Towards a national disability care model

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Glossary

ABS	Australian Bureau of Statistics
ACC	Accident Compensation Commission
ACCS	Accident Compensation Conciliation Service
AIHW	Australian Institute of Health and Welfare
ATE	after the event
CAA	Constant Attendance Allowance
CAB	Citizens Advice Bureau
CDC	consumer-directed care
CFA	conditional fee arrangement
DHS	Department of Human Services
DWP	Department for Work and Pensions
ELCI	Employers' Liability Compulsory Insurance
EPN	Endorsed Provider Network
HACC	Home and Community Care
HM	Her Majesty's
HSE	Health and Safety Executive
IIDB	Industry Injuries Disablement Benefit
NACVA	National Association of Certified Valuation Analysts
NCS	National Care Service
NDIS	national disability insurance scheme
NHS	National Health Service
ONS	Office for National Statistics
PC	Productivity Commission
SI	serious injury
SSA	Social Security Agency
TAC	Transport Accident Commission
VAGO	Victorian Auditor-General's Office
VCAT	Victorian Civil and Administrative Tribunal
VWA	Victorian Workers Association
WRMC	Workplace Relations Ministers' Council

Executive Summary

Access Economics was commissioned by Maurice Blackburn, Slater & Gordon and Shine Lawyers to examine the viability of a national no-fault insurance scheme in the greater context of providing better outcomes for people with a profound or severe disability. To achieve this task, this study has reviewed existing disability insurance schemes, including:

- Victoria's hybrid schemes, including the Transport Accident Commission (TAC) scheme and the WorkSafe scheme;
- United Kingdom's hybrid workers compensation scheme; and
- New Zealand's no-fault scheme administered by the Accident Compensation Commission (ACC).

Each scheme's characteristics were evaluated in the context of five performance dimensions, including:

- equity in access to disability care and support services;
- effectiveness in reaching desired outcomes;
- appropriateness of care and support;
- responsiveness in meeting individual needs and preferences; and
- sustainability in terms of financial risk and viability.

The assessment of various models and subsequent recommendations have been made in the context of providing disability care and support services for people with a 'severe' or 'profound' disability. As the Productivity Commission's Issues Paper does not offer a specific definition of what constitutes a severe or profound disability, this study has been guided by definitions commonly used in Australia. In addition, a 'catastrophic' injury was assumed to result in a severe or profound disability.

The Productivity Commission's Terms of Reference did not consider income support for people with a disability. As such, this aspect has not been specifically investigated within this report. However, it will be a critically important factor for the Productivity Commission to consider when determining the feasibility of a national disability insurance scheme.

As there will be trade-offs between performance dimensions, it is problematic to determine the most appropriate disability scheme for Australia without knowing what value society places on each dimension. For example, determining trade-offs between aspects such as equity and efficiency depends on normative judgements. Furthermore, a system that is perceived to be equitable at conception, but comes at a high cost, may quickly develop inequities through reductions in rights and benefits aimed at mitigating costs (e.g., the ACC has encountered this to some extent in New Zealand). Aside from questions of fairness arising, fundamental affordability questions also arise. Therefore a recommendation on a preferred disability insurance scheme has not been made. Instead, the report focuses on strengths and weaknesses of no-fault and fault based scheme characteristics and their applicability to the Australian context.

One of the primary arguments for a no-fault based system is reduced barriers to accessing disability care and better health outcomes due to earlier access. However, removing the right

to the common law of tort and offering statutory based compensation will not be costless. It may reduce the capability to achieve good health for some people, thereby creating inequities. This is especially the case for people with greatest need.

Furthermore, statutory benefit compensation is generally based on an 'average' level of impairment and does not consider the individual situation of the person with a disability. Given each person's welfare is based on their own individual circumstances, common law of tort provides flexibility in delivering alternative compensation levels to people with different impacts from the same disability, and can therefore address heterogeneous needs and preferences.

Although several arguments have been presented against a fault based system (e.g., high transaction costs and delayed access to compensation) recent reforms throughout Australia have commenced to address these problems. For example, jurisdictions have imposed caps on the level of damages and legal costs. Disability insurance schemes have reduced access to common law through the use of impairment thresholds, and disputes over compensation must go through alternative dispute resolution processes (consisting of mediation and conciliation) before common law is made available, with reasonable access to medical and disability care provided throughout the process, and mechanisms to minimise costs and enhance early settlement prospects.

Based on an analysis of characteristics within disability insurance schemes operated by the TAC, WorkSafe, ACC and within the UK, this report arrives at several conclusions for the Productivity Commission to consider when evaluating the feasibility of a national disability insurance scheme for Australia (see Chapter 4).

- A national disability insurance scheme should be built around delivering proper incentives to minimise potential costs from disability. This includes incentives to prevent injuries, reduce risky behaviours, promote rehabilitation, and to offer appropriate and responsive care.
- A decentralised delivery model for people requiring disability care is desirable in order to best meet individual needs and preferences. People with a disability should have the option to receive care through a consumer-directed care model *and* the option to relinquish care responsibility to a designated case manager.
- Stakeholders should have the option to dispute decisions made by the scheme's administrators. This should first involve an initial internal review, and then the option for independent external review.
- Consistent with existing schemes, a refund / repayment element should be built into a national scheme to avoid double dipping. Mechanisms should also be used to minimise the risk of cost shifting onto the public system.

Given the complexity of determining the long term cost of disability care, it is imperative that a national disability insurance scheme is operated on a fully funded basis. This would ensure future liabilities are incorporated into revenue generation mechanisms, thereby introducing incentives to manage expenditure risk. Any scheme must avoid the problem of unfunded liabilities and therefore costs falling back onto the government. If common law rights were removed under a national scheme, and the scheme was not fully funded, some of the cost burden associated with negligent conduct would shift from the private sector to the public purse. For example, this issue has been encountered by the ACC, which has necessitated

amendments to legislation on various occasions (including in 2010) to ration care in an attempt to manage cost blowouts.

Even if the Productivity Commission find a national disability insurance scheme feasible, there is no guarantee that jurisdictions would support replacing their own disability schemes, especially when some consider their schemes to be relatively effective and efficient (e.g., Victoria and the TAC and WorkSafe schemes). Jurisdictions may believe that a national scheme could result in poorer disability care outcomes. For example, in the most recent Council of Australian Governments (COAG) meeting, Victoria rejected adopting full funding of the Home and Community Care (HACC) program by the Commonwealth Government.

Rather than implementing a national scheme, a national body could be established to implement incentives to improve current schemes and to coordinate consistency across jurisdictional scheme design and administration. However, it is unclear whether this model would be effective, and it would not solve the problem of providing disability care to those not covered by jurisdictional schemes.

Therefore, a good starting point for a national disability insurance scheme is to develop a no-fault based system for care and support services that covers people currently uncovered by jurisdictional schemes, but also operates in parallel to existing jurisdictional schemes. This will avoid delays in provide immediate benefits to those most in need while negotiations and draft legislation proceeds for an all encompassing national disability insurance scheme if supported by jurisdictions.

Access Economics

1 Scope of the inquiry

The scope of the inquiry in terms of the people potentially covered by a national disability insurance scheme crucially depends on the definition of eligibility. Eligibility determines access, and unless eligibility is granted to everyone with a disability, regardless of how that disability was acquired, different definitions of eligibility will result in different access across disability types.

The Productivity Commission notes that the definition of eligibility within the inquiry is not yet confirmed. Instead they will be looking to develop a more detailed response to the scope of a scheme, and the possibility of a new disability insurance scheme, once submissions have been collected and consultations undertaken with a wide range of stakeholders.

However, the Issues Paper also notes that one of the aims of a national disability insurance scheme will be to reduce the inequity in access to disability services. Consequently, the definition of access, eligibility and therefore the scope of the inquiry, will be determined in part by the definition of equity. Consequently, equity as it relates to a national disability insurance scheme also needs a clear definition.

But it's not as simple as that. Many overlapping and contradictory definitions of equity could be used. Equity in access is defined as people having the same opportunity to use disability services regardless of their demographic, geographic or socioeconomic status. It refers to people experiencing the same costs of utilisation, and does not require the actual use of these disability services. That is, people can choose to not access disability services. This definition allows patients with equal need to utilise disability services differently due to their alternative preferences.

Equity can also be defined in terms of disability service utilisation according to need. This can be further categorised into horizontal equity and vertical equity.

- Horizontal equity dictates people with equal needs have equal access to disability care services.
- Vertical equity dictates people with greater needs have greater access to disability care services.

Even these basic definitions of equity have limitations as they relate to eligibility and scope as 'need' and 'access' must first be defined.

There are alternative definitions of need, which have different policy implications for the allocation of resources. Need is synonymous with the level of disability, so that people with similar disability have a similar need for disability services, and those with greater disability will have greater need. This definition seems reasonable and is in line with the definition of vertical equity.

However, defining need based on the level of disability does not consider a person's capacity to benefit from disability services, or provide insight into whether a person has a right to the same level of resources even though benefits from disability services may be lower. For example, this definition does not provide a definitive answer on whether a mobility aid is

needed more by a young, outgoing person in the workforce compared to an older person who may derive a smaller benefit from the aid due to a reduced need to be mobile.

An alternative definition of need is the capacity to benefit from disability care services in reaching some predefined goal such as improved social interaction or reduced disability burden. Within this definition, those who can transform the same level of disability services into greater health outcomes are those with a greater need. Using the previous example and this definition, the younger person will be in greater need of a mobility aid because it would generate greater benefits.

Defining need for disability services based on the capacity to benefit suggests every person with a disability needs disability care services because they will provide some benefit, no matter how small. This leaves the question of how much, and what, disability services should be covered by a national disability scheme, and does not provide any indication on the amount of resources that would be needed to improve outcomes.

Equally as important in defining need is the interpretation of access. The broad definition of access can be defined through the costs of utilisation. These include not only the monetary costs associated with the disability service, but other costs such as time and opportunity costs. Any disability scheme looking to improve access under this definition will need to focus on reducing costs to the care recipient associated with disability services. This not only includes reducing the cost of purchasing disability services, but all associated costs including the cost to accessing services (e.g., transport) and the opportunity cost associated with disability (e.g., lost income).

A similar definition of access is one that measures the value of disability care in terms of potential utility gained. Thus a person who has a higher opportunity cost associated with disability would have greater access to disability care under this definition, because a reduced burden through disability care is expected to result in greater utility gain. That is, the person has greater access to the benefits provided by disability services. This definition implicitly requires measuring the capacity to benefit from disability care services, including the capacity to improve health outcomes and the capacity to return to a normal functioning lifestyle, such as a quick return to work.

In either of these two definitions the policy choices are generally the same. In order to increase access a disability insurance scheme must reduce the price of disability care for those with higher marginal utilities from income (typically those on a low income) or those with greater opportunity costs (typically those in work).

Access can also be measured using the maximum attainable consumption of the disability service in question. Access to disability care is therefore defined as the capacity to consume disability care. If a person has the ability to consume more care, regardless of the cost associated with consumption, they have greater access to care under this definition. This definition is sufficiently different to the last two in defining scope and eligibility, and will generate alternative policy directions in order to achieve access.

Although these definitions may seem relatively compatible, they tend to conflict. For example, ensuring equality in access to disability care services does not necessarily mean there will be distribution of resources according to need. Consequently, equal access does not translate

into equity as the former is an objective measure, while the latter is concerned with fairness and justice of social arrangements.

If a national disability scheme aims to provide equal access, it may result in equities. For example, denying a wealthy person additional disability care services to ensure equal access with a poor person who has the same condition could be considered inequitable. Reducing the capacity to benefit from disability care to ensure equal access regardless of where that person lives could also be considered inequitable. In fact, unequal access to disability care is necessary if vertical equity is an objective of the national disability insurance scheme.

Equity of access primarily focuses on whether people have the same opportunity to undertake health care, which, as previously discussed, depends on the cost to the care recipient. It does not require disability care to be used by the person. Alternative preferences for disability care and different budget constraints will ensure utilisation of health care services will be different in the Australian disability support system.

The Productivity Commission Issues Paper does not shed any light on whether these alternative definitions of eligibility and equity will be incorporated within the inquiry or whether the definition of equity will be all encompassing. If the definition of equity specifically relates to one definition, this needs to be explicitly stated to enable stakeholders to work towards a common goal. As part of this, the Productivity Commission needs to refine the definition of each component that make up equity, such as access and need.

1.1.1 Defining disability

Within the Issues Paper, the Productivity Commission has provided a set of possible definitions that could be applied to disability. For example, the Issues Paper includes definitions drawn from the United Nations Convention on the Rights of People with Disabilities, the World Health Organization, and the Australian Bureau of Statistics (ABS) (PC, 2010). It also refers to definitions of a 'profound' and 'severe' core activity limitation as classified by the ABS. However, it is unclear how the Productivity Commission will relate the definition of disability associated with an acquired condition to the definition of a 'catastrophic' injury.

To ensure comparability of this study with Inquiry outcomes, the definitions of disability (severe and profound) and catastrophic injury outlined in Table 1.1 have been used to guide the scope of this study.

The definition of 'catastrophic injury' in the Issues Report is vague. Among personal injury lawyers and insurance companies, a catastrophic injury generally includes those that have serious, long-term disability effects on the person injured. They are usually sustained from a sport or recreation accident, motor vehicle accident or assault. Catastrophic injuries may result in:

- traumatic brain damage;
- severed spinal cord (causing paralysis);
- amputations;
- loss of sight or hearing;
- burn and scald injuries;

Table 1.1: Definitions used in the evaluation of alternative disability schemes

	Source	Definition
Disability	ABS	Limitation, restriction or impairment, which has lasted, or is likely to last, for at least six months and restricts every day activities.
	UN Convention on the Rights of People with Disabilities	Interaction of long-term physical, mental, intellectual or sensory impairments, and attitudinal or environmental barriers that 'hinder…full and effective participation in society on an equal basis with others'.
	WHO	Covers impairments, activity limitations, and participation restrictions. An impairment is a problem in body function or structure; an activity limitation is a difficulty encountered by an individual in executing a task or action; while a participation restriction is a problem experienced by an individual in involvement in life situations. Reflects an interaction between features of a person's body and features of the society in which he or she lives
Core activities	ABS	Self-care such as bathing and eating, mobility and communication.
Profound disability	ABS/AIHW	Person is unable to do, or always needs help with, a core activity task.
Severe disability	ABS/AIHW	Person sometimes needs help with a core activity, and/or has difficulty understanding or being understood by family or friends and/or can communicate more easily using sign language or other non-spoken forms of communication.
	Guide to Social Security Law (FaHCSIA, 2010)	They are consistently associated with a severe, moderate or profound disability that is permanent or likely to be permanent. To be included there must be clear diagnostic criteria that are widely accepted, and the disability must be reasonably prevalent.
Moderate or mild disability	ABS/AIHW	Person needs no help or supervision, but has difficulty with a core activity task, or the person uses aids and equipment but needs no help with a core activity task.
Catastrophic injury	Australian Injury	Can include traumatic brain damage, a severed spinal cord, amputations, the loss of sight, burn and scald injuries and a catalogue of damage caused as a result of multiple fractures and organ failure.
	University of Western Australia, School of Population Health	Any traumatic injury resulting in the need for long-term attended care for activities of daily living, such as meal preparation and personal hygiene.

Source: Access Economics.

- catalogue of damage caused by multiple fractures; and
- organ failure.

These injuries result in severe disabilities for the purposes of determining Carers Payments under the Guide the Social Security Law. Consequently, for the purposes of this study, catastrophic injury is defined as one that causes a severe or profound disability.

Currently the degree of disability severity is measured using guidelines provided by jurisdictional governments (e.g., Workcover NSW, 2009). These have generally been based on the American Medical Association Guide to the Evaluation of Permanent Impairment. Determining permanent impairment and whether a person is profoundly or severely disabled involves a clinical assessment to determine:

- whether the claimant's condition has resulted in impairment;
- whether the condition has reached maximum medical improvement (MMI);
- whether the resultant impairment is permanent;
- the degree of permanent impairment that results from the injury; and
- the proportion of permanent impairment due to any previous injury, pre existing condition or abnormality (Workcover NSW, 2009).

The definition of profound and severe disability is generally determined by a minimum injury threshold. However, these thresholds vary across jurisdictions. Any definition of profound and severe disability determined by the Productivity Commission must therefore consider the range of minimum injury thresholds currently being used throughout Australia and their relationship with no-fault insurance schemes.

It is proposed that a national disability insurance scheme measure the level of disability sustained through an injury using the general framework already in use by jurisdictions. The definition should remain comprehensive in terms of coverage of medical injuries and illness, and cover:

- all new disabilities;
- exacerbation of a prior disability;
- acceleration of a prior condition leading to disability; and
- recurrence of a prior condition leading to disability.

It is also proposed that the degree and severity of impairment should be a key determinant of eligibility under a national disability insurance scheme. This means the type of injury that caused the disability should bear no relevance to measuring eligibility for benefits.

2 Alternative disability insurance schemes

This chapter provides evidence from a comprehensive literature review on the characteristics that make up disability schemes in New Zealand, the United Kingdom, and Victoria. It first provides an overview of what is meant by a fault versus no-fault scheme, and outlines the characteristics that make up these definitions. The chapter then investigates each scheme based on seven specific design issues associated with disability schemes.

2.1 Fault versus no-fault disability insurance schemes

Disability care varies throughout the world. For people who are disabled unrelated to injury, for example through ageing or congenital abnormalities, care is generally delivered through social welfare and public health care programs using funding from general tax sources or hypothecated levies. However, countries vary the way they structure their disability insurance frameworks to meet the cost of personal injury resulting from workplace accidents, motor vehicle accidents, and other types of accidents resulting from negligence. Different structures include:

- fault based systems, where funding for disability care is met through compensation established through a tort system, and those who cannot establish fault must rely on the social welfare system and their own resources;
- no-fault based systems, where funding for disability care is met through a compulsory funded disability insurance scheme and the need to establish fault is not required; and
- 'hybrid' system, which has some characteristics of a no-fault system (usually for less severe injuries) and the opportunity to pursue compensation through a tort system.

Arguments for and against fault and no-fault based disability insurance systems are listed in Table 2.1. In general, proponents of a fault based system argue that the common law of tort is the appropriate system to determine negligence and fair compensation. They argue a no-fault based system reduces the capacity of the person experiencing a disability to seek appropriate levels of compensation, and that the removal of establishing fault reduces the incentive to avoid negligence, thereby leading to riskier behaviour and more injuries.

Proponents of a no-fault based system argue that a tort based system presents substantial barriers to seeking compensation for some people, due to the associated cost and risk, and can therefore delay access to disability care. They believe a no-fault system can reduce or eliminate barriers to accessing disability care, therefore leading to better health outcomes.

Proponents of a hybrid system argue there are benefits and costs associated with both systems, and that a hybrid system can deliver the best of both worlds while minimising undesirable outcomes, such as those set out in Table 2.1.

Table 2.1: Arguments for and against a common law of tort based compensation system

Against common law	For common law
▪ Runs counter to the basic principle of a no-fault scheme.	▪ Is a fundamental right.
▪ Can be slow, denying the victim access to timely compensation.	▪ Provides an efficient process to monitor the adequacy and propriety of a no-fault scheme
▪ High transaction costs, reducing the amount of compensation available for injured or ill workers and their dependents.	▪ Intended to provide 'just' compensation for those harmed because of the negligence of others.
▪ Is inimical to rehabilitation and return to work because it promotes confrontation between the employer and employee.	▪ Provides an incentive for employers to prevent work related fatality, injury and illness.
▪ May delay rehabilitation and hamper effective injury management because damages are determined by the severity of the injury sustained.	▪ A system with no common law would discriminate against those harmed as a result of the negligence of others (compared to those harmed outside the system).
▪ Compensation is not guaranteed, which can leave some injured or ill workers without adequate income support.	▪ There are some cases for which statutory benefits are too inflexible to cover particular cases (e.g., disfigurement).
▪ Damages are provided as lump sums, which can be dissipated by the victim or otherwise prove inadequate to meet longer term need.	▪ Without common law some people would suffer from under compensation.
	▪ Prevents employers from shifting costs on to others.

Source: PC (2004).

Recently jurisdictions have sought to circumvent some of the issues regarding the common law of tort. In 2002, the Commonwealth Government commissioned Justice David Ipp to examine the scope for possible reforms to the law of negligence (Commonwealth of Australia, 2002). Each jurisdiction has individually legislated in response to the recommendations, in order to narrow the scope of the potential liability, and reduce the damages which may be awarded. Details of reforms to tort law in Australia in response to the Ipp Report (Commonwealth of Australia, 2002) are summarised in Table 2.2.

Furthermore, common law principles exist that aim to reduce the severity of the disability before settlement occurs. The plaintiff has a duty to take reasonable steps to maximise benefits from rehabilitation, and the lawyer must ensure their client is actively involved with rehabilitation. Hybrid schemes also provide access to health, rehabilitation and disability care prior to, and throughout, a common law action.

Table 2.2: Legislative responses to the Ipp report

IPP recommendations	Examples
Limiting the duty and standard of care to narrow the scope of potential liability	In most jurisdictions, the test of 'obvious risk' and 'reasonableness' were further refined. For example, recreational service providers are not liable for personal injury or death suffered as a result of obvious risk.
Limiting the negligence of professionals, including medical practitioners	For most jurisdictions, professionals will not be negligent for injury arising from the provision of a professional service if it is established that the professional acted in a manner that was widely accepted by peer professional opinion as competent professional practice.
Limiting liability for mental harm	Most states have followed the recommendation of no liability if harm is not recognised as psychiatric illness.
Time limitation in bringing a tort action	Most jurisdictions have introduced a three year period from the 'date of discoverability' (i.e. when the plaintiff knew or ought to have known injury occurred). For Victoria, the limitation period is whichever is the first to expire from: ■ the period of three years from the date on which the cause of action is discoverable; or ■ the period of 12 years from the date of the act or omission alleged to have resulted in the death or personal injury with which the action is concerned.
Caps on the level of damages and impairment thresholds.	Introducing caps for general damages and thresholds to remove small claims form the system. For example, in some jurisdictions caps have been introduced on non-economic loss/general damages and loss of earning capacity based on some multiple of average weekly earnings. Discount rates are also being used to reduce the total amount of compensation. Furthermore, a level of impairment must be reached before people can access common law.
Limits on legal costs	Limiting legal costs by placing caps based on the award of damages. For example, in NSW, the maximum legal cost for claims up to $100,000 is the greater of 20% of the amount recovered or $10,000.
Contributory negligence	Concurrent parties are liable for personal injury and the claim can be apportioned to each party based on the level of liability. This means plaintiffs can be held responsible for their own injury and have their compensation amount reduced accordingly. For example, in Victoria this recommendation was implemented in 2004.

Source: Minter Ellison (2007).

This report does not explicitly address the arguments for, or against, common law of tort as outlined in Table 2.1. The purpose of the study was to examine the viability of a national no-fault disability insurance scheme in the greater context of providing better outcomes for people with a disability, and to inform debate on whether a national no-fault scheme is the appropriate model for Australia's future disability care and support needs for people with profound or severe disabilities.

To undertake this task, New Zealand's no-fault scheme was examined to determine its applicability to the Australian context, noting the delivery of disability care services and health care are different, and outcomes using the same type of scheme in Australia may not be forthcoming.

Since 1974, New Zealand has had a no-fault based scheme operated by the Accident Compensation Corporation (ACC) for compensating people with personal injuries. The scheme replaced a former tort-based system through findings of a Royal Commission into Compensation for Personal Injury (known as the Woodhouse Commission) that the economy will be negatively affected if the wellbeing of the workforce is reduced through personal injury. The Woodhouse Commission noted five general principles for rehabilitation and compensation, including:

- community responsibility;
- comprehensive entitlement;
- complete rehabilitation;
- real compensation; and
- administrative efficiency (Woodhouse, 1967).

The Woodhouse Commission noted that remedies provided by the common law of tort were considered inadequate to encourage rehabilitation and to minimise the impact of injury. It concluded that the fault principle cannot logically be used to justify the common law of tort remedy and is erratic and capricious in operation. Establishing fault was seen as irrelevant because the common law of tort remedy was seen to fall short of the five general principles for rehabilitation and compensation (Easton, 2004).

Hybrid schemes currently used in Victoria were also examined in this study. They included the Transport Accident Commission (TAC) scheme and the WorkSafe scheme, a division of the Victorian WorkCover Authority. Both schemes are owned and administered by the Victorian Government.

The TAC was established on 1 January 1987 following Parliament's creation of the *Transport Accident Act 1986 (Vic)* (the Act). The purpose of the Act was to establish a compensation scheme 'in respect of persons who are injured or die as a result of transport accidents'. The Act guides the TAC in the types of benefits it can pay and any conditions that apply. Apart from compensation, primary objectives of the TAC scheme include reducing the incidence and cost of transport accidents, promoting road safety in Victoria and improving Victoria's trauma system.

WorkSafe is primarily governed by the Victorian WorkCover Authority (VWA) using an established framework set by the *Accident Compensation Act 1985* (*Vic*) and the *Accident Compensation (WorkCover Insurance) Act 1993 (Vic)*. Aside from administering compensation, WorkSafe is active in promoting safe work environments to reduce the incidence of workplace accidents, and supporting the occupational rehabilitation of injured workers to encourage their early return to work.

The TAC and WorkSafe both operate as insurance schemes and are predominantly funded through compulsory insurance premiums. Under WorkSafe these are paid by Victorian employers, and under the TAC premiums are paid through motor vehicle registration. A key

feature of both compensation schemes is the combination of no-fault and common law of tort benefits, providing Victorians with coverage regardless of fault, while allowing those who can prove fault to pursue further compensation through the courts (although eligibility requirements need to be met before the common law of tort can be used). A claimant retains the right after settlement of common law to care and support payments from the TAC and WorkSafe.

For an international comparison, the hybrid scheme used in the United Kingdom to cover workplace injuries was also investigated. The hybrid scheme includes a no-fault component, allowing access to benefits regardless of the cause of the disablement and common law of tort rights to a civil claim against an employer for 'at fault' benefit if the disablement was a result of negligence.

No fault compensation is provided through the Industry Injuries Disablement Benefit (IIDB) scheme, a social security payment, with the support of the National Health Service (NHS), disability care and other income support programs.

The IIDB acts as a safety net for employees disabled at work. The IIDB is operated though the social security system and is paid based on the degree of disablement to anyone deemed to have suffered illness or injury as a result of their employment (DWP, 2007a). The claimant does not have to prove negligence by the employer, they only need to show that the disability was caused at work. Moreover, people are still eligible in the injury or sickness occurred outside the workplace so long as the employee was undertaking an activity for their employer and the incident occurred in England, Scotland or Wales (DirectGov, 2010a).

Employees in the UK hybrid scheme have a right to make a claim for compensation under the common law of tort if their disablement was a result of negligence or breach of contract by their employer. These claims are pursued through the legal system and, if successful, are paid for by Employers' Liability Compulsory Insurance (ELCI). Under the *Employers' Liability (Compulsory Insurance) Act 1969* employers in the UK that have employees in England, Scotland or Wales are required to have ECLI for all of their employees (HSE, 2008).

The UK hybrid scheme ensures that those who are unable to establish negligence or breach of contract on part of their employers through the tort system, or unwilling to make a claim against their employer, are provided with a base level of compensation in conjunction with health and disability services.

Several characteristics of the New Zealand, Victorian, and UK disability schemes were reviewed based on the list of characteristics outlined in the Productivity Commission's Terms of Reference. They include:

- coverage and entitlements;
- claimants behaviour;
- choice;
- interaction with health and aged care system, employment services, education and training, accommodation and welfare services, and income support;
- governance and administrative arrangements; and
- appeal and review processes for claimants and participants.

These characteristics are discussed in detail below.

2.2 Coverage and entitlements

The principal objective of a disability insurance scheme should be to provide adequate and appropriate disability care for people with permanent disability, and to provide effective rehabilitation services and return to work programs for people who are temporarily disabled as a result of injury or illness. This must be achieved within a financially sustainable framework that embodies a balance between fair and just compensation and scheme affordability.

There are significant variations in coverage and entitlements across the Victorian, New Zealand and UK disability schemes, which is the result of different approaches to disability insurance, differing reliance on compensation through common law, and alternative roles the social welfare system plays in social security and delivering disability care and support services. In general, all schemes provide statutory benefits to compensate people who suffer disability as a result of an accident, and these benefits are intended to cover lost income, medical and rehabilitation expenses, and a diminished wellbeing if the injury meets some impairment threshold and is permanent. However, the level and duration of benefits (and therefore coverage and entitlements) offered under each scheme vary.

2.2.1 Victoria

The TAC defines injury as a 'physical or mental injury and includes nervous shock suffered by a person who was directly involved in the transport accident or who witnessed the transport accident or the immediate aftermath of the transport accident' (the Act, s3). For WorkSafe, the *Accident Compensation Act* 1985 s 83(1) states that coverage extends to injuries 'deemed to arise out of or in the course of employment', which is consistent with definitions used in all other jurisdictions except Tasmania (which uses a narrower definition of 'arising out of and in the course of employment').

Specific WorkSafe entitlements such as common law and impairment benefits require a minimum level of injury to be reached before compensation can be claimed. To be entitled to litigate the work injury must be medically assessed as 'serious', defined as the worker having a 30% or more whole person impairment (VWA, 2010). Impairment benefits are paid to workers who have a minimum level of impairment of:

- 5% for musculoskeletal injuries;
- 10% for other physical injuries; and
- 30% for psychiatric conditions (VWA, 2010).

Impairment is assessed by independent impairment assessors. Assessors are doctors specially trained to conduct impairment assessments that comply with the requirements of the AMA Guides to the Evaluation of Permanent Impairment and other methods prescribed by the *Accident Compensation Act 1985*.

For the purpose of TAC lump-sum payments, permanent impairment refers to a permanent physical or psychological condition caused by a transport accident injury (TAC, 2010). Impairment is medially assessed following the Act's guidelines as outlined in section 46. Clinical tests are conducted to measure how, and to what degree, the injury has affected body movement or organ function. The effect of the injury on lifestyle is not considered. Each

injury is given a percentage rating, based on the level of impairment. People whose impairment rating is greater than 10% are entitled to a one-off lump sum payment. Impairment payments are made in addition to other TAC benefits, such as medical services or income support. Table 2.3 outlines lump-sum benefits associated with differing degrees of impairment.

Table 2.3: TAC's impairment benefit table

Degree of impairment	Lump sum benefit [(a)]
10% or less	0
11%-19%	$5,270 +((**D**-10) x $1,180)
20%-49%	$17,570 +((**D**-20) x $1,750)
50%-59%	$70,550 +((**D**-50) x $2,050)
60%-79%	$91,330 +((**D**-60) x $2,350)
80%-89%	$140,510 +((**D**-80) x $4,680)
90%-99%	$192,040 +((**D**-90) x $9,360)
100%	$295,100

Note: (a) **"D"** is the degree of impairment expressed as a percentage number. Benefits are effective on or after 1 July 2010
Source: TAC (2010).

An expected length of time for disability is not defined by either scheme. TAC assistance for loss of income is paid fortnightly for up to 18 months after an accident. A claimant's entitlement period is the period a claimant is certified as unfit for work. If a claimant can prove a loss of earning capacity they will be entitled to a second fortnightly payment that commences 18 months *after* the date of the transport accident. Loss of earning capacity payments cease at the occurrence of the first of the following events:

- the expiry of three years from the date of accident, which applies to a client who is less than 50% impaired;
- the normal retirement age is reached, however if no normal retirement age is set for that occupation, the age of 65 applies to a client who is 50% or more impaired;
- the pecuniary loss component of a common law action settles;
- the client is deceased; or
- the client no longer has a loss of earning capacity.

WorkSafe income assistance is provided through weekly payments provided for up to 130 weeks and in some cases, payments can continue until retirement age. A worker's entitlement is linked to:

- their capacity to work;
- current weekly earnings;
- ability to return to suitable employment; and
- willingness (reasonable effort) to participate in a rehabilitation/return to work program (VWA, 2010).

Entitlement to compensation through WorkSafe is available if a worker's employment is connected with Victoria. If a worker is outside Victoria when an injury occurs, it does not preclude an entitlement to compensation, so long as employment is with a Victorian registered business. Diseases proven to be directly caused by work are also covered, for example asbestosis related conditions. Workers can claim compensation whether they are permanent or casual, full time or part time, employed by the people where they work or are employed under contract.

All Victorian's are covered by the TAC scheme. Section 35(1) of the Act states that a person is who is injured as a result of a transport accident is entitled to compensation if:

- the accident occurred in Victoria;
- the accident occurred in another State or Territory and involved a registered motor vehicle and, at the time of the accident, the person was
  - a resident of Victoria;
  - the driver of, or a passenger in, a registered motor vehicle.

WorkSafe and TAC schemes are both systems of statute based, compulsory insurance that provide a range of entitlements to injured Victorians. These are summarised below.

- Income assistance – indexed payments provided to cover the loss of income for injured claimants who are unable to return to work. This is a temporary support while recovering and stops upon return to work.
- Medical and disability care services – compensation to cover reasonable costs of services and treatments, including rehabilitation. There are maximum fees for most services.
- Death claims – support for dependants of a deceased worker for some funeral expenses and counselling services, as well as financial support.
- Impairment benefits – lump sum payments for clinically assessed permanent non-economic loss and maiming.
- Common law – for claimants who suffer a 'serious injury' if the accident was due to negligence by another party.
- Voluntary settlements (WorkSafe) – lump sum payments can replace a worker's ongoing entitlement to weekly payments (VWA 2010; TAC 2009).

Both schemes cover medical and disability care expenses for as long as necessary. Service necessity is reviewed regularly, taking into consideration changing needs and the effectiveness of ongoing treatment when determining what is reasonable for continued funding.

No direct compensation or support is available for informal carer's of injured workers. Other personal and household services, including respite care and child care, may be reimbursed if WorkSafe or the TAC has granted prior approval to access these services. In addition, a dependent partner and children may receive a weekly pension for up to three years after a worker's death. Other entitlements including burial and family counselling costs can be paid.

Under the WorkSafe scheme, exceptions to entitlement, or entitlement to reduced compensation, may occur in the following circumstances:

- a mental injury was caused wholly or predominantly by management action taken on reasonable grounds and in a reasonable manner;
- an injury to a worker is proved to have been deliberately or wilfully self inflicted;
- the injury was attributable to the worker's own serious and wilful misconduct (e.g. under the influence of alcohol or drugs);
- a transport accident where the worker was the driver and is convicted or found guilty of driving offence; and
- a worker does not disclose pre-existing injuries and diseases (VWA, 2010).

2.2.2 New Zealand

New Zealand has a comprehensive no-fault disability scheme administered by the Accident Compensation Corporation (ACC). All citizens and residents of New Zealand are covered by the scheme, and are eligible for benefits if they have suffered personal injury, defined as diagnosed damage to the body (i.e. merely establishing pain is insufficient). This can include:

- physical injury;
- mental injury suffered due to physical injury;
- mental injury caused by certain criminal acts (e.g. sexual abuse or criminal injury);
- damage (other than wear or tear) to dentures or prostheses that replace part of the human body; and
- death due to physical injury.

Personal injury does not cover illness unless it is an occupational gradual process injury, disease or infection. Furthermore, emotional conditions such as stress and loss of enjoyment are not considered personal injury and people suffering these conditions are not eligible for benefits. The exception is mental injury caused by physical injury or sexual abuse. Injuries related to age, non-traumatic hernias (e.g. from coughing or sneezing) and non-occupational gradual process injuries are also not covered.

Eligibility for benefits is regardless of age, employment status, where and how the injury was sustained and whether the benefit recipient contributed to the injury. The scheme also covers the medical treatment of overseas visitors who are injured while in New Zealand, although benefits are limited. In exchange for certainty of compensation, all rights to pursue compensation through the common law of tort are waived except in the extreme cases of gross negligence or deliberate intention to cause harm.

Benefits are not means-tested and cover two parts – rehabilitation costs and compensation costs. Rehabilitation costs include all costs associated with medical treatment and rehabilitation programs that assist with recovery from an injury, such as vocational and social rehabilitation, medical and hospital treatment, and public health acute services. As well, the ACC can arrange various types of help for managing the disability at home, including child care, attendant care, equipment and house and vehicle modifications for more serious injuries. Total claims paid for rehabilitation costs in 2009 amounted to NZ$1.9 billion (ACC, 2010a).

Compensation costs are a form of income support and include weekly compensation (based on earnings lost as a result of the injury), independence allowances, lump sum payments and

death benefits (in cases where an injury-related death occurs). Weekly compensation is 80% of the claimant's weekly earnings prior to their injury (according to their income tax statement or previous employment history) up to a maximum of $1,341.31 per week (s46 *Accident Compensation Act 2001* (NZ)). Compensation costs totalled NZ$1.2 billion in 2009 (ACC, 2010a). People who have suffered less than 10% impairment as a result of injury are eligible for treatment and services, but not for compensation payments.

In cases of permanent impairment of more than 10%, claimants may also be entitled to receive a lump sum payment on top of rehabilitation and compensation costs. This is expected to cover the loss of wellbeing suffered through disability (e.g. a reduced quality of life through disfigurement).

The lump sum amount is adjusted for the level of permanent whole body impairment suffered, which is assessed by the ACC according to American Medical Association Guides to the Evaluation of Permanent Impairment. Consequently, benefits do not distinguish between the type of impairment but the amount of functional loss. For example, a person who loses an eye is rated as 24% impaired, while the loss of an arm is rated as 60% impaired. Lump sum payments by level of impairment are summarised in Table 2.4.

Table 2.4: Lump sum payment by level of impairment [(a)]

Level of impairment	Lump sum payment
%	$ (NZD)
10	3,078.46
15	5,307.25
30	14,829.5 4
50	38,211.04
80 or greater	123,138.27

Note: (a) As at 2007.
Source: ACC (2010).

Lump sum payments apply per-person rather than per-injury, and people who receive lump sum payments may still be eligible for other ACC cover for modifications to their accommodation and vehicle, specialised equipment such as mobility scooters, treatment costs (including related travel and accommodation expenses) and weekly compensation.

Families of people who have died as a result of a criminal act or an accidental injury may be eligible for support from ACC. These include survivor grants, funeral grants and child care support.

2.2.3 United Kingdom

The United Kingdom operates a hybrid scheme for workers compensation. No fault compensation is provided through the Industry Injuries Disablement Benefit (IIDB) scheme, while if the disablement is a result of employer negligence the employee is able to pursue additional compensation through the common law of tort.

To receive the IIDB, the degree of disablement, measured by a rating out of 100, is assessed by a medical practitioner. Guidelines for the level of disablement associated with 55 injuries are provided under the *Social Security (General Benefits) Regulations Act 1982.* Some of the

injuries listed in the schedule are presented in Table 2.5. If the injury is not included in the schedule of benefit it may still be possible to claim. In this event the degree of disablement isdetermined by comparing the injury with the injuries that are prescribed in the legislation (DWP, 2010a). Usually an injury must be the result of a specific incident rather than from long term performance of a task. Some types of long term damage, such as deafness, are covered as an industrial disease (DWP, 2010a).

Table 2.5: Injuries covered by the IIDB [(a)]

Injury	Degree of disablement
1. Loss of both hands or amputation at higher sites	100
2. Loss of a hand and a foot	100
4. Loss of sight to such an extent as to render the claimant unable to perform any work for which eyesight is essential	100
5. Very severe facial disfiguration	100
6. Absolute deafness	100
7. Forequarter or hindquarter amputation	100
Amputation cases – upper limbs (either arm)	
8. Amputation through shoulder joint	90
12. Loss of thumb	30
Amputation cases – lower limbs	
18. Amputation of both feet resulting in end-bearing stumps	90
28. Amputation below knee with stump exceeding 13 centimetres	40
Other injuries	
32. Loss of one eye, without complications, the other being normal	40
33.-55. Loss of fingers or toes[(b)]	1-14

Notes: (a) This is an excerpt of the full list of 55 injuries. (b) Items 34-55 specifically state the degree of disablement for different amounts of different fingers and toes lost.
Source: DWP (2010a).

An industrial disease is defined as a disease that a person is at risk of contracting as a result of their occupation when this risk is not common to everyone (DWP, 2010a). To be eligible for compensation the person must:

- be diagnosed with one of the approximately 70 diseases listed in the *Social Security (Industrial Injuries) (Prescribed Diseases) Regulations 1985;*
- meet the criteria for work in terms of occupation, industry and type of job (e.g. if diagnosed with primary carcinoma of the nasopharynx the job must have involved 'exposure to wood dust in the course of the processing of wood or the manufacture or repair of wood products, for a period or periods which amount in aggregate to at least 10 years'(DWP, 2010a));
- demonstrate that the disease was a direct result of employment (if employed within one month of the onset the presumption is generally that employment is responsible unless otherwise demonstrated);
- a medical practitioner must determine that the person has a loss of faculty as a result of the disease; and

- the degree of disablement resulting from the loss of faculty must be determined by a medical practitioner (DWP, 2010a).

If there are multiple disablements the degree of disablement is the sum of the disablement for each injury or disease, with an upper limit of 100%. The IIDB is based on the current level of disablement, it does not take into account future disablement. Exceptions are diffuse mesothelioma and asbestos-related lung cancer, which are automatically classified at 100% disablement regardless of the stage of the disease (DWP, 2010a). The expected length of time with disablement affects the period of time that the payment is awarded for, which can be:

- life — it is not subject to revision;
- provisional award — there will be a review in the future; or
- time limited final award — this is for a fixed period often 12 or 24 months and is only awarded when it is unlikely that the award will be renewed (DWP, 2007a).

If the degree of disablement progresses or improves then the recipient must apply for a re-assessment (Directgov, 2010a).

The definition of a disability for a claim made through the civil courts (ELCI) is based on a medically accepted definition of the condition. There are no official boundaries on the type of disability or illness that warrants compensation. In a civil case the key objective is to demonstrate that employer negligence contributed to the personal injury suffered by the employee (DWP, 2007a). The amount of compensation will depend on the damages that the complainant has established, which will related the impact of the injury or disease on their quality of life (such as pain and suffering) and financial circumstances (such as reduced earning capacity, increased medical expenses) (CAB, 2010b).

Disabled employees can only receive one form of compensation. If a compensation claim is successful, the IIDB payment is recovered by the Department of Work and Pensions (DWP) through the compensation recovery scheme (DWP, 2010c). The government is also able to reclaim part of the cost of ambulance and hospital services provided by the National Health Service (NHS) through the NHS injury cost recovery scheme (DH, 2007). This amount is charged to the compensator in addition to the damages awarded, however, there are circumstances where they are permitted to deduct some of the cost against the damages awarded, reducing the amount of compensation the employee receives. For example, if the employee received a social security payment that provided income support, the employer can deduct cost of repayment of that benefit from the damages awarded for loss of income. However, they cannot deduct this cost against component awarded for pain and suffering (DWP, 2010c). Regardless of the compensation arrangement, anyone who is disabled is able to access government subsidised health care and disability support services.

Self-employed people, people disabled by the actions of an employer who are not employees (e.g. people who live near the workplace or were visiting the workplace) and the families of employees who are exposed to industrial disease through the employee are not able to receive compensation through IIDB or workers compensation insurance. Depending on the circumstance it is possible for these people to obtain compensation via common law channels. Compensation to members of the armed forces injured while serving are also covered by a separate system (SSA, 2005) and are not eligible for compensation under IIDB or the common law of tort.

Compensation for employment related disability through IIDB or a civil settlement is in the form of a cash payment. Although there is no formal provision of services there are other government schemes that provide services to disabled people and their informal carers.

To receive IIDB the employee must file a claim for the payment with the Department of Work and Pensions. The details of the claim, the events of the accident or the workplace conditions that could result in an industrial disease, are then verified with the employer. Payment will not begin until 90 days (excluding Sundays) after the injury was incurred, at which time the level of disablement is assessed often through a medical examination (DWP, 2010a). A minimum of 14% disablement is required to receive a payment, although there are a number of exceptions to this rule (e.g., asbestos related illnesses are paid from a 1% level of disablement while hearing loss must be at 20% disablement to be deemed eligible). Payment can be made on a weekly, monthly or quarterly basis, as preferred by the recipient (DWP 2010a).

The IIDB comprises four benefits (DWP, 2007a).

- **Disablement benefit** -- the core payment – is non-means tested and is tax free. There is no restriction on returning to paid employment. The rates of payment are shown in Table 2.6. The current maximum weekly payment is £145.80 for a person with 100% disablement and at least one dependant.
- **Constant Attendance Allowance** (CAA) – is payable if disablement is 100% and daily care and attention is required. This benefit is paid at four rates ranging from £29.20 and £116.80 per week, depending on the amount of care required.
- **Exceptionally Severe Disablement Allowance** – people receiving CAA at the highest two rates are able to receive and additional £58.40 per week.
- **Reduced Earnings Allowance and Retirement Allowance** – Reduced Earnings Allowance compensates for loss of earning when a person is unable to return to their previous occupation after an industrial accident or illness. Retirement Allowance replaces Reduced Earnings Allowance when the recipient reaches retirement age. Both payments were abolished 1 October 1990 but can still be claimed if disablement (accident or onset of disease) occurred before that day.

Table 2.6: Weekly Disablement Benefit rates, 2010

Degree of disablement	Percentage payable	Benefit (per week)	
		Aged over 18	Aged over 18 with no dependants
%	%	£	£
95 – 100	100	145.80	89.35
85 – 94	90	131.22	80.42
75 – 84	80	116.64	71.48
65 – 74	70	102.06	62.55
55 – 64	60	87.48	53.61
45 – 54	50	72.90	44.68
35 – 44	40	58.32	35.74
25 – 34	30	43.74	26.81
14 – 24	20	29.16	17.87

Source: DirectGov (2010a) and DWP (2010a).

In a civil claim against an employer the employee is entitled to compensation for the damages caused by the employer's negligence. A claimant will typically obtain legal representation to handle the claim on their behalf. The basis for determining the size of compensation is evidence of non-pecuniary loss (pain and suffering), guided by the *JSB guidelines* for personal injury (Hazards, 2001), and pecuniary losses (such as loss of income both past and future and medical expenses). The assessment of pecuniary losses implicitly means that higher income earners or people who are less able to work as a result of their disability are likely to receive more compensation.

Damages are typically paid in a single lump-sum payment, which allows the claimant to invest and earn interest on the sum. A discount rate of 2.5% is applied to the settlement to determine the present value of the losses (DWP, 2003). Damages awarded do not include disbursements (costs of legal representation), and in small claims cases — claim less than £5,000 or if both parties agree to a small claims track (CAB, 2010b) — it does not cover other legal costs (advicenow, 2008a). A person is only entitled to receive compensation from one scheme and compensators are liable to repay IIDB and some NHS costs through the compensation cost recovery and NHS injury cost recovery schemes (DWP, 2007a). Part of these repayments can be deducted from the awarded compensation (DWP, 2010c).

The cost recovery scheme is not the only form of rationing in the system. Under the *Limitation ACT 1980* (UK) a civil claim must be lodged within three years of the occurrence of the injury or onset of the industrial illness (DWP, 2003). The court can make an exception if it is deemed just (DWP, 2003). Although there is no time limitation on claiming IIDB, the payment is only available for time spent living with disability, it does not cover death by industrial accident or illness. However, it is possible to claim the IIDB for the period between disablement and the death particularly if the death due was due to illness (Directgov, 2010b).

In the event of death, the husband, wife or civil partner of the deceased can also claim the Bereavement Payment, which is a one-off tax-free lump sum payment of £2,000 (CAB, 2010b) and the Bereavement Allowance or the Widowed parents allowance – weekly payments for one year after the death (Directgov, 2010b). If the death was a result of negligence, the family can mount a civil claim.

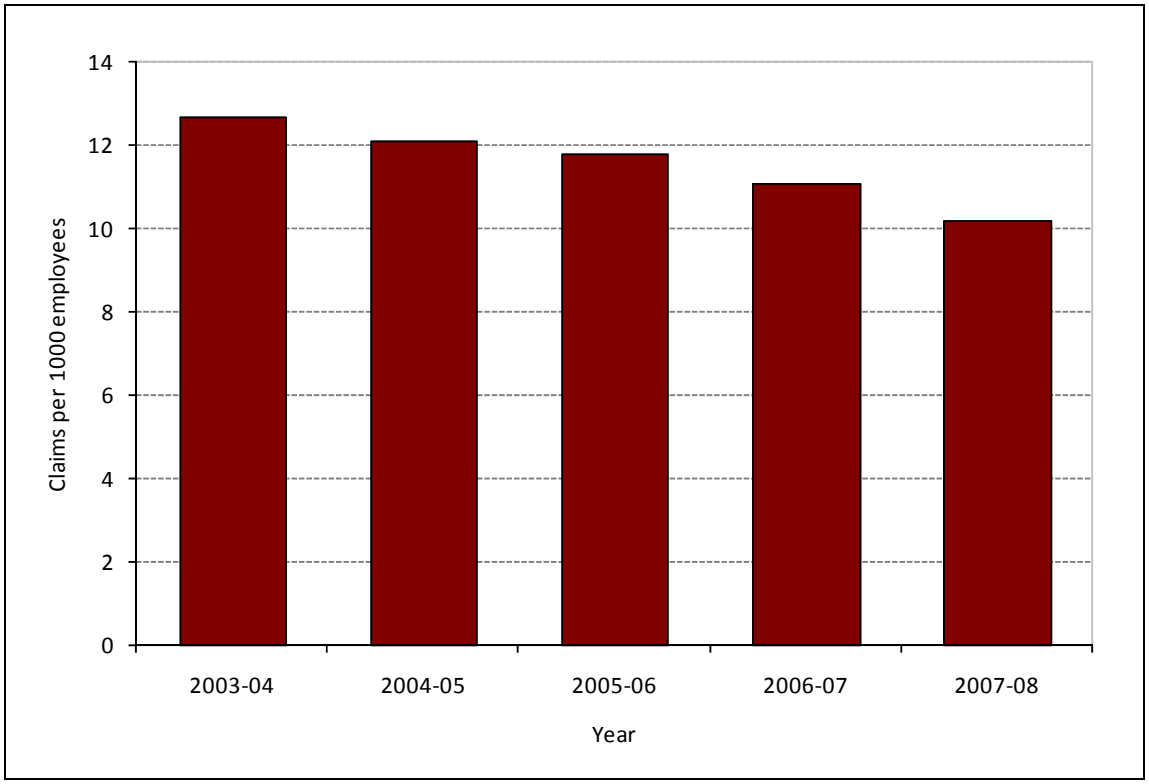
2.3 Claimant behaviour

Given difference coverage and entitlements across the Victoria, New Zealand, and UK schemes, claimant behaviour also varies. This is because the way an injured person is treated during the early stages of a claim can condition their expectation of claims and their behaviour towards seeking claims. Restrictions on claims imposed by each disability insurance scheme also determine behaviour, for example, the opportunity to pursue a common law avenue for compensation purposes.

2.3.1 Victoria

The most recent Workplace Relations Ministers' Council report on worker's compensation found that incidence rates for WorkSafe claims have steadily decreased in Victoria from 12.7 claims per 1,000 employees in 2003-04 to 10.2 in 2007-08 (WRMC, 2009). This is showed in Chart 2.1.

Chart 2.1: Incidence rate of claim lodgements under WorkSafe [(a)]



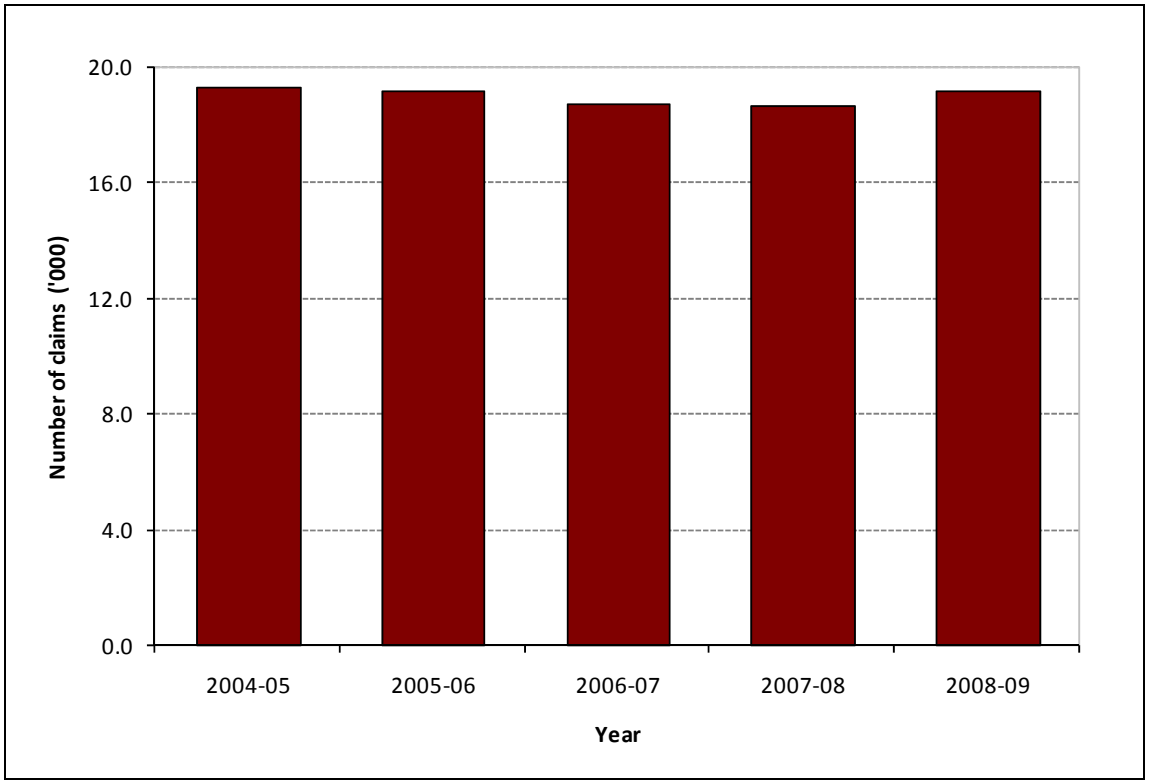
Note: (a) Includes all accepted workers' compensation claims involving temporary incapacity of one or more weeks plus all claims for fatality and permanent incapacity.
Source: WRMC (2009).

TAC claim lodgements have varied over the past six years, although trends are not as pronounced as those under WorkSafe. Chart 2.2 shows there were 19,292 claims in 2004-05, which fell to 18,692 in 2007-08, but increased to 19,162 in 2008-09. Given population growth in Victoria, the number of claims per person has therefore been trending downwards over the same period.

The Australian and New Zealand Return to Work Monitor survey found that 67% of surveyed Victorians considered the process of applying for WorkSafe compensation as simple, while 25% found it a complicated process (Campbell Research & Consulting, 2009). These results suggest that the complexity of the claim process may deter some workers from applying for compensation.

A Victorian Auditor-General's Office (VAGO) report of the TAC scheme found that 92% of claimants were receiving the services and benefits they required to meet their needs and had achieved maximal recovery and independence, given their injury (VAGO, 2001). However, around 8% believed management of cases by the TAC was less than satisfactory and contributed to the underachievement of rehabilitation outcomes. VAGO (2001) also noted that the TAC did not provide comprehensive and consistent information regarding benefits and entitlements. This suggests some people may have under-claimed given they were not informed of all entitled benefits.

Chart 2.2: Number of TAC claim lodgements



Source: TAC (2009).

2.3.2 New Zealand

Claims accepted by the ACC are funded by levies that are paid into specific accounts for the purpose of particular compensation injuries. Table 2.7 summarises the means by which the ACC scheme is funded and the injuries each account funds.

The number of new claims registered (claims accepted as covered by ACC) has been trending upwards at a rate faster than population growth in NZ. However, in 2008-09, new claims registered remained steady from the year before. Chart 2.3 shows average monthly new claims registered in the preceding 12 months. Claims in Earner's and non-Earner's accounts have trended upwards since 2004, while motor vehicle accident claims have remained steady. Worker's compensation has decreased slightly over the same period.

A characteristic of the New Zealand system is the low levels of claims among certain population subgroups. Bismark et al (2006) matched those who filed a claim for compensation with epidemiological data on medical injuries to identify the number of people who suffered an adverse event and did not claim. The authors found that the proportion of injured patients in New Zealand who seek compensation after sustaining a compensable injury was low. This is

Table 2.7: Means by which the ACC scheme is funded

Funding source	Account name	What it pays for
Premiums paid by all employers	Employers' Account	Work-related personal injuries (except for work injuries for self-employed or work injuries suffered before 1 July 1999, which are funded by the residual accounts). Levy: $0.75 per $100 of liable earnings
Premiums paid by all income earners in the paid workforce through PAYE	Earners' Account	Non-work injuries suffered by people in paid employment (except motor vehicle accidents). Levy: $1.51 per $100 of liable earnings
Premiums from self-employed people and private domestic workers	Self-employed Work Account	Work-related injuries to self-employed people and private domestic workers.
Direct payment from government	Non-earners' Account	Injuries to people who are not in the paid workforce, such as students, beneficiaries, retired people and children.
A tariff on the price of petrol and from a component of the motor vehicle licensing fee	Motor Vehicle Account	Injuries involving motor accidents on public roads. Levy: $287 per vehicle
The Earners' and Non-earners' Accounts	Medical Account	Injuries that result from error by medical practitioners or from rare and severe outcomes of medical or surgical procedures.
Premiums paid by employers and self-employed persons	Residual Claims Account	Work injuries before 1 July 1999 and non-work injury suffered by earners prior to 1 July 1992. Levy: $0.56 per $100 of liable earnings

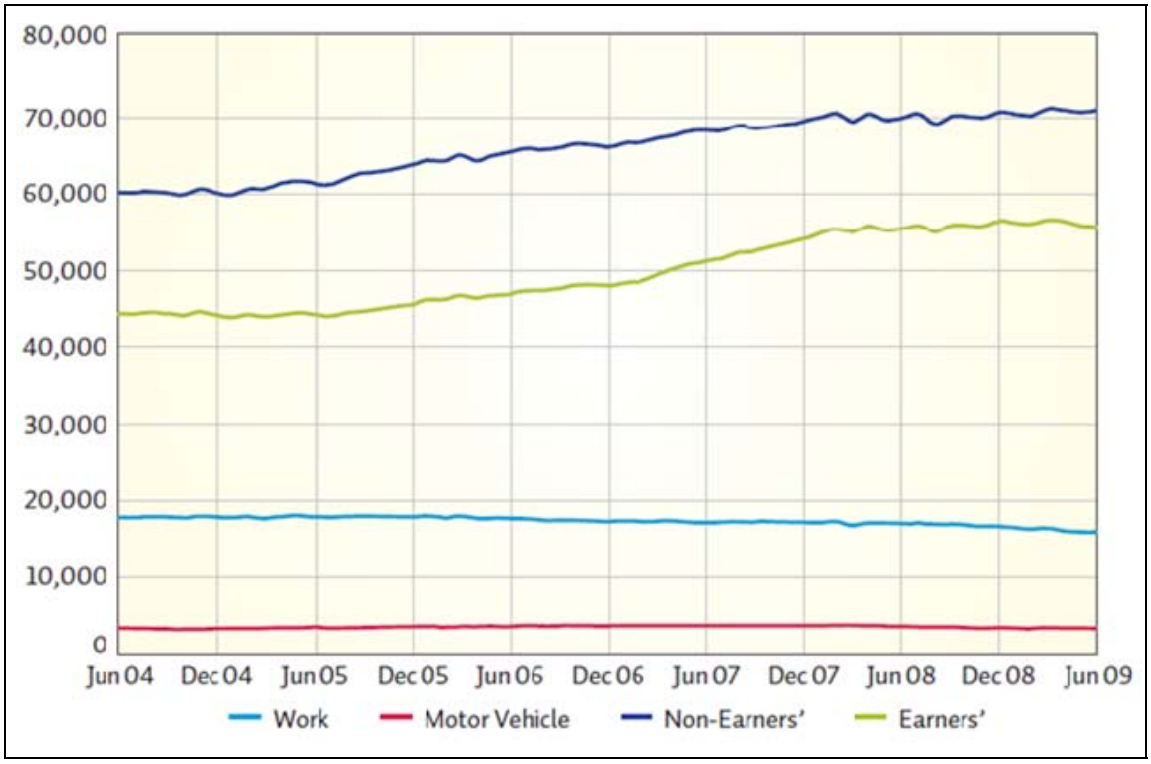
Source: ACC (2010a).

particularly pronounced amongst elderly people, and those who are from lower socio-economic groups or from minority groups such as those of Maori and Pacific ethnicity. Possible reasons for low proportion of claims include:

- patients may be unable to distinguish between natural illness and injury arising from medical negligence and hence are unaware they are able to claim;
- other sources of service and financial support for injured patients may be adequate without the need for compensation, since hospital care is free and primary care is heavily subsidised; and
- the lack of compensation for people with no or minimal earnings may discourage these groups from claiming (Bismark et al, 2006).

The ACC introduced new rules in 2009 for 'sensitive' claims so that victims of crime resulting in a diagnosed mental injury are only eligible for benefits if the crime was of a certain activity, including sexual abuse or assault (s21 *Accident Compensation Act 2001* (NZ)). Claims are also reviewed every 16 weeks. This change to eligibility for benefits has caused a significant reduction in benefits for mental injury. For example, only 178 of the 1,498 victims of crime who applied for counselling compensation in the six months to 30 April 2010 were granted benefits (Collins, 2010). This gives an acceptance rate of 11.9%, compared to roughly 93.8% in the year to June 2001.

Chart 2.3: New claims registered by the ACC [(a)]



Note: (a) Average per month in the preceding 12 months.
Source: ACC (2010a).

One primary argument against a no-fault scheme compared to a fault or hybrid scheme is the potential increase in the number of claims under a no-fault scheme. It is thought that the number of claims will increase if the requirement to establish fault is removed because it reduces the cost associated with claiming (e.g. lawyers are no longer necessary). However, according to a study of medical misadventure claims in New Zealand, the number of claims is not significantly higher than under some tort jurisdictions in the United States (Davis et al, 2002). For example, around 97% of patients eligible to claim under the New Zealand scheme did not claim. These results are also consistent with estimates from other countries that have no-fault schemes (e.g. Denmark) (Davis et al, 2002). Once reason noted is that patients may not be aware that they have incurred a disability due to a medical misadventure, or that they have an opportunity to apply for compensation.

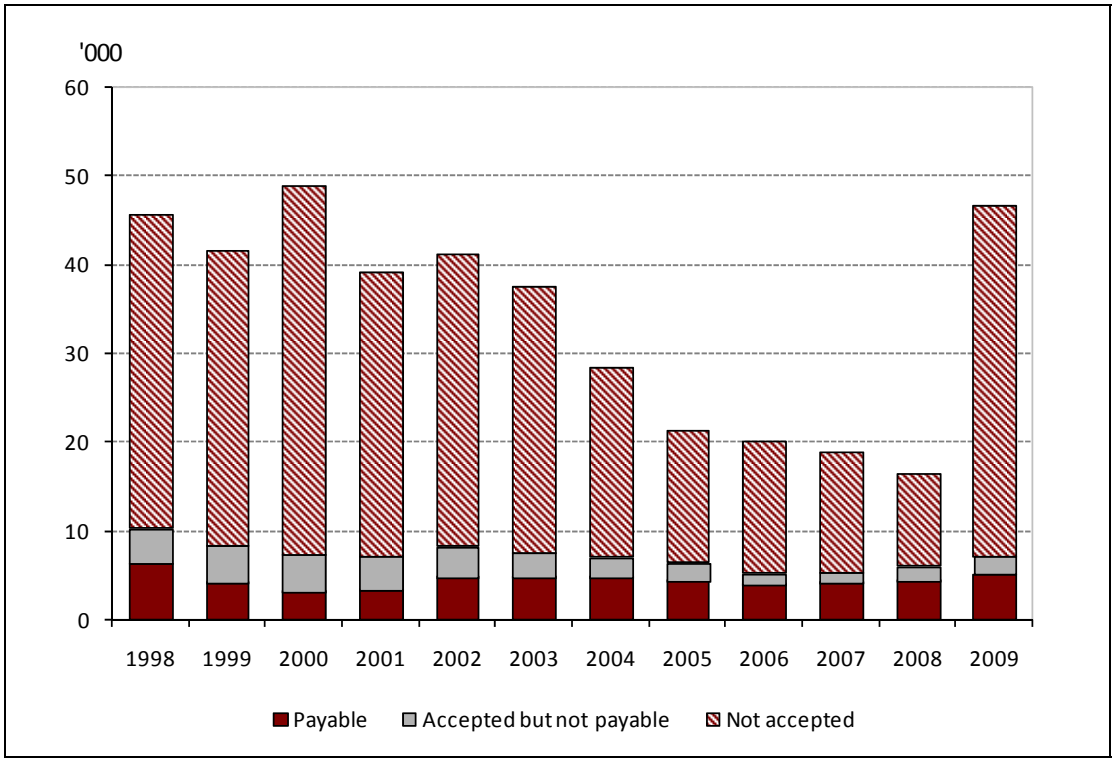
2.3.3 United Kingdom

New claims for IIDB have been trending down since 2000, while the number of claims accepted paid has remained relatively stable (Chart 2.4). This suggests the proportion of claims that are not accepted has also been trending down.

In 2009 there was a surge in the number of new claims. This was due to osteoarthritis of the knee being listed as an industrial disease. However, the surge in claims was not proportionally reflected in the number of claims accepted and paid. This increase in unsubstantiated claims may be due to several reasons, including:

- a low cost of applying coupled with difficulty understanding the eligibility rules; and

Chart 2.4: New claims made for IIDB



Notes: The 2009 figure is the sum of the first three quarters. In 2009, osteoarthritis of the knee was added to the schedule of industrial diseases.
Source: DWP (2009a).

- difficulty in verifying claims are strictly related to employment when other environmental factors may have contributed to the condition (e.g. sport injuries).

Payments from IIDB are generally timely. Although there is a 90 day waiting period for injuries (excluding Sundays) before payment can begin, provided that the claim is filed around 30 days before this date payment should begin promptly (DWP, 2010a). In comparison the average time to settle a personal injury case is 18 months (DAS, 2009).

The real value of insurance claims paid through ELCI has increased by around 50% since 1985. For example, Chart 2.5 shows that the real value index increased from 80 in 1985 to just under 120 in 2003. This is in comparison to an increased of just over 75% in the real value of all liability insurance claims from a real value index of 80 in 1985 to just over 140 in 2003.

Sandbach (2004) showed that the number of civil claims against employers for personal injury by accident fell between 2000-01 and 2003-04. The author attributes the fall in civil claims to the abolishment of legal aid for personal injury claims and the high cost of pursing legal action. However, claims against ELCI rose during that period from 219,183 to 291,210. More recently, there has been a decrease in claims against ELCI. In 2007-08 there were 199,153 settled claims while in 2009-10 there were only 140,088 (DWP, 2010f).

Chart 2.5: Value of insurance claims in the UK

Source: Office of Fair Trading (2005).

The costs associated with a civil claim are not inconsequential and create a barrier to claiming compensation. In addition to the long time period involved in settling a claim, the claimant needs to hire legal representation and purchase after the event (ATE) insurance to cover the legal costs (not including the legal representation) of the case in the event that their claim is unsuccessful. The costs of ATE insurance, often paid for through a loan, not only subtracts a substantial amount out of compensation, it can result in a debt for the claimant if their claim is unsuccessful (advicenow, 2008a). In small claims cases (where the damages are below £5,000) the claimant must meet all of their own legal costs, which reduces the worth of pursing the claim.

A popular type of legal service, that has increased the accessibility of legal representation, is the conditional fee arrangement (CFA) also known as 'no win, no fee'. The idea of a CFA is that the lawyers do not charge a fee if the case is not won, reducing the risk to the claimant of undertaking the claim and allowing those who do not have the means to hire a lawyer to do so. However, this does not mean that the net result of a claim made under a CFA is zero or positive because claimant is still liable for legal costs regardless of the outcome (advicenow, 2008a). The increased accessibility created by the principle of a CFA is offset to some extent by the distortion it creates in legal firms incentives to take on a case. It is in a legal firm's interest to give preference to high value cases that have a high chance of success. Those who do not have large claims or may lack clear evidence of negligence may be left without a common law avenue to seek compensation, even if their employer was at fault (Sandbach, 2004).

2.4 Choice

The amount of choice provided to a person with a disability is crucial to meeting individual preferences. Choice not only relates to accessing health care and disability services, but also relates to type of funding (lump sum versus periodic payments) and control over benefits within the confines of management, accountability and appropriate rehabilitation outcomes and long-term disability care.

2.4.1 Victoria

Under WorkSafe and TAC schemes, a claimant is entitled to choose their own healthcare professionals from the public, private or not-for-profit sector. There are no lists of, or referral to preferred healthcare professionals. Both the TAC and WorkSafe require healthcare providers to register with the respective scheme before their fees can be reimbursed.

The schemes maintain control over compensation by determining reasonable care services directly related to a claimant's disability. A maximum amount of possible fee reimbursement is also enforced. Weekly payments and impairment benefits are provided to the claimants without conditions limiting where the money can be spent.

These compensation methods facilitate the greater use of client oriented care as claimants can choose their preferred means of treatment, healthcare services and rehabilitation pathways. Claimants are accountable for keeping their own records of services and receipts for fees to be reimbursed. Some claimants may not know what types of services can be accessed and are thus encouraged to seek advice from a healthcare professional regarding the best treatment path for their injury. WorkSafe claimants with 'high-risk injuries' are assigned a care manager who is primarily responsible for identifying services required by the injured worker.

2.4.2 New Zealand

The ACC provides compensation for a whole range of support for people who have suffered a disability from an accident. Injured people who require treatment or surgery have the option of choosing 'full payment' or 'part payment' by ACC. If they choose to have the ACC pay for their surgery in full, they forgo the choice of where and when they receive their surgery. Extras such as single rooms and television will not be covered.

Under 'part payment', patients generally have more choice in deciding where, how and when to get treatment. The ACC pays a set amount for the treatment and the patient or their private health insurer covers the gap.

For elective surgeries and non-urgent treatments, patients can choose where to have the surgery. However, they must first obtain ACC approval, especially if they elect to have private surgery even if the patient has private health insurance.

2.4.3 United Kingdom

Compensation under both schemes is provided in cash, allowing the recipient to use the payment to purchase anything they choose. This could include the purchase of care and support services. Although care and support services are subsidised in the UK, the amount of subsidisation is usually means-tested (Age UK, 2009a). The subsidisation can be received in

the form of services or a direct cash payment. When services are provided the local authority, who is responsible for coordinating services, is able to request a financial contribution from the user.

Although services are not supposed to be denied based on means, there is no restriction in purchasing additional services from the private or not for profit sector without the assistance of the local authority. Compensation payments in the form of cash thus may be important in ensuring that the individual is able to choose the best possible services for their needs. That said, the size of the IIDB payment is low, only 30% of the 2009 average weekly earnings (ONS, 2009), and the greater the level of disability the lower earning potential is likely to be. In a civil settlement a large proportion of the payment may end up going towards legal fees. The result is that compensation may not have a large impact on the type of services the person is able to access, especially for the most disadvantaged.

2.5 Interaction with other systems

The effectiveness and affordability of a disability insurance scheme depends, in part, on the interaction between benefits delivered under the scheme, and other systems already in place that can be used to gain access to disability care and rehabilitation, including:

- income and welfare support services through social security;
- health and aged care system;
- other disability support systems, such as HACC;
- employment services, education and training; and
- the judicial system and access to the common law of tort.

Therefore an evaluation of a fault versus no-fault scheme has been undertaken in the context of these interactions.

2.5.1 Victoria

As Commonwealth payments are calculated based on a worker's pre-injury average weekly earnings, any payments received within a financial year will contribute to total income and therefore affect the amount of income support available through the TAC and WorkSafe.

However, once compensation from the TAC or WorkSafe commences, either through periodic payments or a lump sum, it generally excludes the recipient from receiving Commonwealth income support, for example, through Centerlink. This rule was established in the *Social Security Act 1991* to prevent 'double dipping'. For people who receive periodic compensation payments based on economic loss, compensation is reduced dollar for dollar from the amount of income support otherwise paid by the Commonwealth. However, receiving compensation does not exclude people from accessing Commonwealth income support. If period payments are insufficient, the person may still receive partial income support from the Commonwealth.

For recipients of lump sum compensation that contains an economic loss component, a social security preclusion period is established during which time the recipient cannot access Commonwealth income support.

Claimants are entitled to Commonwealth income support while they are waiting for compensation claims to be assessed. Once a claim is accepted by the TAC or WorkSafe, and compensation begins, any income support benefits received prior to the start of compensation must be paid back to the Commonwealth Government.

Interaction between the Victorian schemes and the health care system is most evident where compensation is provided to the claimant to cover the costs of health care services. Health care providers are required to report clinical information in relation to the claimant's injury or illness to determine liability or entitlements. A treating health care provider report provides information about the effectiveness of the treatment or service and evaluates the claimant's progress towards rehabilitation and return to work goals.

The TAC and WorkSafe will fund the reasonable cost of hospital services. The conditions for payment are in accordance with an agreement between the Department of Human Services (DHS) and the schemes. Where a compensation claim is not submitted, the public health care system may pay some of the treatment costs. The amount paid will depend on whether the care recipient chooses to access health care through the public or private system as the Commonwealth funds these types of services differently.

Claimants receiving compensation from the TAC and WorkSafe can attend an aged care facility for respite, but this is intended only to provide a break for carers and is not a permanent arrangement. The schemes do not refer claimants to any health care services and each service provider will have their own set of eligibility criteria.

Income assistance and compensation cease when a claimant reaches the age of 65 or the normal retirement age for their industry. Public support for disability care must then be accessed through Commonwealth Government social security payments, community care programs, and residential care facilities.

The TAC is known for its road safety public education campaigns which emphasise the personal costs of dangerous driving practices using emotive, educational and enforcement based themes. The TAC also provides a range of resources for the general public, including teaching packs for schools, tips for safe driving and information on learning to drive. Return to work programs, vocational re-training and occupational physiotherapy are also funded by the TAC.

WorkSafe pairs with employers to facilitate their injured worker's return to work. WorkSafe requires employers to alter their worker's daily tasks to allow them to return to employment, even if they cannot work at full capacity. It is the responsibility of employers to ensure that a suitable new or modified role is offered to the injured worker. The employer is also responsible for any training required for a new role.

Under the WorkSafe scheme, a worker is entitled to sue their employer for damages under common law. They can also take legal action against WorkSafe for additional compensation. In relation to industrial accidents and diseases, the common law has been modified over time because this right co-exists with the no-fault regimes of workers' compensation and employers have a duty of care towards their employees. Duty of care is also part of the common law right to claim damages for personal injury.

The *Accident Compensation Act 1985* regulates how common law rights can be exercised. Managing a common law claim begins when WorkSafe receives a 'serious injury' (SI)

application from the worker. The following list outlines the process of seeking compensation through common law.

- If the claimant is found to have a 30% or more impairment the claim proceeds to a pre-litigation conference.
- The conference process attempts to negotiate damages. If settled, the claim can be finalised. If not settled, strict time limits apply in which:
  - a statutory offer is to be made by WorkSafe (default causes a deemed offer of NIL);
  - a statutory counter offer is to be made by the worker (default causes a deemed offer of the maximum); or
  - if either offer is accepted, the claim can be finalised.
- If the worker is not satisfied with any offer, they can issue a damages writ and have the claim heard in court. A court will determine the damages amount payable to the worker (unless settled prior to hearing). If either the worker or WorkSafe is not satisfied with a court decision either party can appeal.

TAC claimants who suffer 'serious injury' due to another person's negligence can lodge a common law claim. Common law damages are payable for economic loss (up to a maximum of $1,013,560) and for pain and suffering (up to a maximum of $450,460). Economic loss can also be paid to the dependants of a person killed in a transport accident, up to a maximum of $737,800 (TAC, 2010).

During 2008-09, the TAC resolved 912 common law claims, (up from 885 in 2007-08), the highest number in any one year achieved in the history of the scheme. More than half of the claims resolved at common law (55%) were achieved within twelve months from the date of application, (TAC, 2009).

2.5.2 New Zealand

Sickness and congenital disabilities are not covered under the ACC scheme. People who fall ill or have a disability from birth have to rely on social welfare, the public health system or private insurance. Generally, the amount of government assistance an individual receives is less than that received under ACC.

Health providers need to register with the ACC to be able to receive payments from the ACC for treatment costs incurred by claimants. Health providers may include:

- ambulance and emergency care;
- surgery;
- prescription medicine;
- dental treatment;
- services for hearing loss;
- services for visual impairment;
- counselling;
- approved treatment providers; and

- registered counsellors.

The relationship between the health service provider and the ACC will determine how claimants get reimbursed for treatment costs. Treatment providers such as doctors, nurses and physiotherapists need to register to receive payment for services provided to patients who have approved injury claims. They are generally able to lodge claims on behalf of patients. On the other hand, health providers can contract with the ACC to provide a wide range of services to meet particular client needs from the contracted provider. These may include:

- community health services (e.g. counselling and community nursing);
- social rehabilitation (e.g. home help, attendant care and home and vehicle modifications); and
- vocational rehabilitation (e.g. workplace assessment and employment maintenance programs).

Contracting with the ACC allows more flexibility in terms of the type of services that can be reimbursed, as well as timelier access to treatment and rehabilitation services. Contracted providers are bound by contractual terms including performance expectations and invoicing, pricing and payment terms including any co-payments. On top of this, physiotherapists can become a part of ACC Endorsed Provider Network (EPN). This now allows for physiotherapists to charge patients a gap on top of receiving reimbursements from ACC.

For injured persons who are eligible for compensation and are entitled to receive weekly income support or are on unpaid parental leave, they are also eligible for vocational rehabilitation. This may include modifying the workplace, short-term assistance for travel to work, and training to build on existing skills to prepare for a new occupation if necessary.

In addition, if a child is injured and the injury affects their ability to participate and learn at school or early childhood activities, the ACC will provide assistance to enable them to continue schooling. For example, if the child needs to be absent from school for a lengthy period due to their injury and therefore have difficulty keeping up with lessons, the ACC may be able to help fund a teacher aide.

2.5.3 United Kingdom

Although the amount of IIDB is based on the level of disability, the payment is small relative to average weekly income. If the income earning capacity of the person is reduced, or if there care needs are high, other support systems are required to ensure effective care is received.

There are a number of income supplements available to disabled people and their informal carers, based on means and level of disability. Payments available exclusively to the sick and disabled or their carers include the following.

- **Statutory sick pay —**if an employee (who earns at least an average of £97 per week) is unable to work due to a medical condition the employer must pay £79.15 per week for the for the first 28 weeks after 8 days of the medical condition (Levell et al, 2009).
- **Employment and Support Allowance —** for people who are unable to return to their previous employment due to disablement after the period of statutory sick pay has ended. Eligibility is based on a means-test (sufficiently low) or number of National Insurance credits (sufficiently high). The base rate for a single person is £64.30 per

week. Services to assist with finding new employment are also provided. Once IIDB payments begin this payment ceases (Directgov, 2010d).

- **Carer's Allowance —** paid to the informal carer of a disabled person who requires more than 35 hours a week of care. For carers of IIDB recipients the person must be eligible for the Constant Attendance Allowance. The rate of payment for care of an adult is £84.80 per week (Directgov, 2010e).
- **Working Tax Credit —** if the disability puts the person at a disadvantage in getting a job, the person works at least 16 hours a week and earns below an income threshold (Levell et al, 2009).

Disabled people might also be able to access means-tested benefits available to all low income earners including:

- income support, must be employed but not full-time;
- housing benefit to assist with rent payments;
- council tax benefit, to assist people liable for council tax payments;
- discretionary housing benefits for people who need additional help with rent or council tax liabilities; and
- social fund payments, which provide assistance for a variety of expenses including small interest free loans for unexpected costs, cold weather payments to assist with heating costs and warm clothes, assistance with funerals costs, and other assistance at the discretion of the administrators (Levell et al, 2009).

The UK public health care system can be accessed through the National Health Service (NHS). The NHS provides non-means tested access to physicians, hospital, prescription medication, dental care and optometry mostly free of charge. Alternatively, private health care is available for those who are willing and able to pay, often facilitated by purchasing private health insurance (The Commonwealth Fund, 2010). However, the majority of people in the UK use the public system (Colombo and Tapay, 2005).

Access to aged care and other disability support services is coordinated by local authorities.[1] Local authorities are responsible for assessing the care needs of people who request access to services. The criteria is set by the local authority and therefore varies across the UK, however it is supposed to be within the parameters set by the *Fair Access to Care Services (FACS)* guidance, issued by the Government. If a person meets the local authorities criteria they cannot be denied access to services. However, there is scope to means-test access to subsidised services. Again this varies between authorities. All local authorities are required to provide the option of consumer-directed care if the person meets the eligibility requirements. Consumer-directed care can be received in the form of a direct payment – a cash payment in lieu of services- or a personal budget – the individual chooses the services that they want however the local authority organises the purchase on their behalf.

There are a number of government programs and charitable organisations that provide assistance to the disabled. Some examples of these follow.

[1] Local authorise differ by location but include the relevant County, Metropolitan Borough, London Borough, the City of London or the Unitary Authority (Age UK, 2009).

- **Independent living fund —** a government funded trust used to help severely disabled people remain living in the community, rather than in residential care. The person must be receiving £320 per week in government benefits to be eligible. There is also an asset based means-test (Independent Living Fund, 2010).
- **Motability —** a charity that provides leases on cars, powered wheelchair, scooters for the price of the mobility allowance - hence it is low cost (Motability, 2010).
- The **Disabled Facilities Grant (DFG) —** this program helps disabled people modify their house with a variety of adaptations to aid mobility (Directgov, 2010f)

The UK Government provides many services to assist disabled people find suitable employment. These include schemes such as:

- **Job Introduction Scheme —** provides a grant to the employer for the first six weeks of new employment;
- **Access to Work —** provides financial assistance for the adaption of the workplace to make it suitable for the person's disability, as well as assistance with transport to and from work; and
- **Pathways to work —** provides advice and assistance in finding work and a small payment for the first year of employment (Directgov, 2010g).

2.6 Governance and administration

Good governance of a disability insurance scheme involves separation of regulatory and service functions to ensure appropriate incentives minimise the potential for a conflict of interest between setting appropriate service standards and providing the service. Most importantly, the regulatory body should be independent with the primary goal of regulating in accordance with established legislation. Those within the regulatory body should have the requisite skills and experience and be held accountable for decisions made on day to day functioning.

2.6.1 Victoria

The TAC and WorkSafe are governed by Boards which are accountable to the Victorian Government, stakeholders and the community. The WorkSafe Board is elected by the Governor in Council and is informed by an Advisory Committee. The Committee consists of members who have sound knowledge of accident compensation law and experience in the provision of treatment for injured workers. The Committee advises the Board to ensure that appropriate compensation is paid to injured workers and that occupational rehabilitation and an early return to work is promoted. Members of the Advisory Committee are appointed by the Victorian Minister for Work Cover.

The Victorian Government can influence scheme spending through the election of Advisory Committee members and by providing funding for certain TAC and WorkSafe initiatives. For example, the Victorian Government supplied WorkSafe with a funding package that enabled WorkSafe to pay increased weekly payment benefits and to double the lump sum death benefits (Holding, 2010).

Administration efficacy of the TAC was measured by VAGO (2001). Table 2.8 shows the calculation of average administration costs per major injury claim for 1996-97 to 2000-01. The

table highlights that, over the five year period, the average administration cost per claim increased by 37%.

Administration efficiency within WorkSafe is comparatively similar to the Australian average for jurisdictional run worker's compensation schemes. In 2007-08, 5.3% of total expenditure was spent on regulation, dispute resolution and other administration costs compared to an Australian average of 5% (WRMC, 2009).

Table 2.8: Average administration cost per major injury claim

Item	1996-97	1997-98	1998-99	1999-00	2000-01
Administration costs ($ million)[(a)]	2.9	3.1	3.7	4.1	4.8
Number of claims managed[(b)]	1,863	1,921	1,972	2,182	2,259
Average administration cost per claim	**$1,556**	**$1,614**	**$1,876**	**$1,879**	**$2,125**

Note: (a) Comprises salaries and related on-costs, information technology and other operating costs (b) Includes Motor Accident Board claims under management.
Source: VAGO (2001).

2.6.2 New Zealand

The Accident Compensation Corporation is governed by the *Injury Prevention, Rehabilitation, and Compensation Act 2001* (NZ), now called the *Accident Compensation Act 2001* (NZ). The ACC is governed by a Board that is appointed by the Minister for ACC. Within the Board structure, there are three committees:

- Investment Committee – reviews the investment activity of ACC's investment portfolios and controls the operational frameworks for the investment of funds;
- Audit and Risk Committee – monitors and reviews processes, systems and results to help ensure the Board fulfils its audit responsibilities; and
- Remuneration Committee – reviews the performance and remuneration of the Chief Executive and senior management.

In terms of administrative efficiency, the ACC aims to maintain the percentage spend on administration costs in the Work Account below the average of similar Australian schemes. In 2007-08, 11.7% of total expenditure was spent on regulation and other administration, compared to an average of 5% in Australia (WRMC, 2009). Administration costs and operating costs were 8% and 13% higher respectively in 2008-09 than the year before due to increased staffing costs and depreciation and amortisation costs.

2.6.3 United Kingdom

The IIDB is administered by Jobcentres plus, which is one of three operational organisations within the DWP (DWP, 2010d). Jobcentres plus staff assess applications for IIDB, however, appeals against decisions are handled by an independent tribunal.

The DWP is required to meet efficiency targets in administering payments, which they aim to meet through productivity improvements such as through better utilisation of information technology (DWP, 2010e). Since eligibility for IIDB is based on the degree of disablement

rather than income status there is little that can be done by Jobcentres plus to assist people to move off the payment – a key performance target for the DWP (DWP, 2007b).

Although the DWP provides compensation payments for those disabled at work it is largely the responsibility of the Health and Safety Executive (HSE) to promote and enforce workplace safety (HSE, 2009a).

The provision of disability support services is coordinated by local authorities. Local authorities are able to provide their own services or purchase them from private and not-for profit providers. To ensure consistency in access and quality of services the UK Government monitors local authority's spending (Communities and Local Government, 2010). Several departments are involved in this process.

- The Department of Health issues guidance on the appropriate provision of services to disabled individuals, local authorities are expected to plan to meet these.
- The Department of Communities and Local Government organises Local Area Agreements with local authorities which are three year contracts between the central government and the local authorities to achieve a set of outcomes in return for the receipt of largely unrestricted 'block grants'. The local authority is able to decide how the funding will be spent in order to achieve the targets (NACVA, 2010).
- Performance is monitored by the National Audit Office, which requires local authorities to report on 198 national indicators (Communities and Local Government 2007; Shakespeare 2010).

The efficiency and effectiveness of this system is unclear. A recent report estimated that the cost of monitoring local government spending and performance is at minimum £2 billion (Shakespeare, 2010). This degree of monitoring may not be necessary to obtain an effective outcome. The premise for allowing local government to coordinate service provision is that they have a better idea of the needs of their community. In order to be re-elected they must meet the needs and demands of the community. Consequently there is an incentive already built into the system for local authorities to meet the performance standards set by the central government in order to avoid negative publicity. The system might also generate competition between local authorities because recipients are able to observe the services provided in other areas and demand that they receive similar services.

In response to the changing disability landscape the UK Government has recently announced the National Care Service (HM Government, 2010a). This will integrate social security and disability care and support services into a single portal, allowing support to be better targeted to individual needs and reduce the burden of self-coordination of benefits. The NCS will work in close partnership with the NHS to support people's health and wellbeing. Reliance on local authorities to coordinate individuals with services will remain unchanged (HM Government, 2010a).

ELCI is provided by private insurance companies but is subject to government regulation. The Financial Services Authority, an independent government body, regulates the insurance industry ensuring that the products sold comply with the ELCI Act (DWP, 2003). The Health and Safety Executive (HSE), also an independent government body, is able to enforce the ACT by investigating employer insurance status (DWP, 2003). The cost of insurance premiums reflects the value of claims being paid out, making it the interest of employers to collectively minimise risk in the workplace. Although the individual incentive provided by insurance

premiums is low, due to moral hazard, violations of workplace safety laws can result in criminal prosecution thus there is an individual incentive to comply with the law (HSE, 2010d).

2.7 Appeal and review process

The appeal and review process within a disability insurance scheme is important to establishing access to disability services and the amount of compensation a person receives. It also has a direct influence on efficiency because extended delays in the decision making process can impose financial hardship on workers as they use their sick, annual or long service leave while waiting for a decision.

2.7.1 Victoria

The TAC provides three ways in which claimants can have a decision reviewed. First, a TAC review manager considers all the relevant information, including any new information claimants are able to provide, and will either change or uphold the original decision. The review manager works independently of the area where the original decision was made. This option is free and it usually takes between four and six weeks.

Further, a claimant can pursue a dispute resolution using the dispute resolution agreement between the TAC, the Law Institute of Victoria and the Australian Lawyers Alliance. The new process is designed to, where possible, resolve disputes quickly and simply.

Lastly, claimants can request a review of the decision by the Victorian Civil and Administrative Tribunal (VCAT). This option is available if requested within 12 months from the day claimants become aware of the original decision. There is a fee of $300 for a VCAT review. If a claim is lodged with VCAT then the TAC must reconsider its decision. If the TAC does not change its decision, VCAT may require conference to try to resolve the dispute. If the dispute is not resolved VCAT will set a hearing date. Claimants can represent themselves or have a lawyer represent them. After the hearing, VCAT will make a decision (TAC, 2010).

Under the WorkSafe scheme potential claimants can have decisions reviewed by the Accident Compensation Conciliation Service (ACCS). The ACCS provides an independent service that facilitates the resolution of disputes by involving all parties - workers, employers and WorkCover agents or self-insurers - in an informal, non-adversarial process to achieve an agreement (VWA, 2010). In most disputes, this form of conciliation is a compulsory step before proceedings can be taken in court. WorkSafe also provides the WorkCover Assist service that can help with claim disputes as they progresses through the conciliation process.

Common law claims can also be pursued under both schemes. The TAC and WorkSafe can allocate each claim to a panel of approved legal representatives. This panel prepares the required documentation for common law and attempts to negotiate damages. If the claimant accepts the damages then the claim is settled. If the claimant does not settle then they can issue a damages writ and the claim will proceed to court. A court will determine the damages amount payable to the worker. If either the worker or WorkSafe is not satisfied with the court decision either party can appeal.

2.7.2 New Zealand

There are review and appeal processes in place if any party to a claim does not agree with the decision regarding the denial of a claim, unreasonable delay in claim processing, and any decision under the Code of ACC Claimants' Rights (Hitzhusen, 2005).

Those who can review the ACC decision include the claimant, employer or health professional disputing their involvement in the injury, and a levy payer disagreeing with the levy paid or is payable. The review process involves three stages, including:

- the claimant must submit an application for review of a coverage decision in writing within three months of the date of receipt of the decision;
- mediation occurs between the disagreeing party and the ACC; and
- an independent review of the case is made by reviewers who are instructed to undertake investigative approach and hearing at which representatives of the ACC may attend. The independent reviewer has 28 days to make a decision.

The decision made by the independent reviewer is binding upon the ACC, applicant and any other party involved with the claim. However, the ACC or claimant may appeal a review decision to the District Court. A party dissatisfied with the District Court's decision on a point of law may appeal to the High Court, followed by petition for review by the Court of Appeal.

To ensure disputes are resolved efficiently and effectively, mediation is the preferred method for dispute resolution for ACC. In general however, the ACC scheme has very few disputes to resolve compared to Australian schemes (WRMC, 2009).

2.7.3 United Kingdom

There are separate appeals processes for decisions made in regards to social security payments (including IIDB), disputes with the NHS or local authorities providing social services and civil claims. These processes, although different, share the premise that an individual should have the right to complain and have their complaint heard by an independent party but that this right has to have a limit to prevent the appeals process from becoming excessively lengthy.

A social security payment decision, including IIDB, can be appealed within one month of notification of the decision. The first stage of the appeals process is to contact the DWP and discuss (verbally or in a written statement) the complaint against the decision. The DWP is able to reconsider their decision if there is sufficient evidence that the decision was incorrect. If the DWP decides to stand by its decision, the applicant has the right to appeal to an independent tribunal. The 'First-tier Tribunal' run by the Ministry of Justice, will assess the evidence provided as well as potentially holding a hearing and make a decision as to whether to uphold the DWP's initial decision. If the decision is upheld it can only be appealed to the Upper Tribunal on a point of law – that is if it can be demonstrated that the first-tier tribunal has not correctly applied the law. The decision cannot be appealed on the basis of the evidence presented or dissatisfaction with the decision (DWP, 2010b). Until the appeal is resolved the DWP's decision is upheld in terms of the provision of payment. If it is overturned the applicant will receive back payment and in some cases may be eligible for a small amount of compensation (Newcastle City Council 2010a; 2010b)

A decision made by a local authority providing social services or the NHS follows a similar appeals process. The first step is to file a complaint with the relevant service using their complaints procedure. The complaint must be filed within 12 months of the incident or within 12 months of when the person first became aware of the problem. If the complaint is not resolved then the individual can refer the matter to the relevant Ombudsman (Parliamentary and Health Service Ombudsman for the NHS and the Local Government Ombudsman for social services) (advicenow, 2008b). Ombudsman deal with problems involving maladministration — when an organisation is providing incorrect information, not following its own policies and procedures, providing unfair treatment or providing poor service. Their recommendations cannot legally be enforced. However, they may be able to negotiate a small amount of compensation for the inconvenience caused by the maladministration (advicenow, 2008c). It is also possible to request a judicial review if there is evidence that a public body has made an unlawful decision. This must usually be requested within three months of the decision. In general, damages are not awarded in judicial reviews (The Public Law Project, 2006).

A decision made about a civil claim for personal injury can be appealed in the court system, as with any tort claim if there are legal grounds for doing so there must be discernable evidence that the appeal could be successful. An appeal must be filed with the Civil Appeals Office within 21 days of the initial decision and a judge of the Court of Appeal decides whether or not there are grounds for appeal (HM Courts, 2008b). A second appeal can only be launched if there is a compelling reason as to why it should be heard (HM Courts, 2008a).

3 Performance of alternative disability insurance schemes

This chapter measures the performance of no-fault and hybrid disability schemes. Performance dimensions are first established through definitions, recognising the need to evaluate alternative schemes in terms of inputs (characteristics), outputs and the associated outcomes for people with a disability. The chapter then presents a comparison of each scheme's characteristics against these performance dimensions.

3.1 Introduction

The potential performance of a national no-fault scheme versus a hybrid scheme in Australia was evaluated using information on scheme characteristics discussed in Chapter 2 and a 'first principles' approach. Performance dimensions that were investigated include:

- equity in access to disability care and support services;
- effectiveness in reaching desired outcomes;
- appropriateness of care and support;
- responsiveness in meeting individual needs and preferences; and
- sustainability in terms of financial risk and viability.

The use of performance dimensions recognises the need to evaluate alternative schemes in terms of inputs (characteristics), outputs and the associated outcomes for people with a disability. There are several options to improving disability care in Australia, and a no-fault based system is not the only option. For example, a viable alternative may be to improve disability insurance schemes used in Victoria and then to apply on a nationwide basis.

3.2 Equity in access to disability care

Equity is central to understanding social justice attached to disability care services because freedoms and human capabilities are dependent on health. Equity in the achievement and distribution of health therefore is incorporated and embedded in a larger understanding of justice. In so much as disability care is a process used to achieve better health, inequalities in disability care and non-discrimination in disability care delivery are also relevant to social justice. Equity is not found in achievements of good health alone, as people may choose to not care about their health. Equity is also found in the capability to achieve good health.

Probably the greatest mistake in defining equity is attributing equality to equity. Equality does not mean equity. A national disability insurance scheme could deliver inequitable equality, for example through denying a wealthy person disability care services to ensure equal disability outcomes with a low income person who has the same condition. Another example of inequitable equality is providing the same disability care services to those with different needs. Both of these outcomes are undesirable.

For the purposes of this study, equity is defined as the achievements in delivering improved health outcomes and providing the opportunity and capability to obtain disability care at the right place and right time based on the level of disability (regardless of how that disability was acquired) irrespective of income, physical location, cultural background. It encompasses

horizontal equity where people with equal needs receive equal benefits, and vertical equity, where people with unequal needs receive unequal (but equitable) benefits.

A pervasive theme running through no-fault schemes is the notion of providing disability benefits regardless of how that injury was acquired. It is only necessary to show that the injury, illness or fatality arose under the activities covered by the disability scheme, such as within the course of employment for WorkSafe and IIDB.

Whereas covering disability based on need conforms to the principals of equity, excluding coverage based on some other criteria can lead to inequitable outcomes. Those suffering injuries in circumstances not covered by a scheme will receive nothing from the scheme and must rely on their own resources or the social welfare system. This is despite the fact that their disability care needs may be equivalent to those covered by a scheme.

The level of statutory benefits provided under no-fault based schemes is generally based on the perceived level of need. For example, statutory benefit compensation delivered under TAC, WorkSafe, ACC, and IIDB schemes aim to cover medical and disability care services so long as these are reasonable. Thus a person requiring disability care services for a greater length of time will be compensated accordingly, and this adheres to the definition of horizontal equity. Horizontal equity is reinforced through lump sum benefits based on the degree of impairment, measured using the American Medical Associations Guides to the Evaluation of Permanent Impairment in Victoria and New Zealand, and measured by the type of injuries received under the IIDB.

However, caps on statutory benefits could be considered a violation of vertical equity. For example, WorkSafe has determined reasonable costs up to a maximum amount as set out in a schedule of fees (WorkSafe, 2010a). People with greater need beyond services obtainable using statutory benefit compensation will miss out. For example, the IIDB comprises four types of benefits, all of which are capped based on the level of disability. These caps may lead to equal compensation for equal degree of disability, but to the extent that different disability care services are required for different disability types, people with different needs will have the same access to formal disability care. Thus, compensation should not be based on the level of impairment, but on the need for disability care and the associated cost.

Equity in disability schemes can also be measured by achievements in good health through disability care services, and providing the capacity to achieve good health. In terms of comparing no-fault schemes this generally depends on the quality of services available and there is no data or indication on whether health outcomes are better across TAC, WorkSafe, ACC, or IIDB schemes.

Several arguments have been presented against a fault based system in providing access to disability care services and the capability to achieve good health. These are listed in brief.

- Access to the common law of tort is determined by the risk of failure and the legal costs associated with litigation. As these can be high, the incentive to pursue common law is muted, thereby reducing access to potential compensation.
- Common law damages are uncertain, which can lead to compensation being unfairly distributed. Injured persons can therefore be inappropriately compensated, leading to access to disability care services based on the capability of legal council, rather than according to need.

- Fault based systems can result in extensive delays to compensation. A disability must stabilise before a final assessment of damages can be made, and there are also procedural and tactical delays. This reduces the capacity of the injured person to access care services, and the capability to achieve good health.
- Compensation under a fault based system rests on establishing fault and proving significant, permanent impairment. This provides a disincentive to physical and psychological rehabilitation and return to work before the case is settled. This can lead to reduced capability to improve health outcomes

Despite these arguments, common law action may be appropriate where a person with a disability has greater than average disability care needs, and therefore requires greater compensation than offered under statutory benefits. This is because a fault based system has greater potential to increase the welfare of the injured person as close to what they enjoyed prior to the injury. For example, under the ACC scheme the entitlements are confined to those stipulated by legislation, but under both TAC and WorkSafe schemes those injured by the fault of others, and who meet the relevant impairment thresholds, can be assessed according to the common law principle of restoring (to the extent monetary compensation can) their welfare to the position they would have been before the injury. This is a fundamental difference between no-fault and hybrid schemes, with the latter allowing for heterogeneous differences in compensation needs. It is particularly important in the case of non-economic loss (psychological and physical impacts) as in most cases, the common law component relates to pain and suffering and economic loss, while medical and disability care costs are covered by the no-fault portion of the disability insurance scheme.

As the impact of disability on welfare is heterogeneous, a fault based system can avoid inequities associated with standardisation of statutory benefit payments based on the level of impairment. Removal of common law paths in the ACC scheme, and the restriction to the common law of tort paths for people with a threshold level of impairment in the TAC and WorkSafe schemes, could therefore be considered inequitable on the basis of a reduced capability to improve welfare.[2]

Furthermore, depending on eligibility and coverage under a national disability scheme, removing common law from the disability scheme may result in those people covered by the scheme not being able to pursue greater compensation, while others outside the scheme maintain their right. For example, if a national compensation scheme were to cover all people with disability below the age of 65 years as suggested by the Disability Investment Group (DIG, 2009) then any injury for these people would be compensated through the scheme and the right to litigate would be removed. However, if the person was aged 65 years or over then the right would still exist. Consequently, there would be variation in compensation for the same level of disability, and in the capability to achieve good health, which is counter to the principals of equity.

3.3 Effective in reaching desired outcomes

In the case of a disability insurance scheme, effectiveness can be measured by the extent to which the level of care provided to the injured person, and support provided to informal

[2] It seems this is a classic trade-off with the inefficiencies associated with a common law of tort based system generated by proportionally high administration costs and delay to compensation.

carers, improves welfare outcomes, and is in line with society's expectations of a fair and just social care system.

An explicit objective of an effective disability insurance scheme is to first prevent injury related disability and fatalities through the promotion of safe practices and regulating behaviours. Where prevention fails, the objective becomes one of minimising the welfare impacts to the injured person by reducing the economic cost, improving health, and increasing the quality of life.

The emphasis is to ensure disability care and compensation is provided in a timely manner through early intervention and focusing on rehabilitation. Early intervention is instrumental to reducing the impacts to individual welfare and costs to a disability insurance scheme as it can lead to:

- a reduction in compensation costs;
- retention of productive workers;
- decrease in the loss of earnings for the injured person;
- decrease in financial costs associated with disability; and
- reduction in the psychological effects associated with disability (NOHSC, 1995).

Within no-fault based disability care services, significant funds are invested in preventing injuries because this directly leads to better health outcomes and reduces potential liabilities, thereby increasing sustainability.

WorkSafe attempts to identify areas where Victorian workers are at greatest risk and uses a mixture of incentives, assistance, persuasion and enforcement to prevent accidents at work. Injury prevention activities include:

- training of Health and Safety Representative to improve OH&S in their own workplaces;
- free safety consultation sessions with small business to fix safety issues;
- producing licensing and registration regulations for certain activities, equipment or substances that pose a risk to employees or the public;
- safe work advertising campaigns via television, radio, press and outdoor advertising. The advertising attempts to change the attitudes and behaviours of workers and employers in relation safe work practices; and
- funding the Institute for Safety, Compensation and Recovery Research in conjunction with the TAC and Monash University.

The number road accidents and related claims directly affect the sustainability of the TAC scheme. By preventing accidents, the TAC can reduce accident compensation liabilities. The TAC works with other road safety organisations, such as VicRoads, to reduce the incidence and severity of road trauma. Injury prevention initiatives include:

- road safety advertising campaigns via television, radio, press and outdoor advertising. The advertising attempts to change the attitudes and behaviours of road users in relation to drink driving, speeding, fatigue and car safety;
- joining with the Victorian Police to spread the message of road safety and enforce road rules;

- grants of up to $20,000 for community-based projects conducted by not-for-profit groups to fund a project that addresses specific local road safety issues;
- neurotrauma research grants provided by the Victorian Neurotrauma Initiative (VNI), which is a partnership between the TAC and the Department of Innovation, Industry and Regional Development;
- strategic partnerships with other organisations. For example, learner drivers are encouraged to increase their on-road driving experience through the TAC Cup and the TAC's partnership with ParaQuad Victoria promotes participation and inclusion for people living with a spinal cord injury; and
- 'Vanessa', the TAC's mobile cinema bus that promotes road safety persons aged 18-25 yeas at various events and festivals across Victoria.

The TAC's recent road safety campaigns and initiatives have contributed to the lowest number of road accident fatalities since 1952, with 303 road fatalities in 2009 compared to 332 in the previous year (TAC, 2009a).

In New Zealand, the ACC works in conjunction with injury prevention agencies to reduce the number and severity of injuries. For example, the ACC assists the Department of Labour (Occupational Safety and Health Service) with enforcing regulations under the New Zealand Injury Prevention Strategy (NZIPS) and the Workplace Health and Safety Strategy by providing data on the types of people that have high rate of injuries and collaborating with high risk industries to reduce workplace risk (McLea, 2005). The ACC also works in collaboration with other agencies and organisations to prevent injuries, including the Ministry of Transport, police, Maritime Safety Authority, Civil Aviation Authority, Environmental Risk Management Authority, Business New Zealand and the New Zealand Council of Trade Unions.

In providing support, the ACC contributes substantial amounts of funding to injury prevention. In 2006-07, the ACC spent $40 million on injury prevention programs including:

- providing modified Tai Chi and the Otago Exercise Programme, and a 'Slips, Trips and Falls' campaign to prevent injuries related to falls;
- road and work safety interventions;
- the SportSmart Programme and the ActiveSmart Programme, which are tailored for individual sports to reduce the risk of injury to players; and
- programs aimed at reducing the number of drownings (ACC, 2010b).

Successful injury prevention programs have reduced injuries and the number of claims. For example, the RugbySmart campaign (part of SportSmart) focuses on educating rugby players and coaches about physical conditioning, injury management and safe techniques for contact in rugby. It resulted in less spinal injuries between 2003 and 2005, with fewer claims for serious concussion and brain injuries (ACC, 2010).

In 2010 ACC introduced a Motorcycle Safety Levy program based on the Victorian model. From July 2010, motorcycle owners will be required to pay a levy of NZD $30 (excluding GST) per registered moped or motorcycle. Funds will go into a separate account to be used for moped and motorcycle safety programs that are aimed at reducing motorcycle related injuries.

The ACC aims to prevent workplace injuries through its Workplace Safety Management Practices program aimed at medium and large businesses. In exchange for using systems and procedures that reduce the number of workplace injuries, employers are provided with a discount on their standard ACC workplace cover levies that apply for two years. The discount is based on an independent audit of the employer's workplace safety systems and procedures, and three discount levels are available including 10%, 15% and 20% depending on the quality of health and safety systems. For small businesses, a 10% discount is available for one year if owners attend a free industry-specific training course and complete a self assessment booklet (ACC, 2010a).

The Health and Safety Executive (HSE) in the UK is a non-departmental government body responsible for workplace safety in England.[3] Its primary function is to work with local authorities to inspect, investigate and enforce workplace safety laws (HSE, 2010a). This includes investigating accidents, workplace deaths, complaints made by employees or other members of the public, and randomly inspecting businesses based on the industry and sector risk of poor health and safety standards or if they are involved in hazardous activities (HSE, 2010b). If a breach of workplace health and safety laws is identified the HSE have the power to prosecute both the businesses and individuals involved through the courts (HSE, 2010c).

In addition to enforcing workplace law the HSE also researches, review regulations, collects statistics and provides information, advice, and promotes training on workplace safety. They instigate a variety of initiatives each year aimed at meeting the eight strategic goals set out in *Be part of the Solution.* These goals pertain to improving workplace safety and reducing the burden of regulation. Within these goals there are numerous priorities, which are tackled in a variety of ways (HSE, 2010a). Examples of priorities and corresponding initiatives to achieve the goal 'creating healthier safer workplace' are outlined below.

- Tackling long latency diseases – for example through the Hidden Killer asbestos media campaign, which used media advisements to highlight the health risks of working with asbestos (HSE, 2010a).
- Focusing on slips, trips and falls from height – tackled, for example, through the Ladder Exchange 2008 program where the HSE worked with local authorities to help remove unsafe ladders from the workplace by offering a discount of up to 50% on a new ladder in exchange for an old ladder (HSE, 2010a).
- Delivering effective and efficient interventions – for example, in 2009-10 the HSE organised licensing contractors to undertake a series of focused inspections to obtain an accurate picture of good practise and management in the caving sector, a high-hazard activity (HSE, 2010a).

The HSE is funded by a grant-in-aid from the DWP and from fees and charges raised on activities that require the agent to obtain permission from HSE to undertake certain dangerous activities (HSE, 2003; DWP, 2010h).

No-fault schemes also fund programs and services to ensure disability care and compensation is provided in a timely manner. In fact, one of the primary arguments for a no-fault scheme is

[3] The HSE works closely with the devolved administrations in Scotland and Wales to ensure appropriate management of common interests (HSE, 2010).

the increased speed at which claims are processed and access to rehabilitation is provided, when compared to fault based systems.

Both the TAC and WorkSafe schemes state the provision of rehabilitation to ensure the earliest return to work possible as a major objective. Both schemes provide funding for rehabilitation services and the TAC also provides vocational retraining and occupational retraining to aid claimants' return to work, even if they are not at pre-injury work capacity levels. WorkSafe provides guidelines for employers regarding the return to work of injured employees. These requirements are then enforced by a WorkSafe employee to ensure all efforts are being made to accommodate the injured worker in their return to work.

A Victorian Auditor-General Office review of TAC claims indicated the 92% of claimants (119 cases) had achieved maximal progress against anticipated outcomes given their injury severity and level of ability and participation (VAGO, 2001). This indicates that most claimants were receiving adequate services to meet their needs following injury.

The Workplace Relations Ministers' Council (WRMC) provides a durable return to work indicator that reports on return to work outcomes and injured workers' perceptions of the return to work process. Durable return to work refers to an injured worker who returned to work and was still working at the time of the report survey, seven to nine months after their claim and is measured by the injured worker reporting their work status, sources of income and compensation status. Chart 2.2 shows that the 2007-08 average WorkSafe rate for durable return to work was 75%, which is in line with the Australian average of 75%.

Under the ACC scheme, there is a strong focus on early rehabilitation for injured people so that they can return to productive life and minimise the impact of injury. Rehabilitation rates (the percentage of people who return to work or independence within three, six, nine and 12 months) all decreased during 2008-09 from the year before (ACC, 2010b). Improving rehabilitation rates also reduces the average value of claims and the number of long-term claims, which are significant burdens on the financial sustainability of the ACC.

The extent to which a fault based system prevents injuries rests on the strength of incentives created from internalising injury costs to the negligent party. Indeed, one of the primary arguments for a tort based system is that providing an avenue for compensation based on liability can create positive incentives for people (in the case of motor vehicles and medical practice) and organisations (in the case of employers) to reduce the likelihood of injuring a person where feasible. Actions that mitigate risk of injury also mitigate the risk of being liable and paying out compensation. Where it is not feasible to reduce the likelihood of injury (e.g., it may be too costly), the potential for liability may reduce the number of risky activities.

Similarly, the risk of not receiving compensation for injury due to one's own negligent behaviour may also reduce the number of risky activities. For example, under the common law of tort employees may have their compensation reduced by an amount commensurate with their own negligence in causing the injury or illness.

However, there are several arguments why incentives created from the common law of tort may be muted. Some of these are listed below.

- The incentive to reduce risks will depend on the perceived probability of liability being assigned. A long period between an accident and illness (e.g., asbestos related claims)

will reduce the incentive to reduce risks because the likelihood of liability is greatly reduced.

- The use of insurance (e.g., workers compensation insurance, third party insurance, and medical indemnity insurance) reduces the exposure to liability because compensation is paid out by the underwriter. Although premiums are adjusted once compensation has been awarded, the level of compensation is typically subsumed within a greater risk pool and therefore the adjustment does not reflect the true cost of compensation.
- Incentives to reduce the risk of injury will depend on the level of safety deemed appropriate. If these are set low then the incentive to further reduce risk beyond the threshold will not be forthcoming.

A no-fault based system without incentives to reduce the potential for injury could increase risky behaviour and lead to a greater frequency and increased severity of injuries. An important objective of a no-fault based system should therefore be the creation of incentives to ensure those who participate in risky activity are properly attributed the costs of that activity. For example, a workplace that has poor standards of workplace safety, and therefore imposes a greater expected cost on a disability scheme, should be penalised through greater premiums.

To this effect, some no-fault based systems use risk rated premiums in order to emulate the incentive provided by a fault based system. For example, the TAC uses risk based premiums based on location of where the car is usually kept, type of vehicle, use of vehicle, and whether the person is a pensioner (discounts for pensioners are cross subsidised and are therefore inconsistent with risk rating). WorkSafe also risk rates premiums using five years of historical records of claims experience in the industry with which the business operates, so high risk industries such as manual labour industries and long distance road transport, pay a higher premium. There are over 500 different classifications. Furthermore, for medium and large businesses (those with an annual remuneration over $200,000), premiums are also based on the businesses claims experience relative to the industry experience.

However, risk rating premiums based on claims experience can lead to common causation problems that afflict the fault based system. Basing premiums on claim experience provides an incentive for defendants to dispute claims, which can lead to delayed compensation. For example, ACC applied experience rating between 1992 and 2000 to employers, which gave them the opportunity and the incentive to dispute whether a work-related personal injury claim was indeed work-related. This caused unnecessary delay while boundary claims (those that are on the borderline of being accepted or dismissed by ACC) were being settled, thus contrary to the original desired outcomes of the no-fault scheme (Duncan, 2008). It was argued that experience rating created incentives to find 'fault' and hence delayed a person's return to 'normal' life. While it was recognised that a system of review and appeal was required, experience rating had inadvertently permitted adversarial actions over the ACC's interpretations of statute (Duncan, 2008).

In 2000 the legislation was repealed and claims experience rated premiums were removed. Since then the record of workplace injuries, illness and fatalities has been poor, which has led to the re-introduction of claims experience rating. The *Accident Compensation Amendment Act 2010* (NZ) came into effect in March 2010 and allows the Government to create regulations to put in place systems for experience and risk rating, or risk sharing. This means

levies or premiums can be adjusted according to the claims history, with a no claim bonus for those who make no claims.

Of course, premiums are not the only way of introducing incentives to improve safety and reduce risky behaviour. Penalties for risky behaviour leading to motor vehicle accidents (e.g. speeding tickets and criminal charges) and penalties for breach of occupational health and safety regulations are often severe within no-fault schemes. For example, as at 1 July 2010 the maximum penalties for breaches of the *Occupational Health and Safety Act 2004* in Victoria were $1,075,050 for a body corporate and $215,010 for a natural person.

3.4 Appropriate care and support

An appropriate national disability insurance scheme will provide care that is relevant to the injured person's disability needs and preferences, and is based on established international and domestic standards. This includes within both the processes used to provide effective disability care, and the outcomes associated with care.

The nature of care need is complex. The primary role of health, rehabilitation and disability care services are to enable people to participant in society to the greatest extent possible, and to reduce the disadvantage associated with an injury, including impairment, activity limitation, participation restriction and environmental barriers.

However the mix of services that can achieve these tasks is never clear. Each injured person has their own unique preferences for care that is based on the severity and type of injury, their access to informal care, the lifestyle they would like to lead, and the types of care services available, including:

- income support;
- accommodation support;
- community support;
- community access;
- respite care;
- specialist equipment and environmental modifications; and
- transport services.

The interaction of these services with other systems, such as aged care services, employment services, housing services, health care system, and education, will also impact preferences. Given the wide dispersion in preferences for care, a national disability insurance scheme will need to ensure flexibility in the delivery of care.

Consumer-directed care is one method of attaining choice and flexibility in the provision of care. CDC provides a greater say in the planning of care and in the delivery of services. The recipient of care can be involved in decisions about the range of services they perceive as most appropriate to their needs including:

- controlling when and how the care is delivered;
- taking responsibility for their choice of care provider including hiring and firing them, and training and paying them; and

- managing day to day delivery of care.

Under a CDC framework, care recipients and carers can use allocated funds or benefits to purchase services and equipment from traditional service agencies, or they can use the funds for options outside the formal care system. This is particularly relevant for people from Culturally and Linguistically Diverse (CALD) populations for whom mainstream formal services may not be relevant or well suited to their cultural and/or linguistic needs. Similarly, limited availability and issues regarding access to formal services in rural and remote areas may make CDC models particularly attractive to consumers because it presents the opportunity to arrange flexible, non-traditional care.

The high degree of regulation in the provision of care services in Australia reduces the incentive to providers to offer non-traditional or niche care options. Allowing consumers to allocate their funds according to their needs and preferences should generate a market for these services an expand choice for consumers. It should also increase competition between service providers, driving down prices, promoting service innovation, and increasing the purchasing power of care recipients.

While there are clear advantages of CDC in allowing care recipients to choose the services that meet their preferences, a major disadvantage is that there are high associated information costs. Information about services and associated fees, which may vary between providers, can be costly in terms of the time and effort required to collect this information. Consequently, some people may prefer not to have to make decisions and organise their own care services. An equally important component of choice is therefore the option to relinquish responsibility for making these choices, while ensuring that the care received is at minimum appropriate for the nature of the disability.

The way in which choice is incorporated into no-fault schemes is dependent on the particulars of the scheme. WorkSafe and the TAC provide choice by allowing claimants to choose their own service providers, on the condition that the provider is registered with the scheme. There is a maximum amount of reimbursement for each type of service and fees charged above this must be met by the user. However, choice is limited by restrictions on the types of services that are reimbursable and there must be reasonable justification for the use of each service to treat the disability. This means that some people may not be able to access services that most suit their needs.

Although care services are reimbursed, income support and compensation for impairment are provided in the form of cash payment, allowing the recipient to purchase anything they choose. There are no restrictions on the purchase of health care services thus in principle, lump sum payments could be used to purchase additional services or more expensive services if the recipient desires.

For most clients, the TAC and WorkSafe do not offer case management beyond the role of an agent or treating health care provider. The exception is in the case of those with 'high-risk injuries' who are assigned a care manager for a limited period of time to assist with assessment, planning facilitation and advocacy for options and services to meet individual needs (WorkSafe, 2010b). In the case of WorkSafe, all clients who are assigned a case manager are done so through the TAC case management process. The TAC's case management model is delivered around several principles, including:

- consideration for the client's social, physical, emotional and economic circumstances;

- services are provided over a specified time frame;
- goals are developed based on the client's interests, abilities and objectives;
- clients are empowered to control their own self-management strategies;
- case management services are measured against outcomes that can be demonstrated; and
- interventions are aimed at achieving specific goals (TAC, 2010b).

The ACC also provides choice over service providers by allowing the recipient to be fully compensated if they use the ACC provider and partially compensated if they elect their own provider. There is also compensation in the form of cash benefits.

If a claim is not resolved within six weeks then it is defined as high risk and sent to an ACC branch for intensive management by a case manager. Case management under ACC involves one person becoming responsible for a claim rather than several people dealing with specific parts of the claim. The ACC describes the key features of their case management approach as being:

- early identification of the claimant's needs and early intervention;
- integrated service planning and delivery in partnership with the claimant, family, employer, and health and rehabilitation professionals;
- proactive monitoring of the effectiveness, quality, and costs of services delivered; and
- continuous review and updating of the claimant's case management plan (OAG, 2004).

In the UK, the IIDB does not provide services, only cash payments. However, disability and health care services are accessible to recipients through their local authority and the NHS. These services are provided through a consumer-directed care model. To receive services, the claimant applies to their local authority, who undertake and assessment of care needs. The recipient is able to provide input into their care plan as to what types of services would most suit their needs. Once care needs have been established the local authority determines the amount that will be subsidised, based on the applicant's means. A person cannot be denied care that they require based on a lack of means. Applicants have the option to receive the services in the form of:

- a direct cash payment, which can be used to purchase services; or
- a personal budget, where responsibility for purchasing services is delegated to a local authority.

This maximises the consumers control over their care since they have the option choose their own provider, contribute to the decisions regarding the type of services that they required and they are able to rescind responsibility for this choice if they would prefer to do so. The coordination of services by the local authority, regardless of whether they are subsidised or not, helps to ensure that people are at least receiving care that is appropriate for their needs.

The way in which cash payments are provided can also impact choice. Receiving a lump-sum payment has the advantage of providing closure to the recipient. Once they have received their payment they do not need to have continued contact or be scrutinised by an agency. Free of the burden of ensuring the required ongoing payment, they are able to make decisions about improving their situation based on the final sum of compensation.

All four no-fault schemes provide periodic payments. IIDB is the only scheme that offers a choice in the frequency of payments, allowing weekly, monthly or half-yearly. However, it is also the only scheme that does not provide any compensation in the form of a lump-sum.

Fault based schemes provide compensation in the form of a lump sum payment. This allows recipients to allocate resources towards their care needs based on their preferences for care and other consumptions, since there are no limitations on how the money is spent. However, fault based schemes do not provide guidance to the recipients on the types of services that would be most appropriate to meet their needs. Although some recipients will be better off making these decisions themselves, others would benefit from assistance in managing and coordinating their care needs.

In principle the size of the compensation for disability care services should be commensurate with the expected need for services. However, the amount of compensation is somewhat unpredictable, being influenced by factors such as choice of legal representation, the quality of available evidence and the costs associated with bringing the case both in terms of the amount this subtracts from the final payment and the distortionary impact it may have on the size of the settlement (e.g., it may be cheaper to offer a slightly larger settlement than would be awarded by the courts rather than incur the costs of pursuing the case in court).

In addition, there may be substantial costs associated with disability care long after corresponding injuries and compensation under common law have occurred. Consequently, common law cannot properly allow for unexpected deterioration of a compensable condition, or unexpected increases to disability care costs. Some people may be left without access to disability care and have to rely on the social welfare system.

3.5 Responsive to individual need and preferences

A responsive disability insurance scheme can be defined as one that ensures disability care service providers have respect for individual circumstances through client orientated care. This includes respect for dignity, confidentiality, promptness, quality of amenities, access to social support networks, and participation in decisions regarding the delivery of care.

Responsiveness can be measured by the outcome of disability care, or as client experience throughout the process of care. Measures of responsiveness as applied to a disability insurance scheme including how long clients waited for care and compensation, and the extent to which clients are satisfied with the amount and type of services available.

Under its guidelines, the TAC will accept or deny a claim, or make a further reasonable request for information by the expiration of:

- 21 days after initially receiving the claim; or
- 14 days after receiving:
  - further information requested by the TAC from the client;
  - further information requested by the TAC from a person other than the client; or
  - the results of a medical examination.

The proportion of first income payments made by the TAC within 28 days of a claim lodgement was 80% in 2008-09, which represents a decrease from 81% in 2007-08 and 84% in 2006-07 (TAC, 2009a).

For WorkSafe, timeliness of payments across all private insurers is relatively high. Table 3.1 shows the timeliness of weekly payments and medical reimbursements paid within the recommended time are all above 95%.

Under ACC, the number of claims rejected is low, suggesting the scheme is responsive to disability needs. This is shown in Table 3.2 which presents the proportion of lodged claims which were accepted by the fund, split into the various types of accounts operated by ACC.

Furthermore, under the ACC scheme the speed at which a claim is process and access to compensation is grated is relatively quick. For example, the median number of days from lodgement to decision by the ACC on whether a claim to accept or decline was around one day, while the median days from lodgement to weekly compensation payment is around 15 days (ACC, 2010c).

It is difficult to measure the responsiveness of the IIDB scheme in the UK because access to disability care services is determined by local authorities (i.e., county, metropolitan, borough, London borough, the City of London or the Unitary Authority). As such, there is large variability on the types of services available.

No-fault disability insurance schemes generally control the number and type of services made available to injured persons by evaluating expected need. Consequently, these schemes respond to the needs of the injured person to the extent deemed reasonable by assessors.

Evaluation by the ACC is undertaken through an allocated assessor who determines treatment entitlements. For those with permanent impairment, a client services contact from the ACC works with the injured person to construct a rehabilitation plan, which identifies the assessments needed, the needs of the individual and the services that will be funded to meet these needs. The rehabilitation plan also sets a date on which the injured person can expect to return to normal activities.

Under the TAC and WorkSafe schemes, access to health and disability care services by an injured person is determined by a reasonableness test, although there are also maximum amounts the schemes are willing to pay as reasonable costs for health and rehabilitation services (TAC 2009; WorkSafe 2010a).

Table 3.1: Timeliness of payments under WorkSafe

Agent	Injured workers		Providers
	Weekly payments [a]	Medical reimbursements [b]	Payments [c]
	%	%	%
Allianz	99.0	96.9	98.9
Cambridge	98.2	97.9	99.5
CGU	99.7	97.1	99.3
GBS	96.9	95.0	98.1
GIO	98.1	96.1	98.3
QBE	96.9	97.0	98.9
Total scheme	98.6	96.9	99.0

Note: (a) Paid with seven days (b) Paid within 10 days (c) Paid within 30 days.
Source: WorkSafe (2009).

Table 3.2: Proportion of lodged claims accepted by ACC

Period	Residual	Motor vehicle	Non earners	Earners	Employers/Other	Treatment injury	Self Employed	Sensitive claims
	%	%	%	%	%	%	%	%
30/06/06	74.8	98.8	98.4	98.7	84.8	61.4	96.7	68.3
30/06/07	88.6	98.9	98.7	98.9	87.0	59.7	96.6	69.8
30/06/08	87.9	99.0	98.6	98.9	93.0	64.6	96.5	64.1
30/06/09	85.2	98.7	98.3	98.7	92.1	61.2	95.7	52.0
30/06/10	84.2	98.6	97.8	98.4	91.3	54.8	94.4	

Source: ACC (2010c).

The person with a disability bears the onus of establishing that requested health and disability care services are reasonable given individual circumstances. The test of reasonableness is objective, requiring scheme administrators to weigh the nature and extent of the injury and associated disability, against the requested disability care services. The TAC and WorkSafe are likely to fund a disability care service where:

- there is proper clinical justification;
- the service is likely to be effective in improving health;
- the service allows the person with the disability to be more independent; and
- the treatment is based on evidence and endorsed by professional bodies (TAC, 2010a).

TAC and WorkSafe weigh all relevant factors. For example, in determining benefits for medical and rehabilitation care, WorkSafe considers:

- alternative clinical service delivery models based on the best available evidence;
- verifiable data, service industry guidelines, benchmarking with other purchasers, service cost breakdown and an analysis of service delivery;
- innovating purchasing approaches that facilitate service provider performance, improved outcomes for injured workers and value for money;
- feedback from peak bodies and other stakeholders; and
- requirements of the *Accident Compensation Act 1995* and relevant administrative law decisions (WorkSafe, 2010a).

Although factors may be different depending on individual circumstances, scheme administrators will generally consider reasons presented in favour of accessing the requested disability care services, the nature and effect of the disability, the financial burden on accommodating the needs of the person with a disability and available alternative methods of achieving improved health outcomes. However, even if there is a reasonable alternative to accommodate care needs, this does not mean the initial request for services is unreasonable.

Since a reasonableness test is objective, the subjective preferences of the person with a disability do not determine the amount and type of disability care services made accessible by the scheme. However, preferences are relevant in assessing whether the request for services is unreasonable. Consequently, testing reasonableness is less demanding than determining whether the service is necessary, but more demanding than testing whether the service is convenient. The question is not whether the decision to grant access to disability care services is correct, but whether it could be demonstrated that the request was not objectively reasonable, taking into consideration the individual circumstances of the person with a disability.

The ACC responds to the needs of injured people by offering to fund a wide range of medical treatment, including hospital treatment and surgery costs, allied health care costs, dental, nursing, and specialists costs. It also funds services to manage at home following an injury, such as home help, child care, attendant care and equipment, and travel and accommodation for treatment.

No-fault schemes also have the capacity to respond to alternative preferences over how compensation is delivered. Medical and rehabilitation expenses are reimbursed in the case of the TAC and WorkSafe schemes, while injured persons covered under the ACC also have the option of getting the ACC to pay the provider directly. Furthermore, the TAC, WorkSafe and the ACC provide the opportunity for injured persons to claim statutory benefits as a lump sum payment given a minimum impairment threshold is met. For example, under WorkSafe a lump sum payment will only be provided if the injured person developed a permanent physical impairment of 10% or more, or a psychiatric impairment of 30% or more (WorkSafe, 2010).

Lump sum payments do not aim to replace medical and rehabilitation benefits, instead they aim to cover non-economic loss (to compensate for pain and suffering, disfigurement and reduced life expectation), or death benefits. Commutation of weekly benefits is also possible generally under strict conditions. For example, under WorkSafe settlements for future weekly benefits are allowed when the injured person has no current work capacity indefinitely, has been on benefits for 104 weeks or more, and is aged over 55 years (VWA, 2004).

Periodic payments for medical and rehabilitation enable people with permanent impairment to remain connected to disability care and support services. However, one disadvantage of not allowing the option for lump sum payments is that the injured person becomes locked into the compensation scheme. This can reduce the responsiveness of services to changing disability needs. For example a young person with a permanent impairment covered under either the TAC or WorkSafe must rely on periodic payments for the rest of their life, are tied to the review processes and procedures used by the scheme. Consequently a relationship with the scheme must be maintained. Some people may find this an inflexible arrangement and would rather have complete control over their own disability care services without having to go through a third party.

One reason to not allow the option for lump sum payments for medical and rehabilitation benefits is that it can help minimise the opportunity for cost shifting. Cost shifting occurs when the injury cost that should be covered by a non-fault disability scheme is covered by the government, for example through the public health care system such as Medicare and public hospitals, and disability services such as Home and Community Care (HACC) packages. If people are allowed to take lump sum payments for medical and rehabilitation benefits, but do not have restrictions on how those benefits can be used, there is an incentive to use some of those funds for purposes other than medical care or rehabilitation services because people can fall back on government provided services.

Responsiveness of a no-fault disability insurance scheme will also depend on the mechanisms put in place to handle and resolve disputes in a transparent fashion that is equitable and minimises the cost of delay. Given the nature of no-fault based systems, the dispute is not over who is negligent, but over the extent of the injury and access to compensation and care entitlements. However, in regards to workers compensation a substantial amount of disputes also occur over whether the injured party is an employee and whether the injury was related to work. This is because claims experience rated premiums under a no-fault based system provide an incentive to dispute.

All no-fault based schemes under review have some dispute resolution mechanisms (see Section 2.7). In general, resolution of disputes within the no-fault component of disability insurance schemes starts with an internal review to determine whether the initial decision was mishandled through mistakes, misunderstandings, or poor information exchange. If the

dispute is still unresolved, then alternative dispute resolution mechanisms are used, including conciliation, where a third party will advise on a solution to the dispute (e.g., Victorian Civil and Administrative Tribunal) and all provide an opportunity for the dispute to be heard in court. This is an important part to dispute resolution because it allows points of law to be assessed through specialist expertise and therefore promotes public accountability within the schemes (PC, 2004).

Within dispute resolution process there is likely to be an imbalance of power between the person that is injured and the disability insurance scheme. This is because most people will only claim once for their injury, and therefore will not be familiar with the dispute resolution process. They are also likely to have limited skills in negotiating, legal knowledge, identifying information needs, and the financial capacity to proceed.

Consequently, to reduce the asymmetry of power, and to ensure a fair and just dispute resolution process, it is imperative that injured persons are allowed legal and other representatives to participate on their behalf. In the interests of an efficient dispute resolution, the process should provide incentives for legal representatives to resolve the dispute as quickly as possible.

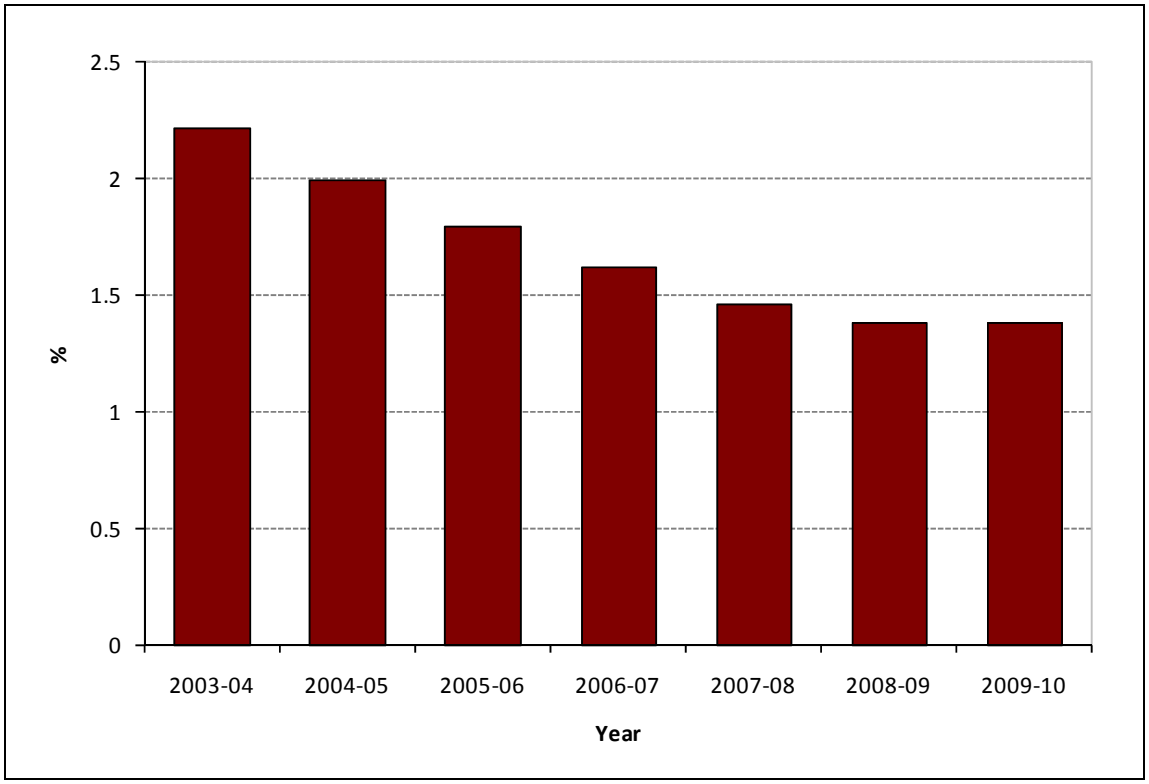
3.6 Financial sustainability

For a disability insurance scheme to be financially sustainable, it should ensure expected costs associated with entitlements, administration of the scheme, and capacity building is matched with expected revenue generated from taxation, compulsory contributions to insurance, or other means and investment over a forecast horizon.

The WorkSafe scheme is primarily financed through a compulsory system of insurance that covers employers for the cost of providing benefits to injured workers. These benefits extend to both economic and non-economic losses suffered by injured workers and may continue for life.

WorkCover insurance premiums are set under section 15 of the *Accident Compensation (WorkCover Insurance) Act 1993*. The average premium for the next financial year, expressed as the percentage of Victorian employers' payroll needed to meet the cost of claims for the policy year, is calculated annually based on the latest assessment of the scheme's financial position. WorkSafe's Board reviews the calculation and recommends a rate to the government for the coming year. The average premium rate for 2009–10 was 1.387%, which was the fifth successive annual reduction since 2003–04. This is shown in Chart 3.1.

Chart 3.1: WorkSafe injury insurance average premium rate

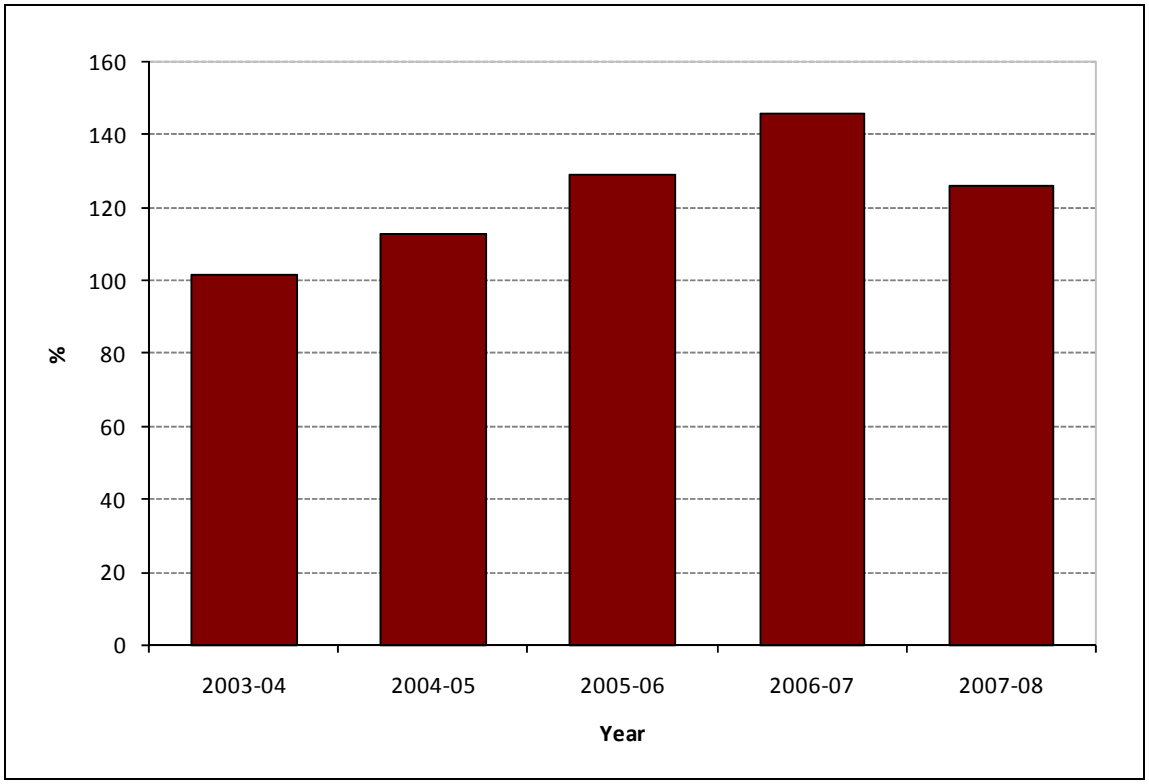


Note: Premium rate is expressed as the percentage of Victorian employers' payroll needed to meet the cost of claims for the policy year.
Source: WorkSafe (2009).

WorkSafe has an objective to manage insurance risk to reduce the volatility of insurance premiums and performance from insurance operations. Key aspects of the processes in place to mitigate risks include the use of the use of detailed internal monitoring tools which link actuarial valuation projections with management information systems to monitor claims patterns (WorkSafe, 2009).

Chart 3.2 shows the standardised ratio of assets to net outstanding claim liabilities for the WorkSafe scheme. Ratios above 100% indicate that the scheme has more than sufficient assets to meet its predicted future liabilities. Conversely, ratios below 100% are an indication of the need for a scheme to increase its premium rates to ensure assets are available for future payments. WorkSafe has maintained sufficient assets compared with liabilities with ratio increases from 102% in 2003-04 to 126% in 2007-08.

Chart 3.2: Standardised ratio of assets to net outstanding claim liabilities for WorkSafe



Source: WRMC (2009).

WorkSafe claims reported by nature of affliction are shown in Table 3.3. The nature of affliction is intended to identify the type of hurt or harm incurred by the worker. All claim numbers are based on standardised claims. The claims payments and movement in outstanding claims liability during the year by payment type are outlined in Table 3.4.

In 2002, WorkSafe introduced a new claims management model as part of a wider reform of the WorkSafe scheme. The new model aimed to improve the return to work outcomes for injured employees and create more cost effective claims management. Under the model, claims are triaged and segmented according to risk, where low-risk claims are handled quickly and high-risk claims are actively managed by a multidisciplinary team lead by a case manager. High-risk claims generally involve complex and/or serious work-related injuries where there is potential for long-term periods of incapacity. High-risk claims represent 25 per cent of all claims and account for around 90 per cent of liabilities (VAGO, 2009).

Table 3.3: Causes of underlying claims, WorkSafe

Affliction	Sep 85 to Jun 00	2000/01	2001/02	2002/03	2003/04	2004/05	2005/06	2006/07	2007/08	2008/09	Total
Fractures	44,225	2,508	2,364	2,244	2,314	2,314	2,284	2,384	2,430	2,308	65,375
Dislocations	3,301	230	212	251	227	242	215	211	222	235	5,346
Musculoskeletal	376,362	19,856	19,572	18,836	18,835	17,591	17,320	15,804	16,067	15,434	535,677
Concussion	2,642	128	104	196	170	172	186	176	200	191	4,165
Open wound	47,022	2,001	1,831	2,164	2,262	2,124	2,081	2,051	2,054	2,016	65,606
Superficial	9,195	593	671	209	171	197	169	129	135	153	11,622
Contusion/crushing	37,012	1,576	1,373	2,189	2,076	2,118	2,525	2,327	1,945	1,836	54,977
Burns	6,818	219	205	230	213	182	218	245	229	220	8,779
Poisonings	1,565	86	80	103	89	67	75	83	62	38	2,248
Exposure	1,762	57	52	76	58	49	59	60	61	56	2,290
Multiple injuries	4,936	126	140	146	128	139	101	103	96	130	6,045
Other injuries	8,292	356	487	156	187	163	97	232	230	217	10,417
Deafness	42,682	802	958	798	692	712	1,124	1,164	1,424	1,738	52,094
Skin diseases	4,870	142	132	196	221	170	173	150	179	149	6,382
Digestive system	17,370	919	834	1,094	1,152	1,110	1,012	982	915	861	26,249
Infections or Parasites	1,684	70	84	53	71	54	49	50	49	36	2,200
Respiratory system	2,757	136	124	158	190	130	124	93	109	110	3,931
Circulatory system	6,312	176	140	239	191	161	156	157	155	128	7,815
Mental disorders	26,660	2,417	2,565	2,785	2,922	2,791	2,612	2,570	2,518	2,601	50,441
Other afflictions[(a)]	4,379	339	312	265	303	248	262	220	264	232	6,814
Total	**649,846**	**32,737**	**32,240**	**32,388**	**32,472**	**30,734**	**30,842**	**29,191**	**29,344**	**28,689**	**928,483**

Note: (a) Other afflictions include internal injury, neoplasm (cancer) and foreign body and other diseases.
Source: WorkSafe (2009).

Table 3.4: WorkSafe claims paid, including liability movement

Entitlement	2008	2009
	$ (000s)	*$ (000s)*
Weekly compensation	247,202	537,693
Medical and like services	416,451	431,424
Maims and impairment benefits	(107,391)	125,573
Common law	573,201	439,411
Other payment types	96,308	126,147
Claims handling expenses[(a)]	(3,167)	51,470
Risk margin[(b)]	17,389	33,406
Self-insurer exit settlements	(3,307)	4,130
Gross claims incurred	**1,236,686**	**1,749,244**

Notes: (a) Claims handling expenses is an allowance made for the direct expenses to be incurred in settling claims.
(b) The prudential risk margin provides for the inherent uncertainty in the central estimate of the outstanding claims.
Source: WorkSafe (2009).

Each claimant categorised as high-risk is assigned a case management action plan (CMAP) with specific treatment and service options to assist with timely recovery and return to work. Services and actions identified in the CMAP are delivered to maximise recovery. In 2009 planned services were delivered in a timely manner for 88% of cases and they were generally appropriate to injured workers' identified needs in 84% of cases. There was no evidence of inappropriate treatment in terms of the intensity and mix of services (VAGO, 2009).

The financial performance of the WorkSafe scheme has improved significantly since the claims management model was introduced in 2002 (VAGO, 2009). Consecutive reductions in outstanding claims liabilities during the past five years linked to claims management initiatives have contributed to significantly reducing long-term claims costs and maintaining a fully funded scheme.

The TAC scheme is predominantly funded by payments made by motor vehicle registration fees. In 2008-09, the TAC funded a total of $836.9 million in support services and benefits. The number of new claims received was 19,162 and a total of 40,383 people received funded support from the TAC. The average claim size in 2008-09 was $50,365, up from $47,813 in 2007-08 (TAC, 2009).

The TAC's standardised ratio of assets to net outstanding claim liabilities for 2008-09 was 81.3%, down from 104.5% in 2007-08, indicating that the scheme has insufficient assets to meet its predicted future payments. This poor financial performance is due to weak investment markets that delivered a negative return of 12.2% in 2008-09 compared to negative 6.6% in 2007-08 (TAC, 2009a).

TAC claims expenditure is rising in all areas and especially in long-term care (VAGO, 2001). VAGO suggests that the TAC's ongoing challenge is to understand its cost drivers and to manage them in effectively meeting the objectives of the scheme. Without careful management, the scheme could eventually require additional community funding or provide reduced benefits (VAGO, 2001).

The TAC's financial performance and its ability to sustain the long-term financial viability of the scheme is dependent upon the volume and cost of transport accident claims received, and its revenue from premiums and returns achieved on investments. In 2009 the TAC's assets totalled $7.1 billion while liabilities were $7.4 billion. This resulted in a net loss after tax for the second year running. Table 3.5 shows that the TAC made a loss of $971 million in 2008-09, which is a further deterioration from a $517 million loss in 2007-08. The reason for the large losses was an unexpected loss in investment returns, with the fund losing over $2.0 billion within the period. [4]

Table 3.5: Impacts on TAC profits from various revenue and expense sources

	2004-05	2005-06	2006-07	2007-08	2008-09
Performance from insurance operations	364	437	380	398	103
Difference between actual investment returns and long-term expected returns	373	428	438	(1,046)	(1,305)
Change in inflation assumptions and discount rates	(108)	(34)	152	(106)	(193)
Tax	(164)	(227)	(279)	237	424
Net profit/(loss) after tax	**465**	**604**	**691**	**(517)**	**(971)**

Source: TAC (2009).

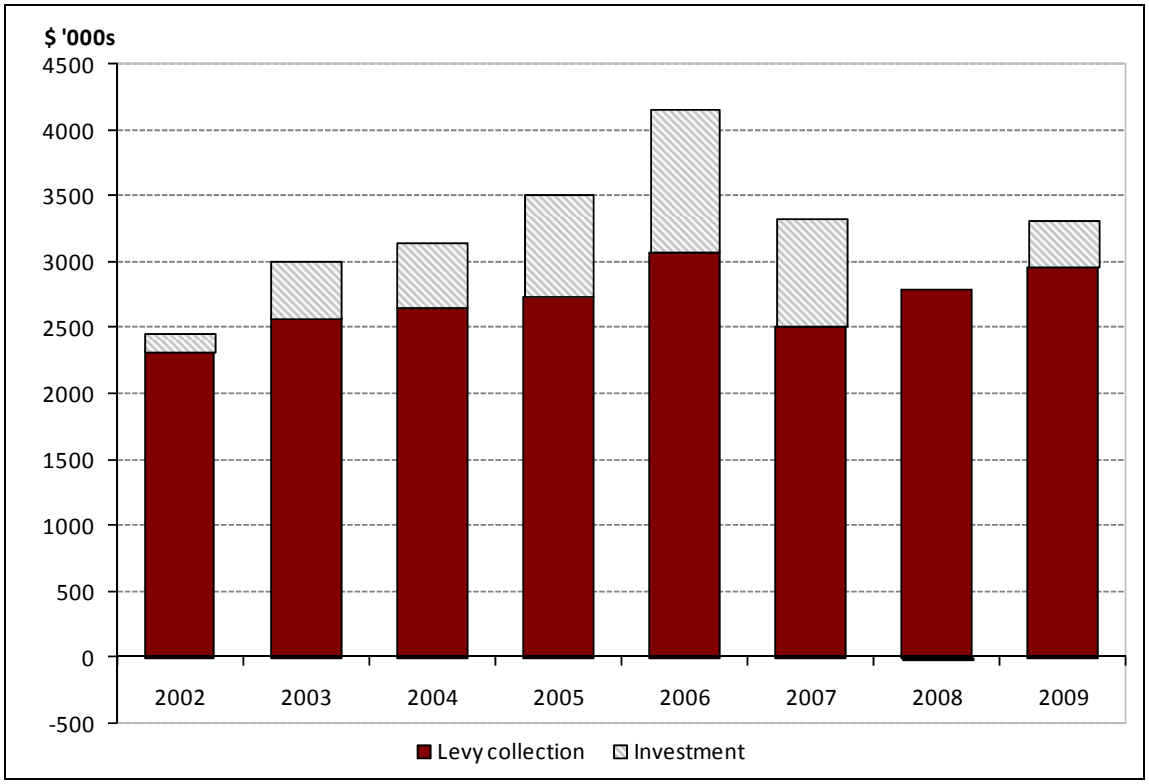
The ACC is currently financed through government contributions, levies paid by employers, and tariffs on petrol and motor vehicle licensing. Levies are calculated regularly based on forecast claims (e.g., if claims are predicted to rise, there will be pressure to increase levies to fund expected claims). In 2008-09, the ACC collected $4.18 billion in levies (ACC, 2010b).

Chart 3.3 shows the amount of revenue collected through levies and investment between 2002 and 2009. Investment income dropped significantly and was negative in 2008 as a result of the Global Financial Crisis (ACC, 2010b). Levy collection has increased since 2007 after a large drop between 2006 and 2007.

Levy rates (for the work, motor vehicle and earner's accounts) are set by the government and vary according to forecast future costs of claims. To manage revenue risks, the *Accident Compensation Act 2001* (NZ) requires that these accounts be fully funded so that there is sufficient levy income to meet the present and future costs of claims. Thus, rates in the motor vehicle and earner's accounts are predicted to increase in future years to achieve full funding by 2014.

[4] The TAC is also required to pay the Victorian Government a dividend each year, as determined by the Victorian Treasurer in consultation with the TAC Board, Chairman and the Minister for Finance. In 2008-09 dividends were $139.3 million relating to the 2007/08 results, based on the policy of providing 35% of performance from insurance operations.

Chart 3.3: Levy revenue and investment income for ACC



Note: In New Zealand dollars.
Source: Access Economics using data from ACC Annual Reports.

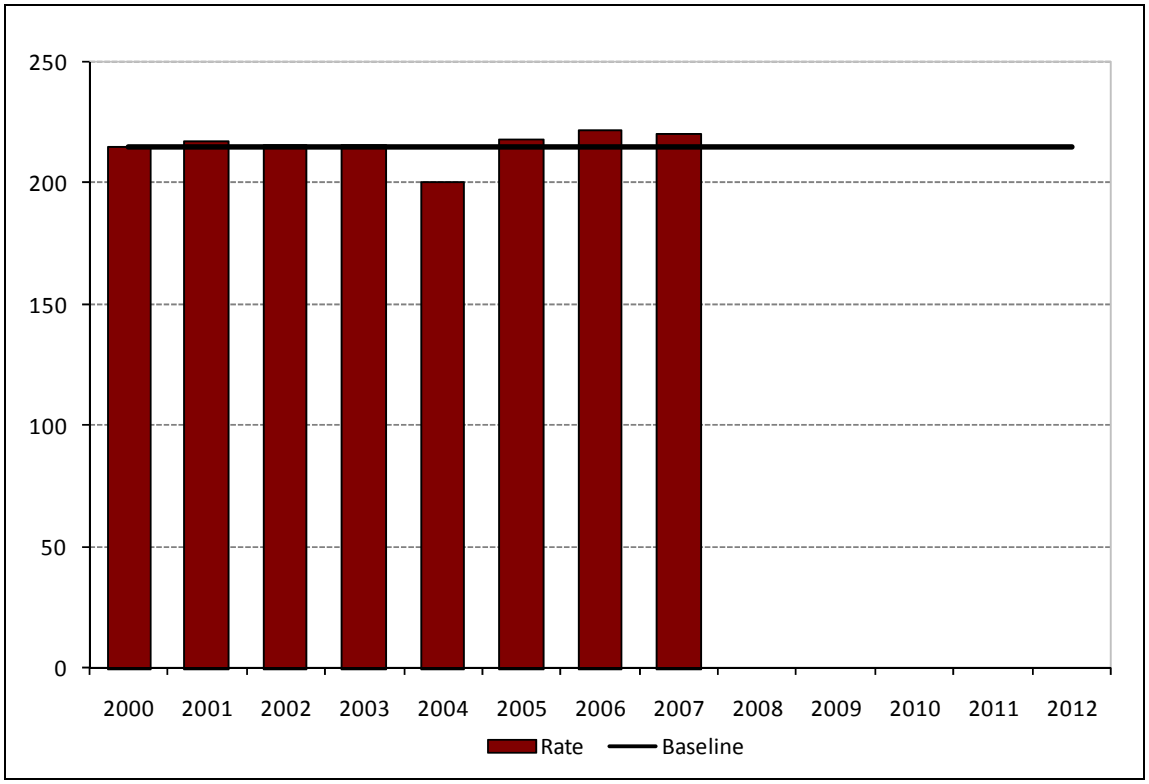
Revenue collected from levies is invested by ACC to offset the cost of claims. This matches expected revenue to cost as most injuries require ongoing rehabilitation, medical expenses or earnings replacement for years following the injury. The investment portfolios adopted by the ACC needs to balance the objectives of maximising returns (to allow ACC to charge lower average levy rates over time) while minimising the risk of significantly increasing levy rates to meet long-term obligations.

Sustainability of the scheme depends on future claims, which depends on the future rate of injury. Chart 3.4 shows the ACC's forecast of the rate of serious non-fatal injury per 100,000 person years at risk. The rate of injury has been increasing slowly since 2004, and has been above the baseline rate between 2005 and 2007. The trend in the number of claims in the short term is expected to remain flat.

The ACC also incurs administrative costs (including claims handling, net operating, injury prevention, levy collection and investment costs) and operating costs (including claims handling and net operating costs). Operating costs have trended upwards since 2002-03 and increased by 13% in 2008-09 due to increased personnel costs and depreciation costs. However, the operating costs as a proportion of claims paid have remained steady since 2002-03 at around 12%.

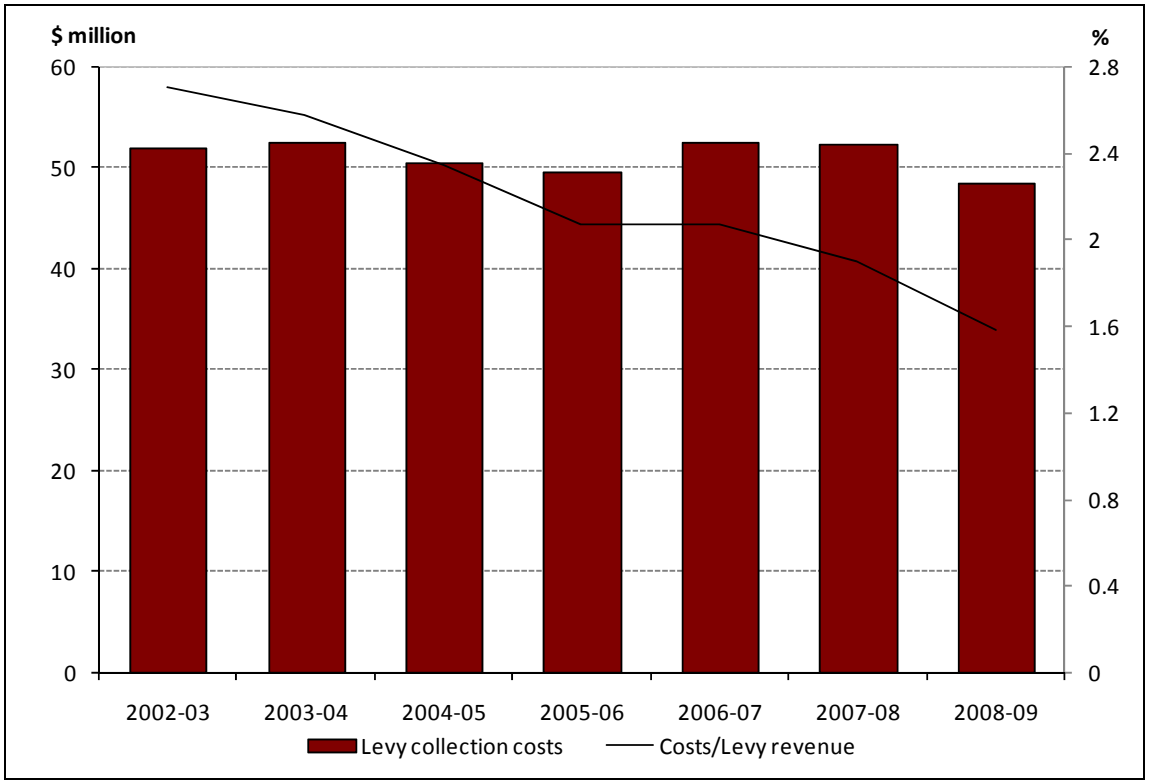
Chart 3.5 shows that levy collection costs have generally been steady at around NZ$50 million between 2002-03 and 2007-08. In 2008-09, levy collection costs dropped by 11% as the ACC

Chart 3.4: Rates of serious non-fatal injury (per 100,000 person years at risk)



Source: ACC (2010b).

Chart 3.5: ACC levy collection costs



Note: In New Zealand dollars.
Source: ACC (2010b).

decreased its use of external collection agencies for levy debt. Levy collection costs as a percentage of levy revenue has been trending downwards since 2002-03. Shortfalls in the non-earner's account (for injuries to people not in the paid workforce at the time of injury) are funded by government appropriation.

A key measure of financial sustainability is the number of long-term claims (claims in receipt of weekly compensation for more than 12 months). Since 2006, the number of long-term weekly compensation claims has trended upwards and there were 15,271 long term claims in 2008-09.

Recently, the ACC's outstanding claims liability has been outgrowing its assets. In 2008-09, current outstanding claims were valued at NZ$23.8 billion compared to assets of NZD$11 billion (ACC, 2010c), representing a shortfall of NZ$12.8 billion. While assets have remained relatively steady over time, the increase in claims liability means the ACC scheme is becoming increasingly unsustainable in the long term. In 2007-08, outstanding claims amounted to only $18 billion, 28% lower than 2008-09 (ACC, 2010b).

There are several reasons why the ACC's liability has been trending upwards, including:

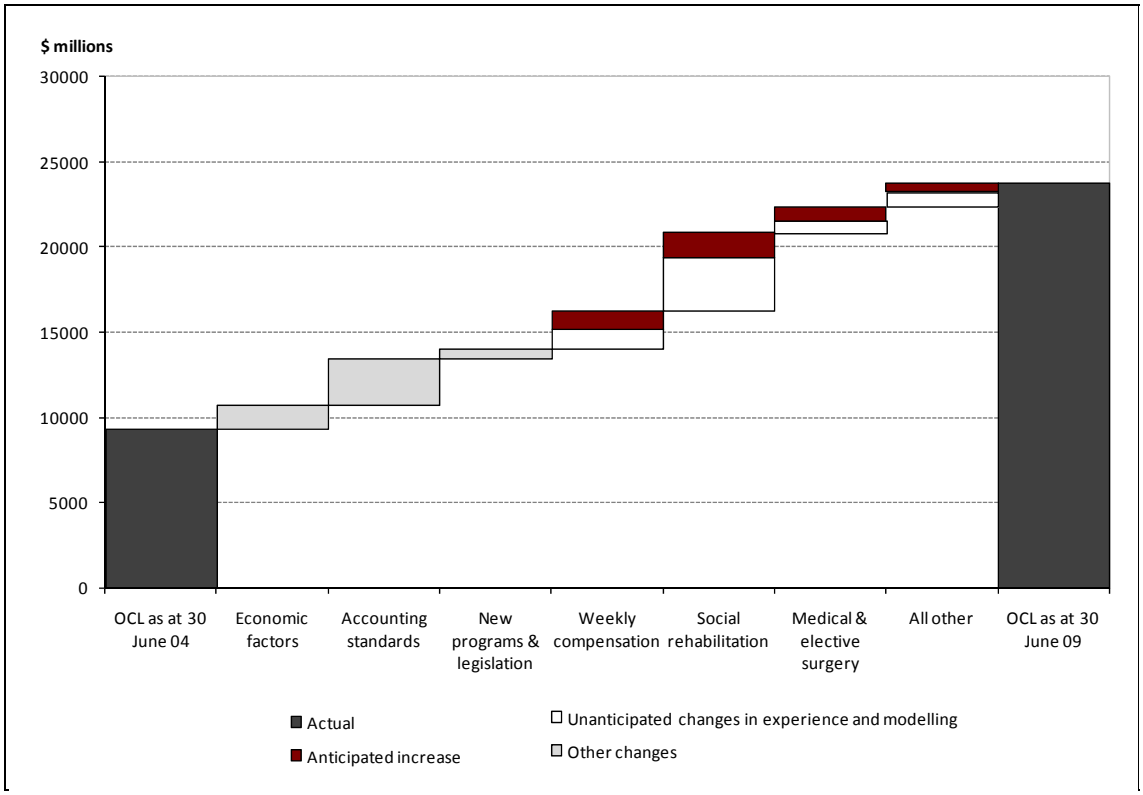
- increased number of claims due to:
  - an ageing population;
  - improved awareness of the ACC scheme and its services; and
  - improved health care allowing people to survive serious accidents but live longer with serious disability.
- increased time to return to work or independence;
- health inflation causing increased costs for medical treatment and rehabilitation due to:
  - rising wages in the health sector;
  - supply pressures; and
  - increased number and type of services available.
- broader entitlements and access to coverage.

Chart 3.6 shows the main drivers of ACC's outstanding claims liability, which is calculated based on the future expected cost of claims adjusted to reflect expected future inflation, and discounted to present value by a risk-free interest rate. Outstanding claims liability more than doubled from $9.4 million to $23.8 million between 2003-04 and 2008-09 (ACC, 2010b). The main drivers were unanticipated changes in social rehabilitation costs and changes in weekly compensation costs, mainly due to longer than expected recovery times (PWC, 2009).

The increased cost in claims has necessitated increased levy rates. Chart 3.7 shows that overall levy rates have been increasing since 2007-08. In particular, the levy rate for earners' account has increased by 30% between 2007-08 and 2009-10 and motor vehicle levies increased by 40% in the same period.

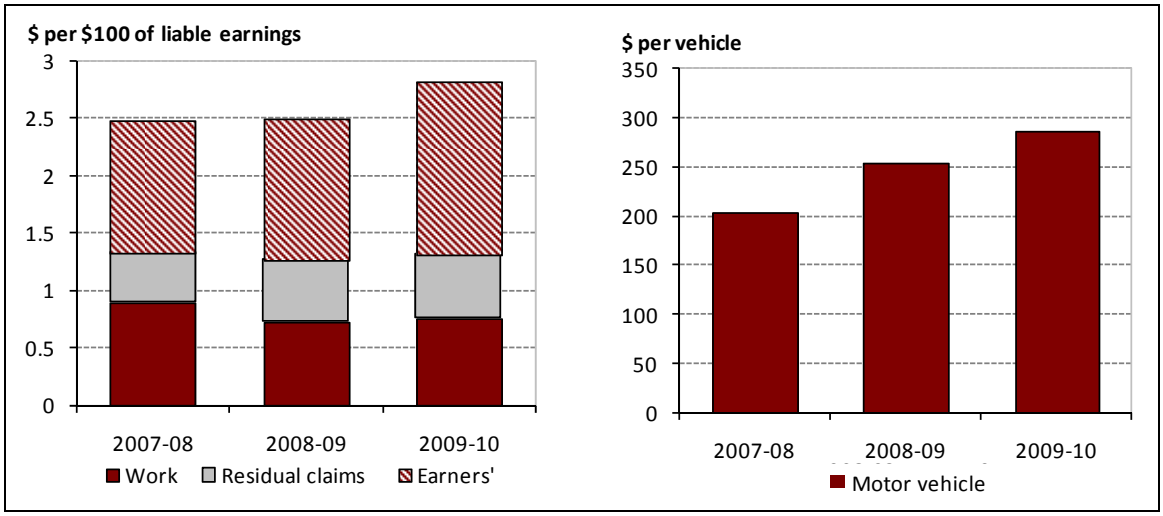
In 2009, a new ACC Board was appointed with a greater emphasis on actuarial, financial and investment management expertise as well as increased transparency to deal with the ACC's funding issue. The Board is responsible for reassessing the ACC's current financial health and long-term sustainability (ACC, 2010c).

Chart 3.6: Drivers of outstanding claims liability



Note: in New Zealand Dollars
Source: ACC, 2010b.

Chart 3.7: Levy rates by account



Note: in New Zealand Dollars
Source: Access Economics calculations based on data from ACC Annual Reports.

In addition, the *Accident Compensation Act 2010* (NZ) was introduced with the primary purpose to help contain rising liability costs, as well as improving coordination between government agencies and the ACC. The Act makes some changes to the collection of levies but most significantly, it works to restrict the level of coverage and entitlements for injured people by:

- reinstating a three-part test for work-related gradual process, disease, and infection making it more difficult for people who have suffered a work related illness from obtaining compensation;
- reintroducing disentitlement for clients who self-injure or commit suicide;
- strengthening disentitlement for criminals injured while committing a crime for which they are imprisoned; and
- setting a threshold of 6% hearing loss before an individual can be considered for ACC cover.

The ACC has also proposed several changes to address the gap between assets and liabilities by changing the administration and operation of the scheme. These are listed below.

- The ACC has introduced the Better at Work and Stay at Work programs to improve rehabilitation outcomes. By coordinating arrangements between the injured person, their employer and their treatment provider, people can return to work sooner. This reduces recovery time and their reliance on weekly compensation.
- The ACC introduced an upfront 'triage' of new claims to categorise new claims according to expected rehabilitation time and costs. This allows for more timely and comprehensive rehabilitation assistance for complex cases.
- The ACC is also building working relationships with treatment providers to control health inflation, which is outstripping the general level of inflation in New Zealand. The ACC has introduced new arrangements with treatment providers that focus on outcomes and value for money, as well as improved monitoring of the performance of providers.

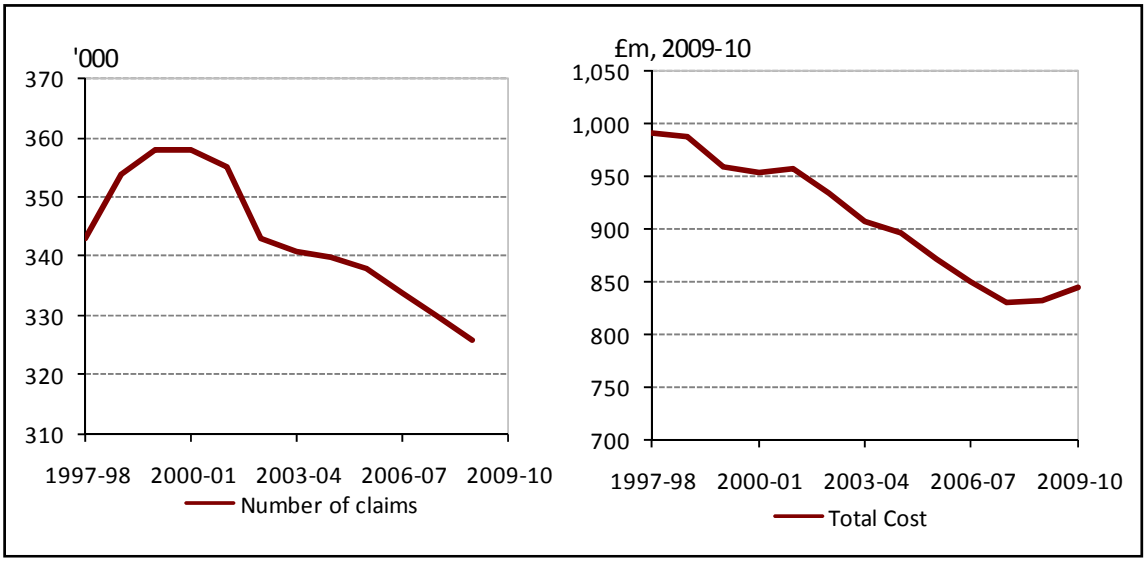
The ACC operates on a 'fully funded' basis. The *Accident Compensation Amendment Act 2010* (NZ) extended the final date for full-funding to March 2019. However, this merely delays the sustainability problem of the ACC rather than solving it. While the ACC's claims liability is made up of future costs (i.e. ongoing costs associated with longer term serious injury claims) and do not need to be met immediately, the liability poses a burden on future generations to pay for injuries.

There have been arguments for the ACC to become, at least partly, privatised. According to Hitzhusen (2005), this may increase administrative efficiency but still maintain the ACC's primary objective of providing a comprehensive and compulsory no-fault insurance scheme. On the other hand, this could potentially introduce increased competition pressures among private providers and the efficacy of the ACC may be compromised in the pursuit of profit (Hitzhusen, 2005).

In the UK, the IIDB is financed through general tax revenue (DWP, 2007a). In 2009-10 (the year ended 6 April) it cost £844 million pounds to provide the IIDB (DWP, 2010g). At September 2009 there were 324,360 people in receipt of the benefit (DWP, 2010f). The number of recipients has been falling in the past 10 years (Chart 3.8). This reflects both the changing composition of industry in the UK and improved workplace safety measures.

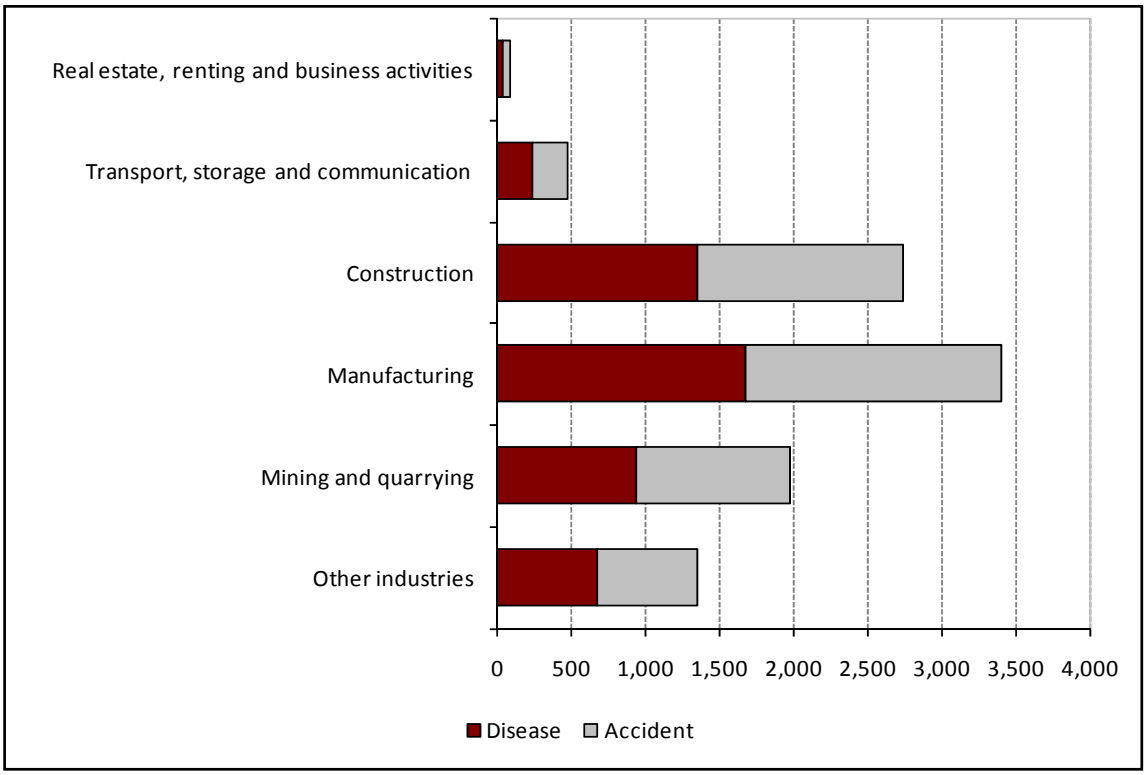
Chart 3.9 shows new claims made for IIDB in the year ending September 2009 by industry. Construction, manufacturing and mining, and quarrying make up 80.7% of total claims and

Chart 3.8: IIDB recipients by number and cost[(a)]



Notes : (a) The UK financial year runs from April 6 to April 5.
Source: DWP (2010f; 2010g).

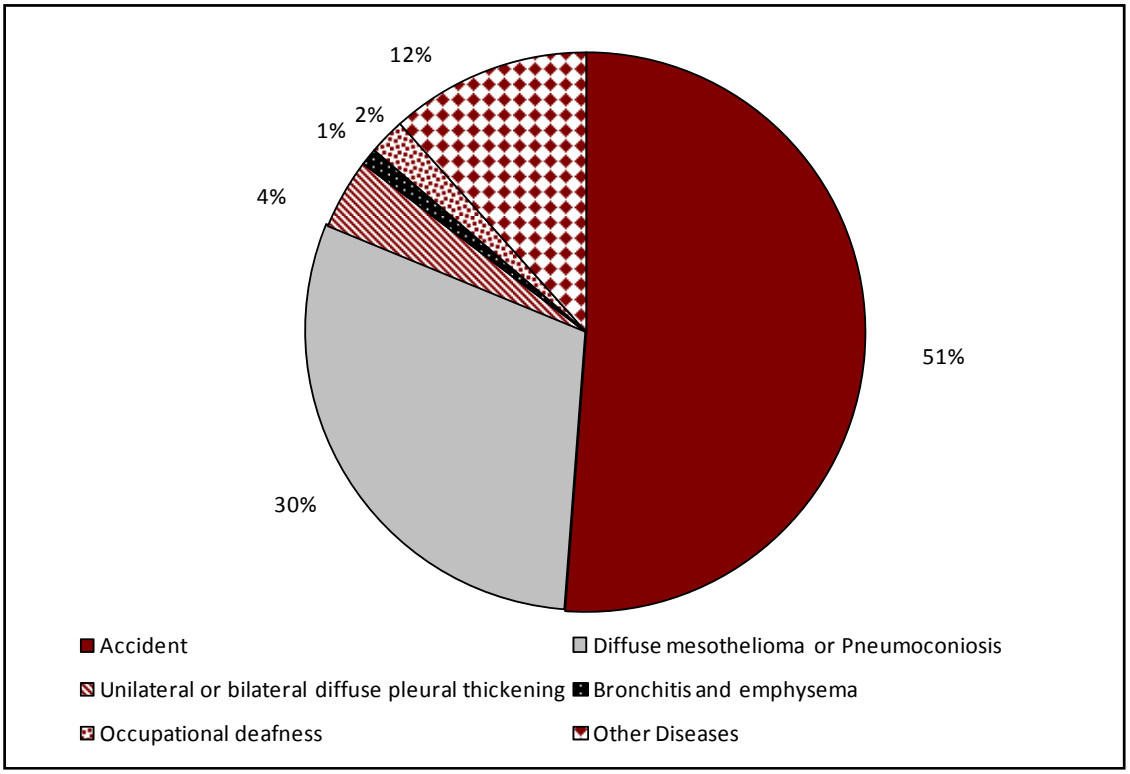
Chart 3.9: New claims for IIDB by industry and type of claim, year to September 2009



Source: DWP (2010f).

equal shares of disease and accident claims. This reflects in part that IIDB was introduced in 1948 and the types of disease and accidents that are covered by the scheme are most relevant to manual labourers. Chart 3.10 shows the breakdown of the new claims made over this

Chart 3.10: Share of new claims for IIDB by disease/injury, year to September 2009



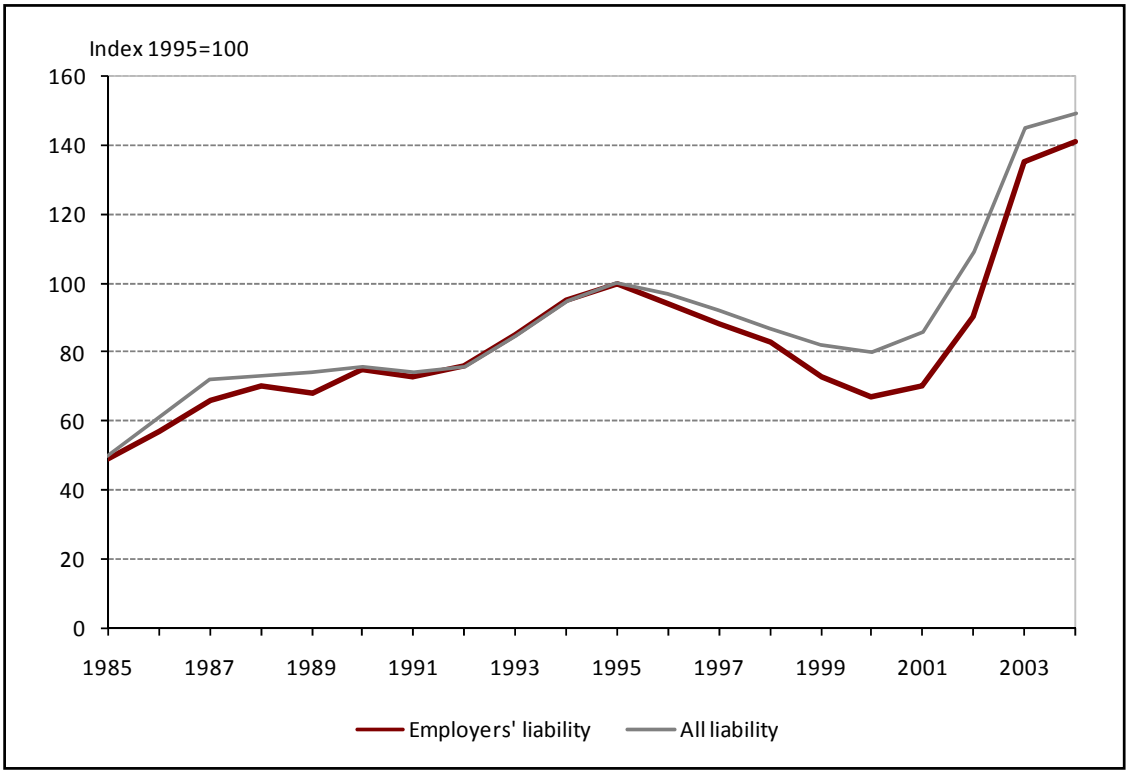
Source: DWP (2010f).

period by accident versus disease, with disease broken down further into types of disease. The split between accidents and disease is roughly equal, with only 1% more claims for accident than disease. Largest number of claims for disease are for asbestos related illness, accounting for 60% of disease claims and 30% of claims overall. The second most common illness is occupational deafness, accounting for 12% of new claims over the year.

The cost of making a civil claim against an employer is met by both the claimant (the employee) and the defendant (the employer). In personal injury cases there is no access to legal aid, which means that the government does not bear any of the cost. Both sides must meet the cost of disbursements (paying their legal representatives). Other legal costs are included in the damages awarded to the party that losses the case. Much of these costs are paid for by that party's insurance. Employees will usually take out insurance specifically to cover these costs while employers are covered by their ECLI. Although insurance companies pay for damages award if the employer is found negligent, this cost is implicitly passed on to business through insurance premiums.

Insurance premiums increased sharply from 2001 to 2003 (Chart 3.11). In 2002 alone there was a 50% increase in ELCI premiums (Office of Fair Trading, 2005). There are number of factors that are likely to have contributed to these increases. The first is an expansion in liability to include 'long tail claims'. These are claims that are made years after the event occurred, which is particularly problematic for occupational disease claims (DWP, 2003). When calculating premiums the insurance company needs to take into account the effect of yet unknown hazards in the workplace that could result in large claims a long time in the

Chart 3.11: UK Insurance premiums



Notes: The 2004 figure is an estimate.
Source: Office of Fair Trading (2005).

future — this problem is highlighted through the surge in costs as a result of asbestos related claims. The Office of Fair Trading (2005) has also suggested that increasing legal costs and damages awarded, lower investment returns and loss shocks such as September 11 will have also contributed. However, they also cite changes in the competitive environment of the insurance industry as a key factor. There has been little follow up research on the issue of rising premiums, and given many of the issues were specific to the time period, it is likely that premiums have levelled off in recent years.

A great deal of the risk in regards to compensating for workplace injury in borne by the government. It is thus in their interest to invest in injury prevention programs and create incentives for employers to provide safe workplaces. This is done is several ways. First, by legislating rules for undertaking activities that has been identified as dangerous. For example, the *Control of Asbestos Regulations 2006* introduced in 2006 banned any new use of asbestos. It also regulates the safety conditions for working with existing asbestos (HSE, 2006). As such over time should cease to be a major source of workplace disablement. However, this type of regulation is only suitable after the risks have already been made publically known, which will typically only occur once people start to experience disablement. By this time there may already be a large number of new claimants for the medium term. Second, the government has provided laws that allow the employer to be held criminally responsible if they knowingly place an employee in danger. Finally, the HSE undertakes various campaigns to encourage awareness and enforce workplace safety. They have performance targets in place in regards to reducing the number of accidents in the workplace (HSE, 2009b).

4 Policy implications for a national disability scheme

This chapter draws together findings from measuring the performance of no-fault schemes versus hybrid schemes, and the applicability of core characteristics to a national disability scheme in the Australian context, given different income support, health and aged care systems, judicial and crisis accommodation systems. Each type of scheme has been evaluated based on their strengths and weaknesses, opportunities for weaknesses to be improved, and the risks associated with implementing a national disability scheme. Issues for the Productivity Commission to consider in the process of evaluating the feasibility of a national disability insurance scheme to replace existing disability insurance schemes have been listed.

4.1 Equity

The nature of, and variations in, disability schemes within New Zealand, Victoria and the UK means there is no definitive conclusion on whether a no-fault based scheme versus a fault based scheme is the more equitable. Characteristics of both schemes lend themselves to equitable and inequitable outcomes, so including a no-fault scheme while excluding the right to the common law of tort could be seen as an inequitable outcome for some people, especially those with severe and profound disabilities. Issues for the Productivity Commission to consider in constructing an equitable national disability scheme are listed below.

- A disability insurance scheme should cover people based on their level of disability, regardless of how, or where, that disability was acquired. For example, the ACC scheme covers people that have suffered a personal injury regardless of age, employment status, where and how the injury was sustained and whether the benefit recipient contributed to the injury. Excluding people from a national disability scheme based on some personal characteristic, such as age, could be considered inequitable because it could polarise access to disability care.
- To ensure vertical equity, a disability insurance scheme should base benefits on the level of expected need for disability care and not the level of impairment. This is because the level of impairment may not serve as a good proxy for the level of disability care needed. For example, the TAC and WorkSafe schemes provide access to medical and disability services based on reasonable need for care. Basing compensation on the level of impairment may result in the disability care needs of some people not being met if their needs are greater than average.
- Excluding the option of pursuing compensation through the common law of tort will remove some inequities in a disability scheme, but introduce others. This is especially the case for those with greater than average levels of disability care needs who require compensation above those offered under statutory benefits. Thus common law should be available for those with profound or severe disabilities.
- Including the option of pursuing compensation through the common law of tort will necessitate mechanisms to be put in place that reduce, or remove, potential issues with a fault based system. These include:
  - regulating the cost associated with the judicial process through public court scales or legislated caps to provide greater access to compensation through the common law of tort;

- providing a detailed framework to calculate the need for disability care, the cost associated with that care, and the non-economic costs associated with physical and psychological disability in order to reduce variation in compensation payments.
- introducing cost schedules, or legislative provisions, designed to encourage the early resolution of claims; and
- introducing incentives and legislative provisions to ensure the person claiming takes reasonable actions to reduce their impairment prior to compensation being awarded.

4.2 Effectiveness

For a national disability insurance scheme to be effective, it needs to first aim to prevent injuries from occurring through promoting and regulating safe behaviours. Where this fails, the objective is to minimise the individual and social cost of an injury through timely and effective rehabilitation, and in the case of permanent disability, funding disability care services that meet the needs and preferences of the individual and their informal carers. Issues for the Productivity Commission to consider in constructing an effective national disability scheme are listed below.

- To be effective in reducing the frequency and severity of injuries, a national disability scheme must invest in injury prevention programs, promote legislation and industry standards that reduce risky behaviours, and promote best practice rehabilitation processes. For example, the TAC undertakes road safety campaigns, WorkSafe undertakes workplace safety campaigns and trains health and safety representatives to improve occupational health and safety, the ACC has invested heavily into road and work safety interventions and programs to reduce sporting injuries, and the Health and Safety Executive in the United Kingdom researches, review regulations, collects statistics and provides information, advice, and promotes training on workplace safety.
- The decision to adopt programs and regulations to prevent injuries should be based on a cost benefit analysis and be undertaken from the perspective of society. All economic and health related benefits and costs should be included in the analysis.
- To ensure clear signals, a national no-fault scheme should risk rate premiums to reflect the expected costs associated with injury due to risky behaviour. For example, the TAC calculate premiums based on the type of vehicle, its use, and the postcode at where the vehicle is usually kept. In the case of the workplace, if an employer imposes a high expected cost on the scheme (e.g., through increased risk of injury, poor claims management practices, or poor rehabilitation procedures), then this should be reflected through high premiums. Where an employer reduces their expected cost on the scheme (e.g., through improved safety and rehabilitation practices) this should be reflected in reduced premiums. For example, WorkSafe calculate premiums based on industry risk and five years of historical records of claims experience.
- If risk rated premiums are to introduce proper incentives, then the risks used to calculate premiums must be changeable through behaviour. For example, the TAC premiums are not based on age (excluding pensioners) or gender because these risk factors cannot be changed at an individual level. However, WorkSafe premiums are based on the industry with which the employer operates and claims experience, as both

the industry and business has the capacity to reduce risks through changing workplace behaviours.

- To avoid incentives for preventing injury and rehabilitation being dulled, cross subsidisation of alternative risk groups should be minimised. If some cross-subsidisation must occur (e.g., to ensure affordability), then it should be explicit and transparent, and accompanied by independent regulatory monitoring of premiums.
- To increase incentives for improved workplace safety, a national disability scheme should impose penalties for poor workplace safety procedures. For example, the maximum penalties for breaches of the *Occupational Health and Safety Act* 2004 in Victoria are $1,075,050 for a body corporate and $215,010 for a natural person. However, penalty rates must be based on the potential social costs from injuries, including economic and non-economic costs. This means the scheme must be able to define with some predictability the relevant standard of liability.

4.3 Appropriateness

A national disability insurance scheme that delivers appropriate care and compensation will ensure the processes used to evaluate claims, and the care delivered for rehabilitation and disability care, are based on international best practice. As part of this the care recipient should have the opportunity to be involved in all decisions regarding the care that they receive to ensure that it most meets their needs. Issues for the Productivity Commission to consider in constructing an effective national disability scheme are listed below.

- All clients should have the option to receive care through a consumer-directed care model (personal budget and direct payment schemes) allowing them to be involved in:
  - choosing service providers (as in TAC, WorkSafe, ACC and the UK schemes);
  - determining any specific training that may be required for workers delivering services;
  - managing delivery problems with providers; and
  - choosing the services that meet their preferences regardless of what those preferences might be.

  For example, the ACC and UK disability insurance schemes offer direct payments rather than allocate services. This provides the greatest amount of flexibility in choice of amount and type of health, rehabilitation and disability care services.
- There should be an option to relinquish responsibility for choosing appropriate care to a designated case manager who organises care based on an internationally accepted standard for the disability and living arrangements of the person. For example, the UK model of consumer-directed care allows people to access disability care services through a direct cash payment, or a personal budget where responsibility for purchasing services is delegated to a local authority.
- Support needs to be provided to informal carers to reduce the personal and financial cost associated with providing ongoing assistance to a person with a disability. This includes:
  - accurate information on the person's condition, caring needs, disability care services available that can best meet needs, and support services available for the carer;

- assistance in life long care planning so the person with a disability and their carer can plan for the future once the carer dies. This is particularly important for older carers looking after children;
- provision of flexible, accessible respite care services over short and long periods; and
- appropriate income support for carers required to reduce their hours of work to care for a person with a disability.

- A scheme will need to deliver access to an experienced intermediary who provides assistance and advice in choosing appropriate care services, locating providers and budgeting for the costs of care. For example, in the UK a local authority undertakes an assessment of care needs and the care recipient is able to provide input into their care plan on what types of services are preferred.

4.4 Responsiveness

A responsive national disability insurance scheme will ensure disability care is client oriented, such that care is responsive to client expectations and preferences, is delivered in a timely manner, and clients are satisfied with the amount and type of care received.

Although the disability schemes under investigation within this report offer insight into achieving a responsive disability insurance scheme, there is a risk that moving to a national disability insurance scheme may increase national uniformity at the expense of responsiveness to jurisdictional and local needs. For example, if agreement from jurisdictional governments was required to make changes to the national disability scheme, the scope for regulatory innovation is likely to be reduced. Issues for the Productivity Commission to consider in constructing a responsive national disability scheme are listed below.

- A national no-fault disability insurance scheme should establish targets for timeliness of claim processing, including:
  - decision on whether to accept a claim;
  - time until first compensation payment is made;
  - time taken for medical payments to be reimbursed; and
  - time taken for private providers of health and disability care services to be paid.

  For example, the TAC aims to make a decision on a claim 21 days after initially receiving the claim, and make income payments within 28 days. WorkSafe also monitors timeliness of payments and aims to deliver weekly payments within seven days of accepting a claim, pay medical reimbursements within 10 days, and pay network providers for services delivered within 30 days.

- Other key performance indicators should be developed and data collected to measure responsiveness. A good proxy for responsiveness is client satisfaction. Consequently, a client satisfaction survey should be undertaken each year that measures some of the dimensions of responsiveness, such as autonomy, communication, confidentiality, timeliness, access to social support, quality of services received and choice. The results should be made public. For example, WorkSafe monitors the operation of its scheme against a five year corporate plan, and has constructed a client service index that measures client satisfaction across five service indicators, including:
  - employer satisfaction with inspectorate;

  - health and safety representative satisfaction with inspectorate;
  - employer satisfaction with advice and guidance material;
  - injured worker satisfaction with agents; and
  - employer satisfaction with agents.

- A reasonableness test should be used to determine the amount and type of health, rehabilitation and disability care services made available. For example, the TAC and WorkSafe undertake a reasonableness test that considers whether there is clinical justification, the service is likely to be effective, the service provides independence to the person with a disability, and the treatment is based on evidence and is endorsed by professional bodies
- Lump sum payments should be allowed for non-economic cost compensation and lost income, however access to government income support should be withdrawn for the period the lump sum is intended to cover. For example, the Commonwealth Government currently has mechanisms in place to determine a preclusion period for people who receive lump sum compensation payments for economic loss. This is to reduce the possibility of double dipping.
- Access to health, rehabilitation and disability care through statutory benefits should still be allowed for those people who receive statutory and common law lump sum payments for non medical expenses. For example, under the TAC and WorkSafe schemes a person retains the right to statutory benefits for health, rehabilitation and disability care after settlement of common law. However, lump sum payments for health, rehabilitation and disability care services costs should only be allowed where mechanisms have been put in place to stop cost shifting onto the government.
- All claim rejections should be accompanied by a detailed written explanation on why the claim was rejected and the information used to establish the decision. Written explanation on the right to dispute, and information on how to initiate the dispute resolution process should also be provided.
- Administration of the scheme should include dispute resolution mechanisms that allow disputes to be settled as quickly as possible while maintaining equity. It should include:
  - initial case review by review officers who have had no previous involvement with the decision; and
  - the option of having the case reviewed by an independent external party.

  For example, once an internal review has been made, disputes over the TAC's decisions can be reviewed by the Victorian Civil and Administrative Tribunal (VCAT), while WorkSafe disputes are reviewed by the Accident Compensation Conciliation Service (ACCS) before the dispute is allowed to proceed to court.
- Legal and other representatives should be allowed within all stages of the external review process in order to balance the initial asymmetry of power. However, incentives should be used to avoid delayed resolution.

4.5 Sustainability

A sustainable disability insurance scheme will depend on the capacity to match expected costs with revenue. This in turn depends on the capacity to manage expenditure risk, such as the prevention of injuries to, the cost of delivering health, rehabilitation and disability care

services, and the volatility associated with asset markets. Issues for the Productivity Commission to consider in constructing a sustainable national disability scheme are listed below.

- A board should be appointed based on their expertise and skills in managing large insurance funds. They must be independent of Commonwealth and jurisdictional governments, and have the ability to appoint advisory bodies. However, their accountability must be with the Commonwealth Government.
- In order to ensure transparency in managing a national disability insurance scheme, it should contain several portfolios that have been established based on the source of injury. For example, the ACC scheme has six accounts that are independently funded, including the employers' account, earners' account, self-employed work account, non-earners account, motor vehicle account, medical account, and residual claims account.
- Operate portfolios independently, including setting revenue targets, investment in injury prevention programs, and managing risk pools. Cross-subsidisation of accounts should be avoided.
- A national disability scheme should use a sustainable framework that includes:
  - investing in cost effective injury prevention programs through community awareness campaigns, research and consultation, using a client segmentation approach;
  - using early intervention programs, case managers and rehabilitation coordinators to reduce time taken for rehabilitation;
  - implementing a network providers approach to the delivery of services along with a procurement policy that ensures efficient service delivery. This would enable better management of rising medical costs due demographic ageing, international shortage of skilled personnel, new technology, higher cost treatment options, and risk averse practices;
  - operating a claims management system to contain expenditure and liabilities, that monitors potential over-servicing by providers and has disciplined case follow-up;
  - a prospective and retrospective evaluation such as return on investment analysis should ideally be undertaken for all investments so that the returns are identified appropriately, and not simply treated as cost 'blowouts';
  - setting revenue generating mechanisms on a fully funded basis that instil proper incentives to reduce prevent injuries, reduce risky behaviour, promote rehabilitation, and to offer appropriate and responsive care; and
  - ensuring the scheme has a standardised ratio of assets to net outstanding claim liabilities of between 100% and 110%.
- A scheme should use incentives to encourage injured persons to participate in rehabilitation, including:
  - benefit step-downs, where benefits start at a relatively high level and then taper off to a minimum support level as the injured person becomes more capable of returning to work; and
  - benefit caps that are commensurate with care needs.
- A portfolio investment strategy should be adopted that appropriately matches long term liabilities with expected investment returns using domestic and international debt, inflation linked products, and equities. The strategy should be implemented by an

independent body that reports to the Commonwealth Department of Treasury and the Commonwealth Department of Finance.

- The performance of the scheme should be measured using a performance measurement framework and quantifiable performance indicators that measure scheme inputs (e.g., medical and administration costs), outputs (e.g., the number of claims per 1,000 people), and outcomes (e.g., the average time to rehabilitation). Underlying causes of major risks to injury and expenditure should also be monitored.

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