclosure of information during the conciliation phase that will be relied upon in arbitration.

Medical Panels

A significant source of workers’ compensation disputes is the area of medical opinion. Government dispute resolution bodies and courts, which rely upon conciliatory or legal processes, however, have a limited ability to resolve disagreement efficiently over medical issues. It is also clear that, where an adversarial environment exists, there are real risks of ‘doctor shopping’ on both sides to support ambit positions in negotiation. Many systems therefore provide for questions of a medical nature to be referred to a panel of independent medical ‘umpires’.

Both the HWCA and the JSC recommend that medical panels be used at any time in the dispute resolution process. As expensive resources, however, their use should be restricted to determining questions of a purely *medical* nature and considered as a last resort to avoid delays and overloading of panels. (HWCA 1996, p153; JSC p78-9) It is therefore important that legislation clearly defines what constitutes a ‘medical question’ so that effective screening takes place. Once invoked, medical panels are best utilised where panel decisions are binding, set medical precedent for the system, and are considered as authoritative medical opinion by the courts rather than as only one of several opinions. (TMS, Resolving Disputes, p6)

The Act has allowed for medical questions to be referred to medical panels for resolution since 1988, and the recent reforms saw further refinement of these provisions to encourage their use. Conciliators now have the power to refer medical questions to medical panels. In addition to a number of administrative alterations, the definition of a ‘medical question’ was clarified, and the legislation altered to limit the use of a medical panel where there is conflicting medical opinion between the worker’s doctor and the employer or insurer’s doctor.

I note that granting conciliators the power to refer medical questions to medical panels was, on the face of it, a positive step. Medical issues are often debated at length and unsuccessfully during conciliation, when the question could in fact be resolved relatively quickly by a panel of impartial and authoritative individuals. In practice, however, medical panels are being used rarely, if at all in Tasmania. The Tribunal, which is committed to the use of medical panels where appropriate, acknowledges the under-utilisation of medical panels. In its 2002–03 Annual Report, the Tribunal acknowledged that the opportunity to use a medical panel is not being recognised at an early enough time during the conciliation process. It also stated its commitment to improving its processes so that added emphasis is placed on the early identification of ‘medical questions’ and referral of these questions to a medical panel. (p11) I strongly support this move and recommend that the WorkCover Tasmania Board monitors and supports the steps being taken by the Tribunal to ensure the early identification of medical questions and referral to medical panels.

Definition of a Medical Question

In many cases, disputes over medical opinion are not referred to medical panels due to structural, rather than cultural factors. The Workers Rehabilitation and Compensation Act 1988 (Section 3) is very specific in terms of what constitutes a 'medical question', that is, one that directly relates to the existence, nature or extent of an injury, level of impairment and/or a worker's capacity for work. Questions regarding what is reasonable treatment for an injured worker are not included and therefore cannot be referred to a medical panel.

It is apparent to me that the current process for resolving such disputes – particularly those where a treatment option is relatively expensive – raises significant problems. Firstly, where non-expert parties debate differences of technical opinion, processes become distinctly adversarial. If the parties have legal representation and the debate is conducted in a legalistic manner, the process is even more adversarial. Secondly, there is a significant risk that determinations will be made on the basis of inappropriate and/or irrelevant considerations.

The third reason, while more philosophical in nature, has significant practical implications for injured workers. In the absence of a reliable, expeditious and authoritative process for resolution, these disputes appear to be presented to the Tribunal for resolution only after the treatment has been incurred. It has been put to me that the financial risk for the worker can act as a significant disincentive to treatment where the time factor is important to the end result. There is a major difference in the position of a worker with savings or other financial support, and the worker with little or no capacity for unexpected expenses. This, in effect, can lead to discriminatory outcomes, depending on the worker's financial capacity to take the risk that they may not be compensated for a treatment recommended by, or through, their doctor.

To address these issues, I recommend that:

- the definition of 'medical question' be expanded to include questions regarding 'significant medical treatment';
- a definition of 'significant medical treatment' be developed and incorporated into the legislation to enable the Tribunal to effectively screen matters for referral to a medical panel;
- processes be developed to ensure medical panels can be invoked promptly once a referral has been made; and
- the provision under Section 77 of the Act – which allows the Tribunal to determine prospective questions regarding medical or rehabilitation services – be promoted to encourage its application in conjunction with the early referral of significant matters to a medical panel.

Medical disputes – process issues

It is my view that the process for disputing medical treatments as prescribed in the *Act* could be improved. Prior to the recent reforms, disputes over liability for medical

expenses were subject to the same process as disputes over initial liability (discussed later in this section). However, the procedure proved, in most cases, unnecessarily complex and lengthy, resulting in significant delays in payments being made to doctors and other allied health professionals.

Changes included in the 2000 reform package sought to address this by creating a new process for the disputation of medical accounts. These disputes are now subject to Section 77AA, requiring an employer to pay a claim for expenses promptly (within 28 days) or refer it to the Tribunal for resolution via normal dispute resolution processes. As a result, S77AA disputes have reduced somewhat. The number of these disputes, however, remains significant, particularly given that the majority relate to a more significant dispute on a fundamental issue of entitlement to workers' compensation generally. There is therefore little prospect of resolving these disputes individually, as they usually become subsumed by the broader issue associated with the claim. (WR&C Tribunal Annual Report 2002–03, p8)

I also heard reports that repeated disputation over successive expenses – particularly in the case of long-term claims where issues of full or partial recovery were being debated – was a substantial source of stress for injured workers. This is claimed to increase workers' vulnerability at a time when there tends to be an increased focus on settlement discussions with insurers. Several injured workers even went so far so as to claim that employers and insurers were using the process vexatiously to 'wear them down' prior to offering unreasonably low settlements. While I am not asserting that the latter is in fact the case, I am convinced that the situation causes undue stress for workers and an often unnecessary administrative burden on the Tribunal.

I note that this is but one example of where there is a perception of poor ethical behaviour by insurers which might be overcome if the industry spoke with one voice with respect to fair dealing with injured workers.

In my view, a structural approach is also needed to address this particular issue. I therefore recommend that the procedure for dealing with Section 77AA medical disputes be replaced by a process whereby the Tribunal may make an Interim Order to relieve the employer/insurer of liability in respect of a particular account, a group or type of accounts, or all accounts in respect of treatment. This should help ensure that the resolution of disputes over medical treatment focuses on the broader issues associated with a claim or, if appropriate, the particulars of a particular expense incurred.

The combined effect of the above recommendations regarding medical panels and medical questions with the revised process for disputing medical accounts, should result in a more streamlined, speedy process to benefit both workers and employers/insurers.

Initial Disputation of Liability for a Claim

Without Prejudice Payments

Upon receipt of a workers' compensation claim, the employer must commence payment of weekly benefits to the worker, even if there are questions surrounding the

employer's liability for the claim. As discussed earlier, this offers significant benefits for the injured worker, the employer-worker relationship and injury management.

I note that the without prejudice payments provision does not include payments for medical treatment, which might include important diagnostic and treatment services. Where liability for a claim is not finalised quickly, injured workers may not be able access the medical services they need as part of what is referred to as 'early intervention'. Of course, the continuity of income support afforded by without prejudice payments will help many workers access these services. However, I consider it unlikely that workers in the lower income brackets could afford the same level of access. Furthermore, we should not assume that workers themselves understand the strong relationship between early intervention and subsequent recovery rates. We must recognise that their decision-making about whether to expend household funds on an expensive diagnostic or treatment service may reflect very poor understanding of the risks.

I am pleased that several insurers I spoke to indicated that, in the interests of early intervention and injury management, they generally paid for medical treatment on a without prejudice basis. This approach is both consistent with best practice and highly rational, given that it is widely recognised that early intervention is one of the most effective ways of reducing the costs associated with work-related injury. While I am not aware of the extent of this practice across all insurers, where initial liability is in question, I can, however, see potential for workers to miss out on important early medical interventions. For the reasons described above, it is my view that in such cases where expenditure on early medical services is left to the worker's judgment, there is a strong probability that the interventions may not occur.

However, there are a number of other factors which hinder early intervention and hamper the proactive efforts of these insurers. Obviously early intervention cannot occur until the employer and insurer are advised of the injury. Early reporting of the injury is therefore critical to early intervention and successful injury management. However, it is clear to me that early reporting is not taking place. I believe this is due to a widespread lack of understanding, among both workers and small business employers, of the risks associated with delayed reporting and a worker culture variously characterised by stoicism, guilt or fear of retribution.

In recognition of the importance of early intervention I suggest that, in an ideal world, without prejudice payments would be extended to include all medical payments. While I note that other jurisdictions are experimenting with innovative methods in this area, I do, however, believe it is important to be very cautious about 'borrowing' features of schemes different from our own. In any case, this approach would represent a major change to the scheme and I am sensitive to the difficulty of predicting the cost implications of the combination of recommendations in the area of without prejudice payments, initial liability disputes and medical disputes. At this stage, I therefore think it prudent to take a more moderate approach and harness natural incentives into our system and procedures. I believe we should look for ways to encourage voluntary without prejudice medical payments through, for instance, an insurer Code of Conduct. Prescriptive provision for without prejudice medical intervention, however, would be warranted for serious cases deemed necessary and urgent by the worker's treating doctor, which meet certain specified criteria. It may be appropriate for the Tribunal to make determinations where some doubt regarding such

a matter exists. I believe that this gateway should be narrow, and therefore it is worth considering the application of a minimum cost or other threshold to ensure such determination of significant interventions only, and a maximum total cost limit to provide some certainty to insurers.

I therefore recommend that any capacity to voluntarily engage in without prejudice intervention be taken advantage of by:

- Encouraging the provision of without prejudice medical interventions, through for example, an industry developed insurer Code of Conduct;

- Investigating and addressing any potential legal or administrative obstacles arising from the above recommendation which might prejudice the insurers' position regarding any subsequent liability dispute; and

- Enabling the Tribunal to make an interim order for a medical expense to be paid in exceptional cases, where a medical practitioner deems that failing to provide the service would have a significant negative effect on the worker's health or employment outcomes; and the treatment meets specified criteria, for example, relating to cost and clearly demonstrated urgency in respect of outcomes.

These options and all other individual recommendations relating to initial liability disputes should be considered in the context of the two broad options for change detailed at the end of this section.

During the course of the review, however, I heard requests from employers for these without prejudice payments to be recoverable, not just in the case of fraud – which is already provided for in the legislation – but also where the dispute for liability is found in favour of the employer. The current *Act* does allow, in such a case, for an employer to recover benefits by deducting overpaid weekly benefits from a worker's sick leave (section 81AA). It is not evident how frequently this provision has been applied by employers. In my view this would not appear to cause significant hardship for the worker, given that he/she would have taken the time off in sick leave in any case. I therefore do not support change to the provision regarding recovery of without prejudice payments.

It was brought to my attention that there may be some ambiguity in the Act with regard to the provisions for the recovery of overpaid benefits. Section 81AA states that '*An employer may deduct from a worker's sick leave entitlements any period during which the worker was paid compensation by way of weekly payments or other benefits if liability to make those payments or pay those benefits is subsequently determined not to exist*.' It appears that some employers/ insurers are interpreting this as permission to deduct overpayments from workers' *future* sick leave entitlements where existing sick leave balances do not cover the amount owed. I believe this to be against the intention of the legislation, which was to allow deductions from existing sick leave entitlements only. I recommend that Section 81AA be amended to clarify that overpaid benefits may only be deducted from a worker's existing sick leave balance available at the time that the overpayment was identified.

The Act is silent on the re-crediting of sick leave deductions in the event of a dispute being subsequently quashed. I believe that it is important that the payment recovery

through sick leave entitlements be reciprocal. I recommend that the legislation be amended so that where overpayments have been recovered from a worker's sick leave but liability is later found to rest with the employer, the employer must restore the deducted sick leave entitlements.

Initial liability disputes – the process

The employer's initial decision to accept or reject liability for a claim is of critical importance for employers and workers. For the worker, it signifies, among other things, the perceived validity of their injury, their value as a worker and a measure of the employer-worker relationship. For the employer, the significance of the initial decision relates to two factors. Firstly, a dispute at this point in time (under Section 81A of the Act) enables a fundamental shift in the burden of proof to the worker. If the Tribunal finds that a 'genuine dispute' exists, payments cease, and the onus is on the worker to prove his or her initial entitlement to workers' compensation via the Tribunal procedures for general disputation. Secondly, failing to dispute liability within 28 days represents, by default, an admission of liability by the employer. As a result, historically there has been a tendency for employers/insurers to dispute liability in order to protect their position while considering the issues.

Prior to the 2000 reforms, the time period for an employer to make the initial decision to dispute initial liability for a claim was 14 days. However, this did not allow enough time to obtain the information necessary to make the decision. A significant number of claims were being disputed as a means of 'buying more time' due to a lack of available information, rather than because an authentic dispute over a substantial liability issue existed. This is clear because a significant proportion of claims were subsequently accepted by the employer before being heard in the Tribunal.

All liability disputes, however, even those abandoned prior to hearing, can severely damage the employer-worker relationship, and as a consequence, adversely affect recovery outcomes. Workers commonly complain that the process suggests their integrity is being challenged and they have to justify making a claim for an injury they did not choose to have. It was felt important to remove the incentive for employers or their insurers to use the initial disputation provisions as a delay tactic or to simply shift the burden of proof to the worker, given their difficulties in having sufficient evidence within the timeframe. The 2000 reforms therefore included an extension of timeframe to 28 days for making the initial liability decision.

According to statistics cited in the Tribunal's 2002–03 Annual Report, Section 81A referrals decreased from 8 per cent of all claims lodged in the 2000–01 financial year to 6.5 percent in 2002–03 (p11). The extended timeframe therefore appears to have resulted in some reduction in disputation rates and, according to reports heard during the review, has been well received by employers and insurers.

I have heard many complaints, however, about long delays – often up to two to three months – between the referral of a Section 81A dispute to the Tribunal and the actual hearing to determine whether a genuine dispute exists. In addition, the statistics show that one third of S81A referrals in 2002–03 were subsequently accepted by the employer before being heard at the Tribunal (data provided by Tribunal staff).

Close examination of the process, however, has highlighted a number of serious problems that are contributing to delays and inefficiencies in the system. The employer has 28 days in which to lodge a Section 81A dispute, specifying the date by which it expects to obtain the necessary information to present at a hearing before the Tribunal. The timeframe specified is often in the vicinity of two or three months, to allow time for investigations to be conducted and reports to be prepared. The worker is notified of the dispute and continues to receive without prejudice payments, which the employer may or may not be able to recover if a genuine dispute is subsequently determined. The Tribunal records the referral and schedules a hearing after the specified date. From the Tribunal's point of view, the matter is 'shelved' until the date of the hearing or the employer withdraws the referral. Where a report is obtained prior to the hearing that supports the worker's claim for entitlement, the employer may withdraw the dispute and accept liability, but by that time the damage to the relationship is done.

It is important to understand that the cause of these delays is not related to Tribunal resourcing factors – a complaint made frequently and unfairly – but instigated *at the request of the employer/insurers* who require more time to obtain information necessary to the primary decision. I have heard that this information is largely associated with medical assessments and other investigative reports. Given that employers must continue without prejudice payments until a hearing occurs and determination made, this suggests to me that the delays are not merely driven by 'tactics'. I note that payments are often not easily recoverable if liability is subsequently rejected. Insurers are clearly prepared to delay hearing dates at their own risk.

The problem of delays following workers receiving Section 81A dispute notices and hearing dates therefore appears to be structural; the result of an unreasonably short timeframe for lodging a Section 81A dispute in the first instance, and inevitably long timeframes for investigative reports to be produced. I therefore recommend that the time limit for employers to decide initial liability and therefore make without prejudice payments be extended to 12 weeks.

It is important to understand that this recommendation will have little effect on actual practice, but will remove an adversarial feature of the process that is clearly having a significant negative impact on the employer-worker relationship. In addition, the recommended timeframe is a time *limit* and would in no way be a barrier to finalising the primary decision and referral of a dispute earlier, should the information to make that decision be available.

Of course, given the extended period for without prejudice payments, it is critical that administrative processes following referral to the Tribunal do not result in further delay. Employers and insurers must have confidence in prompt hearing of their initial liability disputes. While it would appear that the Tribunal's resources are adequate for this, I recommend that the WorkCover Tasmania Board monitor the timeframes for scheduling genuine dispute hearings in the Tribunal to ensure delays are not occurring.

Once Section 81A disputes reach a hearing, the Tribunal must determine whether a 'genuine dispute' exists. At present, the threshold for what constitutes a 'genuine dispute' is very low, due to a precedent set by the court which, provided the dispute was

not frivolous or made without adequate enquiry, did not see a need 'to look beyond the employer's declared attitude' (Cox J. in *State of South Australia v Wall* [1980] at 194). As a consequence, many s81A disputes may be classed as 'artificial'[8].

The potential impact of the low threshold is evident when the consequences of the genuine dispute determination are considered. Firstly, the Tribunal must order the cessation of compensation payments to the worker. This can create financial hardship and feel like a punishment for many workers. It may also prevent the worker obtaining necessary treatment, thereby threatening rehabilitation and return to work outcomes. Secondly, if a worker wishes to contest the employer's decision to deny liability, he/she must lodge his/her own dispute to the Tribunal and assume the burden of proof for entitlement to compensation. In the context of the low threshold, this shift in the burden of proof to the worker is of serious concern. The ability of injured workers to cope with the immediate physical and psychological consequences of their injuries, obtain necessary treatment and competently manage proving their entitlement, with little or no understanding of the system, appears to be severely limited at this time. In a no-fault scheme providing for without prejudice payments, it is unlikely that such a power imbalance was ever intended. It appears to have come about as an unforeseen consequence of the time needed to gather evidence on whether to dispute, the natural incentive of employers and insurers to protect their position and the legal interpretation which prevented the Tribunal acting as an effective gatekeeper. It is important that where the consequences of a provision are so significant, all the factors affecting the power balance between the parties are carefully considered.

In my view it is important that the Tribunal is in a position to apply a test of reasonableness to ensure that the dispute process is not used unnecessarily or inefficiently. I recommend that the Tribunal be empowered to apply a more stringent test for what constitutes a genuine dispute, namely, whether a prima facie case has been made that there are reasonable grounds for dispute. This would involve an assessment of the material put before it, without reference to the other side, as to whether a reasonable person could be satisfied that there are sufficient grounds to justify the dispute.

Related to this and other issues discussed above, I recommend that all Section 81A referrals must be lodged with sufficient information to support a prima facie case. This will ensure that only well considered cases are referred and that the Tribunal has sufficient information to apply the test.

Despite the legislative intent to de-formalise disputation and encourage alternative dispute resolution, the process for disputing initial liability (under Section 81A) remains highly formal, adversarial and based on somewhat arbitrary considerations. I have heard many reports from injured workers that the process involved little, if any, verbal communication between the employer and worker, did not make sense to them and caused them significant stress.

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[8] The Productivity Commission, in its *National Workers' Compensation and OHS Frameworks: Interim Report* distinguishes 'artificial' disputes – those that are generated by the handling of claims, including mistakes and misunderstandings; and 'genuine' disputes – when the parties have shared all the information, but remain at odds and require the intervention of a third party. (2003, p280)

In most cases, the injured worker learns that the employer is disputing the claim via a short formal letter citing the relevant section of the legislation under which the dispute is being lodged. This practice is inconsistent with the intent of Section 81A(1)(b) that requires the employer must 'inform the worker of the reasons for disputing liability'. A number of negative consequences follow. The injured worker frequently does not understand the reference to the legislation and therefore does not understand what the dispute is about. Many injured workers also reported that during the time between receiving the notice of dispute and the hearing, they heard nothing from their employer and felt 'abandoned'. They experience feelings of confusion and anger at being left 'in the dark' and at a disadvantage. The resulting disempowerment can be a source of great stress and the employer-worker relationship inevitably suffers as a result.

In practice, the insurer, as the employer's 'agent', usually issues the dispute notice to the worker. Over time, these notices have become very sparse in terms of detail and the reason for the dispute communicated primarily through citing the relevant section of the Act. From my discussions with Tribunal personnel, it appears that this practice has evolved as a means by which the employer/insurer may 'keep its options open regarding the grounds for the dispute' in order to protect its legal position in any possible future stages of the process. Where there are potentially long delays between the lodgement of Section 81A disputes and subsequent hearings, it is important that the employer communicates the reason for the dispute to the worker clearly.

One of the advantages of extending the timeframe for without prejudice payments and finalising initial liability is that it will reduce the pressure on employers to keep their options open regarding the grounds for dispute. In my view, they will therefore have sufficient time to gather all the information and evidence they need to make a decision, and communicate without any doubt, the precise reasons for the dispute to the Tribunal and the worker in plain English.

I therefore recommend that the WorkCover Tasmania Board considers what steps can be taken to facilitate better communication between the employer, the insurer and worker during disputation, particularly in relation to the initial liability decision. I suggest that a combination of face-to-face and improved written communication, regarding the reasons for disputation and to try to resolve any minor questions, would greatly alleviate existing communication problems.

The question of who should appropriately make the initial dispute was raised during the review. The Act clearly states that liability disputes under s81A must be lodged by the employer. The aim of this is to ensure that employers remained central to the decision and subsequent process. However, I heard that in practice, it is frequently the insurers who drive decision-making and disputation over liability. Evidently, many employers do not understand the 'genuine dispute' provision, are often not actively involved in the disputation process and at times either do not agree with, or are ambivalent about, the decision taken by insurers to dispute liability. What is essentially happening in practice appears to me to be contrary to the intent of the legislation.

Two insurers suggested to me that initial disputation is often based on complex legal and technical grounds that the insurer, rather than the employer, understands. They proposed that making the insurer the primary decision maker could be beneficial as it

could distance the employer from the process and therefore help protect the employer-worker relationship. I am not convinced by this argument. When viewed in the broader context of the dispute resolution process and best practice principles, I feel that the employer should not in any way be absolved of responsibility for the initial liability decision and consequent action. To do so would remove the employer's incentive to try to resolve issues with the worker in the first instance and manage the employer-worker relationship through the process. I do not support change to the provision requiring the employer to lodge disputes over initial liability.

It is widely agreed that injured workers and many small business employers lack an understanding of the workers' compensation system and the disputation process, in particular. The Tribunal is planning to alleviate the problem somewhat by designing a web site and publishing a new range of brochures covering key areas of the disputation process. While I strongly support the Tribunal's efforts to this end, I believe that the problem must be seen in the context of an apparent lack of knowledge and understanding of the scheme generally. I recommend that a coordinated approach to all scheme communications, including those relating to dispute resolution, activities be undertaken under the direction of the WorkCover Tasmania Board.

Workers' compensation legislation is highly complex, the result of years of evolution and learning. Implementing significant change brings considerable risk. It is clear to me that there are myriad interconnections and complex relationships between the specific elements of the scheme and the dispute resolution system, which, when considering change, introduce additional risk. It is my view that simple fixes should be considered against significantly reengineering systems, particularly in the case of the workers' compensation dispute resolution process. While a root and branch approach could be taken with respect to addressing the problems identified with initial liability decisions and disputes, this would involve major change to the legislation. I believe the simpler approach outlined above is preferable at this time. Given that a broader review of the scheme is likely when the legislation has matured, I offer for future consideration a more radical approach under Term of Reference 3.

Initial liability disputation – recommended approach

It is clear to me that there are significant issues associated with the process for disputing initial liability. Clearly it is not working as originally intended. It is very important that the changes proposed to the complex process of initial liability disputation are seen as an integrated package. I therefore believe it is helpful to summarise the recommended approach, as follows:

- Section 81AA to be amended to clarify that overpaid benefits may only be deducted from a worker's *existing* sick leave entitlements, available at the time that the overpayment was identified.

- The legislation be amended so that where overpayments have been recovered from a worker's sick leave but liability is later found to rest with the employer, the employer must restore the deducted sick leave entitlements.

- The time limit for employers to decide initial liability and therefore make without prejudice payments be extended to 12 weeks.

- The WorkCover Tasmania Board to monitor the timeframes for scheduling genuine dispute hearings in the Workers' Rehabilitation and Compensation Tribunal to ensure delays are not occurring.

- The Tribunal be empowered to apply a more stringent test for what constitutes a genuine dispute, namely, whether a prima facie case has been made that there are reasonable grounds for dispute.

- All Section 81A referrals must be lodged with sufficient information to support a prima facie case.

- The WorkCover Tasmania Board to consider what steps can be taken to facilitate better communication between the employer, the insurer and worker during disputation, particularly in relation to the initial liability decision.

- A coordinated approach to all scheme communications, including those relating to dispute resolution, activities be undertaken under the direction of the WorkCover Tasmania Board.

SETTLEMENTS

It is possible under certain circumstances for claims to be 'settled out' with a payment from the insurer, allowing the injured worker to exit the scheme and absolving the insurer of further liability. This has proved a difficult issue for this review because evidence is not yet available to assess the materiality of what is happening with respect to injured workers accepting settlements and leaving the statutory benefits scheme. I note that this is to be expected due to the relative immaturity of the model noted earlier and inconsistencies in the data as noted in the 2002–3 WorkCover Tasmania Board's Annual Report (p63). For these reasons I have chosen to recommend measures that I believe reinforce the existing intent rather than suggest fundamental change.

There are two sets of issues which I believe need to be addressed. The first is concerned with the nature of settlements and their relationship to the underlying objectives of the scheme. The second set is concerned more with the process of negotiation by which settlement arrangements are arrived. In my discussions with injured workers it was this process which was of most concern. It is also very important that the following discussion is understood in the context of other proposals made elsewhere in this review. In particular, these should significantly assist in removing the perception of a power imbalance in the negotiation process and improve the trust that is so important between workers, employers and insurers.

Understanding settlements has been hampered by the differing use of terminology and often unconscious assumptions being made about relationships. For instance, in some cases, common law damages and lump sum settlements by agreement are referred to as if they were the same thing.

We need to carefully distinguish at least the following: an action for damages through the courts under common law; a voluntary agreement by the parties which involves a lump sum payment to the worker and indemnifies the employer from any further obligations through a common law deed of release; redemption or commutation of

statutory benefits under the terms permitted by the legislation; and the form of any settlement or redemption whether lump sum or structured as an annuity. We need to examine the issue of lump sum settlements in terms of what can be done now to ensure the intent of the legislation is effective. I also discuss some longer-term issues such as those posed by structured settlements under Term of Reference 3.

A major focus prior to the recent amendments was the increase in common law settlements and the resultant impact on costs. In its benefits model put forward for discussion, the JSC recommended that access to common law damages continue to be available, but be limited to injured workers with a greater than 30 per cent whole of person impairment. The legislation was subsequently amended to impose such a restriction in access to common law under Section 138AB. This was brought in essentially to reduce costs by eliminating the expense associated with the adversarial legal process. However, it appears to have also been assumed that this measure would also prevent lump sum settlements by agreement through a deed of release under common law, thereby leaving the parties with only the process of redemption of benefits as controlled by the legislation.

While Section 138AB certainly restricts access to pursuing common law damages in court, it would appear not to restrict voluntary agreements accompanied by a common law deed of release. There seem to be differing views as to whether the legislation is effective in placing any requirements on these voluntary agreements. However, under Section 39, the legislation is quite restrictive in the constraints it imposes on ‘settlements of claims by agreement’.

There are a number of arguments against permitting settlement of claims by a lump sum payment. These have been dealt with extensively in previous reports. There are two potential undesirable outcomes. The first is that lump sums will be mismanaged and fail to provide security to workers in the longer term. The second is that as a consequence of settling a claim out of the scheme, there will be cost shifting to the social security and health systems as workers fall back on these after running through their money.

Given that these areas lie within the expenditure responsibilities of the Commonwealth, the Australian Government is concerned that the design of the states’ workers’ compensation schemes may encourage this sort of cost shifting. I am persuaded that the Tasmanian scheme seeks to limit this. Furthermore, it should be noted, as did the JSC (para 8.16), that the Commonwealth’s taxation policy, whereby redemptions/commutations are taxed as income, is a powerful incentive for workers to seek undifferentiated lump sum payments under common law. As there is no identification of the income being capitalised, despite a strong presumption that a major component involves release from the obligation to make income payments, these payments are currently treated as non-taxable capital. This is taken up further under Term of Reference 3.

It is also important to be aware that the existence of lump sum payments can undermine the culture of long-term income support by introducing perverse incentives. There has been a concern in several jurisdictions to try to eliminate what is variously referred to as the ‘lotto mentality’ or ‘pot of gold’ problem – that is, that the seeking of a lump sum settlement encourages behaviours which go against the objectives of the workers’ compensation system. The prospect of a lump sum

payment agreement may encourage exaggeration of injury, non-commitment to rehabilitation and return-to-work and the use of an adversarial legal process which significantly raises scheme costs.

This is not to say that there is no case for lump sums. It may be that there are special circumstances where a settlement can provide some finality to the process, and a capital sum may provide a basis for injured workers to move on with their lives. Most authorities, however, agree that this should be a limited option. There are some who accept the arguments for finality but argue that structured settlements, which pay the benefits over time, are needed to prevent dissipation and cost shifting.

I believe it is too early to ascertain whether the intent of the legislation is being undermined purely from the number of settlements. However, I think it critical that the intent of the legislation with respect to lump sums, as expressed in the restrictions that were put in place over settlement of claims, is respected. The legislation under Part IV deals with claims for compensation and their settlement by agreement. Section 39 makes clear that a claim for compensation may not be settled by agreement unless the injury in respect of which the claim is made is stable and stationary and 12 months have elapsed since the date the claim was lodged. Section 89 places identical restrictions on redemption of liability for weekly payments through a lump sum payment.

As noted above, the tax policy stance of the Commonwealth Government means that explicit redemption of the liability to the weekly income stream is bound to be unattractive to the parties. However, I do not believe that this means that Section 39 fails to limit voluntary agreements under a common law deed of release, insofar as they are seen as extinguishing claims for compensation.

It has been brought to my attention that in some cases, the requirements of Section 39 appear to have been ignored by licensed insurers. To my mind it should be unnecessary for the Crown to have to resort to enforcement in this area. I think the community has the right to expect that insurers will practise to the intent of the legislation. I can only imagine in these few cases that a calculated judgement is being made to the effect that a worker satisfied with his settlement is unlikely to complain, and that the instances are sufficiently small as to be likely to be seen as an irritation rather than a provocation to legislative amendment. In my opinion, this is simply not good enough. The community has a right to expect that the licensed insurers will comply with the restrictions, even if in individual cases it might seem in both their interests, and those of the injured worker, to settle earlier.

It has been put to me that the requirement to wait for a year prevents the settling of small claims which could assist with people moving on with their lives and also lower administrative costs for the scheme. While I understand that administrative advantages might flow from, for example, exempting settlements below a certain threshold from the minimum period restriction, I think a change would undermine the culture the legislation seeks to support. The point of the restriction is to ensure that all parties are focused, in the first instance, on rehabilitation and return-to-work. Even with relatively small claims we would surely run the risk of introducing perverse incentives. I note also that Section 39(3) allows referral of any settlement agreement to the Tribunal for review, and the Tribunal has powers to set aside the agreement if the settlement terms or process are deemed unfair. Many of the issues raised with

respect to settlements related to the perception that a financially inexperienced worker is negotiating with a highly experienced claims manager. The concern is that as a consequence, decisions may be short-sighted and ill-advised. The existing Tribunal power of review should ensure that settlements are at least open to a process for redress, and again, I think insurers should commit to acceptance of this process.

As mentioned earlier, workers drew to my attention the perception that they were in a very poor bargaining position in the negotiation process regarding settlements. I have already referred to the pressure that can emerge around the current second step-down, which is usually around the same time that the restriction on settlement is lifted one year from the date of injury. I believe that the change proposed to the second step-down should enable injured workers to approach the issue of settlement from a position where they feel under less financial pressure and can make a more considered judgment on the merits of acceptance or otherwise. I have also pointed out that any involvement in the settlement process by a rehabilitation provider would, to my mind, represent an obvious conflict of interest. Insurers must therefore commit to a clear separation of roles or it will be necessary to invoke regulations or licence conditions to ensure this is the case.

In a similar vein, I am concerned about the stories I heard where injured workers believed that insurers were using administrative means to ‘soften them up’ to accept a settlement. Examples of this included changing processes or practice at the end of the first year over such matters as the acceptance or rejection of routine medical or rehabilitation expense claims, or simply dealing with things much more slowly. I also heard stories of changed methods of payment, seemingly designed to inconvenience the worker. I would like to believe that these things, if they do occur, are unfortunate exceptions. However, there appear to be no protections in place to prevent their occurrence. I believe it is in the interests of the insurers to ensure that they all negotiate fairly and ethically, and certainly in talking to them this has their full support. In the first instance, I think it would be appropriate for the industry to develop its own Code of Conduct for such matters. It might also include advising workers to seek independent advice on any settlement.

From the above I do not think it is appropriate at this time to propose legislative change with respect to settlements. I note that the changes I am recommending with respect to the operation of the benefits model should be beneficial in putting injured workers in a position to take a more considered and empowered approach to settlements.

In addition, there is insufficient experience with the pattern of settlements that is emerging to draw firm considerations with respect to how the objectives of the scheme are being served. This is a matter for later consideration. However, I believe it is essential that insurers commit to observing the restrictions intended by the legislation. In addition, they should be given time to consider what elements of fair dealing should be appropriately contained in a Code of Conduct. I note that in other jurisdictions, for example South Australia, the legislation has effectively prevented the sort of settlement by common law deed of release being used in Tasmania. This therefore remains an option should an effective Code not be developed. Alternatively, it might be possible to use the avenue of licence conditions.

I recommend that licensed insurers be given the opportunity to develop a Code of Conduct which clearly respects the intent of the legislation with regard to settlements and contains appropriate commitments to fair dealing and avoidance of perceptions of conflict of interest. This should be monitored by the WorkCover Tasmania Board with a view to enforcement through licence conditions or other means, if ineffective.

ROLES, FUNCTIONS AND ACCOUNTABILITY

In looking at the problems faced by injured workers negotiating their way through the workers' compensation system, it is apparent that the roles and functions and accountabilities of the various agents that workers encounter are unclear, at least from the standpoint of the people in the process. I am conscious that in other jurisdictions where the schemes are government run or managed, there has been a great deal of intervention in the process with respect to these issues.

By contrast, Tasmania has a privately underwritten scheme. We need to very carefully balance the level of prescription needed to provide a framework of trust with respect to roles, functions and accountabilities, against the very real benefits that flow from the dynamically competitive environment in which the private insurers compete with one another to improve positions. The overarching issue here is that, to the extent that the overall pattern of incentives drives congruence between good injury management and cost management, then we can safely leave the operations of the private providers to efficiently drive the system and to seek desirable innovation.

The WorkCover Tasmania Board has an ongoing program in this area. It is presently looking at the issue of accreditation of rehabilitation providers. I note that other jurisdictions have gone down this track. In Western Australia, which has a system with many underlying similarities to that in Tasmania, there is a process for accrediting rehabilitation providers, from which we may learn a great deal. General practitioners (GPs) are accredited in Tasmania, but significant issues over their role were brought to the attention of the review.

Successful injury management is seen to depend on effective three-point contact between the employer, doctor and worker. Of course, in the Tasmanian system the insurer may be acting as agent for the employer with respect to many matters. One of the critical elements in the process as mentioned earlier is trust. It emerged as a key theme in all cases I encountered during the course of my review that workers do place their trust in their general practitioner. The GP is seen, no doubt quite rightly, as being essentially concerned with the worker's welfare, with no conflict of interest. It seems to me that GPs could potentially play a more significant role in the system by employing this currency of trust to drive the effectiveness of a three-point contact. For a variety of reasons this does not appear to happen to the degree required. There are of course issues of hard-pressed GPs dealing with workers' compensation matters against the background of the rest of their activity. There are issues associated with their knowledge and expertise in relation to how the system works. The way GPs might deal with employers and insurers and the skills that might be needed in such dealings is also an issue.

There is practical evidence that information is not conveyed effectively. Concerns were raised with me from a number of quarters that the 'Medical Certificate Form 2',

which is critical to rehabilitation and defining capacity for work, is not properly used. In complicated systems it is very important that information is provided on a common basis. The process may need to be looked at in terms of achieving greater clarity in the information chain through the use of standards, which make medical judgements easier to objectively compare.

I note that some jurisdictions are actively pursuing the concept of evidence-based medicine in this regard and this may be worth further analysis.

COMMUNICATION OF ALL RELEVANT MEDICAL INFORMATION

It would appear to be a basic principle that the general practitioner or any treating specialist working through the GP should have full access to all relevant medical information from the very earliest stage. This would seem to be essential to support the critical three-point contact referred to earlier. I can see no reason why all such information should not also be made available to the insurer in the interests of parity. However, I have listened to many anecdotes raising concerns that this did not occur. Assertions were made of 'doctor-shopping' on both sides. Clearly this is evidence of an adversarial environment. This seems also to sit with the related issue of under-use of medical panels. Again this is an issue of detail, but one which goes to the heart of worker trust that the principal goal is injury management, and insurer trust that this is not simply about achieving a higher payout.

The WorkCover Tasmania Board should investigate whether effective communication of all relevant medical information can be successfully achieved under existing legislation or whether change is needed.

INSURERS AND INJURY MANAGEMENT

I was impressed by the commitment shown to the philosophy of injury management by all insurers. Indeed, some expressed their frustration at being unable to use their expertise in driving the outcomes envisaged by the legislation. For example, some believed that outcomes would be greatly enhanced if they had the capacity to intervene earlier on a without prejudice basis.

In looking at the role of the insurer it is important to once again think of the two very different groups of workers involved. It seems quite clear that the insurers play a critical role with the first group of workers and have processes in place that work very well in terms of the aims of the scheme. However, there are major issues of trust involved with the more difficult group of the long-term injured. The major issue here is the perception that the rehabilitation provider can act as the agent of the insurer, with the risk of mixing effective rehabilitation and injury management with the conflicting imperatives of claim management. Given that it is vital that the trust of the injured worker is not lost in the process, it is very important that questions of injury management are separated carefully from questions of claim management.

In the course of this review several examples were put before me where this trust had clearly broken down and where the injured worker had come to see the rehabilitation provider as an agent of claim management rather than injury management. It was asserted in some cases that rehabilitation providers had become involved in the

settlement process, which would clearly be highly undesirable. In the case of seriously injured workers, there is strong potential for a conflict of interest to arise between the role of the rehabilitation provider, in terms of seeking the best return to work and injury management outcomes, and the commercial imperative to contain costs. Many workers appear to be unaware of the nature of the relationship between the rehabilitation provider and the insurer at the start of the process.

There are also serious concerns where the rehabilitation provider is vertically integrated in the insurer's operation. The use of in-house rehabilitation providers may, at the very least, raise the perception of a potential conflict of interest. However, this is a very complex issue as there may be real efficiencies to be gained through the use of in-house providers. The ability to take an integrated approach across the issues of occupational rehabilitation and therapeutic help may be extremely valuable. I am also concerned to retain the competitive dynamic where different insurers can and will test different improvements to seek greater business efficiency and drive superior outcomes for the scheme.

In any case, the potential conflict of interest, that some see as occurring through direct ownership by the insurer, can just as easily exist where the relationship is contractual. Any system where the rehabilitation provider is paid by the insurer and may be significantly dependent for income, will face this problem. I believe the solution lies in clear separation of roles, clear ethical commitments by the parties, and sensible accreditation standards for those who carry out expert roles.

I am therefore not, in the first instance, attracted to regulatory intervention in this area beyond that envisaged in the current processes being undertaken by the WorkCover Tasmania Board regarding the registration of rehabilitation providers. However, there are a number of issues where the process should be made much clearer to the injured worker, and the respective roles of insurer and any rehabilitation provider made clear and transparent. These range from practical issues with respect to exactly how the worker is to be involved in the development of a return to work plan, through to the non-involvement of rehabilitation providers in any process that moves towards financial settlement.

It seems to me that at this stage the best approach would be to invite industry to develop its own code of conduct to overcome these problems. I strongly believe that guidance and transparency may go a long way to removing perceptions of potential conflict of interest, while retaining the advantages of a system where innovation is not fettered by excessive prescription.

In discussions with stakeholders on this matter, choice of rehabilitation provider emerged as an issue. That the worker should have some choice in their rehabilitation provider seems to be a universally accepted 'truth'. However, it seems that the degree of choice is not agreed. I do not think it reasonable to give the injured worker unfettered choice as this may be exercised in a misguided manner. I think it is preferable to guide choice by getting the incentives right and ensuring ethical standards of behaviour so that the scheme can harness the expertise of the insurer.

Insurers could be required to offer the worker a panel from which to choose a rehabilitation provider. Provided this protection existed and the worker could, within limits, change their provider, then I see no difficulty with 'in-house' providers if this

is the preferred business structure. I have not delved into the question of panel size, or into whether, for instance, it is acceptable to have a default provider and only offer a panel if the worker is dissatisfied. I regard these as matters of detail for the WorkCover Tasmania Board to discuss with the industry.

I must point out that, in practice, most of the workers I spoke to had been given a choice and that most reported positive experiences with their provider, though not necessarily the first. There will of course always be personality clashes and changing needs and the insurers accept the need for a degree of choice.

I recommend that the WorkCover Tasmania Board require that insurers provide a panel of rehabilitation providers from which the worker may choose, the detailed arrangements for which to be worked out in consultation with the industry.

TERM OF REFERENCE 3

In the course of addressing Terms 1 and 2, identify and make recommendations with respect to any issues that should inform the State's deliberations with respect to those matters which should appropriately be considered in a broader review of the legislation.

It is the Minister's intention to conduct a broader review of the legislation following the conclusion of the present national inquiries. To that end, under Term of Reference 3, he has asked me to identify and make recommendations with respect to any issues which should inform such a broader review. Principal among the national inquiries underway is the Productivity Commission's Inquiry into National Workers' Compensation and Occupational Health and Safety Frameworks.

While this review was underway, the Productivity Commission released its Interim Report. An interim report of course is only finalised after further input and consultation. However, much of the discussion has informed my findings under the first two terms of reference.

I note also that, if the final report of the Productivity Commission is as ringing in its endorsement of the fundamental features of the Tasmanian scheme as its interim report, this may cast doubt on the value of proceeding with a major broad review in the medium term. Nevertheless, I have identified a number of matters which I believe should inform any future review process.

In line with the Minister's request, the matters considered under Term of Reference 3 are those where I neither propose a change now or a process which is intended to result in a change or decision at this time. Rather, I take the opportunity to air a number of issues, which may need to be considered.

THE PHILOSOPHY OF INJURY MANAGEMENT

In 1995 the *Workers' Compensation Act 1988* was significantly revised. The changes included the insertion of a section on rehabilitation and, to reflect and emphasise the new focus, the Act was renamed the *Workers' Rehabilitation and Compensation Act 1988*.

More recently, the objective of rehabilitation has become subsumed into an integrated approach to facilitating recovery and restoring the worker to the workplace termed injury management. In the Productivity Commission's Interim Report, injury management is described as being concerned with early intervention, rehabilitation and a durable return to work, consistent with the injury or illness. (p39) It is apparent to me that there is still much to do in the Tasmanian scheme to build an holistic focus on injury management.

There is little in the current Act regarding rehabilitation. This is not surprising as the issues are complex and might be better dealt with by relying on natural incentives and loose structural solutions, rather than a strong systemic and regulatory response. I suspect that the behavioural and cultural change required could largely be achieved through standards, codes, and guidance to industry groups involved.

Critical to this task is understanding what we are really trying to do. There is considerable common ground in the area of injury management and related behavioural concepts. What seems to be missing is a coherent philosophy among the players. This also appears to be the case in other jurisdictions. A future review would provide the opportunity to advance consistent commitment to and practice in injury management.

It occurred to me during the review that a major issue for injury management in a competitive scheme such as Tasmania's relates to the chain of participants, each with different objectives and incentives. I was acutely aware that the injured worker encounters a number of agents with substantially different 'voices' as he/she navigates the system. At best, this can be confusing for workers. At worst, it can lead to antagonism between the parties and lack of commitment to the scheme and its principles. However, I do not believe we should seek to divest the agents of their independence. The challenge is achieving equilibrium between the need to get the various agents working in harmony and the need to ensure their independence serves as a system of checks and balances.

There are valuable lessons to be learned from the Sporting Analogy presented in Appendix A. It seems to me that reconciling countervailing interests and incentives with coherent shared objectives will greatly improve outcomes. This is far too large and complex an issue to be resolved in this review, however, I offer some observations which may inform future development.

Despite research indicating that effective injury management serves the interests of all parties in producing better health, social and financial outcomes, the injured worker's experience within the system is characterised by a series of discordant voices. The voices belong to the various key 'agents' institutionalised in the system, that is, employers, insurers, doctors, rehabilitation providers, unions and lawyers. The complexity of the scheme and evident lack of understanding among most workers and employers compounds the problem so that workers lose confidence in the experts. During the course of this review, I saw evidence of increased skills, training and practices in terms of injury management and workplace safety. However, this seemed confined for the most part to large organisations. Of course, the value of this to the scheme must therefore be considered in the context of structural changes in work, for example, increased use of contractors and Tasmania's relatively high proportion of small business.

Issues associated with the roles of various agents in the scheme, particularly the employer, insurer and rehabilitation provider, permeate this report. Let us now consider the role of the doctor, a central agent and expert. Doctors, particularly general practitioners (GPs), are usually among the first experts workers see following an injury and tend to have regular contact from that point until recovery. Importantly, GPs provide key information into the system via certification relating to treatment and rehabilitation, including fitness for work. This information is fundamental to the claim and as such is vital to ensuring the integrity of the system. Studies also suggest that in addition to primary medical care and certification, GPs can have a much broader influence. They can play a pivotal role in the coordination and cooperation between the injured worker and the employer and insurer. Doctors can also influence attitudes towards the system and between the key parties. The consequent benefits to the scheme can be significant. I heard assertions to this effect during the review, which

are supported by research undertaken in Western Australia indicating that GPs who were proactively involved in injury management and, by definition, the key relationships, typically achieved better return to work outcomes and significant cost savings per claim. (WA 1998, p ix–x)

The Sporting Analogy (Appendix A) illustrates how doctors fulfil this role in the professional sporting arena. The ‘club doctor’ bridges the gap between the view of the injured individual as a patient, and the view of the individual as an athlete whom all parties wish to return to the game as soon as possible. Recognising the valuable contribution the doctor can make, some states have introduced specific requirements for ‘three point contact’ to take place between the employer, worker and medical practitioner. The central relationship between the employer and worker is supported by the provision of advice by the doctor as an independent authoritative third party.

Clearly the role of doctors in the system is critical, however it seems to me it is not well understood or reinforced in Tasmania. Essentially the GP is the ‘gatekeeper’ of the system. Medical practitioners themselves commented to me that despite the importance of this role, GPs are untrained and lack accountability and recognition in relation to this gatekeeper role. At present, doctor accreditation requirements for workers’ compensation certification are far from rigorous, and it would appear that doctors do not ‘own’ their role in the system. For example, I heard that GPs tend not to see themselves as part of the workers’ compensation system. It is easy to see how a tight medical focus could eclipse other considerations such as whether a condition is work-related, which, while within the realm of the doctor’s expertise, is a much more central concern for the insurer. Medical opinion in relation to the cause of injury as well as other key information, such as capacity for regular or alternative work-related duties, is critical to the effective and efficient operation of the scheme and highly reliant upon input from the GP.

Additionally, the screening role of the GP in flagging potentially complex cases to other agents in the system, namely insurers, is significant, but I suspect, badly understood. It was put to me by one medical practitioner, that the lack of training for doctors in workers’ compensation matters presented a risk that issues ‘become medicalised too early’. The implication was that the focus is on a medical solution focusing purely on the doctor-patient relationship, rather than a solution that also acknowledges the centrality of employer-worker relationship and, as a consequence, early return to work.

In my view there is at present no incentive to link the normal professional medical approach to the requirements of the workers’ compensation system in Tasmania. Currently accreditation is generally open to any medical practitioner. However, given the importance of the doctor’s role and its potential for achieving scheme objectives, there may be value in asking whether the role ought to be limited to those who have been through a specialised course of accreditation. I believe this to be a national issue with far ranging consequences.

In addition to cultural factors associated with understanding of the scheme objectives and workplace injury management, there appear to be structural impediments relating to financial and behavioural factors. For example, solutions also need to recognise the natural conflict for doctors between clinical care and administration; and consider

existing financial constraints to the expansion of the GP's traditional role to include information provision and injury management coordination.

In competitive market-driven schemes such as Tasmania's, I believe the independence of the various agents is essential. The problem, it seems to me, is replicating the situation underlying the Sporting Analogy in the sphere of workers' compensation. While congruence in terms of voice and motivation is indeed fundamental, independence is important for ensuring balance.

Where there are independent agents, however, there are likely to be differences of opinion, and this is particularly so in complex systems where boundaries are not always clear. How disagreement between the agents is handled has significant philosophical and practical implications. A possible rule of thumb might be that where there are questions of a technical nature referral to the relevant 'experts' can close the gap between the different views. In contrast differences of view concerned with basic issues of reasonableness and community standards are appropriately tested by opposition – for example, before a Tribunal with some sort of legal process.

It must be understood that it is foolish to seek to eliminate all adversarial processes. They have their place. The point is to ensure they are a last resort and confined to areas where the matter does not easily admit of technical resolution.

The distinction of course is not neat. Under Term of Reference 2 I noted that, despite having provision for medical panels since 1988, they have not yet been invoked in Tasmania. As a result, medical questions have tended to be debated in the Tribunal via adversarial processes between opposing parties and their legal counsel. My recommendations therefore included encouraging early referral of medical questions to medical panels and expanding the definition of a medical question to include significant medical treatment. Discussion with almost all stakeholders supported the use of expert panels to resolve technical issues. It was even put to me by insurers that panels be utilised to resolve questions over appropriate rehabilitation. While I am inclined to favour a future scheme which recognises the specialised nature of knowledge and decision-making associated with rehabilitation, this would be premature and requires further consideration in light of further experience in the use of panels and comprehensive work in the broader area of injury management. There would also need to have been progress in the area of accreditation.

In my view, it is precisely in a privately underwritten scheme that we can harness this underlying tension in a creative way. Tension between the checks and balances and the harmonious voices gives the scheme its dynamism. The focus here on the doctor is simply an illustrative example; I suggest a future review would encourage processes to harmonise the voices of all agents.

I recommend that a future review have as a principal focus ensuring a coherent injury management philosophy is developed and that the accreditation and incentive structure be refined to drive its ownership by all involved in injury management.

ACCESS TO COMMON LAW

The current terms of reference preclude discussion of the current restriction of access to common law. The issue of the future role of common law in association with the

statutory arrangements, however, is a matter under national consideration, and a matter which a broader review will no doubt need to address. I therefore make some limited observations on access to common law in respect of matters that have arisen in the course of this review.

The Productivity Commission's Interim Report devotes an entire chapter to the issue of common law access. It essentially covers the whole gamut of the advantages and disadvantages, in terms of the objectives, of dealing with work-related injuries and fatalities through common law action vis-a-vis statutory schemes, and the difficulty with common law access sitting alongside statutory schemes. The interim conclusion of the Commission is a recommendation that common law should not be included in a national framework for workers' compensation on the grounds that it:

- does not offer stronger incentives for accident reduction than the statutory no-fault scheme;
- does not compensate seriously injured workers to a greater extent than statutory schemes;
- may over-compensate less seriously injured workers who, in the normal course of events, could be expected to be rehabilitated and returned to work;
- delays rehabilitation and return to work;
- if there are psychological benefits to be derived from receiving a lump sum, this could be obtained through statutory benefits; and
- is a more expensive compensation mechanism than statutory workers' compensation.

If common law is to be included in a national framework, then access should be restricted to the more seriously injured workers, subject to meeting a minimum impairment threshold. Impairment should be based on a consistent guide such as that published by the American Medical Association and non-economic loss only. (PC. I.R p183/4)

I note that this interim recommendation could be regarded as an endorsement of the position currently enshrined in Tasmanian legislation. However, a number of issues were drawn to my attention in the process of my review which pertained to the position reached in the Interim Report. A critical argument put to me was that the existence of access to common law was an important and powerful incentive in reducing workplace risk and ensuring that employers paid great attention to safety procedures. I note that the interim conclusion of the Productivity Commission is that empirical studies do not support this position. However, representations made to me question the data and evidence upon which such a position would be based. I can only say that in my view the Productivity Commission is the best placed of our institutions with the expertise in statistics and analysis of incentives to make such a judgement. I urge any party that can provide persuasive evidence of a powerful incentive effect from common law to use the period prior to the final report to make this point clear.

Perhaps the greatest advantage of the common law approach is that it caters for individual circumstance. In contrast, statutory schemes must deal in averages, so that benefits are designed for a standard set of circumstances. The problem with common law, however, is that it is costly and adversarial, and therefore inimical to the values that underpin a no-fault statutory scheme.

Given that individual factors are of greatest importance in the most severe cases, it is perhaps a sensible compromise to allow the most serious cases access to common law. This captures the advantages of this system where they are of most value, without undermining the core values and incentives that underpin the statutory scheme that applies to the bulk of affected workers.

An important issue raised in Section 7.4 of the Productivity Commission's Interim Report is the argument that common law may provide workers with a sense of vindication through establishing fault for their injury through the justice system. At present, the Commission takes the position that vindication is only felt in those few cases which proceed to trial. (p182)

I suspect this understates the strength of the argument. In cases where workers have reason to believe that their employer was negligent, then financial compensation may seem to them an inadequate form of redress, as they would expect some form of acknowledgment of the negligence. Even common law settlements made prior to trial no doubt give the affected parties some feeling of having had their basic positions vindicated in that the employer, or more correctly his insurer, is made to pay. However, it should not be beyond the design of the legislation covering the workplace to ensure that, in cases where the authorities have reason to believe some form of negligence was involved, action is taken against the employer through other legislative channels. The worker could then be made aware of that action. This touches on some very broad issues with respect to the relationship between workers' compensation legislation generally and the suite of legislation which governs occupational health and safety. I note that the Productivity Commission is proposing a national position on the latter.

On the basis of the Commission's Interim Report, I recommend that a future review address itself only to any final national recommendations on common law access which are at variance with the present Tasmanian situation.

SETTLEMENTS

It is very important to the long-term achievement of the scheme's objectives that there is an appropriate role for settlements. As mentioned earlier there is very limited information available at this time on settlements under the amended legislation. It was also noted that the Commonwealth Government's taxation policy was a barrier to structured settlements and indeed encouraged the taking of lump sums under common law deed of release.

It seems to me that future tax treatment is going to be critical to the materiality and nature of settlements. Furthermore, the present arrangement is likely to make the collection of meaningful data in the appropriate conceptual categories exceedingly difficult, because of the powerful incentive to bundle the payments in a deliberately

non-transparent way to minimise exposure to tax. It is possible that changes to tax treatment may be an outcome of the current national enquiries. It may therefore be appropriate at that time to revisit the role of settlements.

The recent 2002–03 Annual Report of the WorkCover Tasmania Board contains an excellent discussion of the statistical problems associated with payments. It seems quite clear that there has been a significant increase in negotiated settlements under a common law deed of release, up from $9 million in 2001–02 to $15 million in 2002–03. This seems likely to pose significant problems in understanding what is occurring with respect to settlements. While it appears some insurers reported negotiated settlements as redemptions, most did not. Indeed, given that the tax protection hinges on the sum under common law deed of release being undifferentiated, there is likely to an understandable reluctance by the parties to identify the component which is payment for lost earnings. It is therefore not at all clear to me how the related data reporting needs identified and discussed in the Report (p64) can be met. This raises difficulties as to how the WorkCover Tasmania Board can monitor, among other things, whether there is equity in treatment in the sense of like payments in like situations. The draft tax ruling (TR 2002/D13) referred to in the Interim Report of the Productivity Commission, appears distinctly unhelpful in proposing that commutations (income redemptions) will be taxed as income in the year it is received. All this would appear to do is reinforce the use of negotiated settlement by common law deed of release.

The JSC recognised that the taxation position was a major barrier to the introduction of structured settlements. These have wide support because they combine the advantages of finality, through exit from the scheme, with the protection of periodic payment as a barrier to dissipation of benefits and cost shifting. The Productivity Commission Interim Report draws attention to tax exemption to structured settlements granted in December 2002 which does not, at present, extend to workers' compensation claims. However, the Interim Report makes no recommendation in this regard. There may well be an understandable reluctance on behalf of the Tax Office to surrender entitlement to revenue. However, it seems curious from a whole of government perspective and the concerns over cost shifting, that the Commonwealth should allow this situation to continue.

In any case it is not clear to me that structured settlements would be attractive, even with such an exemption, when compared with the current avenue of a negotiated lump sum undifferentiated settlement. It is therefore likely that the whole area will need to be revisited if progress is made on a national model.

I recommend that the WorkCover Tasmania Board seek ways to improve its data collection on settlements, so that a future broader review has a practical basis upon which to assess whether settlements are occurring in harmony with the scheme's objectives.

SCHEME ACCESS AND COVERAGE ISSUES

Scheme access is a critical issue for workers' compensation schemes because of the cost and incentive issues posed. It needs to be recognised that the separation of workers' compensation from other systems of social welfare support means that we

have imposed the cost of the no-fault scheme on employers. Workers' compensation costs are a significant cost of doing business and inevitably, there are incentives to try to shift or avoid such costs. It is important that we do not allow such incentives to negatively impact on the structure of business relationships, which would be inefficient and result in inequitable outcomes for injured workers.

In a dynamic economy structural change will occur in rapid response to opportunities that offer lower costs. Australian jurisdictions have relied on a common law definition of worker, as this offers a flexible instrument, which can be interpreted by the Courts as circumstances change. Heavy prescription in statute of what constitutes a worker may result in the rearrangement of relationships in order to avoid the consequences of the legislation. But the essence of the definition of worker is the nature of the relationship between the employer and the worker in terms of control. The notion is that the contract between the parties is a contract *of* service because the employer exercises control over how the work is carried out. The contrast is made to a contract *for* the provision of services, which it delivered under the independent control of one party to another. While at this level the difference seems simple, in practice it can be exceedingly complex to determine whether someone is a worker or independent contractor.

In the Productivity Commission's Interim Report, reference is made to the Full Bench of the Australian Industrial Relations Commission (AIRC) summary of the current state of the law as it applies to the definition of a 'worker'. A number of issues are raised which look at the totality of the relationship. A number of what are termed 'indicia' is listed, but the point is made that no list should be regarded as comprehensive and that specific features of the relationship in a particular case will nevertheless be relevant to determination of the ultimate question.

It seems to me that we need to be clear as to the purpose the common law definition serves in workers' compensation legislation. The point is surely to assign the costs of the system to those parties who control the risk environment in which the work takes place. A contract of service is a proxy for the degree to which those risks are outside an individual's capacity to control or manage, and are indeed within the capacity of the employer to control or manage.

This use of a definition as a proxy for a particular purpose may be important because the distinction between contract of service and contract for the provision of services serves a much wider range of purposes than simply that in workers' compensation legislation. Indeed I think that many of the indicia put forward by the AIRC are ones that would not be of particular interest in a workers' compensation context. Nevertheless, we need a definition that rests on a set of principles accepted by the courts.

I note that the Heads of Workers' Compensation Authorities' report of May 1996 agreed upon three principles which had underpinned coverage of workers, the first of which related to the common law concept of employment. The point was made that common law is worked out from case to case and it is desirable to express the principles which flow from the common law cases in statutory form (Section 4.18,p.54). I do not think that at this stage we can add any more than advising a watching brief on the role of changing relationships in the use of contractors, and trying to ensure that the courts are not inhibited by statutory provisions from looking

behind the written relationships to the fundamental relationship in determining employer or worker status. Indeed, while uncertainty is often regarded as the enemy of good practice, I suspect that in a rapidly changing economy, uncertainty as to how the courts will view such relationships is a desirable feature of our system. It may serve as a check on the incentive to exploit differences in structural arrangements to avoid the costs of workers' compensation.

In terms of coverage, I was unsure of whether to deal with an issue relating to Section 4B(2) of the existing Act under Term of Reference 2 or Term of Reference 3. This Section has the effect that if a contractor takes out his or her own personal accident insurance then the contractor is taken not to be a worker. I have some concern that this provision provides a powerful incentive to changing employment arrangements to shift the responsibility for the taking out of insurance onto the contractor. There are two problems I can see. Firstly, I am concerned that this provision may appear to drive a cost advantage which distorts business relationships by allowing a business to avoid its workers' compensation obligations through contracting out an activity. If this is occurring it both reduces overall economic efficiency and undermines the objectives of the scheme. Secondly, it is not clear to me how there can be effective enforcement of the intent which is surely to have on-going assurance that such contractors do indeed have alternative insurance protection in place.

This may well be a matter which the WorkCover Tasmania Board should investigate irrespective of any future review, if evidence comes to light of changed practices consequent to the provision in the legislation.

I recommend that a future review examine whether changing working relationships in the Tasmanian economy have implications for the principles governing coverage in the Tasmanian legislation.

DISPUTE RESOLUTION

INITIAL LIABILITY DISPUTE RESOLUTION PROCESS

Under Term of Reference 2 I discussed in detail the problems associated with the scheme's dispute resolution system. I focused most of my analysis on the processes relating to the initial liability decision and associated disputation. Given the complexity of the interconnections between these processes and other elements of the scheme design, I developed two options for change – a 'fine-tuning' of the existing process and a re-engineered solution. I have proposed my preferred fine-tuning under Term of Reference 2, with a view to ongoing monitoring of the situation. However, should the problems persist, I offer my ideas for more radical change for consideration in the broader review of the scheme.

If significant problems with the process persist, it may be necessary to consider abolishing Section 81A altogether and revising several other related provisions. Under a re-engineered process, I would expect the extended period for without prejudice payments to continue and for initial liability disputes to be referred to the Tribunal with sufficient information to make a prima facie case for reasonable grounds for dispute. However, based on the information available, the Tribunal would determine whether reasonable grounds existed, and order whether payments to the worker

should continue or cease. The burden of proof rests with the employer throughout and, if a reasonable question is found to exist, the Tribunal could initiate a conciliation conference as a matter of urgency.

Shifting the burden of proof, in particular, would be a significant departure from the existing model. I do not recommend this approach in the first instance, as I believe it to be an important quid pro quo for without prejudice payments. Moreover, should my recommendation to extend the initial liability decision and without prejudice payment period be accepted, I believe that the need for this quid pro quo will be even stronger. It is therefore my view that shifting the burden of proof for initial entitlement should only be considered as a last resort.

I recommend that there be monitoring of the effectiveness of fine-tuning the dispute process with a view to looking again in a broader review if the changes are ineffective in reducing disputation.

SECONDARY PSYCHIATRIC/PSYCHOLOGICAL INJURY

The exclusion of secondary psychiatric or psychological injury from impairment assessments was raised as a concern during the review. Such conditions might include stress or depression arising as a consequence of the primary injury. Under the present Tasmanian scheme, secondary injury cannot be considered in the assessment of the level impairment for lump sum payments or to meet the whole of body impairment threshold for accessing common law.

This provision was introduced in conjunction with the restriction on common law access, following similar moves in other states which were seeking to retain the integrity of common law thresholds. It is my understanding that many injured workers seeking access to common law were claiming relatively minor secondary psychiatric or psychological injury in an effort to ‘bump up’ their impairment assessment scores to the required level. It was put to me that, in this context, including impairment of this nature can be problematic in that many ‘healthy’ people might measure similarly low levels at various times in their lives and that both the experience and measurement of such impairment is relatively subjective. Some states, such as Victoria and New South Wales, have similar exclusion provisions.

Arguments against such exclusion hold that they are based on the ‘outmoded philosophy of mind/body dualism’ and exclusion is inconsistent given that symptoms arising from secondary *physical* injury may be included in the calculation of impairment levels.

At least part of the problem appears to be that it may be undesirable to exclude serious secondary psychiatric or psychological injuries but we want to avoid incentives to ‘gaming’ through exploiting greater subjectivity in assessment.

This is clearly an issue for all schemes and the situation may become clearer nationally. I recommend that a future review critically examine the rationale for exclusion of secondary psychiatric and psychological injuries.

POLICIES, PREMIUMS AND THE ANTI-DISCRIMINATION ACT

An important issue was brought to my attention with regard to potential conflict between practices associated with policy writing and premium setting and the *Anti-Discrimination Act*. I heard representations that, in order to minimise their exposure to risk, insurers may require employers to provide information about their employees' workers' compensation histories and charge higher premiums accordingly.

The charging of different premium rates for insurance services is allowed under the Act, but it must be based on relevant actuarial and/or statistical data. It was put to me that in response to their insurers' requirements, employers may be requiring workers and prospective employees to disclose their workers' compensation history, and, where there is such a history, they avoid hiring these people. It has been suggested to me that both the disclosure requirement and subsequent discriminatory action may be in breach of the *Anti-Discrimination Act* and may also be in conflict with the intent of the National Privacy Principles. While there is an exception where the disability or condition affects the applicant's ability to perform the inherent requirements of the position, it has been suggested much information sought goes well beyond this. If the law is being broken then I urge the relevant authorities to enforce it. Once again it may well be that the community can be given an adequate level of assurance on this matter through the suggested insurers' Code of Conduct.

There may be a broader issue here. I do understand the pressures on insurers to obtain all the information they need to accurately assess and price risk. It follows that employers feel a similar pressure to protect themselves against consequent premium increase. However, the very high value our society places on protecting against discrimination is clear from the various legislation at State and Commonwealth level. This is a complex and important issue with national implications and may therefore need to be explored in the context of a broader review informed by the national developments.

I recommend a future review examine the balance between insurers having access to appropriate information in assessing risks and issues of discrimination and rights to privacy.

PREMIUM RATES

As noted earlier, the connection between costs and premiums charged in Tasmania's privately underwritten scheme is not direct. Clearly also, affordability has been central in the debate which led to the recent amendments to the legislation. The Productivity Commission inquiry is required 'to report on premium setting principles necessary to maintain fully-funded schemes while delivering to employees equity, stability and simplicity' and, in doing so, to identify 'models that provide incentives to reduce the incidence of injury and improve safety in the workplace'. (PC Interim Report, p209)

Chapter Nine of the Interim Report provides an excellent discussion of most of the issues. It can also be read as a broad endorsement of premium setting and monitoring as it occurs under the Tasmanian scheme.

Nevertheless, it is worth commenting on some of the issues raised both to inform any future review, if it should need to respond to specific recommendations from the Productivity Commission inquiry, and because it became apparent to me that the level of understanding of the principles of premium setting was generally low.

For reasons outlined below, I believe it is reasonable to start with the assumption that the industry is competitive. In particular, this means there are sufficient insurers competing for business to keep constant downward pressure on premiums and upward pressure on quality of service to clients. While there are some perceptions of an 'insurance club' and some belief that there is a lack of competition in premium setting and price discrimination to some business classes, I can see no obvious evidence of this. In fact, the changing market shares, the very volatility of premiums and the poor profitability record of the industry are persuasive evidence of competitive pressures. This suggests that competitive underwriting acts as an important efficiency driver for affordability of the scheme. That is, for any given benefit level, competitive provision will deliver it with the lowest premium rates over time.

Adjusting the benefit level with efficient delivery is surely the key to long-term affordability. The jurisdictions that are highly interventionist in premium setting, often with a view to affordability, can end up with a premium structure which does not cover costs. There are at present significant unfunded liabilities in New South Wales, Victoria and South Australia. Inevitably, these must be paid for either by employers in the future or fall generally on taxpayers. There is of course a risk in private provision of the failure of an insurer, as occurred in recent years with HIH, resulting in an unfunded liability arising, having to be accepted by the nominal insurer and the cost levied on all employers. However, there are protections in terms of prudential oversight, which limit the residual risk.

I do not assert that there are no potential benefits in premium controls. They allow, for instance, the smoothing of market volatility. This may aid the signalling role of premiums in relation to workplace safety performance. Clearly, in market schemes which are going through a bout of savage price competition for market share, falling premiums all round can suppress the relativities in premiums which should send positive reinforcement signals to good safety performers. The signalling role of premiums was undoubtedly weakened by the market turbulence created by HIH both before and after the failure of the business. However, to my mind, the hidden costs of suppression of dynamic efficiency drivers and the potential of contingent liability arising are much larger than the signalling benefit. In any case, this signal is of necessity attenuated to medium and small businesses because of the nature of the premium setting process which must take account of much more than an individual businesses claim experience. In any case, I can see no evidence that government foresight can be expected to be superior to that of the market.

I did hear arguments similar to those put to the Productivity Commission to the effect that premium setting favours large business and that small employers with good claims experience had been faced with inexplicable large increases in premiums.

In making the first argument, the point was made that we need to look wider than the simple workers' compensation insurance market, on the basis that insurers would discount workers' compensation insurance in order to win presumably more lucrative general insurance business with large companies. The implication is that the costs of

any discounting would be shifted to smaller businesses to their detriment. In essence, this argument still relies on the existence of monopoly power, or at least tacit collusion. Otherwise, the attempt by any one insurer to "tax" small business to cross-subsidise larger businesses would expose a profitable opportunity to other insurers.

This is a complex area within the expertise of the Australian Competition and Consumer Commission and the Productivity Commission. However, again, I can see no evidence for this lack of competition, rather the contrary.

I suspect much of the problem lies in a lack of understanding by employers, especially in small and medium sized businesses, of the principles of premium setting. Fundamentally, insurers make money by the accurate pricing of risks. It is not and can never be an exact science because there are always going to be limitations on what the insurer can know about the client business. The various methods used to classify workplace risks, including industry class rating, experience rating and size of employers, are best seen as rather rough and ready ways of framing up the risk-assessment, presumably before applying the art of judgement. I would be very reluctant to support any prescription around the use of these factors, precisely because it might inhibit the competitive pressure to 'sharpen the pencil'. However, I realise this is cold comfort to a business which does not understand the basis of a premium being offered, particularly if a significant increase has occurred when they feel their claim record has improved. I suspect many, if not most businesses imagine a much higher weight is ascribed to experience rating than is in fact the case. I do not intend here to repeat the points well made and discussed in the Productivity Commission Interim Report.

I suspect the way forward in Tasmania is twofold. First of all, the WorkCover Tasmania Board needs to build credibility for its suggested industry premium rates published under the Act in association with continued education over their meaning and value. I note, in this context, that in its Interim Report the Productivity Commission endorses this sort of light-handed approach. Secondly, the insurance industry needs to acknowledge the gap of trust that exists because of the very complexity of premium setting. It should aim to be as transparent as possible over the principles being applied, in particular, so that the small business sector gains a greater understanding. Given that the same problem exists in the two other jurisdictions with privately underwritten schemes, perhaps there is a role for the Insurance Council of Australia in developing educational materials from a whole of industry perspective. The interim recommendation of the Productivity Commission (Interim Report, p237) appears to provide a convenient basis to work from. The crucial point for a future review will be that, in examining any need for change, to be fully cognisant of the dynamic efficiency advantages of the present Tasmanian system.

I recommend that any future review which embraces premium setting explicitly include considerations of dynamic efficiency with those of allocative efficiency and fairness.

ACKNOWLEDGEMENTS

A fundamental element of this review has been talking to injured workers about their experiences. While at times harrowing, their stories have been critical in informing me with respect to how the whole process operates. Indeed, the only people who see the whole process are those who experience it. It seems inadequate to thank them for their generosity with their time. I would rather say that I found their courage in adversity inspirational and their preparedness to share deeply personal experiences with a stranger, in order to help others, heart-warming.

I would like to thank the organisations and individuals who made submissions to this review and attempted to disabuse me of error, a process which required much patience on their behalf.

I also cannot speak highly enough of the willingness of the policy people I spoke to in other jurisdictions to give freely of their time in explaining the workings of different schemes.

I am also indebted to Rod Lethborg and Tania Foale of Workplace Standards Tasmania for clarifying many details of the intent and workings of the present legislation.

Lastly, I had the immense good fortune to be assisted in this project by Louise Wilson. Her combination of analytic insight, excellent interpersonal skills and common sense have been invaluable. Many of the key insights are hers. I, of course, bear full responsibility for any errors of facts or judgment.

APPENDIX A

THE SPORTING ANALOGY

Most of us, at one time or another, have watched team sports. It is easy to identify with the vivid image of an injured footballer, for example, receiving immediate attention to an injury, often while still on or leaving the field. There are reports from the dressing room of the diagnosis of the nature of the injury. There may be comment from the coach or team captain as to when the player is expected to resume training and playing. There is no doubt that all involved are focused, as a team, on early intervention and rehabilitation.

Many of the experts I spoke to among the rehabilitation providers, insurers and government agencies drew this analogy to team sporting injuries. There is broad agreement that, for similar injuries, the outcomes from a sporting injury are far superior to those incurred in a normal workplace. The athlete recovers more quickly and to a greater degree, and achieves a higher level of rehabilitation. Most importantly, there was agreement that the difference in initial fitness plays only a very minor role in explaining this.

The Sporting Analogy is highly suggestive of lessons we can draw in approaching injury management in the workplace. The key is not in the injury occurring on a sports field, but rather in the power of the team approach. All involved, the injured athlete and all around him, including the medical and rehabilitation professionals, share the single motivation to the earliest possible return to play. The shared motivation drives trust and commitment, resulting in superior outcomes. From this, we can draw out some contrasts and lessons for the workplace in general.

The first point is the commitment to prevention. Much care and training goes into avoiding injury. There will also be careful assessment of whether the athlete is fit to play and the safety of the playing environment. While it may be only a minor influence, it is interesting that both the team and the individual are motivated towards fitness in avoiding injury. In Tasmania, efforts to encourage this broadly through the Premier's Physical Activity Council and initiatives in workplaces are surely welcome. We also know that many employers have become much more aware of the need to provide a safe working environment and there is evidence of better safety training. This of course is much easier in larger organisations which can afford to put in place sophisticated systems. We need to reinforce the message that all businesses have a significant investment in the skills of their workforce that they should seek to protect by taking an interest in the general fitness and well-being of their employees.

When an injury occurs, it is approached with common purpose. This can be contrasted with the different 'voices' the injured worker hears as he moves through the workers' compensation system. We need to find ways of getting the various professionals the worker encounters to share ownership of the objectives of the scheme and as far as possible speak with one voice. Where there are genuine disagreements over the facts, we need as far as possible to have these resolved before an injury management strategy is developed between the parties.

The injured athlete knows he can trust the team who will assist him through the recovery process. We need to ensure that there are no impediments in incentives or conflicts of interest, whether real or perceived, which might break the trust for an injured worker. Once the worker loses belief in a 'team' outcome and comes to see it as 'me against them', then all the perverse incentives of an adversarial process start working against good outcomes. A simple example might make this clear. An injury occurs which will require working through the pain to achieve the best outcomes. The rehabilitation provider may know that the earlier this is done the better the outcomes. However, given the high pain factor it will require a high degree of motivation. A busy general practitioner (GP) may be focused on making the patient as comfortable as possible and fail to reinforce this. There may be no effective dialogue between the two leading to a common position on injury management.

The worker also needs to have confidence in the rehabilitation program. If he loses trust and suspects that rehabilitation is aimed more at proving work capacity and lowering his benefits than injury management in the interests of his health and fitness for work, he will lose motivation. Lack of a common view on injury management between the professionals and lack of trust in the process can significantly undermine the self-motivation the injured worker needs.

Key Lessons

The first lesson we can take from the Sporting Analogy is the central importance of three-point contact between the GP, the worker and the employer, so that early intervention occurs where appropriate and in a coordinated way. Secondly, we must ensure there is effective communication and trust between the professionals, particularly the GP and rehabilitation provider. Thirdly, the structure of checks and balances must be such that the worker can trust the 'voices' he is advised by and that as far as possible, they give complementary advice. Finally, while the above would motivate early intervention, we must not have perverse incentives against this. If there is a prospect of a future legal dispute, this can be a powerful incentive not to do anything which might later advantage the other side. If the employer and insurer are to pay for early treatment of injury, it must not be able to be used as evidence of acceptance of liability For instance, it may well be that the window of effective intervention will close before the question of entitlement is resolved. Alternatively, if the system allows a 'pot of gold' or 'lotto' culture, then the worker may not be committed to rehabilitation as a result of having a different objective at odds with the social objectives.

In the Sporting Analogy, the athlete is not distracted by different financial objectives and furthermore, the issue of changed income does not arise. I believe it is an implicit lesson that the level of benefits should be such as to be consistent with a manageable reduction in the standard of living and, in particular, must not be so stringent as to create a level of stress which undermines the motivation of the individual to rehabilitation.

The Sporting Analogy has been useful in my thinking on key matters in this review. However, it is only an analogy. It is easy to find flaws with any analogy if it is stretched beyond its purpose. For instance, in this case one could easily ask what happens when a sporting injury is so serious that it terminates a professional athlete's

career. It is questionable whether the same team response would still exist. However, poking holes like this is to miss the point. I commend the focus on a team approach to injury management and of getting the incentives right so that 'voices' are in harmony with the needs of the injured worker so vividly brought out by the Sporting Analogy.

APPENDIX B

SUMMARY OF THE KEY PROVISIONS CONTAINED IN THE WORKERS' REHABILITATION AND COMPENSATION AMENDMENT ACT 2000 AND THEIR INTENT

CHANGES	INTENT
Weekly Benefits Weeks 0-13 – 100% NWE Weeks 14-52 – 85% NWE Week 53-10 years – 70% NWE	• To strike a fair balance between cost reduction and support for injured workers. • Aimed to reduce premium levels to closer to the national average (source: proposals paper), and in acknowledgement that pre-2000 benefits levels were higher than most State and Territory schemes. • Larger step-downs intended to provide greater incentive to return to work. JSC received evidence suggesting that the pre-2000 step-downs were too small and hindered effective return to work. • First step-down delayed until week 14 on basis that it would affect fewer workers. • Level and timing of step-downs determined via process of design principles, likely costs and consultation to reconcile needs of key stakeholders.
• Weekly benefits extended to 10 years	• Provide greater income security for injured workers • Affordability made possible by introducing second step-down and raising threshold for accessing common law.
• The dollar cap on weekly benefits is removed	• To put all compensation recipients on an even footing, regardless of the level of weekly benefit received from the system.

Medical and Rehabilitation Costs • All reasonable costs paid • Entitlement limited to ten years from date of initial entitlement	• To limit workers' entitlements to medical and rehabilitation services to the period of entitlement for weekly benefits. • Affordability made possible by introducing second step-down and raising threshold for accessing common law.
Death Benefits • Increase lump sum to $174,452.13 • Provide weekly payments to spouse for two years • Increase benefits for dependent children by providing weekly payment of 10% of the Basic Salary (currently $47.28 from 1 January 2003) for each dependant child until 16 years of age (or 21 if full time student)	• To increase death benefits for relatives of injured workers, in recognition that pre-2000 death benefits were low by Australian standards. • Bring benefit in line with the recommended maximum lump sum payable for permanent impairment. • In line with HWCA recommendation that lump sum benefits be supplemented by weekly benefits to dependants for a period. The payment of both a lump sum and temporary weekly benefits recognises that families are likely to require assistance to stabilise its financial position following the death of an income earner.
Impairment and Non-Economic Loss • Increase maximum lump sum to $174,452.13	• Part of general intention to increase support and income security for workers and their families.
• Replacement of Table of Maims to assess physical impairment with WorkCover Guides based on American Medical Association (AMA) Guides for Evaluating Permanent Impairment, Fourth Edition	• The previously used Table of Maims provided a finite list of specific injuries and corresponding amounts of compensation for non-economic loss equal to number of units (or the percentage thereof) specified. The Table was historically-based and reflected industrial injuries most likely to have been suffered in the late 19th and early 20th centuries. Injuries were expressed as percentages of a statutory maximum for total loss of a body part, however, with the changing nature of work and injuries, the majority of awards were for partial losses where a part payment was made. The Table was therefore limited as a range of occupational impairments, for example, occupational asthma, were not covered and the changing nature of injuries meant that partial loss needed to be calculated fairly and reliable.

	• The WorkCover Guides, largely based on the AMA Guides, replaced the Table of Maims as a more reliable and detailed methodology for assessing levels of permanent impairment of a physical nature. The use of the guides was expected to provide fairer, more consistent results – particularly in relation to partial loss – and ensure applicability to all types of existing and emerging occupational injuries and illnesses. Exceptions to this provision include psychological/ psychiatric impairment (see below) and hearing loss, which continues to be assessed using guidelines issued by the Commonwealth National Acoustic Laboratory.
• Extend compensation to psychological and psychiatric impairment • A threshold of 5% shall apply for physical and hearing impairment except for fingers and toes. A threshold of 10% shall apply for psychological and psychiatric impairment	• Compensation was previously restricted to loss of intellectual capacity consequent to damage to the brain. • Replaces implicit thresholds for physical impairment from Table of Maims by one consistent with the new impairment assessment methodology. Creates a reasonable threshold for psychological and psychiatric impairment.
Redemption Allow redemption of statutory benefits where: • The injury is stable and stationary; and • At least 12 months has elapsed from the date the claim was lodged.	• The ability to redeem a claim for weekly payments was removed in 1995. This forced more claimants to seek settlement of their claim at common law. It was expected that employers, workers and insurers would support restoration of the right to settle a claim for compensation by agreement in the 2000 reform package. However, the right to redeem an entitlement to statutory benefits had to be balanced against the objective of return to work. The ability to redeem a claim at any time would encourage a settlement culture and reduce the incentive for early return to work. For this reason, redemption of weekly payments was reintroduced in 2000, with some restrictions. • The Act also provides for a review of redemption agreements by the Tribunal, which now has the power to allow or disallow the redemption but not to modify the quantum.

Common Law	
• There is no access to common law where the whole person impairment (WPI) is less than 30%	• Common law was identified as the main cost driver of workers' compensation in Tasmania prior to 2000 reforms. The HWCA determined that, as a matter of best practice in an ideal, workers' compensation should operate exclusively as a no fault system without recourse to common law for damages. However, access to common law remains a highly contentious issue, and the JSC acknowledged that many argue that common law is a fundamental right and is also the most equitable means of establishing the extent of damage suffered by injured workers. The JSC also noted that advocates argue that the possible threat of common law action provides an important incentive for employers to provide safe workplaces. • Restrictions to common law were therefore introduced in 2000 to contain the costs of Tasmania's workers' compensation scheme, while ensuring access for very seriously injured workers. All workers, however, would have access to more generous no fault statutory benefits.
• An irrevocable election to initiate common law action must be made within two years (Tribunal may extend timeframe if injury not yet stable/stationary), but statutory benefits will continue to be paid.	The year timeframe to initiate common law action, which must be lodged with the Tribunal and accompanied with medical evidence that the 30% whole person impairment (WPI) threshold has been met, was designed to provide: • a process for substantiating that 30% WPI threshold has been met; and • some certainty for insurers in assessing their likely liability in relation to a claim, whilst allowing flexibility for workers whose injuries have not stabilised within this timeframe.
• Introduction of compulsory commencement weekly payments on a 'without prejudice' basis for all new claims until liability is accepted or the Tribunal orders that payments cease.	Automatic without prejudice payments were introduced as one of several of provisions designed to: • make the system less adversarial; • ensure injured workers have access to access to benefits they need at that time most critical to injury management, i.e., the first few weeks, and help preserve the relationship between the worker and employer.

Coverage • Clarifies coverage of unincorporated contractors, salespersons and participants in Commonwealth training programs • Provides a mechanism for a contractor deemed to be a worker to elect to be excluded from the Act by taking out personal accident insurance	• The rapidly changing nature of work and employment relationships makes it difficult to clearly define who is covered by the scheme. This change implements the JSC recommendation that the common law concept of employment be retained, but that the legislation provide for the "deeming" of additional classes of workers to provide greater certainty. • The key issue was whether unincorporated "contractors" operating as sole proprietors or in partnership should be covered. There was concern that some employees are forced to become contractors and thereby cease to be covered by the Act. • Consultation with employers and workers identified a solution to provide greater certainty for workers fitting the description above: ○ A contractor who does not sublet a contract or employ any worker, is deemed to be a worker of the person making the contract. ○ However, if the contractor elects to take out his own personal accident insurance, the contractor is taken not to be a worker during the period the insurance remains valid.
• Amends the definition of injury and disease to include the aggravation, or deterioration of an existing injury or disease.	• Brings Tasmania into line with other jurisdictions to ensure the aggravation or deterioration of a pre-existing injury is covered by the Act.

Dispute Resolution • Increased emphasis on conciliation • Conciliation process refined and made compulsory for all disputes	• The increased emphasis on conciliation of disputes represented the formalisation of an ongoing shift to 'alternative dispute resolution' processes, designed to reduce the adversarial nature of the dispute resolution system. Dealing with disputes via an informal, non-adversarial environment in the first instance often mitigates the need for formal legal process of determination. This approach was intended to: o reduce stress and increase equity for the worker during the process; o help preserve/repair the employer/worker relationship, and as a consequence, improve return to work rates; and o lower costs due to quicker resolution of disputes and less reliance on legal processes and professionals
• Conciliators powers increased, including, the power to require parties to produce relevant reports and proofs of evidence • Evidence prevented from being presented at arbitration if it was not disclosed during conciliation	• Providing conciliators with these additional powers was intended to ensure all parties complied with their requirement to participate in the conciliation process and exchange all relevant information. • Full disclosure of information and evidence during conciliation required facilitating open communication and access by both parties to all available information.
• Tribunal given power to award costs if a party unreasonably obstructed the conciliation process or failed to make a reasonable attempt to resolve a claim	• Additional provision to reinforce the primacy of conciliation.
• Tribunal given power to consider the necessity and cost of a medical service before it is obtained and a cost incurred.	• Enables the Tribunal to consider questions regarding medical expenses prospectively.
Medical Issues • Amends the definition of a 'medical question' and makes the decisions of medical panels final and binding on all parties	• This provision aims to ensure that purely medical questions are resolved via a process premised on medical expertise, rather than a legal process.

• Liability for medical expenses and associated disputation removed from Section 81A treatment and subject to a separate process. Employer must now either pay a claim for medical or related expenses or refer it to the Tribunal within 28 days of receiving the claim. Failure to do so within the required time results in a penalty.	• This amendment requires the employer to take prompt action in respect of a claim for expenses. • Previously medical expenses were subject to the Section 81A disputation process, that is, the same as that applying to initial liability disputes, resulting in potentially long delays in payment.
• Tribunal given power to order a reduction or termination retrospectively.	• The previous legislation prevented the Tribunal from making a retrospective order on an application to reduce or terminate weekly payments. In some cases this allowed a worker to receive a higher income from compensation than if he/she were at work. Allowing the Tribunal to make an order effective from the date of application to the Tribunal enables recovery of any overpayments determined by such an order.
Other	
• Copies of all medical reports to be provided to the worker's treating doctor	• This provision was added to ensure the injured worker's treating doctor has access to *all relevant* medical information in order to best assess and treat the worker's condition. There has been some evidence in the past that some medical reports were being withheld from workers and their doctors in an attempt to protect information in case of subsequent disputation.
• Employers with 50 employees or more to nominate a suitably qualified person to perform the role of rehabilitation coordinator	• This was one of a number of measures introduced in 2000 to facilitate – in workplaces with sufficient resources – effective injury management through the coordinated involvement of the relevant parties – the injured worker, employer, treating doctor, other service providers, insurer and workmates.
• The WorkCover Board to develop and publish average industry premium rates	• Intended to facilitate a better informed market place
• Fees may be prescribed by regulation.	• Provides ability to regulate fees for services provided under the Act, should fee variations be felt to be contributing to significant cost increases. • In the absence of a prescribed fee the normal fee (including any discounts normally available) is to be charged.

• Codes of Practice may be developed for the provision of services provided under the Act	• Intended as a means of providing guidance to service providers.
• Changes to scheme governance arrangements, including replacement of Workplace Safety Board by WorkCover Tasmania Board, with changes to voting rights	• Intended to increase the employer and employee representation b restricting voting rights to representatives of those parties only.

APPENDIX C – LIST OF CONSULTATIONS

Submissions were received from the following organisations and individuals:

- Unions Tasmania
- Tasmanian Chamber of Commerce and Industry (TCCI)
- Workers Compensation Action Group
- Construction, Forestry, Mining and Energy Union (CFMEU)
- Australian Manufacturing Workers' Union (AMWU)
- Australian Nursing Federation
- Rail, Bus and Tram Union (RTBU)
- Australian Plaintiff Lawyers Association (APLA)
- Dr Peter Sharman
- Dr Tim Stewart
- HEMSEM
- CGU
- Insurance Australia Group
- Housing Industry Association
- Tasmanian Occupational Health and Safety Services
- Launceston Community Legal Centre
- National Insurance Brokers Association (NIBA) of Australia
- Mr Brenton Best MHA
- Tasmanian Greens
- Ms Larainne Robertson
- Tasmanian Association of Vocational Rehabilitation Providers
- Mr Gary Rainbow
- Mr Roger Jago
- Mr Stuart Slater

- Mrs Ruth L Carey
- Mrs Mary Dicker
- Mr Phillip Charlesworth

OTHER CONSULTATIONS:

- Insurance Council of Australia (ICA)
- GIO
- Allianz
- ReCovre
- QBE
- Royal and Sun Alliance
- Comalco Bell Bay
- Tasmania Bar Association
- Mr Dean Ewington

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- Chief Commissioner, Tasmanian Workers' Rehabilitation and Compensation Tribunal
- Workplace Standards Tasmania staff
- WorkCover New South Wales
- WorkCover Corporation of South Australia
- ACT WorkCover

And the many injured workers who kindly chose to share their stories in confidence with me

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